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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

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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

1 and there's others that are unverified --

2 MS. LOVE: Oh, okay.

3 MS. ROMERO: -- that were on there.

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

6 MS. ROMERO: She is online.

7 MS. LOVE: Okay, perfect.

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

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

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

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

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

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

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

25 DR. RITCHIE: Okay. Second?

1 MR. VARGAS: Second.

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

6 MR. AUTIO: Move to approve.

7 MR. VARGAS: I'll second it.

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

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

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

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

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

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

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

1 facilities.

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

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

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

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

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

25 So we don't have these rates, for lack

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

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

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

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

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

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

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

13 MR. AUTIO: For surgery centers?

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

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

24 MS. LUERA: No.

25 MR. AUTIO: No. Does not absolutely.

1 MS. LUERA: No, it does not.

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

5 MS. LUERA: It's an estimate.

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

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

10 MR. AUTIO: Right.

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

12 MR. AUTIO: Data.

13 MS. LUERA: Yeah.

14 DR. RITCHIE: Mr. Clark?

15 MR. CLARK: Thank you, Mr. Chair. This
16 is Troy Clark for the record. So is it fair to say
17 that if -- if what we're saying is 41.03 per a hundred
18 visits on the surgery center line -- I'm sorry --
19 152.25, wrong line -- if we divide that by 1.056239
20 percent -- if I can do that right.

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

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

24 MS. LUERA: It would have been last
25 year.

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

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

11 MR. CLARK: Yep.

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

14 DR. RITCHIE: What did they actually
15 pay?

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

19 DR. RITCHIE: Plus the deficit
20 repayment?

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

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

6 MS. LUERA: For losses?

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

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

17 MR. CLARK: Excellent.

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

20 MS. LUERA: Yes.

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

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

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

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

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

1 20,000 or 10,000. I did 5,000. There's some material
2 to check?

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

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

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

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

22 MR. CLARK: Yeah.

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

25 MR. CLARK: Whether it's an audit or

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

2 DR. RITCHIE: Yeah. They certify.

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

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

9 DR. RITCHIE: Well --

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

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

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

23 MS. LUERA: Okay.

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

1 become more and more accurate.

2 MR. CLARK: Yeah.

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

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

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

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

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

1 accurate their estimates are.

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

11 And the next year when you reported
12 2024, that set your premium for 2025. So your volume
13 was, in essence, in arrears. But they also adjusted
14 for that when they would account for your deficit, as
15 the terminology we would use, that you'd get a higher
16 rate to catch it up if for some reason you
17 underestimated in the previous. So it caught up.

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

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

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

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

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

14 MS. LUERA: Sure.

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

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

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

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

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

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

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

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

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

25 DR. RITCHIE: Well, do we have the data

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

3 MS. LUERA: Yes.

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

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

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

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

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

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

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

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

1 apply those rates times the submitted volumes by the
2 applicants.

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

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

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

17 DR. RITCHIE: Right. And the inflation
18 factor.

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

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

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

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

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

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

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

23 MS. LOVE: Never happens.

24 MR. AUTIO: And it also begs --

25 MS. LOVE: It will -- it never happens

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

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

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

14 I agree more with this, that the
15 increase factor should not just be whatever CPI was.
16 That makes sense. But I'm still confused about the
17 5.6, to Kathy's point.

18 MS. LOVE: For outpatient healthcare
19 facilities?

20 MR. AUTIO: For outpatient healthcare.
21 Yeah.

22 MS. LOVE: Right.

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

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

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

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

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

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

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

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

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

17 So I know that he based it on the
18 500,000 excess of 5,000, and then applied the 5.62.
19 That's about as much as I want to say about -- or can
20 say about how he calculated the numbers. But -- and
21 he's our expert, so.

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

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

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

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

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

15 DR. RITCHIE: Right.

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

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

20 MS. LUERA: That's the --

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

23 MS. LUERA: That's the best.

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

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

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

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

12 DR. RITCHIE: Based on volume.

13 MS. LOVE: Okay.

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

16 DR. RITCHIE: Okay.

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

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

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

5 MS. LOVE: Yes.

6 MR. CLARK: Yeah. That is what --

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

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

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

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

23 MR. MARTINEZ: Excellent. Thank you.

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

1 it, Troy?

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

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

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

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

16 MS. LOVE: And I have a question.

17 DR. RITCHIE: Yes.

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

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

25 MS. LOVE: Okay.

1 DR. RITCHIE: Okay. Great. Good
2 question.

3 MS. LOVE: Thanks.

4 DR. RITCHIE: Okay.

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

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

13 MS. LUERA: Yes.

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

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

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

4 DR. RITCHIE: True.

5 MR. CLARK: And we've seen that on the
6 hospital side. Right. We thought they were way
7 overpaid and way -- or way underfunded and then way
8 overfunded, and dollars moving back and forth. And
9 there's a lot more of them. A lot more dollars than
10 \$60,000. So I think there needs to be an additional
11 comment about the variability -- the variability of
12 the rates moving forward.

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

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

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

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

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

10 MS. LOVE: So -- so --

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

15 MS. LOVE: Is that -- go ahead.

16 DR. RITCHIE: Mr. Vargas?

17 MS. LOVE: Yeah, please.

18 DR. RITCHIE: Mr. Vargas?

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

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

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

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

16 MR. AUTIO: Well, I --

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

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

21 MS. LOVE: You would have that.

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

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

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

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

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

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

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

1 and so it's not their initial application year?

2 DR. RITCHIE: Probably so.

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

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

9 MS. LOVE: Ah.

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

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

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

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

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

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

8 DR. RITCHIE: Yeah, Mike.

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

12 DR. RITCHIE: Yes. Go ahead.

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

19 MS. LUERA: By the actuary, yes.

20 But --

21 MR. DEKLEVA: Because --

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

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

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

9 MR. DEKLEVA: Okay. Thank you.

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

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

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

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

1 good or bad, so --

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

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

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

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

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

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

25 DR. RITCHIE: Is there any discussion

1 from anyone online?

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

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

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

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

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

25 DR. RITCHIE: Yeah, please.

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

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

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

10 MR. CLARK: There we go.

11 DR. RITCHIE: No batch provision down
12 here below.

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

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

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

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

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

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

1 DR. RITCHIE: Yes, Ms. Love.

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

7 This total that you've recommended of
8 19.7 in your motion based on Mr. Walling's
9 recommendation is basically the deficit surcharge
10 minus his negative indicated assessment for future
11 claims for next year; right?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So we're already in a condition of the

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

8 You know, not taking a big dip now and
9 a recovery in years three, four, and five when there
10 wouldn't be a 3.5. That's why the deficit number of
11 26.8 percent is there, which really amounts to about
12 half of what is outstanding on the deficit. So it's
13 paid off this year and the following year.

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

16 MS. LOVE: I know. I know.

17 DR. RITCHIE: Can he walk and chew gum?
18 Mr. Martinez, did you have a comment?

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

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

1 recommendations. So is there a second on that
2 recommendation?

3 MR. AUTIO: I'll second.

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

6 DR. RITCHIE: Yes.

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

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

12 MR. MARTINEZ: Okay.

13 DR. RITCHIE: I'm sorry. It's Exhibit
14 6, page 1, revised note. You're right. The hospital.
15 Sorry.

16 MR. MARTINEZ: So Exhibit 6, page 1, I
17 have without the risk margin that's 50 to 65 or 55 to
18 65; 23.4 recommendation.

19 DR. RITCHIE: That's the old order.

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

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

1 MS. LOVE: Okay.

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

4 MR. MARTINEZ: Correct.

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

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

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

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

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

15 MR. MARTINEZ: Okay.

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

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

25 DR. RITCHIE: Okay. Is there any

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

2 MS. ROMERO: Dr. Richie?

3 DR. RITCHIE: Agree.

4 MS. ROMERO: Vice Chair Love?

5 MS. LOVE: No objection.

6 MS. ROMERO: Mr. Clark?

7 MR. CLARK: Yes.

8 MS. ROMERO: Mr. Autio?

9 MR. AUTIO: Yes.

10 MS. ROMERO: Mr. Dekleva?

11 MR. DEKLEVA: Agree.

12 MS. ROMERO: Mr. Martinez?

13 MR. MARTINEZ: Yes.

14 MS. ROMERO: Ms. Stevens?

15 MS. STEVENS: Yes.

16 MS. ROMERO: Mr. Vargas?

17 MR. VARGAS: Yes.

18 MS. ROMERO: Ms. Starace?

19 MS. STARACE: Yes.

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

22 MR. AUTIO: Well, should we do
23 physicians?

24 DR. RITCHIE: Yes.

25 MR. AUTIO: Okay.

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

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

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

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

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

25 MR. AUTIO: Yes.

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

3 DR. RITCHIE: Thank you.

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

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

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

13 MR. AUTIO: Yes. It would include
14 those.

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

17 DR. RITCHIE: Otherwise that does
18 change that number.

19 MR. CLARK: Correct.

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

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

25 DR. RITCHIE: Class plans, yes.

1 MS. LUERA: Page 21 of 85.

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

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

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

16 MR. AUTIO: No objection to that
17 amendment.

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

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

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

1 acclamation and not do a full vote. Okay.

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

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

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

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

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

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

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

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

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

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

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

1 Mr. Autio?

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

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

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

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

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

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

25 Is there any discussion of that? Any

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

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

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

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

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

1 member of that subcommittee?

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

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

4 Yeah.

5 MR. AUTIO: Sorry.

6 DR. RITCHIE: Is that Mr. Vargas?

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

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

11 DR. RITCHIE: I believe that is
12 experienced people.

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

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

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

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

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

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

5 MR. VARGAS: My pleasure.

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

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

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

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

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

1 or something along those lines.

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

6 MS. LUERA: Yes.

7 MR. AUTIO: Okay.

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

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

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

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

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

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

1 not?

2 MS. LUERA: I don't think so.

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

7 MS. LUERA: So --

8 DR. RITCHIE: Or just publishes it on
9 31 October.

10 MS. LUERA: Yes. She --

11 DR. RITCHIE: Publishes it on 31
12 October.

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

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

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

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

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

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

4 MR. AUTIO: I think with the simplicity
5 of the

6 MS. LOVE: I agree. I --

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

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

10 DR. RITCHIE: Yeah.

11 MS. LOVE: Yeah.

12 DR. RITCHIE: So I don't --

13 MS. LOVE: For the first time ever.

14 Yeah.

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

17 MS. LOVE: Yeah.

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

25 So a Tuesday afternoon, the 15th,

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

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

4 DR. RITCHIE: Friday the 11th.

5 MR. VARGAS: This is Ray Vargas.

6 MR. CLARK: I prefer Friday the 11th.

7 DR. RITCHIE: Okay.

8 MR. AUTIO: That works for me also.

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

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

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

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

22 MS. LOVE: I set it for an hour.

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

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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.

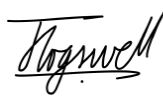
So then we will adjourn this meeting and meet again on that date in October. Thank you everyone for contributing and coming.

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

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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

DIANA ROBERSON

[1 - ability]

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[recommend - risk]

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[ritchie - sorry]

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[sorry - territory]

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[testifying - upcoming]

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