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)

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)

P R O C E E D I N G S

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

Chairman Ritchie.

MR. RITCHIE: Present.

MS. LUERA: Chair Love. Vice Chair Love.

MS. LOVE: Present.

MS. LUERA: Mr. Clark. No?

Mr. Autio.

MR. AUTIO: Present.

MS. LUERA: Mr. Dekleva.

MR. DEKLEVA: I'm here.

MS. LUERA: Mr. Martinez.

He's -- he's not.

MS. LOVE: He's no longer --

MS. LUERA: No longer. Okay.

And then Mr. Vargas. Anyone?

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

MS. LUERA: No -- present.

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

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

MR. RITCHIE: All right.

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

MR. RITCHIE: Oh, Vince is on.

MR. WARD: I'm here.

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

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

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

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

MS. LOVE: Yes. That is late.

MR. RITCHIE: I don't know.

MS. LOVE: Thank you so much, Ritchie.

Okay. We have six.

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

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

MR. RITCHIE: Okay. Please do.

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

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

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

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

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

MR. AUTIO: Motion to approve.

MR. RITCHIE: Accepted.

Any second?

MR. CLARK: Second.

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

Okay. Hearing no objection, they are approved.

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

Please take it away.

MS. LUERA: Okay.

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

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

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

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

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

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

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

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

MR. AUTIO: No, I was just curious.

MR. RITCHIE: That's fine.

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

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

MR. RITCHIE: Right.

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

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

MS. LUERA: Yes.

MR. RITCHIE: Okay.

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

MS. LOVE: So these surcharges reflect

deficit surcharges as well as surcharges for the year?

MS. LUERA: Yes. Yes.

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

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

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

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

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

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

MS. LUERA: Right.

MS. LOVE: Yeah.

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

MS. LUERA: Right.

MS. LOVE: Okay.

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

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

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

them "employed" --

MS. LUERA: Absolutely.

MS. LOVE: -- "doctor." Because -- because "agent" has sort of a legal term. And an individual provider -- independent provider can be an agent of someone else but not employed. And I think the idea is we're trying to point out that these are employed doctors.

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

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

MS. LUERA: Yeah.

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

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

MS. LOVE: Yeah.

MR. RITCHIE: Yeah.

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

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

Presbyterian want to make sure that everyone knew --

MS. KANE: They know who's --

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

MS. LOVE: Yeah.

MS. KANE: Yeah. Right.

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

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

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

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

Okay. So moving on to the -- the

individual provider count.

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

MS. GALLEGOS: That's all right.

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

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

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

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

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

MS. LUERA: They would be lumped in

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

MR. RITCHIE: With the MD, DOs?

MS. LUERA: Yes.

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

MS. LUERA: The surcharges.

MR. RITCHIE: The surcharges?

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

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

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

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

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

MR. RITCHIE: Right.

MS. LUERA: -- an independent provider --

MR. RITCHIE: The insurance of that.

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

MR. RITCHIE: Right.

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

MR. RITCHIE: Yeah. Well --

MS. LOVE: Right?

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

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

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

MR. RITCHIE: And the cap's higher.

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

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

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

MS. LOVE: Well, right.

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

MS. LOVE: The cap's higher but the

PCF's exposure is not.

MR. RITCHIE: That's true.

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

MS. LOVE: It's -- yeah.

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

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

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

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

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

MS. LOVE: Right.

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

MS. LOVE: Yeah.

MS. KANE: So let's check.

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

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

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

UNIDENTIFIED SPEAKER: -- agent termination.

MS. LUERA: Is there a question?

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

MS. LUERA: Okay.

MS. GALLEGOS: They came off mute.

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

MR. RITCHIE: Okay.

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

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

MR. RITCHIE: Okay.

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

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

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

MS. KANE: Yes.

MR. RITCHIE: Yeah.

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

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

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

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

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

MS. LUERA: Yes.

MS. KANE: Because --

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

MS. KANE: Or comparable. Wherever you

are.

MS. LUERA: Okay. Yep. Of course.

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

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

MS. KANE: Not closed yet.

MS. LUERA: -- at different times.

MS. KANE: We know.

MS. LUERA: Yes.

MR. RITCHIE: Yes.

MS. LUERA: Okay.

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

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

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

MS. LUERA: Sure. Yes.

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

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

MR. RITCHIE: Okay.

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

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

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

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

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

MS. KANE: Okay.

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

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

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

MR. WALLING: Sure.

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

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

is -- is impacted by this.

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

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

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

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

MR. CLARK: Christian, quick question.

MR. MYERS: Yeah.

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

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

MR. MYERS: By year -- calendar year.

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

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

MR. CLARK: Okay.

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

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

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

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

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

professional.

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

MR. CLARK: So are you reviewing --

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

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

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

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

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

MR. CLARK: -- any one individual case?

MR. WALLING: Yeah. We're not even

doing that yet.

MR. CLARK: Okay.

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

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

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

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

MR. CLARK: Right. Right.

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

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

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

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

MS. LUERA: The number --

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

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

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

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

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

Mr. Walling, you want to talk real quick?

MR. WALLING: Sure.

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

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

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

many are going just to future medical?

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

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

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

MR. RITCHIE: Right.

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

MR. RITCHIE: Exactly.

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

MR. RITCHIE: Right.

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

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

MR. RITCHIE: Right.

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

MS. LOVE: Especially if you've got a bunch of --

MS. KANE: Seriously ill people.

MS. LOVE: Yeah.

MR. RITCHIE: Right.

MS. LOVE: Birth injury cases --

MS. KANE: Yes.

MS. LOVE: -- that are going to go long term.

MS. KANE: Right.

MR. RITCHIE: Right. We need to account for them. But that's the intention of the fund --

MS. KANE: Exactly.

MR. RITCHIE: -- is to pay future medical.

MS. KANE: Right.

MR. RITCHIE: So the question --

MS. LOVE: We can -- we can debate that. But the -- the point here that's relevant today is the importance of: If you settle with a patient and agree to pay for their future medicals, what are we going to do to make sure the money's going to be there for them?

MS. KANE: Right. Which was the point

you made.

MS. LOVE: Yeah.

MR. RITCHIE: Exactly.

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

MS. LOVE: Thank you.

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

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

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

MS. LUERA: We got --

MR. CLARK: -- claims or --

MS. LUERA: Yeah. Medical bills.

MR. CLARK: -- bills processed for --

MS. LUERA: Yes.

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

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

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

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

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

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

MS. LOVE: Yes.

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

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

MR. CLARK: -- we paid claims on.

MS. LUERA: Yes.

MS. LOVE: Right.

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

need to treat.

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

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

MS. KANE: Lucky.

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

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

MS. LUERA: Yes.

MR. BERENBERG: So some of the patients --

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. KANE: Yes.

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

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

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

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

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

MR. RITCHIE: Yeah, sorry.

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

MR. RITCHIE: Yes.

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

payments.

MR. RITCHIE: Right, right.

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

MS. LUERA: Years and years.

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

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

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

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

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

Yes, sir.

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

MS. LUERA: This is just PCF.

MR. AUTIO: Just PCF.

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

MS. LUERA: What the PCF --

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

MS. LUERA: Plus past.

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

MS. LUERA: Yes.

MR. AUTIO: Okay.

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

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

MS. LUERA: -- incredibly high.

MR. AUTIO: -- in this case --

MS. LUERA: Correct.

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

MS. LUERA: Yes.

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

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

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

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

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

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

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

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

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

just the number of settlements per quarter as a trend.

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

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

MS. LUERA: There is --

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

MS. LUERA: Yes.

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

MS. LUERA: Exactly.

MR. CLARK: Okay.

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

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

MS. LUERA: Right.

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

MS. LOVE: Trust the accountant

MR. AUTIO: Famous last words.

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

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

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

MS. LUERA: Yes.

MR. AUTIO: Settlements and judgements?

MS. LUERA: Yes, yes.

MR. AUTIO: Okay.

MS. LUERA: Any other questions?
MR. RITCHIE: No.
MS. LUERA: Okay. All right. Thank you.
MS. KANE: I think it's --
MR. RITCHIE: Yeah. Back to Rob. Mr. Walling?
MR. WALLING: Okay. Yep. Sorry. Give me a second.
MR. RITCHIE: Okay. No problem.
MR. WALLING: Okay. So I've already given you a sneak peek at this exhibit, but this is where I'd like to start. It -- it's worthwhile to look at the incremental changes in the PCF between year end '23 and year end '24.
MS. KANE: It's -- Rob, did you have --
MR. RITCHIE: Or is it at a different tab? Is it --
MS. KANE: There's nothing there.
MR. MYERS: Is he sharing on the --
MS. KANE: Do you want share --
MS. LUERA: Try minimizing that and --
MR. WALLING: I am sharing.
MS. KANE: Well, we --
MS. LUERA: Okay.

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

MR. RITCHIE: If he wants to sign --

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

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

MS. KANE: I think we have it.

MR. WALLING: Okay.

MS. KANE: It's just very tiny.

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

MR. WALLING: That's fine. Okay.

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

MS. LOVE: Is it in here?

MR. WALLING: Something's not driving here.

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

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

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

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

MS. GALLEGOS: Who has this again?

MR. RITCHIE: Who's gotten both?

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

MS. KANE: Yes, please.

MS. GALLEGOS: Okay.

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

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

MR. AUTIO: I'd like one.

MR. RITCHIE: Maybe email it to us.

MR. AUTIO: Maybe -- maybe six.

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

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

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

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

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

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

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

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

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

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

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

MS. LOVE: No.

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

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

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

MS. LUERA: Sure.

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

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

MS. LUERA: Understood.

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

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

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

MR. AUTIO: I definitely didn't --

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

MS. LUERA: The study?

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

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

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

MR. RITCHIE: How did you find that?

MS. KANE: I think I'm killing trees. Who else would like --

MR. AUTIO: I'll probably --

MR. RITCHIE: I'll --

MS. KANE: Can you two share?

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

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

MR. AUTIO: Thank you.

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

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

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

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

MS. LOVE: No.

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

MR. RITCHIE: I don't think --

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

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

MR. RITCHIE: The report?

MS. LUERA: The actuarial statement, yes.

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

MR. RITCHIE: All right. Well,

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

MR. WALLING: Sure.

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

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

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

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

By comparison, the hospitals performed

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

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

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

those legislative infusions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. RITCHIE: Go right now?

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

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

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

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

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

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

MS. LOVE: Okay.

MR. RITCHIE: Okay. Any other questions?

All right. No other questions here,

Rob.

MR. WALLING: Okay.

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

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

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

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

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

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

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

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

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

underfunded.

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

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

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

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

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

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

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

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

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

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

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

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

MR. WALLING: So --

MS. KANE: So is there a separation --

MR. WALLING: Yeah.

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

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

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

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

MS. KANE: Going forward --

MR. WALLING: So that's --

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

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

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

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

MS. KANE: Absolutely.

MR. WALLING: I guess what I'm trying

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

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

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

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

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

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

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

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

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

MR. RITCHIE: Yeah.

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

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

MR. AUTIO: You're assuming he does.

MS. KANE: I was being kind.

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

MS. KANE: Well, the rurals for us.

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

MR. WALLING: Right.

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

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

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

MR. WALLING: Yeah. Page 2.

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

MR. WALLING: That's correct.

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

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

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

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

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

things worse.

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

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

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

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

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

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

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

MR. WALLING: Correct.

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

MR. WALLING: Correct.

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

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

MR. RITCHIE: Just less bad.

MS. LOVE: So don't get excited.

MR. RITCHIE: Yeah.

MR. CLARK: I feel less bad.

MR. AUTIO: Always good news at these meetings.

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

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

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

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

MR. RITCHIE: First one scares me.

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

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

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

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

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

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

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

MR. CLARK: Again, they would shoot me for that. But -- and -- and I say that because if I'm one of the members and there's not a mechanism to charge me if it's short and you come try and charge me, I'm going to say "not allowed."

MS. KANE: Should -- the question is should --

MR. CLARK: So why should I -- why should I have the option to get the refund back?

MS. KANE: God -- God forbid anyone talks about the act and changing it. But should there be a mechanism? To me, there should be. A true up. Whatever phrase you want to call it.

MR. CLARK: That's not a mechanism. That'd just keep us in.

MR. WALLING: I -- you know, my -- my concern is the hospitals are --

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

MS. LOVE: I mean, it seems to me that the superintendent of insurance has the power to reimburse overcharges.

MR. CLARK: Right, I think.

MS. KANE: Well, let's see if I have that. Let's make sure.

MS. LOVE: Yeah.

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

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

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

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

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

MR. CLARK: But as a board member --

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

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

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

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

MS. LOVE: Yeah.

MR. CLARK: My hospitals would love to

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

MS. KANE: Look, I think --

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

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

MR. CLARK: Right.

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

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

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

MR. RITCHIE: That's all the time.

MS. KANE: Yeah. And people are --

MR. RITCHIE: Still paying.

MS. KANE: And still in the group.

MR. RITCHIE: Right.

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

MS. LOVE: I think somebody could get creative.

MS. KANE: Yes. And then people react.

MS. LOVE: Yeah. Understood.

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

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

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

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

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

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

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

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

MR. AUTIO: Yeah.

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

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

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

MR. RITCHIE: Yeah.

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

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

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

MR. RITCHIE: Right.

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

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

MS. LOVE: Right.
MR. CLARK: Because you'd have to --
MS. KANE: Well, let us -- let us go look at the statute too. And let's --
MR. AUTIO: I hope not because then there's a bunch of patients with no really --
MS. LOVE: Well, the hospital, then, has to pick up.
MR. AUTIO: Well, I guess, I mean, maybe.
MR. CLARK: They're not going to ask for the surcharge back, what's paid, you know, to cover those because they've paid prospectively for the payments to go out --
MS. KANE: I don't know what they anticipated -- I wasn't hearing the statute changed -- what they anticipated when the hospitals went out, if they really understood that claims come through on a -- on this lag basis. I don't know how --
MR. CLARK: I understand.
MS. KANE: I don't know how --
MR. CLARK: Yeah.
MS. KANE: -- how that was all done. So --
MR. RITCHIE: Yeah. I don't think we

appreciate how far the tail was.

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

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

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

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

MS. LOVE: Right.

MS. KANE: I don't know --

MR. CLARK: Is Rob still on?

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

MR. CLARK: Rob, are you still on?

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

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

The 2024 hospital surcharge is 68.89

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

MR. WALLING: That is just the surcharge.

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

MR. WALLING: Yeah. Not the deficit surcharge.

MR. CLARK: Okay.

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

MR. RITCHIE: Right.

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

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

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

MS. LOVE: Boom. Yep. Even --

MR. RITCHIE: So that doesn't --

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

MR. RITCHIE: That meaning future medical?

MS. KANE: -- as something?

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

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

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

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

MR. CLARK: Yeah.

MS. KANE: I -- I understand --

MR. CLARK: "Amounts due from a

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

MS. KANE: While you were in.

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

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

MR. CLARK: Okay.

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

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

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

something? Yeah.

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

MS. KANE: Right.

MR. RITCHIE: -- that interpretation. Okay.

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

Troy? Nick? Anyone? Kathy?

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

MR. RITCHIE: Like what you just said.

MS. KANE: Okay.

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

MS. KANE: The point in question.

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

MS. KANE: How we're going to really

handle the transition from --

MR. RITCHIE: Right.

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

MR. RITCHIE: Right.

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

MR. RITCHIE: Right.

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

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

MS. KANE: Can we --

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

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

MR. RITCHIE: Right.

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

MR. RITCHIE: Right. And when do you

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

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

MR. RITCHIE: Yeah.

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

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

Like, that type of structure?

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

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

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

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

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

MR. MYERS: Okay.

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

MR. RITCHIE: Okay. It would --

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

MR. RITCHIE: Yeah.

MS. LOVE: -- good idea.

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

MS. LOVE: Yeah.

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

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

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

MS. LOVE: Yeah.

MS. KANE: Right.

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

MS. KANE: Yes.

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

MS. KANE: That would be very helpful.

MR. RITCHIE: -- recommendation. Exactly.

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

MR. RITCHIE: Yeah. I understand.

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

MR. RITCHIE: Yeah.

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

MR. RITCHIE: Right.

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

MR. RITCHIE: Absolutely.

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

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

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

MS. KANE: Find those asset managers, then.

MR. RITCHIE: Yeah.

MS. KANE: Okay.

MR. RITCHIE: Rob, quick question.
MR. WALLING: Yes.
MR. RITCHIE: I might have missed this early on. What are you using for the rate of inflation for setting next year's rates?
MR. WALLING: I don't remember. Give me a second.
MS. KANE: Medical inflation, not just general.
MR. RITCHIE: Well, no. The statute says we use --
MR. AUTIO: It's the CPI.
MR. RITCHIE: -- CPS. And so --
MR. WALLING: CPI, specifically for estimating the --
MR. RITCHIE: Urban CPI.
MS. KANE: You mean for the --
MR. WALLING: -- the coverage layer.
MR. RITCHIE: The cap.
MS. KANE: I'm sorry.
MR. RITCHIE: Yeah. For the cap. I'm sorry.
MS. KANE: I'm think of something else. I was making -- I was thinking the discount rate. Sorry.

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

MS. KANE: Yeah.

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

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

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

MR. RITCHIE: Right.

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

MR. RITCHIE: Right.

MR. MYERS: And that's 2.87 annually.

MR. RITCHIE: 2.7? Okay.

MR. MYERS: 2.87.

Right, Rob? On page 2?

MR. WALLING: Yep. Exactly.

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

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

MR. RITCHIE: Yeah.

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

MR. RITCHIE: Yeah.

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

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

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

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

Okay. Yeah, Troy.

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

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

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

MR. RITCHIE: Yeah.

MS. KANE: Right.

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

MS. KANE: Can you find that for us?

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

MR. RITCHIE: Right.

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

MR. RITCHIE: I thought there was --

MR. CLARK: -- and specialty.

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

MR. RITCHIE: Yes.

MR. CLARK: Right.

MS. KANE: Yes. Those other entities.

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

MS. KANE: Yeah.

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

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

MR. WALLING: I thought so.

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

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

MR. CLARK: Is that in the report somewhere?

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

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

describe how the -- those entities are being --

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

MS. LUERA: Not enough data.

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. LUERA: Right.

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

MR. WALLING: Yep.

MR. RITCHIE: Okay. Good question.

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

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

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

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

MR. WALLING: Correct.

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

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

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

MR. WALLING: Yep.

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

MR. WALLING: Yeah. We should add that.

MR. RITCHIE: Okay. Any other questions?

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

Next meeting, did you have it down?

MR. AUTIO: Got that scheduled. Right?

MR. RITCHIE: Yeah. We have it scheduled.

MR. AUTIO: September 30th, I think.

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

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

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

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

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

MR. CLARK: Running an annual meeting.

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

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

Okay. So --

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

MR. RITCHIE: Exactly.

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

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

MS. LUERA: Correct.

MR. RITCHIE: -- experience.

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

MR. RITCHIE: Good point.

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

MS. LOVE: Super.

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

MS. LOVE: Yeah.

MS. KANE: -- ready.

MS. LOVE: That sounds great.

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

MS. LOVE: That sounds great.

MS. KANE: All right? Yeah.

MR. RITCHIE: Yes. Thank you.

All right.

MS. KANE: No trouble -- having been on

a board, I understand that.

MS. LOVE: Thank you.

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

MS. LOVE: Thanks, everyone.

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

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

MR. RITCHIE: Yeah.

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

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

CERTIFICATE

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

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

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