



March 1, 2012

Honorable Donald C. White, Chair
Banking and Insurance Committee
Senate of Pennsylvania
286 Main Capitol
Harrisburg, PA 17120

Honorable Michael J. Stack, Minority Chair
Banking and Insurance Committee
Senate of Pennsylvania
543 Main Capitol
Harrisburg, PA 17120

Honorable Nicholas A. Micozzie, Chair
Insurance Committee
Pennsylvania House of Representatives
105 Ryan Office Building
Harrisburg, PA 17120

Honorable Anthony M. DeLuca, Minority Chair
Insurance Committee
Pennsylvania House of Representatives
115 Irvis Office Building
Harrisburg, PA 17120

Dear Senators and Representatives:

Enclosed please find the Office of Mcare's Annual Report of Operations for 2011. This report was prepared pursuant to the Medical Care Availability and Reduction of Error Act, Act 13 of 2002, 40 P.S. § 1303.743. Among the many tabs, the report includes data regarding the total amount of claims paid and expenses incurred from 2002 through December 31, 2011.

In addition to a hardcopy of the 2011 Annual Report of Operation, enclosed please find a CD-Rom loaded with the 2011 Medical Malpractice Data Call report generated from data submitted by medical malpractice insurance carriers and self-insured health care providers, requirements set forth in the aforementioned section.

If you have any questions about these reports, please feel free to contact me, Deputy Insurance Commissioner for Mcare Joe DiMemmo, or Legislative Director Kari Kissinger at 717-783-3501.

Sincerely,

A handwritten signature in blue ink that reads "Michael Consedine". The signature is fluid and cursive, written in a professional style.

Michael F. Consedine
Insurance Commissioner

Enclosures

Act 13 of 2002

Medical Care Availability and Reduction of Error Fund

Michael F. Consedine
Insurance Commissioner
Department of Insurance

Annual Report of Operations 2011

Mission Statement

The Medical Care Availability and Reduction of Error Fund (“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.

Office of Mcare

2011 Annual Report of Operations

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About Mcare

The Medical Care Availability and Reduction of Error Fund (“Mcare”) 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.

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. 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 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
visit our website at
www.insurance.pa.gov

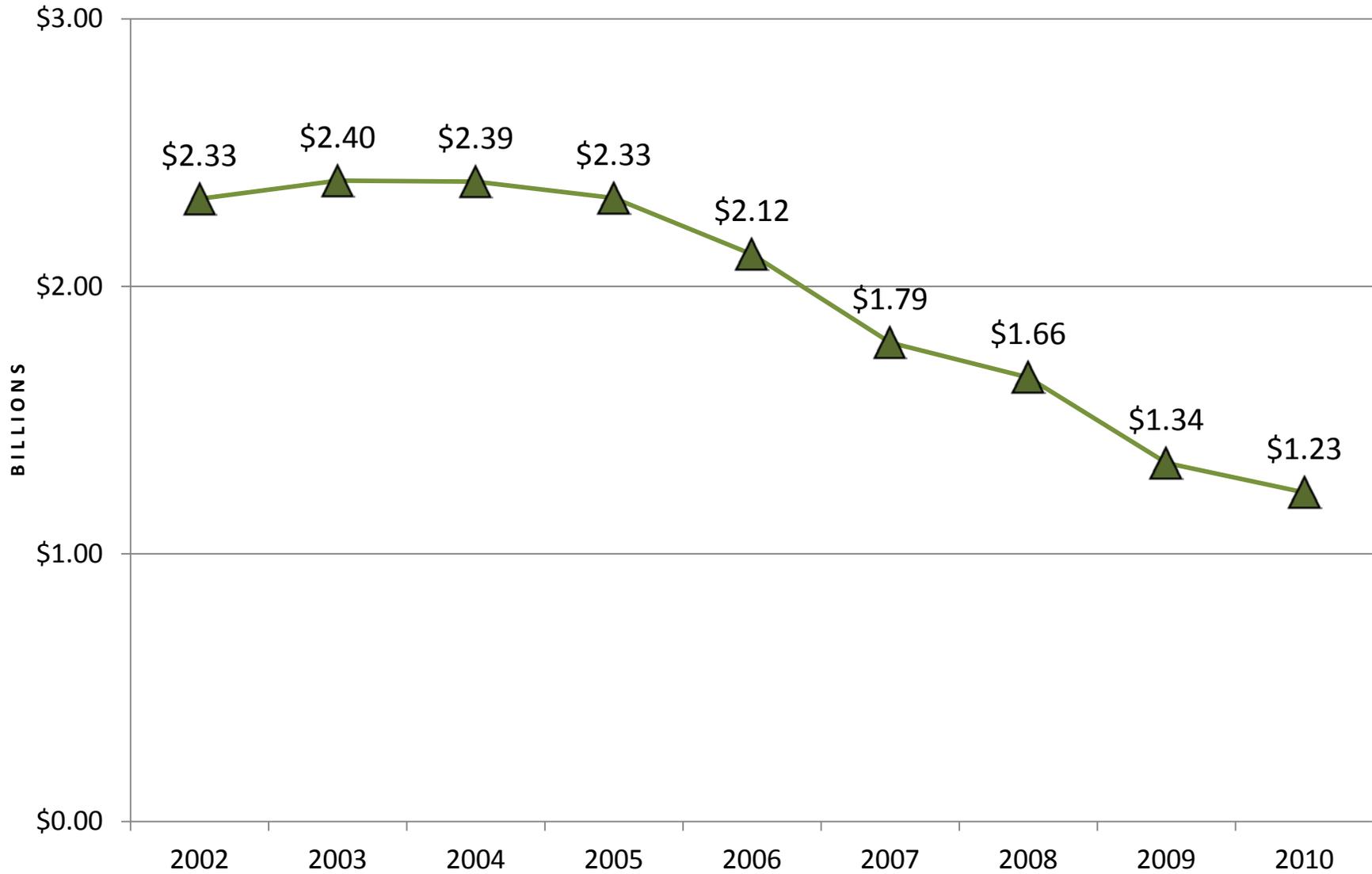
MEDICAL CARE AVAILABILITY AND REDUCTION OF EFFOR FUND
CASH BASIS
STATEMENT OF OPERATIONS
JANUARY 1, 2011 TO December 31, 2011

FUND BALANCE JANUARY 1, 2011		123,604,963
ADD:		
ASSESSMENT REVENUE	184,221,709	
INTEREST ON SECURITIES	1,867,830	
OTHER REVENUES	1,233,226	
ABATEMENT REPAYMENT REC'D	2,727	
CASH IN TRANSIT 12/31/11	-1,545,632	
REDEPOSIT OF CHECKS	325,224	
ACCOUNTS PAYABLE	297,374	
TOTAL FUNDS AVAILABLE		186,402,458.00
SUB TOTAL		<u>310,007,421.00</u>
OTHER DEDUCTIONS		
CLAIMS PAID DECEMBER 31, 2011	170,395,012	170,395,012
OPERATING EXPENSES		
SALARIES	2,727,223	
PAYROLL TAXES & BENEFITS	1,665,576	
DATA PROCESSING SERVIICES	183,347	
LEGAL FEES & SERVICES	6,473,822	
OFFICE SUPPLIES	30,176	
CONSULTANTS- PHYSICIANS	615,915	
TELECOMMUNICATIONS	55,187	
REAL ESTATE	565,233	
TRAVEL, TRAINING, DUES,	24,059	
SAP TIMING AND PAYABLES @ 12/31/11	-2,762,329	
<u>TOTAL OPERATING EXPENSES</u>	<u>9,578,209</u>	9,578,209
TOTAL DEDUCTIONS	<u>179,973,221</u>	179,973,221
FUND BALANCE DECEMBER 31, 2011		<u>130,034,200</u>
Carrier Credits Payable		1,104,000
2002 Credit Letter Payable		4,980,000
Estimated 1/1/2012 Fiscal Balance		<u>123,950,200</u>

Source: **COMMONWEALTH'S SAP ACCOUNTING RECORDS AND BUREAU OF FISCAL MANAGEMENT MONTHLY REPORTS.**

History of Assessment Rates and Coverage Limits			Coverage Limits (per Occurrence/per Annum) in Millions					
			Non-hospital			Hospital		
			Mcare Limit	Basic Limit	Total Aggregate Limits for Mcare & Non-hospital	Mcare Limit	Basic Limit	Total Aggregate Limits for Mcare & Hospital
Year	Percentage	Policy Effective Date						
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% (102% & 68%)	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
1996	164%							
1997	75%							
1998	64%	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
1999	59%							
2000	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
2001	61%							
2002	50%							
2003	43%							
2004	46%							
2005	39%							
2006	29%							
2007	23%							
2008	20%							
2009	19%							
2010	21%							
2011	19%	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

**Office of Mcare
Unfunded Liability Report
as of 12/31/2010**



Estimation of 2010 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 \$1.23 billion as of December 31, 2010.

**PENNSYLVANIA MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR FUND**

ESTIMATION OF 12/31/2010 UNFUNDED LIABILITY

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

**Philadelphia, PA
July 2011**



July 15, 2011

Mr. Peter Adams
Deputy Insurance Commissioner
Pennsylvania Mcare Fund
30 North Third Street
8th Floor, Suite 800
Harrisburg, Pennsylvania 17108

Dear Mr. Adams:

Enclosed is our report on the Fund's unpaid claim liabilities as of December 31, 2010. We appreciate the assistance you and your staff have provided in the course of our analysis, and look forward to working with you in the future.

Please do not hesitate to call Mark Proska at (267) 330-6612 should you have any questions or require anything further.

Sincerely,

Mark R. Proska
Director
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

John F. Gibson
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Enclosure

cc: R. Waeger, Mcare Fund

PricewaterhouseCoopers LLP, 2 Commerce Square, Suite 1700, 2001 Market Street, Philadelphia, PA 19103-7042
T: (267) 330 3000, F:(267) 330 3300, www.pwc.com/us

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INTRODUCTION

Background

The Commonwealth of Pennsylvania established the Medical Care Availability and Reduction of Error Fund¹ (the Fund) on January 13, 1976 as part of its effort to make professional liability insurance available at a reasonable cost and to provide for prompt and fair compensation to persons sustaining injury due to the negligence of a health care provider.

The Fund currently provides excess coverage (to varying historical limits) for health care providers that have exhausted their primary limits (Excess claims), and also provides first dollar coverage, including defense, for claims that are reported within the statute of limitations, but four or more years after the occurrence event (Section 715 claims²). The historical mandatory primary and Fund limits of medical malpractice coverage (000's) are included in the table on the following page:

¹ Pursuant to the provisions of Act 13 of 2002 (hereafter, "Act 13"), Medical Care Availability and Reduction of Error (Mcare) Fund (hereafter, "the Fund") assumed the rights of the Medical Professional Liability Catastrophe Loss Fund on October 1, 2002.

² Section 715 of Act 13 of 2002 included a provision for eliminating the Fund's first-dollar coverage of late reported claims. More specifically, all medical professional liability insurance policies issued on or after January 1, 2006 are required to provide coverage (within the primary policy limit) for claims that are brought forth four or more years after the breach of contract or the tort occurred, and which occurred after December 31, 2005. Although the Fund will no longer provide first-dollar coverage for these late reported claims, coverage will be provided by the Fund for late reported claims in excess of the primary policy limit (as is the case for Excess claims). We have assumed that the limits of Fund coverage as of the date of accident will apply. Note that other conditions must also be met for a claim to qualify for Section 715 coverage, as specified in Act 13. Prior to Act 13, these late reported claims were known as Section 605 claims.

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

Policy Year Effective	Mandatory Primary Occ / Agg Limits		Mcare Fund Excess Occ / Agg Limits	Section 605/715 Limits ³
	Hospital	Physician		
1996 & Prior	200 / 1,000	200 / 600	1,000 / 3,000	1,000
1997 & 1998	300 / 1,500	300 / 900	900 / 2,700	1,000
1999 & 2000	400 / 2,000	400 / 1,200	800 / 2,400	1,000
2001 & 2002	500 / 2,500	500 / 1,500	700 / 2,100	1,000
2003 – 2005	500 / 2,500	500 / 1,500	500 / 1,500	1,000
2006 - 2010	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)

The mandatory primary coverage limits may increase (with corresponding decreases in the Fund coverage limits) in 2012 and 2015, 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 2015. The limits of insurance assumed herein are shown in the table below (000’s).

Policy Year Effective	Mandatory Primary Occ / Agg Limits		Mcare Fund Excess Occ / Agg Limits	Section 605/715 Limits
	Hospital	Physician		
2011	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)
2012 – 2014	750 / 3,750	750 / 2,250	250 / 750	250 (excess)
2015 & Sub	1,000 / 4,500	1,000 / 3,000	0 / 0	0

The Fund is supported by an assessment collected from each participating health care

³ A window of time exists during which reduced Fund coverage may exist for Section 715 (late reported) claims. In general, Section 715 claims reported to the primary carrier on or after November 26, 2000 and on or before March 19, 2002 may be subject to reduced limits of coverage. The impact of this change in coverage limits is not expected to be significant to our analysis. Note that Section 605/715 claims also erode Fund aggregate limits.

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

provider. Act 13 requires an assessment that will, in the aggregate, produce an amount sufficient to accomplish the following:

- i) Reimburse the Fund for the payment of reported claims which became final during the preceding claims period⁴;
- ii) Pay expenses of the Fund incurred during the preceding claims period;
- iii) Pay principal and interest on moneys transferred into the Fund; and
- iv) Provide a reserve that shall be 10% of the sum of (i), (ii), and (iii) above.

These amounts are collected via the application of an assessment rate to the policy year prevailing primary premium, which is based on the JUA occurrence rates applicable to the health care provider. Given that the assessments are primarily designed to reimburse the Fund for claims and expenses paid during the preceding claims period, the Fund effectively operates on a pay-as-you-go basis. The Fund does not maintain a reserve dedicated to support the liability for claims that have been incurred but not yet paid⁵; however, the Fund does require regular actuarial evaluations of its projected unfunded liability.

PricewaterhouseCoopers LLP (PwC) was engaged to provide the Fund with an actuarial central estimate of its unpaid claims expense (i.e., the unfunded liability) as of December 31, 2010. This report is neither intended nor necessarily suitable for any other purpose. The estimates contained herein are meant to represent an expected value over the range of reasonably possible outcomes.

⁴ The Fund's fiscal year for claim payments ends on August 31, with actual payment on the claims settled within the fiscal year being made on or about December 31.

⁵ In any given year, the Fund may have a shortage or an excess of assessments collected relative to the claims payments and operating costs for the year, resulting in corresponding year-end shortfall or surplus. The estimate of the unfunded liability contained herein includes no adjustment for the Fund's cumulative surplus of \$123 million as of December 31, 2010.

Distribution and Use

This report was prepared for internal use by the Fund's management, including the Pennsylvania Insurance Department. We understand that the Fund may release this report to the Pennsylvania Medical Society and the Hospital Association of Pennsylvania. The supporting exhibits are an integral part of this report; as such, the report must only be released in its entirety. Third parties reviewing this report should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein that would result in the creation of any duty or liability by PwC to the third party. PwC is available, subject to the Fund's approval and expense, to answer questions regarding this report. Other use or further distribution of this report is not authorized without prior written approval of PwC.

Conditions and Limitations

In our analysis we have relied, without audit or further verification, on data received from the Fund, including but not necessarily limited to:

- by-claim information, including data such as: claim type (Excess⁶ or Section 715), open date, claim status, coverage limit, breast implant / pedicle screw claims, "no exposure" claims, primary report date, Fund payment information, etc.;

⁶ This analysis, as did previous analyses, combines drop-down claims with Excess claims. Drop down claims are those for which the primary aggregate limits have been exhausted and the Fund's coverage limits "drop down" to provide first-dollar coverage. These claims have historically been a relatively small portion of the Fund's aggregate annual claims payments.

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

- the Fund's interpretation of Act 13 provisions;
- historical surcharge collections by policy type; and
- information contained in PwC's previous estimates of the Fund's liability.

The calculations in this report rely on the accuracy of the paid loss and claim count data provided. We have not audited this data but have reviewed the data provided for reasonableness. Any changes to the data may require modification to the estimates in this report. In this report, paid loss and claim count triangles have been restated according to each claim's current status (e.g., Excess vs. Section 715) in order to provide for a historical database that is more reflective of the Fund's current procedures. The updated triangles were compared to last year's triangles for reasonableness and consistency; differences observed were not significant.

The Fund does not establish a provision for case reserves on open claims. Case reserves represent an estimate of the case value based on a claims adjuster's assessment of the relevant case-specific facts and circumstances. Commercial reinsurers (who, like the Fund, often provide coverage above a primary insurer) often receive further insight into their potential exposure from routine case reporting from their primary insurers, assuming the primary insurer is also assessing the exposure in the reinsurance layer, which can serve as a leading indicator of the reinsurer's costs and assist with the analysis of underlying trends. However, the Fund does not receive regular case reporting from the primary insurers on the potential Fund exposure.

The calculations in this report also rely on information provided by the Fund and on the Fund's interpretation of recent legislation, of which many provisions are neither time-tested nor court-tested. Any changes to the data provided or in the "application" of

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

recent legislation relative to the interpretation assumed herein may necessitate modification to the estimates in this report.

The projected ultimate losses, calendar year claims payments, and the estimate of unfunded liability shown in this report are estimates and as such, are subject to variability. This variability arises from the fact that not all factors affecting the ultimate liability have taken place nor can they be evaluated with absolute certainty. Such factors include, but are not limited to, tort reform, expected future inflationary trends and jury awards. The absence of case reserve information may also subject our projections to a higher degree of uncertainty. Our projection of liabilities is based on the Fund's historical payment experience, the projected effect of changes in the Fund's limits of coverage, and our estimate of the impact of changes in Pennsylvania-filed cases over time⁷ on the Fund's claims obligations. We have not anticipated additional extraordinary changes to the various factors that might impact the future costs of claims. We have however, used methods of estimating the unpaid claim liability that we believe produce reasonable results given current information. No guarantee, either expressed or implied, should be inferred that losses will develop as shown in this report. Furthermore, since the projections contained herein include projections of future years' incidents (i.e., incidents that will not occur until some time in the future), the uncertainty surrounding these estimates is significantly increased.

Act 13 provisions and other recent legislation and rules of civil procedure contribute additional uncertainty to the estimates contained herein. The process of resolving medical malpractice claims, through both settlements and verdicts, is a fluid process

⁷ <http://www.aopc.org/NR/rdonlyres/BBoA5D64-4210-42B6-85AA-77E59E329BAD/o/MedMalFilingsStatewide20002010.pdf>

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

that may change over time. Furthermore, changes in handling, processing, negotiating, adjudicating, or otherwise resolving these claims that tend to occur over time could influence the impact of these provisions.

The Pennsylvania Property and Casualty Insurance Guaranty Association (PPCIGA) provides coverage where the primary carrier has become insolvent. PPCIGA coverage is limited to the lesser of \$300,000 or the limits of the original policy. This creates a potential “gap” in coverage, whereby a physician who had primary limits greater than \$300,000 may receive only \$300,000 in coverage from PPCIGA. Although the Fund does not directly provide coverage for this gap, the Fund may be indirectly impacted by the reduction in primary coverage available to pay claims. Furthermore, PPCIGA retains the right of first recovery from collateral sources. These factors add additional uncertainty to the projections contained herein.

Defense and Other Costs

Our estimates do not include a provision for the costs of providing defense for Section 715 claims. These costs, which have averaged approximately 18% per year of the Section 715 claims paid over recent years, have historically been included in the Fund’s operating (rather than claims) budget. Note that defense is provided by the primary insurers for those claims where the Fund's coverage is provided on an excess basis.

Similarly, our estimates do not include a provision for the cost of claims administration nor for the Fund’s other operating costs.

Breast Implant and Pedicle Screw Claims

The Fund has been able to identify reported claims with exposure to breast implant or pedicle screw liability. These exposures resulted in significant historical reported claim activity. However, nearly all breast implant and pedicle screw claims are closed with relatively minor historical Fund payment activity (less than \$10 million). To avoid the potential distortive effects on our projections, the data included herein excludes these claims, as was the case in prior reports. The unpaid claim estimates shown herein do not include a provision for these exposures.

Reinsurance Recoverables

The Fund has not purchased reinsurance for many years, and reinsurance recoveries over recent calendar years have been insignificant. Future reinsurance recoveries are also expected to be insignificant, and no adjustment for reinsurance recoverables has been made to our estimate of the unfunded liability.

Severity Codes

The Fund recently began more thoroughly capturing severity information for certain claims. This information provides a rough indication of the severity of a plaintiff's alleged injury. The nine indicators range from "Emotional" to "Grave". Injuries of different severity codes may have different characteristics, such as different average costs and different paid loss development patterns. During the course of our review, we investigated whether there appeared to be any significant changes in the distribution of

claims, in particular for codes with a similar average cost. At this time, shifts in the distribution of claims appear to be largely attributable to changes in the Fund layer of coverage - increases in the primary coverage increase the likelihood of less severe cases being fully captured by the primary layer. Conversely, there is an increased likelihood for a proportionally greater amount of Fund claims to arise from more severe injuries. We would not expect other shifts in the distribution of claims to materially distort our analysis at this time. We will continue to monitor severity code information and adjust our estimates of the unfunded liability as warranted in the future.

Qualifications of PwC Actuaries

Mark R. Proska and the peer reviewer for this assignment, John F. Gibson, are members of the American Academy of Actuaries and Fellows of the Casualty Actuarial Society and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

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, 2010, excluding breast implant and pedicle screw exposure, to be approximately \$1.23 billion, assuming the limits of Fund coverage proceed as currently contemplated under Act 13. Namely, the estimates contained herein assume that basic coverage limits increase in 2012 and 2015, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2015. If the basic coverage limits are not increased in 2012 and 2015, Fund coverage will continue into and beyond 2016 and the total Fund payout (i.e., our estimates of the unfunded liability) would increase. We have not estimated the amount of the increase in the unfunded liability should the basic coverage limits not increase.

During the course of our review, the Fund provided us with a projection of 2011 claim payments of approximately \$170 million. The projection is relatively close to the average of the last three claim years, and we have incorporated this information into our projection of the unfunded liability. However, our projections also give some consideration to longer-term trends in claims payments, and the application of projected payment patterns to the projected unfunded liability results in an initial estimate of 2011 claims payment that is higher than the \$170 million projection provided by the Fund. As such, we have adjusted our initial projected payout of the unfunded liability to reflect the Fund's projection of the 2011 payments of \$170 million.

We have also assumed that a reduced level of payments, as observed during recent years, will continue into 2012, and have adjusted the projected 2012 payments to \$185 million, which is roughly the average of the Fund's expected 2011 payments of \$170 million and our initial projection of the 2012 payments of \$203 million (Summary Exhibit 8 of Technical Appendix).

The adjusted payment pattern assumes that the recent decrease in payments has effectively “pushed” the projected payments out in time. As such, the projected 12/31/2010 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.

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

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

Accident Year	Jan-1 Unfunded Liability	Cost of New Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability	Discounted (4%) Dec-31 Unfunded
2010				1,226,480	1,028,081
2011	1,226,480	176,512	170,000	1,232,992	1,040,075
2012	1,232,992	128,287	185,000	1,176,278	999,326
2013	1,176,278	93,576	207,788	1,062,066	906,152
2014	1,062,066	72,148	204,454	929,760	794,942
2015	929,760	17,690	195,287	752,163	645,378
2016	752,163		171,669	580,494	499,524
2017	580,494		140,900	439,594	378,605
2018	439,594		112,901	326,694	280,849
2019	326,694		84,054	242,640	208,029
2020	242,640		60,249	182,391	156,101
2021	182,391		44,925	137,466	117,420
2022	137,466		33,447	104,019	88,670
2023	104,019		24,953	79,066	67,264
2024	79,066		18,543	60,523	51,411
2025	60,523		13,637	46,885	39,830
2026	46,885		10,528	36,357	30,895
2027	36,357		8,228	28,129	23,903
2028	28,129		6,333	21,796	18,526
2029	21,796		4,953	16,843	14,314
2030	16,843		3,940	12,903	10,946
2031	12,903		3,114	9,788	8,270
2032	9,788		2,377	7,411	6,223
2033	7,411		1,762	5,649	4,710
2034	5,649		1,293	4,356	3,605
2035	4,356		945	3,411	2,805
2036	3,411		674	2,737	2,242
2037	2,737		480	2,257	1,852
2038	2,257		366	1,891	1,560
2039	1,891		307	1,583	1,315
2040	1,583		261	1,323	1,107
2041	1,323		223	1,100	929
2042	1,100		196	904	770
2043	904		171	733	630
2044	733		147	586	508
2045	586		125	461	403
2046	461		101	360	319
2047	360		85	275	246
2048	275		75	200	181
2049	200		62	138	126
2050	138		50	87	81
2051	87		37	50	47
2052	50		24	26	24
2053	26		15	11	10
2054	11		8	3	3
2055	3		2	0	0
2056	0		0	0	0
2057	0		0	0	0
		488,212	1,714,692		

Pennsylvania Mcare Fund
 Estimation of 12/31/2010 Unfunded Liability and
 Estimate of Future Years' Claims Payments

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 Discounting 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 the Fund does not currently maintain assets in support of the liability.

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 12/31/2009

The total expected unfunded liability of \$1.23 billion has decreased 8.6% from our December 31, 2009 estimate of \$1.34 billion. The breakdown of the change in the undiscounted estimate since December 31, 2009 is shown in the following table:

Rollforward of Estimated Unfunded Liability (000's) from 12/31/2009 to 12/31/2010				
		<u>Excess</u>	<u>Section 715</u>	<u>Total</u>
(1)	Prior Estimated Liability	943,656	401,106	1,344,762
(2)	<u>Less Prior Estimated DD & PJI</u>	<u>13,946</u>	<u>5,928</u>	<u>19,873</u>
(3)	Prior Estimated Liability Ex. DD & PJI	929,710	395,178	1,324,888
(4)	Plus Change in Prior Accident Year Ultimate	(88,293)	(71,072)	(159,365)
(5)	Less Paid During Year	124,613	20,664	145,277
(6)	<u>Plus Accident Year 2010 Ultimate</u>	<u>169,467</u>	<u>18,641</u> (a)	<u>188,108</u>
(7)	Current Estimated Liability Ex. DD & PJI	886,271	322,083	1,208,354
(8)	<u>Current Estimated DD & PJI</u>	<u>13,294</u>	<u>4,831</u>	<u>18,125</u>
(9)	Current Estimated Liability	899,565	326,915	1,226,480

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

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
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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 \$157 million as compared to the prior projections, as shown in the table on the following page:

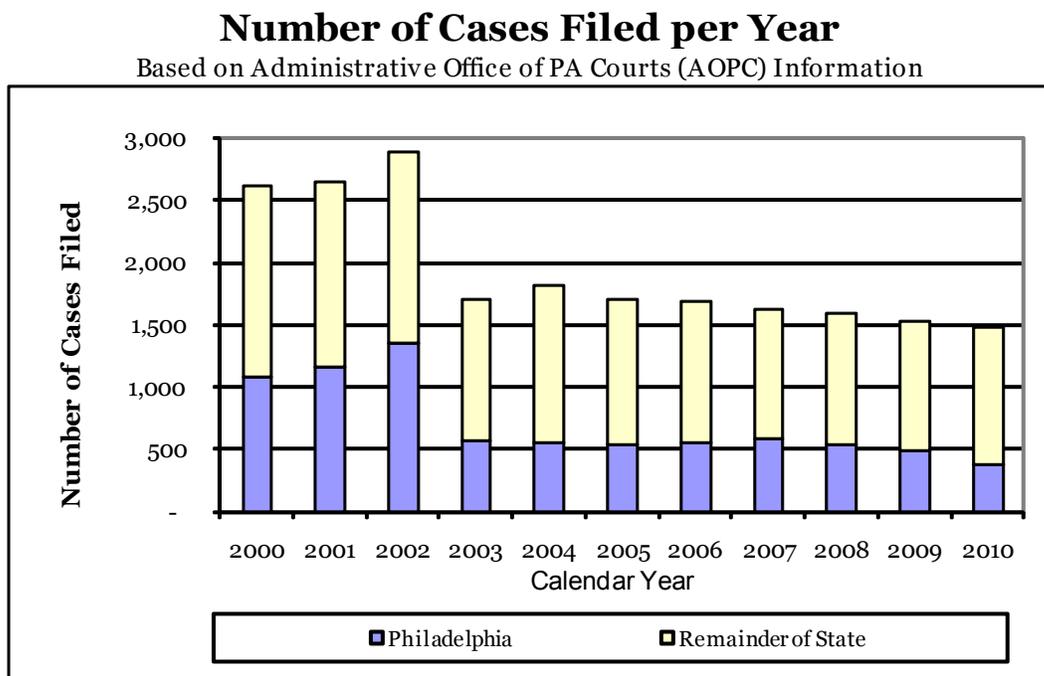
Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
Estimate of Future Years' Claims Payments

Accident Year	Current Selected <u>Ultimate</u>	Prior Selected <u>Ultimate</u>	Change in Selection
1976	47,688,502	47,720,237	(31,735)
1977	60,041,590	60,082,048	(40,458)
1978	86,452,348	86,485,837	(33,488)
1979	97,805,939	97,835,995	(30,055)
1980	136,021,404	136,059,803	(38,399)
1981	150,737,926	150,794,817	(56,891)
1982	173,700,957	173,765,335	(64,378)
1983	178,554,194	178,675,910	(121,716)
1984	166,785,671	166,928,652	(142,981)
1985	179,193,133	179,481,354	(288,222)
1986	171,799,503	172,113,416	(313,913)
1987	196,360,415	196,821,643	(461,228)
1988	216,446,231	217,127,800	(681,569)
1989	215,992,504	217,001,458	(1,008,953)
1990	255,924,920	257,042,611	(1,117,691)
1991	292,841,993	294,821,860	(1,979,867)
1992	272,761,637	274,678,522	(1,916,885)
1993	254,470,252	256,319,197	(1,848,945)
1994	293,486,780	295,642,295	(2,155,515)
1995	324,324,489	324,928,816	(604,326)
1996	310,885,257	313,491,271	(2,606,013)
1997	329,741,669	334,959,523	(5,217,854)
1998	280,492,709	285,903,881	(5,411,172)
1999	239,141,331	247,538,176	(8,396,845)
2000	233,995,118	244,058,020	(10,062,902)
2001	201,179,626	211,527,337	(10,347,710)
2002	161,621,868	172,268,873	(10,647,005)
2003	178,170,850	187,762,461	(9,591,611)
2004	177,515,518	190,594,717	(13,079,200)
2005	189,130,806	206,265,307	(17,134,501)
2006	171,364,839	191,277,108	(19,912,268)
2007	187,742,932	195,297,021	(7,554,088)
2008	192,890,600	206,818,889	(13,928,290)
2009	<u>201,989,716</u>	<u>214,528,248</u>	<u>(12,538,532)</u>
Total	6,827,253,231	6,986,618,439	(159,365,208)

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 2010 as compared to the pre-Act 13 years 2000 through 2002, with particular concentration in Philadelphia County. The average statewide decrease in cases filed is approximately 45%, with Philadelphia County experiencing an average decrease of approximately 70% and the remainder of the state (ROS) experiencing an average decrease of approximately 30%, as shown below:



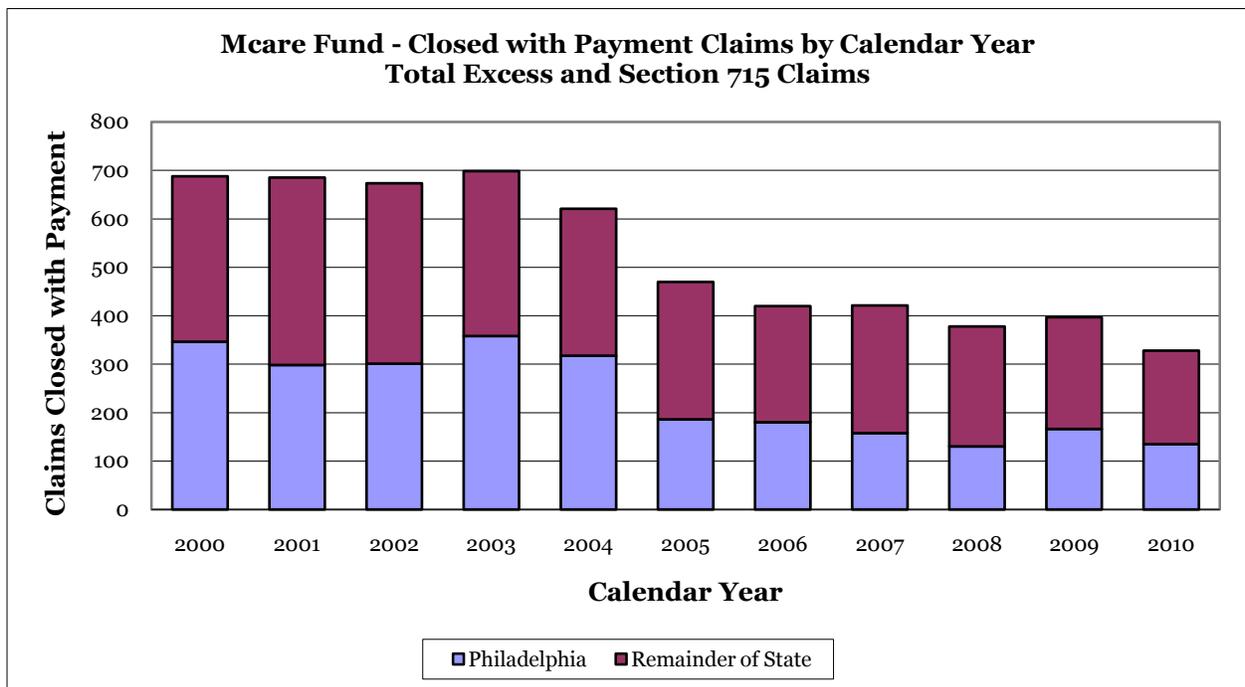
Possible causes for the decrease in claims activity for recent years include venue reform (Section 3 of Act 27 of 2002), certificate of merit procedures (Rule of Civil Procedure 1042.3, 2003), and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number of case filings, with a particular

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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.

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 2010 as compared to prior years. The average statewide decrease in claims closed with payment is approximately 40%, with Philadelphia County experiencing an average decrease of nearly 50% and ROS experiencing an average decrease of approximately 30%, as shown below:



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 that the reduced

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number of filings and apparent shift of claims away from Philadelphia may not result in a commensurate level of cost savings, we concluded 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 for Excess claims. Based on this review, as well as in consideration of the AOPC data and our prior projections, we included an "AOPC Credit" of 35% and 55% within our Philadelphia projections for Excess claims and Section 715 claims, respectively, and an "AOPC Credit" of 5% and 30% within our ROS projections for Excess claims and Section 715 claims, respectively. These AOPC credits are generally consistent with those used in our prior projections.

Other Recent Legislative Provisions

Other elements of the 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). These other elements of the recent legislation may also have an impact on the Fund's obligations, although the impact of these elements has not been explicitly estimated herein. These provisions have generally been in place for several 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, Sheet 1 the indicated post-Act 13 liability after discounting the Fund's liabilities at a 4% annual rate of interest is approximately \$1.03 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%	\$1.10 billion
3%	\$1.06 billion
4%	\$1.01 billion
5%	\$0.97 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. The Fund does not currently maintain assets in support of the liability.

ANALYSIS

Methodology

Our analysis of liabilities was completed separately for Excess claims and Section 715 claims. Supporting calculations are included in the Technical Appendix, Section 1 and Section 2, respectively. Within each section, separate projections are provided for Philadelphia and Remainder of State (ROS), based on the venue county of the claim. Data was organized by year of occurrence. To estimate the unfunded liability as of 12/31/2010, losses paid to date are subtracted from the projected ultimate losses for accident periods 2010 and prior.

There have been no significant changes to the methodology contained herein as compared to that of our prior report. Losses are projected to ultimate values using the following methods:

- Paid Loss Development Method;
- Future Cost per Closed-With-Payment (CWP) Claim Method; and
- Paid Bornhuetter-Ferguson Method.

In constructing our analysis, we have considered the nature of the Fund's exposures and selected methods applicable to the available data that reflect the nature of these exposures, the development characteristics associated with these claims, and the reasonableness of the underlying assumptions of the methods. In selecting our assumptions not only have we considered the reasonability of the assumptions but also the sensitivity of the estimates to reasonable alternative assumptions.

Paid Loss Development
(Exhibit 6 [ROS] and Exhibit 14 [Philadelphia])

Paid loss development is a common technique for estimating ultimate loss. In this method, ultimate losses are estimated by calculating past paid loss development factors and applying them to exposure periods with further expected paid loss development.

The paid loss development method assumes that losses are paid at a consistent rate. It provides an objective test of incurred loss projections because paid losses contain no reserve estimates, nor are they as greatly influenced by changes in claims reserving policies and procedures as are incurred losses. It is especially useful for coverages where losses develop early and are paid quickly, such as automobile physical damage, or in instances where case reserves are not established. In our estimates for Excess, separate paid loss development factors have been estimated assuming the Fund coverage attaches at \$200,000 limits (as it does for policies effective prior to 1997) and assuming the Fund coverage attached at \$500,000 limits (as it does for policies effective in 2001 and subsequent). For each year, the paid loss development pattern employed is based on these patterns, adjusted to reflect the estimated average Fund attachment point for the accident year.

In some circumstances, claim payments are made very slowly and it may take years for claims to be fully reported and settled. Paid losses for recent periods may be too immature or erratic for accurate predictions based on a paid loss development methodology.

Future Cost per CWP Claim Method
(Exhibit 7 [ROS] and Exhibit 15 [Philadelphia])

The future cost per closed-with-payment claim method multiplies the projected number of claims closing with payment in future calendar years by the estimated average loss per claim for each calendar year. This method is useful when the ultimate claim estimates and average loss estimates are reliably estimable.

If loss development methods produce erratic or unreliable estimates for the more recent periods, the future cost per closed-with-payment claim method can provide more stable results while maintaining consistency with historical loss experience. However, a substantial number of unusual claims can distort claim averages or make them very volatile.

As was the case with last year's analysis, our projection of ultimate claim costs contemplates the prevalent limits of Fund coverage separately within the closed-with-payment claim projection and the average claim cost projection, since the frequency and severity of claims are impacted by changes in the Fund coverage limits over time. The methodology also considers the estimated impact of the "AOPC Credit" on the number of claims expected to close with payment.

Paid Bornhuetter-Ferguson
(Exhibit 8 [ROS] and Exhibit 16 [Philadelphia])

The Paid Bornhuetter-Ferguson method is a combination of the paid loss development method and a loss per exposure method. The amount of losses yet to be paid is based on

initial expected loss estimates. These expected losses are then modified to the extent paid losses to date differ from what would have been expected based on the selected paid loss development pattern.

To determine initial expected loss estimates, we rely largely on the Fund's actual experience, by matching our "expected" paid loss with the Fund's actual paid loss over a period of several *calendar* years. The "expected" calendar year paid loss is calculated by an iterative process.

- First, an initial estimate of accident year 2010 loss is selected and adjusted to prior accident years for loss trend and changes in Fund attachments and limits. The estimated impact of the "AOPC Credit" is also considered in determining the initial estimates of accident year losses.
- Next, calendar year claim payments are estimated by applying the paid loss pattern underlying the paid loss development method to the estimate of ultimate loss by accident year calculated in the first step.
- Then, the projected calendar year claim payments from the second step are compared with the actual calendar year claim payments provided by the Fund.
- Finally, the process is repeated by adjusting the initial estimate of accident year 2010 loss until the projected calendar year claim payments equal the actual calendar year claim payments.

This methodology is often used to align expected and actual paid loss over a period of several *accident* years, rather than *calendar* years. We believe the calendar year approach of our projection methodology increases the extent to which the projections

Pennsylvania Mcare Fund

Estimation of 12/31/2010 Unfunded Liability and
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directly reflect emerging experience, and we have "matched" the experience over six calendar years. Similarly, our prior projections matched the experience over the six prior calendar years. As a result of the continuing favorable development of recent years, the current projections give greater weight to recent favorable emerging experience. We will continue to monitor emerging experience in future projections and adjust the span of years included accordingly.

This method is fundamentally similar to a Cape-Cod Bornhuetter-Ferguson method, which is commonly used when initial estimates of loss for recent years are difficult to determine. In general, Bornhuetter-Ferguson methods avoid some of the distortion that could result if a large development factor were applied to a small base of paid losses to calculate ultimate losses and therefore tend to limit unwarranted fluctuations in liability estimates.

Selections

(Exhibit 5 [ROS] and Exhibit 13 [Philadelphia])

For accident years prior to the late-1990's, ultimate loss selections are based primarily on the paid loss development method. For more recent accident years, the selections give less weight to the paid loss development method, and the two other methods are given increasing weight. For the most recent accident years, the paid loss development method is given no weight, as we believe the ultimate losses indicated by the paid loss development method are too volatile.

Discounting

Discounting is the process of recognizing that investment income can be earned on invested assets funding the associated liabilities until such time as the losses are paid, and reduces the liability estimate by the current value of the expected investment income. The amount of the discount is determined by evaluating the cash flow of the future payments. The cash flow varies by year based on the maturity of the accident period.

The unpaid claims estimated herein have been discounted to reflect the investment income that could be earned from 12/31/2010 until the final date of payment. While post-Act 13 experience can be expected to have a slightly different payment pattern than pre-Act 13 experience, we expect that the relative effect on the discount would not be significant.

The attached discounted estimates assume a 4.0% rate of return and the paid loss pattern underlying the paid loss development method. However, as discussed above, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. Estimates of the discounted unfunded liability can be produced under various discount rate assumptions.

Future Year Projections

The Fund is scheduled to provide coverage (to varying limits) for health care providers beyond 2010. Projections of Excess losses for future years 2011 through 2015 assume

Pennsylvania Mcare Fund

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an underlying trend of 7.0% per annum at 2010 limits of coverage, based on the trend of projections for recent accident years. Projections of Section 715 losses for future years 2010 through 2015 assume an underlying pre-Act trend of 6.0% per annum at 2010 limits of coverage, based on the trend of projections for recent accident years. Coupled with slight trends implicit in the factors used to adjust for changes in the limits of coverage, the overall trend in the projections of the future excess coverage provided by the Fund is approximately 7.0% per annum. These projections, and the resulting estimates adjusted for changes in the limits of coverage provided by the Fund, are shown in Exhibit 5, Sheet 2 (ROS) and Exhibit 13, Sheet 2 (Philadelphia).

Delay Damages and Post-Judgment Interest

Prior to Act 135 of 1996, delay damages and post-judgment interest were generally included within the limits of coverage provided by the Fund. Pursuant to Act 135, these costs are now shared with other carriers in proportion to the share of loss and outside the Fund limits of coverage. Data for recent calendar years indicate that Fund costs for delay damages and post-judgment interest have ranged from approximately 1.0% to approximately 2.5%. We have selected 1.5% as the estimated ratio of these costs to loss and have increased our estimates of the unfunded liability projections accordingly.

Calculation of 2011 Mcare Assessment Rate

The Executive Summary of the study produced by PricewaterhouseCoopers LLP that serves as the basis for setting the 2011 Mcare Assessment rate at 19% in order to generate \$177,083,438 in assessment dollars.

**PENNSYLVANIA MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR FUND**

2011 YEAR ASSESSMENT CALCULATION
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

October 2010

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.

2011 Assessment Rate

Exhibit 1 presents the indicated 2011 assessment rate of 19%. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2011 prevailing primary premium.

The Act requires an assessment that will, in the aggregate, produce an amount sufficient to accomplish each 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 2011 prevailing primary premium. Hence the projection of 2011 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2011 payment obligations of the Fund and the 2011 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2007, 2008, and 2009 assessments as the basis for our estimate of the 2011 prevailing primary premium.

Since the 2011 assessment rate is based largely on the Fund's obligations for the 2010 claim year, any significant change in Fund's claim or expense obligations from 2010 to 2011 may result in a significant change to the Fund's year-ending surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2011. To the extent the funds available in 2011 are insufficient to meet the Fund's 2011 obligations, additional funding or borrowing may be required.

Differences between projected 2011 prevailing primary premium and actual 2011 prevailing primary premium will result in a difference between projected and actual assessment revenue. This variable contributes additional uncertainty regarding the degree to which the funds available will be sufficient to meet the Fund's 2011 obligations.

ANALYSIS

2011 Assessment Rate

The Act outlines the four categories to be funded via the assessment. The aggregate assessment for 2011⁶ 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 2011 prevailing primary premium.

Claim Settlements

The largest component of the 2011 assessment is the amount of claim settlements for the Fund's 2010 claim year ending August 31, 2010. These claims are payable on or about December 31, 2010. The Fund expects that payments for the 2010 claim year will total approximately \$146.5 million.

Fund Operating Expenses

Operating expenses paid of \$14.5 million for claim year ending August 31, 2010 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 August 31, 2010, and does not currently expect to require borrowing to meet its 2010 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.

⁶ We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2011.

Prevailing Primary Premium

The Fund provided unabated assessment and policy count data for policies effective in 2007, 2008 and 2009. 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-plus⁷). Assessment collections for tail policies are not expected to be material in the aggregate for policy year 2011. Our projections of policy year 2011 assessments exclude assessments collected in 2007, 2008 and 2009 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;

⁷ 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 2011 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 2007 assessments have been adjusted for changes effective 01/01/2008, 01/01/2009, 01/01/2010, and 01/01/2011. This calculation is included in its entirety under separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2008 assessments have been adjusted for changes effective 01/01/2009, 01/01/2010, and 01/01/2011. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2009 assessments have been adjusted for changes effective 01/01/2010 and 01/01/2011. 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 01/01/2008, 01/01/2009, 01/01/2010, and 01/01/2011 are as follows:

Changes Effective 01/01/2008

Base Rate Change

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:

<i>Non-Institutional Changes</i>		
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%

<i>Non-Institutional Changes</i>		
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)	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 previously assumed that all specialists coded 01059 in 2007 would remain coded as 01059 in our 2008 projection. Based on our review of 2008 data, we continue to believe this simplifying assumption is reasonable in the context of the prevailing primary premium projection.

Changes Effective 01/01/2009

Base Rate Change

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:

<i>Non-Institutional Changes</i>		
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%
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.

Changes Effective 01/01/2010

Rate Change

The JUA decreased its base rates 8.9% for institutional healthcare providers and 6.1% for non-institutional healthcare providers.

Note that the JUA modified its approach in this filing to separately calculate each rate by class code / territory based on a loss cost approach that considers fixed and variable components of expense rather than on a loss ratio approach that treats all expenses as variable. The loss ratio approach was used in prior rate filings.

Given the fixed vs. variable nature of the rate computation, the year-over-year change in the JUA rates by class code / territory may not match the base rate change discussed above.

For entities where the JUA rating is computed as a factor of the underlying premium for each health care provider (e.g., Professional Corporations, Professional Associations or Partnerships; Other Third Party Entities that Provide Health Care or Professional Medical Services to Inmates of Prisons and Other Detention Facilities, and Birth Centers), the JUA intends to subtract fixed costs from the underlying premium for each healthcare provider prior to the application of the rating factor, after which a single fixed cost charge is added to the total premium developed for each insured entity. We understand that the Fund intends to follow the JUA's methodology for adjusting the premium for the above entities for fixed cost expenses.

Our methodology does not explicitly recognize that the rating procedure will be changing for these health care providers. However, given the relative size of the prevailing primary premium

for affected health care providers (less than 3% of the total prevailing primary premium), we believe the impact of this change is not significant in the overall context of the prevailing primary premium.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	+4.9%
007	+5.0%
010	-3.9%
011	+9.9%
012	+5.0%
020	+5.0%
022	-4.3%
030	-5.0%
035	+5.0%
050	-5.0%
060	-5.0%
070	-5.0%
080	-5.0%
090	-5.0%
100	+5.0%
120	-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:

<i>Non-Institutional Changes</i>		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	No change Terr 3 rel.	0.0%
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-9.9%
Delaware (23)	change Terr 5 rel.	-6.7%
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.	-3.0%
All Other	change Terr 2 rel.	-5.4%

Specialty Changes

Specialty changes that resulted in a class change are listed below. Note that the impact is relative to the 2009 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
00608	Hematology - No Surgery	move to class 00508	-25.4%
00656	Utilization Review	move to class 00556	-25.4%
00634	Administrative Medicine - No Surgery	Move to class 00534	-25.4%
00637	Physicians - Practice Limited to	Move to class 00537	-25.4%

Specialty Code	Specialty	Change	Impact
	Acupuncture (other than acupuncture anesthesia)		
00682	Pharmacology - Clinical	Move to class 00582	-25.4%
00742	Nephrology - No Surgery	Mover to class 01142	-14.2%
01049	Nuclear Medicine - No Surgery	Move to class 00649	-37.7%
01034	Occupational Medicine - Including MRO or Employment Physicals	Move to class 00624	-37.7%
01013	Orthopedics - No Surgery	Move to class 00613	-37.7%
02055	Ophthalmology - Surgery	Move to class 01755	-5.7%
02011	Neurology - Excluding Major Surgery	Move to class 02511	+9.4%
02040	Infectious Disease - Excluding Major Surgery	Move to class 02540	+9.4%
03022	Cardiology - Including Right Heart or Left Heart Catheterization	Move to class 02223	-9.6%

The 2010 filing also includes the creation of the following new specialties: Specialty 00599 (Physicians Not Otherwise Classified - No Surgery), Specialty 01799 (Physicians Not Otherwise Classified - Excluding Major Surgery), Specialty 02599 (Physicians Not Otherwise Classified - Excluding Major Surgery) within new Classes 005, 017, and 025.

Changes Effective 01/01/2011

Rate Change

The JUA decreased its base rates by 9.4%.

Class Rate Changes

The JUA made no changes to the Class structure or relativities in this year's filing.

County / Territory Changes

The JUA made no changes to the County / Territory structure or relativities in this year's filing.

Specialty Changes

The JUA made no Specialty changes in this year's filing.

Results

The indications for the 2011 prevailing primary premium are \$892 million based on 2007 remittances, \$905 million based on 2008 remittances, and \$927 million based on 2009 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2007), Excerpt B (2008), and Excerpt C (2009). The entire calculation is included under separate cover as Appendix A, Appendix B, and Appendix C, respectively. Based on these indications, our projection of 2011 prevailing primary premium is \$920 million.

Note, however, that this projection may vary from the actual 2011 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 2010 and 2011;
- shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2010 and 2011; and
- changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2010 and 2011.
- additional recording of data, notably for 2009, where policy adjustments and late reported

assessments will cause the assessment data to change. The year-over-year increase in 2008 data was less than 1%.

Note that an abatement program has not yet been extended to 2008 through 2011. 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 2011 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. Non-hospital experience rating adjustments were applied to a relatively limited number of health care providers, and we understand that the Fund has presently ceased applying experience rating adjustments to non-hospital health care providers. As such, we have not attempted to measure the impact of this program.

2011 Assessment Rate

The cost components of the assessment total \$177.1 million. Given the 2011 prevailing primary premium projection of \$920 million, the indicated 2011 assessment rate is 19%.

Since the 2011 assessment rate is based largely on the Fund's obligations for the 2010 claim year, any significant change in the Fund's claim or expense obligations from 2010 to 2011 may result in a significant change in the year-ending December 31 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2011 and the degree to which 2011 assessments are abated, if at all. To the extent that funds

available in 2011 are insufficient to meet the Fund's 2011 obligations, additional funding or borrowing will be required.

Change from Prior

The indicated 2011 assessment rate of 19% is lower than the 2010 assessment rate of 21%. As the chart below indicates, both the claims obligations and projected prevailing primary premium decreased. All else being equal, a decrease in the Fund's claims obligations causes the assessment rate to decrease, while a decrease in the projected prevailing primary premium causes the assessment rate to increase. The decrease in the Fund's claims obligations more than offset the impact of the decrease in the prevailing primary premium, resulting in a decrease in the assessment rate. The 2010 and 2011 assessment rate calculations are summarized below.

	<u>2011</u>	<u>2010</u>	<u>Assessment Rate Impact</u>
(1) Prior Claim Year Claims Settled	146,484,944	178,236,910	-3%
(2) Prior Claim Year Operating Expenses	14,500,000	11,588,427	0%
(3) Target Reserve	<u>16,098,494</u>	<u>18,982,534</u>	<u>0%</u>
(4) Assessment Costs, (1)+(2)+(3)	<u>177,083,438</u>	<u>208,807,871</u>	<u>-3%</u>
(5) Projected Prevailing Primary Premium	920,000,000	995,000,000	1%
(6) Indicated Assessment Rate, (4) / (5)	19%	21%	-2%

QUALIFICATIONS of PwC ACTUARY

Mark R. Proska and the peer reviewer for this report, John F. Gibson, are members of the American Academy of Actuaries and Fellows of the Casualty Actuarial Society and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

EXHIBITS

Pennsylvania Medical Care Availability and Reduction of Error Fund

Indicated 2011 Assessment Rate

(1)	Claim Year Ending 08/31/2010 Claims Settled	146,484,944
(2)	Claim Year Ending 08/31/2010 Operating Expenses	14,500,000
(3a)	Claim Year Ending 08/31/2010 Principal and Interest Paid or Payable	-
(3b)	Claim Year Ending 08/31/2010 Borrowing Transfers	-
(4)	Target Reserve	<u>16,098,494</u>
(5)	2010 Assessment Costs	<u><u>177,083,438</u></u>
	(5) = (1)+(2)+(3a)+(3b)+(4)	
(6)	Projected Policy Year 2011 Prevailing Primary Premium	920,000,000
(7)	Indicated 2011 Assessment Rate	19%
	(7) = (5) / (6)	

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 2011 Prevailing Primary Premium

	Projected Prevailing <u>Primary Premium</u>	Implied Assessment <u>Rate</u>
(1) Projection Based on 2007 Assessment Remittances	892,385,606	19.8%
(2) Projection Based on 2008 Assessment Remittances	905,480,263	19.6%
<u>(3) Projection Based on 2009 Assessment Remittances</u>	<u>927,427,462</u>	<u>19.1%</u>
(4) Projected 2011 Prevailing Primary Premium	920,000,000	19.2%

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) Selected based on the indications of (1) through (3).

Calculation and Application of 2011 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**

2011 EXPERIENCE MODIFICATION FACTORS
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

December 2010

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

Distribution		
From	To	Count
	80.0%	0
80.0%	85.0%	113
85.0%	90.0%	30
90.0%	95.0%	21
95.0%	100.0%	14
100.0%	105.0%	4
105.0%	110.0%	6
110.0%	115.0%	4
115.0%	120.0%	3
120.0%		13
Total All Rated Hospitals		208

Since the increase or decrease in the individual hospital's prevailing primary premium may not exceed 20%, there are no modification factors lower than 80% or higher than 120%.

Revenue Impact

The 208 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 2009 baseline assessments. When applied to the 2010 baseline assessments, many of which are estimates, the 2010 modified assessment is approximately 0.1% higher than the 2010 baseline

assessment. We do not expect a significant revenue impact when these factors are applied in 2011.

Comparison to 2010 Experience Modification Factors

Of the 208 experience modification factors computed herein, two are for hospitals that have been rated for the first time. Of the remaining 206 modification factors, 170 are within 5% and 181 are within 7.5% of the 2010 filed experience modification factors. Of the 198 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 165 are within 5% and 176 are within 7.5% of their 2010 filed experience modification factors.

Of the 36 experience modification factor changes greater than 5%, 15 are Band 3 hospitals, where 2 arise from hospitals that changed band assignment from Band 2 to Band 3, and 16 are Band 4 hospitals. Similarly, of the 25 experience modification factor changes greater than 7.5%, 12 are Band 3 hospitals, where 2 arise from hospitals that changed band assignment from Band 2 to Band 3, and 10 are Band 4 hospitals. As mentioned above, steps were taken to ensure that unsupported 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.

A comparison of the 2011 experience modification factors to the 2010 experience modification factors for hospitals that have been experience rated for 2011 is included in the attached Summary Exhibit.

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 2006 through 2009;
- 2) Estimating and compiling the baseline assessments for each hospital for each policy year 2007 through 2010;
- 3) Calculating a rate of recoupment⁷ 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.

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.

Compiling Fund Payment Data (Exhibits 5 and 9)

The Fund provided payment data by hospital by claim year for Excess and Section 715 claims. 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 2007 through 2010 is used 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 2007 through 2010⁸. For policy year 2010, information was provided by the Fund for those hospitals who have remitted their 2010 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2010 assessment, the 2010 baseline assessment is estimated as the average of the 2008 and 2009 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes.

⁸ Note that tail assessments are also removed.

Calculating Yearly Rates of Recoupment (Exhibit 3)

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

Rates of recoupment are established as the ratio of the Fund payment data for each claim year (ending 2006 through 2009) to the baseline policy year assessment data for the subsequent policy year (2007 through 2010). 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 2006/2007 through 2009/2010, 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 2010/2011 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 2010/2011 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 while 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	-17.5%	-17.5%
Band 3	-7.5%	-5.0%
Band 4	0.0%	0.0%
Band 5	12.5%	12.5%

For Band 3, we elected to change the a priori modification from -5.0% to -7.5%. Long-term experience for Band 3 hospitals has been favorable relative to indications which led to this change. We will continue to monitor band experience and adjust a priori factors accordingly in future reviews.

Determining an Individual Hospital Credibility Weighting Procedure (Exhibit 7)

Actuarial Standard of Practice No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property / Casualty Coverages*, 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' 2009 policy year prevailing primary premiums, adjusted for the JUA's 2010 rate change. To calculate P, we divided the Fund's 2009 baseline policy year assessment by the

Fund's 2009 assessment rate of 19.0%. We then adjusted the total to reflect the JUA's filed rate change of -8.9% for policy year 2010. Policy periods were annualized where we observed that the 2009 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) 2006/2007, 2007/2008, and 2008/2009 to predict 2009/2010
- 2) 2006/2007, 2007/2008, and 2009/2010 to predict 2008/2009
- 3) 2006/2007, 2008/2009, and 2009/2010 to predict 2007/2008
- 4) 2007/2008, 2008/2009, and 2009/2010 to predict 2006/2007

The results of these analyses are shown in Exhibit 7. The indications vary, but do support partial credibility at the individual hospital level. Since we expect that the predictive value of the data would be relatively stable over time, we have selected K values 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. In general, the higher the K value, the lower the credibility applied to the individual hospital. 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.

Band	Current Calculations		Prior Calculations	
	Selected K	Implied Avg Z	Selected K	Implied Avg Z
Band 1	40,000,000	0.3%	40,000,000	0.4%
Band 2	20,000,000	2.5%	20,000,000	2.7%
Band 3	9,000,000	9.2%	10,000,000	9.3%
Band 4	7,000,000	21.3%	8,000,000	20.9%
Band 5	6,000,000	43.5%	7,000,000	46.4%

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 0.3% credibility and the average Band 5 hospital receives 43.5% 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 2011 assessments, we estimated modification factors that are revenue neutral based on the 2009 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2011 assessments⁹. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance¹⁰ adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

⁹ As a test, we applied the modification factors to the 2010 baseline policy year assessments, approximately 20% of which are estimates. The resulting modified assessments were approximately revenue neutral.

¹⁰ The adjustment is required to achieve a revenue neutral impact.

2011 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		\$88,321,177				\$34,110,670				\$43,513,165	\$ 4,450,000
Percent of Region to Total Paid Claims		51.83%				20.02%				25.54%	2.61%

Total Paid Claims:	\$170,395,012
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Mcare Paid Claims by Region 2007 - 2011

	Total Annual Claim Payment	<u>Eastern</u>		<u>Central</u>		<u>Western</u>		<u>Other</u>	
		Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims
2007	\$170,395,012	\$88,321,177	51.83%	\$34,110,670	20.02%	\$43,513,165	25.54%	\$4,450,000	2.61%
2008	\$173,892,874	\$94,374,144	54.27%	\$28,566,309	16.43%	\$45,602,421	26.22%	\$53,500	0.03%
2009	\$139,651,883	\$81,095,486	58.07%	\$28,147,236	20.16%	\$27,259,161	19.52%	\$3,150,000	2.26%
2010	\$146,484,944	\$88,496,871	60.41%	\$15,151,943	10.34%	\$37,501,130	25.60%	\$5,335,000	3.64%
2011	\$170,395,012	\$88,321,177	51.83%	\$34,110,670	20.02%	\$43,513,165	25.54%	\$4,450,000	2.61%

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
2007	\$ 191,365,811	422	\$ 453,473	308	\$ 621,318
2008	\$ 173,892,874	377	\$ 461,254	280	\$ 621,046
2009	\$ 178,236,910	396	\$ 450,093	292	\$ 610,400
2010	\$ 146,484,944	329	\$ 445,243	255	\$ 574,451
2011	\$ 170,395,012	353	\$ 482,705	264	\$ 645,436

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

PA Department of Insurance

Summary of Annual Fund Claim Payments by Health Care Provider Group
2002-2011

Year	<u>Individuals</u> MD's, DO's, Podiatrists Certified Nurse Midwives				<u>Medical Corps</u>				<u>Institutions</u> Hospitals, Nursing Homes Birth Center, Primary Care Centers				<u>Totals</u>	
	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
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
2010	194	59%	\$ 87,936,023	60%	10	3%	\$ 5,592,973	4%	125	38%	\$ 52,955,948	36%	329	\$ 146,484,944
2011	230	65%	\$ 110,890,028	65%	18	5%	\$ 8,543,331	5%	105	30%	\$ 50,961,653	30%	353	\$ 170,395,012

Office of Mcare

**2011 Claims Payment by Commercial
Carrier and Self-Insurer**

Company Code	Total Fund Payments
S10	\$ 3,700,000
S12	\$ 1,375,000
S24	\$ 500,000
S32	\$ 950,000
S41	\$ 500,000
S48	\$ 1,000,000
S51	\$ 1,000,000
S53	\$ 500,000
S60	\$ 1,000,000
003	\$ 12,407,633
011	\$ 1,975,000
031	\$ 12,962,642
032	\$ 2,275,000
045	\$ 205,000
052	\$ 100,000
067	\$ 17,993,170
086	\$ 5,407,500
093	\$ 1,600,000
103	\$ 500,000
119	\$ 855,083
121	\$ 200,000
124	\$ 425,000
126	\$ 1,000,000
129	\$ 2,750,000
136	\$ 1,550,000
143	\$ 139,261
144	\$ 12,324,000
145	\$ 2,425,000

Office of Mcare

**2011 Claims Payment by Commercial
Carrier and Self-Insurer**

Company Code	Total Fund Payments
155	\$ 13,953,751
156	\$ 5,375,000
160	\$ 1,313,804
162	\$ 1,200,000
184	\$ 1,818,092
194	\$ 500,000
197	\$ 2,537,500
199	\$ 1,850,000
202	\$ 7,845,426
203	\$ 500,000
207	\$ 12,832,067
208	\$ 120,000
211	\$ 7,236,287
219	\$ 2,000,000
220	\$ 1,590,000
221	\$ 3,585,275
222	\$ 500,000
223	\$ 618,521
224	\$ 1,000,000
228	\$ 1,250,000
229	\$ 2,500,000
241	\$ 650,000
243	\$ 500,000
245	\$ 2,900,000
246	\$ 2,700,000
250	\$ 1,000,000
253	\$ 1,650,000

Office of Mcare

**2011 Claims Payment by Commercial
Carrier and Self-Insurer**

Company Code	Total Fund Payments
256	\$ 500,000
258	\$ 250,000
261	\$ 500,000
271	\$ 500,000
276	\$ 1,000,000
293	\$ 500,000
Totals	\$ 170,395,012

Office of Mcare

2007 - 2011 Claims Payment by Commercial Carrier and Self-Insurer

Carrier Code	2007	2008	2009	2010	2011
S01	\$ 1,175,000		\$ 700,000		
S07		\$ 2,000,000			
S10		\$ 3,000,000	\$ 2,500,000	\$ 3,000,000	\$ 3,700,000
S11			\$ 750,000		
S12	\$ 70,000	\$ 500,000	\$ 700,000	\$ 500,000	\$ 1,375,000
S14		\$ 1,000,000			
S23		\$ 906,250			
S24					\$ 500,000
S32					\$ 950,000
S34		\$ 1,000,000			
S36		\$ 1,500,000	\$ 750,000		
S41				\$ 500,000	\$ 500,000
S43		\$ 500,000		\$ 750,000	
S45		\$ 400,000			
S48	\$ 500,000	\$ 1,000,000			\$ 1,000,000
S49	\$ 200,000				
S51					\$ 1,000,000
S53			\$ 1,200,000		\$ 500,000
S54		\$ 500,000			
S57				\$ 500,000	
S60				\$ 400,000	\$ 1,000,000
S62	\$ 700,000			\$ 500,000	
003	\$ 9,453,248	\$ 10,728,436	\$ 20,094,627	\$ 11,007,385	\$ 12,407,633
011	\$ 3,109,150	\$ 3,950,000	\$ 5,340,251	\$ 1,600,000	\$ 1,975,000
020				\$ 500,000	
031	\$ 15,019,312	\$ 16,042,750	\$ 17,861,959	\$ 9,520,502	\$ 12,962,642
032	\$ 7,825,000	\$ 4,109,736	\$ 5,600,000	\$ 2,130,000	\$ 2,275,000
039					
045	\$ 162,500	\$ 350,000	\$ 100,000	\$ 700,000	\$ 205,000
052					\$ 100,000
055				\$ 125,000	
067	\$ 34,215,389	\$ 18,239,903	\$ 13,458,485	\$ 7,770,531	\$ 17,993,170
086	\$ 15,463,599	\$ 13,739,896	\$ 4,340,859	\$ 675,000	\$ 5,407,500
088					
093	\$ 2,525,000	\$ 1,865,000	\$ 4,025,000	\$ 2,325,000	\$ 1,600,000
102					
103					\$ 500,000
112		\$ 500,000			
119	\$ 5,325,000	\$ 1,750,000	\$ 675,000	\$ 394,917	\$ 855,083
121	\$ 675,000	\$ 500,000	\$ 2,147,661	\$ 700,000	\$ 200,000
124		\$ 500,000			\$ 425,000
126	\$ 2,967,496	\$ 2,441,655	\$ 1,800,000	\$ 661,031	\$ 1,000,000
129	\$ 2,700,000	\$ 6,575,000	\$ 5,250,000	\$ 7,700,000	\$ 2,750,000
131		\$ 557			
135	\$ 250,000		\$ 3,630,987		
136	\$ 7,996,750	\$ 7,950,000	\$ 4,797,784	\$ 2,325,000	\$ 1,550,000

Office of Mcare

2007 - 2011 Claims Payment by Commercial Carrier and Self-Insurer

Carrier Code	2007	2008	2009	2010	2011
139				\$ 500,000	
143	\$ 1,000,000		\$ 1,425,000		\$ 139,261
144	\$ 11,175,000	\$ 10,219,400	\$ 11,875,000	\$ 5,675,000	\$ 12,324,000
145	\$ 2,800,000	\$ 600,000	\$ 1,792,500	\$ 7,200,000	\$ 2,425,000
155	\$ 13,489,405	\$ 6,620,790	\$ 14,544,463	\$ 13,200,000	\$ 13,953,751
156	\$ 5,980,000	\$ 6,650,000	\$ 6,120,000	\$ 5,860,000	\$ 5,375,000
157					
159	\$ 240,000		\$ 25,000		
160	\$ 800,000	\$ 700,000	\$ 500,000		\$ 1,313,804
161	\$ 1,231,250	\$ 1,465,000	\$ 1,555,000		
162	\$ 2,360,013	\$ 2,214,073	\$ 700,000	\$ 5,693,463	\$ 1,200,000
164	\$ 5,050,000	\$ 1,250,000			
166		\$ 175,000			
167			\$ 150,000		
169	\$ 500,000				
183	\$ 500,000	\$ 500,000	\$ 500,000		
184	\$ 5,625,000	\$ 9,360,039	\$ 1,500,000	\$ 2,500,000	\$ 1,818,092
194	\$ 500,000		\$ 550,000	\$ 1,000,000	\$ 500,000
196	\$ 1,400,000	\$ 250,000	\$ 1,500,000	\$ 1,200,000	
197	\$ 1,550,000	\$ 5,550,000	\$ 2,699,000	\$ 3,700,000	\$ 2,537,500
199	\$ 3,100,000	\$ 1,575,000	\$ 2,950,000	\$ 1,765,000	\$ 1,850,000
201		\$ 500,000	\$ 300,000		
202	\$ 1,225,000	\$ 1,200,000	\$ 4,200,000	\$ 5,075,000	\$ 7,845,426
203	\$ 600,000	\$ 100,000	\$ 200,000		\$ 500,000
207	\$ 8,670,000	\$ 9,450,000	\$ 14,675,834	\$ 12,209,500	\$ 12,832,067
208				\$ 912,615	\$ 120,000
211	\$ 1,000,000	\$ 2,875,000	\$ 1,512,500	\$ 3,750,000	\$ 7,236,287
212				\$ 400,000	
219	\$ 500,000	\$ 850,000		\$ 450,000	\$ 2,000,000
220	\$ 725,000	\$ 940,000	\$ 1,125,000	\$ 1,950,000	\$ 1,590,000
221	\$ 1,150,000	\$ 742,559	\$ 3,500,000	\$ 3,050,000	\$ 3,585,275
222	\$ 452,699	\$ 850,000		\$ 1,010,000	\$ 500,000
223				\$ 800,000	\$ 618,521
224	\$ 500,000	\$ 300,000	\$ 650,000	\$ 500,000	\$ 1,000,000
228	\$ 1,500,000	\$ 500,000	\$ 2,250,000	\$ 300,000	\$ 1,250,000
229	\$ 500,000	\$ 1,131,830	\$ 300,000	\$ 950,000	\$ 2,500,000
234				\$ 200,000	
239			\$ 500,000	\$ 800,000	
241	\$ 810,000		\$ 550,000	\$ 400,000	\$ 650,000
243					\$ 500,000
245	\$ 3,850,000	\$ 3,300,000	\$ 500,000	\$ 1,000,000	\$ 2,900,000
246	\$ 1,675,000	\$ 1,100,000	\$ 1,255,000	\$ 1,850,000	\$ 2,700,000
248			\$ 160,000	\$ 500,000	
250	\$ 325,000	\$ 1,000,000			\$ 1,000,000
251			\$ 200,000		
253	\$ 250,000		\$ 2,000,000	\$ 6,000,000	\$ 1,650,000

Office of Mcare

2007 - 2011 Claims Payment by Commercial Carrier and Self-Insurer

Carrier Code	2007	2008	2009	2010	2011
256		\$ 375,000			\$ 500,000
258			\$ 250,000	\$ 300,000	\$ 250,000
261				\$ 1,000,000	\$ 500,000
271					\$ 500,000
276				\$ 500,000	\$ 1,000,000
293					\$ 500,000
Totals	\$ 191,365,811	\$ 173,892,874	\$ 178,236,910	\$ 146,484,944	\$ 170,395,012

Office of Mcare
**2011 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
001	\$ 9,802
003	\$ 11,528,434
011	\$ 2,517,764
021	\$ 69,248
023	\$ 58,515
031	\$ 17,082,087
032	\$ 850,036
052	\$ 82,015
067	\$ 11,664,186
090	\$ 66,122
103	\$ 338,583
110	\$ 35,584
112	\$ 91,767
113	\$ 8,969
121	\$ 544,695
124	\$ 681,762
127	\$ 295,790
129	\$ 3,933,494
137	\$ 79,619
138	\$ 746,057
144	\$ 15,346,247
145	\$ 3,442,954
155	\$ 12,374,903
156	\$ 7,120,403
162	\$ 17,354
165	\$ 11,689
179	\$ 30,926
186	\$ 37,941
194	\$ 92,114
196	\$ 1,084,854
197	\$ 4,267,282

Office of Mcare
**2011 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
198	\$ 87,992
199	\$ 4,066,444
202	\$ 6,695,543
203	\$ 1,316,906
206	\$ 27,596
207	\$ 12,826,590
208	\$ 1,674,013
210	\$ 801,109
211	\$ 6,668,187
212	\$ 215,612
216	\$ 5,539
217	\$ 288,634
218	\$ 259,598
219	\$ 3,318,917
220	\$ 1,859,464
221	\$ 3,398,490
222	\$ 3,071,613
223	\$ 675,243
224	\$ 1,542,118
225	\$ 58,234
226	\$ 64,177
227	\$ 2,755
228	\$ 1,302,163
230	\$ 7,414
232	\$ 107,545
234	\$ 171,751
235	\$ 60,010
236	\$ 14,613
237	\$ 35,052
239	\$ 2,372,644
241	\$ 784,380

Office of Mcare
**2011 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
242	\$ 30,820
243	\$ 19,320
244	\$ 70,052
245	\$ 4,742,434
246	\$ 1,684,051
247	\$ 21,938
248	\$ 286,594
249	\$ 19,562
250	\$ 51,022
251	\$ 44,006
252	\$ 53,143
253	\$ 3,521,960
257	\$ 38,693
258	\$ 1,602,098
261	\$ 1,287,625
262	\$ 36,892
264	\$ 949
265	\$ 71,118
266	\$ 23,275
267	\$ 470
268	\$ 1,674
271	\$ 2,180,681
274	\$ 145,726
275	\$ 379,604
276	\$ 437,079
277	\$ 56,052
279	\$ 471,708
282	\$ 37,291
285	\$ 282,494
286	\$ 116,830
289	\$ 11,298

Office of Mcare
**2011 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
290	\$ 60,690
292	\$ 13,718
293	\$ 57,361
294	\$ 5,982
296	\$ 7,908
297	\$ 8,824
298	\$ 26,780
303	\$ 29,308
305	\$ 38,319
307	\$ 653
308	\$ 510,497
310	\$ 4,024,366
313	\$ 723
314	\$ 42,310
315	\$ 13,585
316	\$ 12,325
318	\$ 7,288
320	\$ 135,342
900	\$ 1,486
Total	\$ 171,015,466

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 27, 2012.

PA Department of Insurance

Office of Mcare

Assessment Remitted by Commercial Carrier for 2007 - 2011

	2007	2008	2009	2010	2011
Carrier Code	Amount ¹				
001	\$ 26,450	\$ 18,923	\$ 17,490	\$ 12,880	\$ 9,802
003	\$ 16,320,565	\$ 16,195,191	\$ 14,638,418	\$ 14,189,708	\$ 11,528,434
011	\$ 3,077,043	\$ 3,231,450	\$ 2,478,285	\$ 2,783,920	\$ 2,517,764
021	\$ 101,967	\$ 87,719	\$ 82,229	\$ 81,444	\$ 69,248
023	\$ 105,614	\$ 65,366	\$ 51,034	\$ 58,115	\$ 58,515
026	\$ 55,443	\$ 9,870			
031	\$ 26,109,577	\$ 23,321,704	\$ 21,572,060	\$ 21,275,570	\$ 17,082,087
032	\$ 3,941,745	\$ 2,357,489	\$ 1,640,523	\$ 1,288,057	\$ 850,036
052	\$ 175,840	\$ 114,486	\$ 201,056	\$ 102,925	\$ 82,015
067	\$ 17,232,813	\$ 15,474,041	\$ 15,815,478	\$ 15,188,312	\$ 11,664,186
090	\$ 165,092	\$ 139,276	\$ 124,663	\$ 70,966	\$ 66,122
103	\$ 555,681	\$ 544,718	\$ 451,207	\$ 415,644	\$ 338,583
110	\$ 26,465	\$ 31,004	\$ 35,085	\$ 39,745	\$ 35,584
112	\$ 255,200	\$ 229,238	\$ 182,861	\$ 107,368	\$ 91,767
113				\$ 2,434	\$ 8,969
118			\$ 7,157		
121	\$ 882,765	\$ 776,633	\$ 678,983	\$ 679,222	\$ 544,695
124	\$ 1,147,023	\$ 916,065	\$ 885,896	\$ 830,255	\$ 681,762
127	\$ 236,203	\$ 242,147	\$ 331,553	\$ 360,200	\$ 295,790
129	\$ 7,285,969	\$ 5,985,395	\$ 5,253,971	\$ 5,343,647	\$ 3,933,494
130	\$ 39				
137	\$ 156,052	\$ 136,705	\$ 118,536	\$ 118,127	\$ 79,619
138	\$ 589,153	\$ 616,309	\$ 596,813	\$ 717,329	\$ 746,057
139	\$ 163,506	\$ 149,005	\$ 56,086		
144	\$ 20,302,265	\$ 18,671,568	\$ 16,847,286	\$ 18,066,209	\$ 15,346,247
145	\$ 4,065,134	\$ 4,092,757	\$ 4,089,908	\$ 4,233,318	\$ 3,442,954
155	\$ 15,193,657	\$ 15,775,505	\$ 14,719,619	\$ 14,964,745	\$ 12,374,903
156	\$ 10,559,191	\$ 8,189,946	\$ 10,276,763	\$ 9,120,723	\$ 7,120,403
162	\$ 90,671	\$ 53,423	\$ 35,851	\$ 16,938	\$ 17,354
165			\$ 184	\$ 22,085	\$ 11,689
169				\$ 4,180	
179	\$ 176,742	\$ 79,223	\$ 37,368	\$ 36,539	\$ 30,926
182	\$ 11,369	\$ 4,368			
186	\$ 147,557	\$ 147,828	\$ 108,211	\$ 103,706	\$ 37,941
191	\$ 92,138	\$ 54,711	\$ 20,188		
194	\$ 552,999	\$ 113,328	\$ 21,707	\$ 106,229	\$ 92,114
196	\$ 1,342,237	\$ 1,152,322	\$ 1,266,641	\$ 1,189,945	\$ 1,084,854
197	\$ 6,001,678	\$ 5,680,512	\$ 4,925,958	\$ 4,958,432	\$ 4,267,282

Office of Mcare

Assessment Remitted by Commercial Carrier for 2007 - 2011

	2007	2008	2009	2010	2011
Carrier Code	Amount ¹				
198	\$ 8,144	\$ 6,734	\$ 6,218	\$ 107,345	\$ 87,992
199	\$ 4,568,319	\$ 4,774,694	\$ 4,587,769	\$ 4,849,906	\$ 4,066,444
200	\$ 905	\$ 241			
202	\$ 9,201,982	\$ 8,584,080	\$ 7,820,445	\$ 8,111,110	\$ 6,695,543
203	\$ 1,530,507	\$ 1,304,080	\$ 1,294,032	\$ 1,369,529	\$ 1,316,906
206	\$ 50,555	\$ 41,631	\$ 54,164	\$ 24,312	\$ 27,596
207	\$ 21,081,910	\$ 20,796,507	\$ 19,139,405	\$ 14,797,783	\$ 12,826,590
208	\$ 2,584,709	\$ 2,046,417	\$ 1,868,086	\$ 1,968,885	\$ 1,674,013
210	\$ 402,201	\$ 561,387	\$ 780,717	\$ 877,311	\$ 801,109
211	\$ 9,471,805	\$ 9,612,577	\$ 8,350,530	\$ 8,930,080	\$ 6,668,187
212	\$ 214,146	\$ 197,423	\$ 185,955	\$ 183,657	\$ 215,612
215	\$ 60,933				
216	\$ 10,985	\$ 7,052	\$ 7,039	\$ 7,392	\$ 5,539
217	\$ 514,874	\$ 459,023	\$ 384,630	\$ 357,590	\$ 288,634
218	\$ 241,409	\$ 232,387	\$ 258,318	\$ 285,174	\$ 259,598
219	\$ 5,488,259	\$ 5,216,379	\$ 4,344,993	\$ 3,990,674	\$ 3,318,917
220	\$ 2,220,812	\$ 2,088,440	\$ 2,096,936	\$ 2,170,930	\$ 1,859,464
221	\$ 6,101,049	\$ 4,865,316	\$ 4,409,132	\$ 4,461,733	\$ 3,398,490
222	\$ 3,663,769	\$ 3,500,720	\$ 3,302,708	\$ 3,466,802	\$ 3,071,613
223	\$ 3,967,074	\$ 3,849,643	\$ 3,500,761	\$ 3,417,807	\$ 675,243
224	\$ 1,903,972	\$ 1,816,699	\$ 1,715,929	\$ 1,772,875	\$ 1,542,118
225	\$ 48,129	\$ 48,020	\$ 47,223	\$ 55,395	\$ 58,234
226	\$ 96,197	\$ 90,967	\$ 82,373	\$ 81,390	\$ 64,177
227	\$ 4,010	\$ 3,675	\$ 3,338	\$ 3,360	\$ 2,755
228	\$ 1,768,490	\$ 1,701,835	\$ 1,607,351	\$ 1,633,760	\$ 1,302,163
229	\$ 3,753,361	\$ 2,422,927	\$ 2,324		
230	\$ 15,416	\$ 22,103	\$ 20,715	\$ 20,859	\$ 7,414
232	\$ 54,951	\$ 32,884	\$ 60,383	\$ 101,537	\$ 107,545
233	\$ 43,869	\$ 4,592	\$ 617	\$ 119	
234	\$ 219,645	\$ 211,825	\$ 225,656	\$ 211,684	\$ 171,751
235	\$ 86,273	\$ 81,046	\$ 73,644	\$ 73,290	\$ 60,010
236	\$ 59,594	\$ 49,931	\$ 77,890	\$ 53,065	\$ 14,613
237	\$ 6,774	\$ 25,463	\$ 37,613	\$ 18,081	\$ 35,052
239	\$ 2,850,125	\$ 2,862,069	\$ 2,544,367	\$ 2,501,542	\$ 2,372,644
241	\$ 1,112,562	\$ 1,011,930	\$ 927,277	\$ 936,689	\$ 784,380
242	\$ 43,943	\$ 41,115	\$ 37,341	\$ 37,599	\$ 30,820
243	\$ 32,439	\$ 30,088	\$ 26,843	\$ 23,892	\$ 19,320
244	\$ 80,052	\$ 101,064	\$ 89,529	\$ 88,776	\$ 70,052

PA Department of Insurance

Office of Mcare

Assessment Remitted by Commercial Carrier for 2007 - 2011

	2007	2008	2009	2010	2011
Carrier Code	Amount ¹				
245	\$ 5,505,853	\$ 5,229,282	\$ 5,082,741	\$ 5,427,909	\$ 4,742,434
246	\$ 3,017,049	\$ 2,873,591	\$ 2,391,645	\$ 2,146,947	\$ 1,684,051
247	\$ 100,909	\$ 98,780	\$ 25,672	\$ 30,620	\$ 21,938
248	\$ 472,532	\$ 374,798	\$ 302,166	\$ 313,505	\$ 286,594
249	\$ 1,584	\$ 11,495	\$ 11,427	\$ 21,289	\$ 19,562
250	\$ 657,154	\$ 613,888	\$ 549,842	\$ 482,819	\$ 51,022
251	\$ 285,173	\$ 178,568	\$ 73,792	\$ 53,983	\$ 44,006
252	\$ 100,293	\$ 84,861	\$ 78,382	\$ 67,892	\$ 53,143
253	\$ 4,207,896	\$ 4,117,837	\$ 3,965,972	\$ 4,128,501	\$ 3,521,960
257	\$ 35,491	\$ 35,638	\$ 69,671	\$ 48,673	\$ 38,693
258	\$ 2,916,690	\$ 2,594,610	\$ 2,105,917	\$ 1,914,326	\$ 1,602,098
261	\$ 1,306,907	\$ 1,223,152	\$ 1,318,928	\$ 1,193,784	\$ 1,287,625
262	\$ 24,994	\$ 21,229	\$ 26,752	\$ 33,772	\$ 36,892
263			\$ 3,080		
264	\$ 2,894	\$ 1,161	\$ 1,075	\$ 920	\$ 949
265	\$ 107,210	\$ 106,640	\$ 28,958	\$ 13,756	\$ 71,118
266	\$ 45,041	\$ 28,808	\$ 25,919	\$ 26,099	\$ 23,275
267	\$ 970	\$ 1,038	\$ 536	\$ 573	\$ 470
268	\$ 7,111	\$ 6,439	\$ 5,204	\$ 1,752	\$ 1,674
271	\$ 445,181	\$ 958,412	\$ 1,669,991	\$ 2,509,786	\$ 2,180,681
272	\$ 7,177	\$ 8,822			
274	\$ 211,445	\$ 174,291	\$ 164,117	\$ 181,037	\$ 145,726
275	\$ 610,171	\$ 538,695	\$ 469,953	\$ 546,542	\$ 379,604
276	\$ 672,192	\$ 598,144	\$ 538,114	\$ 538,184	\$ 437,079
277				\$ 33,446	\$ 56,052
278		\$ 566			
279	\$ 175,728	\$ 228,393	\$ 216,826	\$ 540,063	\$ 471,708
281	\$ 1,176	\$ 943	\$ 949		
282	\$ 48,300	\$ 68,160	\$ 84,290	\$ 46,873	\$ 37,291
285		\$ 98,668	\$ 273,106	\$ 420,044	\$ 282,494
286		\$ 38,594	\$ 50,081	\$ 78,039	\$ 116,830
287		\$ 28,721			
289				\$ 13,782	\$ 11,298
290		\$ 3,929	\$ 113,197	\$ 65,930	\$ 60,690
292	\$ 286		\$ 37,934	\$ 11,491	\$ 13,718
293			\$ 49,751	\$ 52,828	\$ 57,361
294			\$ 2,944	\$ 7,299	\$ 5,982
296	\$ 3,048	\$ 4,270	\$ 2,682	\$ 2,814	\$ 7,908

Office of Mcare

Assessment Remitted by Commercial Carrier for 2007 - 2011

	2007	2008	2009	2010	2011
Carrier Code	Amount ¹				
297			\$ 33,500	\$ 18,398	\$ 8,824
298			\$ 5,495	\$ 24,403	\$ 26,780
303				\$ 19,540	\$ 29,308
305			\$ 2,678	\$ 45,945	\$ 38,319
307				\$ 1,272	\$ 653
308				\$ 365,405	\$ 510,497
310			\$ 3,225	\$ 4,889,546	\$ 4,024,366
313			\$ 572	\$ 882	\$ 723
314				\$ 25,112	\$ 42,310
315				\$ 53,824	\$ 13,585
316					\$ 12,325
318					\$ 7,288
320					\$ 135,342
900	\$ 5,337	\$ 3,242	\$ 6,278	\$ 2,428	\$ 1,486
Total	\$ 241,685,784	\$ 223,716,854	\$ 207,334,681	\$ 209,882,883	\$ 171,015,466

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 27, 2012.

Office of Mcare

**2011 Assessment Remitted by
Self-Insurer**

Company Code	Amount ¹
S10	\$ 3,854,963
S12	\$ 1,446,944
S40	\$ 320,988
S41	\$ 61,967
S49	\$ 515,631
S51	\$ 8,770
S53	\$ 182,334
S54	\$ 341,407
S57	\$ 39,633
S58	\$ 10,656
S60	\$ 372,579
S61	\$ 9,306
S63	\$ 157,935
S64	\$ 12,459
S67	\$ 14,561
TOTALS	\$ 7,350,133

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 27, 2012.

PA Department of Insurance

Office of Mcare					
Assessments Remitted by Self-Insurer 2007 - 2011					
Carrier	2007	2008	2009	2010	2011
S10	\$ 4,692,818	\$ 4,515,980	\$ 4,401,573	\$ 4,580,935	\$ 3,854,963
S12	\$ 1,579,563	\$ 1,533,370	\$ 1,442,094	\$ 1,497,885	\$ 1,446,944
S34	\$ 149,334				
S40	\$ 425,328	\$ 405,479	\$ 398,985	\$ 421,831	\$ 320,988
S41	\$ 102,625	\$ 98,300	\$ 84,109	\$ 75,339	\$ 61,967
S43	\$ 201,996	\$ 276,166	\$ 265,791		
S46	\$ 14,279	\$ 12,820	\$ 11,331		
S47	\$ 145,913	\$ 135,249			
S49	\$ 790,576	\$ 781,081	\$ 662,475	\$ 640,551	\$ 515,631
S51	\$ 713,553	\$ 687,254	\$ 667,269	\$ 540,122	\$ 8,770
S53	\$ 340,490	\$ 201,167	\$ 190,741	\$ 182,191	\$ 182,334
S54	\$ 367,418	\$ 340,441	\$ 343,321	\$ 372,268	\$ 341,407
S57	\$ 63,396	\$ 55,414	\$ 49,877	\$ 52,078	\$ 39,633
S58	\$ 17,387	\$ 12,503	\$ 13,637	\$ 16,372	\$ 10,656
S59	\$ 27,285	\$ 24,514	\$ 22,223	\$ 11,932	
S60	\$ 459,988	\$ 412,089	\$ 419,605	\$ 399,292	\$ 372,579
S61	\$ 13,766	\$ 12,516	\$ 11,367	\$ 11,445	\$ 9,306
S62	\$ 387,338	\$ 806,096			
S63	\$ 269,323	\$ 285,887	\$ 250,675	\$ 244,193	\$ 157,935
S64	\$ 18,134	\$ 16,912	\$ 15,095	\$ 15,199	\$ 12,459
S66			\$ 467,498		
S67				\$ 3,004	\$ 14,561
TOTALS	\$ 10,780,510	\$ 10,613,238	\$ 9,717,666	\$ 9,064,637	\$ 7,350,133

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 27, 2012.

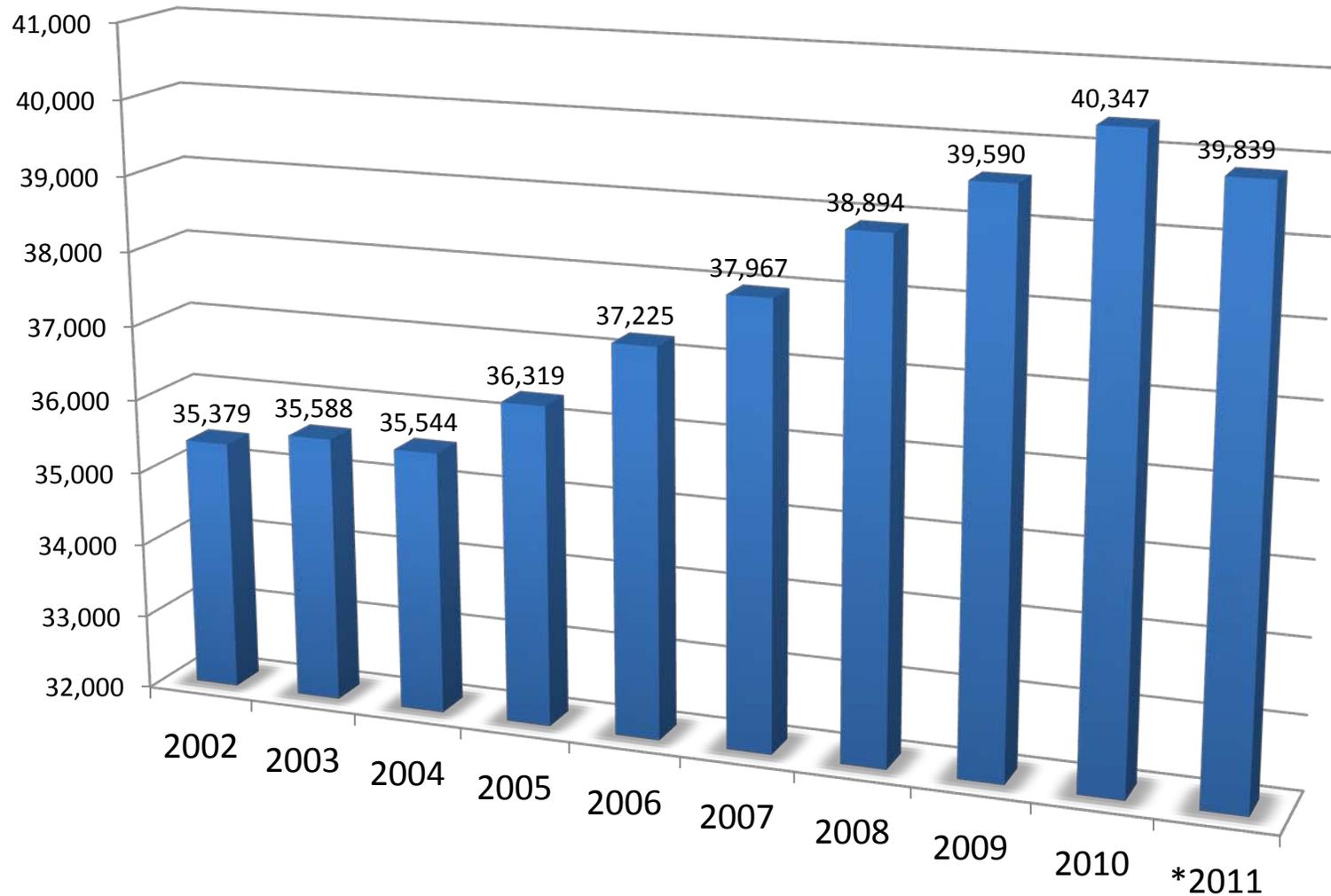
Office of Mcare

Count of Unique Health Care Providers by Provider Type by Assessment Year

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Total Annual Count of Unique Providers
2002	35,379	1,098	225	236	736	6	3	37,683
2003	35,588	1,095	231	233	728	6	4	37,885
2004	35,544	1,104	231	231	716	5	4	37,835
2005	36,319	1,089	244	225	720	5	3	38,605
2006	37,225	1,110	253	224	709	5	3	39,529
2007	37,967	1,110	266	224	714	4	4	40,289
2008	38,894	1,125	266	222	710	5	4	41,226
2009	39,590	1,138	255	218	710	5	4	41,920
2010	40,347	1,162	271	220	694	5	4	42,703
*2011	39,839	1,162	274	209	662	5	4	42,155

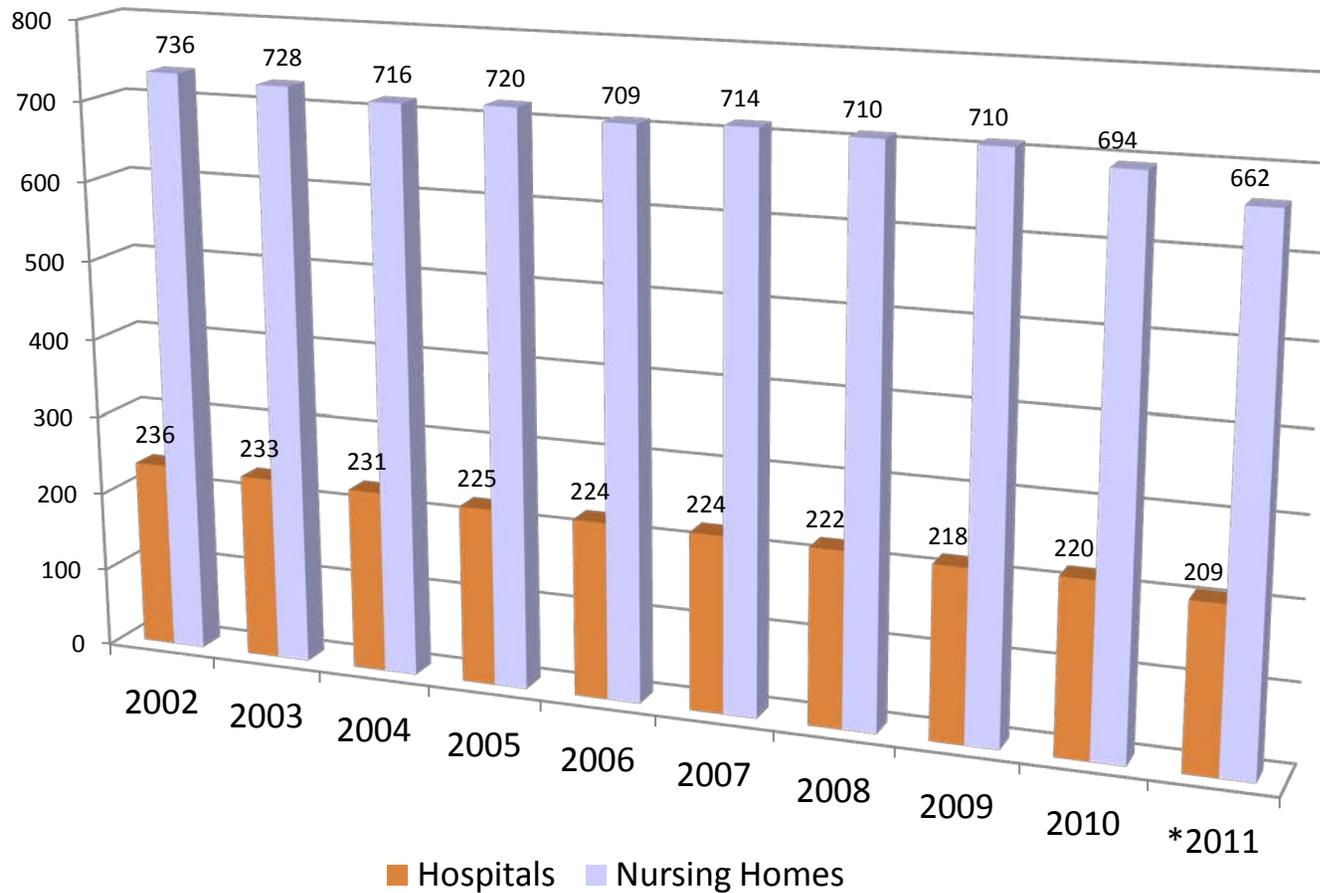
*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that has been reported and processed as of 2.27.2012 are included in the counts.

Unique Count of Physicians (MD/DO)



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Unique Count of Hospitals and Nursing Homes



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

PA Department of Insurance

Office of Mcare

Amount of Assessment Received by Provider Type by Assessment Year

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Ctrs	Birth Centers
2002	\$ 251,668,439	\$ 4,930,891	\$ 514,318	\$ 64,779,436	\$ 4,061,429	\$ 915,800	\$ 6,212
2003	\$ 293,928,743	\$ 5,917,644	\$ 825,749	\$ 73,105,848	\$ 8,777,237	\$ 880,037	\$ 14,632
2004	\$ 351,232,070	\$ 6,481,276	\$ 1,210,251	\$ 76,947,309	\$ 9,887,447	\$ 947,025	\$ 20,432
2005	\$ 293,875,833	\$ 6,161,599	\$ 1,280,876	\$ 75,094,669	\$ 8,957,666	\$ 885,526	\$ 20,382
2006	\$ 218,095,808	\$ 5,018,479	\$ 1,078,760	\$ 61,334,521	\$ 6,427,609	\$ 897,225	\$ 15,572
2007	\$ 184,561,327	\$ 3,692,160	\$ 965,769	\$ 49,332,468	\$ 5,367,569	\$ 767,941	\$ 18,061
2008	\$ 171,338,225	\$ 2,989,440	\$ 997,445	\$ 45,414,872	\$ 5,223,110	\$ 813,838	\$ 20,708
2009	\$ 159,304,902	\$ 2,819,523	\$ 890,670	\$ 41,907,180	\$ 4,757,676	\$ 776,744	\$ 19,991
2010	\$ 161,986,003	\$ 2,913,910	\$ 983,643	\$ 41,599,152	\$ 4,556,478	\$ 784,659	\$ 24,203
*2011	\$ 132,790,865	\$ 2,416,693	\$ 805,975	\$ 33,309,384	\$ 3,549,832	\$ 657,926	\$ 20,025

*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the amount.

Assessment Remitted on Behalf of Physicians (MD/DO)



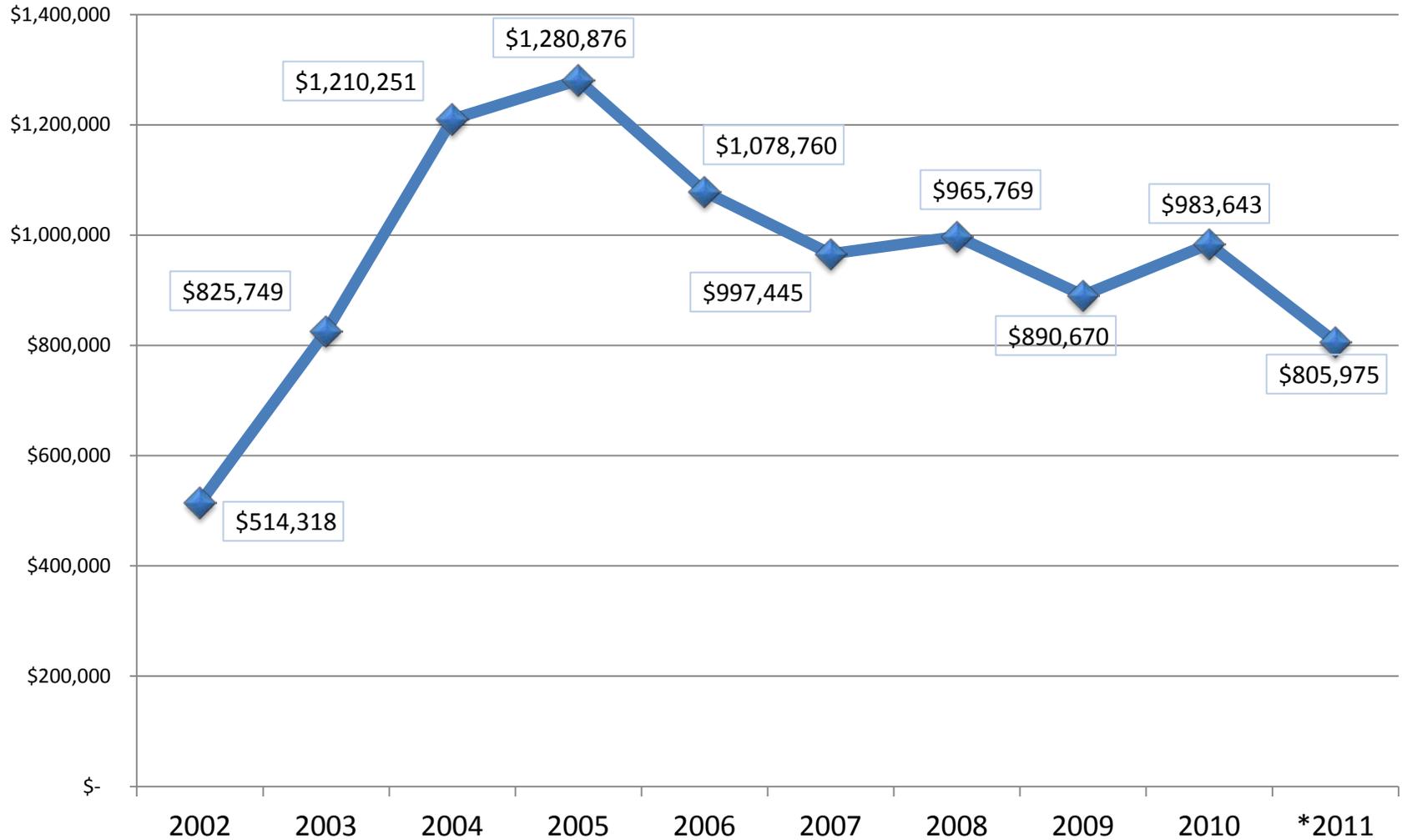
*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Assessment Remitted on Behalf of Podiatrists



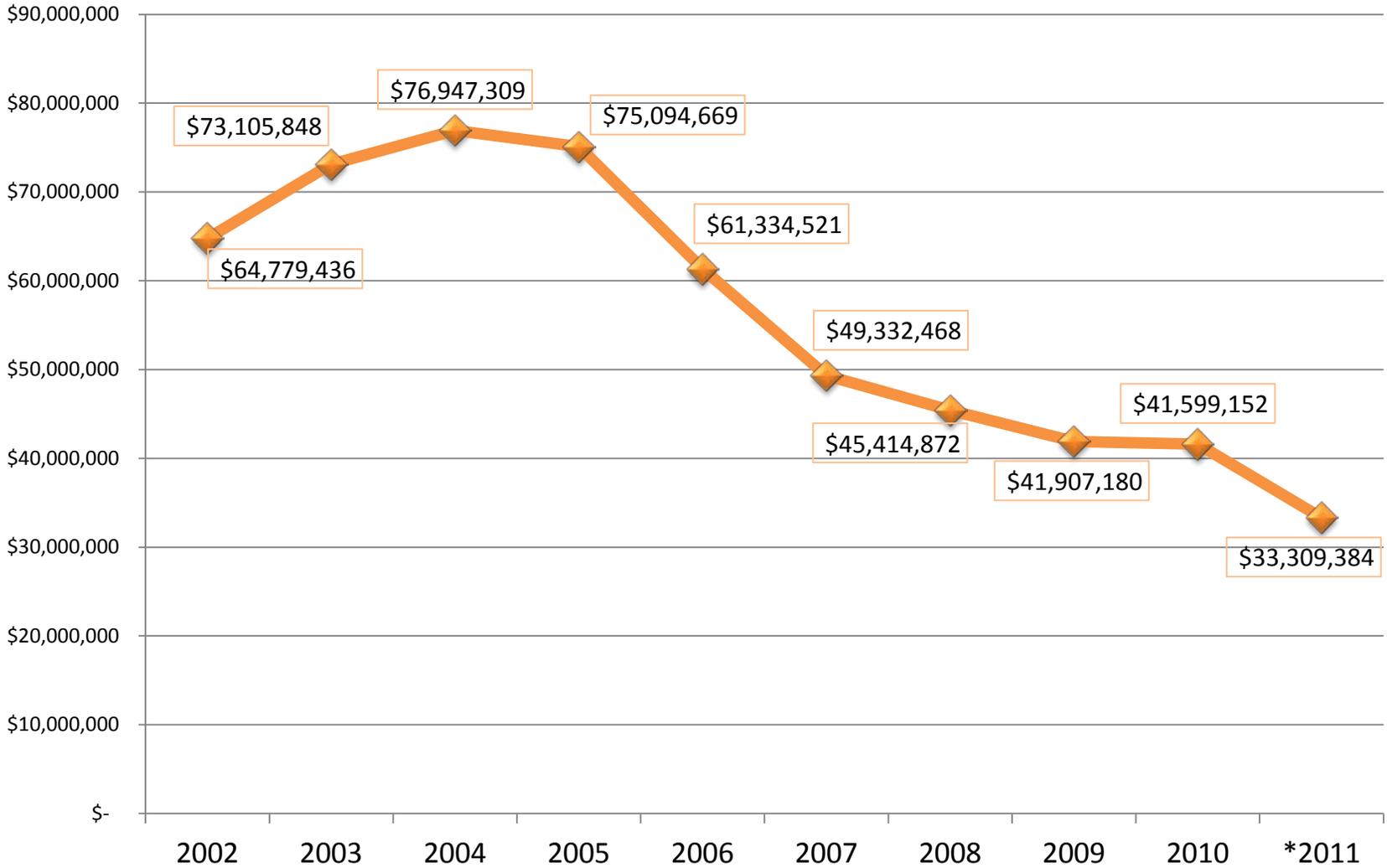
*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Assessment Remitted on Behalf of Certified Nurse Mid-Wives



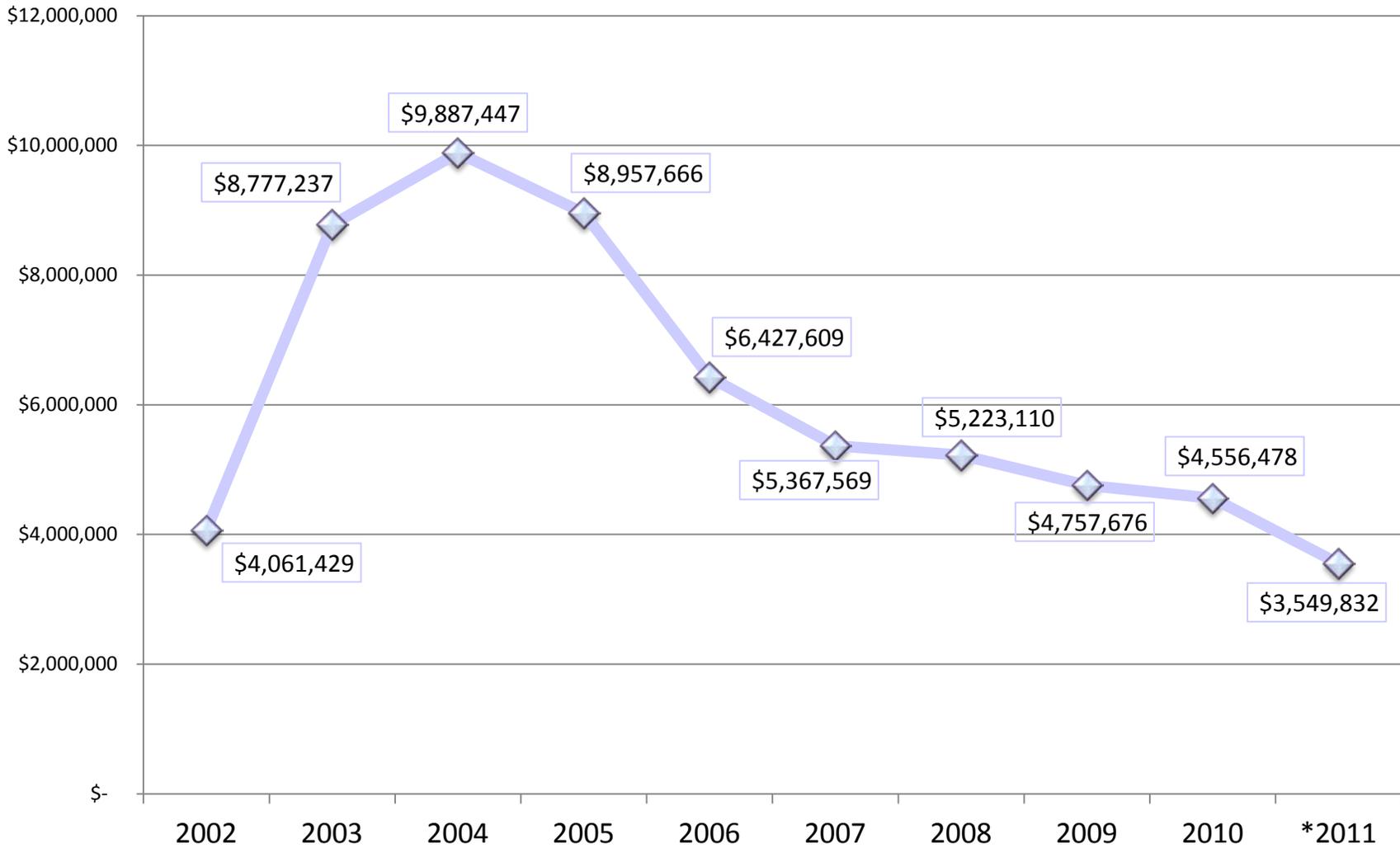
*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Assessment Remitted on Behalf of Hospitals



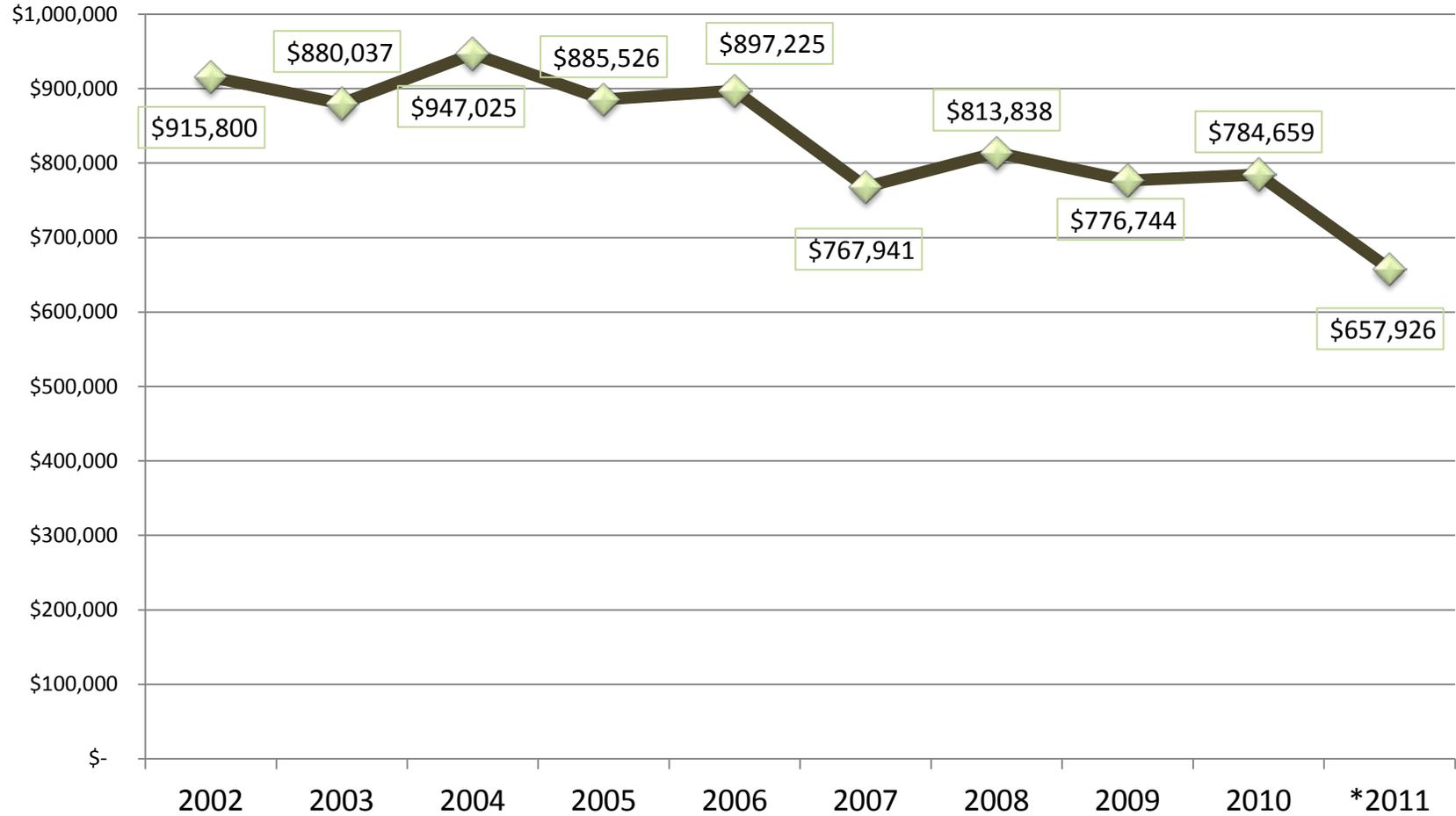
*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Assessment Remitted on Behalf of Nursing Homes



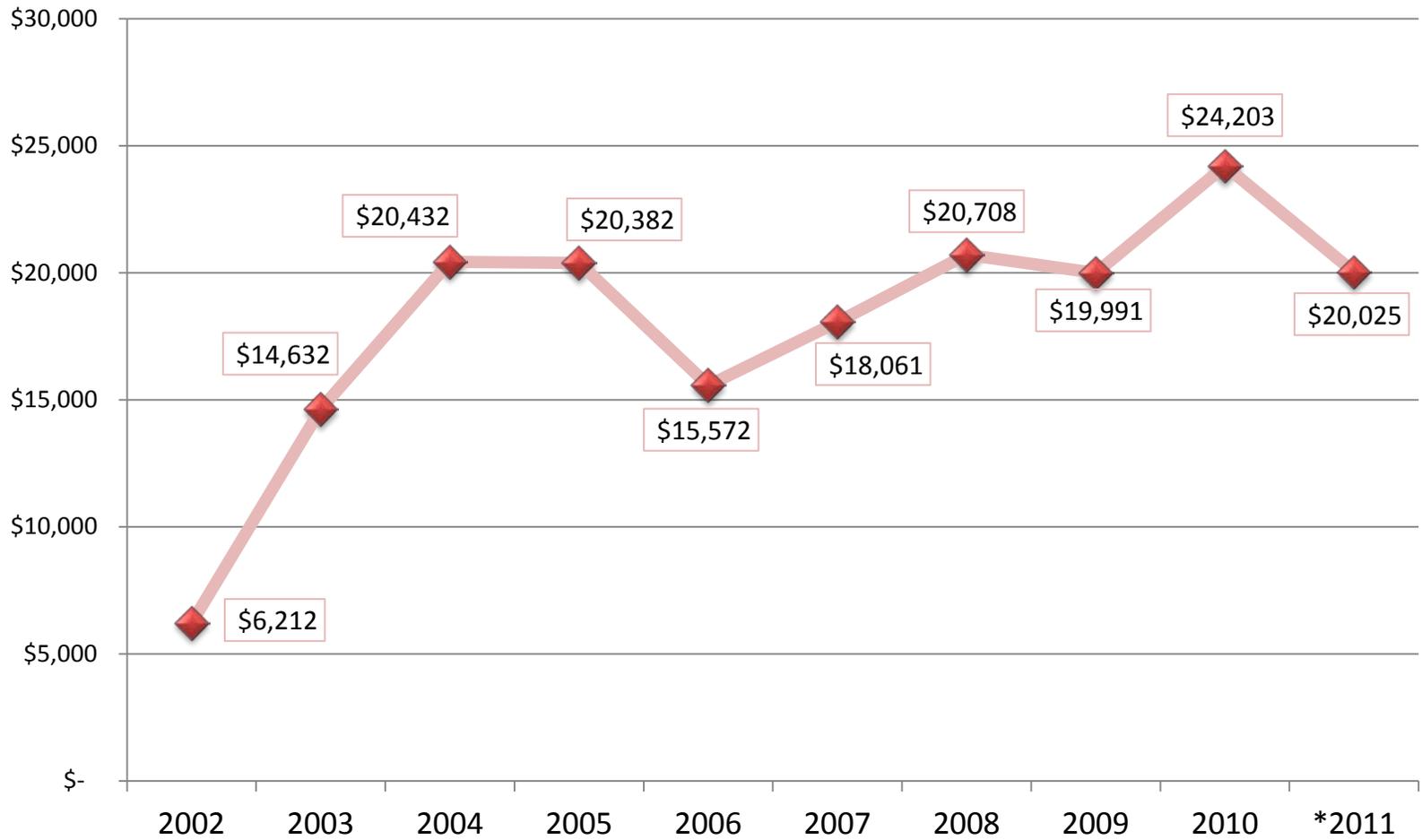
*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Assessment Remitted on Behalf of Primary Health Care Centers



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

Assessment Remitted on Behalf of Birth Centers



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2012. Coverage for policies that have been reported and processed as of February 27, 2012 is included in the counts.

PA Department of Insurance

Office of Mcare

Yearly Average Unabated Assessment by Provider Group

	Physicians			Podiatrists			Hospitals			Nuring Homes		
	Yearly Average	% Change over Prior Year	% Change from 2002 to 2011	Yearly Average	% Change over Prior Year	% Change from 2002 to 2011	Yearly Average	% Change over Prior Year	% Change from 2002 to 2011	Yearly Average	% Change over Prior Year	% Change from 2002 to 2011
2002	\$7,113			\$4,490			\$274,489			\$5,518		
2003*	\$8,259	16%		\$5,403	20%		\$313,755	14%		\$12,056	118%	
2004*	\$9,881	20%		\$5,870	9%		\$333,103	6%		\$13,808	15%	
2005*	\$8,091	-18%		\$5,657	-4%		\$333,751	0%		\$12,440	-10%	
2006*	\$5,858	-28%		\$4,520	-20%		\$273,812	-18%		\$9,064	-27%	
2007*	\$4,861	-17%		\$3,326	-26%		\$220,234	-20%		\$7,516	-17%	
2008	\$4,405	-9%		\$2,656	-20%		\$204,567	-7%		\$7,387	-2%	
2009	\$4,023	-9%		\$2,477	-7%		\$192,233	-6%		\$6,671	-10%	
2010	\$4,006	0%		\$2,506	1%		\$189,086	-2%		\$6,561	-2%	
2011	\$3,320	-17%	-53%	\$2,074	-17%	-54%	\$160,254	-15%	-42%	\$5,384	-18%	-2%

* Assessment Year in which the Abatement Program was in place; however, the averages are based on unabated assessments.