09

Act 13 of 2002

Medical Care Availability and Reduction of Error Fund

Joel Ario
Insurance Commissioner
PA Department of Insurance

Annual Report of Operations 2009

Issued March 1, 2010

Office of Mcare

2009 Annual Report of Operations

Table of Contents **Tab No.**

About Mcare

The Medical Care Availability and Reduction of Error Fund ("Mcare"), a deputate of the Pennsylvania Insurance Department, was created by Act 13 of 2002 ("Act 13"), and signed into law on March 20, 2002. Mcare is the successor to the Medical Professional Liability Catastrophe Loss Fund, better known as the "CAT Fund" which originally was established by section 701(e) of the Health Care Services Malpractice Act, Act 111 of 1975 (40 P.S. §§ 1301.101-1301.1006), et seq. and began to accept coverage and accrue unreserved liabilities starting in calendar year 1976.

PURPOSE

Mcare is a special fund within the State Treasury established, among other things, to ensure reasonable compensation for persons injured due to medical negligence. Money in the fund is used to pay claims against participating health care providers and eligible entities for losses or damages awarded in medical professional liability actions in excess of basic insurance coverage ("primary coverage') provided by primary professional liability insurance companies ("primary carriers") or self-insurers. Mcare also administers a compliance program to ensure adherence to the provisions of Act 13 and its attendant applicable regulations.

REVENUE STREAM

Act 13 of 2002, section 712(d) states in part,

> "…the fund shall be funded by an assessment on each participating health care provider. Assessments shall be levied by the department on or after January 1 of each year. The assessment shall be based on the prevailing primary premium for each participating health care provider and shall, in the aggregate, produce an amount sufficient to do all of the following:
>
> (i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.
> (ii) Pay expenses of the fund incurred during the preceding claims period.
> (iii) Pay principal and interest on moneys transferred into the fund in accordance with section 713(c).
> (iv) Provide a reserve that shall be 10% of the sum of subparagraphs (i), (ii) and (iii)."

Under section 712(g), the fund is required to adjust up to 20% the annual assessment of those participating providers with a claims experience of severity and frequency over the five most recent claims period.

In addition to the annual assessments, the fund receives supplemental funding under section 712(m), beginning January 1, 2004 and is to set to expire nine calendar years thereafter on December 31, 2013. These funds consist of surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system, also known as the "Auto CAT Fund."

In addition to the above funding sources, Act 44 of 2003, section 443.7 established within the General Fund a special account known as the Health Care Provider Retention Account. It directs the department to assist in administering funds appropriated under this section. This account is used to provide funding for the Abatement Program.

PARTICIPATION

Act 13, as amended, mandates that each health care provider who renders 50% or more of his or her professional health care business or practice within Pennsylvania ("participating health care provider") must obtain primary coverage with a primary carrier licensed or approved by the Pennsylvania Insurance Department or with an approved self-insurance plan. In addition, each participating health care provider must obtain statutory excess professional liability coverage with Mcare by paying a certain percentage of the prevailing primary premium charged by the Pennsylvania Professional Liability Joint Underwriting Association (JUA) to Mcare. The appropriate percentage ("assessment") varies each year based upon payments made by Mcare in the previous year.

Participation in Mcare is mandatory for hospitals, nursing homes, birth centers, primary health centers, physicians, podiatrists and certified nurse midwives licensed by this Commonwealth and conducting 50% or more of their health care business within this Commonwealth. If a health care provider has Mcare coverage, that coverage would apply. Most professional corporations, professional associations and partnerships owned entirely by health care providers may elect to insure their primary liability. If they elect to purchase primary coverage, then their participation in Mcare is mandatory. Mcare participation is limited to those types of professional corporations, professional associations, or partnerships that were in existence as of November 26, 1978.

The following health care providers are not subject to the mandatory insurance coverage and Mcare assessment requirements: (a) health care providers who do not practice in Pennsylvania; (b) health care providers who are exclusively federal government employees; (c) health care providers who are exclusively Commonwealth employees; (d) health care providers who are exclusively forensic pathologists; (e) health care providers who are retired, whether or not they provide care for themselves or their immediate family members; (f) health care providers who practice exclusively as members of the Pennsylvania or U.S. military forces; and (g) health care providers who practice exclusively under a volunteer license.

COVERAGE REQUIREMENTS

Historically, the mandatory coverage limits for health care providers has varied. Currently, the total required amounts of medical professional liability coverage, including primary and Mcare coverage, for health care providers, excluding hospitals, are $1,000,000 per occurrence and $3,000,000 per annual policy year aggregate. For hospitals, the required total coverage amounts are $1,000,000 per occurrence, and $4,000,000 per annual aggregate. The current total coverage amounts required for health care providers participating in Mcare are as follows:

A. Primary Coverage for Participating Health Care Providers

Act 13 requires participating health care providers to obtain primary coverage in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate. Hospitals must obtain primary coverage in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate.

B. Mcare Coverage for Participating Health Care Providers

Mcare provides participating health care providers coverage of $500,000 per occurrence and $1,500,000 per annual aggregate in excess of the primary coverage. Mcare provides hospitals coverage of $500,000 per occurrence and $1,500,000 per annual aggregate in excess of the primary coverage. Mcare coverage is applicable to malpractice committed in Pennsylvania or outside of Pennsylvania by a participating health care provider.

C. Primary Coverage for Nonparticipating Health Care Providers

A health care provider conducting less than 50% of its health care business in Pennsylvania and not electing to participate in Mcare ("nonparticipating health care provider") is required under Act 13 to maintain coverage in the amount of $1,000,000 per occurrence and $3,000,000 per annual aggregate by a primary carrier licensed or approved in Pennsylvania.

D. Mcare Coverage for Nonparticipating Health Care Providers

Mcare does not provide coverage for nonparticipating health care providers. Nonparticipating health care providers obtain their required $1,000,000/$3,000,000 limits of coverage from primary carriers licensed or approved in Pennsylvania.

E. Mcare Coverage for Nonparticipating Health Care Providers Electing to Participate in Mcare

Nonparticipating health care providers may elect to participate in Mcare. Mcare coverage is applicable to malpractice committed in Pennsylvania or outside of Pennsylvania by a nonparticipating health care provider electing to participate in Mcare.

REPORTING COVERAGE TO MCARE

The primary insurance carrier must submit proof of insurance to Mcare for each policy issued to a participating health care provider, eligible professional corporation, eligible partnership, and eligible professional association on a Form 216 Remittance Advice ("Form 216"), together with the appropriate assessment payment for each health care provider identified on the Form 216. A copy of the Form 216 may be found on Mcare's website.

Mcare has the authority to determine the amount of the annual assessment that will be levied on each participating health care provider and eligible entity. The assessment is a percentage designated by Mcare of the prevailing primary premium charged by the JUA for health care providers of like class, size, risk and kind. A health care provider must pay the assessment to their primary carrier in sufficient time for it to forward proof of insurance and the applicable assessment payment to Mcare within 60 days of the effective date of the health care provider's primary policy.

A participating health care provider's failure to obtain primary coverage in the amount mandated by Act 13, or to pay the assessment required, will result in Mcare certifying the health care provider's noncompliance to the appropriate licensure board for possible disciplinary action. In addition, Mcare will not provide coverage to that health care provider in the event of a claim made against him or her.

CLAIMS REPORTING

If all statutory requirements are satisfied, Mcare provides coverage in excess of the applicable primary coverage. If it is anticipated that a judgment, award, or settlement in a particular case will exceed the available primary coverage for a health care provider, the primary carrier must promptly notify Mcare in writing of the medical professional liability claim. This notification must be made through submission of a Form C-416 to Mcare. A copy of the Form C-416 may be found on Mcare's website.

Section 715 of Act 13 provides an exception to Mcare's role as statutory excess carrier in instances where the claim alleges malpractice prior to January 1, 2006. Under Section 715, Mcare provides first dollar indemnity up to $1,000,000 and the cost of defense for a claim if certain requirements are met. Specifically, the claim must be filed more than four years after the date the breach of contract or tort occurred, must be filed within the applicable statute of limitations, and the primary carrier must submit a Form C-416 requesting Section 715 status for the claim within 180 days of the date on which notice of the claim was first given to the health care provider or its insurer. In the event of multiple treatments occurring less than four years before the date on which the health care provider or its insurer received notice of the claim, Section 715 coverage will not apply.

Pursuant to Act 13, Section 715 coverage ends as of January 1, 2006. Specifically, primary carriers are required to provide first dollar indemnity and cost of defense for all claims occurring four or more years after the breach of contract or tort and after December 31, 2005.

SUMMARY

This narrative is provided for general informational purposes only and is not inclusive of all Mcare programs, procedures, rules, or regulations. For additional information, please contact Mcare at the following address:

Medical Care Availability and Reduction of Error Fund
30 North 3rd Street, 8th Floor
P.O. Box 12030
Harrisburg, PA 17108-2030
(717) 783-3770
or
www.insurance.pa.gov/mcare

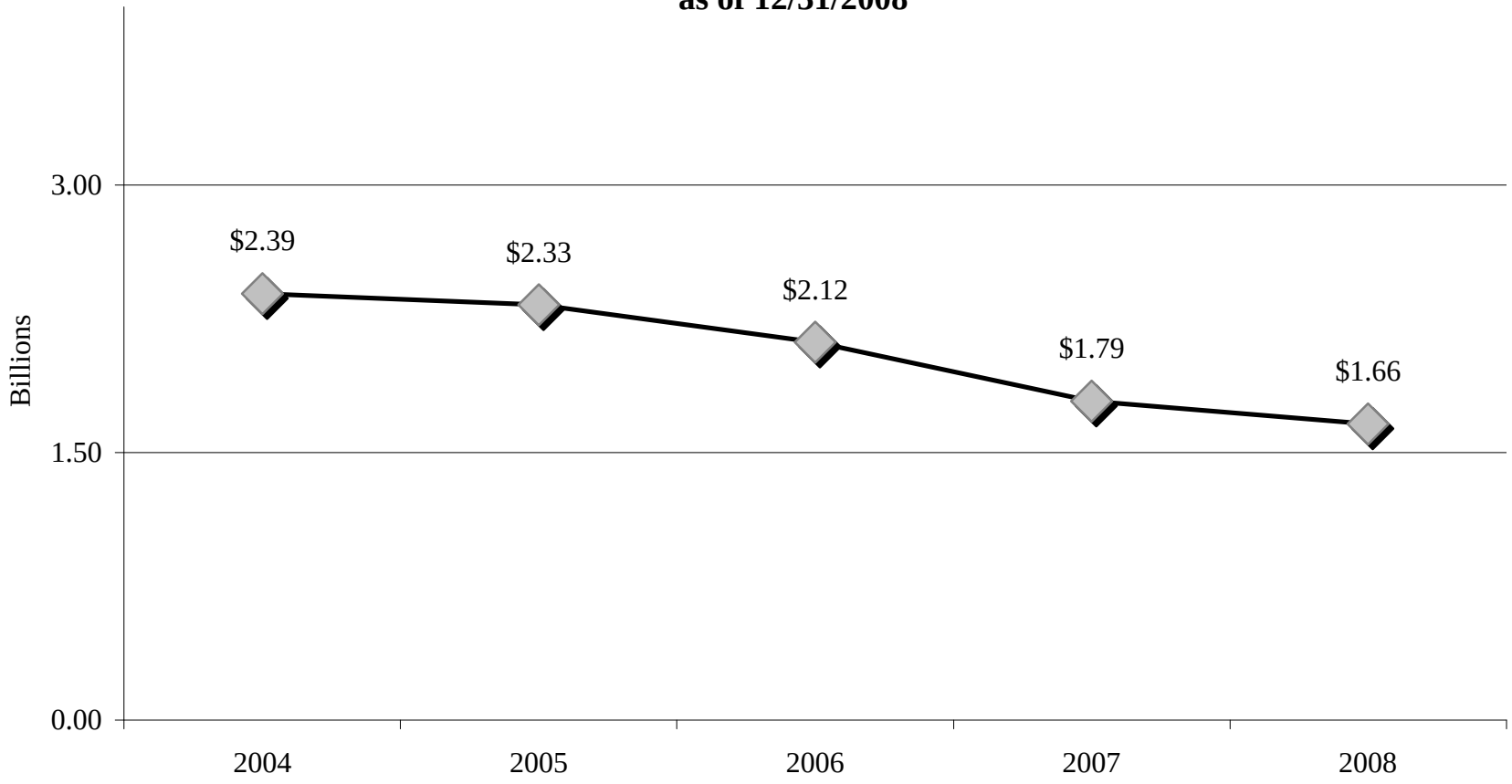
MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND
CASH BASIS
STATEMENT OF OPERATIONS
JANUARY 1, 2009 TO DECEMBER 31, 2009

FUND BALANCE JANUARY 1, 2009			104,351,436.72
ADD:	HCP EXPERIENCE RATED ADJ	42,661.26	
	AUTO CAT FUND 1/1/09-6/30/09	21,644,540.90	
	HEALTH CARE PROVIDER ASSESSMENT	217,509,503.46	
	INTEREST ON SECURITIES	3,162,232.75	
	ABATEMENT REPAYMENT	2,056,093.94	
	OTHER REVENUES	87,457.37	
	REFUND OF EXPENDITURES	25,475.44	
	CASH IN TRANSIT @ 12/31/08	652,744.69	
	CASH IN TRANSIT @ 12/31/09	1,694,922.03	
	ACCOUNTS RECEIVABLE @ 12/31/08	-2,590.50	
	TOTAL ADDITIONS		246,873,041.34
TOTAL FUNDS AVAILABLE			351,224,478.06
DEDUCT:			
	2009 CLAIMS PAID - DEC, 2009	178,236,910.00	
	INTRA-AGENCY TRANSFER	100,000,000.00	
	TOTAL DEDUCTIONS	278,236,910.00	
OPERATING EXPENSES:			
	SALARIES	3,872,059.73	
	PAYROLL TAXES & BENEFITS	1,337,474.07	
	DATA PROCESSING SERVICES	7,084.67	
	LEGAL & CONSULTING FEES	3,356,533.90	
	OFFICE SUPPLIES	38,949.26	
	TELECOMMUNICATIONS	61,789.42	
	REAL ESTATE	564,624.41	
	TRAVEL, TRAINING, DUES, SUBSCRIPTIONS	28,754.07	
	OTHER OPERATIONAL EXPENSES/ACCRUED PAYABLES	2,495,616.75	
	PAYABLES @ 12/31/08	808,194.65	
	PAYABLES @ 12/31/09	-978,177.19	
	TOTAL OPERATING EXPENSES	11,592,903.74	
TOTAL DEDUCTIONS:			289,829,813.74
FUND BALANCE DECEMBER 31, 2009			61,394,664.32

History of Assessment Rates and Coverage Limits

Year	Percentage	Policy Effective Date	Coverage Limits (per Occurrence/per Annum) in Millions: Non-hospital — Mcare Limit	Non-hospital — Basic Limit	Non-hospital — Total Aggregate Limits for Mcare & Non-hospital	Hospital — Mcare Limit	Hospital — Basic Limit	Hospital — Total Aggregate Limits for Mcare and Hospital
1976	Greater of 10% or $100	01/13/76 - 12/31/82	$1.0/$3.0	$0.1/$0.3	$1.1/$3.3	$1.0/$3.0	$0.1/$1.0	$1.1/$4.0
1977	Greater of 10% or $100							
1978	nil							
1979	nil							
1980	Greater of 10% or $100							
1981	22%							
1982	38%							
1983	41%	01/01/83 - 12/31/83	$1.0/$3.0	$0.15/$0.45	$1.15/$3.45	$1.0/$3.0	$0.15/$1.0	$1.15/$4.0
1984	52%	01/01/84 - 12/31/96	$1.0/$3.0	$0.2/$0.6	$1.2/$3.6	$1.0/$3.0	$0.2/$1.0	$1.2/$4.0
1985	70%							
1986	87%							
1987	87%							
1988	61%							
1989	59.5%							
1990	50%							
1991	68%							
1992	90%							
1993	91%							
1994	93%							
1995	170%							
1996	164%							
1997	75%	01/01/97 - 12/31/98	$0.9/$2.7	$0.3/$0.9	$1.2/$3.6	$0.9/$2.7	$0.3/$1.5	$1.2/$4.2
1998	64%							
1999	59%	01/01/99 - 12/31/00	$0.8/$2.4	$0.4/$1.2	$1.2/$3.6	$0.8/$2.4	$0.4/$2.0	$1.2/$4.4
2000	61%							
2001	61%	01/01/01 - 12/31/02	$0.7/$2.1	$0.5/$1.5	$1.2/$3.6	$0.7/$2.1	$0.5/$2.5	$1.2/$4.6
2002	50%							
2003	43%	01/01/2003 to present	$0.5/$1.5	$0.5/$1.5	$1.0/$3.0	$0.5/$1.5	$0.5/$2.5	$1.0/$4.0
2004	46%							
2005	39%							
2006	29%							
2007	23%							
2008	20%							
2009	19%							

Office of Mcare
Unfunded Liability Report
as of 12/31/2008



*From 2000 forward, the report includes provisions for delay damages

Estimation of 2009 Unfunded Liability

The attached is the Executive Summary of a report by PricewaterhouseCoopers LLP that was the basis for determining the value of the unfunded liability at $1.66 billion as of December 31, 2008.

Tab 5

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

ESTIMATION OF 12/31/2008 UNFUNDED LIABILITY

ESTIMATE OF FUTURE YEARS' CLAIMS PAYMENTS PURSUANT TO ACT 13 OF 2002

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

July 2009

EXECUTIVE SUMMARY

This section provides a synopsis of the key findings of our study. The explanation of the calculations made in this report is contained in the ANALYSIS section.

Total Unfunded Liability

We estimate the Fund's unfunded liability as of December 31, 2008, excluding breast implant and pedicle screw exposure, to be approximately $1.66 billion, assuming the limits of Fund coverage proceed as currently scheduled under Act 13. Namely, the mandatory primary coverage limits are scheduled to increase (with corresponding decreases in the Fund coverage limits) in 2010 and 2013, subject to the Commissioner's assessment of basic insurance coverage capacity. The estimates contained herein assume that basic coverage limits increase as scheduled, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2013. If the basic coverage limits are not increased in 2010 and 2013, Fund coverage will continue into and beyond 2014 and the total Fund payout would increase accordingly.

Assuming changes in the Fund coverage limits proceed as scheduled, the projected year-beginning unfunded liability, cost of covered "new" occurrences, calendar year claims payments, and resulting year-ending unfunded liability are included in the table below:

Accident Year	Jan-1 Unfunded Liability	Cost of Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability	Discounted (4%) Dec-31 Unfunded
2008				1,656,051	1,372,974
2009	1,656,051	228,215	237,268	1,646,997	1,371,170
2010	1,646,997	164,126	247,208	1,563,915	1,309,025
2011	1,563,915	120,908	254,755	1,430,067	1,202,216
2012	1,430,067	96,309	254,740	1,271,636	1,070,888
2013	1,271,636	24,015	242,218	1,053,433	890,213
2014	1,053,433		217,563	835,870	708,259
2015	835,870		186,411	649,459	550,178
2016	649,459		154,121	495,338	418,063
2017	495,338		119,345	375,993	315,441
2018	375,993		87,107	288,886	240,952
2019	288,886		64,505	224,381	186,085
2020	224,381		48,877	175,504	144,652
2021	175,504		37,379	138,125	113,059
2022	138,125		27,747	110,378	89,834
2023	110,378		21,026	89,352	72,402
2024	89,352		16,666	72,686	58,632
2025	72,686		13,211	59,475	47,766
2026	59,475		10,399	49,076	39,278
2027	49,076		8,491	40,586	32,358
2028	40,586		6,926	33,660	26,727
2029	33,660		5,538	28,121	22,257
2030	28,121		4,433	23,688	18,714
2031	23,688		3,525	20,163	15,938
2032	20,163		2,811	17,353	13,765
2033	17,353		2,308	15,045	12,008
2034	15,045		1,912	13,133	10,577
2035	13,133		1,622	11,512	9,378
2036	11,512		1,469	10,042	8,284
2037	10,042		1,361	8,682	7,254
2038	8,682		1,306	7,376	6,239
2039	7,376		1,199	6,176	5,289
2040	6,176		1,095	5,082	4,406
2041	5,082		1,034	4,048	3,548
2042	4,048		921	3,127	2,769
2043	3,127		798	2,329	2,082
2044	2,329		665	1,664	1,501
2045	1,664		504	1,160	1,057
2046	1,160		395	765	704
2047	765		322	444	410
2048	444		186	257	240
2049	257		130	127	120
2050	127		79	48	45
2051	48		32	16	15
2052	16		13	3	3
2053	3		3	0	0
		633,572	2,289,623		

As shown in the table above, we have projected 2009 claims payments to be $237 million based on the methods and assumptions contained herein. Currently, the Fund is projecting 2009 claim year payments to be approximately $190 million; this is relatively close to the average of the last three claim years, which also emerged lower than our original projections. We have attempted to incorporate the apparent continued reduction in payment activity into our selection of the unfunded liability; however, our assumptions also give some consideration to longer-term trends and result in an estimated 2009 claims payment that is higher than expected by the Fund based on information available to date.

Given the apparent continued decrease in Fund payment activity during 2009 relative to longer-term trends, we have attempted to provide an adjusted estimate of payout of the projected Unfunded Liability assuming the Fund's projection of the 2009 payments of $190 million. We have also assumed that the reduced level of payments observed during recent years will continue into 2010, and have adjusted the projected 2010 payments to $220 million, which is roughly the average of the Fund's expected 2009 payments of $190 million and our unadjusted projection of the 2010 payments of $247 million.

The adjusted payment pattern assumes that the recent decrease in payments has effectively "pushed" the payments out in time. As such, the projected 12/31/2008 unfunded liability is unchanged on a nominal basis, but the stream of payments, future years-ending unfunded liability, and present value of the unfunded liability differ, as shown below:

Accident Year	Jan-1 Unfunded Liability	Cost of Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability	Discounted (4%) Dec-31 Unfunded
2008				1,656,051	1,357,681
2009	1,656,051	228,215	190,000	1,694,266	1,402,532
2010	1,694,266	164,126	220,000	1,638,392	1,368,851
2011	1,638,392	120,908	255,191	1,504,108	1,263,999
2012	1,504,108	96,309	260,525	1,339,892	1,129,356
2013	1,339,892	24,015	256,426	1,107,481	936,813
2014	1,107,481		233,604	873,877	740,681
2015	873,877		195,937	677,940	574,372
2016	677,940		160,662	517,278	436,684
2017	517,278		124,187	393,090	329,964
2018	393,090		91,361	301,730	251,802
2019	301,730		68,052	233,678	193,822
2020	233,678		50,810	182,868	150,765
2021	182,868		38,943	143,925	117,853
2022	143,925		29,047	114,878	93,521
2023	114,878		21,878	93,000	75,384
2024	93,000		17,292	75,708	61,107
2025	75,708		13,774	61,934	49,776
2026	61,934		10,927	51,007	40,841
2027	51,007		8,870	42,137	33,605
2028	42,137		7,222	34,915	27,726
2029	34,915		5,798	29,117	23,038
2030	29,117		4,649	24,469	19,311
2031	24,469		3,684	20,784	16,399
2032	20,784		2,904	17,880	14,151
2033	17,880		2,367	15,514	12,350
2034	15,514		1,958	13,556	10,887
2035	13,556		1,660	11,896	9,662
2036	11,896		1,494	10,402	8,555
2037	10,402		1,377	9,025	7,520
2038	9,025		1,309	7,716	6,511
2039	7,716		1,218	6,497	5,553
2040	6,497		1,118	5,380	4,658
2041	5,380		1,060	4,320	3,784
2042	4,320		962	3,358	2,974
2043	3,358		842	2,516	2,250
2044	2,516		713	1,803	1,627
2045	1,803		556	1,247	1,136
2046	1,247		430	817	752
2047	817		345	472	438
2048	472		208	264	247
2049	264		136	127	120
2050	127		80	48	45
2051	48		32	16	15
2052	16		13	3	3
2053	3		3	0	0
		633,572	2,289,623		

Estimates of the liability reflecting the time value of money contained herein employ a discount rate assumption of 4%; however, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. Estimates at other discount rates are included in the Other Comments section below. Discounted estimates contained herein assume that the Fund's payments continue to be made at the end of each calendar year. Note that, since the Fund does not currently maintain assets in support of the liability, discounted estimates are for illustrative purposes only.

Separate projections of liability were made for Excess and Section 715 claims, excluding breast implant and pedicle screw claims, and our findings for each of these projections are discussed separately below.

Comparison to Projection as of 12/31/2007

The total expected unfunded liability of $1.66 billion has decreased 7.4% from our December 31, 2007 estimate of $1.79 billion. The breakdown of the change in the undiscounted estimate since December 31, 2007 is shown in the following table:

Rollforward of Estimated Unfunded Liability (000's) from 12/31/2007 to 12/31/2008

		Excess	Section 715	Total
(1)	Prior Estimated Liability	1,126,495	662,418	1,788,913
(2)	Less Prior Estimated DD & PJI	16,648	9,789	26,437
(3)	Prior Estimated Liability Ex. DD & PJI	1,109,847	652,629	1,762,476
(4)	Plus Change in Prior Accident Year Ultimate	(115,517)	(83,664)	(199,182)
(5)	Less Paid During Year	140,734	30,949	171,683
(6)	Plus Accident Year 2008 Ultimate	209,410	30,556 (a)	239,966
(7)	Current Estimated Liability Ex. DD & PJI	1,063,005	568,572	1,631,577
(8)	Current Estimated DD & PJI	15,945	8,529	24,474
(9)	Current Estimated Liability	1,078,950	577,100	1,656,051

(a) Includes the estimated portion of losses above the primary policy limit for late-reported claims.

The decrease in the projection is primarily due to the continuation of favorable Fund claim payment trends; our projections give increasing weight to the favorable emerging experience. Based on information gathered by the Administrative Office of Pennsylvania Courts (AOPC), the number of medical malpractice cases filed in Pennsylvania in recent post-Act 13 years (2003 and subsequent) is significantly lower than pre-Act 13 experience (2000/2001). The Fund has also experienced a recent reduction in the number of claims that are closing with payment. Given the consistency and persistency of the reduction in cases filed observed by the AOPC and in the number of claims closed with payment by the Fund, we have included an explicit adjustment to recognize anticipated savings. Further discussion is included in the *Reduction in Claim Activity* section below. Our projections of ultimate loss have decreased by $199 million as compared to the prior projections, as shown in the following table:

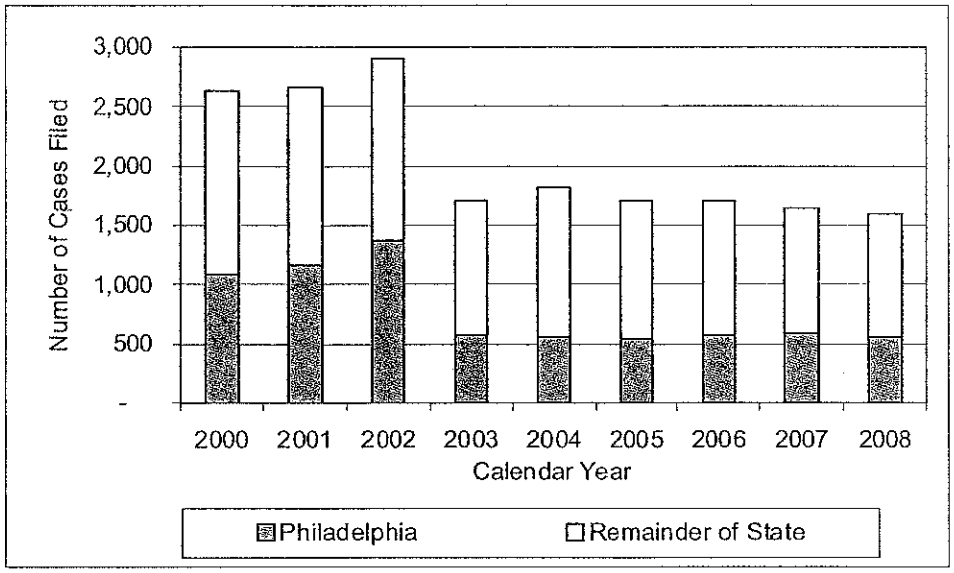
Accident Year	Current Selected Ultimate	Prior Selected Ultimate	Change in Selection
1976	47,128,077	47,222,232	(94,155)
1977	60,320,980	60,449,429	(128,449)
1978	86,890,327	87,011,307	(120,980)
1979	98,051,926	98,169,232	(117,306)
1980	136,361,778	136,531,058	(169,280)
1981	151,199,874	151,434,160	(234,285)
1982	174,254,900	174,516,685	(261,785)
1983	179,400,425	179,788,506	(388,081)
1984	167,599,191	167,961,194	(362,004)
1985	180,443,335	179,928,554	514,782
1986	173,019,221	172,247,716	771,505
1987	198,049,744	197,681,445	368,299
1988	218,436,866	218,278,924	157,942
1989	218,604,177	217,567,781	1,036,396
1990	258,408,404	259,602,625	(1,194,221)
1991	294,102,232	292,882,295	1,219,937
1992	273,144,824	275,880,876	(2,736,052)
1993	258,144,605	260,367,882	(2,223,278)
1994	296,385,862	297,313,018	(927,157)
1995	325,683,539	329,282,841	(3,599,303)
1996	317,443,232	320,171,201	(2,727,969)
1997	337,840,920	345,731,772	(7,890,853)
1998	287,220,819	288,282,806	(1,061,987)
1999	254,897,035	267,295,985	(12,398,950)
2000	259,870,076	276,766,987	(16,896,911)
2001	226,259,806	237,994,372	(11,734,566)
2002	192,665,171	213,633,819	(20,968,648)
2003	213,044,232	237,865,137	(24,820,905)
2004	235,499,991	260,309,650	(24,809,659)
2005	261,906,751	287,003,984	(25,097,233)
2006	244,181,434	267,437,257	(23,255,823)
2007	251,387,630	270,418,606	(19,030,976)
Total	6,877,847,382	7,077,029,336	(199,181,954)

Reduction in Claim Activity

Information collected by the Administrative Office of Pennsylvania Courts (AOPC) indicates that there has been a reduction in claims filed during 2003 through 2008 as compare to the pre-Act 13 years 2000 through 2002, with particular concentration in Philadelphia County. The average statewide decrease in cases filed is approximately 40%, with Philadelphia County experiencing an average decrease of over 50% and the remainder of the state (ROS) experiencing an average decrease of approximately 25%, as shown below:

Number of Cases Filed per Year

Based on Administrative Office of PA Courts (AOPC) Information



Where possible to do so, incentives to bring suit in Philadelphia versus other venues include a higher percentage of plaintiff's verdicts as well as a larger number of relatively high jury verdicts in Philadelphia County. According to statistics compiled by the AOPC, 32% of total verdicts in Philadelphia County were plaintiff verdicts for the period from July 2003 through December 2008; 14% of total verdicts in the remainder of the state were plaintiff verdicts for the same period. Of the plaintiff verdicts, Philadelphia County has a greater portion of large verdicts compared to the remainder of Pennsylvania. AOPC statistics indicate that 44% of medical malpractice plaintiff verdicts in Philadelphia County resulted in awards greater than $1 million, compared with 34% in the remainder of the state during the period July 2003 through December 2008. While several other counties have had large jury awards, the number of large jury verdicts is significantly higher in Philadelphia County than any other venue in Pennsylvania.

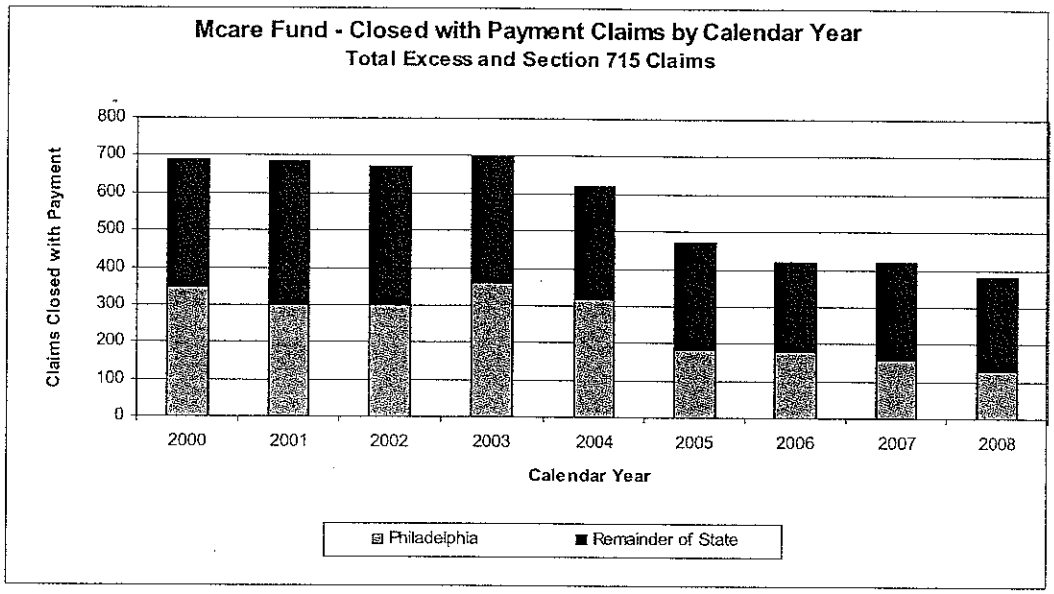
It is not entirely clear what is causing the decrease in claims activity for recent years, although possibilities include venue reform (Section 3 of Act 27 of 2002), certificate of merit procedures

(Rule of Civil Procedure 1042.3, 2003), and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number of case filings, with a particular concentration in Philadelphia County, is likely a combination of some cases that would have been brought in Philadelphia previously that are now being brought outside Philadelphia (as a result of venue reform) or not at all. The extent to which this reduction in the number of claims results in a reduction in the total costs to the Fund is uncertain for several reasons:

- The reduced number of cases may be a reduction in less meritorious cases, in which case a reduction in the number of cases may not lead to a commensurate decrease in costs, particularly in the excess layers of coverage provided by the Fund.
- Certain counties or areas may have a tendency for higher awards or settlements because those areas see the most complicated medical cases. To some extent, a higher average award or settlement may be indicative of a higher degree of alleged damage associated with more complicated medical cases. The movement of cases out of Philadelphia and into surrounding counties may simply increase the average award of the surrounding counties.
- As claims have moved to other counties, the process of disposing of those claims may have slowed. Fund payments for recent years have been approximately 20% to 35% lower than we have projected based on historical payment patterns. If this is partially due to a temporary slow-down in payment resulting from venue reform, any resulting savings may be offset, at least partially, by the inflationary impact of delaying the resolution of these claims.

Closed-with-Payment Fund claim statistics provide some corroboration of the information observed by the AOPC, allowing for a time delay between case filing and claim payment. Namely, the number of Fund claims closing with payment fell dramatically in 2005 through 2008 as compared to prior years. The average statewide decrease in claims closed with payment

is approximately 35%, with Philadelphia County experiencing an average decrease of nearly 50% and ROS experiencing an average decrease of approximately 25%, as shown below:



We believe the data compiled by the AOPC and recent Fund claims payment activity are indicative of savings to be realized by the Fund. Although the possibility exists, as cited above, that the reduced number of filings and apparent shift of claims away from Philadelphia may not result in a commensurate level of cost savings, we believe that the consistency and persistency of the change in claims activity warrants reflection in our estimates. To that end, we reviewed the Fund closed-with-payment activity, making adjustments to reflect the expected effect of changes in the Fund limits of coverage over time. Based on this review, as well as in consideration of the AOPC data and our prior projections, we included an "AOPC Credit" of 35% within our Philadelphia projections and 10% within our ROS projections.

Other Recent Legislative Provisions

Other elements of recent legislation are expected to have a less direct or less significant effect on the Fund's future payments, are more difficult to estimate, or lack sufficient information to actuarially quantify at this point in time, including but not necessarily limited to: Patient Safety initiatives (Chapter 3 of Act 13), Remittitur (Section 515 of Act 13), Statute of Repose (Section 513 of Act 13), Collateral Sources (Section 508 of Act 13), Payment of Damages / Reduction to Present Value (Sections 509/510 of Act 13), and the "180-day rule" and "continuing course of treatment" provision (Act 135) . Although not explicitly estimated herein, these other elements of recent legislation may also have an impact on the Fund's obligations. These provisions have generally been in place for a few years; to the extent paid loss or claim activity has been impacted, our projections implicitly reflect the impact of these provisions. That said, these provisions may subject to future challenge and interpretation by the courts, and therefore contribute additional uncertainty to the estimates contained herein.

Discounting

As summarized in Summary, Exhibit 1, the indicated post-Act 13 liability after discounting the Fund's liabilities at a 4% annual rate of interest is approximately $1.37 billion. Discounting is the process of recognizing the time value of money (i.e., investment income potential) since payment of the unfunded liability will take many years. The projected liability (including delay damages and post-judgment interest) at various discount rate assumptions is included below:

Discount Rate	Discounted Unfunded Liability
2%	$1.50 billion

Discount Rate	Discounted Unfunded Liability
3%	$1.43 billion
4%	$1.37 billion
5%	$1.32 billion

The attached exhibits employ a discount rate assumption of 4%; however, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. Since the Fund does not currently maintain assets in support of the liability, discounted estimates are for illustrative purposes only.

Calculation of 2009 Mcare Assessment Rate

The attached is the Executive Summary of a study by PricewaterhouseCoopers LLP that was the basis for setting the 2009 Mcare Assessment rate at 19 percent.

Tab 6

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

2009 YEAR ASSESSMENT CALCULATION
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

September 2008

EXECUTIVE SUMMARY

This section provides a synopsis of the key findings and recommendations contained in our study. The explanation of the calculations made in this report is contained in the ANALYSIS section.

2009 Assessment Rate

Exhibit 1 presents the indicated 2009 assessment rate of 19%. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2009 prevailing primary premium.

The Act requires an assessment that will, in the aggregate, produce an amount sufficient to do all of the following:

(i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.

(ii) Pay expenses of the fund incurred during the preceding claims period.

(iii) Pay principal and interest on moneys transferred into the fund.

(iv) Provide a reserve that shall be 10% of the sum of (i), (ii), and (iii) above.

These amounts are to be collected via the application of an assessment rate to the policy year 2009 prevailing primary premium. Hence the projection of 2009 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2009 payment obligations of the Fund and the 2009 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2005, 2006, and 2007 assessments as the basis for our estimate of the 2009 prevailing primary premium.

Since the 2009 assessment rate is based largely on the Fund's obligations for the 2008 claim year, any significant change in Fund's claim or expense obligations from 2008 to 2009 may result in a significant actual year-end 12/31/2009 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2009. To the extent the funds available in 2009 are insufficient to meet the Fund's 2009 obligations, additional funding or borrowing may be required.

Differences between projected 2009 prevailing primary premium and actual 2009 prevailing primary premium will result in a difference between projected and actual assessment revenue. This variable contributes additional uncertainty to degree to which the funds available to the Fund will be sufficient to meet its 2009 obligations.

ANALYSIS

2009 Assessment Rate

The Act outlines the four categories to be funded via the assessment. The aggregate assessment for 2009[5] must cover: claim settlements, operating expenses, principal and interest on moneys transferred to the Fund, and a target reserve amount. These costs are recouped by applying an appropriate assessment rate to the 2009 prevailing primary premium.

Claim Settlements

The largest component of the 2009 assessment is the amount of claim settlements for the Fund's 2008 claim year ending August 31, 2008. These claims are payable on or about December 31, 2008. The Fund expects that payments for the 2008 claim year will total approximately $173.9 million.

Fund Operating Expenses

Operating expenses paid of $11.8 million for claim year ending 08/31/2008 was provided by the Fund, which includes Fund overhead expenses and legal expenses largely associated with the defense costs of Section 715 claims.

Principal and Interest on Moneys Transferred

The Fund had no moneys outstanding during the claim year ending 08/31/2008, and does not currently expect to require borrowing to meet its 2008 obligations.

Target Reserve

The Act requires that the assessment calculation be adjusted to include a reserve amount equal to 10% of the above three items.

[5] We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2009.

Prevailing Primary Premium

The Fund provided unabated assessment and policy count data for policies effective in 2005, 2006 and 2007. Data was provided for each unique set of the following variables: primary policy type, product code, county code, and specialty code.

A general description of these variables follows:

Primary Policy Type

This field contains either CM (claims-made), OC (occurrence), or OP (occurrence-plus[6]). Assessment collections for tail policies are not expected to be material in the aggregate for policy year 2009. As such, our projections of policy year 2009 assessments exclude assessments collected in 2005, 2006 and 2007 arising from tail policies.

Product Code

This field provides general information regarding the nature of the exposure (e.g., hospital, nursing home, etc.). This field will include one of eight product codes, as follows:

- BC – birth center;
- HS – hospital;
- MC – professional corporation;
- MD – other doctor , resident, or fellow;
- MW – nurse midwife;
- NC – nursing home;

[6] This type of policy provides coverage on a claims-made basis, but includes a provision for pre-funding the tail payment.

- PC – primary health center; and
- SC – podiatrist.

County Code

The field indicates the rating county of the exposure.

Specialty Code

This field indicates the specialty code of the exposure. These codes are typically the JUA specialty codes, although ISO specialty codes are used for some health care providers.

The projected 2009 prevailing primary premium has been estimated by adjusting historical assessments for the changes in the underlying JUA class assignments, territory assignments, and rates. Namely, the 2005 assessments have been adjusted for changes effective 01/01/2006, 01/01/2007, 01/01/2008, and 01/01/2009. This calculation is included in its entirety under separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2006 assessments have been adjusted for changes effective 01/01/2007, 01/01/2008, and 01/01/2009. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2007 assessments have been adjusted for changes effective 01/01/2008 and 01/01/2009. This calculation is included in its entirety under separate cover in Appendix C. An excerpt of this calculation is attached as Excerpt C.

The relevant changes effective 01/01/2006, 01/01/2007, 01/01/2008, and 01/01/2009 are as follows:

Changes Effective 01/01/2006

Note that the changes effective 01/01/2006 discussed below apply only to the calculation based on the 2005 assessment (Appendices A / Excerpts A). The 2006 and 2007 assessments implicitly reflect these changes and do not require modification for changes effective 01/01/2006.

Base Rate Change

The JUA decreased its base rates 1.9% for institutional healthcare providers and increased its base rates 1.8% for non-institutional healthcare providers.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
010	-10.0%
012	+5.3%
020	-11.2%
030	-10.0%
035	-10.0%
060	-10.0%
090	-9.2%
130	+5.0%
900	+5.0%

County / Territory Changes

Changes resulting from modifications to the mapping of county to rating territory and of territorial relativities are as follows:

Non-Institutional Changes		
County (County Code)	Change	Impact
Bucks (09), Lackwanna (35), Montgomery (46)	change Territory 4 rel.	-5.6%
Delaware (23)	move from T1 to T5 change Territory 5 rel.	-5.0%
Armstrong (03), Jefferson (33)	move from T2 to T3	+9.1%
Chester (15), Monroe (45)	move from T5 to T4, offsets Terr 5 rel chg	+0.0%
Fayette (26), Lawrence (37)	move from T3 to T6	+8.3%
All Other	no change	+0.0%

Specialty Changes

The specialty changes implemented include those that simply clarified the class plan. One exception to this is for specialty 01222 (Radiology - No Surgery), which was modified to become specialty 01253 (Radiology excluding Deep Radiation – No Surgery). A new specialty was created, 02053 (Radiology including Deep Radiation – No Surgery). Based on available Fund data, we assumed that all health care providers in specialty 01222 will stay in their current class 012.

Changes Effective 01/01/2007

The JUA increased its base rates 7.7% for institutional healthcare providers and increased its base rates 11.8% for non-institutional healthcare providers.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
007	+5.1%
012	+10.0%
050	-10.0%
060	-5.0%
090	-5.0%
100	+10.0%
130	-15.0%
900	+5.0%

County / Territory Changes

Changes resulting from modifications to the mapping of county to rating territory and of territorial relativities are as follows:

Non-Institutional Changes		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	change Terr 3 rel.	-8.3%
Bucks (09), Chester (15), Montgomery (46)	change Terr 4 rel.	-5.9%
Fayette (26)	move from T6 to T4	+23.1%
Lackawanna (35), Monroe (45)	move from T4 to T6	-23.5%
Delaware (23)	no change Terr 5	0.0%
All Other	change Terr 2 rel.	-9.1%

Specialty Changes

Specialty changes that resulted in a class change are listed below. Note that the impact is relative to the 2007 rates for Territory 1. The impact includes the impact of any class changes filed, but excludes any filed changes to territory relativities.

Specialty Code	Specialty	Change	Impact
00644	Pulmonary – No Surgery	move to 01044	+50.0%
01043	Oncology – No Surgery	move to 00743	+34.3%
01215	Pathology – No Surgery	move to 00715	-27.5%
01544	Pulmonary Medicine – No Surgery except Bronchoscopy	move to 02069	+36.8%
02283	Anesthesiology – Other than Pain Management only – excluding Major Surgery	move to 02083	-21.8%

In addition, there was a change to the corporation rating factor in 2007. A "corporation" includes professional corporations, professional associations or partnerships which are entirely owned by health care providers. The corporation rating factor changed from 10% to 15% of the total unabated Mcare assessments for each shareholder, owner, partner and employed health care provider.

Changes Effective 01/01/2008

The JUA increased its base rates 5.4% for institutional healthcare providers and increased its base rates 12.8% for non-institutional healthcare providers.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	-11.1%
012	+4.5%
020	-1.3%
022	+2.9%
030	-2.2%
035	-3.0%
060	-2.0%
070	-1.9%
080	-1.7%
100	+5.0%
130	-15.0%
900	+5.0%

County / Territory Changes

Changes resulting from modifications to the mapping of county to rating territory and of territorial relativities are as follows:

Non-Institutional Changes		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	change Terr 3 rel.	-8.0%
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-8.0%
Delaware (23)	change Terr 5 rel.	-8.0%

Non-Institutional Changes		
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)	change Terr 6 rel.	-8.0%
All Other	change Terr 2 rel.	-8.0%

Specialty Changes

There were no specialty rate relativity changes in the 2008 filing. The following rule change affects 2008 class coding. Specialty 01559 (Radiation Oncology – including Deep Radiation – No Surgery) was created. Prior to 2008, radiation oncologists who did not perform surgery were coded in specialty 01059 (Radiation Oncology – No Surgery), although additional assessments may have been applied for the practice of deep radiation. Specialty 01059 was renamed (Radiation Oncology – Excluding Deep Radiation – No Surgery). Based on a review of the Fund data—which includes a field to indicate whether the health care provider practices deep radiation—we determined that relatively few non-surgeon radiation oncologists performed deep radiation. Therefore, we assumed all specialists coded 01059 in 2007 remain coded 01059 in our 2008 projection.

Changes Effective 01/01/2009

The JUA decreased its base rates 4.4% for institutional healthcare providers and increased its base rates 1.2% for non-institutional healthcare providers.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	+4.7%
007	+5.0%
010	+4.4%
012	+10.0%
020	-1.9%
022	-2.8%
030	-5.0%
035	-3.4%
050	-5.0%
060	-5.0%
070	-5.0%
080	-5.0%
090	-5.0%
100	+5.0%
900	+5.0%

County / Territory Changes

Changes resulting from modifications to the mapping of county to rating territory and of territorial relativities are as follows:

Non-Institutional Changes		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	change Terr 3 rel.	-5.1%

Non-Institutional Changes		
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-8.0%
Delaware (23)	change Terr 5 rel.	-8.0%
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)	no change Terr 6 rel.	0.0%
All Other	change Terr 2 rel.	-8.0%

Specialty Changes

Specialty changes that resulted in a class change are listed below. Note that the impact is relative to the 2008 rates for Territory 1. The impact includes the impact of any class changes filed, but excludes any filed changes to territory relativities.

Specialty Code	Specialty	Change	Impact
01044	Pulmonary Medicine – No Surgery	move to 01144	+10.0%
01282	Anesthesiology – Pain Management Only – No Surgery	move to 01582	-13.0%
03545	Urological Surgery	move to 03045	-22.8%

In addition, the following rule change affects 2009 class coding. Specialty 01199 (Physicians Not Otherwise Classified – No Surgery (NOC)) was created.

Results

The indications for the 2009 prevailing primary premium are $1.058 billion based on 2005 remittances, $1.104 billion based on 2006 remittances, and $1.096 billion based on 2007

remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2005), Excerpt B (2006), and Excerpt C (2007). The entire calculation is included under separate cover as Appendix A, Appendix B, and Appendix C, respectively. Based on these indications, we have projected a 2009 prevailing primary premium of $1.090 billion.

Note, however, that this projection may vary from the actual 2009 prevailing primary premium due to numerous factors including, but not limited to:

- Possible changes in the relative size of Pennsylvania's health care industry during 2008 and 2009;
- shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2008 and 2009; and
- changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2008 and 2009.
- additional recording of data, notably for 2007, where policy adjustments and late reported assessments will cause the assessment data to change. Historically, assessments increase roughly 1% to 2% beyond the last quarter of the subsequent year.

Note that an abatement program has not yet been extended to 2008 or 2009. It is not clear at this time what impact, if any, assessment abatements have on the size, mix, and average effective date of the provider population, and in turn, the prevailing primary premium. This subjects the prevailing primary premium estimate for 2009 to additional uncertainty.

Act 13 also instituted other changes that may impact the prevailing primary premium, including the provisions of Section 712(g), which allow the Fund to increase the prevailing primary premium of a health care providers based on the health care provider's Fund claims experience. The Fund has previously implemented experience rating of hospitals, but adjusted the prevailing primary premium of non-hospitals for the first time during 2007. Based on our discussions with

the Fund, we understand that the non-hospital experience rating adjustments were applied to a relatively limited number of health care providers in 2007 and 2008, and are expected to be applied similarly in 2009. We have not attempted to measure the impact of this program at this time.

2009 Assessment Rate

The cost components of the assessment total $204.2 million. Given the 2009 prevailing primary premium projection of $1.090 billion, the indicated 2009 assessment rate is 19%.

Since the 2009 assessment rate is based largely on the Fund's obligations for the 2008 claim year, any significant change in Fund's claim or expense obligations from 2008 to 2009 may result in a significant actual year-end 12/31/2009 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2009 and the degree to which 2009 assessments are abated. To the extent that funds available in 2009 are insufficient to meet the Fund's 2009 obligations, additional funding or borrowing will be required.

Change from Prior

The indicated 2009 assessment rate of 19% is lower than the 2008 assessment rate of 20%. The decrease in the assessment rate is the net result of two underlying changes: the change in the assessment costs and the change in the projected prevailing primary premium. The 2008 assessment costs of $204.2 million (discussed above) have decreased approximately 10% from the 2007 assessment costs of $226.5 million, driven predominantly by a 9% decrease in claims paid by the Fund during the claim year. The projected policy year 2009 projected prevailing primary premium of $1.090 billion has decreased by 3% from the 2008 projected prevailing primary premium of $1.120 billion, driven by the changes to the JUA rates described above. The 2008 and 2009 assessment rate calculations are summarized below.

		2009	2008
(1)	Prior Claim Year Claims Settled	173,892,874	191,365,811
(2)	Prior Claim Year Operating Expenses	11,764,894	14,571,029
(3)	Target Reserve	18,565,777	20,593,684
(4)	Assessment Costs, (1)+(2)+(3)	204,223,545	226,530,524
(5)	Projected Prevailing Primary Premium	1,090,000,000	1,120,000,000
(6)	Indicated Assessment Rate, (4) / (5)	**19%**	**20%**

EXHIBITS

Pennsylvania Medical Care Availability and Reduction of Error Fund

Indicated 2009 Assessment Rate

(1)	Claim Year Ending 08/31/2008 Claims Settled	173,892,874
(2)	Claim Year Ending 08/31/2008 Operating Expenses	11,764,894
(3a)	Claim Year Ending 08/31/2008 Principal and Interest Paid or Payable	-
(3b)	Claim Year Ending 08/31/2008 Borrowing Transfers	-
(4)	Target Reserve	18,565,777
(5)	2008 Assessment Costs (5) = (1)+(2)+(3a)+(3b)+(4)	204,223,545
(6)	Projected Policy Year 2009 Prevailing Primary Premium	1,090,000,000
(7)	Indicated 2009 Assessment Rate (7) = (5) / (6)	**19%**

Notes:

(1) Provided by Fund.
(2) Provided by Fund.
(3a) Provided by Fund, including principal and interest paid or payable for moneys transferred.
(3b) Provided by Fund, including transfers outstanding or received during the claim year.
(4) 10% of (1) through (3), per Section 712(d)(1)(iv) of Act 13 of 2002.
(6) Exhibit 2.

Pennsylvania Medical Care Availability and Reduction of Error Fund

Projected 2009 Prevailing Primary Premium

(1) Projection Based on 2005 Assessment Remittances	1,057,790,718
(2) Projection Based on 2006 Assessment Remittances	1,104,402,712
(3) Projection Based on 2007 Assessment Remittances	1,096,388,336
(4) Projected 2009 Prevailing Primary Premium	1,090,000,000

Notes

(1) Appendix A, last page (or last page of Excerpt A).
(2) Appendix B, last page (or last page of Excerpt B).
(3) Appendix C, last page (or last page of Excerpt C).
(4) Based on the indications of (1) through (3).

Calculation and Application of 2009 Hospital Experience Modification Factors

Hospital experience rating by the Mcare Fund is required under section 712(g)(4) of Act 13 of 2002. Hospital experience rating involves increasing or decreasing the Mcare assessments applicable to each hospital to reflect differences in claims experience. The factors to be used in determining experience rating are as follows:

> "Any adjustment shall be based on the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent claims period."

By statute, the modification factors may result in no more than a 20 percent upward or downward adjustment to the assessment otherwise applicable to a hospital, and the hospital experience rating adjustments in each calendar year must be "revenue neutral" in aggregate.

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

2009 EXPERIENCE MODIFICATION FACTORS
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

December 2008

EXECUTIVE SUMMARY

This section provides a synopsis of the key findings contained in our study. The explanation of the calculations made in this report is contained in the ANALYSIS section.

Spread of Experience Modification Factors

The 211 experience modification factors as calculated in Exhibit 1 fall into the following ranges:

Distribution		
From	To	Count
	80.0%	0
80.0%	85.0%	96
85.0%	90.0%	42
90.0%	95.0%	25
95.0%	100.0%	12
100.0%	105.0%	11
105.0%	110.0%	5
110.0%	115.0%	4
115.0%	120.0%	3
120.0%		13
Total All Rated Hospitals		211

Revenue Impact

The 211 experience modification factors are expected to be revenue neutral to the Fund in total. Namely, the factors are determined such that they are revenue neutral when applied to the 2007 baseline assessments. When applied to the 2008 baseline assessments, many of which are estimates, the 2008 modified assessment is approximately 0.2% lower than the 2008 baseline assessment. As such, we do not expect a significant revenue impact when these factors are applied in 2009.

Comparison to 2008 Experience Modification Factors

Of the 211 experience modification factors computed herein, four are for hospitals that have been rated for the first time. Of the remaining 207 modification factors, 165 are within 5% and 182 are within 7.5% of the 2008 filed experience modification factors. Of the 196 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 161 are within 5% and 176 are within 7.5% of their 2008 filed experience modification factors.

Of the 42 experience modification factor changes greater than 5%, seven arise from those hospitals whose band assignments have changed from last year. Similarly, of the 25 experience modification factor changes greater than 7.5%, five arise from hospitals whose band assignment has changed from last year. As mentioned above, steps were taken to ensure that unwarranted changes in the band assignment did not occur. However, some fluctuation in band assignment is normally expected to occur for hospitals lying near the endpoints of a given band's range and for hospitals that have merged.

ANALYSIS

Methodology

The calculation of the Experience Modification Factors included in Exhibit 1 can be broken into a series of several steps as follows:

1) Compiling the Fund payment data for each hospital for each claim year 2004 through 2007;
2) Estimating and compiling the baseline assessments for each hospital for each policy year 2005 through 2008;
3) Calculating a rate of recoupment[7] for each hospital for each year and for each hospital band for each year;
4) Calculating the four relative rates of recoupment for each hospital showing the ratio of the hospital rate of recoupment to the total hospital rate of recoupment for each year and weighting these four relative rates of recoupment together to estimate an average relative rate of recoupment (weighted rate) for the individual hospital;
5) Determining appropriate *a priori* modification factors;
6) Determining an appropriate credibility weighting procedure and credibility weighting the hospital weighted rate with its band's *a priori* modification factor; and
7) Computing experience modification factors that lie within the bounds prescribed by Act 13 and that are revenue neutral.

Each of these steps is described below.

Compiling Fund Payment Data (Exhibits 5 and 9)

The Fund provided payment data by hospital by claim year for Excess and Section 605 claims.

[7] The rate of recoupment is defined as the ratio of one claim year's Fund payments to the subsequent policy year's baseline assessments.

As mentioned previously, combined data was used in our analysis in order to fully reflect the *"frequency and severity of claims paid by the Fund"*. The total payment data (included as Exhibit 9) is sorted by hospital by claim year as shown in Exhibit 5.

Compiling Policy Year Assessment Data (Exhibits 4 and 8)

The Fund provided information by hospital and type of policy (occurrence, claims-made plus, claims-made, or tail). Policy year non-tail assessment data for 2005 through 2008 is employed in this analysis. In Exhibit 8, an adjustment is made to the assessments provided by the Fund in order to derive the baseline assessment that is used in the experience modification computation. Namely, the assessments are adjusted to remove the impact of the charged experience modification factors. This adjustment is required because the experience modification factor is applied to the unmodified assessment; as such, it is necessary to compute each hospital's experience relative to its historical unmodified assessment.

This baseline assessment data is then sorted on Exhibit 4 by hospital by policy year for policy years 2005 through 2008[8]. For policy year 2008, information was provided by the Fund for those hospitals who have remitted their 2008 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2008 assessment, the 2008 baseline assessment is estimated as the average of the 2006 and 2007 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes.

Calculating Yearly Rates of Recoupment (Exhibit 3)

The Fund operates on a recoupment basis. Namely, one policy year's assessment is meant to

[8] Note that tail assessments are also removed.

recoup the prior claim year's payments, operating expenses, and other costs. As such, there is an expected relationship between a given claim year's payments and the *subsequent* policy year's assessments.

We have interpreted the Act 13 provision that the experience modification factors be "*based on the ... past five most recent claims periods*" to include claim years ending 2004 through 2008. However, given the expected relationship between a claim year's payments and the *subsequent* policy year's assessments, use of the claim year ending 2008 data would require estimation of each individual hospital's 2009 assessment. We did not feel that it would be appropriate to estimate the 2009 assessments for each of the 211 rated hospitals, especially in light of the estimation required for the 2008 assessments. As such, the expected 2008/2009 rate of recoupment is not included in the statistics of Exhibits 1 through 5. However, as shown on Exhibit 6, we have reviewed the expected 2008/2009 experience when selecting the *a priori* experience modification factors (described below) for each band, assuming that the relative differences between the 2008 and 2009 assessments will be equal for each band.

Rates of recoupment are established as the ratio of the Fund payment data for each claim year (ending 2004 through 2007) to the baseline policy year assessment data for the subsequent policy year (2005 through 2008). The band rates of recoupment are calculated as the ratio of the sum of the Fund payments for each claim year to the sum of the baseline policy year assessments for the subsequent policy year for each hospital within the band.

Calculating the Weighted Average Relative Rate of Recoupment (Exhibit 2)

A hospital's yearly experience is measured relative to the overall hospital experience for that particular year. This "relative rate of recoupment" provides a measure as to whether the

particular hospital is "better" or "worse" than average for the particular year. These four measures are weighted together to provide a weighted average relative rate of recoupment or "weighted rate" (WR). We have judgmentally chosen weights of 20/25/25/30 for 2004/2005 through 2007/2008, respectively, in order to give slightly more weight to the experience of more recent years as shown in Exhibit 2.

Determining A Priori Modification Factors (Exhibit 6)

A review of several statistics by band indicates that relative rates of recoupment and relative frequencies tend to increase as the band increases. In addition, the projected 2008/2009 relative rate of recoupment by band also tends to increase with the "size" of the band. Since an individual hospital's experience is not fully credible, we have calculated experience modification factors that are a combination of the individual hospital experience and the band experience.

In combining these components, we have attempted to balance actuarial and practical considerations in a Plan that meets the aforementioned requirements of Act 13. A primary consideration is the degree of credibility that is associated with the apparent differences in experience by band. In Exhibit 6.2, the relative recoupment rate by band is shown by year and for the four-year average. In Exhibit 6.3, the relative frequency by band is similarly displayed. Exhibit 6.4 contains the details of the actuarial methodology we have employed in an attempt to measure the credibility associated with a given year's band indicated relativity to the "average"; the method employs the relationship of the dispersion of relativities within each band and the dispersion of relativities between the bands to determine the credibility of the band experience.

Exhibit 6.1 summarizes the band indications. Our selected band a priori 2008/2009 modification factor is based on a review of the various indications. As was the case in prior years, we have

kept our selected relativities in a tighter range than would otherwise be indicated for a number of reasons. The large number of observations for some bands may cause the calculated credibility to be higher than the "true" credibility. Furthermore, the Plan should produce relatively stable results from year-to-year in addition to being responsive to changes in the underlying experience. Since experience from one year to the next may vary, too much emphasis on the raw indications may tend to emphasize responsiveness at the sacrifice of stability. Lastly, since Act 13 requires final modification factors not to exceed +/-20%, we have selected a priori modification factors within this range.

The selected a priori modification factors, and those selected in the prior year, are summarized in the table below:

Band	Current A Priori Factors	Prior A Priori Factors
Band 1	-17.5%	-17.5%
Band 2	-12.5%	-12.5%
Band 3	-5.0%	-7.5%
Band 4	0.0%	0.0%
Band 5	12.5%	12.5%

Determining an Individual Hospital Credibility Weighting Procedure (Exhibit 7)

Actuarial Standard of Practice No. 25 states, "Credibility procedures should be used in … prospective experience rating," and that, "the actuary should select credibility procedures that do the following:

a. produce results that are reasonable in the professional judgment of the actuary,

b. do not tend to bias the results in any material way,

c. are practical to implement, and

d. give consideration to the need to balance responsiveness and stability."

We have used a traditional credibility formula of the form:

$$\text{credibility} = Z = P / (P + K)$$

P is typically some measure of the exposure represented by the risk. To establish a credibility procedure sensitive to the *"class, size, risk, and kind"* of each hospital, we have chosen P equal to the hospitals' 2007 policy year prevailing primary premiums, adjusted for the JUA's 2008 rate change. To calculate P, we divided the Fund's 2007 baseline policy year assessment by the Fund's 2007 assessment rate of 23.0%. We then adjusted the total to reflect the JUA's filed rate change of +5.4% for policy year 2008. Policy periods were annualized where we observed that the 2007 policy year data did not represent an annual policy term.

We have employed a least-squares approach to assess the predictive value of individual hospital historical rates of recoupment. Namely, for each band, we determined the K value that minimized the weighted sum squared error for each of four available projection possibilities, as follows:

1) 2004/2005, 2005/2006, and 2006/2007 to predict 2007/2008
2) 2004/2005, 2005/2006, and 2007/2008 to predict 2006/2007
3) 2004/2005, 2006/2007, and 2007/2008 to predict 2005/2006
4) 2005/2006, 2006/2007, and 2007/2008 to predict 2004/2005

The results of these analyses are shown in Exhibit 7. The indications vary, but do support credibility at the individual hospital level, particularly for hospitals in Band 2 through Band 5. Since we expect that the predictive value of the data be relatively stable over time, we have selected K's that we believe are consistent with current and prior indications, and assign credibility to an average sized hospital in each band similar to the credibility that an average sized hospital in the same band received last year. The table below summarizes changes from

the prior calculation to the selected K and to the implied average Z, the credibility of an average sized hospital in each band.

	Current Calculations		Prior Calculations	
Band	Selected K	Implied Avg Z	Selected K	Implied Avg Z
Band 1	40,000,000	0.4%	30,000,000	0.5%
Band 2	30,000,000	1.9%	20,000,000	2.7%
Band 3	10,000,000	9.8%	10,000,000	9.2%
Band 4	8,000,000	21.0%	8,000,000	20.3%
Band 5	7,000,000	43.3%	7,000,000	41.8%

As shown above, the average credibility is generally similar to that of last year. Individual hospital experience is generally given limited credibility: the average Band 1 hospital receives 0.4% credibility and the average Band 5 hospital receives 43.3% credibility.

The "credible modifier" for a given hospital is calculated as the credibility weighted average of the hospital indicated modifier and its band's a priori modification factor.

Computing Experience Modification Factors (Exhibit 1)

To achieve a revenue neutral impact on 2009 assessments, we estimated modification factors that are revenue neutral based on the 2007 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2009 assessments[9]. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance[10] adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

[9] As a test, we applied the modification factors to the 2008 baseline policy year assessments, approximately 22% of which are estimates. The resulting modified assessments were approximately revenue neutral.
[10] The adjustment is required to achieve a revenue neutral impact.

2009 Mcare Paid Claims by Region

Eastern			Central			Western			Other
County			County			County			
Bucks	Lehigh	Philadelphia	Adams	Lancaster	Tioga	Allegheny	Elk	Potter	Includes all other states and the United States District Courts where an Mcare defendant was involved.
Chester	Montgomery		Berks	Lebanon	Union	Armstrong	Erie	Somerset	
Delaware	Northampton		Bradford	Luzerne	Wayne	Beaver	Fayette	Venango	
			Carbon	Lycoming	Wyoming	Bedford	Forest	Warren	
			Centre	Mifflin	York	Blair	Greene	Washington	
			Clinton	Monroe		Butler	Indiana	Westmoreland	
			Columbia	Montour		Cambria	Jefferson		
			Cumberland	Northumberland		Cameron	Lawrence		
			Dauphin	Perry		Clarion	McKean		
			Franklin	Pike		Clearfield	Mercer		
			Fulton	Schuylkill		Crawford			
			Huntingdon	Snyder					
			Juniata	Sullivan					
			Lackawanna	Susquehanna					
Region Paid Claims		$99,000,482			$38,467,073			$36,201,648	$ 4,567,707
Percent of Region to Total Paid Claims		55.54%			21.58%			20.31%	2.56%

Total Paid Claims:	**$178,236,910**

PA Department of Insurance

Office of Mcare

Claim and Case Payment - 5 Most Recent Years

Year	Fund Money	**Claim** Count	Average **Claim Value**	**Case** Count	Average **Case Value**
2005	$ 232,588,740	471	$ 493,819	373	$ 623,562
2006	$ 209,522,349	423	$ 495,325	322	$ 650,691
2007	$ 191,365,811	422	$ 453,473	308	$ 621,318
2008	$ 173,892,874	377	$ 461,254	279	$ 623,272
2009	$ 178,236,910	396	$ 450,093	292	$ 610,400

Note: One "case" houses 1 to many "claims"

Summary of Annual Fund Claim Payments by Health Care Provider Group

2000-2009

	Individuals				Medical Corps				Institutions				Totals	
	MD's, DO's, Podiatrists Certified Nurse Midwives								Hospitals, Nursing Homes Birth Center, Primary Care Centers					
Year	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
2000	550	79%	$ 256,516,538	75%	30	4%	$ 16,681,399	5%	119	17%	$ 68,146,290	20%	699	$ 341,344,227
2001	529	76%	$ 237,838,807	74%	26	4%	$ 17,586,312	5%	137	20%	$ 66,244,013	21%	692	$ 321,669,132
2002	496	74%	$ 242,058,227	70%	21	3%	$ 15,287,490	4%	157	23%	$ 90,702,013	26%	674	$ 348,047,730
2003	495	71%	$ 261,412,315	69%	33	5%	$ 21,352,127	6%	173	25%	$ 95,956,330	25%	701	$ 378,720,772
2004	450	73%	$ 235,414,423	73%	18	3%	$ 10,448,473	3%	152	25%	$ 74,476,793	23%	620	$ 320,339,689
2005	337	72%	$ 171,099,732	74%	20	4%	$ 10,068,307	4%	114	24%	$ 51,420,701	22%	471	$ 232,588,740
2006	304	72%	$ 151,833,293	72%	26	6%	$ 14,186,262	7%	92	22%	$ 43,502,794	21%	422	$ 209,522,349
2007	273	65%	$ 123,762,853	65%	25	6%	$ 12,560,972	7%	124	29%	$ 55,041,986	29%	422	$ 191,365,811
2008	256	68%	$ 116,967,358	67%	16	4%	$ 8,165,387	5%	105	28%	$ 48,760,129	28%	377	$ 173,892,874
2009	285	72%	$ 127,713,538	72%	14	4%	$ 9,012,513	5%	97	24%	$ 41,510,859	23%	396	$ 178,236,910

Office of Mcare

2009 Claims Payment by Commercial Carrier and Self-Insurer

Company Code	Total Fund Payments
S01	$ 700,000
S10	$ 2,500,000
S11	$ 750,000
S12	$ 700,000
S36	$ 750,000
S53	$ 1,200,000
003	$ 20,094,627
011	$ 5,340,251
031	$ 17,861,959
032	$ 5,600,000
045	$ 100,000
067	$ 13,458,485
086	$ 4,340,859
093	$ 4,025,000
119	$ 675,000
121	$ 2,147,661
126	$ 1,800,000
129	$ 5,250,000
135	$ 3,630,987
136	$ 4,797,784
143	$ 1,425,000
144	$ 11,875,000
145	$ 1,792,500
155	$ 14,544,463
156	$ 6,120,000
159	$ 25,000
160	$ 500,000
161	$ 1,555,000
162	$ 700,000
167	$ 150,000
183	$ 500,000
184	$ 1,500,000
194	$ 550,000
196	$ 1,500,000
197	$ 2,699,000
199	$ 2,950,000
201	$ 300,000
202	$ 4,200,000
203	$ 200,000
207	$ 14,675,834
211	$ 1,512,500

Office of Mcare

2009 Claims Payment by Commercial Carrier and Self-Insurer

Company Code	Total Fund Payments	
220	$	1,125,000
221	$	3,500,000
224	$	650,000
228	$	2,250,000
229	$	300,000
239	$	500,000
241	$	550,000
245	$	500,000
246	$	1,255,000
248	$	160,000
251	$	200,000
253	$	2,000,000
258	$	250,000
Totals	$	178,236,910

Office of Mcare

2009 Assessment Remitted by Commercial Carrier

Company Code	Amount [1]	
001	$	17,490
003	$	14,482,148
011	$	2,515,152
021	$	82,229
023	$	46,343
031	$	21,578,558
032	$	1,622,998
052	$	178,918
067	$	15,469,888
090	$	116,684
103	$	438,085
110	$	34,764
112	$	206,992
118	$	7,157
121	$	652,832
124	$	889,203
127	$	276,683
129	$	1,341,333
137	$	104,047
138	$	600,673
139	$	56,086
144	$	16,760,526
145	$	4,084,919
155	$	14,783,611
156	$	10,289,997
162	$	36,309
186	$	105,393
191	$	13,879
194	$	21,954
196	$	1,189,043
197	$	4,921,584
00198	$	6,218
00199	$	4,555,666
202	$	7,851,162
203	$	1,310,027
206	$	56,414
207	$	19,083,477
208	$	1,645,410

Office of Mcare

2009 Assessment Remitted by Commercial Carrier

Company Code	Amount [1]	
210	$	378,847
211	$	6,916,091
212	$	185,731
216	$	7,039
217	$	387,189
218	$	258,318
219	$	4,347,650
220	$	2,076,781
221	$	4,153,740
222	$	3,301,094
223	$	3,419,675
224	$	1,719,791
225	$	47,223
226	$	82,373
227	$	3,338
228	$	1,566,570
229	$	2,324
230	$	20,715
232	$	46,391
233	$	617
234	$	224,356
235	$	73,644
236	$	77,890
237	$	38,920
239	$	2,410,628
241	$	930,344
242	$	37,341
243	$	26,893
244	$	88,945
245	$	5,056,872
246	$	2,234,539
247	$	20,491
248	$	291,672
249	$	2,676
250	$	552,458
251	$	73,792
252	$	77,550
253	$	4,015,184

Office of Mcare

2009 Assessment Remitted by Commercial Carrier

Company Code	Amount [1]	
257	$	69,671
258	$	2,108,458
261	$	1,260,943
262	$	27,620
263	$	3,080
265	$	16,298
266	$	22,912
267	$	403
268	$	5,204
271	$	1,619,916
274	$	164,519
275	$	426,494
276	$	536,852
279	$	216,826
281	$	949
282	$	96,641
285	$	273,106
286	$	20,081
290	$	104,005
292	$	35,078
293	$	45,470
294	$	2,944
297	$	33,500
298	$	5,495
900	$	6,278
Total	$	199,692,287

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 7, 2010.

Office of Mcare

2009 Assessment Remitted by Self-Insurer

Company Code	Amount [1]	
S10	$	4,365,928
S12	$	1,441,730
S40	$	398,985
S41	$	84,109
S43	$	265,791
S46	$	11,331
S49	$	654,995
S51	$	304,876
S53	$	190,741
S54	$	341,393
S57	$	49,877
S58	$	13,637
S59	$	22,223
S60	$	441,628
S61	$	11,367
S63	$	249,604
S64	$	15,095
S66	$	467,498
Total	$	9,330,808

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 7, 2010.