

Patient's Compensation Fund Advisory Board Meeting

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

Thursday, July 10, 2025

1:31 p.m.

Office of Superintendent of Insurance

6200 Uptown Boulevard Northeast, #400

Albuquerque, NM 87110

Reported by: James Cogswell

JOB NO: 7360127

A P P E A R A N C E S

List of Attendees:

Kathleen J. Love, Board Vice Chair

Roman Martinez, Board Member

Troy Clark, Board Member

Nick Autio, JD, Board Member

Michael Dekleva, Board Member (by videoconference)

Vincent Ward, Board Attorney (by videoconference)

Alice Kane, Superintendent of Insurance

Christian Myers, Chief Actuary, OSI

Stephen Thies, OSI General Counsel

Gloria D. Regensberg, OSI Staff Counsel (by  
videoconference)

Frances Gallegos, OSI Law Clerk

Debbie Luera, Integrion

Jennifer Fetherolf, Integrion (by videoconference)

Robert Walling, Pinnacle Actuarial Resources (by  
videoconference)

Barry Berenberg, Senior Counsel, New Mexico Mutual

Debra Alvarez, OSI (by videoconference)

Patricia Salazar, OSI (by videoconference)

Placido Gonzales, OSI (by videoconference)

Matt Lawrence (by videoconference)

Samantha Reiss (by videoconference)

Adam Douma (by videoconference)

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A P P E A R A N C E S (Cont'd)  
List of Attendees (Cont'd):  
Agnes Gallegos-Bintz (by videoconference)  
Megan Barrett (by videoconference)  
Chris DeWald (by videoconference)  
Karen Tiegler (by videoconference)  
Daniel Linton (by videoconference)  
Jennifer Romero (by videoconference)  
Russ (by videoconference)  
Sarah Koob (by videoconference)  
Jenica Cortese (by videoconference)  
Danine Baca (by videoconference)  
Sandra Duncan (by videoconference)

1 P R O C E E D I N G S

2 MS. LUERA: Okay. We're ready to start  
3 roll call.

4 Chairman Ritchie.

5 MR. RITCHIE: Present.

6 MS. LUERA: Chair Love. Vice Chair  
7 Love.

8 MS. LOVE: Present.

9 MS. LUERA: Mr. Clark. No?  
10 Mr. Autio.

11 MR. AUTIO: Present.

12 MS. LUERA: Mr. Dekleva.

13 MR. DEKLEVA: I'm here.

14 MS. LUERA: Mr. Martinez.

15 He's -- he's not.

16 MS. LOVE: He's no longer --

17 MS. LUERA: No longer. Okay.

18 And then Mr. Vargas. Anyone?

19 MS. LOVE: I don't see Ray here. And  
20 then we also have Roman Martinez, a new Martinez.

21 MS. LUERA: No -- present.

22 MS. LOVE: Ray's not, but Roman  
23 Martinez is present. He's here --

24 MS. LUERA: Oh, he is? Oh, okay. Got  
25 it. Okay.

1 MR. RITCHIE: All right.

2 MS. LOVE: Did you go -- did you go  
3 through all the pages of people who are here?

4 MR. RITCHIE: Oh, Vince is on.

5 MR. WARD: I'm here.

6 MS. LOVE: Okay. So we'll get started.

7 MR. RITCHIE: Okay. Do we have a  
8 quorum for voting?

9 MR. AUTIO: And then Troy Clark just  
10 walked in.

11 MR. RITCHIE: Oh, there you go. He  
12 just walked in. Better late than never.

13 MS. LOVE: Yes. That is late.

14 MR. RITCHIE: I don't know.

15 MS. LOVE: Thank you so much, Ritchie.  
16 Okay. We have six.

17 Do you want to start the -- the  
18 PowerPoint? Yeah. The PowerPoint?

19 MS. GALLEGOS: If Ritchie says that's  
20 okay --

21 MR. RITCHIE: Okay. Please do.

22 MS. GALLEGOS: -- then we'll do it.

23 MR. RITCHIE: So we've had the roll  
24 call. Thank you, everyone, for attending on this hot  
25 Friday or Thursday afternoon. Feels like Friday --

1                   So first order of business beyond the  
2     roll call is approval of the agenda. I think everyone  
3     got one. There's copies on the table. Does anyone  
4     have any questions about the agenda? Additions?

5                   Okay. Any objections to approving the  
6     agenda? None seen. We'll accept that.

7                   Next is approval of the minutes. Does  
8     anyone have any additions, subtractions for the  
9     minutes? Okay.

10                  MR. AUTIO: Motion to approve.

11                  MR. RITCHIE: Accepted.

12                  Any second?

13                  MR. CLARK: Second.

14                  MR. RITCHIE: All right. Okay. Any  
15     objection to approving the minutes?

16                  Okay. Hearing no objection, they are  
17     approved.

18                  Then we'll go on to Item Number 2,  
19     report on the PCF status.

20                  Please take it away.

21                  MS. LUERA: Okay.

22                  All right. If we could advance  
23     the -- I'm sorry. Nope. We're packaged in the -- if  
24     you could scroll two more. Yes. Right there is  
25     great.

1                   So I have prepared an abbreviated  
2     report on PCF status for the meeting today because we  
3     have very important information to discuss with --  
4     with Mr. Walling. So I have data here as of the end  
5     of first quarter. Just due to the timing of this  
6     meeting, we don't have second quarter data quite ready  
7     yet; but I'm happy to report on that at -- at the next  
8     meeting if the Board wishes.

9                   So we have eight participating carriers  
10    in 2025. The two largest carriers, obviously, are the  
11    ones insuring the hospitals. Then we have Doctors  
12    Company with about 9.6 million surcharges and Medical  
13    Protective with about 5.7 million. They're by far the  
14    largest carriers who are insuring the independent  
15    providers here in New Mexico.

16                  So we have -- again, total surcharges  
17    are just shy of 139 million. That is, obviously, up  
18    from prior years based on the surcharge increases that  
19    went into effect January 1.

20                  So this is a fairly good picture, given  
21    that everyone has a common renewal date with PCF of  
22    January 1, 2025. The bulk of the surcharges that are  
23    going to come in for the year are front-loaded in the  
24    January-through-March time period. We will have  
25    additions, subtractions as the year goes through; but

1 this is a fairly good number in terms of what PCF is  
2 going to collect for this year.

3 MR. AUTIO: Debbie, how does this  
4 compare to last year? Do you -- do you have a  
5 comparison to last year, where we were in the first  
6 quarter of last year?

7 MS. LUERA: I have a trend -- I have a  
8 trend on hospital surcharges. I can definitely put  
9 that together. I was just trying to keep this --

10 MR. AUTIO: No, I was just curious.

11 MR. RITCHIE: That's fine.

12 MR. AUTIO: No, that's fine. Thank  
13 you.

14 MS. LUERA: Yeah, it -- it is up; and  
15 it's mostly due to the -- the hospitals needing to --

16 MR. RITCHIE: Right.

17 MS. LUERA: -- eradicate the deficit by  
18 the end of next year.

19 MR. RITCHIE: So it's mostly in those  
20 first two?

21 MS. LUERA: Yes.

22 MR. RITCHIE: Okay.

23 MS. LUERA: That's where we saw the --  
24 the largest increases.

25 MS. LOVE: So these surcharges reflect



1 deficit surcharges as well as surcharges for the year?

2 MS. LUERA: Yes. Yes.

3 Okay. If we could move to the next  
4 slide, please.

5 Okay. So this is just an overview of  
6 all of the participants. We have 14 hospitals and  
7 outpatient healthcare facilities, 417 group entities,  
8 and 5,013 individual providers. Now, keep in mind,  
9 these are only those who have enrolled in that first  
10 quarter of the year.

11 These numbers are lower than what we  
12 saw at the end of last year. Because, if you  
13 remember, the last meeting, we talked about lots of  
14 contractors coming into the state to cover hospital  
15 contracts and things of that nature. We haven't seen  
16 all of those really front-loaded for the year. So  
17 that's going to be some of the surcharge money that  
18 comes in later in the year. So our -- our count is  
19 down, but it's not really an apples-to-apples to --  
20 comparison to look at where we were at the end of last  
21 year versus where we are now.

22 MS. LOVE: So last year's included all  
23 locum tenens doctors. You're saying this year's  
24 doesn't, and so that would account for the  
25 difference --

1 MS. LUERA: Unless they enrolled in the  
2 first quarter.

3 MR. RITCHIE: You'd have to look at end  
4 of year -- compare it to end of year --

5 MS. LUERA: Right.

6 MS. LOVE: Yeah.

7 MR. RITCHIE: -- to get apples to  
8 apples?

9 MS. LUERA: Right.

10 MS. LOVE: Okay.

11 MS. LUERA: Yes. So, again, we have  
12 that 139 million in surcharges. So if we look at the  
13 breakout -- I should have brought my glasses -- we've  
14 got just about -- it's almost a half-and-half between  
15 hospital and individual. And then we have about 3.1  
16 million in entity surcharge. That's the 10 percent  
17 surcharge to cover the liability for the entity based  
18 on the enrolled providers.

19 And then when we break out the  
20 individual surcharges, you can see that the bulk of  
21 those surcharges, just about three quarters of it, is  
22 hospital-employed providers. And then we've got about  
23 16 million in independent providers.

24 MS. LOVE: Does it make sense for us to  
25 start calling -- instead of "agent doctors," calling

1       them "employed" --

2                       MS. LUERA:   Absolutely.

3                       MS. LOVE:   -- "doctor."   Because --

4       because "agent" has sort of a legal term.   And an  
5       individual provider -- independent provider can be an  
6       agent of someone else but not employed.   And I think  
7       the idea is we're trying to point out that these are  
8       employed doctors.

9                       MS. LUERA:   Absolutely.   I can -- I can  
10       make that change.

11                      MR. RITCHIE:   Yeah, we need to work on  
12       the nomenclature.   Like, I am a contractor at  
13       Presbyterian, just like the guy who repairs the  
14       elevators.   So --

15                      MS. LUERA:   Yeah.

16                      MR. RITCHIE:   -- yeah, we need to come  
17       up with some good nomenclature --

18                      MR. AUTIO:   "Employed," I think,  
19       would -- would be right.

20                      MS. LOVE:   Yeah.

21                      MR. RITCHIE:   Yeah.

22                      MS. KANE:   But as a contractor, are you  
23       covered by the hospital policy?

24                      MR. RITCHIE:   No.   Not at all.   And  
25       that was the point.   That's why it's bright yellow.

1       Presbyterian want to make sure that everyone knew --

2                       MS. KANE:   They know who's --

3                       MR. RITCHIE:   Right.  I have nothing to  
4       do with Presbyterian for no surprise billing or  
5       anything like that.

6                       MS. LOVE:   Yeah.

7                       MS. KANE:   Yeah.  Right.

8                       MS. LUERA:   Absolutely.  I will -- yes.  
9       Nomenclature, noted.  I will make that change going  
10      forward.  I think that will -- that will make things a  
11      little more clear.

12                      Okay.  I think we're ready to move on  
13      to the next.  So this is the trend of hospital  
14      surcharges.  For 2025, we had one hospital that --  
15      that did not renew their PCF coverage.  That's San  
16      Miguel.  I think I reported on that last meeting.

17                      So, Fran, if you don't mind scrolling  
18      down just a tiny bit so we can see the totals at the  
19      bottom.

20                      So, on the hospital side, you can see  
21      the increase year over year, even though a couple of  
22      the -- the hospitals are no longer participating.  
23      Again, that is mostly due to the deficit repayment  
24      that the hospitals are doing.  Any questions on that?

25                      Okay.  So moving on to the -- the

1 individual provider count.

2 Yeah. Fran, if you could scroll just a  
3 little more so folks can see what the -- sorry. I  
4 should have just sent you the PowerPoint. That  
5 would've been much easier. But the file was huge.

6 MS. GALLEGOS: That's all right.

7 MS. LUERA: So here's the breakout by  
8 provider type. We have 3,219 MDs and DOs, 975 -- and  
9 I'm sorry. I will change this nomenclature as well.

10 CN is nurse practitioner. So we've got  
11 975 enrolled nurse practitioners, 290 CRNAs, and 529  
12 physician assistants as of 3/31. That breakout is  
13 showing just about 55 percent are independent  
14 providers and 45 percent are hospital-employed  
15 providers.

16 MR. CLARK: Quick question: When you  
17 say "nurse practitioner," does that include nurse  
18 midwives or do we not have any nurse midwives?

19 MS. LUERA: Nurse -- we do have nurse  
20 midwives. They're actually -- we don't rate those out  
21 separately as a -- as a rate class. They are Rate  
22 Class 2, I think. So they would actually --

23 MR. CLARK: In which category are they  
24 lumped in?

25 MS. LUERA: They would be lumped in

1 with the MDs and DOs. I -- I do have a way to go back  
2 and pull that out, but because they're in Rate Class  
3 2, they were lumped in with the --

4 MR. RITCHIE: With the MD, DOs?

5 MS. LUERA: Yes.

6 MR. RITCHIE: Okay. Now, the 45  
7 percent agent, 54 percent independent -- the prior one  
8 said 75 percent hospital-employed, 25 percent  
9 independent? Or what was the --

10 MS. LUERA: The surcharges.

11 MR. RITCHIE: The surcharges?

12 MS. LUERA: Yes. The surcharge  
13 amounts, the dollars.

14 MR. RITCHIE: Right. And this is by  
15 number?

16 MS. LUERA: That's by count. Yes.

17 MR. RITCHIE: Right. So there's  
18 substantial difference, and that's the different in  
19 rate.

20 MS. LUERA: There's a very significant  
21 difference in rate between --

22 MR. RITCHIE: Right.

23 MS. LUERA: -- an independent  
24 provider --

25 MR. RITCHIE: The insurance of that.

1 MS. LOVE: It's because of the risk --  
2 it's because of the risk factor.

3 MR. RITCHIE: Right.

4 MS. LOVE: If you're working in a  
5 hospital, you're going to -- probably doing surgeries  
6 and procedures.

7 MR. RITCHIE: Yeah. Well --

8 MS. LOVE: Right?

9 MS. LUERA: It's more the -- the  
10 deficit repayment.

11 MR. RITCHIE: -- no. It's the deficit  
12 repayment and stuff, I think.

13 MR. CLARK: Deficit repayment and the  
14 cap is higher on a --

15 MR. RITCHIE: And the cap's higher.

16 MR. CLARK: -- hospital-employed versus  
17 an independent.

18 MR. RITCHIE: And that's kind of what I  
19 was highlighting.

20 MR. AUTIO: Yeah. But the cap's not  
21 drawn from this --

22 MS. LOVE: Well, right.

23 MR. AUTIO: -- so it wouldn't be the  
24 cap --

25 MS. LOVE: The cap's higher but the

1 PCF's exposure is not.

2 MR. RITCHIE: That's true.

3 MR. AUTIO: Yeah. It's -- it's got to  
4 be deficit.

5 MS. LOVE: It's -- yeah.

6 MR. RITCHIE: It's got to be deficit  
7 repayment? Okay.

8 MS. LOVE: Yeah. Some of it's got to  
9 be risk too. I mean, I think that you probably have  
10 higher class -- class in terms of the rating  
11 doctors --

12 MS. KANE: I'm not sure. Let us check  
13 on that --

14 MR. RITCHIE: I don't know about that.

15 MS. KANE: -- because it may just  
16 be -- the entity may be taking the risk as opposed to  
17 the individual doctors --

18 MS. LOVE: Right.

19 MS. KANE: -- and the -- and the entity  
20 pays it.

21 MS. LOVE: Yeah.

22 MS. KANE: So let's check.

23 MR. RITCHIE: And many of the employed  
24 are, like, hospitalists at a hospital, which would not  
25 have a particularly high risk.



1 MS. LOVE: Right. That's true. That  
2 is true.

3 MS. LUERA: Okay. Okay. Think we're  
4 ready to move on. Okay. So --

5 UNIDENTIFIED SPEAKER: -- agent  
6 termination.

7 MS. LUERA: Is there a question?

8 MS. GALLEGOS: Is there a question? I  
9 think they just didn't --

10 MS. LUERA: Okay.

11 MS. GALLEGOS: They came off mute.

12 MS. LUERA: Okay. So the next item on  
13 the agenda was balance sheet. And I apologize. OSI  
14 staff is very busy closing out the fiscal year since  
15 it just ended. So we did not get the updated  
16 financials as of 6/30. So if it's okay with the  
17 Board, we'll report on that at the next meeting.

18 MR. RITCHIE: Okay.

19 MS. KANE: Any surprises? Do you have  
20 any? Or you have no sense yet?

21 MS. LUERA: We don't -- we don't have  
22 the trial balance yet, so we weren't able to -- but I  
23 don't expect -- I don't expect surprises.

24 MR. RITCHIE: Okay.

25 MS. KANE: So when you get it done --

1 Do -- do you guys want to wait for the  
2 board meeting, or should we just send it out?

3 MS. LOVE: I was just going to ask if  
4 we could see it in advance because --

5 MS. KANE: Yes.

6 MR. RITCHIE: Yeah.

7 MS. LOVE: -- it's going to be a hefty  
8 meeting. It'd be nice to do some review --

9 MR. RITCHIE: And it'd be nice to see  
10 if there is a difference and if we need to watch the  
11 timing of these meetings. If we keep having this  
12 meeting now, they're always probably not going to be  
13 here.

14 MS. KANE: So we -- maybe we should  
15 move it a few weeks.

16 MR. RITCHIE: We may need to move the  
17 meeting a little bit to capture that.

18 MS. KANE: And can you give us the last  
19 year's and this year's, just so people can have a  
20 comparison?

21 MS. LUERA: Yes.

22 MS. KANE: Because --

23 MS. LUERA: End of last fiscal year  
24 versus, like, this fiscal year?

25 MS. KANE: Or comparable. Wherever you

1 are.

2 MS. LUERA: Okay. Yep. Of course.

3 MS. KANE: I don't know which -- you  
4 know, the State's on, like, July.

5 MS. LUERA: State's -- State's on  
6 fiscal. We try to run it calendar, but it's hard  
7 because different things are being closed out --

8 MS. KANE: Not closed yet.

9 MS. LUERA: -- at different times.

10 MS. KANE: We know.

11 MS. LUERA: Yes.

12 MR. RITCHIE: Yes.

13 MS. LUERA: Okay.

14 MS. KANE: This just popped in there, I  
15 think, by mistake.

16 MS. LUERA: That's just -- yeah. I try  
17 to put that periodically to show we're -- moving to  
18 the next.

19 MR. MYERS: All right. Can I tee this  
20 one off?

21 MS. LUERA: Sure. Yes.

22 MS. KANE: And -- and this is really  
23 the result of the number of the -- the questions that  
24 have been coming up. We wanted to look at the future  
25 medical -- you know, for people that were depending on

1 us for future medicals. So we're starting, you know,  
2 to delve into that. We're not finally there, but  
3 we're going to give you where we are today.

4 MR. RITCHIE: Okay.

5 MS. KANE: Ray raised an extremely good  
6 point last time.

7 MR. MYERS: Yeah, yeah. At -- at our  
8 last board meeting, yeah, Kathy Love had asked about  
9 how are these impacting surcharge and how do we think  
10 about these -- reserving for these going forward.  
11 Debbie and some of the actuaries at Pinnacle and I  
12 have chatted a -- a couple times about this, and I'm  
13 going to let Rob talk about the details.

14 But in general, you know, prior to  
15 2022, we were paying out a significant number of lump  
16 sums. We didn't really have many of these future  
17 medical claims. They started popping up in 2022. We  
18 had --

19 MS. KANE: Do you want to put the chart  
20 up?

21 MR. MYERS: -- like, four of them?  
22 Yeah. We can. I -- I -- well, let me just finish  
23 talking through this.

24 MS. KANE: Okay.

25 MR. MYERS: And then right -- as of now

1 we have 56, so, clearly, they're becoming a more  
2 significant issue. As far as the -- so there -- there  
3 are really two things we wanted to look at. One is,  
4 are these becoming large enough to impact the  
5 surcharges today? And then, also, is there anything  
6 we can do to reserve for these going forward? And how  
7 do we think about these in the future?

8 Rob, I know you and I had talked about  
9 those two things and you were going to provide some  
10 additional details. Can I -- can I turn it over to  
11 you?

12 MR. WALLING: Sure.

13 I -- I think Debbie had some basic data  
14 on the magnitude of the incremental payments. At --  
15 at this point -- oh, there we go -- you know, relative  
16 to the overall size of the program, the future medical  
17 payouts are -- are relatively diminished. I think it  
18 is something that we're going to continue to monitor  
19 closely because shifting to a model that is more  
20 future-medical-heavy changes almost every assumption  
21 in our analysis.

22 It's going to stretch out payment  
23 timing. It's going to shift what the paid claim  
24 severities look like. It changes our discount. So  
25 literally, almost every aspect of -- of what we do

1 is -- is impacted by this.

2 But as you can see, the data itself is  
3 just too early to get any indication. I -- I don't  
4 think, based on, you know, Danny [ph] and I going back  
5 and looking through the analysis, that it affects any  
6 of the assumptions in this year's study. It --  
7 because these are affecting more current years, they  
8 don't really change our historical data substantially.  
9 So I don't think it has an impact on our modeling of  
10 ultimate losses as of year end '24. But I -- I think  
11 this is something that, as we kind of start up the  
12 work for next year, we're going to pay, candidly, much  
13 closer attention to because it impacts so many  
14 different aspects of our analysis.

15 And one thing that we talked about,  
16 which I -- I think is probably a good idea -- I -- I  
17 do -- in my spare time, when I'm not doing patient  
18 comp funds, I do second injury funds for workers'  
19 comp. And workers' comp deals with a very similar  
20 issue. And what they tend to do with those programs  
21 is they model out the future medical claims separately  
22 relative to the overall program reserves, just to make  
23 sure that the indications coming out of the future  
24 medical model are consistent with the overall reserve  
25 levels. And -- and I think, probably, a similar

1 approach will -- will be a useful -- I guess I'll call  
2 it "reasonableness check."

3 So more to come. But as of right now,  
4 I don't think it -- it affects our analysis to the  
5 point that we need to make a modification to it.

6 MR. CLARK: Christian, quick question.

7 MR. MYERS: Yeah.

8 MR. CLARK: Is the graph that we're  
9 seeing here, are these amounts paid out in the -- in  
10 those years or they're amounts paid out last year and  
11 this -- these are the years the claim is associated  
12 with?

13 MS. LUERA: They're the amounts paid  
14 out during that calendar year.

15 MR. MYERS: By year -- calendar year.

16 MR. CLARK: Regardless of which year  
17 the claim was associated?

18 MR. MYERS: No matter when the claim  
19 was -- yeah.

20 MR. CLARK: Okay.

21 MR. MYERS: So there -- yeah, there  
22 could be one claim that shows up in all of these bars.

23 MR. CLARK: Well, I just wondered if  
24 some of the -- and I don't know that we know this  
25 since we don't know which claim you're relating to --

1 with the pandemic, was there delays in care? Yes.  
2 And that -- thus you see a spike in '23?

3 MR. AUTIO: And, Christian and Rob, I  
4 don't -- this might come up later and we might discuss  
5 it in more detail, but is there -- what -- what's  
6 the -- can you give us a sense of what the methodology  
7 is to, you know, looking at what those future meds  
8 will be? Especially with, you know, 57 patients now,  
9 it just seems like -- and I can imagine, you know,  
10 the -- their future meds could be across the spectrum,  
11 from someone who might just need an additional surgery  
12 to someone who might need decades of care. I mean,  
13 how do you account for -- for that to make sure those  
14 patients that do need years of -- of medical care --  
15 how -- how do we account to make sure that's provided  
16 for?

17 MR. WALLING: Typically, there is some  
18 measure of life expectancy, which will, obviously, be  
19 based on their age but also on their level of  
20 impairment. Typically, we also tend to model what we  
21 think the annual medicals are going to be based on  
22 their own historicals. In some states, we actually  
23 get more detailed care plans that give us some idea of  
24 what future medicals should look like based on the  
25 assessment of an independent, you know, healthcare



1 professional.

2 So it really depends on how much data  
3 we're going to be able to get available for the  
4 assessment. But at a bare minimum, we're going to  
5 start with, you know, what we see in the annual  
6 payments and their life expectancy; and -- and we'll  
7 start the modeling from there.

8 MR. CLARK: So are you reviewing --

9 MR. WALLING: But your point's well  
10 taken.

11 MR. CLARK: Are you reviewing the  
12 details of each of the 57 cases, then, if you're  
13 think -- if you're adding to that life expectancy and  
14 individual case criteria?

15 MR. WALLING: We're going to need to  
16 see what data is available first. So before we settle  
17 on a methodology, we really need to make an assessment  
18 of -- of what data is readily available for each of  
19 those 57.

20 MR. CLARK: So currently you're just  
21 doing off total medical payouts not indicated by --

22 MR. WALLING: We're not even doing that  
23 yet.

24 MR. CLARK: -- any one individual case?

25 MR. WALLING: Yeah. We're not even

1 doing that yet.

2 MR. CLARK: Okay.

3 MS. LOVE: And -- and I think it  
4 wasn't --

5 MR. WALLING: Yeah, we -- we have not  
6 made a change to methodology. Our intention would be  
7 to probably introduce not so much a change in  
8 methodology as a -- a consistency check next year.  
9 And then if we feel like a -- a new methodology for  
10 the future medicals is required, we probably -- we  
11 might introduce it next year. My gut would be we'd  
12 probably wait one more year as long as the consistency  
13 check looks reasonable next year.

14 But we're -- we're going to, I guess,  
15 take a fairly measured approach to this because, you  
16 know, this year we had \$127,000 in payments in a year  
17 when the PCF had 21 million in payments. So it's --  
18 relative to the overall payment volume, it's pretty  
19 immaterial.

20 MS. LOVE: To address your question,  
21 though, Troy, earlier, about the spike in 2023, my  
22 understanding is that not that many years ago, there  
23 were only, like, six patients who were taking future  
24 meds out of here. So the difference is the  
25 settlements are including future meds as paid out.

1 MR. CLARK: Right. Right.

2 MS. LOVE: There -- there's been a  
3 drastic increase in the number that the Patients'  
4 Compensation Fund is responsible for paying for.

5 MR. CLARK: I agree. I -- I think what  
6 I don't know is when there's 57 in 2023 where there's  
7 70 -- because we see a decrease into '24. '25's a  
8 partial year --

9 MS. LUERA: No, it's been -- it's been  
10 consistently going up. The number --

11 MR. CLARK: Or is the count going up  
12 in the --

13 MS. LUERA: The number --

14 MR. CLARK: My comment was, is '23 just  
15 higher because of maybe delays in care offsetting --

16 MR WALLING: Yeah. It's interesting.  
17 Apparently --

18 MR. CLARK: -- for how many are there  
19 going up. So you would expect that '23 drop to '24 --  
20 that's what made me ask the question, yeah.

21 THE REPORTER: Can I just ask  
22 participants to speak one at a time. This helps me.  
23 Yeah.

24 MR. RITCHIE: All right. You guys have  
25 any questions?

1                   Mr. Walling, you want to talk real  
2 quick?

3                   MR. WALLING: Sure.

4                   Just to get some perspective, this is a  
5 comparison of the actual paid loss data as of year end  
6 '24, here in the third column, and the middle of the  
7 page, as of the prior year. The -- the claim activity  
8 that we saw during '24, the incremental changes,  
9 candidly, are still predominantly pre-COVID. So we're  
10 still looking at, you know, \$13 million of incremental  
11 payments on accident year 2018, another 16 and change  
12 on 2019. So any lingering effects of delays in care  
13 or delays in diagnosis really haven't showed up in --  
14 shown up in the claims data yet -- I -- I guess would  
15 be my -- my overarching comment.

16                  MS. LUERA: I have the data right here.  
17 So in 2022, we had three claimants who actually sought  
18 medical care. In '23, that was nine -- ten. In '24,  
19 we added about five more. So we're up to about 15.  
20 And so far, this year to date -- and again, this is as  
21 of the end of first quarter -- we've only had nine  
22 claimants treat.

23                  MR. RITCHIE: And, Ms. Kane, has there  
24 been a difference in the thought process on reviewing  
25 or deciding, you know, how many -- or lump sum, how

1 many are going just to future medical?

2 MS. KANE: We've been pushing for  
3 future --

4 MR. RITCHIE: Right. And so I think  
5 that's part of it going forward.

6 MS. KANE: Yes. That's what -- that's  
7 a big part of it.

8 MR. RITCHIE: Right.

9 MS. KANE: I think that's what -- you  
10 know, that's the -- you -- you were pointing the idea  
11 in the last meeting.

12 MR. RITCHIE: Exactly.

13 MS. KANE: And that's why we are  
14 looking at it more carefully with Christian --

15 MR. RITCHIE: Right.

16 MS. KANE: -- and whatever to see  
17 what's going on. Because when I showed up, I think  
18 what the -- somebody told me that -- told me, not --  
19 not that I had the actual data -- oh, there are four,  
20 you know. And now we're up to 57. So, obviously, you  
21 have to really --

22 MS. LOVE: It's a big difference.  
23 Yeah.

24 MR. RITCHIE: Right.

25 MS. KANE: -- have to look at it.

1 MS. LOVE: Especially if you've got a  
2 bunch of --  
3 MS. KANE: Seriously ill people.  
4 MS. LOVE: Yeah.  
5 MR. RITCHIE: Right.  
6 MS. LOVE: Birth injury cases --  
7 MS. KANE: Yes.  
8 MS. LOVE: -- that are going to go long  
9 term.  
10 MS. KANE: Right.  
11 MR. RITCHIE: Right. We need to  
12 account for them. But that's the intention of the  
13 fund --  
14 MS. KANE: Exactly.  
15 MR. RITCHIE: -- is to pay future  
16 medical.  
17 MS. KANE: Right.  
18 MR. RITCHIE: So the question --  
19 MS. LOVE: We can -- we can debate  
20 that. But the -- the point here that's relevant today  
21 is the importance of: If you settle with a patient  
22 and agree to pay for their future medicals, what are  
23 we going to do to make sure the money's going to be  
24 there for them?  
25 MS. KANE: Right. Which was the point

1     you made.

2                   MS. LOVE:    Yeah.

3                   MR. RITCHIE:  Exactly.

4                   MS. KANE:    That's why we're here.

5                   MS. LOVE:    Thank you.

6                   MR. CLARK:   So I've got a question.   57  
7     open claims, is that 57 patients?  And you're telling  
8     me only nine have had a -- I'm not using the word  
9     "claim" -- an invoice or a patient -- or a medical  
10    visit this year?  Or is that 57 claims that may be on  
11    10 patients?  Or they have multiple --

12                  MS. LUERA:   So it's 57 patients.  
13    Only -- and again, this is through March.  I don't  
14    have through second half of the year.  I can certainly  
15    update it once we have it.  Yes.

16                  MR. CLARK:   So the numbers you gave us,  
17    the 3, 9, and 15, from previous years would've been  
18    only the number you got --

19                  MS. LUERA:   We got --

20                  MR. CLARK:   -- claims or --

21                  MS. LUERA:   Yeah.  Medical bills.

22                  MR. CLARK:   -- bills processed for --

23                  MS. LUERA:   Yes.

24                  MR. CLARK:   They're not relative to the  
25    57?  We didn't grow from 3 to 57.  We had -- we went

1 from 3 to 9 to 15, and we're 9 so far. So we aren't  
2 growing since we're only partway into the year. But  
3 57 is --

4 MS. LUERA: We -- we grew to 57 that we  
5 have an obligation --

6 MR. CLARK: Right. But they're not  
7 all --

8 MS. LUERA: -- to pay future meds on,  
9 but they're not treated.

10 MR. CLARK: But the starting point was  
11 not three?

12 MS. LOVE: Yes.

13 MR. CLARK: You said in 2022, there  
14 were three. But there were three that --

15 MS. LUERA: There were three that we  
16 paid on.

17 MR. CLARK: -- we paid claims on.

18 MS. LUERA: Yes.

19 MS. LOVE: Right.

20 MS. LUERA: And we -- there was one  
21 future medical claimant that came over when Integrion  
22 took over who has passed away, unfortunately. So he  
23 went off. But we have consistently, year over year,  
24 been adding more claimants, patients who we have an  
25 obligation to pay their future medical should they



1 need to treat.

2 MS. LOVE: It's not that far off, Troy.  
3 It's not that far off because just not that long ago,  
4 there were just, like, four or six.

5 MR. CLARK: And I remember hearing  
6 those numbers. I guess I'm more surprised that there  
7 are 57 and we've only had 9 medical bills on them in 6  
8 months. That's -- that's what surprised me --

9 MS. KANE: Lucky.

10 MR. RITCHIE: I hope so. I mean,  
11 obviously, that's good.

12 MR. BERENBERG: I don't think it's nine  
13 medical bills. I think it's nine patients that had  
14 medical bills. Is that correct?

15 MS. LUERA: Yes.

16 MR. BERENBERG: So some of the  
17 patients --

18 MR. RITCHIE: Yeah, can we look at  
19 that?

20 MR. CLARK: Multiple medical bills.  
21 But that means to me there's 48 that have not turned  
22 any costs. That's great for them they haven't had to,  
23 if it's because they really didn't have a need.

24 MS. LOVE: Or it's being paid  
25 elsewhere.

1                   MR. RITCHIE: Well, that's good for the  
2 fund, obviously.

3                   MR. CLARK: Exactly. That's all I'm  
4 trying to do, is trying to figure out the correlation  
5 between the dollars, the number of claims, and the  
6 number of people.

7                   MS. KANE: And that's really what we're  
8 going to hopefully have Christian and Rob doing in a  
9 more, you know, methodology, actuarial fashion, which  
10 I am totally incapable of doing.

11                  MR. RITCHIE: We'll figure out how many  
12 of that -- those open claims, the 57 open claims, so  
13 to speak, how many of them per year are going to  
14 submit bills --

15                  MS. KANE: Well, it won't be -- it  
16 won't be that clear.

17                  MR. RITCHIE: I know. But that's what  
18 we're shooting for, is that kind of actuarial  
19 analysis.

20                  MS. KANE: He'll explain ultimately  
21 what the methodology is that he thinks is, you know,  
22 accurate. Because I could describe it and it wouldn't  
23 be what they're doing.

24                  MR. RITCHIE: Oh, no, no. It's -- it's  
25 going to be kind of a guess to -- to get --

1 MS. KANE: Well, projection -- you  
2 know, educated projections based on -- like, do it in  
3 every other kind of situation.

4 MS. LUERA: Project the future based on  
5 the past.

6 MS. KANE: Yes.

7 MR. RITCHIE: Right. There's a  
8 disclaimer, then --

9 MS. KANE: Unlike our climate change  
10 issue, this one is different.

11 MR. WALLING: And estimating the  
12 payments for the next 60 years for a birth claim based  
13 on two years of payments.

14 MR. RITCHIE: Okay. So, Mr. Walling,  
15 continue.

16 MS. KANE: Rob, did you want to say  
17 that again because we were --

18 MR. RITCHIE: Yeah, sorry.

19 MS. KANE: -- we were being rude and  
20 talking --

21 MR. RITCHIE: Yes.

22 MR. WALLING: Oh, no. It's -- it's  
23 estimating how big an iceberg is. We're going to  
24 estimate what future medicals on a birth injury claim  
25 are for the next 60 years based on 2 calendar years of

1 payments.

2 MR. RITCHIE: Right, right.

3 MS. KANE: So he's got -- he's trying  
4 to tell you he's got a very small pool. Okay. Which  
5 is why this is probably going to take a while to get  
6 us comfortable because the -- he keeps on saying what  
7 data is available. You know, it's only -- it's got a  
8 short time. And, actually, we'd love to have --

9 MS. LUERA: Years and years.

10 MS. KANE: Okay. Who's doing the next  
11 slide, 13?

12 MS. LUERA: Oh, that's me again. Cool.  
13 Yes. Okay. Okay.

14 So as usual, we have our report on  
15 tracking allocations of settlement. Again, this data  
16 is the first quarter. I will have updated numbers the  
17 next time we meet.

18 So through March 31st of this year,  
19 we've had 25 settlements, with 15.2 million in total  
20 PCF payouts. When we break that down, 3.4 million has  
21 been paid on behalf of individual providers. About  
22 two-thirds of that has been paid on behalf of  
23 independent providers, 2.5 million, and about 900,000  
24 on behalf of hospital-employed providers. We have an  
25 additional 9.6 million that's been paid out on behalf

1 of a hospital and 2.1 million and change paid out on  
2 behalf of an entity. So the pie chart on the right  
3 shows the breakdown of -- of the dollars paid in a  
4 more visual format, just so you can see that.

5 Yes, sir.

6 MR. AUTIO: So -- so that average is  
7 if -- if -- 15.2 million over 25 settlements, that  
8 would come out to 600,000 per, on average. Right?  
9 And that's -- that -- is this -- is this the total  
10 settlement amount, including the -- the other insurer;  
11 or is this just payouts from the PCS?

12 MS. LUERA: This is just PCF.

13 MR. AUTIO: Just PCF.

14 MS. KANE: So you don't capture that  
15 initial -- you know, you don't capture the above and  
16 below. You just capture --

17 MS. LUERA: What the PCF --

18 MR. AUTIO: Which is -- I guess is why  
19 I'm asking. Because the -- the PCF's layer of  
20 exposure should be 500,000 max per occurrence. Right?

21 MS. LUERA: Plus past.

22 MR. AUTIO: Plus -- so that's -- that's  
23 the --

24 MS. LUERA: Yes.

25 MR. AUTIO: Okay.

1 MS. LUERA: And sometimes they're  
2 negligible and sometimes they're --

3 MR. AUTIO: Well, I guess it would just  
4 be past meds --

5 MS. LUERA: -- incredibly high.

6 MR. AUTIO: -- in this case --

7 MS. LUERA: Correct.

8 MR. AUTIO: -- since future are being  
9 paid as --

10 MS. LUERA: Yes.

11 MS. KANE: They're not being accounted  
12 for here.

13 MR. BERENBERG: And it's more than 500  
14 because of the inflation, I guess.

15 MR. AUTIO: Yeah. That's true. That's  
16 true. Well, and independent providers only. Right?  
17 Yeah. Okay.

18 Okay. No, that -- that answered my  
19 question. Thanks.

20 MS. LUERA: So if we go to the next  
21 slide, this is just showing the payouts by accident  
22 year. So the claims that we were able to settle in  
23 the first quarter go all the way back to 2011. And  
24 you can see the -- and then we have a jump to 2017.  
25 And we basically have payouts on all the accident

1 years since 2017, with the exception of 2024, just  
2 because it's too early to be settling those out yet.  
3 So this is just a -- a good chart to show you sort of  
4 the lag time in -- from accident year to the year that  
5 they are settled and paid by the PCF.

6 Okay. I think we can go to the next  
7 slide.

8 So I wanted to show some -- some  
9 trended data on the number of settlements. Now, some  
10 settlements include both a hospital and an independent  
11 provider. So this -- when you add the two numbers,  
12 it's not -- like, I just said that we had 25  
13 settlements, I think. But if you look at 1Q '25, it  
14 shows 29 because we -- we counted twice when there was  
15 an independent provider and a hospital provider  
16 included there.

17 So you can see, third quarter of 2024,  
18 which kind of tracks with prior years, we had a lot of  
19 settlements and a lot of money paid out. So you can  
20 kind of see, like, we get off to a bit of a slow start  
21 in the first quarter and then it really ramps up  
22 second and third quarter. And then fourth quarter,  
23 it -- it tends to slow down a little bit. So we are  
24 in a really busy time right now in terms of trying to  
25 get some of these claims settled. So again, this is

1 just the number of settlements per quarter as a trend.

2 And then if we go to the next slide,  
3 there's a payment trend that shows the amount paid per  
4 quarter. So again, we are seeing a bit of a spike,  
5 which would be expected, of payments being made for  
6 hospitals and employed physicians. We started to see,  
7 in 2024 we had -- we had a very busy first quarter for  
8 independent providers and then it dropped down. And  
9 so the past four quarters have been sort of more  
10 reasonable or normal levels in terms of amounts paid.  
11 And hospitals -- hospital claim settlements do  
12 continue to be fairly frequent.

13 MR. CLARK: Question: Is there any  
14 timing difference between the last two charts?  
15 Sometimes you'll settle and the payment takes place  
16 two weeks, four weeks, a month later.

17 MS. LUERA: There is --

18 MR. CLARK: So is it possible that a  
19 claim settled in Q3 -- and it's in the Q3 column on  
20 the first graph -- but it didn't pay till Q4 --

21 MS. LUERA: Yes.

22 MR. CLARK: -- so the -- the two do not  
23 line up?

24 MS. LUERA: Exactly.

25 MR. CLARK: Okay.



1 MS. LUERA: Yes. That is -- it's very  
2 frequent that that happens. A lot of times, we know  
3 it's settled at mediation but it takes -- it can take  
4 60, 90, 120 days to agree on the settlement language;  
5 and so it won't get paid. Yeah. So good point,  
6 Mr. Clark. The -- the numbers do not line up.

7 MR. CLARK: You just -- you just can't  
8 make a correlation of amount per claim --

9 MS. LUERA: Right.

10 MR. CLARK: -- by quarter from -- from  
11 this data.

12 MS. LOVE: Trust the accountant

13 MR. AUTIO: Famous last words.

14 Is -- is that truly just settlements?  
15 I know there are, fortunately, many judgements. But  
16 are those judgments included or just strictly  
17 settlements captured there?

18 MS. LUERA: If -- if it's paid out,  
19 it's captured here.

20 MR. AUTIO: Okay. So those are used  
21 synonymously here?

22 MS. LUERA: Yes.

23 MR. AUTIO: Settlements and judgements?

24 MS. LUERA: Yes, yes.

25 MR. AUTIO: Okay.

1 MS. LUERA: Any other questions?  
2 MR. RITCHIE: No.  
3 MS. LUERA: Okay. All right. Thank  
4 you.  
5 MS. KANE: I think it's --  
6 MR. RITCHIE: Yeah. Back to Rob.  
7 Mr. Walling?  
8 MR. WALLING: Okay. Yep. Sorry. Give  
9 me a second.  
10 MR. RITCHIE: Okay. No problem.  
11 MR. WALLING: Okay. So I've already  
12 given you a sneak peek at this exhibit, but this is  
13 where I'd like to start. It -- it's worthwhile to  
14 look at the incremental changes in the PCF between  
15 year end '23 and year end '24.  
16 MS. KANE: It's -- Rob, did you have --  
17 MR. RITCHIE: Or is it at a different  
18 tab? Is it --  
19 MS. KANE: There's nothing there.  
20 MR. MYERS: Is he sharing on the --  
21 MS. KANE: Do you want share --  
22 MS. LUERA: Try minimizing that and --  
23 MR. WALLING: I am sharing.  
24 MS. KANE: Well, we --  
25 MS. LUERA: Okay.

1 MS. KANE: Well, it hasn't gotten here  
2 yet. It's on the --

3 MR. RITCHIE: If he wants to sign --

4 MS. KANE: Well, I'm not sure what it  
5 says. I failed the sight test.

6 MR. WALLING: Okay. Let me know if the  
7 slides lag because I do tend to dance around a little  
8 bit.

9 MS. KANE: I think we have it.

10 MR. WALLING: Okay.

11 MS. KANE: It's just very tiny.

12 MR. RITCHIE: Can't read it, but we've  
13 got it.

14 MR. WALLING: That's fine. Okay.

15 So -- end of year in '23, at the bottom  
16 of the middle of the page, you can see we're at \$292  
17 million. At year end '24, that had increased by a  
18 little over \$100 million to 395 million.

19 MS. LOVE: Is it in here?

20 MR. WALLING: Something's not driving  
21 here.

22 MS. KANE: Rob, it's Alice. Just a  
23 question. We -- that's very tiny. And maybe some  
24 people can see it with laser vision, but is it in --  
25 is it in your report?

1 MR. WALLING: Do you have a copy of my  
2 report?

3 MS. KANE: Yeah. We have the report.  
4 What page?

5 MR. WALLING: It's Exhibit 1, page 3.  
6 I don't have your page number, and I apologize.

7 MS. GALLEGOS: Who has this again?

8 MR. RITCHIE: Who's gotten both?

9 MS. GALLEGOS: No, we didn't have  
10 enough reports for everybody? Do you want me to make  
11 the whole report --

12 MS. KANE: Yes, please.

13 MS. GALLEGOS: Okay.

14 MS. LUERA: I'm sorry. I thought we  
15 had them done.

16 MS. GALLEGOS: How many -- how many  
17 copies?

18 MR. AUTIO: I'd like one.

19 MR. RITCHIE: Maybe email it to us.

20 MR. AUTIO: Maybe -- maybe six.

21 MR. RITCHIE: Yeah. It'd be six.

22 MS. KANE: It'd be six. And I think I  
23 have one extra in my office.

24 MR. CLARK: No, I just didn't print it  
25 off. I didn't see it.

1 MS. LOVE: This one doesn't have the  
2 report. That's just the PowerPoint.

3 MR. WALLING: Yeah. That's the  
4 PowerPoint.

5 MR. CLARK: I didn't see an email this  
6 morning.

7 MS. LOVE: That's going to be the  
8 PowerPoint too.

9 MR. CLARK: Was it on this morning's  
10 email that had the transcript?

11 MR. RITCHIE: It wasn't in the  
12 transcript. Was it?

13 MR. CLARK: I didn't see it earlier,  
14 and I don't see it there now. So I don't know.

15 MR. RITCHIE: I didn't even get an  
16 attachment on the transcript.

17 MS. LOVE: No.

18 MR. CLARK: I don't know. Oh, yeah.  
19 Doesn't even have an attachment on that one.

20 MS. LOVE: No. I don't think it's  
21 emailed.

22 Debbie, can you send the PowerPoint  
23 around today to everybody too?

24 MS. LUERA: Sure.

25 MS. LOVE: That'd be great. Thank you.

1 I can only absorb so much in a meeting. I need to  
2 actually study --

3 MS. LUERA: Understood.

4 MR. RITCHIE: Well, yeah, look at how  
5 small it is.

6 MR. CLARK: Would it come from Frances  
7 or would it come from Debbie?

8 MS. LUERA: Frances. I didn't --

9 MR. AUTIO: I definitely didn't --

10 MR. RITCHIE: I don't -- I can't find  
11 it.

12 MS. LUERA: The study?

13 MS. LOVE: Oh, is it this Otter thing?

14 I

15 MR. MYERS: I don't know what that is.

16 MS. LOVE: Open in Otter? Shared, PCF  
17 Advisory Board meeting. Open in Otter.

18 MR. RITCHIE: How did you find that?

19 MS. KANE: I think I'm killing trees.

20 Who else would like --

21 MR. AUTIO: I'll probably --

22 MR. RITCHIE: I'll --

23 MS. KANE: Can you two share?

24 MR. RITCHIE: Yeah. We can share. Or  
25 all three can share.

1 MS. KANE: Apologies. I -- I do paper,  
2 so --

3 MR. AUTIO: Thank you.

4 MS. KANE: We'll get it as quickly as  
5 possible.

6 MS. LOVE: I don't know what this Otter  
7 thing is, then. It doesn't seem --

8 MS. KANE: Is there any way to blow  
9 this up?

10 MR. RITCHIE: So do we think it's in  
11 this Otter thing or not?

12 MS. LOVE: No.

13 MR. MYERS: I don't know what the Otter  
14 thing is. I ain't got that thing.

15 MR. RITCHIE: I don't think --

16 MR. MYERS: It's -- I don't think I  
17 have any --

18 MS. LUERA: I -- I'm trying to email it  
19 to everybody right now.

20 MR. RITCHIE: The report?

21 MS. LUERA: The actuarial statement,  
22 yes.

23 MS. KANE: Next time we'll make sure  
24 you have it email ahead of time. Apologies.

25 MR. RITCHIE: All right. Well,

1 let's -- since we're not even getting a chance to read  
2 much in here, in this downtime, can you give us --  
3 Rob, can you give us kind of a high level without --

4 MR. WALLING: Sure.

5 MR. RITCHIE: Actually, it's -- the  
6 view's better. I mean, I can see some of that now.  
7 You may just need to increase the size. So let's try  
8 to keep going, please.

9 MR. WALLING: Okay. Let's do that.

10 So at a very high level, we had \$59  
11 million worth of payments -- loss payments last year,  
12 benefits payments last year. And if you compare that  
13 59 million to, kind of, what our running rate estimate  
14 of ultimate losses are, it's -- it's actually -- it  
15 looks better than we would have anticipated. So I'm  
16 going to call that slightly better paid loss activity  
17 than I would have anticipated.

18 It's really quite interesting in that  
19 the payments for the physicians were worse than  
20 expected, where we saw \$37.4 million worth of paid  
21 losses related to the physicians, relative to, kind  
22 of, a run rate of something on the order of \$20  
23 million a year for the -- for the physicians and  
24 surgeons.

25 By comparison, the hospitals performed



1 very well in calendar year '24. We saw only 21.6  
2 million of payments compared to a run rate that's  
3 typically in the high \$40 million range. So a pretty  
4 significant disparity between the claims experience  
5 that we saw for the hospitals during the year, which  
6 was very good, and the experience for the physicians  
7 and surgeons, which, candidly, was -- was much worse  
8 than expected.

9 As a result of that and a result of  
10 the -- the legislative infusions, we've ended up in a  
11 situation where, if you view the two programs, the  
12 physicians program and the hospital program, as  
13 separate, kind of, segregated accounts of the PCF, the  
14 infusions associated with the physicians and surgeons  
15 have essentially eliminated the deficit. We're  
16 looking at a fund balance of about \$82 million,  
17 relative to discounted reserves of -- of 80 million.  
18 And so, kind of, the only remaining deficit is  
19 associated with the hospital program.

20 So, obviously, when you -- you know,  
21 when you make these kind of legislative infusions, it  
22 has a really positive effect on the financial health  
23 of the program; and we're -- we're seeing that at a  
24 very high level. So, candidly, a very -- a very much  
25 brighter picture in -- in those small part due to

1 those legislative infusions.

2 So like I said, a fund balance of about  
3 82 million for the docs, that's consistent with their  
4 reserve levels. So there's essentially no deficit and  
5 no need for a deficit surcharge. The hospitals,  
6 there's still a deficit position of about \$34 million,  
7 discounted, about 26.5, that has a -- a surcharge for  
8 the next two years.

9 Let's get to the rates, if you don't  
10 mind. I'm going to -- sorry. This is the part that  
11 makes your head spin if the -- if the display is  
12 lagging.

13 But in terms of the indicated rate  
14 levels, for the physicians, we're showing an indicated  
15 rate increase of about 13.6 percent, based on the  
16 available information. Again, we're just running a --  
17 a little bit higher loss ratio historically than our  
18 breakeven. Our breakeven talks about projected  
19 surcharges of about 19.3 million to -- we're -- we're  
20 projecting more like 23.7. And that's really the  
21 basis for the increase, is the disconnect between what  
22 we expect to -- to collect next year and what we think  
23 the -- the losses are.

24 We do make adjustments for claims  
25 adjustment expenses of 3.6 percent and overhead of 1.1

1 percent. It's probably worth a second to talk about  
2 this.

3 Part of the reason that I'm so  
4 passionate about birth injury funds and PCFs is this  
5 bit, that their total expense load is 4 percent of --  
6 of premiums. It's an extremely efficient way of  
7 delivering benefits to -- to the participants in the  
8 program. Birth injury funds are the same way.

9 But that -- that 1.1 percent of -- of  
10 surcharges, overhead charge, compare that to -- to the  
11 Doctors Company or Medical Protective, there's no  
12 comparison. But the -- the indicated premium change  
13 for the docs is 13.6 percent. If you increase that to  
14 include a risk margin, it goes up to 23 percent.

15 We have that summarized here, where you  
16 can see that the increased loss factors, the cost of  
17 living adjustment to the PCF coverage layer also adds  
18 an additional 2 percent rate increase. But you'll  
19 see, as I said before, there's no class plan changes.  
20 There's no deficit surcharges. So the rate increase  
21 for the physician is just the -- the 13.6 percent  
22 assessment change plus the 2.1 percent for the -- the  
23 ongoing cost-of-living increases.

24 If you look at the hospitals by  
25 comparison, remember, the experience looks pretty

1 good. And so what we're showing -- sorry -- what  
2 we're showing for the hospitals on Exhibit 6, page 2  
3 is an indicated increase of -- of assessments of only  
4 2.6 percent. We've seen a plateauing of the  
5 experience. The hospital experience looks, actually,  
6 pretty good.

7                   Unfortunately, we are still dealing  
8 with the deficit surcharges, so there's still a  
9 deficit surcharge lingering out there. But on a -- on  
10 a pure experience basis, because the amount of claims  
11 payments during the year were so much lower than  
12 expected, we're seeing an overall indicated change for  
13 the hospitals of 2.6 percent.

14                   The reserve analysis has a lot of  
15 details in it. There's a lot of -- you know, a lot of  
16 interesting information in terms of claims trends.  
17 There's a lot of interesting information in terms of  
18 the -- I'm just going to go back and at least get you  
19 a little bit of a flavor for that.

20                   So back in the appendices, we've put  
21 all of the gory details. But this gives you a sense.  
22 Like, part of the reason that we talk about the timing  
23 of payments is it takes a long time for PCF claims  
24 to -- to flow. So if you look at, like, Appendix 6  
25 page -- Appendix 10 page 1, you get a flavor for this,

1 that there's a lot of years where we don't see any  
2 claimants until you're -- until three years after the  
3 accident year and that for most of these, we're -- you  
4 know, you're seeing five-to-ten-year delays until you  
5 have final settlements on PCF claims.

6 In some cases, you actually see  
7 settlements that -- that go even further out than  
8 that, where the 2015 year -- 2014 year just had a  
9 claim settle. Actually, the 2015 year did too. So --  
10 so it's not uncommon for these claims to have eight,  
11 nine, ten-year settlement lags, which is part of what  
12 makes getting the reserves right, candidly, so  
13 difficult.

14 When we look at the severities -- let  
15 me try and -- try and give you a little bit of a  
16 flavor for that. The claim severities -- this is for  
17 the -- the physicians. You'll see that the -- the  
18 paid severities are kind of all over the place.

19 In -- in Column 4, you'll see that in  
20 some years -- like 2015, the average claim severity is  
21 \$600,000. In other years you'll see it as low as, you  
22 know, a quarter of a million dollars, you know,  
23 \$262,000.

24 And that volatility is -- is one of the  
25 challenges we really deal with in terms of trying to

1 make some kind of assessment. Actually, back to your  
2 point about COVID, is -- is that paid severity so far  
3 of 147,000 on the 2021 year -- is that an aberration?  
4 Is that going to be one of those low-severity years?  
5 Or are we just seeing more lags in -- in the  
6 settlement of those claims due to COVID?

7 And so in the early years for these  
8 portfolios of claims, it really requires a steady hand  
9 to not overreact to what we see in the first eight  
10 claims. So hopefully, that gives you a little bit of  
11 a flavor for what we -- what we work on when it comes  
12 to looking at the -- the claim frequencies and the  
13 claim severities. I'm going to stop scrolling around  
14 and ask if folks have any questions on the reserve  
15 analysis.

16 MR. RITCHIE: Go right now?

17 MS. LOVE: I -- I have a question. And  
18 I'm not exactly sure if I can articulate this very  
19 well, but I'll try. When you say that the claims  
20 experience for hospitals has been better than  
21 expected, are you also comparing that to the number of  
22 cases that are currently pending for the hospitals?

23 Because I remember looking at a chart  
24 last year that showed the number of claims pending and  
25 a relatively small number of cases that had settled.

1 So I just want to make sure that we have an accurate  
2 picture and it's not just a matter of cases just sort  
3 of being out there and not having settled yet.

4 MR. WALLING: We do look very closely  
5 at both closed claims -- in other words, settled  
6 claims -- and reported claims. And our frequency and  
7 severity method very directly looks at those reported  
8 claims and makes sure that we're not kind of  
9 underestimating the ultimate losses based on what we  
10 see in that claims activity.

11 I can show you an example of that  
12 really quickly. This is perfect. We -- you know,  
13 that's not going to work really well. Unfortunately,  
14 that -- that exhibit's not going to answer the  
15 question you have.

16 But, yes, we are monitoring very  
17 closely both the closed claims activity and the  
18 reported claims activity because if those claims are  
19 still sitting out there reported, they're  
20 still -- there's -- there's still a potential for  
21 unpaid claims.

22 MS. LOVE: Okay.

23 MR. RITCHIE: Okay. Any other  
24 questions?

25 All right. No other questions here,

1 Rob.

2 MR. WALLING: Okay.

3 MS. KANE: I have a question. So, Rob,  
4 when the hospitals leave and you see this lag time --  
5 and I know we have the deficit, but does it all work?  
6 When I see a ten-year lifetime --

7 MR. WALLING: That's an interesting  
8 question. And, you know, the question of do we -- do  
9 we make some assessment to -- to have a buffer, you  
10 know, almost like an escrow account on a -- on a home  
11 sale? Do -- do we build some buffer, or do we have  
12 some mechanism to assess them if the claims turn out  
13 to be worse than I model them?

14 There -- there's a lot of questions  
15 there. And it's -- a -- a non-trivial part of that is  
16 not really an actuarial question. It's a policy  
17 question. But we do need to think long and hard about  
18 how we're going to deal with the situation when -- I  
19 mean, to -- to point it in either direction.

20 What if the hospital experience turns  
21 out to be \$20 million better than I estimated? Are --  
22 are we going to return surcharges? Conversely, if  
23 it's -- you know, if it's \$20 million worse than I  
24 estimate -- and are -- are we going to ask for more  
25 money? You know, are we going to ask for forgiveness



1 or permission? Or are we going to try and fund  
2 this -- you know, the -- the hospital part of the  
3 program, to make sure there's enough, to make sure  
4 that we're protecting the PCF, and then release that  
5 if it's not needed? Lots of questions and -- and lots  
6 of issues for the board members to wrestle with.

7 MS. KANE: You know, the only -- and  
8 it's not even a good analogy. But the Massachusetts  
9 FAIR Plan sort of overestimating the hurricanes that  
10 were going to come to Cape Cod -- and I think they  
11 gave back 600 million this year. On the other hand,  
12 when you underestimate, like we did in our FAIR plan,  
13 the backstop was an assessment. So it's -- this is  
14 not a simple situation. And to be honest, in light of  
15 what's going on with the hospitals and what's going to  
16 be happening with the new -- you know, with the new  
17 federal legislation, I think this is really going to  
18 be a difficult situation.

19 Troy, I mean, I'm speaking up for you,  
20 but --

21 MR. CLARK: Well, it's a challenge --

22 MR. WALLING: It's funny that you bring  
23 up the -- the Massachusetts FAIR plan. The good  
24 people of Florida are dealing with an -- an insurer of  
25 last resort that's several billion dollars

1 underfunded.

2 MS. KANE: Right. Okay. So it's --  
3 right.

4 MR. CLARK: Yeah. There's both sides  
5 of the equation. I guess -- I thought you had more to  
6 present, so I'm going to jump to my question because  
7 I'm a little confused. That leaves me wondering from  
8 your comments if there's a potential overpayment by  
9 the hospitals. But as I look at the date, I'm  
10 wondering if there's the risk of having a balance left  
11 there.

12 So, Rob -- and bear with me. I'm sure  
13 I'm missing something that you can fill in -- but as  
14 your comments say that the hospital experience was  
15 better than expected, as I look at your summary, when  
16 you look at the deficit, compared to where it was last  
17 year, you're saying the deficit decreased from -- I'm  
18 trying to find the number. I think it was 37 million.

19 MR. WALLING: It -- it's a big number,  
20 and a big part of that is the legislative infusion.

21 MR. CLARK: I'm talking about, well,  
22 for last year, it was the hospital portion only. So  
23 we reduced from 37 million down to 34 million or a  
24 roughly \$3 million reduction. But that concerns me  
25 when last year, we charged a 46 percent surcharge for

1 deficit reduction in what should have been two final  
2 years. So in my mind, the deficit -- if there's no  
3 change in the estimate, the deficit should have been  
4 reduced by half. And it only went down by 3 million.

5 So it seems to me like we had a 46  
6 percent surcharge, which is indicative of close to  
7 half of the remaining balance of the deficit. That  
8 was 46 percent of the surcharge level -- additional  
9 for deficit reduction. 46 percent -- I'm trying  
10 to -- what I can't find in there is the number of  
11 total surcharges from last year, but I believe it's  
12 right around 100 million. And yet our deficit only  
13 went down by 3 million.

14 Help me close that gap. Because I see  
15 the experience on the hospital shows to be improved,  
16 but the deficit only went down by three. And I -- I  
17 would think it should have gone down by improvement in  
18 expectation plus the amounts paid for the deficit  
19 reduction. So I'm missing something.

20 MR. WALLING: And I -- and I'm going to  
21 ask a kindness. I -- I guess what I'm -- yeah. I'm  
22 going to have to ask a -- a kindness, just to make  
23 sure I am coming up with the same numbers as you are.

24 I -- I do -- yeah. I mean, we are  
25 still showing a \$34 million deficit for the hospitals,

1 based on, basically, the incremental change caused by  
2 one good calendar year of experience. And -- and I  
3 think what you're seeing is it's better but it's --  
4 there -- there is still the issue of, you know,  
5 does -- does one data point make a trend, candidly.

6 MS. KANE: Rob, can I ask a question?

7 MR. WALLING: So --

8 MS. KANE: So is there a separation --

9 MR. WALLING: Yeah.

10 MS. KANE: -- between the experience  
11 and the -- and the -- I'm sorry. And I see the --  
12 because the experience got better and there's only a  
13 2.6 percent rate increase. So how do you -- how do  
14 they correlate between the rate increase and the  
15 deficit? Or do they?

16 MR. WALLING: Well, we have made so  
17 much progress on the surcharges for the hospital  
18 outside of the deficit surcharges. We've gone from  
19 charging 31, 32 million dollars a year to charging 68  
20 million last year. So ignoring the deficits for a  
21 moment, we've seen a -- a dramatic increase in the  
22 surcharges we're getting from the hospitals.

23 The modest rate indication basically  
24 says, on a going forward basis, that 58 million is  
25 pretty close to what we need for next year's claims.

1 The ongoing deficit surcharge basically says there's  
2 still a \$43 million hole, that there's still a \$43  
3 million delta between the surcharges that have been  
4 collected and what we think the ultimate losses are.

5 MS. KANE: Going forward --

6 MR. WALLING: So that's --

7 MS. KANE: -- beyond next year. Is  
8 that what you're saying?

9 MR. WALLING: Repeat what you just  
10 said, please.

11 MS. KANE: Going forward beyond next  
12 year. I mean, the 58 sort of correlates, you know,  
13 to -- to 1 year. The -- the issue, I guess, I don't  
14 quite -- I -- I can't quantify -- but that would be  
15 fine if they -- the hospitals were staying in and we  
16 could sort of adjust with rates and whatever. But  
17 we're going to have this cliff and -- and in the next  
18 year. And then we're also going to have the lag with  
19 the claims and settlements and, you know, that -- if  
20 you can help me understand how that all is going to  
21 work out, you know.

22 MR. WALLING: A really good question.  
23 And there -- there's a lot of moving parts here.

24 MS. KANE: Absolutely.

25 MR. WALLING: I guess what I'm trying

1 to make sure we're clear about is the rate indication  
2 is an estimate of what the surcharges need to be for  
3 next year's claims. The surcharge estimate is an  
4 attempt to quantify the difference between the  
5 surcharges that have been paid in and the losses that  
6 we believe are going to be paid out for the claims for  
7 2024 and prior. So they're two separate and distinct  
8 things.

9 MS. KANE: The -- the priors that  
10 haven't been -- you know, "incurred but not recorded"  
11 or whatever IBNR means.

12 MR. WALLING: Well, yeah. And in this  
13 case, there's really no difference between a -- a case  
14 reserve and an IBNR reserve, like you would see in  
15 most insurance companies. There aren't case reserves.  
16 And -- and so for our purposes, the unpaid claims  
17 are -- the reserves are the unpaid claims reserves,  
18 whether it's case or IBNR.

19 So -- but the -- the -- and -- and I  
20 confess, I don't know how we're going to -- how the --  
21 the PCF is going to deal with favorable development  
22 or -- or adverse development once, kind of, we --  
23 we've got no more financial control over the  
24 hospitals. Are we going to be able to assess that?  
25 Are we going to invest the funds for the hospitals

1 in -- in such a way that we're -- we're going to  
2 offset any adverse development with investment income?

3 I -- I guess I'll go back to what I  
4 said a moment ago. Those are policy decisions that --  
5 that I don't know what decisions the Board's made.  
6 And -- and so I'm --

7 MS. KANE: I'm don't think --

8 MR. WALLING: -- I'm flying a little  
9 blind.

10 MS. KANE: Well, I think they need a  
11 lot more information. I mean, I'm speaking for the  
12 Board, but --

13 MR. RITCHIE: Yeah.

14 MS. KANE: -- for me even to, you know,  
15 understand it, I think there's a lot more work that  
16 has to be done before this -- this goes forward. And  
17 I -- I guess I'm -- I'm also very concerned -- I'm  
18 sure Troy is more concerned than I am -- about what's  
19 going to happen going forward with the hospital  
20 systems, based on the reduction in reimbursements and  
21 everything else. It's -- I don't know.

22 I don't know how you sleep at night,  
23 Troy.

24 MR. AUTIO: You're assuming he does.

25 MS. KANE: I was being kind.

1 MR. WALLING: I -- I have a lot of  
2 hospital clients all over the country that are -- that  
3 share your concern, the teaching hospitals,  
4 especially.

5 MS. KANE: Well, the rurals for us.

6 MR. CLARK: Can I go back? Are you --

7 MR. WALLING: Right.

8 MR. CLARK: Are you done with your line  
9 of questions?

10 MS. KANE: My -- my soliloquy? I'll be  
11 quiet.

12 MR. CLARK: I'm still stuck, Rob; and  
13 you know I'm slow. So let me go -- let me start  
14 with -- on your executive summary, page 2 --

15 MR. WALLING: Yeah. Page 2.

16 MR. RITCHIE: -- under "PCF surplus  
17 deficit," the second bullet, it says that as of  
18 December 23rd of -- I'm sorry -- December of '23, the  
19 deficit was 37.7 million, indicating that it's been  
20 reduced by only \$3.4 million.

21 MR. WALLING: That's correct.

22 MR. CLARK: Here's where I'm stuck. If  
23 last year we calculated an estimated surcharge and  
24 then we added 46 percent of that -- which I don't -- I  
25 still can't find the exact number of what last year's



1 surcharges were calculated, separated into two pieces  
2 of deficit reduction. I can find the total amount.  
3 But we added 46 percent to that, roughly \$35 million;  
4 but we only reduced by 3.4.

5 That tells me that either the expected  
6 loss got worse -- so that the actual payment of the  
7 deficit surcharge that we assessed the hospitals last  
8 year, even though it was in the \$30 million ranges, it  
9 only reduced the deficit by 3.4 million because the  
10 expected loss got bigger from where it was last year.  
11 But as we -- as you walked us through the surcharges  
12 for this year, we said, actually, the experience has  
13 gotten better, not worse. That's where I'm getting  
14 the disconnect.

15 MR. WALLING: Here's -- here's -- well,  
16 here's the -- here's the missing piece. Between year  
17 end '23 and year end '24, we actually added in another  
18 year. So we actually added in another year of claims  
19 experience.

20 And so part of what we're seeing is  
21 that the 2024 year actually added to the deficit that  
22 our -- our initial estimate, which is really -- you  
23 know, it's our first guess. Actually added to the  
24 deficit. So part of that delta that you're seeing is  
25 that adding in the new accident year '24 actually made

1 things worse.

2 So part of what we're -- we're dealing  
3 with and why you're not seeing more of an improvement  
4 is that our first estimate of the 2024 hospital  
5 ultimate -- you know, to ultimate settlement basis --  
6 still has them running a -- a little bit of a deficit.  
7 So that's why you're not seeing more of an  
8 improvement.

9 And, you know, at -- at a high level,  
10 I'm going to take a conservative position in the first  
11 two or three years for any accident year for this  
12 program, physicians or -- or hospitals. And then when  
13 we have those years where the claims experience is a  
14 little bit better, then I actually get to release  
15 those reserves.

16 But, no, I think the piece you're  
17 missing, trying to kind of pull numbers from where  
18 you're pulling versus what I'm looking at, I think the  
19 difference is that you actually add in accident year  
20 2024 to the analysis and that that's having an impact  
21 on the -- the fact that the deficit's not coming down  
22 more.

23 MR. CLARK: So I follow that  
24 mathematical equation. That makes more sense to me.  
25 The last piece I need to get connected, and maybe I

1 want to use different words -- when you said the  
2 experience at the hospitals improved, is it correct,  
3 then, to say it is better than it was but it was still  
4 below expectation? So it improved --

5 MR. WALLING: I -- I think that's --

6 MR. CLARK: -- it improved, but that's  
7 why there is some of those dollars offsetting the  
8 deficit reduction.

9 MR. WALLING: Correct.

10 MR. CLARK: Because that's the piece  
11 that I was having a hard time matching up with, was  
12 the mathematical equation to your comment that said  
13 things looked better at the hospital. I went, those  
14 go in two different directions.

15 MR. WALLING: Correct.

16 MR. CLARK: But they -- if it's just  
17 that it's not as bad as it was before, so that's the  
18 improvement, as opposed to what was in a positive  
19 situation, which I was interpreting, then it makes  
20 sense. Is that a correct interpretation of the  
21 description?

22 MR. WALLING: Yeah. I -- I think  
23 it's -- it's less bad. I -- I think it was --

24 MR. RITCHIE: Just less bad.

25 MS. LOVE: So don't get excited.

1 MR. RITCHIE: Yeah.

2 MR. CLARK: I feel less bad.

3 MR. AUTIO: Always good news at these  
4 meetings.

5 MR. WALLING: And, actually, I mean,  
6 remember that when I'm talking about these -- these  
7 calendar year changes in payments, part of what I'm  
8 looking at is we saw \$21 million of payments for 2023  
9 and prior. We would have otherwise anticipated  
10 something more like 46 million. And so -- you know.

11 But for some of those older years, for  
12 the 2017, '18, '19 year, we saw a lot less payment  
13 activity than we anticipated. And so there was still  
14 payment activity where they're still -- they're still  
15 producing ultimate losses that are higher than the  
16 surcharges from that period, but it is better. So,  
17 yeah, that -- that's as good an answer as I can give  
18 you, unfortunately.

19 MR. CLARK: I follow it. It just -- I  
20 think it exacerbates the swing of possibilities. If  
21 it's better and we see this for three more years, we  
22 could have the hospitals overpaying by 30, 40 million  
23 dollars. If it's that everything's backed up but it's  
24 just not processing through, we can have the hospitals  
25 underpaying by 30, 40 million dollars. And --

1 MR. WALLING: And -- and that second  
2 scenario scares me.

3 MR. RITCHIE: First one scares me.

4 MR. WALLING: And I -- I don't scare  
5 easy, but the idea of settlements being held up and  
6 delaying the flow of payments into the data is a -- a  
7 very real concern.

8 MS. LOVE: Is there anything to say  
9 that they can't be reimbursed for overpayments? I  
10 mean, they're still participating in the Medical  
11 Malpractice Act, just not in the fund.

12 MS. KANE: I think that is what he's  
13 sort of saying.

14 MS. LOVE: But if you're overpaying --

15 MS. KANE: As the Board, do we sort of  
16 say, you know, whatever the swing is, we either give  
17 you the money back or we assess you?

18 MR. CLARK: I'd say if I put myself as  
19 Troy Clark -- as -- as I'll be shot by my members --  
20 there's not a mechanism in the statute to charge them  
21 if it's short. As a board member, I would have to  
22 say, if there's not a mechanism to charge them for an  
23 underpayment, there shouldn't be a mechanism to pay  
24 them any the excess back. I think the two ought to  
25 stay in balance.

1 MS. LOVE: I don't know if that's true.

2 MR. CLARK: Again, they would shoot me

3 for that. But -- and -- and I say that because if I'm

4 one of the members and there's not a mechanism to

5 charge me if it's short and you come try and charge

6 me, I'm going to say "not allowed."

7 MS. KANE: Should -- the question is

8 should --

9 MR. CLARK: So why should I -- why

10 should I have the option to get the refund back?

11 MS. KANE: God -- God forbid anyone

12 talks about the act and changing it. But should there

13 be a mechanism? To me, there should be. A true up.

14 Whatever phrase you want to call it.

15 MR. CLARK: That's not a mechanism.

16 That'd just keep us in.

17 MR. WALLING: I -- you know, my -- my

18 concern is the hospitals are --

19 MS. KANE: Well, that's for others --

20 MS. LOVE: I mean, it seems to me that

21 the superintendent of insurance has the power to

22 reimburse overcharges.

23 MR. CLARK: Right, I think.

24 MS. KANE: Well, let's see if I have

25 that. Let's make sure.

1 MS. LOVE: Yeah.

2 MS. KANE: That's what I'm saying. Do  
3 we have it? He's saying it's not in the act. So  
4 let's see --

5 MS. LOVE: Well, I don't know that -- I  
6 don't think it's in the act. I think the  
7 superintendent of insurance, as the custodian of this  
8 money, probably has somewhere --

9 MS. KANE: Let's -- let's check.

10 MS. LOVE: -- the power to do that.

11 MS. KANE: Let's check how much  
12 authority because --

13 MR. CLARK: But as a board member --

14 MS. KANE: -- whenever I do something,  
15 they say --

16 MR. CLARK: -- fiduciary to the PCF,  
17 I'd have to say, should they have that right if  
18 there's not the right to go back after all the  
19 charge --

20 MS. LOVE: I -- I understand  
21 your -- your argument, but --

22 MR. CLARK: I just think I -- I'm  
23 caught.

24 MS. LOVE: Yeah.

25 MR. CLARK: My hospitals would love to

1 say I have no downside, then, if it's short but I get  
2 all the upside if it's overfunded.

3 MS. KANE: Look, I think --

4 MR. CLARK: That's not the way we  
5 usually do --

6 MS. KANE: -- I think fair is to true  
7 up.

8 MR. CLARK: Right.

9 MS. KANE: Let's -- let's see if --  
10 where there's authority if we have to do something.  
11 Okay? And then what the Board would like to do as  
12 well. Okay? I mean, to me, that's -- God forbid I  
13 use this word -- fair.

14 I'm -- I'm kidding, Troy. I don't want  
15 use that word.

16 No, I -- no, I -- let -- let's see.  
17 Let us look into it. Because this -- this is --  
18 we're -- we're sitting in the world I lived in in  
19 insurance. You know, you can fix things -- adjust  
20 reserves, release reserves because people are all  
21 skilled at --

22 MR. RITCHIE: That's all the time.

23 MS. KANE: Yeah. And people are --

24 MR. RITCHIE: Still paying.

25 MS. KANE: And still in the group.



1 MR. RITCHIE: Right.

2 MS. KANE: This is a -- this is a  
3 different situation. But I think it should be fair,  
4 and I certainly think -- well, that's what I think.  
5 Let me see what authority we have or authority we need  
6 or -- I'm glad you think I have more authority than  
7 the rest of the world does.

8 MS. LOVE: I think somebody could get  
9 creative.

10 MS. KANE: Yes. And then people react.

11 MS. LOVE: Yeah. Understood.

12 MR. AUTIO: I guess while you're  
13 looking at it, though, my concern is that if we do try  
14 and protect against the hospitals having underpaid by  
15 increasing surcharges so that we cover future  
16 losses --

17 MS. KANE: I don't think we can do that  
18 enough. I mean -- I mean, they're only going to be  
19 here one more year.

20 MR. AUTIO: Yeah, no. I mean, that's  
21 what I'm saying. It'd be a massive increase. But,  
22 you know, that -- that could also drive hospitals to  
23 just not participate. I mean, they don't have to sign  
24 up again.

25 MS. LOVE: Well, aren't we being --

1     aren't we being told by Mr. Walling that that's  
2     accounted for? I mean, he's accounting for the  
3     expected payouts; and it keeps doing better each year.  
4     So if we're doing our jobs, we should be pretty close.

5                     MS. KANE: Now, I don't think -- I  
6     don't think this is a payout issue --

7                     MR. AUTIO: I just heard him say he's  
8     scared of what's going to happen.

9                     MS. KANE: It's an experience issue.  
10    And -- and -- you know, and having seen, you know,  
11    many -- you know, many moments when you think you  
12    had -- brilliant actuaries have a handle on something,  
13    you're surprised sometimes. And -- and this is not --  
14    you know, this isn't auto insurance. This is spiky  
15    stuff.

16                    MR. AUTIO: Yeah.

17                    MS. KANE: But -- but let us -- you  
18    know, seriously, let Christian and Rob and -- you  
19    know, we really have to deal with -- in my view, aside  
20    from that this thing is always a problem, we have to  
21    deal with, you know, two things changing. One is  
22    more -- more patients here for future medicals and the  
23    other is, you know, what happens -- how do we deal  
24    with the fact that we've got claims that, when you  
25    look at -- go back -- I mean, look what we're paying

1 out. When you go to page 14, you go back to 2-11.  
2 And what's going to come through the pipeline while  
3 they're here? So is it a -- is it a ten-year, you  
4 know, or a seven-year, you know, period while the  
5 hospital's claims will still come through here? I  
6 don't know.

7 So -- so there are a number of moving  
8 parts that Christian's going to have to stay awake at  
9 night with Rob, trying to figure it out.

10 MR. RITCHIE: Yeah.

11 MS. KANE: And you -- and you thought  
12 that their plan was tough.

13 MR. RITCHIE: Well, we are -- we're  
14 looking at ten years out. Right?

15 MS. KANE: That's what -- that's  
16 what -- if it's -- this is a little bit more -- that's  
17 maybe more predicted in the future than climate. That  
18 being said, this is still very, you know, volatile.

19 MR. RITCHIE: Right.

20 MS. LOVE: Now, doesn't the statute  
21 read that once the hospitals are out, there are to be  
22 no more payments on their behalf? What's the other  
23 question?

24 MR. CLARK: I don't think it's payments  
25 out of the fund.

1 MS. LOVE: Right.

2 MR. CLARK: Because you'd have to --

3 MS. KANE: Well, let us -- let us go  
4 look at the statute too. And let's --

5 MR. AUTIO: I hope not because then  
6 there's a bunch of patients with no really --

7 MS. LOVE: Well, the hospital, then,  
8 has to pick up.

9 MR. AUTIO: Well, I guess, I mean,  
10 maybe.

11 MR. CLARK: They're not going to ask  
12 for the surcharge back, what's paid, you know, to  
13 cover those because they've paid prospectively for the  
14 payments to go out --

15 MS. KANE: I don't know what they  
16 anticipated -- I wasn't hearing the statute changed --  
17 what they anticipated when the hospitals went out, if  
18 they really understood that claims come through on  
19 a -- on this lag basis. I don't know how --

20 MR. CLARK: I understand.

21 MS. KANE: I don't know how --

22 MR. CLARK: Yeah.

23 MS. KANE: -- how that was all done.

24 So --

25 MR. RITCHIE: Yeah. I don't think we

1 appreciate how far the tail was.

2 MS. KANE: Yeah. I don't -- right.  
3 They didn't have this in front of them.

4 MR. RITCHIE: No. They only thought,  
5 well, three, four years, you -- you had a pretty good  
6 idea of claims that were coming in -- you know, going  
7 to come in. But, no, it's ten years, seems like.  
8 So -- yeah.

9 MS. KANE: Yeah. But ten's a good  
10 number.

11 MR. RITCHIE: Well, yeah. I'm pulling  
12 it out the --

13 MS. LOVE: Right.

14 MS. KANE: I don't know --

15 MR. CLARK: Is Rob still on?

16 MS. KANE: Of course, if those lawyers  
17 could move faster, maybe we wouldn't have so many --

18 MR. CLARK: Rob, are you still on?

19 MS. KANE: I think he might -- it got  
20 too complicated. He went off.

21 MR. CLARK: I've got one more question.  
22 Exhibit 5 -- and this number's in a couple different  
23 places. I went and just picked this one. I finally  
24 found it.

25 The 2024 hospital surcharge is 68.89

1 million. Is that the total of the surcharge plus the  
2 deficit recovery? I think in prior years, we had  
3 talked about, that's just the surcharge number.

4 MR. WALLING: That is just the  
5 surcharge.

6 MR. CLARK: Okay. So we did back that  
7 up. So --

8 MR. WALLING: Yeah. Not the deficit  
9 surcharge.

10 MR. CLARK: Okay.

11 MS. KANE: I think we really need to do  
12 two things. And I'm just a visitor here, but let us  
13 look at the patient compensation act and sort of see  
14 what we can find out with the authorities and whatever  
15 and then really ask Robert and Christian to sort of  
16 grapple with these issues from an actuarial --  
17 actuarial mindset and then talk about, you know,  
18 what -- where the Board has to come up with some  
19 policy recommendations maybe to the legislature.  
20 Because you are the advisory board to the legislature.

21 MR. RITCHIE: Right.

22 MS. KANE: You should have, arguably,  
23 some influence, which I do not have, I can -- I can  
24 assure you. I may have authority, but --

25 MR. AUTIO: And so, I mean, just since

1 we're having this discussion, I mean, I -- I frankly  
2 think Kathy's right under 41-5-6K; and it's very  
3 relevant for all us to think about. But it says  
4 "Beginning January 1, 2027, amounts due from a  
5 judgment or settlement that's against a hospital or a  
6 hospital-controlled outpatient healthcare facility  
7 shall not be paid from the fund." Period.

8 MS. LOVE: Boom. Yep. Even --

9 MR. RITCHIE: So that doesn't --

10 MS. KANE: Even if it's been sitting  
11 here as --

12 MR. RITCHIE: That meaning future  
13 medical?

14 MS. KANE: -- as something?

15 MR. AUTIO: I mean, I read the sentence  
16 and --

17 MR. RITCHIE: It doesn't seem right  
18 with future medical.

19 MS. LOVE: Yeah. Well, future medical  
20 is after a settlement, so --

21 MS. KANE: -- those -- those poor  
22 patients that were -- let's look at it. Okay?

23 MR. CLARK: Yeah.

24 MS. KANE: I -- I understand --

25 MR. CLARK: "Amounts due from a

1 judgment or settlement against a hospital" -- you guys  
2 are attorneys, not me. But I would say one reading of  
3 this is judgments due -- amounts due from a judgment  
4 or a settlement beginning January 1st -- so that's --  
5 if the settlement takes place before --

6 MS. KANE: While you were in.

7 MR. CLARK: -- cut a claim after that  
8 date, it would not be. But if it's -- it could also  
9 be read as to say nothing, whether -- regardless of  
10 when the incident happened.

11 MS. KANE: Let us -- let us really look  
12 at this.

13 MR. CLARK: Okay.

14 MS. KANE: And it doesn't mean that you  
15 aren't reading plain English; but let us look at the  
16 whole thing and see where we go, what we think it is,  
17 what we think it -- is that the right answer, do we  
18 think it should be a different answer, do we want to  
19 do anything to recommend a different -- you know, how  
20 do we want to deal with this.

21 MR. RITCHIE: I recommend the  
22 interpretation for the statute. Well, what we think  
23 the interpretation is --

24 MS. KANE: Would you recommend, if we  
25 don't like the interpretation, maybe we should do



1 something? Yeah.

2 MR. RITCHIE: Well, it's the same  
3 statute but that -- to -- to match that --

4 MS. KANE: Right.

5 MR. RITCHIE: -- that interpretation.  
6 Okay.

7 Then, really, out of this committee,  
8 that's one thing. I think that's what we need to come  
9 down as far as action items out of the committee, is,  
10 you know, asking for that. Any other action items,  
11 then, for Mr. Walling? Integrion? OSI? For more  
12 data for the future to help make a decision, to make  
13 our way through this?

14 Troy? Nick? Anyone? Kathy?

15 MS. KANE: So can I be clear? So  
16 what -- you'd like -- what do we --

17 MR. RITCHIE: Like what you just said.

18 MS. KANE: Okay.

19 MR. RITCHIE: I mean, looking from the  
20 OSI standpoint -- okay -- and looking what the statute  
21 says, what you think the interpretation is --

22 MS. KANE: The point in question.

23 MR. RITCHIE: -- and how we're going to  
24 handle that.

25 MS. KANE: How we're going to really

1 handle the transition from --

2 MR. RITCHIE: Right.

3 MS. KANE: -- the hospitals leaving  
4 with pending -- with claims coming in or still sitting  
5 there.

6 MR. RITCHIE: Right.

7 MS. KANE: And then -- and then how the  
8 actuaries will look at it.

9 MR. RITCHIE: Right.

10 MS. KANE: And then, finally, how we're  
11 looking at those -- the -- the future medical claims.

12 MR. RITCHIE: Right. And what the  
13 options are for funding them in the future if  
14 necessary. As in, if there's not enough there to fund  
15 them, can we assess? Or if there is enough there to  
16 fund them but it's been overfunded --

17 MS. KANE: Can we --

18 MR. RITCHIE: -- is that returned or  
19 not?

20 MS. KANE: -- distribute? Can we  
21 distribute?

22 MR. RITCHIE: Right.

23 MS. KANE: Assess or distribute based  
24 on where we're going.

25 MR. RITCHIE: Right. And when do you

1 decide that? Do you go out ten years and then do it?  
2 Or -- you know, because this is really in perpetuity  
3 or something.

4 MS. KANE: I think that should -- to  
5 give us some recommendations of how it would look.

6 MR. RITCHIE: Yeah.

7 MS. KANE: I have no -- I would not be  
8 helpful in making that determination. But let them  
9 come back to us and sort of say this is how it would  
10 all operate.

11 MR. MYERS: Rob, do -- do you think it  
12 would be possible to essentially -- like, given the --  
13 the model underlying the surcharges today, kind of  
14 model out what we would expect to pay out in hospital  
15 claims for the next -- I don't know -- 10 to 15 years  
16 and then, like, do some sensitivity around -- okay --  
17 if we were wrong with these assumptions, plus or minus  
18 1 percent, like, this is what the dollars would be  
19 paid over the next 10 years. Just so we could see,  
20 like, this is really how much we could be over or  
21 under in each of these given calendar years. And then  
22 we can come back and discuss, like, okay, do we want  
23 to have the option where we're surcharging the --  
24 these hospitals every year? Or once every five years  
25 we do a look back and see how much we were on or off?

1 Like, that type of structure?

2 MR. WALLING: I -- I think there's  
3 really two elements. One is exactly what you  
4 described, which is scenario testing differences in  
5 the assumptions. What if the severities are higher  
6 than we expected? What if the frequencies are higher  
7 than expected? What if inflation is higher than  
8 expected?

9 I -- I think the other is stochastic  
10 modeling, risk margin modeling, that we already have  
11 in the rate indications. We already gave you a rate  
12 indication for the hospitals at a higher level of  
13 statistical confidence. One way to kind of build -- to  
14 hedge our bet on the hospitals is simply to implement  
15 the rate change with the risk margin instead of  
16 without.

17 So we could go through that same  
18 exercise on the hospital reserves. We could certainly  
19 make an -- you know, do an analysis of the investment  
20 income we expect to generate from the hospital fund.  
21 That's a key assumption here. If -- if we're  
22 generating 1 percent return on those funds, it's a  
23 very different picture than if we're generating 3 or  
24 or 4 percent return.

25 So, yeah, I -- I very much like the

1 idea of scenario testing. We do that for most of our  
2 PCF and birth fund clients. It certainly makes all  
3 sorts of sense here.

4 MR. MYERS: Okay.

5 MS. KANE: Okay. And then I would say,  
6 if we're going to assume that we're going to deal with  
7 investment income, we need an asset manager. We  
8 really -- I mean, this is the ability to do asset --  
9 asset allocation in an asset manager. And this hasn't  
10 been managed out yet.

11 MR. RITCHIE: Okay. It would --

12 MS. LOVE: I think that's a really --

13 MR. RITCHIE: Yeah.

14 MS. LOVE: -- good idea.

15 MS. KANE: You know, and I've been  
16 trying to get --

17 MS. LOVE: Yeah.

18 MS. KANE: I lived in a world from my  
19 past where you had asset managers working with the  
20 actuaries, coming up with a plan that matched assets  
21 and liabilities, and told you -- and what's the risk  
22 profile here and everything else. So I think -- I  
23 think that should be a --

24 MS. LOVE: Yeah. Until they create  
25 their buffer.

1 MR. RITCHIE: And you need a  
2 recommendation from the Board?

3 MS. LOVE: Yeah.

4 MS. KANE: Right.

5 MR. RITCHIE: And the Board can help  
6 you with that. So we could make a recommendation from  
7 the Board --

8 MS. KANE: Yes.

9 MR. RITCHIE: -- to help you with  
10 your --

11 MS. KANE: That would be very helpful.

12 MR. RITCHIE: -- recommendation.

13 Exactly.

14 MS. KANE: So I'm not getting anywhere.

15 MR. RITCHIE: Yeah. I understand.

16 MS. KANE: I mean, I put 40 million  
17 somewhere, you know, but trust me.

18 MR. RITCHIE: Yeah.

19 MS. KANE: You know, I mean, having sat  
20 through many investment committee meetings and having  
21 very professional people really look at the asset and  
22 liabilities with the actuaries to come up with a plan,  
23 was -- didn't always work out but -- much more solid  
24 than --

25 MR. RITCHIE: Right.

1 MS. KANE: -- what's going on right  
2 now. And the money was just sitting there before,  
3 so --

4 MR. RITCHIE: Absolutely.

5 MS. KANE: I think it's -- that should  
6 have happened.

7 MR. WALLING: And -- and I'll compare  
8 that to Wisconsin PCF, where they've got Baird  
9 managing all of their funds. Their investments are  
10 not part of the Wisconsin State Investment Fund.  
11 They're a separate account, under separate management.  
12 And they keep track very closely of the returns  
13 they're getting on their assets to pay future claims.

14 Virginia, same way. Virginia birth  
15 fund has been generating a 6 to 7 percent return on  
16 their invested assets for decades because they  
17 recognize a lot of those payments take -- you know,  
18 take decades before they manifest. So it allows them  
19 to take very long bond positions and actually take  
20 a -- a stronger position in equities than most  
21 government insurance programs.

22 MS. KANE: Find those asset managers,  
23 then.

24 MR. RITCHIE: Yeah.

25 MS. KANE: Okay.

1 MR. RITCHIE: Rob, quick question.

2 MR. WALLING: Yes.

3 MR. RITCHIE: I might have missed this  
4 early on. What are you using for the rate of  
5 inflation for setting next year's rates?

6 MR. WALLING: I don't remember. Give  
7 me a second.

8 MS. KANE: Medical inflation, not just  
9 general.

10 MR. RITCHIE: Well, no. The statute  
11 says we use --

12 MR. AUTIO: It's the CPI.

13 MR. RITCHIE: -- CPS. And so --

14 MR. WALLING: CPI, specifically for  
15 estimating the --

16 MR. RITCHIE: Urban CPI.

17 MS. KANE: You mean for the --

18 MR. WALLING: -- the coverage layer.

19 MR. RITCHIE: The cap.

20 MS. KANE: I'm sorry.

21 MR. RITCHIE: Yeah. For the cap. I'm  
22 sorry.

23 MS. KANE: I'm think of something else.  
24 I was making -- I was thinking the discount rate.  
25 Sorry.



1                   MR. RITCHIE: Right. Yeah. The urban  
2 CPI. Isn't it?

3                   MS. KANE: Yeah.

4                   MR. WALLING: Yeah. We're discounting  
5 at three-and-a-half percent, and we're trending  
6 at -- we're actually trending the losses at five  
7 percent, in part -- which is different than the  
8 process of estimating the coverage layer. Part of  
9 what happens in the PCF layer is claims from ten years  
10 ago that wouldn't meet the -- the threshold today  
11 would trend in. So that 5 percent is something we've  
12 used for a long time to reflect, basically, the fact  
13 that we're in an excess layer and claims 10 years ago  
14 that weren't big enough to get into the PCF are big  
15 enough now, after you adjust them for inflation.

16                  MR. RITCHIE: Okay. So the cap will go  
17 from its current level and would be increased by 5  
18 percent for next year?

19                  MR. WALLING: No. Sorry. The cap  
20 specifically --

21                  MR. RITCHIE: Right.

22                  MR. WALLING: -- the legislation says  
23 that we have to use CPI.

24                  MR. RITCHIE: Right.

25                  MR. MYERS: And that's 2.87 annually.

1 MR. RITCHIE: 2.7? Okay.

2 MR. MYERS: 2.87.

3 Right, Rob? On page 2?

4 MR. WALLING: Yep. Exactly.

5 MR. RITCHIE: Okay. So we'll know what  
6 the cap's going to be, and we'll just add 2.87  
7 percent. Okay.

8 MR. WALLING: Which is what we're  
9 showing in Exhibit 3.

10 MR. RITCHIE: Yeah.

11 MR. WALLING: So we're actually showing  
12 that for you.

13 MR. RITCHIE: Yeah.

14 MS. KANE: That's the simplest  
15 calculation we have.

16 MR. WALLING: Yeah. I'm -- I'm told  
17 what -- what number to pull from the CPI.

18 MR. RITCHIE: I'm -- I'm a simple  
19 surgeon. He gives me simple. So -- okay.

20 Because, I mean, I -- obviously, I know  
21 that's a starting point for all your other  
22 calculations too for what you increased.

23 Okay. Yeah, Troy.

24 MR. CLARK: Mr. Chair and Mr. Waller,  
25 if I look at your executive summary, we've covered the

1 physicians and the hospitals. But we made this  
2 mistake last year. Did we cover the other entities,  
3 surgery centers and entities, on what their projected  
4 surcharge should be? I think entities, we've all just  
5 done a gross up; but I don't think we've discussed  
6 whether there's any recommended changes to that. I'm  
7 worried about --

8 MS. KANE: The three categories. We've  
9 got three categories.

10 MR. RITCHIE: Yeah.

11 MS. KANE: Right.

12 MR. RITCHIE: I think I saw somewhere  
13 that they said no change, but could be totally wrong.

14 MS. KANE: Can you find that for us?

15 MR. CLARK: Well, one thing I saw is no  
16 change in relative classes --

17 MR. RITCHIE: Right.

18 MR. CLARK: -- meaning the -- on the  
19 physician class grouping allocations --

20 MR. RITCHIE: I thought there was --

21 MR. CLARK: -- and specialty.

22 MR. AUTIO: And just to be clear, we're  
23 talking about independently owned outpatient  
24 healthcare facilities?

25 MR. RITCHIE: Yes.

1 MR. CLARK: Right.

2 MS. KANE: Yes. Those other entities.

3 MR. CLARK: The one we missed last  
4 year --

5 MS. KANE: Yeah.

6 MR. CLARK: -- and had to come back and  
7 talk about.

8 So is there a recommendation on that,  
9 Mr. Walling?

10 MR. WALLING: I thought so.

11 MS. LOVE: Rob, I assume we're doing it  
12 the same as we did last year.

13 MR. WALLING: Yeah. That's the  
14 intention.

15 MR. CLARK: Is that in the report  
16 somewhere?

17 MR. WALLING: Sure. The outpatient  
18 facilities rates are in Exhibit 3, page 2. So,  
19 basically, we're trending the -- the prior rates  
20 forward. We're adjusting it for the increased limits  
21 to the new coverage layer and producing the rates.

22 MS. KANE: So how would you describe  
23 their experience? Like, we've talked about the  
24 hospitals and their experience and it's at 2.1 and  
25 then the -- the deficit surcharge. How would you

1 describe how the -- those entities are being --

2 MR. WALLING: We -- we don't evaluate  
3 that claims experience separately.

4 MS. LUERA: Not enough data.

5 MS. KANE: Oh, there's not enough data?

6 MR. MYERS: So we just increase them by  
7 5 percent per year, plus the change in the limit. Is  
8 that right?

9 MR. WALLING: Yep. That's exactly  
10 right.

11 MR. CLARK: Can you say that again,  
12 please.

13 MR. WALLING: And -- and candidly, they  
14 just don't have that many claims.

15 MR. MYERS: So rather than, like,  
16 looking at all of their experience and evaluating what  
17 to do for the increase, we just used a 5 percent  
18 assumed trend and we increased them. Like, if the  
19 coverage is -- the cap is the same, we would just  
20 increase it by 5 percent every year. But then on top  
21 of that, we also have the -- the limit changing. So  
22 it's, like, 5 percent plus the CPI piece.

23 MR. WALLING: Yeah. Essentially, what  
24 we're doing is we're saying that the -- the claims  
25 experience for this -- for that particular corner of

1 the program isn't credible for the purpose of setting  
2 the rates. That's all.

3 MR. RITCHIE: So what we can -- so it  
4 looks -- so it'd be a 7.87 percent increase for them?  
5 The 5 percent plus the 2.87 percent?

6 MS. LUERA: Again, it's kind of  
7 compounded, so that's close. Like --

8 MR. RITCHIE: So as a board member, let  
9 me ask --

10 MS. LUERA: You take the 5 and then  
11 take the --

12 MR. RITCHIE: But the 2.87 is the CPI  
13 for this year?

14 MS. LUERA: Right.

15 MR. RITCHIE: Which is compounded from  
16 before? Because it was based on -- it keeps going up  
17 so --

18 MR. WALLING: Yep.

19 MR. RITCHIE: Okay. Good question.

20 MS. LOVE: Can you -- can you explain  
21 for us, just so we know, how -- how do we justify to  
22 outpatient healthcare facilities if we don't have the  
23 adequate claims experience for them and they're not  
24 having a lot of claims. How do we justify the 5  
25 percent increase at all?

1                   MR. WALLING: Basically, the same way  
2     that we justify the rate indications for the other two  
3     cohorts. When you are -- are setting rates for these  
4     kind of very infrequent, very severe claims,  
5     ultimately, you have to apply a credibility standard  
6     that says how many claims do I have to be predictive.  
7     And so when you're looking at this program, there's  
8     just simply not enough experience for us to rely on  
9     the experience for setting rates.

10                  And so for the outpatient facilities,  
11     instead, we're basing it purely on, essentially, an  
12     exposure rate that's based on an analysis of the --  
13     the filed and approved rates of carriers in the  
14     marketplace. And we're adjusting them for inflation  
15     because there simply isn't credible data for us to  
16     base the rates on -- on an experience basis. That's  
17     all.

18                  MR. CLARK: Just so I'm clear as a  
19     board member, it's very clear for me to look and see  
20     what our actuary's recommendation is on page 3: 13.6  
21     without risk margin, 23 on the independent physicians,  
22     2.6 and 11.1 on the hospitals. For the outpatient  
23     surgery -- I'm sorry -- for the outpatient healthcare  
24     facilities, it's not a percentage. It's that rate --  
25     it's this rate table on page 4.

1 MR. WALLING: Correct.

2 MR. CLARK: But if we calculate it, it  
3 results in the -- whatever mathematical --

4 MR. WALLING: Essentially, it's a 5  
5 percent increase plus a 2 percent increase for the  
6 change in coverage layer.

7 MR. CLARK: Okay. But the way we would  
8 communicate it if we are communicating our  
9 recommendation to the superintendent is either  
10 consistent with this chart or some deviation from this  
11 chart. But that's the recommendation from the  
12 actuary?

13 MR. WALLING: Yep.

14 MR. CLARK: Okay. I was just looking  
15 for the percentage number. Thank you.

16 MR. WALLING: Yeah. We should add  
17 that.

18 MR. RITCHIE: Okay. Any other  
19 questions?

20 All right. Then we're looking at the  
21 future.

22 Next meeting, did you have it down?

23 MR. AUTIO: Got that scheduled. Right?

24 MR. RITCHIE: Yeah. We have it  
25 scheduled.



1 MR. AUTIO: September 30th, I think.

2 MR. RITCHIE: September 30th? 9:30?

3 MS. LOVE: September 30th at two  
4 o'clock.

5 MR. AUTIO: Two o'clock. Two to five.

6 MR. CLARK: Okay. I will not be here,  
7 Mr. Chair.

8 MR. RITCHIE: I hope you're somewhere  
9 fun.

10 MR. CLARK: Running an annual meeting.

11 MR. WALLING: I appreciate the -- the  
12 committee's flexibility. I'm -- I'm the cause of the  
13 scheduling. My wife's having one of those birthdays  
14 that ended in zeros, and I'm -- I'm taking her to  
15 Mykonos for ten days. So I -- I appreciate you  
16 working with me on that.

17 MR. RITCHIE: Well, we try to be  
18 flexible as we can. We got a lot of members, so we  
19 can't be perfect. But thank you.

20 Okay. So --

21 MS. LOVE: I hope it's a nice trip.

22 MR. RITCHIE: Exactly.

23 So September 30th, two o'clock. We  
24 will adjourn until then. However, we will get  
25 information, more information as the -- updates from

1 the OSI -- right? -- on the --

2 MS. LUERA: Correct.

3 MR. RITCHIE: -- experience.

4 MS. LOVE: Yeah. And the more -- more  
5 stuff we have regarding the current status of PCF in  
6 advance, the better, just because since we're getting  
7 up into September, it's going to be a hefty meeting,  
8 it seems. So we're going to do some work ahead of  
9 time, maybe.

10 MR. RITCHIE: Good point.

11 MS. KANE: I think we will produce  
12 reports and things in response to some of the  
13 questions. We'll send them out --

14 MS. LOVE: Super.

15 MS. KANE: -- when they're --

16 MS. LOVE: Yeah.

17 MS. KANE: -- ready.

18 MS. LOVE: That sounds great.

19 MS. KANE: As opposed to just a package  
20 before the meeting.

21 MS. LOVE: That sounds great.

22 MS. KANE: All right? Yeah.

23 MR. RITCHIE: Yes. Thank you.

24 All right.

25 MS. KANE: No trouble -- having been on

1 a board, I understand that.

2 MS. LOVE: Thank you.

3 MR. RITCHIE: Thanks, everyone, for  
4 coming. Thanks, everyone online --

5 MS. LOVE: Thanks, everyone.

6 MR. RITCHIE: -- for coming too.  
7 Appreciate it.

8 MS. LOVE: Debbie, thanks for all your  
9 hard work.

10 MR. RITCHIE: Yeah.

11 MS. LOVE: Putting all that stuff  
12 together for us.

13 (Whereupon, the meeting concluded at  
14 3:13 p.m.)

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CERTIFICATE

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



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

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ADELE DEON

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[honest - influence]

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[pushing - regensberg]

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[separate - speaking]

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