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BEFORE THE NEW MEXICO SUPERINTENDENT OF INSURANCE  
AS CUSTODIAN OF THE PATIENT'S COMPENSATION FUND  
  
IN THE MATTER OF DETERMINING  
PATIENT'S COMPENSATION FUND  
SURCHARGE RATES FOR CALENDAR  
YEAR 2025

REPORTER'S TRANSCRIPT OF PROCEEDINGS

THURSDAY SEPTEMBER 5, 2024

1:04 P.M. (Mountain Time)

VIA MICROSOFT TEAMS VIDEOCONFERENCING PLATFORM

This matter came on for hearing before the Patient's  
Compensation Fund Board, on Thursday, September 5,  
2024, via Microsoft Teams Virtual Conferencing  
Platform, hosted by the State of New Mexico, Office  
of the Superintendent of Insurance

PATIENT COMPENSATION BOARD:

- WILLIAM RITCHIE           BOARD CHAIR   (NM Medical Society)
- KATHY LOVE               BOARD MEMBER (NMTLA)
- TROY CLARK               BOARD MEMBER (Hospital representative)
- NICHOLAS AUTIO           BOARD MEMBER (NM Medical Society)
- RAY VARGAS, II           BOARD MEMBER (NMTLA)
- MICHAEL DEKLEVA         BOARD MEMBER (Hospital representative)
- CARMELA STARACE         BOARD MEMBER (Patient Advocate)
- ELLEN STEVENS           BOARD MEMBER (Patient Advocate)

- BARRY BERENBERG         COUNSEL FOR OSI
- VINCENT WARD             COUNSEL FOR PCF BOARD
- Reported By:             Mary Therese Macfarlane, CCR

1 ALSO PRESENT:  
2 ALICE D. KANE OSI  
JENNIFER ROMERO OSI  
3 CHRIS MYERS OSI  
MELISSA ROBERTSON OSI  
4 TIM VIGIL OSI  
PLACIDO GONZALEZ OSI  
5 COLIN BAILLIE OSI  
DEBBIE LUERA: Integrion Group  
6 CHRIS DeWALD: Integrion gROUP

7  
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1 CHAIRMAN RITCHIE: Good afternoon.

2 I'm Dr. William Ritchie. I'm the Advisory Board  
3 Chair. We are now on the record in OSI Docket No.  
4 2024-0005, titled In The Matter of Determining Patient's  
5 Compensation Funds Surcharge Rates for Calendar Year 2025.

6 Today is September 5, 2024. The time is 1:04.

7 We are physically located at 1120 Paseo Del  
8 Peralta, the Fourth Floor Hearing Room, Santa Fe, New  
9 Mexico.

10 This hearing is also being conducted via Teams  
11 Videoconference and by telephone, as noticed in the Order  
12 Scheduling Hearing to Determine Patients Compensation  
13 Fund's Surcharge Rates filed into the OSI e-docket on  
14 March 6, 2024. Because the hearing is being conducted by  
15 videoconference and by telephone, I ask all those  
16 participants on the videoconference or telephone to mute  
17 your microphone or telephone until called upon. This will  
18 ensure that the court reporter can make a clean record and  
19 that all participant can hear the proceedings.

20 If you are attending via videoconference or  
21 telephone, I will ask anyone that is not identified by me  
22 to please identify yourself by your full name and the  
23 organization you represent, so we may, again, have a  
24 complete record of attendance for this hearing. You may  
25 do so by updating your name in the main meeting or typing

1 your name in the chat function.

2 I also ask that all members or presenters please  
3 speak towards the microphone so we all hear you, and most  
4 importantly so the court reporter may hear you.

5 Before you give your comment please state your  
6 name for the record.

7 There may be times when I or the court reporter  
8 will ask you to slow down or repeat something so that we  
9 may make a correct and complete record of today's hearing.  
10 Thank you for patience, and let's begin.

11 So, then, really, Mr. Ward, if you can fill us  
12 in on the proper technique we have used in the past for  
13 the entire committee to serve as hearing officer.

14 MR. WARD: Well, I believe that the appointment  
15 order, that's been done, so with the board acting as the  
16 hearing officer I think the next order of business, if I  
17 understand you correctly, would be to turn it over to Mr.  
18 Berenberg for the presentation.

19 CHAIRMAN RITCHIE: That sounds like what we've  
20 done in the past. Just making sure we're still in the  
21 right.

22 So, please, Mr. Berenberg, the floor is yours.

23 MR. BERENBERG: Thank you. I'm Barry Berenberg.  
24 I'm counsel for the Superintendent of Insurance in her  
25 role as the custodian of the Patient Compensation Fund. I

1 provide those services under Integrion's contract with  
2 OSI, the Office of the Superintendent of Insurance, as a  
3 third-party administrator for the PCF.

4 I will be examining Mr. Robert Walling, who is  
5 the actuary from Pinnacle Resources, and we will get more  
6 details about that. This will proceed pretty much as it  
7 has in the previous two years that I've done this, and the  
8 purpose of this is for me to examine Mr. Walling today to  
9 establish the evidentiary foundation for the rate  
10 recommendation.

11 What we've done before is: I have several sort  
12 of top-level topics, and what we found has worked best is  
13 let me get through the whole topic, I'll then say when  
14 I've finished the topic, and then that's the best time to  
15 answer questions rather than interrupting the flow.

16 So I'll make that announcement when we're making  
17 the transition.

18 So I'm ready to get into Mr. Walling's  
19 background, if there's any questions before that.

20 (Note: No audible response.)

21 I'm going to share my screen. Hopefully this  
22 will work. We tested it.

23 And does everybody see the resume or CV for  
24 Robert Walling?

25 (Note: Multiple affirmative responses.)



1 My report as of August 1st summarizing the  
2 results of our analysis of the PCF, based on data as of  
3 year end 2023.

4 Q. And this has a draft watermark on it, but it's  
5 my understanding that this actually is the final report.  
6 Is that correct?

7 A. There have been no changes, and I can certainly  
8 send you a final with the draft watermark removed.

9 Q. What was your role in preparation of this  
10 report?

11 A. I'm the account executive and the appointed  
12 actuary for this report, so I oversee all of the work of  
13 my project manager, who is also a credentialed actuary,  
14 and our actuarial analysts that support us in the  
15 analysis.

16 Q. All right. I'm skipping ahead to page 8 of the  
17 report, which is page 11 in the .pdf, and there are four  
18 bullet points here. Are these the specific tasks that you  
19 conducted under this report?

20 A. Uhm, yes. It's worth noting that the first two  
21 bullets are further subdivided between qualified providers  
22 and the hospitals.

23 Q. And did you perform the work for these items?

24 A. Yes.

25 Q. And does your training and experience enable you



1 to do each of those items to perform that work?

2 A. It does. I meet the qualification standards of  
3 the Casualty Actuarial Society to perform these services.

4 MR. BERENBERG: I'd move to offer Mr. Walling as  
5 a qualified actuarial expert on the subject of the report  
6 and to offer expert testimony concerning those subjects.

7 Are there any objections?

8 CHAIRMAN RITCHIE: I see none.

9 MR. BERENBERG: Okay. I will then move to admit  
10 the exhibit. I'm sorry, admit the report as Exhibit B.

11 MR. WARD: Dr. Ritchie, you should just for the  
12 record indicate acceptance of those exhibits so there's no  
13 confusion.

14 CHAIRMAN RITCHIE: Okay. Is there any  
15 discussion or objections from the board on these exhibits?  
16 (Note: Pause.)

17 Hearing none, then there's no objections to them  
18 being admitted.

19 MR. WARD: Okay.

20 Q. (MR. BERENBERG) So in the past what we've done  
21 is we've looked at this first, which is to estimate the  
22 ultimate liabilities or losses incurred by the PCF.

23 How does that relate to loss reserves?

24 A. The terminology is, candidly, interchangeable.  
25 The process of estimating the ultimate liabilities on the

1 balance sheet of the PCF are fundamentally the process of  
2 estimating the unpaid claims liabilities for claims that  
3 have already occurred but haven't been paid by the PCF at  
4 this time.

5 Q. And this is divided into two categories?  
6 There's physicians, and then there's the hospitals and  
7 employed physicians. Is that correct?

8 A. That is correct.

9 MR. BERENBERG: So let's move on to Indicated  
10 Loss Reserves for Physicians.

11 I'm going to ask you to go to page 30 -- 36,  
12 sorry, of the .pdf. It's labeled as Exhibit 1, page 4.

13 MS. LOVE: Excuse me. This is Kathy Love.

14 Mr. Chairman, I have a point of clarification.  
15 I'm wondering if, as we go forward, it would be useful for  
16 the board, and as well as Integrion, to start referring  
17 to, instead of "the physicians" the "independent  
18 providers" versus the hospitals and the employed  
19 physicians just for clarity, because now we have a number  
20 of providers who are qualified healthcare providers who  
21 are not actually physicians.

22 CHAIRMAN RITCHIE: Well, I would prefer  
23 independent practitioners, since hospitals are also  
24 considered providers in nomenclature for certain  
25 insurances, et cetera. So I think practitioners perhaps

1 is a better term.

2 MS. LOVE: No problem. And If you don't want to  
3 make that change for this report, I would just suggest  
4 that going forward we try to make that adjustment.

5 Mr. Walling, that may be -- I don't expect you  
6 to change that nomenclature today, because I know you're  
7 prepared under this report, but maybe for future meetings  
8 we can make that adjustment.

9 THE WITNESS: Sure. We've always been sensitive  
10 to the fact that there are allied (phonetic) health  
11 professionals in the program, and the independent  
12 physicians and surgeons has always been shorthand. But  
13 I'm happy to shift to "practitioners" if that's the  
14 nomenclature that this group would prefer.

15 MR. BERENBERG: And I will try to remember to  
16 use the term practitioners.

17 Q. Mr. Walling, you asked me to go to page 36 of  
18 this .pdf, which is Exhibit 1, page 4. And what does this  
19 page show?

20 A. So this page provides a summary of our analysis  
21 using the data as of 12-31-2023 versus the analysis we  
22 performed as of year end 2022.

23 And so you'll see the '23 data on the far left,  
24 the '22 data in the middle, and then the difference  
25 showing over on the right-hand half of the exhibit.

1           This is important, in the sense that you can see  
2 on the right-hand side that these incremental paid losses  
3 related to independent practitioners during the 2023  
4 calendar year amounted to \$12.5 million. That \$12.5  
5 million, if you compare it to some of the historical paid  
6 losses or some of the historical ultimates, is a little  
7 better than the long-term averages for the ultimates.

8           You'll see that our estimated ultimates, uhm,  
9 for the older years came down in the difference column  
10 that's labeled New Mexico PCF ultimate Losses, but we did  
11 see some increases, for example in the 2018 accident year,  
12 and also in accident years '21 and '22.

13           The summary exhibit has behind it a lot of  
14 workpapers that are in the appendices of the report.

15           We did see some, like I said, some favorable  
16 paid claims experience. Leaning against that, and we  
17 talked about this on a prior board call, there are some  
18 increases in the number of closed claims and some  
19 increases in the estimated number of ultimate claims that  
20 are maybe pushing against us a little bit, but by and  
21 large what you see here is that the reserves increased on  
22 an undiscounted basis from \$71.6 million in the middle of  
23 the table at the bottom -- or, actually, just look at the  
24 extra insert table down at the very bottom. We added in a  
25 new accident year that has ultimates of around 19.9

1 million. We subtracted out \$12.5 million in Paid, and so  
2 our estimate of the Undiscounted Reserves for the  
3 Independent Practitioners has increased to \$78.6 million  
4 for, again, the Independent Practitioners.

5 Q. I'm going to skip ahead two pages to Exhibit 2.  
6 Can you walk us through this exhibit?

7 A. Sure. So this is where we actually make that  
8 selection to develop that \$78 million reserve estimate.  
9 What you will see in the middle of the page in Columns 4,  
10 5, 6 and 7, are four distinct actuarial methodologies for  
11 estimating ultimate losses and expected loss ratio, which  
12 is based on the historical surcharges collected; a paid  
13 development method that is based on historical claims  
14 payment and extrapolated then to an ultimate settlement  
15 basis; a frequency and severity method that assumes that  
16 you can estimate the number of closed claim accounts with  
17 payments and an estimated severity per claim, as a means  
18 of estimating the ultimate; and the B-F method in Column 4  
19 is essentially a weighted average of the expected loss  
20 ratio method and the paid method where, uhm, more weight  
21 is given to the paid method the more mature the claims  
22 experience is.

23 So you see in the 2000 year in the very top row  
24 the B-F method is identical to the paid method, whereas in  
25 the 2023 year the B-F method is identical to the expected

1 loss ratio method. And the weight given to those two  
2 methods is derived, the B-F method vary based on the  
3 expected percent of ultimates paid in each of the years.

4 Over on the right-hand side you get some  
5 information about how the ultimate loss ratio, or ultimate  
6 loss estimates compare to the actual collected surcharges.

7 You will see that it's a bit cyclical, so for a  
8 year like 2015 the claims experience was far better than  
9 the collected surcharges, whereas our estimates for 2018  
10 are that the ultimate loss payments for that accident year  
11 are going to be more than 185 percent of the collected  
12 surcharges for that year.

13 Q. Looking at Column 8, you have a selected  
14 ultimate loss of \$305.7 million for the independent  
15 practitioners. Is that correct?

16 A. That's correct.

17 Q. And what does that tell us about expected future  
18 payments?

19 A. Basically if you subtract the paid losses to  
20 date in Column 3 from that \$305 million, so subtract the  
21 227 million in Column 3 from the 305 million in Column 8,  
22 what's left is unpaid. So if we just take those ultimate  
23 losses and break them into their paid and unpaid  
24 component, so remaining unpaid claims liability associated  
25 with the independent practitioners is that \$78 million and

1 change.

2 Q. What is the overall estimated loss ratio for the  
3 independent practitioners across all years?

4 A. Across all years it's 121.5 percent of  
5 practitioner surcharges.

6 Q. And what does the loss ratio mean?

7 A. It's one metric that the insurance industry uses  
8 to measure the underwriting performance of an insurance  
9 program.

10 Q. And is there anything else that you wanted to  
11 cover on these exhibits for the independent loss reserves?

12 A. Uhm, if you scroll up to Exhibit 1 -- sorry,  
13 Exhibit -- uhm, the Fund Summary, page 1. Sorry. Page 30  
14 of the .pdf. There we go.

15 What you will see up here in the very top row,  
16 again is a summary of a number of balance sheet items for  
17 the independent practitioners. You'll see again that 78.6  
18 million of ultimate reserves or ultimate loss liabilities.  
19 You'll see right next to that that same number on a  
20 discounted basis.

21 In Column 3 you'll that see that number  
22 increased to a 75 percent level of statistical likelihood.

23 You'll see that the allocated portion of the  
24 fund balance for the independent practitioners is about  
25 \$60 million, which results in the indicated deficits for

1 the practitioners in Columns 5, 6 and 7.

2 Those numbers are prior to the 2024 legislative  
3 infusion, and so you'll you will see after that infusion,  
4 if we're just looking at the independent practitioners  
5 silo of the Patient Compensation Fund, there's actually an  
6 indicated surplus position that varies between about  
7 \$12.3 million on a discounted basis, about 18 and 1/2  
8 million dollars on a discounted basis without the higher  
9 level of statistical confidence.

10 But that's it.

11 MR. BERENBERG: That's the end of the indicated  
12 loss reserves for practitioners topic, so if there's any  
13 questions for Mr. Walling, this would be the time for it.

14 MS. LOVE: This is Kathy Love. I have a  
15 question.

16 Q. (MS. LOVE) Mr. Walling, am I understanding  
17 correctly in lay person's terms that after those recent  
18 legislative infusion of funds into the Patient  
19 Compensation Fund, the independent practitioners deficit  
20 is completely paid off?

21 A. Based on the currently available information  
22 yes. I think that's a fair interpretation.

23 Q. And in fact there is a surplus of, depending  
24 under what basis you evaluated it, between 12 million and  
25 18 million?



1           A.     Uhm, I think that's fair. I guess I would, just  
2 for the benefit of the group, make it clear that a  
3 traditional insurance company has exactly that kind of  
4 surplus available. And that surplus serves a number of  
5 purposes. It can deal with adverse claims development, it  
6 can deal with -- it's intended to be protection for the  
7 solvency of the insurance company.

8           And so having a positive surplus position,  
9 candidly, is desirable for a PCF, just like it would be  
10 for an insurance company.

11           MS. LOVE: Thank you.

12           MR. BERENBERG: Are there any other questions to  
13 this topic?

14           (Note: No audible response.)

15           MR. BERENBERG: Okay. Then we'll move on to the  
16 Indicated Loss Reserves for Hospitals and Employee  
17 Practitioners.

18           Q.     So, Mr. Walling, you performed a similar  
19 analysis for hospitals, uhm, other healthcare facilities,  
20 their employee practitioners; is that correct?

21           A.     I did.

22           Q.     So I have next to look at page 44, which is  
23 Exhibit 5. Is that what you would like to go to? I'll  
24 try bring it up so that you can see it.

25           A.     That is perfect. Yeah, this is great.

1 Q. So you'll see that for the hospitals and other  
2 healthcare facilities it's a similar exhibit to the one we  
3 just looked at, selecting the ultimate losses based on a  
4 number of methods.

5 You will notice that we don't do a frequency and  
6 severity method for the hospitals, but the other three  
7 methods remain the same.

8 You will also notice in Column 2 that the  
9 hospital surcharges in those early days for the hospitals  
10 receiving coverage were much, much smaller. There were a  
11 limited number of facilities, and it really wasn't until  
12 2017 that we saw a large number of the facilities come in.

13 So you could almost draw a line between 2016 and  
14 prior accident years versus and subsequent, because  
15 there's materially different exposure in those years.

16 You'll also see that the claims experience in  
17 that loss ratio for some of those early years was pretty  
18 high. You'll see in particular the 2014 and '15 years you  
19 had loss ratios of 316 percent of surcharges and 259  
20 percent of surcharges in those two years.

21 Uhm, on the other hand, the experience since  
22 then has been, I guess I'll describe it as a little bit  
23 more stable and a little bit more well-behaved. There's  
24 still a lot of uncertainty here. You'll notice that for,  
25 say, accident year '21 that there's only been \$2.2 million

1 worth of paid claims to date, and yet based on historical  
2 PCF payment activity we're assuming that's going to end up  
3 being something on the order of 40, \$41 million over in  
4 Column 7.

5 So there's a lot of leverage that still remains,  
6 a lot of additional claims settlement activity that needs  
7 to happen before we are going to have the kind of  
8 certainty on the more recent years that we have for some  
9 of those older years.

10 You will note that even in 2018 we're still  
11 indicating about \$13 million in additional unpaid claims  
12 even on a year that's, uhm, what -- what year is it? It's  
13 already six years old.

14 So the nature of these claims, being medical  
15 professional liability in an access layer on an occurrence  
16 form simply take some time to develop.

17 Q. So according to Column 7 you've got the  
18 estimated ultimate losses for the hospitals as 323.6  
19 million. Is that correct?

20 A. Yes.

21 Q. And the overall loss ratio is 127.4 percent?

22 A. It is.

23 Q. So I'm going to go now back --

24 A. Actually, before you jump.

25 Again, compare Column 3 where we have got the

1 paid losses to date, compared to the ultimate losses in  
2 column 7.

3 And now we can make the jump.

4 Q. So let's go to page 36 which is Exhibit 1, page  
5 4.

6 A. The next page.

7 Q. Oh. Got it wrong on that one. Is it Exhibit 1,  
8 page 5 is what you wanted to look at?

9 A. Yes.

10 Q. And can you explain how you derived the  
11 indicated loss reserves for the hospitals and (inaudible).

12 A. So this exhibit looks like Exhibit 1, page 4,  
13 except now we're dealing with the hospitals and healthcare  
14 facilities. What you'll see on the far-left-hand side  
15 you've got the current analysis, last year's analysis is  
16 in the middle, and the change, or the difference, is on  
17 the right-hand side.

18 You will note that that \$323 million ultimate is  
19 down on the bottom-left-hand corner of the table. The  
20 \$109 million of paid losses to date is in the next column,  
21 and so the undiscounted reserves are \$214.2 million.

22 So as I was just saying, essentially about  
23 two-thirds of the ultimate claims obligations for the  
24 hospitals are still unpaid.

25 The other thing that's worth noting about this

1 exhibit is over in the Difference column. You will notice  
2 that the paid claims for the year for the hospitals, for  
3 about \$28.4 million. If you compare that to some of the  
4 ultimate loss selections for the recent years you'll  
5 notice that \$28 million is kind of lower than the current  
6 ultimate loss run rate.

7 We view that as a positive. We view the claims  
8 experience for 2023 calendar year for the hospitals and  
9 healthcare facilities to be performing better than  
10 expectations. And you'll see that that plays out later on  
11 in our analysis.

12 But -- so that favorable development on the  
13 prior years is something that is certainly a good bit of  
14 information as it relates to the hospital program.

15 Q. When you talked about the independent  
16 practitioners, you went over this reconciliation versus  
17 the (inaudible) here.

18 Can you talk about that here?

19 A. Sure. So, uhm, last year, and I mean almost the  
20 middle column in the page, the indicated reserves on an  
21 undiscounted basis were \$195.28 million. If we add in the  
22 '23 accident year we're adding in 50.28 million of  
23 additional reserves.

24 We paid out 28 million on the prior year's --  
25 (Note: Reporter inquiry re echo.)

1 THE WITNESS: I stopped because of the feedback.  
2 I think we're okay now.

3 A. (Continued) And so those factors together  
4 result in indicated reserves as of year end 2023 of  
5 \$214.23 million.

6 Q. Do you have an exhibit that combines the  
7 individual practitioner and the hospital results?

8 A. Yes. You can go up two pages to page 35 of the  
9 .pdf, labeled as Exhibit 1, page 3.

10 Q. What does this show us?

11 A. It shows us that the total undiscounted reserves  
12 have increased from \$266.8 million to \$292.9 million, but  
13 we did see favorable development in many of the prior  
14 accident years. But there is some uncertainty in 2018,  
15 2019, 2020 and 2021, just because of the immaturity of the  
16 claims data. We add the accrual of \$80 million for the  
17 2023 accident year.

18 So one thing that's kind of worth recognizing is  
19 in a program like this where inflation is driving up claim  
20 costs, where the Medical Malpractice Act is providing  
21 cost-of-living adjustments to the coverage, there is going  
22 to be a kind of steady upward pressure on the reserves,  
23 even if everything played out exactly the way we expected  
24 it to.

25 So this increase in the reserves from \$266

1 million to \$292 million is actually a little bit lower  
2 than we would have anticipated, and it's lower because of  
3 that \$13.2 million reduction in ultimate losses from the  
4 prior years.

5 So one way to interpret that negative 13.2  
6 million in the bottom-left-hand corner of the page is that  
7 that is better than expected development for the PCF  
8 during 2023.

9 Q. I'm going to jump to page 10 of the .pdf, and  
10 there is a table showing -- I'm getting feedback. Who  
11 is --

12 So there's a table (Note: Audio drop) ...explain  
13 how the loss reserves were allocated to the hospitals?

14 A. Sure. We went through a process on a  
15 year-by-year basis of allocating the indicated ultimate  
16 losses to each of the hospitals that were participating in  
17 that year, and that is summarized on page 10. The  
18 allocations process, uhm, varies a little bit from year to  
19 year. The more developed the year is, the more  
20 credibility we gave to the actual paid claim experiences.

21 So early on when there's very little paid claim  
22 activity, we're going to allocate based on the surcharges.  
23 The more time has passed and the more claims experience we  
24 have seen, the more of that allocation is attributable to  
25 the paid claims activity rather than the surcharge

1 activity.

2 MR. BERENBERG: That concludes the topic on  
3 Indicated Loss Reserves for the Hospitals.

4 Are there any questions for Mr. Walling?

5 CHAIRMAN RITCHIE: Are there any other  
6 questions?

7 MS. LOVE: I have a question.

8 CHAIRMAN RITCHIE: Go ahead, Ms. Love.

9 MS. LOVE: Kathy Love.

10 Q. (MS. LOVE) Mr. Walling, we know that the  
11 cost-of-living increase under the new Act provides for a  
12 higher cap than the base cap only in cases that result in  
13 a settlement or a verdict that exceed that base cap, and  
14 the data that we've seen from the Patient Compensation  
15 Fund is that most cases that settle are not full cap  
16 cases, and so therefore the cost-of-living increase  
17 doesn't apply to those cases.

18 So my question to you is: How do you go about  
19 calculating the cost-of-living increase? Do you account  
20 for the fact that most cases are below base cap  
21 settlements or verdicts and only provide a cost-of-living  
22 increase on a portion of the reserves, or do you apply a  
23 cost-of-living increase on the total reserves?

24 A. Uhm, the cost-of-living increases really don't  
25 affect the reserves directly, rather the cost-of-living



1 adjustments are kind of baked into the surcharges from  
2 those prior years. So the cost-of-living adjustments are  
3 more of an issue in the funding analysis than they are in  
4 the reserves.

5 We start by using some industry aggregate data  
6 about size-of-loss distributions, and use that information  
7 to guide how we're reflecting the cost-of-living  
8 adjustments.

9 It's also worth noting that inflation doesn't  
10 just affect the top of a coverage layer, it also affects  
11 the bottom. And that's not necessarily a commonly  
12 understood phenomenon. But inflation on the bottom side  
13 is something as simple as, you know, a claim that 10 years  
14 ago cost 180,000, with the same facts and circumstances  
15 today and making appropriate inflation adjustments may  
16 well blow up into the PCF coverage layer, depending upon  
17 facts and circumstances.

18 But there is certainly analysis that goes on  
19 with the cost-of-living at the top of the layer, but  
20 there's also an inflationary effect in the bottom of the  
21 layer. It isn't really a cost-of-living adjustment, per  
22 se, but we do see an effect of claims that maybe wouldn't  
23 have qualified for PCF coverage 10 years ago subject to  
24 inflation and just economic inflation as much as anything  
25 else, potentially growing into the PCF layer just purely

1 due to inflation.

2 But that's more of a funding issue.

3 Q. So is it fair to say, again sort of in lay  
4 person's terms, that you don't add a 2 percent  
5 cost-of-living increase on top of all of the estimated  
6 losses; instead, you're evaluating what has been paid out  
7 in the past, which would already account for the cost of  
8 living increase.

9 Or can you say it better than that?

10 A. I guess what I'd rather say is the historical  
11 paid claim data reflects the coverage that's applicable to  
12 each of the prior accident years, and the prior surcharges  
13 collected also reflect the coverage layers for those  
14 accident periods; therefore, the loss reserve analysis  
15 doesn't tack on some kind of a cost-of-living surcharge or  
16 any kind of explicit factor to increase the otherwise  
17 indicated loss reserves.

18 Nor would that be appropriate.

19 MS. LOVE: Thank you.

20 CHAIRMAN RITCHIE: Mr. Clark.

21 MR. CLARK: Thank you, Mr. Chair. Troy Clark.

22 Mr. Walling, a question.

23 Q. (MR. CLARK) The last three years, in addition  
24 to the base surcharges, the hospitals have been paying a  
25 deficit reduction amount on top of paid surcharges. How

1 have you accounted for those in the various slides that  
2 we've seen? Right now I think we still see page 10 here  
3 by hospital. Are those allocated just into the surcharge  
4 level? Did you turn and push those back into prior years,  
5 make some attempt of allocating it? Do they affect the  
6 current surcharge levels based on the methodology that  
7 calculates based off the payment amount in the current  
8 years? How are those surcharges -- I'm sorry. How are  
9 those deficit repayment portions of the surcharges  
10 accounted for in your analysis?

11 A. In the loss reserve analysis, uhm, the only  
12 effect they have is reduce -- uhm, is the impact they have  
13 on the current fund balance.

14 Now, the answer is a little different when we  
15 get to the funding.

16 But we have made a decision to look at the loss  
17 ratios for that B-F method based just on the surcharges  
18 and not the deficits.

19 Q. Thank you. And I'm assuming you'll cover, when  
20 we get to the funding side, the differences at that point.

21 A. Yep.

22 MR. CLARK: Thank you.

23 CHAIRMAN RITCHIE: Any other questions?

24 MR. DEKLEVA: I do have one. I actually do have  
25 one, at this point, Mr. Walling.

1 Q. (MR. DEKLEVA) Is it correct that the experience  
2 for the hospitals, both with regard to the surcharges paid  
3 in and with the losses paid out, includes plus the  
4 employee physicians, the physicians employed by the  
5 hospitals?

6 A. Yes, it does.

7 MR. DEKLEVA: Okay. Thank you.

8 CHAIRMAN RITCHIE: All right. Please proceed.

9 MR. BERENBERG. We are going to go on to the  
10 topic of the Indicated Deficit and Allocation.

11 Q. Mr. Walling, we've gone over the loss reserve  
12 estimate. Using that, are you able to estimate the fund  
13 balance as of the end of 2023?

14 A. Yes.

15 Q. And I'm going to go to pages 30 and 31. I guess  
16 technically I'm going just to 30. 31 is next.

17 Do these show what the estimated balance is?

18 A. They do.

19 Q. Can you explain?

20 A. So we looked at this for the independent  
21 practitioners. The second row, again for my  
22 balance sheet-type information for the hospitals and other  
23 healthcare facilities, again you'll see our estimated  
24 ultimate reserves at \$214 million, you'll see the  
25 discounting for the time value of money gives you a time

1 value of money benefit of about \$3 million. Adding in a  
2 risk margin to increase the statistical confidence pushes  
3 that number up to \$229 million.

4 The allocated portion of the fund balance  
5 attributable to hospitals and healthcare facilities is  
6 \$159 million, which produces the deficits shown in Columns  
7 5, 6 and 7. You'll see in total that that undiscounted  
8 deficit across all PCF participants is \$73.575 million.  
9 That improves a little bit when you discount for the time  
10 value of money, and it increases a little bit when you  
11 increase the statistical confidence.

12 Because of the nature of the 2024 legislative  
13 infusion that doesn't affect the hospitals, so there's  
14 still a deficit for the hospitals.

15 Uhm, we then go through the process of trying to  
16 allocate that deficit surcharge to the three remaining  
17 calendar years as a means of trying to kind of fill that  
18 hole, and so you'll see that those deficit surcharges for  
19 the hospitals are shown kind of in the bottom of the table  
20 for the hospitals.

21 But the current indicated deficit for the PCF  
22 prior to the legislative infusion is about 73.6 million;  
23 after the legislative infusion is about \$37.7 million over  
24 in Column 9 at the top of the exhibit.

25 Q. So would that be the balance of the fund? Is

1 that a correct way of describing it?

2 A. Essentially that's the difference between the  
3 total funds being held. Kind of think about it as the  
4 asset side of the balance sheet. Uhm, if you add Column 4  
5 and Column 8, so you add essentially \$36 million to the  
6 \$219 million that are already there, you're looking at  
7 \$255 million. If you compare that \$255 million to the  
8 estimated reserves in Column 1 there's a shortfall of  
9 about \$37.675 million.

10 So if you're thinking about this like a  
11 traditional balance sheet and only looking at these items,  
12 the asset side of the balance sheet would be about 255  
13 million, the liability side would be about 293 million,  
14 the equity or the surplus of the business or of the  
15 program would be a deficit of three hundred and -- or,  
16 sorry, 37.675 million.

17 Q. Go to the next page. Does that explain anything  
18 about how you come up with these numbers?

19 Uhm, it gives a little perspective on the  
20 performance of kind of the two elements of the fund, the  
21 independent practitioners versus the hospitals and other  
22 healthcare facilities. And what you'll see is that over  
23 time the independent practitioners have had years of what  
24 I would describe as underwriting gains where their  
25 ultimate losses were less than the collected surcharges.

1 They've also had some years with pretty material losses.  
2 I'll point to 2007 and -8 as noteworthy years where the  
3 underwriting losses were pretty material -- uhm, more than  
4 100 percent of the surcharges -- and that there is a  
5 certain amount of cyclicalality to that, but over the course  
6 of the last 24 years the underwriting gain or loss, as it  
7 relates to the independent practitioners, is about \$54  
8 million.

9 We then separately show the impact of the  
10 legislative infusions to eliminate that deficit.

11 Similarly to the hospitals, we show the  
12 surcharges, we show the ultimate.

13 You can see that, uhm, the underwriting gain or  
14 loss, if you want to think of it that way, for the  
15 hospitals is about \$69.7 million. We show the impact of  
16 the deficit surcharges and of the legislative infusions to  
17 try and get a sense of, again, the performance of the  
18 hospitals relative to all those moving parts.

19 Q. And why do you then allocate the deficit between  
20 the two different groups?

21 A. Uhm, candidly for the purpose of trying to  
22 identify how much of the deficit is attributable to each  
23 of the cohorts, and for the purpose of developing those  
24 deficit surcharges.

25 So there is no -- you know, there's no separate

1 trust account for each of these two cohorts of covered,  
2 uh, entities, but so we need some reasonable method to,  
3 uhm, kind of allocate the current deficit as a means of  
4 trying to come up with an estimate of what kind of deficit  
5 surcharge would retire that deficit over a reasonable  
6 period of time.

7 Q. I want to go back one page. And you've got a  
8 schedule of deficit surcharges. What does that show?

9 A. So basically because after the latest  
10 legislative infusion, uhm, our allocation of the current  
11 fund deficit is eliminated for the independent physicians,  
12 the only deficit that still needs to be dealt with is for  
13 the hospitals and other healthcare facilities.

14 And so the first part of that second, that  
15 amortization of deficit surcharge table simply shows that  
16 there no deficit to retire for the independent  
17 practitioners, and essentially that the deficit surcharge  
18 for the hospitals and other healthcare facilities is going  
19 to be the tool to kind of get the hospital and other  
20 healthcare fund balance back to zero.

21 Q. How were those estimates derived for the  
22 hospitals?

23 A. Uhm, basically it's simply taking the current  
24 deficit position and amortizing it over the two years that  
25 are left, uh, for that amount to be retired.



1 MR. BERENBERG: That ends the topic on Indicated  
2 Deficit and Allocation. Are there any questions for Mr.  
3 Walling on that topic?

4 MS. LOVE: This is Kathy Love, I have a quick  
5 question.

6 Q. (MS. LOVE) On Fund Summary page 2, I just want  
7 to make sure it's real clear again for the lay person.

8 In this chart the selected ultimate losses is  
9 the selected ultimate losses that comes from the actuary  
10 report; is that true?

11 A. Yes.

12 Q. And then the practitioners surcharges is what  
13 was actually collected. Correct?

14 A. Correct.

15 Q. So under selected ultimate losses that is what  
16 the actuary for that year anticipated the pay-out would  
17 be, or the necessary reserves would be for that year?

18 A. Uhm, not quite.

19 Uhm, there are certainly some other moving parts  
20 that underpin the surcharges. There are some other  
21 expense categories, there was an anticipation of  
22 generating investment income during those years. So it's  
23 not quite as simple as you described it.

24 Those surcharges -- and also, uhm, the PCF  
25 didn't always implement the recommendation of the actuary.

1 So I want to make that really clear, as well.

2 But I would describe the surcharges as, uhm, the  
3 PCF's estimate of the surcharges that were necessary to  
4 cover the loss and non-loss expenses of the PCF at that  
5 point in time. But I want to be real clear those weren't  
6 necessarily the actuarial (phonetic) indications at that  
7 time.

8 Q. But the ultimate losses were the indications at  
9 that time?

10 A. Well, no. Those ultimate losses are as of the  
11 data available right now.

12 MS. LOVE: Okay. Great. Understood. Thank  
13 you.

14 CHAIRMAN RITCHIE: Anyone else?

15 MR. DEKLEVA: Yeah. Mr. Walling, I just had a  
16 couple of questions I wanted to make sure I was  
17 understanding the numbers correctly.

18 And Barry -- this is Mike Dekleva for the court  
19 reporter.

20 I'm looking at the Fund Summary page 1 that we  
21 were on a minute ago. Just had a question that that's  
22 really for my own understanding.

23 If we're looking at the hospitals in the  
24 outpatient healthcare facilities, kind of in the middle of  
25 the page -- yes, there we go.

1           If I'm understanding correctly -- let me make  
2           sure I've got the same -- yeah.

3           Q.     (MR. DEKLEVA) So if we look at Item 12 in that  
4           blue box it's the deficit surcharge for the hospitals.  
5           And I want to make sure I understand the number. 2025 is  
6           15 million and change, and 2026 is 15 million and change.  
7           And that would be the amount of the deficit surcharge  
8           necessary to essentially pay off the deficit, then, in  
9           those two years?

10          A.     Correct.

11          Q.     Okay. And my question is: The 15 million  
12          number -- let's just stick with 2025. Is that a total  
13          number to be divided among the hospitals? Is that how  
14          that works?

15          A.     Correct. The way that's actually been  
16          implemented in recent years is actually to rely on that  
17          percentage. So down at the bottom of the column labeled  
18          2025 and 2026 --

19          Q.     Yeah.

20          A.     -- you'll see 25.8 percent and 23.7 percent.  
21          Conceptually the idea is that there would be an additional  
22          25.8 percent assessed on top of the otherwise indicated  
23          surcharge.

24          Q.     Right. Right. So we have -- we would have the  
25          surcharge, Column 14, and then the deficit surcharge on

1 top of it. That's how I was interpreting it. Is that  
2 right?

3 A. That's correct. Yes.

4 Q. Okay. And my question is: Do you know how  
5 that -- let's just stick again with 2025, and we're  
6 talking specifically about the deficit surcharge. How is  
7 that allocated among the different hospitals? If you  
8 know.

9 A. It's allocated based on the -- based on the  
10 surcharges themselves.

11 Q. Okay.

12 A. So the surcharges are determined based on the  
13 risk characteristics of each of the participating  
14 hospitals and other healthcare facilities. That would  
15 determine the surcharge, and then the percentage for the  
16 deficit surcharge would be in addition to that underlying  
17 surcharge.

18 Q. Okay. All right. I follow what you're saying.

19 Does it have anything to do to with -- I'm going  
20 to skip around, and I apologize for that.

21 Let's see. We were looking earlier at the  
22 report itself, and, uhm, there was one page we looked at  
23 with a table that compared the hospitals.

24 A. It is not based on that at all.

25 Q. Okay. And in other words.

1           A.     That is purely an informational item and it  
2 doesn't really affect any of my findings.

3           Q.     And I actually think we had that conversation  
4 last year, Mr. Walling, now that you said that. This is  
5 information that you were asked to come up with by the  
6 PCF, if I'm remembering correctly; it's not used  
7 necessarily to calculate anything. Is that correct?

8           A.     Yes.

9           MR. DEKLEVA: I appreciate it. Thank you.

10          CHAIRMAN RITCHIE: Mr. Clark?

11          MR. CLARK: Thank you. This is Troy Clark, Mr.  
12 Walling.

13                 Somebody's gotta go on mute so we don't get this  
14 echo. There we go.

15          Q.     (MR. CLARK) On the page that is currently being  
16 shown, Funding page 1, I think it is, a couple of quick  
17 questions.

18                 The amounts under Column 2024, are those the  
19 amounts that were assessed at the beginning of this year  
20 to the hospitals and those are known amounts?

21          A.     They are estimates of the final known amount,  
22 but they should be pretty darn close.

23          Q.     Thank you. And then for 2025, under the  
24 surcharge number, I think you answered questions about  
25 lines 12 and 13, but line 14 I presume comes from your

1 actuarial analysis in this report where you determined the  
2 56.52.

3 A. Yes.

4 Q. And for 2026, is that taking that 56-520 and  
5 just adding an inflationary factor or where does that  
6 59-360 come from?

7 A. It's literally just adjusting the 56 for  
8 inflation return.

9 Q. So there was -- the assumption would be the  
10 number of participants and all maintain the same. There's  
11 no new hospitals, no loss of hospitals, et cetera.

12 A. Correct.

13 MR. CLARK: Thank you.

14 CHAIRMAN RITCHIE: Any other questions? (Note:  
15 No response.)

16 Please proceed.

17 MR. BERENBERG: Okay. We're going to move on  
18 now to the Indicated Surcharges, first for the independent  
19 practitioners.

20 Q. Mr. Walling, the purpose of this overall is to  
21 project the surcharges for the upcoming year; is that  
22 correct?

23 A. Correct.

24 Q. And the losses are the depth analyses you  
25 described provide support for the surcharge calculations?

1           A.    They do.

2           Q.    I'm going to go to page -- make sure I get it  
3 right -- 42 of the .pdf, which is Exhibit 4, page 2.

4                   And does this show the overall indicated  
5 surcharge for the independent practitioners?

6           A.    It does.

7           Q.    Can you describe the methods and the assumptions  
8 underlying this exhibit.

9           A.    Sure.  So the methodology here is called a loss  
10 ratio indication.  The idea is to take those loss ratios  
11 we've been talking about and make some adjustments to them  
12 in order to come up with an estimate of what we think next  
13 year's loss ratio is going to be if nothing happened, and  
14 then compare that expected loss ratio to a permissible  
15 loss ratio.  And the relationship between those two loss  
16 ratios is then the indicated rate change.

17                   And so the idea is if my break-even loss ratio  
18 is, I don't know, let's call it 115 percent, and based on  
19 the prior information I think we're going to run 120, then  
20 I need to increase my surcharges to get that loss ratio  
21 don't down to the permissible level.

22                   What you'll see in the top exhibit is we've  
23 taken all the historical surcharges and adjusted them for  
24 the rate changes we've implemented previously.  By "we" I  
25 mean the fund.

1           So all of those surcharges are restated as if  
2 the current surcharge levels had been in place at that  
3 time. Remember, we're trying to implement what the loss  
4 ratio is for our current program.

5           So the first adjustment we're making is this one  
6 where we're restating all the historical surcharges at  
7 current rate levels, if you want to think of it that way.

8           The second adjustment we're going to make is  
9 that we're going to adjust the historical ultimate losses  
10 to the current limits of coverage, and also to adjust them  
11 for inflation, and so what you'll see in Column 5, then,  
12 is trended ultimate losses at the current coverage layer.  
13 And so those trended ultimate loss ratios shown in  
14 Column 6 are restating the historical surcharges or  
15 premiums to the current rates, and the historical losses  
16 to the current coverage and inflation levels.

17           Based on that information we show a bunch of  
18 different averages, and we select a projected loss ratio  
19 of 120.6 percent.

20           So what we're suggesting is that if nothing  
21 changed, if we didn't change surcharges, we didn't change  
22 class plan, we didn't change anything, our best guess is  
23 that next year the independent practitioners' book of  
24 business would run a loss ratio of 120.6 percent.

25           In row 8 you'll see the projected surcharges at



1 the current fee level, which means that the projected  
2 losses, if you just take the surcharges times the loss  
3 ratio, are going to be about 23 million, 23.5 million.

4 If you remove loss adjustment expenses, which  
5 are claims handling fees, and also you discount for the  
6 time value of money, the assumption here is that the new  
7 surcharge revenue coming in can be fully invested and  
8 generate investment income. That's why that discount  
9 factor is so material and why getting that fund balance  
10 back to zero, at worst, is so important.

11 The only way you can generate that kind of  
12 investment income is if you had invested assets supporting  
13 the new claims.

14 We also show a 1.6 percent expense item for non  
15 loss-related expenses: Integrion's fees, legal fees, and  
16 so on.

17 And so we need -- after all of these factors we  
18 need to be able to generate \$21.68 million worth of  
19 surcharge revenue, and right now we're only expecting 19.5  
20 million, so in order to get from 19.5 million to 21.68  
21 million, we need to increase surcharges by \$11 million.  
22 Sorry. Stop. By 11.1 percent. I got on the wrong?

23 But, yeah, you'll see that 11.1 percent  
24 indicated in row 14 of this exhibit.

25 Q. I'm going to jump back for a moment to page 18

1 of the report which is 21 of the .pdf, and there is a  
2 table here. Can you tell us what this shows?

3 A. Sure. Every year we go through the process of  
4 evaluating individual practitioner specialties that look  
5 as if they could be better classified. We have a  
6 classification plan that takes each specialty, assigns it  
7 to a class, and that class has a ratings factor that  
8 adjusts the premiums up or down based on the relative  
9 riskiness of that specialty.

10 This year, in looking at the class plan for the  
11 PCF relative to both the Indiana PCF and the Wisconsin  
12 PCF, and also relative to the class plan of the -- I  
13 forget whether or not it's the two or three largest riders  
14 in New Mexico -- we indicated, I don't know, about a dozen  
15 proposed changes. And you'll see the current class  
16 assignment for each of those specialties in the proposed  
17 class, and then the expected impact of those class  
18 changes.

19 The biggest, uhm, revenue impact increasewise is  
20 hospitalists. Based on the data from Indiana and  
21 Wisconsin and the primary rates in New Mexico, a move from  
22 Class 2 to Class 3 was indicated. That would move the  
23 surcharges for those 277 individuals up by about 20  
24 percent to get them to a level that's more appropriate for  
25 that risk.

1           You'll also see the nonsurgical neurology  
2 classes are being proposed to move from Class 2 to  
3 Class 3.

4           Conversely, you'll see pediatricians without  
5 surgery are moving from Class 3 down to Class 2. That's  
6 about a 16.7 percent decrease for each of those 131  
7 practitioners.

8           In total, if you add all the pluses and minuses  
9 together there is a total increase in surcharges of just  
10 short of \$133,000.

11          Q.    What are relativities?

12          A.    It's just, like, for like your auto insurance.  
13 The relativity for my Tesla and my son's little SUV are  
14 different based on the two relative risk characteristics  
15 of the two vehicles.

16           In that professional liability each specialty is  
17 assigned a class based on the risk characteristics of that  
18 specialty, and specialties that tend to have similar  
19 claims characteristics tend to be put into classes  
20 together. So Class 1 and 2 tend to be nonsurgical  
21 classes. The higher classes, 4, 5, 6, and 7 tend to be  
22 surgical classes that tend to have a lot of risk and when  
23 they do have a claim tend to have very large claims.

24           So each of those class groups.

25           So every Class 1 risk has a surcharge factor of

1 .75; or in other words, their surcharges are reduced by 25  
2 percent relative to Class 2. Class 3 is about a 20  
3 percent increase. If you look at the bottom row there  
4 you'll see that the radiology with minor surgery class has  
5 a surcharge of about 70 percent over -- relative to  
6 Class 2, which is kind of our base class.

7 So the idea is that we're trying, as best we  
8 can, to make it so the surcharges are commensurate by  
9 practitioner specialty to the underlying risk  
10 characteristic.

11 Q. I'm going to jump back to Exhibit 4, page 2,  
12 which is page 42 of the .pdf.

13 A. Yeah.

14 Q. And does this indicate -- do the indicated  
15 change contemplate the cost-of-living increase in the PCF  
16 nonmedical coverage limits?

17 A. No, it does not.

18 Q. So what does the cost-of-living increase apply  
19 to?

20 A. If you go up a page, basically what you'll see  
21 is, uhm, an explicit kind of breakdown of, uhm, the  
22 elements or the components of the indicated rate change.

23 And let's just focus on the top line Without  
24 Risk Margin.

25 The 11.1 percent increase is what is shown on

1 the next page, shown to Exhibit 4, page 2.

2 The offset of minus 0.7 percent is to recognize  
3 that we are generating investment -- sorry, additional  
4 surcharge revenue if we implement all of those class  
5 changes.

6 The 2.4 percent increase in Column 3 is where we  
7 reflect the increase in the PCF coverage limits based on  
8 the cost-of-living adjustment, and so the cumulative  
9 product of those three elements is an overall indicated  
10 rate change of 13 percent for the independent  
11 practitioners.

12 Q. And going back now to page 2, what is the  
13 statistical confidence in the change indicated here?

14 A. So this is essentially at an expected level.

15 I'm hesitant to say a mean level or a 50 percent  
16 confidence level, because actuaries tend to be somewhat  
17 conservative and kind of a distribution of outcomes tends  
18 to skew to the right. So I would describe this as  
19 something on the order of a 55 to 60 percent confidence  
20 level.

21 Q. So what is the overall indicated change in  
22 surcharges for independent practitioners?

23 A. The total change reflecting the cost-of-living  
24 adjustments and the class plan changes and the syndication  
25 is actually plus 13.

1                   That's actually shown on the prior page.

2           Q.    That is this number -- that's the first row,  
3 column 10?

4           A.    That's correct.

5           Q.    So what is your recommendation to the  
6 Superintendent for the surcharges for independent  
7 practitioners?

8           A.    Uhm, I want to -- can I -- uhm, so there was an  
9 issue that came up on the prior board meeting that is  
10 probably worth talking about at this point, and that has  
11 to do with provisions built into this analysis for batch  
12 claims.

13                   If you'll do me a kindness can you scroll down  
14 to the next page?

15                   In row 10, we have a provision for loss  
16 adjustment expenses, and one of the elements of that is a  
17 provision for batch claims. Batch claims, for those of  
18 you newer to the program, are situations where a sustained  
19 pattern of behavior leads to claims. This could be, uh --  
20 so we had a situation in New Mexico where spinal  
21 fusions were being done inappropriately and kind of the  
22 first identification of the problem didn't happen until  
23 dozens of people had been treated with this inappropriate  
24 surgical methodology.

25                   But the idea is it's a little bit like a private

1 practice liability where somebody hiring people is  
2 behaving inappropriately over and over and over again for  
3 a sustained period of time, or a pollution claim where the  
4 release of the pollution happened consistently over a  
5 period of time.

6 There's also this school of thought, as it  
7 relates to medical professional liability claims, that if  
8 a provider is -- has a sustained pattern of behavior, that  
9 can result in what's colloquially called a batch claim.

10 We have had those affect the PCF dramatically in  
11 the past. There was a period of time where we purchased  
12 reinsurance coverage to protect the solvency of the fund  
13 against those batch claims, because they tend to be really  
14 big and they tend to have a lot of dollars involved.

15 And in the prior meeting I think it was Mr.  
16 Clark that brought up, and I apologize if I got the  
17 attribution wrong, this idea that the way the Act is  
18 currently written the underlying coverage is intended to  
19 be limited to, uhm, not -- to not provide coverage for  
20 more than three separate occurrences. And the current  
21 definition of occurrence does specifically relate to an  
22 individual patient.

23 So there's a thought process here that, you  
24 know, if this was executed as written, the potential for  
25 batch claims has been mitigated to some extent.

1           Uhm, I guess -- I'm not a lawyer, I don't play  
2 one on T.V., but I would suggest that there's a challenge  
3 enforcing this. If we've got a practitioner, heaven  
4 forbid, doing something consistently wrong to a number of  
5 patients and you suddenly have dozens or scores of  
6 individuals who have been harmed by this sustained pattern  
7 of behavior, and the underlying coverage is limited to  
8 three occurrences, and theoretically so is the Patient  
9 Comp Fund, that creates a real public policy problem.

10           Having said that, to address the comments from  
11 the last board meeting, I went through the exercise of  
12 removing that provision for the batch claims from the rate  
13 indications for the physicians and for the hospitals, and  
14 we'll get to that in a minute.

15           If you would -- can I ask a favor? Can you go  
16 up a page?

17           If you remove the provision for batch claims in  
18 the independent practitioners analysis, it reduces the  
19 indicated rate change without risk margin for the  
20 independent practitioners from, I think that's 13 percent  
21 to 8.6 percent. And I think given, uhm, some of the  
22 uncertainty related to the batch claims it feels incumbent  
23 on me to provide both those estimates.

24           So if the -- if the belief and understanding is  
25 that the protection against batch claims is going to be



1 enforceable then the indicated rate change is an increase  
2 of 8.6 percent. If there is still sufficient uncertainty  
3 about the potential and the risk associated with batch  
4 claims, then the indicated rate change is plus 13.

5 Sorry for going off script a little bit, Mr.  
6 Berenberg.

7 Q. You're the expert.

8 MR. CLARK: This is Mr. Clark. I'd just like to  
9 say thank you, Mr. Walling, for doing that, giving us the  
10 perspective of both ends of the spectrum. I do agree it's  
11 a public policy issue, does create a public policy issue,  
12 but I think I appreciate knowing the statistical or the  
13 actual mathematics of how it affects the overall rate.

14 THE WITNESS: And I will read that as it the  
15 relates to the hospitals in a minute.

16 MR. BERENBERG: All right. So let me just make  
17 sure that -- I had a question to you: What was your  
18 recommendation for the change in the surcharge for  
19 independent physician?

20 Q. And just so we get the concise answer, could you  
21 tell us what that change is.

22 A. Uhm. Uhm, the recommendation is an increase of  
23 8.6 percent if you're comfortable with the protection  
24 against batch claims; and if you're not, then it's an  
25 increase of 13 percent.

1 Q. You also have a number of 22.6 percent with risk  
2 margin. What does that refer to?

3 A. Essentially what we're showing in that entire  
4 level of statistical confidence is adding in an explicit  
5 risk margin of 8 1/2 percent to reflect ultimate losses  
6 that are going to be sufficient three times out of four.

7 So if we talk about kind of my centralist under  
8 undiscounted under estimate being right 55 to 60 percent  
9 of the time then, the width risk margin is simply a way of  
10 saying if you wanted to make sure that the surcharges were  
11 sufficient 75 percent of the time that an increase on the  
12 order of, uh, what was that, 22.6 percent would be  
13 appropriate.

14 Q. Okay. That, I think --

15 A. Really quickly, one of the reasons I do that is  
16 because we're applying that discount factor because we're  
17 recognizing the time value of money for the future  
18 surcharges, uhm, actuarial standards do suggest replacing,  
19 you know, offsetting some of that with an explicit risk  
20 margin. So part of this is that that discounting process  
21 removes an implicit margin, and so the idea is by showing  
22 you a 75 percent confidence level we're replacing that  
23 implicit margin that was in the undiscounted numbers with  
24 an explicit margin.

25 Q. Uhm, are there any questions for Mr. Walling on

1 the indicated surcharges for the independent  
2 practitioners?

3 MS. STARACE: This is Carmela Starace.

4 MR. AUTIO: Nick Autio. Sorry, Carmela.

5 MS. STARACE: Sorry. You can go ahead first.

6 MR. AUTIO: No, please go ahead.

7 Q. (MS. STARACE) Okay. I am the patient  
8 representative on the board, and so lay person oriented.

9 I just want to understand: The increase you're  
10 recommending is an increase from the current rate that the  
11 Superintendent imposed last year, it's not an increase  
12 from the rate you recommended last year. Is that right?

13 A. Correct. That's absolutely correct. Great  
14 question.

15 MS. STARACE: Thank you.

16 MR. AUTIO. Mr. Walling, this is Nick Autio.

17 Q. (MR. AUTIO) You referenced the 8.6 percent  
18 increase if the board is comfortable that the occurrence  
19 provision can be enforced. Is that 8.6 number referenced  
20 in your report or is that just, you know, research you've  
21 done after Mr. Clark posed his question?

22 A. It was simply a scenario test that I ran after  
23 the previous board call.

24 Q. Okay. So I'm not missing it in your report.  
25 That was just done after the board call.

1 A. That's correct.

2 Q. Great. Thank you.

3 Going to -- turning your attention back to  
4 Exhibit 4, page 2, at page 42 of the .pdf, I just want the  
5 to make sure I'm tracking exactly what you're saying.

6 So if there was no increase whatsoever to  
7 surcharges, we would collect the amount stated in row 8,  
8 the 19.5-some-odd million. Correct?

9 A. Correct.

10 Q. And then with what you are suggesting, the  
11 increase you are suggesting to cover projected losses,  
12 you're suggesting that projected losses could amount to  
13 the \$21.6-some-odd million referenced in Row 13. Right?

14 A. Uhm, that's actually the total income  
15 requirement. So, the idea here is that that's the amount  
16 of income we would need to collect so that after paying  
17 overhead expenses, after paying loss adjustment expenses,  
18 and after collecting investment income, it would be  
19 sufficient to pay out the 23.5 million -- or, sorry,  
20 the -- yeah, the 23.5 million in claims.

21 Q. Okay. Understood. So basically what we're  
22 doing here on this page is, you know, needing to make up  
23 the difference between the 19 and the 21, which would come  
24 out to about \$2.165 million. Right?

25 A. Correct.

1 Q. Okay. And earlier in response to Ms. Love's  
2 question you referenced the fact that there was an  
3 estimated 12 to 13 million-dollar surplus. Is that  
4 correct?

5 A. Correct.

6 Q. And that surplus plus was --

7 (Note: Reporter inquiry.)

8 Q. (Continued) I was just going to clarify that  
9 that surplus was attributed to independent practitioners,  
10 but please explain, Mr. Walling.

11 A. Uhm, essentially what we've tried to do is  
12 allocate the total fund deficit to the two cohorts of  
13 covered individuals and organizations.

14 So if you look at them as kind of separate  
15 accounts -- and I'm hesitant to use that word -- that  
16 essentially the physician account would currently be in a  
17 surplus, a positive surplus position, even though the  
18 overall PCF is still in a negative surplus position or  
19 surplus deficit position, yes.

20 Q. Is that -- and I'm asking this in anticipation  
21 for the board's discussion as to what we'll recommend  
22 surcharges be set at, but is that actual money,  
23 if you will? And excuse my lay terms, but money that  
24 could be used to offset the surcharges that have been  
25 proposed for the independent practitioners?

1           A.    Uhm, (Note:  Pause.)  Uhm, hypothetically, yes.  
2                    Uhm, and in states like Wisconsin that have  
3 hundreds of millions of dollars of surplus balance, they  
4 are commonly used for that.

5                    Uhm, I would be remiss if I didn't level a  
6 pretty strong cautionary message, which is:  Providing a  
7 subsidy for next year doesn't stop inflation, it doesn't  
8 stop the cost-of-living adjustments, and so you run the  
9 risk in subsidizing the rates in any one year of then  
10 putting yourself in a position where the next year you get  
11 a cumulative effect of two indicated changes.  And so  
12 instead of getting some rate -- getting a little bit of  
13 rate twice, all of that comes to roost the next year.

14                   And so you could actually put yourself in a  
15 position where -- let's just say you subsidize that entire  
16 \$2 million.  If I add another year's inflation to this,  
17 suddenly we're talking about, you know, potentially a need  
18 of 23, \$24 million.  And now you're talking about how do  
19 we get from 19.5 million to 24.5 million, and suddenly  
20 you're talking about a really substantial surcharge  
21 increase that came due largely because you did provide a  
22 subsidy for one year.

23                   I just want to be really careful that actions  
24 have consequences.

25           Q.    You know, that's why I asked the question.  I

1 appreciate the answer.

2 So the bottom line, it could -- if we were to,  
3 if the board was to, you know, do some sort of subsidy  
4 like that, it could provide relief, obviously, next year,  
5 but long term it could result in even higher surcharge  
6 increases potentially.

7 A. Yeah.

8 Q. Okay.

9 A. And we have -- we have past experience of that  
10 when there was a difference between the surcharge change  
11 implemented by the PCF versus what the actuary indicated,  
12 and what happens when that comes to roost.

13 MR. AUTIO: Okay. Understood.

14 Thank you for those answers. Appreciate it.

15 CHAIRMAN RITCHIE: Anyone else?

16 (Note: No audible response.)

17 (Note: The reporter requested a recess.)

18 CHAIRMAN RITCHIE: Okay. We can take a break  
19 until 2:45. Please be very prompt.

20 (Note: In recess from 2:32 p.m. to 2:45 p.m.)

21 CHAIRMAN RITCHIE: All right. So it's 2:45.

22 Let's please go back on the record and on the recording.

23 MR. BERENBERG: Did we finish up questions on  
24 indicated surcharges for the practitioners?

25 CHAIRMAN RITCHIE: I believe I called for any

1 other questions, and I didn't hear any more.

2 MR. BERENBERG: All right. Then we are onto our  
3 last topic, which is the indicated surcharge for the  
4 hospitals. And I've already moved to page 1 of Exhibit 6,  
5 page 45 of the .pdf.

6 Q. (MR. BERENBERG) And, Mr. Walling, does this show  
7 the hospital rate level indication?

8 A. It does.

9 Q. And I'm going to go to page 2, because I think  
10 that had the details.

11 Would you walk us through that.

12 A. Sure. So same methodologies, same adjustments  
13 to the surcharges, surcharge levels, excluding the deficit  
14 surcharges.

15 Same adjustments to the ultimate losses for  
16 adjustments for inflationary trends.

17 Same process of selecting the projected loss  
18 ratio. In this case we selected a projected loss ratio of  
19 106.5 percent.

20 Same process of taking the expected surcharges,  
21 uhm, looking at the different expense adjustments and the  
22 16.2 percent discount factor for investment income.

23 Basically investment income collected on the surcharges  
24 between the time the surcharges are collected and the  
25 claims were paid. So there's a time value of money that



1 is here.

2 And the net result of that similar methodology  
3 is what we just talked about in Exhibit 4, is an indicated  
4 assessment level change, excluding deficit surcharges, of  
5 a 1.9 percent decrease.

6 As with the independent practitioners, if you  
7 remove the provisions for the batch claims, that takes  
8 that minus 1.9 percent and changes it to a minus 5.7  
9 percent. So there is about a four-point change in the  
10 indicated decrease in the surcharges if you remove the  
11 provision for batch claims.

12 Q. And if we go back to the previous page, would  
13 that then give the overall recommendation for the  
14 hospitals?

15 A. Correct. And so in Column 3, you'll see without  
16 risk margin you can see a decrease of 1.9 percent. With  
17 the risk margin an increase of 2.4 percent.

18 As I was just saying -- I guess that's 6.5  
19 percent. Sorry. There's about a four-point difference.  
20 If you remove the batch claim provision those two numbers  
21 change to minus 5.7 percent and plus 2.4 percent.

22 Q. And then what does Column 4 show us?

23 A. Those are the deficit surcharges that we talked  
24 about up in the Fund Summary Exhibit 1, where we're trying  
25 to take that deficit and amortize it over the next two

1 years.

2 Q. And then does Column 5 show your recommendation  
3 to the Superintendent?

4 A. Uhm, really Columns 3 and 4 do. They're kind of  
5 two separate recommendations. One is that change in the  
6 underlying hospital surcharges; the other is the  
7 recommendation for the deficit surcharge as a percentage  
8 of the underlying surcharge.

9 So I would -- I guess I would view my  
10 recommendation in two pieces: The change to the  
11 underlying surcharges; and the proposed deficit surcharge.

12 Q. And then Column 5 shows the combination of those  
13 two?

14 A. The composite effect of those two things, yes.

15 Q. You're showing risk margins. What is the  
16 statistical confidence in those levels?

17 A. Same as before. The Without Risk Margin can  
18 viewed as a 55 to 60 percent confidence level. The With  
19 Risk Margin adds an additional 8 and 1/2 percent load to  
20 increase the level of statistical confidence to 75  
21 percent.

22 Q. Those were all the questions I had for you.

23 Before you take questions on this subject, was  
24 there anything else that you wanted to add?

25 A. Just this one little thing. If you remember

1 Exhibit 4, page 1, we have class plan changes for the  
2 practitioners and we had the change in limits for the  
3 practitioners. Neither of those apply to the hospital, so  
4 Exhibit 4, page 1, doesn't contain either of those two  
5 adjustments.

6 MR. BERENBERG: Okay. Are there any questions  
7 for Mr. Walling on the indicated surcharges for hospitals?

8 CHAIRMAN RITCHIE: Mr. Clark.

9 MR. CLARK: This is Troy Clark for the record.  
10 Hopefully just one quick question.

11 Q. (MR. CLARK) Mr. Walling, you indicated the rate  
12 change under Column 3 on this page would go from a minus  
13 1.9 to a minus 5.7 (sic). Knowing that you can't just add  
14 percentages, do you know what that impact would be on your  
15 combined number for Column 5?

16 A. Sure. So the Column 4 number, because we're  
17 decreasing the underlying surcharges, actually goes up a  
18 little bit. So it goes up to 26.8 percent in Column 4,  
19 and then the cumulative effect is an increase of 19.7. So  
20 the cumulative effect of the underlying surcharge change  
21 being minus 5.4, but that's the surcharge of 26-8. The  
22 cumulative then is a total increase of 19.7.

23 Q. Thank you for doing that math for us.

24 A. Yes. And I will send both of those kind of  
25 supplemental exhibits, and supplemental Exhibit 4, page 1,

1 and the supplemental Exhibit 6, page 1, as informational  
2 items when I send the report without the draft watermark.

3 MR. CLARK: No further questions from me, Mr.  
4 Chair.

5 CHAIRMAN RITCHIE: Thank you.

6 MS. LOVE: I --

7 CHAIRMAN RITCHIE: Anyone else? Go ahead.

8 MS. LOVE: Yes, please. This is Kathy Love.

9 Q. (MS. LOVE) Mr. Walling, this is all obviously  
10 good news. Because of our concerns, thinking back to when  
11 we first started doing these hearings, of the board about  
12 the availability of information for conducting risk  
13 assessments for the hospitals, can you tell us any more to  
14 convince us that this isn't going to, uhm, change  
15 drastically over the next couple of years? I mean, I'm  
16 just concerned that -- I just want to be convinced, I  
17 guess, that we have enough claims history to feel  
18 confident in this reduction.

19 A. We have more claims history.

20 I will tell you, as I said earlier in the  
21 reserve section, more than half of -- sorry, more than two  
22 thirds of the ultimate losses for the hospitals are still  
23 unpaid. We are still dealing with, uhm, claims  
24 occurrences that are years away from settlement.

25 So there is still significant uncertainty

1 underlying the reserves for the hospitals; and, candidly,  
2 the only cure for that is time, because on some of  
3 these -- some of the claims that the PCF is on the hook  
4 for literally haven't been reported to the PCF yet. So  
5 there is still significant uncertainty on the hospital  
6 portion of the program that, candidly, only time will give  
7 me better information about the rate at which the hospital  
8 claims settle and the average severity of those hospital  
9 claims.

10 So we're a year smarter, but there is -- I'd  
11 be -- it would be naive of me to tell you I know  
12 everything I need to know about the hospital program.  
13 There's still more to learn.

14 MS. LOVE: Okay.

15 CHAIRMAN RITCHIE: Any other comments,  
16 questions, from the board of Mr. Berenberg and Mr.  
17 Walling?

18 All right.

19 Then I believe our next meeting is 9-11 at 2:00  
20 o'clock, 2:00 p.m.

21 And, Mr. Ward, do we have any other things to be  
22 aware of or things to clean up in the meantime?

23 MR. WARD: I think Debbie has something.

24 MS. LUERA: Yes. Sorry. This is Debbie Luera  
25 with Integrion.

1 Q. (MS. LUERA) Mr. Walling, if I may ask you to,  
2 would you please touch on the independent outpatient  
3 healthcare facility rate that you provided in your study  
4 at page 7 of 85 in the report, so we have it on record  
5 that these rates were developed.

6 A. Sure. So as an extra item there was a request  
7 to develop rates for specific types of facilities,  
8 independent healthcare facilities.

9 The exposure base, in other words the measurable  
10 risk, for a dialysis center is number of visits, for a  
11 pathology lab is \$1,000 in receipts.

12 The approach made here was to form a competitive  
13 analysis based on publicly available rate filings in New  
14 Mexico. So this is driven by New Mexico-specific data.  
15 And it looks like there is an adjustment of an increase of  
16 5.6 percent relative to those same rates last year, which  
17 was basically an inflationary adjustment and a  
18 cost-of-living adjustment.

19 Q. It's my understanding we didn't have those rates  
20 last year, we were just using an entity surcharge. I  
21 could be wrong. I thought this was a new request for this  
22 year just because it was hard to rate facilities and a new  
23 surcharge.

24 So I think what we decided last year was that we  
25 would take 10 percent of the surcharge for any applicable

1 employee physicians. The challenge we ran into was that a  
2 lot of these types of facilities don't have employed  
3 physicians.

4 A. I -- yeah. I -- before I speak, give me just a  
5 hot minute to look over this file really quickly. (Note:  
6 Pause.)

7 So, as you understood it, Ms. Luera, the  
8 surcharge this year, calendar year of January, 2024, was  
9 500,000. That says 500,000 for the non hospital-owned  
10 outpatient healthcare facilities. Correct?

11 Q. That's correct. The limits for these  
12 independent outpatient healthcare facilities were new for  
13 2024, and I was trying to go to the, uhm -- I'm sorry, the  
14 recommendation that the advisory board made last year.

15 THE WITNESS: So if you go to -- Mr. Berenberg,  
16 I'm going to ask you to bear with me. It's probably  
17 something like page 36 of the .pdf. It's labeled  
18 Exhibit 3, page 2. So you will have to scroll down just a  
19 little bit. Yeah. Right.

20 A. And so we started from the rates that were -- we  
21 developed rates effective for 1-1 of '24 based on publicly  
22 available rate filings, and essentially all we did was  
23 trend those forward.

24 I can go pull what we did last year to develop  
25 those base rates, but...

1 Q. Okay. I think it's fine. I just wanted to make  
2 sure that we had on the record that these per-visit or  
3 per-procedure rates had been developed by Pinnacle for the  
4 coming year so that the board can make a recommendation to  
5 adopt or not to adopt.

6 A. Yes.

7 Q. So thank you.

8 CHAIRMAN RITCHIE: All right. Mr. Clark.

9 MR. CLARK: Thank you, Mr. Chair. This is Troy  
10 Clark for the record.

11 Ms. Luera, I guess a question is to make sure  
12 we've got all the information out of Mr. Walling in  
13 regards to this: Do we have the comparative of how this  
14 calculates from the number of entities that we have that  
15 are outpatient healthcare facilities compared to what  
16 their premium was last year that was based off the 10  
17 percent increase?

18 And Mr. Walling has covered independent  
19 practitioners and hospitals with a percentage increase  
20 over prior year. Do we have the information we need to  
21 calculate what that would be for the outpatient healthcare  
22 facilities?

23 MS. LUERA: Well, I can tell you that we have  
24 two -- uh, two independent outpatient healthcare  
25 facilities that applied for PCF coverage in 2024 that did



1 not have any employee physicians, so it was very difficult  
2 to try to calculate a proper surcharge for them.

3 And so having the rates here that are on page  
4 75 -- or page 7 of the report, will assist us in being  
5 able to evaluate the exposure going forward.

6 I don't have with me the exact surcharges for  
7 those two entities but I can follow up on that.

8 MR. CLARK: Again, this is Troy Clark.

9 Thank you Ms. Luera. I think -- it sounds like  
10 you'll have what we need for the September 11th meeting  
11 where we, as a board, make a recommendation. And we need  
12 to make the recommendation on the independent  
13 practitioners, we need to make a recommendation on the  
14 hospitals and their employee physicians. Mr. Walling's  
15 given us his actuarial analysis on those. I just want to  
16 make sure we have the information we need to understand  
17 that whatever the calculated amount is on a per-visit or a  
18 per-receipt or a per-test or whatever it is on the  
19 outpatient healthcare facilities, we'll be able to know as  
20 a board before we make that recommendation to the  
21 Superintendent whether that's a 10 percent increase, a 30  
22 percent increase, a 100 percent increase, 10 percent  
23 decrease, whatever that amounts to over what they were  
24 charged last year.

25 MS. LUERA: Yes, I will be prepared to provide

1 that information to you at the September 11th meeting.

2 MR. CLARK: Perfect. Thank you.

3 MR. AUTIO: And Mr. Chair, this is Nick Autio  
4 for the record.

5 Just to be clear, and I'm sorry if Mr. Clark  
6 already asked this, but with the percentage increase or  
7 decrease for outpatient facilities depending on risk  
8 margin, what's that percentage based on in terms of what's  
9 that a percentage increase or decrease of? Is that what  
10 they were paying last year?

11 CHAIRMAN RITCHIE: Mr. Walling?

12 MR. WALLING: I assume it's actually based on  
13 our previously proposed rates. Again I'll get with  
14 Ms. Luera, and we'll make sure everybody is on the same  
15 page before the 11th.

16 CHAIRMAN RITCHIE: Okay. Okay. Thank you.

17 MR. CLARK: Mr. Chair, this is Troy Clark.

18 My understanding is last year was a separate  
19 calculation that amounted to a total dollar amount which  
20 was based upon a premium increase over the employee  
21 provider rate of 10 percent for the organization.

22 We now have a new methodology. I'm curious as  
23 to what that percentage is, and I don't know that it is --  
24 I think they're telling us it's not the same methodology  
25 that was used, and we're trying to find a methodology that

1 is more accurate that they asked Mr. Walling to produce  
2 this type of scenario.

3 Am I correct on that Ms. Luera?

4 MS. LUERA: Yes. I apologize, I was trying to  
5 find the board's recommendations from last year, and I --

6 MS. LOVE: I have it. This is Kathy Love. I  
7 have it in front of me.

8 MR. LUERA: So it's my recollection, and I'm  
9 getting old so my memory isn't as good as it used to be,  
10 it's my recollection that the only rating basis, rate  
11 mechanism approved or recommended by the board last year  
12 was a 10 percent of the employee physician basis. But as  
13 Integrion was accepting batches, we ran into the issue  
14 that -- and I remember that we talked about it last year  
15 during the same process. Not all of these types of  
16 entities have employed physicians, so in essence they  
17 could submit and say, "Well, we don't have any employees,  
18 so 10 percent of zero is zero."

19 So what they did was they used the hospital  
20 facility rating spreadsheets, which I think they were  
21 paying too much, because, uhm -- because of the deficit  
22 repayment factor built into that, if that makes sense.

23 But let me go back and do some research on that.  
24 I'll have to pull up the surcharges that are actually in  
25 place for those.

1 MS. LOVE: This is Kathy Love.

2 CHAIRMAN RITCHIE: Go ahead.

3 MS. LOVE: I have in front of me the  
4 recommendations that we made last year, so let's just put  
5 those on the record, and then I want to ask a question  
6 about this.

7 What we said on page 5 of 7 of our  
8 recommendations is: The committee does not currently have  
9 data to deviate from Pinnacle's recommendation that \*\*  
10 independent outpatient healthcare facility surcharges be  
11 based upon a charge of 10 percent of the premium for each  
12 covered provider practicing in the Independent Outpatient  
13 Healthcare Facility. The recommended surcharge for  
14 Independent Outpatient Healthcare Facilities is therefore  
15 10 percent of the premium surcharge for each covered  
16 provider practicing in the Independent Outpatient  
17 Healthcare Facility.

18 And then we said: Going forward the PCF should  
19 compile data on a per-procedure basis - as it does for  
20 hospitals - for Independent Outpatient Healthcare  
21 Facilities for use in determining the most appropriate  
22 method of assessing surcharges and surcharge changes in  
23 the future.

24 So I guess my question related to this is: What  
25 was done, what kind of data was compiled and provided to

1 Pinnacle for evaluation?

2 MS. LUERA: Well, we only have two independent  
3 outpatient healthcare facilities that applied for coverage  
4 as an independent OHCS, and so I don't think we provided  
5 that to Pinnacle. I don't think we --

6 MR. WALLING: Well, we do have a -- yeah, we do  
7 have a rate plan.

8 MS. LUERA: Okay. Yeah. We did look at the  
9 rate filing for that, but -- I'm sorry, Pinnacle did. I  
10 still don't think we have sufficient data to be able to...

11 I mean, I can tell you what the exposures were.  
12 One was an ambulatory surgery center and one was a -- uhm,  
13 I believe it was a gastroenterology practice.

14 So those are the exposure types. But, again,  
15 there's only two facilities, so I'm still not confident we  
16 have sufficient data. But the reason we asked Pinnacle to  
17 prepare these exposure surcharges was so that we could  
18 have a more accurate, industry-accepted rating basis.

19 CHAIRMAN RITCHIE: All right. Does that answer  
20 your question or comment, MS. Love?

21 MS. LOVE: Well, I think so, except that I guess  
22 I would like to hear from Mr. Walling about what  
23 additional data would be helpful in evaluating this, if  
24 anything.

25 MR. WALLING: Well, basically, uhm, all of

1 these, uhm -- all of these facility types are commonly  
2 priced in the traditional insurance market, not based on  
3 number of providers but on number of visits or receipts,  
4 depending on the type of specialty, as you can see in  
5 Exhibit 3, page 2.

6 And so one of the -- as I've mentioned in that  
7 classified analysis that we do, we look at the publicly  
8 available filings for the doctor's company, and for  
9 medical perspective as the basis for how we change those  
10 physician relativities.

11 We also looked at that data to look at what the  
12 market prices were for these types of facilities from  
13 those filings. And so our proposed rates for the excess  
14 coverage are based on the publicly available rates for the  
15 underlying coverage, and then we adjust that for the PCF  
16 layer.

17 So that's -- for this really niche, really  
18 limited credibility data, that segment of the healthcare  
19 industry, you're honestly not going to be able to get any  
20 better data than benchmarking it off of the commercial  
21 market.

22 MS. LOVE: And that's based on the national  
23 commercial market?

24 MR. WALLING: No, New Mexico-specific rate  
25 market.

1 CHAIRMAN RITCHIE: All right.

2 Mr. Clark, did you have a question?

3 MR. CLARK: No. Ms. Love just clarified that.  
4 I was going to make sure that was New Mexico commercial,  
5 and he answered it, so no further comment.

6 CHAIRMAN RITCHIE: Okay. Any other questions of  
7 Mr. Walling, Mr. Berenberg?

8 MR. BERENBERG: Not a question. But for Mary, I  
9 still need your email address.

10 (Note: The reporter responded.)

11 CHAIRMAN RITCHIE: And so, as I mentioned  
12 earlier, the next meeting of the board is September 11th  
13 at 2:00 p.m. to go forward and make decisions on our  
14 recommendations, and then we will write that up to present  
15 to the Superintendent.

16 Absent any other comments, I do want to thank  
17 Mr. Berenberg, Mr. Walling, Ms. Luera, the board.

18 As I said earlier, everyone is getting this down  
19 and doing a fine job keeping it clean-cut, and I think  
20 we're having a lot fewer questions, a lot fewer -- a lot  
21 less discussion but more pertinent discussion. So I  
22 really appreciate that.

23 So absent any other comments then we will be  
24 adjourned in this hearing. Thank you.

25 (Note: Hearing concluded at 3:14 p.m.)


1 STATE OF NEW MEXICO )  
2 : ss  
3 COUNTY OF TAOS )  
4

5 REPORTER'S CERTIFICATE

6 I, MARY THERESE MACFARLANE, New Mexico Reporter  
7 CCR No. 122, DO HEREBY CERTIFY that on Thursday,  
8 September 5, 2024 the proceedings in the above-captioned  
9 matter were taken before me; that I did report in  
10 stenographic shorthand the proceedings set forth herein,  
11 and the foregoing pages are a true and correct  
12 transcription to the best of my ability and control.

13 I FURTHER CERTIFY that I am neither employed by  
14 nor related to nor contracted with (unless excepted by the  
15 rules) any of the parties or attorneys in this case, and  
16 that I have no interest whatsoever in the final  
17 disposition of this case in any court.

18 September 9, 2024



19  
20 MARY THERESE MACFARLANE, CCR  
21 NM Certified Court Reporter No. 122  
22 License Expires: 12/31/2024  
23  
24  
25



[0.7 - 24]

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[candidly - close]

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[corner - describe]

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[described - establish]

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[estimate - facts]

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[fair - going]

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[little - mean]

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[speak - surcharges]

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[sure - today]

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[understanding - workpapers]

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**[works - zoom]**

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