BEFORE THE NEW MEXICO SUPERINTENDENT OF INSURANCE
AS CUSTODIAN OF THE PATIENT'S COMPENSATION FUND

IN THE MATTER OF DETERMINING
PATIENT'S COMPENSATION FUND
SURCHAGE 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

ALSO PRESENT:

ALICE D. KANE	OSI
JENNIFER ROMERO	OSI
CHRIS MYERS	OSI
MELISSA ROBERTSON	OSI
TIM VIGIL	OSI
PLACIDO GONZALEZ	OSI
COLIN BAILLIE	OSI
DEBBIE LUERA:	Integrion Group
CHRIS DeWALD:	Integrion gROUP

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CHAIRMAN RITCHIE: Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

MR. BERENBERG: Thank you. I'm Barry Berenberg. I'm counsel for the Superintendent of Insurance in her role as the custodian of the Patient Compensation Fund. I provide those services under Integrion's contract with OSI, the Office of the Superintendent of Insurance, as a third-party administrator for the PCF.

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

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

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

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

(Note: No audible response.)

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

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

(Note: Multiple affirmative responses.)

So this is the same CV that Mr. Walling had last year. He does not have any updates to it. Unless the board wants me to go through it, I would just offer this into evidence as Exhibit A, and then move on to the report.

CHAIRMAN RITCHIE: I do not see any objections.

MR. BERENBERG: Okay. So the CV -- and for court reporter, do you want me to email these exhibits to you, there'll be two of them, this one and the report.

(Note: The reporter responded.)

MR. BERENBERG: I'm going to switch now to the report. I'm trying to zoom in on it, make it a little bit bigger.

Mr. Walling, are you on?

THE WITNESS: Yes.

MR. BERENBERG: Okay. And I'll just ask you as a formality:

EXAMINATION

BY MR. BERENBERG:

Q. Do you recognize the document that I'm showing on the screen right now?

A. I do.

Q. And what is it?

A. It is my report as of August -- I believe just scroll onto the next page.

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

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

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

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

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

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

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

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

A. Yes.

Q. And does your training and experience enable you to do each of those items to perform that work?

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

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

Are there any objections?

CHAIRMAN RITCHIE: I see none.

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

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

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

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

MR. WARD: Okay.

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

How does that relate to loss reserves?

A. The terminology is, candidly, interchangeable. The process of estimating the ultimate liabilities on the balance sheet of the PCF are fundamentally the process of estimating the unpaid claims liabilities for claims that have already occurred but haven't been paid by the PCF at this time.

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

A. That is correct.

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

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

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

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

CHAIRMAN RITCHIE: Well, I would prefer independent practitioners, since hospitals are also considered providers in nomenclature for certain insurances, et cetera. So I think practitioners perhaps is a better term.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So you see in the 2000 year in the very top row the B-F method is identical to the paid method, whereas in the 2023 year the B-F method is identical to the expected loss ratio method. And the weight given to those two methods is derived, the B-F method vary based on the expected percent of ultimates paid in each of the years.

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

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

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

A.   That's correct.

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

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

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

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

Q. And what does the loss ratio mean?

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

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

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

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

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

You'll see that the allocated portion of the fund balance for the independent practitioners is about $60 million, which results in the indicated deficits for the practitioners in Columns 5, 6 and 7.

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

But that's it.

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

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

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

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

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

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

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

MS. LOVE: Thank you.

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

(Note: No audible response.)

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

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

A. I did.

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

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

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

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

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

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

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

Uhm, on the other hand, the experience since then has been, I guess I'll describe it as a little bit more stable and a little bit more well-behaved. There's still a lot of uncertainty here. You'll notice that for, say, accident year '21 that there's only been $2.2 million worth of paid claims to date, and yet based on historical PCF payment activity we're assuming that's going to end up being something on the order of 40, $41 million over in Column 7.

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

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

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

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

A. Yes.

Q. And the overall loss ratio is 127.4 percent?

A. It is.

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

A. Actually, before you jump.

Again, compare Column 3 where we have got the paid losses to date, compared to the ultimate losses in column 7.

And now we can make the jump.

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

A. The next page.

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

A. Yes.

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

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

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

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

The other thing that's worth noting about this exhibit is over in the Difference column. You will notice that the paid claims for the year for the hospitals, for about $28.4 million. If you compare that to some of the ultimate loss selections for the recent years you'll notice that $28 million is kind of lower than the current ultimate loss run rate.

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

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

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

Can you talk about that here?

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

We paid out 28 million on the prior year's --

(Note: Reporter inquiry re echo.)

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

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

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

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

Q. What does this show us?

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

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

So this increase in the reserves from $266 million to $292 million is actually a little bit lower than we would have anticipated, and it's lower because of that $13.2 million reduction in ultimate losses from the prior years.

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

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

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

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

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

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

Are there any questions for Mr. Walling?

CHAIRMAN RITCHIE: Are there any other questions?

MS. LOVE: I have a question.

CHAIRMAN RITCHIE: Go ahead, Ms. Love.

MS. LOVE: Kathy Love.

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

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

A. Uhm, the cost-of-living increases really don't affect the reserves directly, rather the cost-of-living adjustments are kind of baked into the surcharges from those prior years. So the cost-of-living adjustments are more of an issue in the funding analysis than they are in the reserves.

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

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

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

But that's more of a funding issue.

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

Or can you say it better than that?

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

Nor would that be appropriate.

MS. LOVE: Thank you.

CHAIRMAN RITCHIE: Mr. Clark.

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

Mr. Walling, a question.

Q. (MR. CLARK) The last three years, in addition to the base surcharges, the hospitals have been paying a deficit reduction amount on top of paid surcharges. How have you accounted for those in the various slides that we've seen? Right now I think we still see page 10 here by hospital. Are those allocated just into the surcharge level? Did you turn and push those back into prior years, make some attempt of allocating it? Do they affect the current surcharge levels based on the methodology that calculates based off the payment amount in the current years? How are those surcharges -- I'm sorry. How are those deficit repayment portions of the surcharges accounted for in your analysis?

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

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

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

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

A. Yep.

MR. CLARK: Thank you.

CHAIRMAN RITCHIE: Any other questions?

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

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

A. Yes, it does.

MR. DEKLEVA: Okay. Thank you.

CHAIRMAN RITCHIE: All right. Please proceed.

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

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

A. Yes.

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

Do these show what the estimated balance is?

A. They do.

Q. Can you explain?

A. So we looked at this for the independent practitioners. The second row, again for my balance sheet-type information for the hospitals and other healthcare facilities, again you'll see our estimated ultimate reserves at $214 million, you'll see the discounting for the time value of money gives you a time value of money benefit of about $3 million. Adding in a risk margin to increase the statistical confidence pushes that number up to $229 million.

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

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

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

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

Q. So would that be the balance of the fund? Is that a correct way of describing it?

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

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

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

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

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

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

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

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

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

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

So there is no -- you know, there's no separate trust account for each of these two cohorts of covered, uh, entities, but so we need some reasonable method to, uhm, kind of allocate the current deficit as a means of trying to come up with an estimate of what kind of deficit surcharge would retire that deficit over a reasonable period of time.

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

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

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

Q. How were those estimates derived for the hospitals?

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

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

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

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

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

A. Yes.

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

A. Correct.

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

A. Uhm, not quite.

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

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

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

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

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

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

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

CHAIRMAN RITCHIE: Anyone else?

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

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

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

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

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

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

A. Correct.

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

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

Q. Yeah.

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

Q. Right. Right. So we have -- we would have the surcharge, Column 14, and then the deficit surcharge on top of it. That's how I was interpreting it. Is that right?

A. That's correct. Yes.

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

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

Q. Okay.

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

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

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

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

A. It is not based on that at all.

Q. Okay. And in other words.

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

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

A. Yes.

MR. DEKLEVA: I appreciate it. Thank you.

CHAIRMAN RITCHIE: Mr. Clark?

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

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

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

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

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

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

actuarial analysis in this report where you determined the 56.52.
A. Yes.
Q. And for 2026, is that taking that 56-520 and just adding an inflationary factor or where does that 59-360 come from?
A. It's literally just adjusting the 56 for inflation return.
Q. So there was -- the assumption would be the number of participants and all maintain the same. There's no new hospitals, no loss of hospitals, et cetera.
A. Correct.
MR. CLARK: Thank you.
CHAIRMAN RITCHIE: Any other questions? (Note: No response.)
Please proceed.
MR. BERENBERG: Okay. We're going to move on now to the Indicated Surcharges, first for the independent practitioners.
Q. Mr. Walling, the purpose of this overall is to project the surcharges for the upcoming year; is that correct?
A. Correct.
Q. And the losses are the depth analyses you described provide support for the surcharge calculations?

A. They do.
Q. I'm going to go to page -- make sure I get it right -- 42 of the .pdf, which is Exhibit 4, page 2.
And does this show the overall indicated surcharge for the independent practitioners?
A. It does.
Q. Can you describe the methods and the assumptions underlying this exhibit.
A. Sure. So the methodology here is called a loss ratio indication. The idea is to take those loss ratios we've been talking about and make some adjustments to them in order to come up with an estimate of what we think next year's loss ratio is going to be if nothing happened, and then compare that expected loss ratio to a permissible loss ratio. And the relationship between those two loss ratios is then the indicated rate change.
And so the idea is if my break-even loss ratio is, I don't know, let's call it 115 percent, and based on the prior information I think we're going to run 120, then I need to increase my surcharges to get that loss ratio don't down to the permissible level.
What you'll see in the top exhibit is we've taken all the historical surcharges and adjusted them for the rate changes we've implemented previously. By "we" I mean the fund.

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

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

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

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

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

In row 8 you'll see the projected surcharges at the current fee level, which means that the projected losses, if you just take the surcharges times the loss ratio, are going to be about 23 million, 23.5 million.

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

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

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

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

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

Q. I'm going to jump back for a moment to page 18 of the report which is 21 of the .pdf, and there is a table here. Can you tell us what this shows?

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

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

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

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

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

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

Q. What are relativities?

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

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

So each of those class groups.

So every Class 1 risk has a surcharge factor of

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

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

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

A. Yeah.

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

A. No, it does not.

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

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

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

The 11.1 percent increase is what is shown on the next page, shown to Exhibit 4, page 2.

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

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

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

A. So this is essentially at an expected level.

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

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

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

That's actually shown on the prior page.
Q. That is this number -- that's the first row, column 10?
A. That's correct.
Q. So what is your recommendation to the Superintendent for the surcharges for independent practitioners?
A. Uhm, I want to -- can I -- uhm, so there was an issue that came up on the prior board meeting that is probably worth talking about at this point, and that has to do with provisions built into this analysis for batch claims.
If you'll do me a kindness can you scroll down to the next page?
In row 10, we have a provision for loss adjustment expenses, and one of the elements of that is a provision for batch claims. Batch claims, for those of you newer to the program, are situations where a sustained pattern of behavior leads to claims. This could be, uh -- so we had a situation in New Mexico where spinal fusions were being done inappropriately and kind of the first identification of the problem didn't happen until dozens of people had been treated with this inappropriate surgical methodology.
But the idea is it's a little bit like a private

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

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

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

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

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

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

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

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

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

So if the -- if the belief and understanding is that the protection against batch claims is going to be enforceable then the indicated rate change is an increase of 8.6 percent. If there is still sufficient uncertainty about the potential and the risk associated with batch claims, then the indicated rate change is plus 13.

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

Q. You're the expert.

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

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

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

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

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

Q. You also have a number of 22.6 percent with risk margin. What does that refer to?
A. Essentially what we're showing in that entire level of statistical confidence is adding in an explicit risk margin of 8 1/2 percent to reflect ultimate losses that are going to be sufficient three times out of four.
So if we talk about kind of my centralist under undiscounted under estimate being right 55 to 60 percent of the time then, the width risk margin is simply a way of saying if you wanted to make sure that the surcharges were sufficient 75 percent of the time that an increase on the order of, uh, what was that, 22.6 percent would be appropriate.
Q. Okay. That, I think --
A. Really quickly, one of the reasons I do that is because we're applying that discount factor because we're recognizing the time value of money for the future surcharges, uhm, actuarial standards do suggest replacing, you know, offsetting some of that with an explicit risk margin. So part of this is that that discounting process removes an implicit margin, and so the idea is by showing you a 75 percent confidence level we're replacing that implicit margin that was in the undiscounted numbers with an explicit margin.
Q. Uhm, are there any questions for Mr. Walling on

the indicated surcharges for the independent practitioners?

MS. STARACE: This is Carmela Starace.

MR. AUTIO: Nick Autio.   Sorry, Carmela.

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

MR. AUTIO: No, please go ahead.

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

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

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

MS. STARACE: Thank you.

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

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

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

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

A. That's correct.
Q. Great. Thank you.
Going to -- turning your attention back to Exhibit 4, page 2, at page 42 of the .pdf, I just want the to make sure I'm tracking exactly what you're saying.
So if there was no increase whatsoever to surcharges, we would collect the amount stated in row 8, the 19.5-some-odd million. Correct?
A. Correct.
Q. And then with what you are suggesting, the increase you are suggesting to cover projected losses, you're suggesting that projected losses could amount to the $21.6-some-odd million referenced in Row 13. Right?
A. Uhm, that's actually the total income requirement. So, the idea here is that that's the amount of income we would need to collect so that after paying overhead expenses, after paying loss adjustment expenses, and after collecting investment income, it would be sufficient to pay out the 23.5 million -- or, sorry, the -- yeah, the 23.5 million in claims.
Q. Okay. Understood. So basically what we're doing here on this page is, you know, needing to make up the difference between the 19 and the 21, which would come out to about $2.165 million. Right?
A. Correct.

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

A. Correct.

Q. And that surplus plus was --

(Note: Reporter inquiry.)

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

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

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

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

A. Uhm, (Note: Pause.) Uhm, hypothetically, yes.

Uhm, and in states like Wisconsin that have hundreds of millions of dollars of surplus balance, they are commonly used for that.

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

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

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

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

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

A. Yeah.

Q. Okay.

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

MR. AUTIO: Okay. Understood.

Thank you for those answers. Appreciate it.

CHAIRMAN RITCHIE: Anyone else?

(Note: No audible response.)

(Note: The reporter requested a recess.)

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

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

CHAIRMAN RITCHIE: All right. So it's 2:45. Let's please go back on the record and on the recording.

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

CHAIRMAN RITCHIE: I believe I called for any other questions, and I didn't hear any more.

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

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

A. It does.

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

Would you walk us through that.

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

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

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

Same process of taking the expected surcharges, uhm, looking at the different expense adjustments and the 16.2 percent discount factor for investment income. Basically investment income collected on the surcharges between the time the surcharges are collected and the claims were paid. So there's a time value of money that is here.

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

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

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

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

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

Q. And then what does Column 4 show us?

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

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

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

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

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

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

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

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

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

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

A. Just this one little thing. If you remember

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

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

CHAIRMAN RITCHIE: Mr. Clark.

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

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

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

Q.   Thank you for doing that math for us.

A.   Yes. And I will send both of those kind of supplemental exhibits, and supplemental Exhibit 4, page 1, and the supplemental Exhibit 6, page 1, as informational items when I send the report without the draft watermark.

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

CHAIRMAN RITCHIE: Thank you.

MS. LOVE: I --

CHAIRMAN RITCHIE: Anyone else? Go ahead.

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

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

A. We have more claims history.

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

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

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

MS. LOVE: Okay.

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

All right.

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

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

MR. WARD: I think Debbie has something.

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

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

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

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

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

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

So I think what we decided last year was that we would take 10 percent of the surcharge for any applicable employee physicians. The challenge we ran into was that a lot of these types of facilities don't have employed physicians.

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

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

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

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

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

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

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

A. Yes.

Q. So thank you.

CHAIRMAN RITCHIE: All right. Mr. Clark.

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

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

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

MS. LUERA: Well, I can tell you that we have two -- uh, two independent outpatient healthcare facilities that applied for PCF coverage in 2024 that did not have any employee physicians, so it was very difficult to try to calculate a proper surcharge for them.

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

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

MR. CLARK: Again, this is Troy Clark.

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

MS. LUERA: Yes, I will be prepared to provide that information to you at the September 11th meeting.

MR. CLARK: Perfect. Thank you.

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

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

CHAIRMAN RITCHIE: Mr. Walling?

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

CHAIRMAN RITCHIE: Okay. Okay. Thank you.

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

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

We now have a new methodology. I'm curious as to what that percentage is, and I don't know that it is -- I think they're telling us it's not the same methodology that was used, and we're trying to find a methodology that is more accurate that they asked Mr. Walling to produce this type of scenario.

Am I correct on that Ms. Luera?

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

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

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

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

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

MS. LOVE: This is Kathy Love.

CHAIRMAN RITCHIE: Go ahead.

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

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

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

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

Pinnacle for evaluation?

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIRMAN RITCHIE: All right.

Mr. Clark, did you have a question?

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

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

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

(Note: The reporter responded.)

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

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

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

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

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

STATE OF NEW MEXICO)
: ss
COUNTY OF TAOS)

REPORTER'S CERTIFICATE

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

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

September 9, 2024 Mary Therese Macfarlane

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