Medical Care Availability and Reduction of Error Fund

2007 MCARE ASSESSMENT MANUAL

23%

Commonwealth of Pennsylvania
Insurance Department

M. Diane Koken, Insurance Commissioner

Peter J. Adams, Deputy Insurance Commissioner for Mcare

Medical Care Availability and Reduction of Error Fund

PENNSYLVANIA INSURANCE DEPARTMENT

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October 20, 2006

Dear Sir/Madam:

Attached you will find the Medical Care Availability and Reduction of Error (Mcare) Fund's 2007 Assessment Manual. The 2007 Mcare assessment rate is 23%. This manual is intended to provide guidance and clarify procedures with regards to calculating the 2007 Mcare assessment. Although the 2007 Assessment Manual should be read thoroughly in order to understand the entire assessment calculation process, please take note of some particular additions and clarifications relating to the following:

- New Procedures for Electronically Submitting Form e-216
- Modifications to Form e-216 and Exhibit Worksheets
- Changes in Classifications and Territories
- Change in Corporation Rating Factor From 10% to 15%
- Clarified Reporting Procedures for Endorsements, Cancellations, and Corrections on the e-216
- Clarified Reporting Procedures for Credit Balances
- Abatement Repayment Invoicing
- Experience Rating for Health Care Providers Other Than Hospitals

Electronic submission of Form e-216 continues to be the standard for submitting coverage for participating health care providers and eligible entities to Mcare. Should you have any questions, please contact Mcare's Division of Policy Administration.

Sincerely,

Peter J. Adams
Deputy Insurance Commissioner
Medical Care Availability and Reduction of Error Fund

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Medical Care Availability and Reduction of Error Fund ("Mcare")
2007 AS20SESSMENT MANUAL

This manual should be used as a guide to assist primary insurers and self insurers in reporting coverage to Mcare and calculating the assessment for 2007 as required by Act 13 of 2002 ("Act 13"). There are numerous additions and clarifications in this manual; therefore, it is essential that this manual is read in its entirety and whoever reports coverage to Mcare becomes familiar with the information contained herein. For further clarification, refer to Fund Rules and Regulations (31 Pa. Code §242.1 et seq.).

The Mcare assessment is a percentage of the Pennsylvania Professional Liability Joint Underwriting Association ("JUA") rates as approved by the Pennsylvania Insurance Department. For Mcare assessment calculation purposes, the JUA rates to be used are the rates that will become effective January 1, 2007. (Consulting the JUA Rate Manual at www.pajua.com may provide details not specifically addressed herein.) It has been determined that the 2007 assessment rate is 23%.

ABOUT MCARE

Mcare was created by Act 13, which was signed into law on March 20, 2002, and is a Deputate of the Pennsylvania Insurance Department. Mcare provides limits of $500,000/$1,500,000 in coverage for each participating health care provider and eligible entity in excess of primary coverage (basic insurance coverage). Mcare is the successor of the Medical Professional Liability Catastrophe Loss Fund, previously known as the "Cat Fund."

Mcare was established to ensure reasonable compensation for persons injured due to medical negligence in this Commonwealth. Mcare's general purpose is to provide for and to administer funds to pay judgments, awards or settlements in medical malpractice claims against participating health care providers and eligible entities which exceed basic insurance coverage limits provided by primary medical professional liability insurance policies or self-insurance plans. In addition, Mcare administers a compliance program to ensure adherence to the provisions of Act 13 and its attendant regulations.

Mcare is funded by an assessment on each medical professional liability policy for each participating health care provider and eligible entity entitled to Mcare coverage. The assessment is calculated, invoiced and collected by the primary insurer or self-insurer on behalf of insured participating health care providers and eligible entities and then remitted to Mcare. The Mcare assessment is based on the schedule of the JUA's occurrence rates, approved by the Insurance Commissioner, as adjusted by Mcare in accordance with applicable law.

MCARE PARTICIPATION

Mcare participation is mandatory for health care providers, as defined by Act 13, who conduct 50% or more of their health care business or practice within the Commonwealth, unless a statutory exemption exists. (The health care business or practice, as defined in Section 702, is the number of patients to whom health care services are rendered by a health care provider within an annual policy period.) Act 13 defines a "health care provider" as a physician, certified nurse midwife, podiatrist, hospital, nursing home, birth center or primary health center. Health care providers who practice less than 50% but more than 0% in Pennsylvania may choose to participate in Mcare.

Although not defined as a "health care provider," those professional corporations, professional associations and partnerships that are entirely owned by health care providers and which elect to purchase basic insurance coverage must also participate in Mcare.

EXCEPTIONS TO MCARE PARTICIPATION. The following is a list of those health care providers who are not required to participate in the Fund.

- Health care providers who conduct less than 50% of their health care business or practice in Pennsylvania and do not choose to participate;
- Physicians who exclusively practice the specialty of forensic pathology;
- Health care providers who are active military under orders (U.S. or Pennsylvania);
- Retired health care providers, including those providing care for self and immediate family;
- Health care providers who are exclusively covered under the Federal Tort Claims Act;
- Health care providers who are exclusively practicing as volunteer licensees.

COVERAGE LIMITS

For policies effective in 2007, the total required limits of medical professional liability coverage for participating health care providers, excluding hospitals, is $1,000,000 per occurrence and $3,000,000 per annual aggregate. For hospitals, the total required limits are $1,000,000 per occurrence and $4,000,000 per annual aggregate. The total required coverage limits are comprised of basic insurance coverage limits and excess Mcare limits as follows:

A. BASIC INSURANCE COVERAGE LIMITS (PRIMARY)

Act 13 requires participating health care providers, other than hospitals, and eligible participating entities to obtain primary coverage in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate through a licensed or approved medical professional liability insurer or approved self-insurance plan. Hospitals must obtain primary coverage in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate through a licensed or approved medical professional liability insurer or approved self-insurance plan.

B. MCARE LIMITS (EXCESS)

Mcare's limits for participating health care providers and eligible entities are $500,000 per occurrence and $1,500,000 per annual aggregate in excess of the primary coverage.

CONTACTING MCARE

After reading this manual, anyone with questions regarding the interpretation of the 2007 Mcare Assessment Manual or calculation of the Mcare assessment should submit their questions in writing to Mcare.

Mailing Address:
Mcare
Coverage Compliance Unit
P.O. Box 12030
Harrisburg, PA 17108-2030

For Deliveries:
Mcare
Coverage Compliance Unit
1010 N. 7th Street, Suite 201
Harrisburg, PA 17102

Inquiry e-mail: ra-in-mcare-exec-web@state.pa.us
e-216 submission e-mail: ra-in-remittance@state.pa.us
Phone: (717) 783-3770 **Fax:** (717) 705-7342

SECTION I. REMITTANCE ADVICE FORM e-216

A. GENERAL INFORMATION. The standard for submitting coverage for participating health care providers and eligible entities to Mcare is to do so electronically via Form e-216 or one of the other two approved formats listed under Section I (B.).

The Remittance Advice Form e-216 serves as both a coverage reporting form as well as an accounting advice form. The Remittance Advice Form e-216, along with all applicable worksheet Exhibits, is available by:

- Visiting the Mcare web site at **www.mcare.state.pa.us**
- Selecting "Assessment Manuals" from the navigation bar on the left
- Selecting the link for the appropriate year's assessment manual
- Selecting the "Remittance Advice Form e-216" link
- Opening or saving the file

Form e-216 calculates the assessment due for physicians, podiatrists and certified nurse midwives. Although Form e-216 will not calculate the assessment for hospitals, corporations, birth centers, nursing homes and primary health centers, it is necessary for these entities to be added to Form e-216. The worksheets for these entities will calculate the assessment and must be submitted in addition to and along with the completed Form e-216. The Exhibit worksheets, Hospital Roster, and Form 316 are tabbed at the bottom of the Form e-216. Placing the cursor on the small red triangle on the Form e-216 will cause a comment box to appear that describes in detail the information that is needed in that field. All applicable fields of information must be completed. The 2007 Form e-216 is to be used to report coverage for policies effective in 2007 only since it calculates the assessment based on 2007 rates. When reporting mid-term additions and deletions to an existing master policy, use the effective year of the master policy to determine the applicable Form e-216 year and rates.

Form e-216 is the required form to be used by all primary insurers and self-insurers, unless specifically exempted in writing by Mcare.

NOTE: THE EXCEL FORM E-216 SHOULD BE USED AS A TOOL TO ASSIST IN THE CALCULATION OF THE ASSESSMENT; HOWEVER, ALL ASSESSMENTS SHOULD BE MANUALLY REVIEWED FOR ACCURACY BEFORE SUBMITTING TO MCARE.

All coverage and collected assessment payments must be received by Mcare **within 60 days of the effective date of coverage**, in accordance with 31 Pa. Code §242.1 et seq**.**

Please make checks payable to: Medical Care Availability and Reduction of Error Fund or "Mcare". All checks must be accompanied by a completed hard copy Remittance Advice Form e-216 and any applicable exhibits and supporting documentation. The remittance total must be equal to the check amount remitted unless the primary insurer or self-insurer has a prior credit balance and it is properly documented in an attached cover letter as outlined in Section II (E.) on Credit Balances.

B. ELECTRONIC SUBMISSIONS. The standard for primary insurers and self-insurers submitting coverage and payment information to Mcare is to do so electronically via e-mail to Mcare at the following e-mail address: **ra-in-remittance@state.pa.us**. Additionally, the hard copy and payment, if applicable, must be mailed to Mcare.*

The Subject line of the e-mail should be in the following format:

Insurer's 3 Digit Mcare # Official e-216 Date of e-216 Check No. (if applicable)

EXAMPLE: 000 Official e-216 01/01/07 Check No. 123456

Electronic submissions may be sent in one of the following formats:

1. Exhibit 4 – Remittance Advice Form e-216.*
   Transmit the completed Form e-216 by e-mail to Mcare or send a CD or diskette by mail along with a hard copy and the check.

2. Fixed Width Text File Format.*
   Submissions in this format must be pre-approved by Mcare. Specifications for this format can be provided by your Mcare Policy Examiner. Once approved, submissions can be transmitted by e-mail, tape or other electronic media. This type of electronic submission is limited to new, renewal and mid-term addition business. All cancellations, corrections and endorsements must be remitted separately via Form e-216.

3. Comma Separated Value Format.*
   Submissions in this format must be pre-approved by Mcare. Specifications for this format can be provided by your Mcare Policy Examiner. Once approved, submissions can be transmitted by email, tape or other electronic media. This type of electronic submission is limited to new, renewal and mid-term addition business. All cancellations, corrections and endorsements must be remitted separately via Form e-216.

***NOTE:** PRINTED HARD COPIES OF FORM E-216 MUST ALSO BE SUBMITTED. THE HARD COPY MUST CONTAIN THE IDENTICAL HEALTH CARE PROVIDERS AND RELATED INFORMATION THAT WAS ELECTRONICALLY SUBMITTED. ACCEPTANCE OF FORM E-216 WILL TAKE PLACE ONLY AFTER RECEIPT OF APPLICABLE PAYMENT AND ALL OTHER REQUIRED CONDITIONS HAVE BEEN MET.

SECTION II. REPORTING GUIDELINES

A. COMMENT COLUMN. Comments must be completed on each coverage line of the Form e-216. It is very important that this information is accurate. Please be especially careful in using the "New" for business that is new to your company versus the "Rnwl" comment. Please use the "Cncl" comment only for coverage that is actually being cancelled. A description of each comment can be found on the Form e-216 by placing your cursor on the red triangle at the top of the Comment column.

B. RELATED LICENSE NUMBERS are license numbers assigned by Mcare to identify specific hospitals (HS), corporations (MC) or groups (GP). Mcare assigns a GP number to a nonparticipating entity whenever a group of health care providers are reported under the same policy. Mcare identifies the specific related hospital, corporation, or group that individual health care providers are employed by or affiliated with for rating and statistical purposes. Related license numbers can be found on the Mcare website.

When submitting a Form e-216 for health care providers employed by <u>one</u> related license number, indicate the Mcare issued related license number in the related license number field at the top of the Form e-216 (cell B4). This will automatically populate the related license number in the V column on the Form e-216.

If submitting a Form e-216 with <u>multiple</u> related license numbers, please type the related license number in the V column of the Form e-216 corresponding with each line of coverage. One continuous Form e-216 per remittance should be e-mailed regardless of how many related license numbers are reported. If this is problematic, please contact the Policy Examiner who handles your account. Please type the corresponding name of the hospital, corporation, or group as a heading in the name column on the line above each group of health care providers having the same related license number.

C. ENDORSEMENTS AND CANCELLATIONS <u>must be reported to Mcare within 60 calendar days of the effective date of the cancellation or endorsement.</u> Extended reporting endorsements ("tail") are due to Mcare within 120 calendar days of the expiration date of the underlying claims-made coverage. When an endorsement or cancellation is reported to Mcare and the result is a credit, the credit shall be recorded on the Form e-216 with parentheses to distinguish it from a debit. Mcare calculates transactions on a pro rata basis (i.e., for a partial year of coverage).

If the reporting of a cancellation, an endorsement or the sum of an endorsement falls beyond the 60-day reporting requirement and results in an assessment credit, the cancellation or endorsement shall still be reported, but no credit will be issued or accepted by Mcare.

There are six exceptions to the no credit rule for a cancellation or endorsement that is received by Mcare beyond 60 days from the effective date of the cancellation or endorsement:

- Cancellation due to suspension or revocation of the insured's license
- Cancellation by carrier due to nonpayment of premium
- Cancellation or endorsement submitted with the written consent of Mcare
- Abatement adjustment endorsements
- The health care provider is deceased or disabled ☑

ENDORSEMENTS (END) should be reported by simulating cancellation of the previously reported coverage effective the endorsement date. This is done by entering the original policy From Date and To Date and entering the endorsement date in the Cancel Date column, but indicate "**END**" in the Comment column. Then on the next line, show the endorsement date as the From Date and the expiration date as the To Date. Also indicate "END" in the Comment column on this line. The Form e-216 will calculate the assessment for both of these lines. If this method is problematic, please contact the Policy Examiner for alternatives.

ABATEMENT ADJUSTMENTS (EAB$) are considered endorsements by Mcare (i.e. debits or credits); however, "**EAB$**" should be reported in the Comment column of the Form e-216.

CANCELLATIONS (CNCL) should be reported by reporting the full original policy period in the coverage From Date and To Date and inserting the cancellation date in the Cancel Date column. Indicate "**CNCL**" in the Comment column of the Form e-216. The Form e-216 will calculate the return assessment credit.

NOTE: TRANSACTIONS MUST BE REPORTED AND RECEIVED AT MCARE IN CHRONOLOGICAL ORDER. FORM E-216'S MUST BE REVIEWED AND VERIFIED PRIOR TO SUBMISSION.

D. CORRECTIONS (CORR) should be submitted as soon as possible, but no later than 30 calendar days from the date you receive notification from Mcare of the error. Failure by the primary insurer or self-insurer to provide correct information in a timely manner to Mcare may result in the health care provider being reported to the appropriate licensing board for noncompliance and the loss of Mcare coverage in the event of a claim.

The Correction Form e-216 must include a copy of the correspondence from Mcare that identified the discrepancies. To properly report a correction, reverse what was originally reported incorrectly and report a new line with the correct information. This will result in two line items on the Form e-216 per correction. The first line should show the From Date and the To Date that were originally reported, the effective date in the Cancel Date column, and the reverse of the incorrect assessment amount that was originally submitted (if originally reported a debit, report a credit of the same amount and if originally reported a credit, report a debit of the same amount). On the next line report the correct information with the correct assessment amount. Also indicate "CORR" in the Comment column on both lines. Corrected Form e-216s should include only those health care providers being corrected. Do not resubmit entries that were previously reported correctly. The Correction Form e-216 should be given a new Remittance Date but also insert the Remittance Date of the original remittance you are correcting on the line on the e-216 that states "Correcting (date)" (Cell B9).

E. CREDIT BALANCES. When the total of a Form e-216 Remittance Advice results in a credit due the carrier, the credit will be used as payment towards a future Form e-216. All credit balances must be carried forward to the next remittance submitted to Mcare until the credit balance is exhausted.

Credit balances belong to the carrier of record. One credit balance per carrier may be maintained. Mcare does not maintain separate credit balances per insured and Mcare does not transfer credit balances for an insured from one carrier to another. If special circumstances warrant such requests, please contact your Policy Examiner.

When remitting a Form e-216 that *adds* to a credit balance, a cover letter must accompany the Form e-216 referencing the last credit balance and remittance date. The letter must also state the amount of credit being added and what the new credit balance will be.

When remitting a Form e-216 that *uses* credits from an existing balance, a cover letter must accompany the Form e-216 referencing the last credit balance and remittance date. The letter must also state the amount of credit being used, what the new credit balance will be or, if the credit balance is used in full, what the reduced check amount is.

NOTE: 2002 CREDIT LETTERS MAY BE USED AS PAYMENT AGAINST A FULL ASSESSMENT THAT IS PAID, PROVIDED THE HEALTH CARE PROVIDER DID NOT RECEIVE AN ABATEMENT. WHEN SUBMITTING 2002 CREDIT LETTERS ALONG WITH A FORM E-216, CREDITS SHOULD NOT BE REPORTED ON THE FORM E-216. A COVER LETTER MUST ACCOMPANY THE FORM E-216 STATING THE TOTAL AMOUNT OF 2002 CREDIT LETTERS BEING DEDUCTED FROM THE FORM E-216 TOTAL. THE TOTAL 2002 CREDIT LETTER AMOUNT MUST BE SEPARATELY IDENTIFIED IN THE COVER LETTER FROM AN EXISTING CREDIT BALANCE BEING UTILIZED.

SECTION III. CALCULATION OF MCARE ASSESSMENT

This section is designed to assist in the manual calculation of the Mcare Assessment for the various types of health care providers and eligible entities participating in Mcare. When two or more classifications and/or territories are applicable to coverage being reported, the assessment for the highest rated classification and/or territory will apply.

A. PHYSICIANS, PODIATRISTS & CERTIFIED NURSE MIDWIVES

REQUIRED FORM: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)

NOTE: PENNSYLVANIA LAW REQUIRES THAT ALL PARTICIPATING HEALTH CARE PROVIDERS BE PROVIDED WITH FULL, SEPARATE AND INDIVIDUAL LIMITS.

1. Determine highest rated classification. (Refer to Exhibit 3)

2. Determine highest rated territory. (Refer to Exhibit 10)

3. Locate appropriate prevailing primary premium. The assessment for a physician, podiatrist or certified nurse midwife must be calculated by multiplying the prevailing primary premium by the 2007 annual assessment rate of 23%. (Refer to Exhibit 1)

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Submit a completed Remittance Advice Form e-216.

B. PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS & PARTNERSHIPS (SPECIALTY CODE 80999)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)
EXHIBIT 5 (WORKSHEET FOR PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS & PARTNERSHIPS)

NOTE: PENNSYLVANIA LAW PROHIBITS PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS & PARTNERSHIPS FROM SHARING LIMITS WITH ANY HEALTH CARE PROVIDER.

A professional corporation, professional association or partnership which is entirely owned by health care providers and which elects to purchase basic insurance coverage in accordance with Section 711 of Act 13 from the JUA or from a primary insurer licensed or approved by the Insurance Department shall be required to participate in Mcare. Mcare Fund participation is limited to those structural types of professional corporations, professional associations or partnerships that were in existence on November 26, 1978. All Mcare eligible professional corporations, professional associations and partnerships must pay an appropriate assessment, even if the primary policy is provided at no cost.

Professional corporations, professional associations and partnerships that are formed under the laws of another state and provide medical services to patients in Pennsylvania are eligible to participate in Mcare provided they follow the format that is required by Pennsylvania law regarding foreign corporations.

Additionally, if an "S" corporation is registered with the Pennsylvania Department of State's Corporation Bureau as a professional corporation, is owned entirely by health care providers and elects to purchase basic insurance coverage, Fund participation is mandatory.

Proof of eligibility is required for any entities that are newly reported to Mcare. Copies of Articles of Incorporation, approved and stamped by the Pennsylvania Department of State, and a list of owners are required for professional corporations and professional associations. Copies of partnership agreements are required for partnerships. Professional corporations, professional associations and partnerships must be reported on the Remittance Advice Form e-216 and submitted along with their applicable worksheets. Reporting of mid-term endorsements, additions and deletions is not required; however, if choosing to report mid-term changes to a policy, <u>all</u> mid-term changes must be reported.

1. The assessment shall be calculated by computing the sum of 15% of the total 2007 unabated Mcare assessments for each shareholder, owner, partner and employed health care provider. (Refer to Example 1)

Example 1

Five health care providers are shareholders, owners, partners or employees of Professional Corporation "Y" which provides emergency room services in Territory 1.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD123456	John Smith	03531	51	$ 9,328	Y3
MD654321	Jane Smith	03531	51	$ 12,437	
MD012345L	Mark Jones	03531	51	$ 12,437	
MD054321E	Sally Jones	03531	51	$ 12,437	
MD246810	Joseph Miller	03531	51	$ 8,084	PT 16

The sum of the total 2007 unabated assessments for all health care providers who are shareholders, owners, partners or employees of Professional Corporation "Y" is $54,723. ($9,328, $12,437, $12,437, $12,437 and $8,084 = $54,723). Thus, the 2007 assessment owed by Professional Corporation "Y" is $8,208 ($54,723 X 15% = $8,208).

If any of the shareholders, owners, partners or employees have different policy dates than the professional corporation, professional association or partnership policy, they shall be listed on the worksheet with their annual 2007 unabated assessment that is effective or will be effective in the same calendar year as the professional corporation, professional association or partnership's policy. (Refer to Example 2)

Example 2

Professional Corporation "Z" has a policy effective from 7/01/07-7/01/08. The shareholders, owners, partners and employees have individual effective dates as follows:

John Smith	02/01/07-02/01/08	2007 Policy
Jane Smith	07/01/07-07/01/08	2007 Policy
*Mark Jones	11/01/07-11/01/08	2007 Policy

*When Mark Jones renews his 2007 policy on 11/01/07, his assessment will be $14,026. The Corporation's assessment is based on his 2007 assessment even though it is not in effect yet at the time the Corporation renews its coverage.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD123456	John Smith	03531	51	$ 9,328	Y3
MD654321	Jane Smith	03531	51	$12,437	
MD012345L	Mark Jones	03531	51	$12,437	

The sum of the total 2007 unabated assessments for all health care providers who are shareholders, owners, partners or employees of Professional Corporation "Z" is $34,202. ($9,328, $12,437, $12,437 = $34,202). The 2007 assessment owed by Professional Corporation "Z" is $5,130 ($34,202 X 15% = $5,130).

2. Apply other applicable assessment rating factors as outlined in Section IV.

3. Complete the Professional Corporation, Professional Association and Partnership Worksheet (Exhibit 5) and submit with completed Remittance Advice Form e-216. List the annual unabated assessment for each health care provider on the worksheet. Indicate any discounts applied to a health care provider's assessment in the "Other Rating Factors" column. Also indicate specific health care provider addition or deletion dates in the "Other Rating Factors" column if choosing to report mid-term changes.

NOTE: PLEASE SUBMIT THE WORKSHEETS IN THE ORDER THEY APPEAR ON THE E-216.

C. HOSPITALS (SPECIALTY CODE 80612)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)
EXHIBIT 6 (WORKSHEET FOR HOSPITALS)
EXHIBIT 6A (ROSTER FOR HOSPITALS)

NOTE: PENNSYLVANIA LAW REQUIRES THAT ALL PARTICIPATING HEALTH CARE PROVIDERS BE PROVIDED FULL, SEPARATE AND INDIVIDUAL LIMITS.

1. Determine highest rated territory. (Refer to Exhibit 10)

2. The total prevailing primary premium for a hospital will be calculated by computing:

   a. The sum of the annual occupied bed count (patient days divided by 365 and rounded to the nearest whole number) for each of the following bed types: Hospital (acute care), Mental Health/Mental Rehabilitation, Extended Care, Outpatient Surgical, and Health Institution, multiplied by the appropriate rate. (Refer to Exhibit 2)

   PLUS

   b. The sum of the annual visit count for each of the following visit types: Emergency, Other, Mental Health/Mental Rehabilitation, Extended Care, Outpatient Surgical, Health Institution, and Home Health Care, divided by 100 and rounded to the nearest whole number, then multiplied by the appropriate rate. (Refer to Exhibit 2)

3. The assessment for a hospital will be calculated by multiplying the total prevailing primary premium (the sum of the annual occupied bed and visit counts) by the Experience Modification Factor (as provided by Mcare), then multiplied by the annual assessment of 23%. (Mcare assessment = PPP X EMF X 23%)

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete Hospital Worksheet (Exhibit 6) and submit with completed Remittance Advice Form e-216.

6. When health care providers and other entities are covered under a policy issued to a hospital, a complete roster of all participating health care providers and Mcare eligible entities covered under that hospital policy must be submitted along with the Remittance Advice Form e-216 reporting the hospital coverage. In the case of a health system comprised of multiple hospitals, the roster for each hospital must include the health care providers who initially assume their duties at that hospital. (Refer to Exhibit 6A)

D. NURSING HOMES (SPECIALTY CODE 80924)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)
EXHIBIT 7 (WORKSHEET FOR NURSING HOMES)

NOTE: PENNSYLVANIA LAW REQUIRES THAT ALL PARTICIPATING HEALTH CARE PROVIDERS BE PROVIDED FULL, SEPARATE AND INDIVIDUAL LIMITS.

1. Determine highest rated territory. (Refer to Exhibit 10)

   The total prevailing primary premium will be calculated by computing the sum of the annual occupied bed count (patient days divided by 365 and rounded to the nearest whole number) for the appropriate bed type: Convalescent or Skilled Nursing, multiplied by the appropriate rate. (Refer to Exhibit 2)

   Each nursing home must report either convalescent bed counts or skilled nursing bed counts, not both. If 50% or more of patients are age 65 and under, all bed counts must be reported as convalescent. If 50% or more of patients are over age 65, all bed counts must be reported as skilled nursing.

2. The assessment for a nursing home will be calculated by multiplying the total prevailing primary premium by the 2007 annual assessment of 23%.

3. Apply other applicable assessment rating factors as outlined in Section IV.

4. Complete Nursing Home Worksheet (Exhibit 7) and submit with completed Remittance Advice Form e-216.

E. PRIMARY HEALTH CENTERS (SPECIALTY CODE 80614)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)
EXHIBIT 8 (WORKSHEET FOR PRIMARY HEALTH CENTERS)

NOTE: PENNSYLVANIA LAW REQUIRES THAT ALL PARTICIPATING HEALTH CARE PROVIDERS BE PROVIDED FULL, SEPARATE AND INDIVIDUAL LIMITS.

1. Determine highest rated territory. (Refer to Exhibit 10)

2. The total prevailing primary premium will be calculated by computing the sum of the annual visit count for each of the following visit types: Emergency, Other, Mental Health/Mental Rehabilitation, Outpatient Surgical, and Home Health Care, divided by 100, then multiplied by the appropriate rate. (Refer to Exhibit 2)

3. The assessment for a primary health center will be calculated by multiplying the total prevailing primary premium by the 2007 annual assessment of 23%.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete Primary Health Center Worksheet (Exhibit 8) and submit with completed Remittance Advice Form e-216.

F. BIRTH CENTERS (SPECIALTY CODE 80402)

REQUIRED FORMS: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)
EXHIBIT 9 (WORKSHEET FOR BIRTH CENTERS)

NOTE: PENNSYLVANIA LAW REQUIRES THAT ALL PARTICIPATING HEALTH CARE PROVIDERS BE PROVIDED FULL, SEPARATE AND INDIVIDUAL LIMITS.

1. The assessment will be calculated by computing the sum of 25% of the total 2007 unabated assessments for all health care providers who use the facility or who have an ownership interest. (Refer to Example 3)

Example 3

Three health care providers whose specialty codes are 08029 use or have an ownership interest in Birth Center "X" in territory 1.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD654321	Jane Smith	08029	51	$29,648	
MD054321E	Sally Jones	08029	51	$14,824	PT 08
MD246810	Joseph Miller	08029	51	$29,648	

The sum of the total 2007 unabated assessments for all health care providers who use the facility or who have an ownership interest in Birth Center "X" is $74,120. ($29,648, $14,824, $29,648 = $74,120). The 2007 assessment owed by Birth Center "X" is $18,530 ($74,120 X 25% = $18,530).

2. Complete Birth Center Worksheet (Exhibit 9) and submit with completed Remittance Advice Form e-216.

G. SELF-INSURED ENTITIES

REQUIRED FORM: EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)

NOTE: PENNSYLVANIA LAW REQUIRES THAT ALL PARTICIPATING HEALTH CARE PROVIDERS BE PROVIDED FULL, SEPARATE AND INDIVIDUAL LIMITS.

1. Self-insured entities should follow the same procedures as primary insurers when submitting the Form e-216. All renewals and endorsements to the policy, including additions and deletions, should be received by Mcare within 60 calendar days of the effective date of the renewal, additions and/or deletions.

2. The worksheets listed below are also to be used for self-insured entities, when applicable, and must be completed and submitted along with a completed Remittance Advice Form e-216.

   - Exhibit 5 (Worksheet for Professional Corporations, Professional Associations & Partnerships)

- Exhibit 6 (Worksheet for Hospitals)
- Exhibit 7 (Worksheet for Nursing Homes)

SECTION IV. ADDITIONAL ASSESSMENT RATING FACTORS

A. PART-TIME. Physicians, podiatrists and certified nurse midwives who advise their primary insurer or self-insurer in writing that they practice on average:

- "08" 8 Hours or less per week shall be charged 50% of the otherwise applicable Mcare assessment (50% discount).

- "16" 16 Hours or less, but more than 8 hours, per week shall be charged 65% of the otherwise applicable Mcare assessment (35% discount).

- "24" 24 Hours or less, but more than 16 hours, per week shall be charged 80% of the otherwise applicable Mcare assessment (20% discount).

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

B. NEW PHYSICIANS OR NEW PODIATRISTS shall receive the discount indicated herein from the otherwise applicable assessment:

- "Y1" Charge 25% of the otherwise applicable assessment for the first year of coverage (75% Discount).

- "Y2" Charge 50% of the otherwise applicable assessment for the second year of coverage (50% Discount).

- "Y3" Charge 75% of the otherwise applicable assessment for the third year of coverage (25% Discount).

The first year of coverage for a new physician (allopathic or osteopathic) or a new podiatrist begins on the date medical liability coverage is first secured if such coverage is secured within six months after:

1. The completion of (a) a residency program, (b) a fellowship program in their medical specialty or (c) podiatry school or

2. The fulfillment of a military obligation in remuneration for medical school tuition.

Such physicians or podiatrists must be either joining a medical group or opening their own medical practice. If the initial coverage is secured more than six months after (1) or (2) above first occurs, the physician or podiatrist will be considered to be in the year of coverage that would apply if coverage had first been secured within six months after (1) or (2) above.

NOTE: NEW PHYSICIAN AND NEW PODIATRIST DISCOUNTS MAY BE USED ONLY ONCE PER HEALTH CARE PROVIDER.

C. RESIDENTS AND FELLOWS shall receive the discount indicated herein from the otherwise applicable assessment:

- "R" Charge 50% of the otherwise applicable assessment (50% Discount).

A resident or fellow is a physician or podiatrist participating in a medical, osteopathic or podiatry residency or fellowship program who has successfully completed the prescribed period of postgraduate education that is necessary under applicable law to become eligible for unrestricted medical, osteopathic or podiatry licensure in the Commonwealth of Pennsylvania.

NOTE: RESIDENT/FELLOW AND NEW PHYSICIAN DISCOUNTS CANNOT BE USED TOGETHER.

D. SLOT POSITIONS. Only employees of an institution licensed as a hospital and a physician practice plan owned by a licensed hospital or that hospital's corporate parent organization will be permitted to be slot-rated, based upon their clinical time only, to account for risks associated with "blocks" of in-hospital medical service exposures (i.e., several physicians rotating through one full-time equivalent position). The slot positions must be within the scope of duties and normal business of the institution and within a single medical specialty and job description. When added together, all health care providers within this one slot or block of exposure must equal one Full-Time Equivalent (FTE).

When multiple health care providers fill a slot-rated position, the assessment shall be appropriately divided among them on a pro rata basis for the FTE position. If the aggregate hours of clinical time of those filling a slot exceed 40 hours per week, a new slot must be created. Each health care provider in a slot must be reported to Mcare with full, separate and individual coverage limits. Such coverage is available only for the individual professional liability of the health care providers within the slot and is not available for entities. The number of health care providers in any one slot shall be limited to 12.
Slot rating shall be limited to the following specialty codes:

Anesthesiology - Excl Maj S*	(02083)	Neurology - Excl Maj S	(02011)
General or Family Practice - NS	(01520)	Neurosurgery	(10011)
General Surgery and Internal Medicine - Maj S	(07043)	Obstetrics/Gynecology*	(08029)
		Orthopedic Surgery	(09013)
Hematology - NS	(00608)	Pathology - NS	(00715)
Hospitalist - NS	(01522)	Pediatrics - NS	(01067)
Infectious Diseases - NS	(01540)	Psychiatry - NS*	(00619)
Intensive Care Medicine	(01589)	Radiology - Excl Maj S*	(02260)
Internal Medicine - NS	(01510)	Rehabilitation/Physiatry - NS	(00621)
Internal Medicine*	(03010)	Trauma - Maj S	(07084)
Neonatology - NS	(01541)	Urgent Care - Excl Maj S*	(03531)

*See Exhibit 3 for Complete Specialty Code Description

Slot coverage is not available to health care providers associated with group practices for non-hospital environments or to groups that contract to provide medical services within a hospital. Slot rating is not available to a health care provider who works full-time in one specialty (37.5 hours or more per week) at an institution, unless the position is a rotating resident position.

When a health care provider leaves a slot-rated position, but the slot remains open, slot tail must be reported for the health care provider who is leaving. Please provide notification to Mcare in your cover letter when a new slot is opened or an existing slot is closed. If the last health care provider in a slot leaves and the slot closes, tail must be reported for the entire slot on that last health care provider's reported tail coverage. Indicate the retroactive date of the slot in the cover letter and the retroactive date of the health care provider on the e-216. If the retroactive date of the slot (not the last health care provider in the slot) is prior to January 1, 1997, a surcharge is due to Mcare based upon 1996 tail rates and surcharge percentage.

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

E. LOCUM TENENS. Taken from the Latin "to hold the place of, to substitute," a locum tenens health care provider is one who contracts with a medical facility or group, to temporarily supply health care services while a permanent health care provider is absent, for a specified length of time. This term shall also include health care providers who are temporarily engaged to assist during peak periods of the year, test market new services in a community, expand services into new geographical areas and care for patients while new permanent health care providers are recruited.

INDIVIDUAL LOCUM TENENS POLICIES: For individual physicians who provide health care services in locum tenens and are participating health care providers, the assessment shall be reported on a short-term basis for the specific dates being covered. If written on a claims-made basis, tail coverage or its substantial equivalent must be provided and reported to Mcare upon termination of the claims-made coverage.

GROUP LOCUM TENENS POLICIES: For physician groups who provide health care services in locum tenens and are participating health care providers, the assessment shall be prorated through use of Full-Time Equivalents (FTE) and reported for the full annual policy period. Calculate the FTE based on the estimated total number of days included for each locum tenens assignment. At the end of the policy period the FTE should be adjusted for actual total number of days included for each assignment. (Refer to Example 4)

Example 4**:**

The policy period reported is 2/1/07 – 2/1/08. A health care provider has the following assignments in PA: 2/6/07-2/25/07 (20 days), 5/1/07-5/26/07 (26 days), 7/10/07-7/29/07 (20 days), 9/18/07-10/14/07 (27 days), 9/18/07-10/14/07 (27 days), and 11/13/07-12/17/07 (35 days) = a total of 128 days of locum tenens assignment in PA divided by 365 days a year (128 ÷ 365 = 0.35). The FTE reported would be 0.350. Note: 365 days should also be used in a leap year.

Tail coverage or its substantial equivalent must be provided and reported for physicians who end their assignments in Pennsylvania with the locum tenens group if coverage is written on a claims-made basis.

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

F. PRIOR ACTS ("NOSE") AND RETROACTIVE ("RETRO") COVERAGE. When a separate prior acts endorsement is issued on an occurrence policy that provides nose coverage for a claims-made period that paid a surcharge based on 1996 and prior years' rates, a surcharge will be due. The surcharge shall be 164% of the prior acts premium charged by the primary insurer only for that portion that covers a claims-made period that paid a surcharge based on 1996 and prior years' rates. No additional assessment is due on retro coverage reported on claims-made policies. Please note that Mcare will not accept retro coverage that covers any period of time wherein previous underlying claims-made coverage has not been reported to Mcare.

G. EXTENDED REPORTING PERIOD ("TAIL") COVERAGE. Following cancellation, termination or nonrenewal of claims-made coverage in Pennsylvania, a primary insurer writing medical professional liability insurance on a claims-made basis is required to offer, for a period of 60 calendar days, liability protection to a health care provider, eligible professional corporation, professional association or partnership for the liability previously covered by the primary insurer, subsequent to the cancellation, termination or nonrenewal of the claims-made policy. The primary insurer should provide the health care provider, professional corporation, professional association or partnership notice of the 60-day tail option at the time of cancellation, termination or nonrenewal of claims-made coverage.

Tail coverage, regardless of whether it involves the payment of a surcharge, must be submitted to Mcare within 120 calendar days of the cancellation, termination, or nonrenewal of the underlying claims-made coverage.

For claims-made policies with retro dates that are for a period that originally paid a surcharge based on 1996 and prior years' rates, a surcharge will be due. The tail surcharge shall be 164% of the tail premium calculated by the primary insurer using their 1996 rates for only that portion of the tail covering claims-made periods prior to the expiration of the 1996 coverage. (See Example 5, on the following page). There must be a surcharge paid for tails written for claims-made policies with retro dates for periods that originally paid a surcharge based on 1996 and prior years' rates even if the carrier offers the primary tail at no charge. For claims-made policies with retro dates for periods that paid a surcharge based on 1997 and subsequent years' rates, there is no surcharge or assessment due for the tail (See Example 6, on the following page).

Example 5:

Claims-made Policy: 7/1/95 - 7/1/96
Claims-made Policy: 7/1/96 - 7/1/97
Claims-made Policy: 7/1/97 - 7/1/98
Claims-made Policy: 7/1/98 - 7/1/99
Tail Policy: 7/1/95 - 7/1/99

This Health Care Provider retiring on 7/1/99 would owe a surcharge equivalent to 164% of what he/she would have been charged for tail coverage for the period 7/1/95 -7/1/97.

Example 6:

Claims-made Policy: 7/1/01 - 7/1/02
Claims-made Policy: 7/1/02 - 7/1/03
Tail Policy: 7/1/01 - 7/1/03

This Health Care Provider retiring on 7/1/03 would owe no surcharge for tail coverage.

NOTE: FOR PRIMARY INSURERS WHO DID NOT HAVE APPROVED RATES IN PENNSYLVANIA PRIOR TO 1997, TAIL SHOULD BE CALCULATED BY USING THE 1996 RATES OF **PMSLIC** (FOR PHYSICIANS, PODIATRISTS, CERTIFIED NURSE MIDWIVES, PROFESSIONAL CORPORATIONS & BIRTH CENTERS) AND **PHICO** (FOR HOSPITALS, NURSING HOMES & PRIMARY HEALTH CENTERS). The **PMSLIC** and **PHICO** TAIL RATES ARE AVAILABLE ON THE MCARE WEBSITE.

Mcare recognizes two types of extended reporting period coverage. Primary insurers must report on Form e-216 a policy type of "ERP" for tail coverage that is an endorsement to the last claims-made policy or "SAT" for tail coverage that is stand-alone tail.

- **"ERP" EXTENDED REPORTING ENDORSEMENT.** Extended reporting endorsements shall be treated as endorsements to the last underlying claims-made policy that was properly reported to Mcare. Mcare's limits of liability are clearly established pursuant to Act 13 of 2002. A separate aggregate limit for tail endorsements does not exist. Instead, extended reporting endorsements share the aggregate limit of the last properly reported claims-made policy.

- **"SAT" STAND-ALONE TAIL.** Stand-alone tail coverage is written as a completely separate policy. Generally, a primary insurer other than the primary insurer of record for the last claims-made policy will underwrite this type of tail policy. Consistent with Mcare's application of coverage to all stand-alone policies, a stand-alone tail policy will have a separate aggregate limit from the last underlying claims-made policy.

H. BIFURCATION (BIFU). If a health care provider changes the effective date of their professional liability coverage and that change results in a health care provider receiving more than 12 months of the same assessment rate, then the appropriate assessment will be bifurcated to include the assessment percentages applicable to each calendar year over which the new policy is in effect. This allows only 12 months maximum at the same assessment rate for the year that the policy effective date was changed. Report each portion of the bifurcated policy on separate lines on separate Remittance Advice Forms e-216 applicable to the rate year that is being paid (i.e., for the example below report 7/1/06 to 1/1/07 on a line on a 2006 Remittance Advice Form e-216 using the

2006 rates and report 1/1/07 to 7/1/07 on a line on a 2007 Remittance Advice Form e-216 using the 2007 rates). Indicate "BIFU" in the Comment column of the Forms e-216 on both lines of coverage. (Refer to Example 7)

NOTE: THE ASSESSMENT FOR SUBSEQUENT ANNUAL RENEWALS SHOULD NOT BE BIFURCATED AGAIN AND MAY RESULT IN A HEALTH CARE PROVIDER RECEIVING MORE THAN 12 MONTHS OF THE SAME ASSESSMENT RATE.

Example 7:

A health care provider has a policy from February 1, 2006 to February 1, 2007. The 2006 assessment (29%) was reported on this policy. On July 1, 2006, the health care provider cancels his policy and purchases a new policy for the period of July 1, 2006 to July 1, 2007.

(1) The assessment shall be prorated from July 1, 2006 to January 1, 2007 using the 2006 assessment (29%).
(2) The policy period from January 1, 2007 to July 1, 2007 shall be prorated by using the 2007 assessment (23%).
(3) Upon renewal of the July 1, 2007 policy, the 2007 assessment (23%) shall be applied for the full annual period.

	2/1/2006 to 2/1/2007	(29%)
Cancelled	(7/1/2006 to 2/1/2007)	(29%)
	7/1/2006 to 1/1/2007	(29%)
	1/1/2007 to 7/1/2007	(23%)
	7/1/2007 to 7/1/2008	(23%)

I. ABATEMENT. Act 128 of 2006 amended Act 13 to extend the Health Care Provider Retention Program to include 2007 abatements. The 2007 Abatement Program provides assistance in the form of abated assessments to physicians, certified nurse midwives, podiatrists, and nursing homes.

The application process for the Abatement Program is a self-certifying process and must be completed by the statutory deadline. An eligible applicant who desires to receive the abatement must complete the online application located at www.mcare.state.pa.us. All questions on the application must be completed. An enhancement to the online application process is that the application and Certificate of Retention Pledge can be signed electronically. It is not necessary to mail the hard copy of the application and Certificate of Retention Pledge if both are electronically signed online. Upon completion of the online application, Mcare will forward an eligibility status letter to the health care provider's e-mail address that was provided on the application. In addition, an eligibility status letter will be mailed U.S. Postal Service to the health care provider.

A hospital may submit an electronic application specified by Mcare on behalf of an applicant for whom the hospital pays the assessment. Hospitals may request the electronic application directly from the Mcare abatement staff at (717) 783-3770 ext. 243.

If the assessment is paid prior to the application process being completed for that health care provider, the full applicable assessment due must be remitted to Mcare. If a health care provider

has completed the application process and is self-certified as eligible for abatement, the abated assessment may be remitted.

NOTE: ALL COVERAGE INFORMATION AND ASSESSMENT PAYMENTS, IF APPLICABLE, MUST BE REPORTED AND REMITTED TO MCARE WITHIN 60 DAYS OF THE EFFECTIVE DATE OF COVERAGE.

One hundred percent (100%) abatement may be provided to an eligible applicant who would otherwise pay an assessment and who is:

(1) Class 070 as determined by the JUA.
(2) Class 080 as determined by the JUA.
(3) Class 090 as determined by the JUA.
(4) Class 100 as determined by the JUA.
(5) Class 900 as determined by the JUA.
(6) A physician board certified in Emergency Medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine assigned specialty code 03531 providing services in a trauma center or hospital emergency department.
(7) A general or family practitioner who routinely provides obstetrical services in a county other than Allegheny and Philadelphia with a corresponding specialty code as determined by the JUA. For example, in 2007, general and family practitioners who routinely provide obstetrical deliveries were assigned specialty code 03017 by the JUA.

Fifty percent (50%) abatement may be provided to all other eligible applicants who pay an Mcare assessment but do not qualify for 100% abatement.

SECTION V. NONPARTICIPATING TRANSMITTAL (FORM 316)

A. GENERAL INFORMATION. The Nonparticipating Transmittal Form 316 is the required form to be used by primary insurers and self-insurers who provide coverage to nonparticipating health care providers. A nonparticipating health care provider is a health care provider as defined in Section 103 of Act 13 that conducts less than 50% but more than 0% of their health care business or practice within this Commonwealth and does not choose to participate in Mcare. The health care business or practice, as defined in Section 702, is based on the number of patients to whom health care services are rendered by a health care provider within an annual policy period.

Nonparticipating health care providers must secure basic insurance coverage limits as required by and consistent with Act 13 of 2002. Current coverage limits are $1 million per occurrence or claim and $3 million per annual aggregate.

B. ELECTRONIC SUBMISSIONS. The Nonparticipating Transmittal Form 316 can be found as a tab on the Exhibit 4 - Electronic Remittance Advice Form e-216 and is listed as Exhibit 4A in this Manual.

SECTION VI. MCARE INVOICING

A. ABATEMENT REPAYMENT. The Health Care Provider Retention Program requires health care providers that were granted an abatement must repay the abatement received if that health care provider ceases to be eligible. One condition of being eligible for an abatement is that the health care provider must pledge to continue to practice in Pennsylvania during the calendar year in which the health care provider receives the abatement and through the end of the following calendar year. Also, the health care provider must fulfill this retention pledge. If a health care provider ceases providing health care services in the Commonwealth prior to the end of the retention period, the health care provider shall provide written notice to Mcare within 60 days of the date of cessation of health care services. Act 88 provides a number of specific exceptions to the repayment obligation for health care providers who do not fulfill their retention pledges. Repayments of abatements should be paid directly to Mcare rather than to the health care provider's primary malpractice insurer or insurance broker.

Health care providers are responsible for repayment of abatements if they do not fulfill their retention pledge. While the applicable law requires the "pledging" health care provider to be personally responsible for repayment, we recognize there may be circumstances in which another entity may be involved in the repayment of the abatement. Mcare will not get involved in any of these third-party contractual disputes. Repayment is the sole responsibility of the abated health care provider.

Health care providers who have an obligation to repay an abatement but do not do so within 30 days of notice sent by Mcare requesting repayment will be deemed to not have paid their penalty obligations for the malpractice policies for which the abatement was granted. In such circumstances, Mcare coverage will not be available for claims reported to the health care provider, to the health care provider's primary insurer or to Mcare 30 days or more after the abatement repayment notice was sent by Mcare to the health care provider. However, as of the date Mcare receives the abatement repayment from the health care provider, this will no longer be a basis for denial of Mcare coverage. Also, the amount owed for an abatement repayment is a tax obligation under PA law and failure to repay abatements may subject the health care provider to disciplinary action by licensing boards and authorities for noncompliance with Pennsylvania's mandatory malpractice requirements.

B. EXPERIENCE RATING FOR HEALTH CARE PROVIDERS OTHER THAN HOSPITALS. Section 712(g) of Act 13 of 2002 requires the Mcare program to adjust the applicable Mcare assessment of each participating health care provider, other than hospitals, in accordance with the severity and frequency of claims paid by Mcare on behalf of the health care provider during the past five most recent claims periods. Mcare will implement this program effective January 1, 2007, utilizing the claims year payments for the five year period of 2002-2006 as the determinate years or claims periods.

Mcare will invoice the health care providers, other than hospitals, subject to these experience rating adjustment(s). The invoice will list the experience rating adjustment(s) applicable to that health care provider for all policies that become effective or are renewed during the calendar year of the experience rating adjustment, as well as date the experience rating adjustment must be paid.

The experience rated adjustment will be calculated by using the unabated, undiscounted assessment times the experience rated adjustment percentage (10% or 20%) to arrive at the adjustment balance experience rating invoice amount. (Unabated, undiscounted assessment X % = Experience Rating Invoice Amount)

- A 10% adjustment will be applicable to a health care provider's prevailing primary premium if 3 claims have been paid by Mcare during the past 5 most recent claims years.
- A 20% adjustment will be applicable to a health care provider's prevailing primary premium if 4 or more claims have been paid by Mcare during the past 5 most recent claims years.
- A 20% adjustment will be applicable to a health care provider's prevailing primary premium if the health care provider had at least 2 claims, based on severity, paid by Mcare during the past 5 most recent years, and if the health care provider has not had 3 or more claims with Mcare payments. A claim of high severity is one in which a total of $500,000 or more has been paid as a result of a settlement or judgment during the most recent 5 calendar years.

Other considerations:

- The **count** of claim payments (frequency) will consider only claims for which the Mcare Fund made a payment.

- The amount **paid** (severity) on a claim will include indemnity payments only (i.e. cash, annuity costs, administration fees and delay damages). Claims payments include all payments from all parties, not just Mcare payments. Thus, indemnity payments made by any primary insurer, or entity, not just Mcare will be included in the payment calculation.

- Individual participating health care providers include physicians, podiatrists, nurse midwives, nursing homes, birth centers and primary health centers, but not hospitals.

- Any adjustment will be applicable to the undiscounted and unabated assessment of a health care provider for claims paid by Mcare (of any amount) in the most recent five calendar years. This adjustment factor will be applicable to all of that health care provider's assessments for policies that have an effective or renewal date during the calendar year following the five year period during which the health care provider had claims paid by Mcare.

- Any adjustment based upon severity will be applicable to the undiscounted and unabated assessment if a health care provider is not subject to an adjustment for frequency of claims, but had at least two claims based on severity. A claim of high severity is one in which a total of $500,000 or more has been paid as a result of a settlement or judgment during the most recent five calendar years. This adjustment factor will be applicable to all of that health care provider's assessments for policies that have an effective or renewal date during the calendar year following the five year period during which the health care provider had two severe claims paid but did not have three or more claims with Mcare payments.

- Mcare will send invoices to the health care providers subject to an experience rating adjustment. Mcare will not expect primary insurers to collect and remit the experience rating adjustments. The invoice sent to a health care provider will note the experience rating adjustment applicable to that health care provider for all policies that become effective or are renewed during the calendar year of the experience rating adjustment, as well as provide the date the experience rating adjustment must be paid (i.e., the "past due date").

- If a health care provider's coverage is cancelled under this program, the experience rated portion of the assessment is not refundable. If this cancellation is a result of the health care provider switching carriers and replacing a policy, Mcare will have the capability with an Accounts Receivable system to eliminate this double assessment.

- Under this program, outstanding or unpaid experience rated adjustments will result in a denial of claims coverage only as to claims applicable to the line or lines of coverage which have an outstanding experience rated amount. Coverage denial will only apply for the assessment year(s) of non-payment. If an experience rated adjustment is not paid within sixty calendar days of the date Mcare sends the health care provider notice of the adjustment, said health care provider will be considered in noncompliance.

Questions regarding experience rating should be directed to the Director of Medical Malpractice Administration at (717) 783-3770.

SECTION VII. CHANGES TO MEDICAL SPECIALTIES/TERRITORIES

The Pennsylvania Professional Liability Joint Underwriting Association ("JUA") has made the changes outlined in this section, effective January, 1, 2007, which may impact how health care providers' assessments are calculated. Please review the following changes, as providing inaccurate information may result in the health care provider(s) being reported to the appropriate licensure board for non-compliance and may result in the denial of claims.

A. CHANGES TO A DIFFERENT CLASS

Specialty Description	2006	2007
Pulmonary Medicine – No Surgery	00644	01044
Oncology – No Surgery	01043	00743
Pathology – No Surgery	01215	00715
Pulmonary Medicine – No Surgery Except Bronchoscopy	01544	02069
Anesthesiology – Other than Pain Management Only Excluding Major Surgery	02283	02083

B. CHANGES TO TERRITORIES

1. Physicians, Surgeons And Other Health Care Professionals
   - Fayette Co. (26) Moved from Territory 6 to Territory 4
   - Lackawanna Co. (35) Moved from Territory 4 to Territory 6
   - Monroe Co. (45) Moved from Territory 4 to Territory 6

2. Hospitals, Nursing Homes And Primary Health Centers
   - None

SECTION VIII. LINKS TO OTHER RELATED WEBSITES

The links included in this section may be of use to individuals completing Form e-216 and/or other worksheets.

- **INSURANCE DEPARTMENT**
  http://www.insurance.pa.gov

- MCARE FUND
  http://www.insurance.pa.gov/mcare

- **DEPARTMENT OF STATE**
  http://www.dos.state.pa.us

- BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS LICENSURE BOARD
  http://www.dos.state.pa.us/bpoa

- LICENSE VERIFICATION
  http://www.licensepa.state.pa.us

- CORPORATION BUREAU
  http://www.dos.state.pa.us/corps

- **PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION (JUA)**
  http://www.pajua.com

SECTION IX. JUA DEFINITIONS

The definitions supplied in this Section are in accordance with the Pennsylvania Professional Liability Joint Underwriting Association ("JUA"). When completing the necessary forms and/or worksheets, it is important that you keep the following definitions in mind:

1. **Beds**
   The number of beds equals the daily average number of occupied beds, cribs and bassinets used for patients during the previous policy period. The unit of exposure is each bed, computed by dividing the sum of the daily numbers of beds, cribs and bassinets used for patients for each day of the policy period, by the number of days in such period.

2. **Convalescent Facilities**
   Convalescent Facilities are free-standing facilities which provide skilled nursing care and treatment for patients requiring continuous health care, but do not provide any hospital services (such as surgery); and 50% or more of their patients are under 65.

3. **Extended Care**
   All beds located within a hospital, licensed by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous and extended basis.

4. **Health Institutions**
   Health Institutions are facilities that provide non-surgical medical treatment other than as described under Mental Health/Mental Rehabilitation.

5. **Home Health Care**
   Home Health Care Services are organizations which provide nursing, physical therapy, housekeeping and related services to patients at their residences.

6. **Hospital**
   Hospitals are facilities treating all general or special medical and surgical cases, including sanitariums with surgical operating room facilities.

7. **Mental Health/Mental Rehabilitation**
   Mental Health and Mental Rehabilitation are facilities that provide non-surgical medical intervention for:

   a. Short term crisis stabilization for mental health and substance abuse; and
   b. Long-term mental health rehabilitation.

   This includes facilities that assist individuals to develop or improve task and role-related skills, and social and environmental supports needed to perform as successfully and independently as possible at home, family, school, work, socialization, recreations and other community living roles and environments.

8. **Outpatient Surgical**
   Outpatient Surgical Facilities are facilities that provide surgical procedures on an outpatient (same day) basis. Beds are used primarily for recovery purposes, and overnight stays, if any, are the exception.

9. **Primary Health Center**
   Primary Health Center means a community-based non-profit corporation meeting standards prescribed by the Department of Health, which provides preventive, diagnostic, therapeutic, and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

10. **Skilled Nursing Facilities**
    Skilled Nursing Facilities are freestanding facilities which provide the same service as a Convalescent Facility, except that 50% or more of their patients are over 65.

11. **Visits**
    The number of visits equals the total number of visits to the institution (regardless of the number of visits to particular departments within such institution) by outpatients (patients not receiving bed and board services), during the previous policy period. The unit of exposure is each 100 visits.

SECTION X. LIST OF EXHIBITS

Pennsylvania Department of Insurance

Office of Mcare

Exhibit 1

2007

23%

Rates for Physicians, Surgeons, Podiatrists and Certified Nurse Midwives

Prevailing Primary Premium / Assessment / Abated

Class	Territory 1			Territory 2			Territory 3			Territory 4			Territory 5			Territory 6			Class
	PPP	Assess	Abated	PPP	Assess	Abated	PPP	Assess	Abated	PPP	Assess	Abated	PPP	Assess	Abated	PPP	Assess	Abated	
006	7,865	1,809	904	3,933	905	452	4,326	995	497	6,292	1,447	724	7,472	1,719	859	5,112	1,176	588	006
007	15,840	3,643	1,822	7,920	1,822	911	8,712	2,004	1,002	12,672	2,915	1,457	15,048	3,461	1,731	10,296	2,368	1,184	007
010	11,798	2,714	1,357	5,899	1,357	678	6,489	1,492	746	9,438	2,171	1,085	11,208	2,578	1,289	7,669	1,764	882	010
012	24,033	5,528	2,764	12,016	2,764	1,382	13,218	3,040	1,520	19,226	4,422	2,211	22,831	5,251	2,626	15,621	3,593	1,796	012
015	21,848	5,025	2,513	10,924	2,513	1,256	12,016	2,764	1,382	17,478	4,020	2,010	20,756	4,774	2,387	14,201	3,266	1,633	015
020	29,888	6,874	3,437	14,944	3,437	1,719	16,438	3,781	1,890	23,910	5,499	2,750	28,394	6,531	3,265	19,427	4,468	2,234	020
022	38,234	8,794	4,397	19,117	4,397	2,198	21,029	4,837	2,418	30,587	7,035	3,518	36,322	8,354	4,177	24,852	5,716	2,858	022
030	43,565	10,020	5,010	21,782	5,010	2,505	23,961	5,511	2,756	34,852	8,016	4,008	41,387	9,519	4,760	28,317	6,513	3,256	030
03017*	43,565	10,020	5,010	21,782	5,010	0	23,961	5,511	0	34,852	8,016	0	41,387	9,519	0	28,317	6,513	0	03017*
035	54,074	12,437	6,219	27,037	6,219	3,109	29,741	6,840	3,420	43,259	9,950	4,975	51,370	11,815	5,908	35,148	8,084	4,042	035
03531#	54,074	12,437	0	27,037	6,219	0	29,741	6,840	0	43,259	9,950	0	51,370	11,815	0	35,148	8,084	0	03531#
050	58,640	13,487	6,744	29,320	6,744	3,372	32,252	7,418	3,709	46,912	10,790	5,395	55,708	12,813	6,406	38,116	8,767	4,383	050
060	74,720	17,186	8,593	37,360	8,593	4,296	41,096	9,452	4,726	59,776	13,748	6,874	70,984	16,326	8,163	48,568	11,171	5,585	060
070	115,794	26,633	0	57,897	13,316	0	63,687	14,648	0	92,636	21,306	0	110,005	25,301	0	75,266	17,311	0	070
080	128,903	29,648	0	64,452	14,824	0	70,897	16,306	0	103,123	23,718	0	122,458	28,165	0	83,787	19,271	0	080
090	86,147	19,814	0	43,073	9,907	0	47,381	10,898	0	68,917	15,851	0	81,839	18,823	0	55,995	12,879	0	090
100	156,213	35,929	0	78,107	17,965	0	85,917	19,761	0	124,971	28,743	0	148,403	34,133	0	101,539	23,354	0	100
120	5,724	1,317	658	2,862	658	329	3,148	724	362	4,579	1,053	527	5,438	1,251	625	3,721	856	428	120
130	35,110	8,075	4,038	17,555	4,038	2,019	19,310	4,441	2,221	28,088	6,460	3,230	33,354	7,671	3,836	22,821	5,249	2,624	130
900	26,502	6,095	0	13,251	3,048	0	14,576	3,352	0	21,201	4,876	0	25,177	5,791	0	17,226	3,962	0	900

* If not Allegheny (02) or Philadelphia (51)

\# If board certified in Emergency Medicine. Refer to page 22 of the 2007 Assessment Manual for a definition.

Certified Nurse Midwife = 900	80116
Podiatrist Non-Surgical = 120	80993
Podiatrist Surgical = 130	80994

Territory 1 = Philadelphia (51)

Territory 2 = Remainder of State (01, 04-06, 08, 10-14, 16-18, 21, 24, 27-32, 34, 36, 38, 41, 42, 44, 47, 49, 50, 52, 53, 55-62, 64, 66, 67)

Territory 3 = Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)

Territory 4 = Bucks (09), Chester (15), Fayette (26), Montgomery (46)

Territory 5 = Delaware (23)

Territory 6 = Blair (07), Columbia (19), Crawford (20), Dauphin (22), Erie (25), Lackawanna (35), Lawrence (37), Lehigh (39), Luzerne (40), Mercer (43), Monroe (45), Northampton (48), Schuykill (54)

EXHIBIT 2

Year 2007 Prevailing Primary Premiums
Rates for Hospitals, Nursing Homes and Primary Health Centers

EXPOSURE BASE	EXPOSURE TYPE***	RATE	RATE	RATE	RATE
			Territory		
	HOSPITALS	1	2	3	4
Per Occ Bed	Hospital (Acute Care)	8550.06	3796.21	4753.82	7601.01
Per Occ Bed	Mental Health/Mental Rehabilitation	4278.69	1899.74	2378.95	3803.74
Per Occ Bed	Extended Care	380.65	168.99	211.63	338.39
Per Occ Bed	Outpatient Surgical	8550.06	3796.21	4753.82	7601.01
Per Occ Bed	Health Institution	1712.94	760.55	952.40	1522.79
Per 100 Visits	Emergency	854.64	379.47	475.18	759.79
Per 100 Visits	Other	341.86	151.79	190.08	303.93
Per 100 Visits	Mental Health/Mental Rehabilitation	213.67	94.87	118.78	189.93
Per 100 Visits	Extended Care	18.98	8.43	10.54	16.88
Per 100 Visits	Outpatient Surgical	854.64	379.47	475.18	759.79
Per 100 Visits	Health Institution	128.18	56.92	71.28	113.96
Per 100 Visits	Home Health Care	213.67	94.87	118.78	189.93
	NURSING HOMES				
Per Occupied Bed	Convalescent	581.39	258.14	323.26	516.87
Per Occupied Bed	Skilled Nursing	478.80	212.60	266.22	425.66
	PRIMARY HEALTH CENTERS				
Per 100 Visits	Emergency	841.00	373.40	467.59	747.64
Per 100 Visits	Other	336.40	149.35	187.03	299.06
Per 100 Visits	Mental Health/Mental Rehabilitation	210.27	93.37	116.91	186.95
Per 100 Visits	Outpatient Surgical	841.00	373.40	467.59	747.64
Per 100 Visits	Home Health Care	210.27	93.37	116.91	186.95

Territory 1: Delaware (23), Philadelphia (51)
Territory 2: Remainder of State
Territory 3: Allegheny (02), Crawford (20), Erie (25), Lackawanna (35),Lawrence (37), Luzerne (40), Mercer (43)
Territory 4: Bucks (09), Chester (15), Montgomery (46)

EXHIBIT 3

PHYSICIANS, SURGEONS AND OTHER HEALTH CARE PROFESSIONALS SPECIALTY CLASSIFICATION CODES

CLASS 006 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00634	Administrative Medicine – No Surgery
00689	Aerospace Medicine
00602	Allergy/Immunology – No Surgery
00608	Hematology – No Surgery
00688	Independent Medical Examiner
00609	Industrial/Occupational Medicine – No Surgery
00687	Laryngology – No Surgery
00685	Nutrition
00612	Ophthalmology – No Surgery
00665	Otolaryngology or Otorhinolaryngology – No Surgery
00684	Otology – No Surgery
00682	Pharmacology – Clinical
00637	Physicians – Practice limited to Acupuncture (other than acupuncture anesthesia)
00617	Preventive Medicine – No Surgery
00618	Proctology – No Surgery
00619	Psychiatry – No Surgery, including Psychoanalysts who treat physical ailments, perform electro- convulsive procedures or employ extensive drug therapy.
00650	Psychoanalysts who do not treat physical ailments do not perform electro-convulsive procedures and whose use of medication is minimal in order to support the analytic treatment and is never the primary or sole form of treatment shall be eligible for this classification. Except, practitioners of this medical specialty are ineligible for this classification if 25% or more of their patients receive medication.
00621	Rehabilitation/Physiatry – No Surgery
00645	Rheumatology – No Surgery
00681	Rhinology – No Surgery
00623	Urology – No Surgery
00656	Utilization Review
00699	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 007 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00758	Hematology/Oncology – No Surgery
00786	Neoplastic Diseases – No Surgery
00742	Nephrology – No Surgery
00743	Oncology – No Surgery
00715	Pathology – No Surgery
00799	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 010 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01035	Bariatrics – No Surgery
01004	Dermatology – Excluding Major Surgery
01037	Endocrinology – No Surgery
01074	Geriatrics – No Surgery
01007	Gynecology – No Surgery
01049	Nuclear Medicine – No Surgery
01034	Occupational Medicine – Including MRO or Employment Physicals
01013	Orthopedics – No Surgery
01067	Pediatrics – No Surgery
01098	Physicians – Practice limited to Hair Transplants (Plug or Flap Technique or Split Mini Grafts)
01089	Psychosomatic Medicine
01020	Public Health – No Surgery
01044	Pulmonary Medicine – No Surgery
01059	Radiation Oncology – No Surgery
01088	Reproductive Endocrinology – No Surgery – No Obstetrical Delivery
01005	Sports Medicine – No Surgery
01099	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 012 PHYSICIANS - NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01282	Anesthesiology – Pain Management – No Surgery
01206	Gastroenterology – No Surgery
01253	Radiology excluding Deep Radiation – No Surgery
01299	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 015 PHYSICIANS - NO SURGERY

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01520	General or Family Practice – No Surgery
01522	Hospitalist – No Surgery
01540	Infectious Diseases – No Surgery
01589	Intensive Care Medicine
01510	Internal Medicine – No Surgery
01541	Neonatology – No Surgery
01599	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 020 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02002	Allergy – Excluding Major Surgery
02083	Anesthesiology – Other than Pain Management only – Excluding Major Surgery
02022	Cardiology – No Surgery or Excluding Major Surgery – No Catheterization other than Swan-Ganz
02037	Endocrinology – Excluding Major Surgery
02006	Gastroenterology – Excluding Major Surgery
02038	Geriatrics – Excluding Major Surgery
02007	Gynecology – Excluding Major Surgery
02008	Hematology – Excluding Major Surgery
02009	Industrial Medicine – Excluding Major Surgery
02040	Infectious Diseases – Excluding Major Surgery
02089	Neoplastic Diseases – Excluding Major Surgery
02042	Nephrology – Excluding Major Surgery
02011	Neurology – Excluding Major Surgery
02049	Nuclear Medicine – Excluding Major Surgery
02028	Obstetrics – Excluding Major Surgery
02029	Obstetrics/Gynecology, No Obstetrical Delivery – Excluding Major Surgery
02043	Oncology – Excluding Major Surgery
02055	Ophthalmology – Surgery
02013	Orthopedics – Excluding Major Surgery
02065	Otolaryngology/Otorhinolaryngology – Excluding Major Surgery
02087	Otology – Excluding Major Surgery
02015	Pathology – Excluding Major Surgery
02016	Pediatrics – Excluding Major Surgery
02017	Preventive Medicine – Excluding Major Surgery
02018	Proctology – Excluding Major Surgery
02019	Psychiatry – Excluding Major Surgery
02020	Public Health – Excluding Major Surgery
02044	Pulmonary Medicine – Excluding Major Surgery
02069	Pulmonary Medicine – No Surgery except Bronchoscopy
02053	Radiology including Deep Radiation – No Surgery
02021	Rehabilitation/Physiatry – Excluding Major Surgery
02086	Reproductive Endocrinology – Excluding Major Surgery – No Obstetrical Delivery
02085	Rhinology – Excluding Major Surgery
02023	Urology – Excluding Major Surgery
02068	Wound Care Physician – Excluding Major Surgery
02099	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 022 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02221	General or Family Practice – Excluding Major Surgery
02210	Internal Medicine – Excluding Major Surgery
02259	Radiation Oncology – Excluding Major Surgery
02260	Radiology including interventional radiology - Excluding Major Surgery
02299	Physicians Not Otherwise Classified (NOC)

CLASS 030 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform procedures normally included in the practice of cardiology; and to other specialists who assist in major surgery on other than their own patients; who perform normal obstetrical deliveries; or who perform extra-hazardous medical techniques as determined by the Association.

JUA CODES	SPECIALTY DESCRIPTION
03022	Cardiology – Including Right Heart or Left Heart Catheterization
03017	General or Family Practice – Assist in Major Surgery on other than their own patients or performing normal obstetrical deliveries
03007*	Gynecology – Assist in Major Surgery on other than their own patients
03010	Internal Medicine – Assist in Major Surgery on other than their own patients
	03029 Obstetrics/Gynecology, Assist in Major Surgery on other than their own patients-No obstetrical delivery
03043	Oncology – Including Major Surgery
03018	Proctology – Major Surgery
03099	Surgeons Not Otherwise Classified (NOC)

*Obstetrical delivery is rated as Class 08029

CLASS 035 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to Urgent Care physicians and other specialists who work in an urgent care environment more than eight (8) hours per week, physicians who work in a prison environment more than eight (8) hours per week; or to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
03591	Laryngology – Including Major Surgery
03590	Otology – Including Major Surgery
03565	Otorhinolaryngology or Otolaryngology – Including Major Surgery
03586	Prison Physicians – Excluding Major Surgery
03570	Rhinology – Including Major Surgery
03531	Urgent Care including Emergency Medicine, Fast Track and similar services – Excluding Major Surgery
03545	Urological Surgery
03599	Physicians Not Otherwise Classified (NOC)

CLASS 050 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
05015	Colon-Rectal Surgery if 75% or more of total surgical practice
05004	Dermatology – Major Surgery (including such plastic and cosmetic surgery that is consistent with the Dermatology medical specialty)
05007	Gynecology – Major Surgery
05089	Reproductive Endocrinology – Major Surgery – No Obstetrical Delivery
05099	Surgeons Not Otherwise Classified (NOC)

CLASS 060 SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
06047	Colon-Rectal Surgery when 26% or more of the physician's surgical practice is for non colon-rectal surgery
06030	Plastic Surgery
06099	Surgeons Not Otherwise Classified (NOC)

CLASS 070 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
07089	Abdominal – Major Surgery
07003	Cardiac Surgery
07053	Cardio-Thoracic Surgery
07046	Cardiovascular Surgery
07048	Cardio-Vascular-Thoracic Surgery
07088	Endocrinology – Major Surgery
07087	Gastroenterology – Major Surgery
07017	General or Family Practice – Major Surgery
07001	General Practice – Major Surgery
07043	General Surgery and Internal Medicine – Major Surgery
07086	Geriatrics – Major Surgery
07085	Peripheral Vascular Surgery
07025	Thoracic Surgery
07084	Trauma – Major Surgery
07054	Vascular and Thoracic Surgery
07026	Vascular Surgery
07099	Surgeons Not Otherwise Classified (NOC)

CLASS 080 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
08001	General Practice – Major Surgery
08028	Obstetrics – Major Surgery
08029	Obstetrics/Gynecology, Full Range of Procedures
08089	Perinatology, including C-Sections, Amniocentesis and Episiotomies
08087	Reproductive Endocrinology – Major Surgery – Including Obstetrical Delivery
08099	Surgeons Not Otherwise Classified (NOC)

CLASS 090 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
09013	Orthopedic Surgery
09099	Surgeons Not Otherwise Classified (NOC)

CLASS 100 SURGEONS - SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
10011	Neurosurgery
10099	Surgeons Not Otherwise Classified (NOC)

CLASS 120 PODIATRISTS - NON-SURGICAL

JUA CODES	SPECIALTY DESCRIPTION
80993	Podiatry – No Surgery

CLASS 130 PODIATRISTS - SURGICAL

JUA CODES	SPECIALTY DESCRIPTION
80994	Podiatry - Surgery

CLASS 900 CERTIFIED NURSE MIDWIVES

JUA CODES	SPECIALTY DESCRIPTION
80116	Certified Nurse Midwife (CNM)

ADDITIONAL SPECIALTY CODES

JUA CODES	SPECIALTY DESCRIPTION
80402	Birth Centers
80999	Corporate/Association/Partnership Liability
80612	Hospitals
80924	Nursing Homes
80614	Primary Health Centers
80289	Prison Corporate/Association/Partnership/Other Third Party Entities Liability

MEDICAL PROCEDURES

Medical procedures typically are employed as one of many components of a physician's medical practice. This rule applies to those physicians who limit their medical practice to a single medical procedure. If the medical practice of a physician is solely limited to a medical procedure described herein, the physician shall be classified and rated as follows:

JUA CODES	MEDICAL PROCEDURE
07099	*Broncho – Esophagology* – Major Surgery; Rate as Class 070, Surgeon Not Otherwise Classified (NOC)
00699	*Broncho – Esophagology* – No Surgery; Rate as Class 006, Physician Not Otherwise Classified (NOC)
02099	*Cardiology – Angiography*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Cardiology – Arteriography*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
07099	*Colonoscopy and Resection*; Rate as Class 070, Surgeon Not Otherwise Classified (NOC)
02099	*Colonoscopy*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Diskography/Myelography*; Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Endoscopic Retrograde Cholangiopancreatography;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
00699	*Hypnosis;* Rate as Class 006, Physician Not Otherwise Classified (NOC)
07099	*Laparoscopy/Peritoneoscopy;* Rate as Class 070, Surgeon Not Otherwise Classified (NOC)
02099	*Lymphagiography/Phlebography;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Manipulator* - Minor Surgery*;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
02099	*Pneumatic or Mechanical Esophageal Dilatation;* Rate as Class 020, Physician Not Otherwise Classified (NOC)
01099	*Pneumoencephalography;* Rate as Class 010, Physician Not Otherwise Classified (NOC)
02099	*Radiopaque Dye Injection;* Rate as Class 020, Physician Not Otherwise Classified (NOC)

If the physician's medical practice is not solely limited to a medical procedure described herein, the medical specialty of the physician shall be used to determine the applicable rate classification. If the physician's medical practice includes multiple medical specialties, the highest rated classification shall be used.

For Example:

Laparoscopy/Peritoneoscopy are medical procedures which are performed by practitioners of several medical specialties. The rating classification of physicians performing these procedures shall correspond with that of the physician's medical specialty:

Colon-Rectal Surgery	–	Shall be rated as either Class 050 or 060
Gastroenterology	–	Shall be rated as Class 070
General Surgery	–	Shall be rated as Class 070
Obstetrics/Gynecology (Performing the Full Range of Procedures)	–	Shall be rated As Class 080
Obstetrics/Gynecology (Who Assist in Major Surgery on Other Than Their Own Patients)	–	Shall be rated as Class 030
Surgeons – Gynecology	–	Shall be rated as Class 050

2007 REMITTANCE ADVICE (FORM e-216)

For remitting coverage that incepted or renewed in 2007 only

Date: Enter Today's Date

Related Lic. #

Basic Insurance Coverage limit: $500,000/$2,500,000 Hospital
$500,000/$1,500,000 All Others

If correcting, enter
Correcting: 216 Date here

Insurance Company Name
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Fax #
Contact Person's Email

For Fund's Official Use Only

Receipt Date		Check No.	
Carrier Code		Check Amt.	
Count	0	Policy Exam.	
Assess.Total	$0.00		

License #	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Carrier's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow / New Doctor	Policy Modifier	County Code	Specialty Code	Primary Carrier's Premium	Prevailing Primary Premium	Full Assessment	2007 Abatement %	Remitted Assessment	Comment	Related License #
															$ -	$ -		$ -		

2007 Nonparticipating Transmittal Form (FORM 316)

Proof of insurance for health care providers practicing less than 50% in PA and not choosing to participate

Return to Table of Contents

For Fund's Use Only

Receipt Date

Carrier Code

Count 0

Date: Enter Today's Date

Limits: $1,000,000.00/$3,000,000.00

Insurance Company Name
Contact Person's Name
Insurance Company Address
Contact Person's Telephone #
Contact Person's Fax #
Contact Person's Email

License #	Name	From Date	To Date	Cancel/End. Eff. Date	Retro Date	Carrier's Policy #	Pol. Type	Locum Tenens	Cnty Code	Spec. Code	Carrier's Premium	Comment

2007 Exhibit 5

Worksheet for eligible

Corporations, Associations and Partnerships

Insurer's Name	
Insurer's Mcare #	
Date:	
Entity's Name:	
Entity's Address:	

Basic Insurance Coverage Limits: $ 500,000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Entity's License #	From Date	To Date	County Code	Specialty Code	Entity's Assessment
				80999	***$***

List all shareholders, owners, partners and employed health care providers

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors

2007 Exhibit 6

Worksheet for **Hospitals**

(Specialty Code 80612)

Insurer's Name:	
Insurer's Mcare #:	
Date:	
Hospital's Name:	
Address:	

Basic Insurance Coverage Limits: $ 500, 000.00 Per Occ.
$2,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.*

Hospital's Mcare License #	From Date	To Date	Retro Date	County	Territory

List of Annual Occupied Bed Counts

Exposure Type:		Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Hospital (acute care)		$8,550.06	$3,796.21	$4,753.82	$7,601.01	$
Mental Health/Mental Rehab.		$4,278.69	$1,899.74	$2,378.95	$3,803.74	$
Extended Care		$380.65	$168.99	$211.63	$338.39	$
Out-Patient Surgical		$8,550.06	$3,796.21	$4,753.82	$7,601.01	$
Health Institution		$1,712.94	$760.55	$952.40	$1,522.79	$

List of Annual Visit Counts

Exposure Type:		Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	
Emergency		$854.64	$379.47	$475.18	$759.79	$
Other		$341.86	$151.79	$190.08	$303.93	$
Mental Health/Mental Rehab.		$213.67	$94.87	$118.78	$189.93	$
Extended Care		$18.98	$8.43	$10.54	$16.88	$
Out-Patient Surgical		$854.64	$379.47	$475.18	$759.79	$
Health Institution		$128.18	$56.92	$71.28	$113.96	$
Home Health Care		$213.67	$94.87	$118.78	$189.93	$

Prevailing Primary Premium	$
Experience Modification Factor (as provided by Mcare)	1.000
PPP X EMF X 23% = Mcare Assessment	**$**

***A copy of the Mcare's Experience Modification Factor letter sent to the hospital must be attached.**

2007 Exhibit 6A
Hospital Roster

Insurer's Name:

Hospital's Name:

Note: Submit this exhibit along with Exhibit 6 and Form e-216.

Insurer's Mcare #:
Date:

Hospital's Mcare License # (Please do not enter dashes)	Hospital's Policy #	From Date	To Date	County Code

List all Mcare eligible health care providers and entities for whom the above-mentioned hospital pays the assessment.

HCP License # (Please do not enter dashes)	Health Care Provider's Name (Format: Last Name, First Name, Middle Initial)	JUA Specialty Code	For Fund Use Only

2007 Exhibit 7

Worksheet for **Nursing Homes**

(Specialty Code 80924)

Insurer's Name:	
Insurer's Mcare #:	
Date:	
Nursing Home Name:	
Nurs.Home's Address:	

Basic Insurance Coverage Limits: $500, 000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Nursing Home's Mcare License #	From Date	To Date	County Code	Territory	Has the nursing home applied for abatement?

List Annual Occupied Bed Counts

Exposure Type	Bed Count	Terr. 1 Rates	Terr.2 Rates	Terr. 3 Rates	Terr. 4 Rates	Prevailing Primary Premium
Convalescent		$581.39	$258.14	$323.26	$516.87	$ -
or						
Skilled Nursing		$478.80	$212.60	$266.22	$425.66	$ -

Full Mcare Assessment	$
2007 Abatement	0%
Assessment Due	$

2007 Exhibit 8

Worksheet for **Primary Health Centers**

(Specialty Code 80614)

Insurer's Name:	
Insurer's Mcare #:	
Date:	
Primary Health Ctr. Name:	
PHC's Address:	

Basic Insurance Coverage Limits: $500, 000.00 Per Occ.
$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Primary Health Ctr's Mcare License #	From Date	To Date	County Code	Terr.	

List Annual Visit Counts

Exposure Type	Total Visit Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Emergency		$841.00	$373.40	$467.59	$747.64	$
Other		$336.40	$149.35	$187.03	$299.06	$
Mental Health/Mental Rehab.		$210.27	$93.37	$116.91	$186.95	$
Out-Patient Surgical		$841.00	$373.40	$467.59	$747.64	$
Home Health Care		$210.27	$93.37	$116.91	$186.95	$

Prevailing Primary Premium	$
Mcare Assessment	$

2007 Exhibit 9

Worksheet for **Birth Centers**

(Specialty Code 80402)

Insurer's Name	
Insurer's Mcare #	
Date:	
Birth Center's Name:	
Birth Center's Address:	

Basic Insurance Coverage Limits: $500, 000.00 Per Occ.

$1,500,000.00 Per Agg.

Note: Manually add a complete transaction line to Form e-216 and attach this exhibit.

Birth Center's License #	From Date	To Date	County Code	Specialty Code	Birth Center's Assessment
				80402	$

List all shareholders, owners, partners and employed health care providers

License #	Name	County Code	Specialty Code	HCP's Assessment	Other Rating Factors

EXHIBIT 10
COUNTY CODE LIST

01 Adams	24 Elk	47 Montour
02 Allegheny	25 Erie	48 Northampton
03 Armstrong	26 Fayette	49 Northumberland
04 Beaver	27 Forest	50 Perry
05 Bedford	28 Franklin	51 Philadelphia
06 Berks	29 Fulton	52 Pike
07 Blair	30 Greene	53 Potter
08 Bradford	31 Huntingdon	54 Schuylkill
09 Bucks	32 Indiana	55 Snyder
10 Butler	33 Jefferson	56 Somerset
11 Cambria	34 Juniata	57 Sullivan
12 Cameron	35 Lackawanna	58 Susquehanna
13 Carbon	36 Lancaster	59 Tioga
14 Centre	37 Lawrence	60 Union
15 Chester	38 Lebanon	61 Venango
16 Clarion	39 Lehigh	62 Warren
17 Clearfield	40 Luzerne	63 Washington
18 Clinton	41 Lycoming	64 Wayne
19 Columbia	42 McKean	65 Westmoreland
20 Crawford	43 Mercer	66 Wyoming
21 Cumberland	44 Mifflin	67 York
22 Dauphin	45 Monroe	
23 Delaware	46 Montgomery	

TERRITORY DISTRIBUTION:

For Hospitals, Nursing Homes and Primary Health Centers:

Territory 1: Delaware (23), Philadelphia (51)
Territory 2: Remainder of State (01, 03-08, 10-14, 16-19, 21-22, 24, 26-34, 36, 38-39, 41-42, 44-45, 47-50, 52-67)
Territory 3: Allegheny (02), Crawford (20), Erie (25), Lackawanna (35), Lawrence (37), Luzerne (40), Mercer (43)
Territory 4: Bucks (09), Chester (15), Montgomery (46)

For All Other Health Care Providers:

Territory 1: Philadelphia (51)
Territory 2: Remainder of State (01, 04-06, 08, 10-14, 16-18, 21, 24, 27-32, 34, 36, 38, 41-42, 44, 47, 49-50, 52-53, 55-62, 64, 66-67)
Territory 3: Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)
Territory 4: Bucks (09), Chester (15), Fayette (26), Montgomery (46)
Territory 5: Delaware (23)
Territory 6: Blair (07), Columbia (19), Crawford (20), Dauphin (22), Erie (25), Lackawanna (35), Lawrence (37), Lehigh (39), Luzerne (40), Mercer (43), Monroe (45), Northampton (48), Schuylkill (54)