



# Medical Care Availability and Reduction of Error Fund

PENNSYLVANIA INSURANCE DEPARTMENT

Published 2.12.08  
Version 2.1

30 North Third Street, 8<sup>th</sup> Floor  
Harrisburg, PA 17101  
(717) 783-3770 x 243

## FAQs ~ Frequently Asked Questions for 2008 Mcare Assessments

---

### 1. Why did I receive a notice from Governor Rendell about my Mcare abatement?

The Governor sent a letter to all of the state's health-care providers who have recently received abatements to explain his support of the continuation of the Mcare abatement program for another 10 years. This is part of the Governor's broader health reform package that also includes funding for Cover All Pennsylvanians (CAP) program [Cover All Pennsylvanians \(CAP\)](#) which is a program to make health care coverage accessible to the uninsured and low wage small businesses without insurance.

The Governor's letter also informed providers that he has directed the Insurance Commissioner to send the Mcare bills, but extends the due dates of those bills that would normally be due by March 31. This extension will give the Administration and the General Assembly a chance to reach agreement on funding for CAP and fund the abatement. The General Assembly recently adjourned without enacting CAP or an extension of the Mcare abatement program.

### 2. So does that mean that health- care providers will now be invoiced for their Mcare assessments?

Yes. The Insurance Department has given notice to insurers and others collecting Mcare assessments to bill 2008 assessments without abatements under normal timelines.

Because no legislation has been enacted to extend the abatement program beyond 2007 all assessments will be invoiced at unabated rates. Link to [2008 Assessment Manual](#).

However, the Governor has requested that Mcare give providers a payment extension in the hope that abatement legislation will be signed early in the New Year. Click to view [Governor's December 24, 2007 Press Release](#). So that means that the due dates on invoices for 2008 assessments issued after mid-December will be due no earlier than March 31, 2008.

To the extent that the normal billing process has been delayed, those bills will be sent out as soon as possible so that providers have sufficient time and opportunity to make payment arrangements.

Many health care providers had been expecting enactment of a 2008 Abatement Program and had not planned to pay full, unabated 2008 assessments. This is the most effective way for providers to know their 2008 assessment amounts as far as possible in advance of payment due dates.

Health care providers should expect to see a bill from their primary insurer, risk retention group or other parties who bill, collect or remit Mcare assessments.

### **3. What are the new due dates for assessment billing and payments?**

The due dates on invoices for 2008 assessments issued after mid-December will be due no earlier than March 31, 2008. Specifically, any Mcare assessments associated with primary policies with February or March 2008 effective or renewal dates billed after mid-December should provide that payment of the assessment is due to the billing party by the later of March 31, 2008 or 60 days after the effective or renewal dates of the primary policies.

Payments would be outlined as follows:

- For 2008 only, payment of the Mcare assessment associated with a primary policy with a January 2008 effective or renewal date will be due by March 31, 2008 to the individual or entity who bills the health care provider for the Mcare assessment.
- For 2008 assessments associated with primary policies with February 2008 and March 2008 effective or renewal dates, payment of the Mcare assessments will be due to the individual or entity who bills the providers for the Mcare assessments the later of March 31, 2008 or 60 days after the effective or renewal date of the primary policy.
- For all 2008 Mcare assessments associated with primary policies with effective or renewal dates in April 2008 or after, billing of assessments and remission of assessments to the Mcare Fund should be accomplished under standard procedures, which include payment of the Mcare assessment by health care providers so that their assessment payments can be received by the Mcare Fund within 60 days of the effective or renewal date of the primary policy.

### **4. Why was extra time authorized for payment of some 2008 assessments?**

Timeframes for payments of some 2008 Mcare assessments were adjusted because some insurers, in anticipation of legislative action, did not bill health care providers for unabated 2008 assessments in a timely manner.

More than 17,000 assessments have January 1, 2008 effective or renewal dates, for which assessment payments would otherwise have been due by March 1, 2008. Absent the anticipated legislative action, these assessments would normally have been billed to providers in November.

### **5. Why do medical providers pay Mcare assessments?**

Currently, Pennsylvania law requires physicians and several other types of health care providers to carry a minimum of \$1 million per incident of medical malpractice insurance coverage. Physicians, certified nurse midwives and podiatrists must have this insurance in order to be licensed. The first \$500,000 of coverage per incident, which is called the primary layer, is obtained through the private insurance market. The second \$500,000 of coverage for Mcare Fund participating providers is provided by the state-administered Mcare Fund.

Assessments are like premiums – they are what health care providers pay for Mcare coverage and they are used to pay for Mcare claims and operations expenses.

Participating non-hospital providers must have \$3 million in aggregate per policy year. Hospitals must also carry medical malpractice insurance and their required amounts are higher -- \$1 million worth of coverage for each incident and \$4 million total coverage per policy year.

See “[About Mcare](#)” for additional general information.

## **6. What exactly is Mcare and who participates in it?**

“Mcare” stands for the Medical Care Availability and Reduction of Error Fund. It was created under Act 13 of 2002 and is the successor to the Medical Professional Liability Catastrophe Loss Fund, better known as the “CAT Fund.” Participation in Mcare is mandatory for hospitals, nursing homes, birth centers and primary health centers. In addition, physicians, podiatrists and certified nurse midwives licensed by the state who conduct 50% or more of their health care business within Pennsylvania are required to participate unless they qualify under certain exemptions (for example, physicians with an active license who are not practicing in Pennsylvania, physicians who are employed by the federal government and covered by the federal tort act or physicians who are practicing exclusively under a volunteer license or as a forensic pathologist). Those participating health care providers pay an “assessment” to maintain the Mcare layer of coverage and, in addition, they must maintain their primary layer of coverage.

## **7. Generally speaking – how much are Mcare assessments – and how are they determined?**

Premiums reflect risk and vary by type of provider and the part of the state in which the provider practices. For example, the premium for a high risk specialist – such as a neurosurgeon – would be higher than that of a physician who does no surgery in the same part of the state.

As an example, 2008 assessments vary from \$37,007 for neurosurgeons in Philadelphia to \$726 for many physician specialties without surgery in rural parts of the state.

The assessment rate is related to the actuarial risk associated with each physician specialty, as well as the region of the state, as reflected in the base primary rates established by the Pennsylvania Professional Liability Joint Underwriting Association’s (JUA). At the current time, the amount that each provider pays is proportional to the cost of what that provider would pay if buying the basic, primary layer of insurance from the JUA.

## **8. What is the Abatement Program and how long has it been in effect?**

Act 44 of 2003 established the Health Care Provider Retention Program, also known as the Abatement Program. The Abatement Program was created by Governor Ed Rendell to provide eligible health care providers relief from the Mcare assessment for a specific policy year during which the program is in effect.

The Governor created the abatement to encourage health care providers to continue practicing in Pennsylvania while the medical malpractice reforms that had been authorized had a chance to take effect and lower total medical malpractice costs. His goal was to make sure that Pennsylvanians continued to have access to quality health care.

The law initially “abated” doctors and midwives. Podiatrists were added effective in 2005, and nursing homes effective in 2006. The 2003 law provided the abatement for 2003 and 2004. Each year since then, the abatement has been extended by the Legislature for a one-year time period.

High risk specialists including orthopedic surgeons, neurosurgeons, obstetricians delivering babies and other high-risk surgeons and most emergency medicine physicians, along with midwives, receive a 100% abatement of their Mcare assessments. Remaining eligible providers receive a 50% abatement of their Mcare assessments.

Providers must apply for abatement and answer practice history questions in order to determine if they are eligible.

- For example, providers must certify that they will practice medicine in Pennsylvania in the year of the abatement and the following calendar year to receive the abatement. And, doctors with too many malpractice judgments against them are not eligible.

To date, the Abatement Program has provided nearly \$1 billion in financial relief to eligible providers.

### **9. What is the Health Care Provider Retention Account?**

The Health Care Provider Retention Account – which is often called HCPRA – was created as part of the Governor’s medical malpractice reforms in 2003. HCPRA is the fund into which designated cigarette tax revenues are deposited to help pay for the Mcare abatement. Because of improvement in the medical malpractice climate in Pennsylvania, filings and annual Mcare claim payouts have decreased dramatically, and reserves have accumulated in HCPRA that have not been needed to offset the cost of abatement in the last two years. There will be approximately \$414 million in that account by the end of 2007.

### **10. How is the Abatement Program currently funded?**

It is funded through cigarette tax revenues, Auto CAT Fund surcharges, collection of abatement repayments from providers who did not fulfill their retention pledges, revenue from reinsurance, the collection of overdue assessments from prior years, interest income, and assessments from providers without 100% abatements.

### **11. What does it mean when you say Mcare has an unfunded liability?**

Since Mcare is operated on a pay-as-you-go basis, this means that health care providers practicing in the present are paying to settle medical malpractice claims from incidents that happened in the past. For this reason, Mcare continues to build an unfunded liability. That means if Mcare were to end today, there would still be money owed under the program for many years to come. These unfunded liabilities are commonly referred to as the Mcare “claims tail.” Mcare’s current unfunded liability is estimated to be approximately \$2.12 billion (\$1.76 billion in current dollars).

### **12. Is providing affordable health insurance for uninsured Pennsylvanians the best way to use any HCPRA surpluses not needed to fund the Abatement Program?**

In 2003, Governor Rendell proposed the creation of the Health Care Provider Retention Program, also known as the Mcare “Abatement Program” to help physicians and midwives pay for their malpractice insurance. He made this proposal at a time when spiking malpractice premiums were threatening physicians financially and threatening access to care for the people of Pennsylvania.

Mcare claims payments were at an all time high and Pennsylvania was facing a medical malpractice affordability crisis. But since 2002, aggressive medical malpractice reforms such as certificate of merit, venue reform and the Abatement Program have helped to reduce both the number of malpractice cases being filed and the cost of malpractice insurance. Statewide medical malpractice filings were 38 percent lower in both 2005 and 2006 than in the 2000-2002 base period before med mal reforms were implemented. Likewise, the 2007 claims payments for Mcare are 50 percent less than was paid in 2003.

Nearly \$1 billion in public funds has been expended to support the Mcare Abatement Program to help physicians and other health care providers reduce their total out-of-pocket costs for mandatory medical malpractice coverage.

Given the dramatic improvement in the medical malpractice insurance market since 2003, it seems only reasonable that the Commonwealth should seek to use unspent funds to confront Pennsylvania’s current major health care crisis – the crisis of the uninsured.

Added  
1-16-08

### **13. How will the Mcare determine if health care providers paid 2008 assessment payments in a timely manner?**

- A. For policies with January 1, 2008 through January 31, 2008 effective or renewal dates:
- If Mcare receives the assessment payments associated with primary policies by April 30, 2008, Mcare will consider these assessment payments to be timely.
  - If assessment payments are not received by Mcare by April 30, 2008, Mcare will consider the assessment payments to be timely if the providers paid the assessments to their

insurers or other assessment billers by March 31, 2008 (e.g., by mailing the payment to the insurer or biller with a postmark of March 31, 2008 or earlier).

- If the assessment payment was not received by Mcare by April 30, 2008 and the assessment payment was not paid by the provider to the insurer or assessment biller by March 31<sup>st</sup> (e.g., by mailing the payment to the insurer or biller with a postmark of March 31, 2008 or earlier), the provider will not have Mcare coverage for any claim that is made prior to the date the assessment payment is received by Mcare.

B. For policies with February 1 through March 31, 2008 effective or renewal dates:

- If Mcare receives the assessment payments within 90 days of the primary policies' effective or renewal dates, Mcare will consider these assessment payments to be timely.
- If assessment payments are not received by Mcare within 90 days of the primary policies' effective or renewal dates, Mcare will consider the assessment payments to be timely if the providers paid the assessments to their insurers or other billing parties within 60 days of the primary policies' effective or renewal dates (e.g., by mailing the payment to the insurer or biller with a postmark within 60 days of the primary policies' effective or renewal dates or earlier).
- If the assessment payment was not received by Mcare within 90 days from the effective or renewal date, and the payment was not paid by the provider to the insurer or assessment biller by 60 days from the effective or renewal date (e.g., by mailing the payment to the insurer or biller with a postmark within 60 days of the primary policies' effective or renewal dates or earlier), the provider will not have Mcare coverage for any claim that is made prior to the date the assessment payment is received by Mcare.

C. For policies with April 1 through December 31, 2008 effective or renewal dates:

- Health care providers who have primary policies with effective or renewal dates in 2008 after March 31, 2008 are required to pay 2008 Mcare assessments associated with these primary policies under standard procedures, so that these 2008 assessments are received by the Mcare Fund within 60 days of the effective or renewal dates of the primary policies.
- The "standard procedures" referenced in the Commissioner's December 21, 2007 notice to insurers are as provided in 31 Pa. Code, Chapter 242 and applicable statutes.
- If the assessment payment is not received by Mcare within 60 days from the effective or renewal date, the provider will not have Mcare coverage for any claim that is made prior to the date the assessment payment is received by Mcare.

Added  
1-16-08

Office of Mcare

Published 2.12.08  
Version 2.1

BAR IN RIGHT MARGIN DENOTES EDIT SINCE  
PRIOR PUBLISHED VERSION

**14. How must insurers and others billing 2008 assessments remit assessment payments to Mcare?**

- A. For policies with January 1 through January 31, 2008 effective or renewal dates:  
Assessment payments must be remitted to Mcare by April 30, 2008. Assessment payments must be made by the providers to the insurer or assessment biller by March 31, 2008.

Insurers and other billers should send invoices for assessments associated with primary policies with January 2008 effective or renewal dates within 30 days of the notice the Acting Commissioner sent to insurers and other billers on December 21, 2007. However, if an insurer or other biller did not receive this December 21, 2007 notice, they should send invoices for assessments associated with primary policies with January 2008 effective or renewal dates within 30 days of the notice published in the [Pennsylvania Bulletin](#) on January 12, 2008.

- B. For policies with February 1 through March 31, 2008 effective or renewal dates:  
Assessment payment must be remitted to Mcare within 90 days of the policy's effective or renewal date. Assessment payment by the providers must be made to the insurer or assessment biller within 60 days of the policy's effective or renewal date (e.g., by mailing the payment to the insurer or biller with a postmark within 60 days of the policy's effective or renewal date).

Any unbilled assessments associated with primary policies with February or March 2008 effective or renewal dates should be billed so that payment of the assessment is due to the billing party by the **later** of March 31, 2008, or 60 days after the effective or renewal dates of the primary policies.

- B. For policies with April 1 through December 31, 2008 effective or renewal dates:  
Assessment payments should be remitted to Mcare within 60 days of the policy's effective or renewal date, as provided in 31 Pa. Code, Chapter 242 and applicable statutes.

Any Mcare assessments associated with primary policies with April 2008 or later effective or renewal dates should be billed and remitted to the Mcare Fund under standard procedures.

\* \* \*