pennsylvania
INSURANCE DEPARTMENT

2014

ANNUAL REPORT

PENNSYLVANIA INSURANCE DEPARTMENT
Medical Care Availability and
Reduction of Error Fund

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I. EXECUTIVE SUMMARY

During 2014, Mcare continued to provide excellent service to the healthcare provider community as well as the citizens of the Commonwealth. Mcare paid out $156 million in covered medical malpractice claims.

Highlights of Accomplishments for 2014

- During 2014, multi-year litigation regarding the annual assessment calculation was settled. The settlement provided an immediate benefit to Health Care Providers (HCPs) as $61 million was applied to reduce the 2015 assessment. Also, $139 million will be returned to HCPs by April 2016. Finally, $30 million was designated as a reserve fund to moderate any future swings in the assessment amount.

- Mcare continued to increase its focus on being a facilitator for alternative dispute resolution techniques such as mediation and arbitration. Providing a neutral, unbiased and standardized platform removes some of the hurdles that impede these techniques being used to improve efficiency and reduce costs.

- Mcare implemented additional management tools to the outside counsel invoice payment process both to insure that the invoices are processed in a timely fashion and that appropriate oversight regarding invoice accuracy and reasonableness is undertaken.

II. Mcare Background

A patient compensation fund has been part of the Commonwealth's medical professional liability insurance landscape since 1975. At that time, when private carriers were seeking triple-digit rate increases or leaving the medical professional liability insurance market, the legislature developed a solution that required participating HCPs to purchase $1.2 million of medical malpractice insurance (the mandatory insurance requirement). This consisted of a combination of basic insurance coverage from the private market and excess coverage from the Medical Professional Liability Catastrophe Loss Fund (CAT Fund).

In 1995, due to a number of issues raised by all parties involved in the medical professional liability insurance market in the Commonwealth, significant revisions were ultimately made to how the CAT Fund operated by Act 135 of 1996. For example, the basis of the assessment collected from HCPs switched from the actual amount they paid for their medical professional liability insurance coverage to a common specialty and territory specific yet otherwise consistent amount. This provided the Fund with a more predictable assessment calculation methodology. Also, the limits written by the private insurance market increased from $200,000 per occurrence to $500,000 per occurrence over a number of years in $100,000 increments. The overall mandatory insurance requirement remained at $1.2 million.

In the latter half of 2001 and into 2002, there was again turmoil in the Commonwealth's medical professional liability insurance market including the rehabilitation and eventual liquidation of the largest Pennsylvania domiciled hospital insurer. This, coupled with other market disruptions, including a key physician insurer closing its doors to new business and others raising their underwriting standards resulted in executive and legislative branch attention.

The existing patient compensation fund legislation was repealed so that while some provisions of the existing statute were kept and rewritten, the Medical Care Availability and Reduction of Error Act (Mcare Act), Act 13 of 2002 ushered in a new approach to medical professional liability in the Commonwealth. A patient compensation fund was still a key component. New in the Mcare Act was a patient safety authority established to share information on how to improve health care, reasonable tort reforms, including reducing the mandatory insurance coverage to $1 million per occurrence to bring Pennsylvania in line with what is typical in other states and modifications to how Mcare operated. Also included were periodic studies and review of whether the limits provided by Mcare should be decreased with a corresponding

increase in the coverage provided by the private market. The executive branch successfully sought and implemented discounts in the amount HCPs paid to Mcare, with the discounts being partially funded by other sources of revenue, including increased cigarette taxes between 2003 through 2005 and Auto CAT Fund monies between 2004 through 2009.

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III. Mcare Program Review

A. Mcare Claims Program

The Mcare Fund has the statutory authority to adjust claims. It does so in two different contexts. One is where the Mcare Fund is providing excess coverage over coverage provided to a HCP by a private insurer or the HCP is self-insured. The other is under Section 715 of Mcare's enabling statute where Mcare provides the defense counsel and the indemnity payment from the first dollar.

Excess Claims Closed

Mcare closed 4,024 excess claims in 2014. This compares to the 3,460 excess claims that were closed in 2013. These numbers include claims closed without payment.

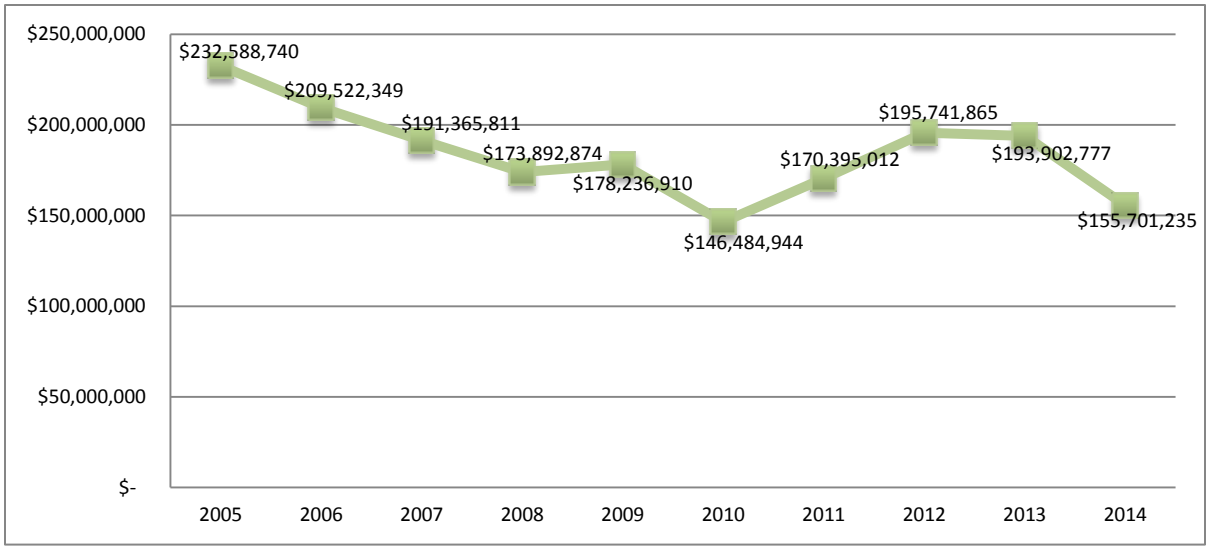
Section 715 Claims Closed

In 2014, Mcare closed 137 Section 715 claims in comparison to 170 in 2013. These claims typically arise from medical malpractice incidents that are covered by policies that were issued on or before December 31, 2005. Section 715 absolves the primary insurance carrier from defense and indemnity obligations and was part of the original patient compensation fund program started in 1975. Medical professional liability claims are subject to the claim being discovered and filed at a much later date than other types of claims. With Section 715 being phased out starting January 2006, primary insurers and self-insurers in Pennsylvania are now subject to typical risks like carriers writing in other states.

Claims Payments

Claims payments for 2014 were down significantly from 2013. In 2014, Mcare paid $156 million as compared to $194 million in 2013. The following graph shows total claims payments for the last 10 years.

Chart 1: Claims Payments by Claim Year for 2005-2014

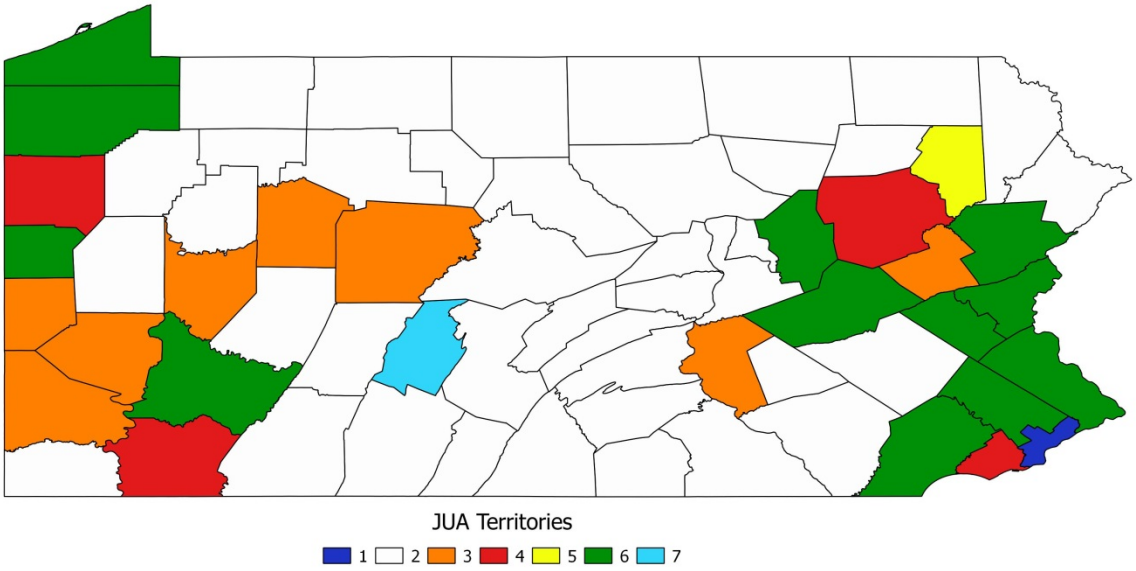


It is believed that the amount paid in 2014 may be an anomaly influenced by activity in the health care market taking time away from those people in institutions and other entities who would otherwise be more focused on closing open claims. Thus, it is possible that 2014 was a one year aberration rather than a beginning of a downward trend.

Claims payments also vary dramatically by county. The following map of the Commonwealth indicates the claims payments, allocated by the venue of the claims litigation and JUA territory.

Additional information on Claims can be found in Appendix B.

2014 Mcare Paid Claims by JUA Territory



JUA Territory	Territory Total	County(ies) Within Territory
Territory 1	$61,778,308	Philadelphia
Territory 2	$21,657,245	Remainder of State
Territory 3	$18,416,875	Allegheny
Territory 3	$7,422,438	Armstrong, Beaver, Carbon, Clearfield, Dauphin, Jefferson, Washington
Territory 3	$25,839,313	Territory 3 Total
Territory 4	$14,551,445	Delaware, Fayette, Luzerne, Mercer
Territory 5	$6,350,000	Lackawanna
Territory 6	$24,849,924	Bucks, Chester, Columbia, Crawford, Erie, Lawrence, Lehigh, Monroe, Montgomery, Northampton, Schuylkill, Westmoreland
Territory 7	$675,000	Blair
Total Paid	**$155,701,235**	

B. Mcare Assessment Revenue

Mcare is financed by assessments collected from HCPs as defined in the Mcare Act and interest on these funds. For 2014, the assessment revenue is $233 million as compared to the assessment revenue of $239 million for 2013.

The statutory assessment formula, as modified by the PAMED/HAP/PPMA settlement has the following components:

1. The amount Mcare paid in claims;
2. The administrative costs of Mcare;
3. Repayment of any funds loaned if claims payments and administrative expenses exceed the amount collected in any given year, and
4. A 10% buffer to help protect from running out of funds if claim payments increase year-over-year, minus
5. Interest Mcare earned during the year and
6. The projected year-end balance.

The collection of the assessment amount is based on a statutorily defined base, the Prevailing Primary Premium (PPP). The PPP is defined as the schedule of occurrence rates approved for the Joint Underwriting Association (JUA). Mcare engages an actuarial firm to project what amount would be raised if every HCP were required to participate in the Fund paid the PPP amount. The firm then determines what percentage of the PPP will raise the amount to be collected using the statutory assessment formula. Below is a chart reflecting the assessment percentage over the last 10 years. (Please note that since the JUA makes annual rate filings, these assessment percentages are not generally calculated using the exact same base. However, from 2014 to 2015 the JUA PPP has remained the same so the decrease year-over-year in the assessment is apples-to-apples).

Assessment Percentage for 10 Most Recent Years

Year	Percentage
2005	39%
2006	29%
2007	23%
2008	20%
2009	19%
2010	21%
2011	19%
2012	23%
2013	25%
2014	23%
2015	12%

The Mcare Act provides for adjustments to hospitals assessments based on loss experience. The range as provided for by statute is a 20% discount up to a 20% surcharge. The following chart compares how this provision affected the hospitals in 2014 as compared to 2013.

Chart 4: Hospitals paying the base Mcare assessment and those paying either a surcharge or discount.

Range	From To (less than)	2014	2013
Discount	80.0%-95.0%	158	149
Base	95.0% - 105.0%	21	31
Surcharge	105.0% 120.0%	30	28
Total of all rated hospitals		**209**	**208**

There is a corresponding experience rating plan contained in the Mcare Act for physicians. The statutory language was found to need additional clarification through the promulgation of regulations before it could be implemented. These regulations are being developed.

Additional information on the assessment, including the calculation of the 2014 assessment can be found in Appendix C.

C. Mcare Coverage Program

Mcare's coverage program is responsible for receiving reports from private insurance companies and self-insurers regarding who has medical professional liability insurance coverage, what type of coverage it is, the periods of coverage, whether a reporting endorsement has been purchased upon the termination of a claims made policy and the assessment amount being paid per HCP.

Acting as a repository for this information makes Mcare an especially reliable source of the number of physicians practicing in the Commonwealth, as well as their specialty and location of practice. As of February 25, 2015, coverage has already been reported and processed for 41,916 physicians for the 2014 coverage year (carriers have 60 days to report coverage so policies beginning towards the end of 2014 may not have been reported yet) as compared to 42,811 for the 2013 coverage year.

Mcare is also a reliable source of information regarding the number of hospitals in the Commonwealth. For 2014, 220 hospitals reported coverage, the same number as in 2013.

Additional information on Mcare coverage statistics can be found in Appendix D.

D. Mcare Compliance Program

The Mcare compliance program is based on the Mcare Act's provision requiring HCPs to submit proof of insurance to Mcare within sixty days of the policy being issued. The process used to implement this statutory provision is that the private insurer or self-insurer reports the coverage to Mcare as part of the assessment payment process. Mcare then evaluates the information received and notifies HCPs of coverage issues. If a HCP does not remedy the coverage issue, they are referred to the HCP's licensing authority for license suspension or revocation as provided for in the Mcare Act.

IV. Mcare Unfunded Liability

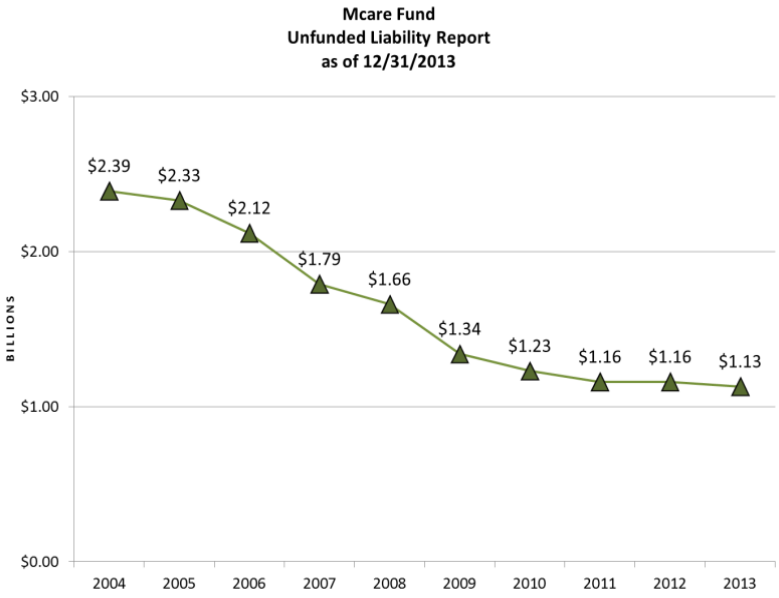
Mcare operates on what has been characterized as a "pay-as-you-go" model. It holds no reserves such as a traditional insurance company would, however the HCPs required to participate in Mcare are mandated as a condition of licensure to pay their Mcare assessment. So in a very real sense, the funds that a traditional private insurance company would have already collected remain in the possession of the HCPs until the funds are needed by Mcare to pay claims or other expenses.

One step to reduce Mcare's unfunded liability was the change in the Mcare Act to place the responsibility for claims reported more than four (4) years from the incident back on the private insurers or self-insureds. This "long tail" portion of the medical professional liability exposure had been the responsibility of a patient compensation fund in Pennsylvania since 1975.

Based on this change, the limits being provided by private insurers increased to $500,000, as well as the overall coverage limit going from $1.2 million to $1 million, the Mcare unfunded liability projection has generally decreased. The annual actuarial study, prepared in 2014 by PricewaterhouseCoopers LLP, concludes that an unfunded liability of $1.13 billion exists as of December 31, 2013. This amount is a decrease over the prior two years from $1.16 billion.

Below is a chart reflecting the projected unfunded liability for over last 10 years.

Chart 5: Mcare Projected Unfunded Liability over the last 10 years



Additional information on the Mcare Unfunded Liability can be found in Appendix E.

V. Limits Step Up and Podiatrist Exit

Limits Step Up

The Mcare Act has a provision that requires a study of the private insurance market's capacity to write increased coverage limits with a corresponding decrease in the coverage limits provided by Mcare. The statute further provides that unless the Commissioner finds that additional basic insurance coverage capacity is not available, the limits written by the market will increase. The first time this analysis was conducted in 2005, the Commissioner did not allow the limits to increase or "step-up". Subsequent studies on a two year cycle as provided for in the Mcare Act have made similar findings so that the limits have not changed. 2015 is a year when a study is due to be conducted with any increase in limits to be effective January 1, 2016.

Podiatrist Exit

Another provision of the Mcare Act provides for the exit of the Podiatrist class of HCPs from the Mcare Fund upon the satisfaction of an arrangement for the class to retire the fund's liabilities associated with podiatrists. Although dialogue has been maintained with the podiatrists, as of this time a mutually desirable retirement plan has not been identified.

APPENDIX

Appendix A

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND
CASH BASIS STATEMENT OF OPERATIONS
Calendar Year 2014
JANUARY 1, 2014 TO DECEMBER 31, 2014

FUND BALANCE JANUARY 1, 2014			$ 169,012,919
Settlement Reserve Fund	$ 30,000,000		
Assessment Relief Fund (Refund Account)	$ 139,012,919		
Set Aside Settlement Funds per SETTLEMENT AGREEMENT Effective 10/3/2014			$ (169,012,919) #1
ADJUSTED FUND BALANCE 01/01/2014			**$0.00**
Receipts:			
ASSESSMENT REVENUE	$ 233,177,978		
INTEREST ON SECURITIES	$ 1,723,241		
INTEREST ON RESERVE FUND	$ 14,363 #2		
INTEREST ON ASSESSMENT RELIEF FUND	$ 66,555 #3		
MISCELLANEOUS REVENUE	$ 470,674		
CASH IN TRANSIT 12/31/14			
REDEPOSIT OF CHECKS	$ -		
NET INCREASE IN FAIR VALUE OF INVESTMENTS	$ 4,578,743		
TOTAL ADDITIONS	**$ 240,031,554**		$ 240,031,554
TOTAL FUNDS AVAILABLE			**$ 240,031,554**
Claims Deductions:			
2014 CLAIMS PAID - DEC, 2014	$ 155,701,235		
CLAIMS DEDUCTIONS	**$ 155,701,235**		
Operating Expenses:			
SALARIES	$ 2,569,462		
PAYROLL TAXES & BENEFITS	$ 1,561,496		
DATA PROCESSING SERVICES	$ 52,608		
LEGAL FEES	$ 5,843,629		
OFFICE SUPPLIES	$ 26,057		
CONSULTANTS	$ 663,337		
TELECOMMUNICATIONS	$ 73,856		
REAL ESTATE	$ 307,638		
OTHER OPERATIONAL EXPENSES	$ 162,620		
TOTAL OPERATING EXPENSES	**$ 11,260,703**		
TOTAL DEDUCTIONS AND EXPENSES:			**$ (166,961,938)**
FUND BALANCE DECEMBER 31, 2014			**$ 73,069,616** #4

FINACIAL SUMMARY of Settlement Agreement Effective 10/03/14

#1	SETTLEMENT AGREEMENT		
	Reserve Fund	$	30,000,000
	Assessment Relief Fund (Refund Account)	$	139,012,919
#2	RESERVE FUND - Not to exceed $30 M		
	Interest on Reserve Fund As of: 12/31/14	$	14,363
#3	ASSESSMENT RELIEF FUND (Refund Account) -		
	Interest on Assessment Relief Fund As of: 12/31/14	$	66,555
#4	ENDING BALANCE 12/31/14	$	73,069,616
	On 09/01/14 the anticipated 2014 ending balance of $61 M was used to lower 2015 Assessment Calculation		

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

Mcare Fund

Summary of Financials from CY 2005 to 2014

		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
1	Beginning Balance [1]	30	59	58	34	104	61	124	130	130	169
2	Settlement Agreement [2]										**(169)**
3	**ADJUSTED BEGINNING BALANCE**	30	59	58	34	104	61	124	130	130	0
	Receipts:										
4	Assessment Revenue	216	162	119	229	218	218	184	209	239	233
5	Interest Earned	5	11	12	4	3	9	2	2	2	2
6	Auto CAT Fund	42	42	45	47	22	0	0	0	0	0
7	Abatement Repayment/Credits	0	6	4	4	2	0	0	0	0	0
8	Transfer from Other Funds	230	0	0	0	0	0	0	0	0	0
9	Loan from Other Funds	0	0	0	0	0	0	0	0	0	0
10	Misc. Other	0	0	1	1	2	0	0	1	4	1
11	Net Increase in Fair Value of Invetments	0	0	0	0	0	0	0	0	0	4
12	Subtotal w/o Beginning Balance or Loan (4+5+6+7+10+11)	263	221	181	285	247	227	186	212	245	240
13	Subtotal w/Beginning Balance and w/o Loan (3+4+5+6+7+10+11)	293	280	239	319	351	288	310	342	375	240
14	**Grand Total Receipts w/Beginning Balance and all categories** (3+4+5+6+7+8+9+10+11)	523	280	239	319	351	288	310	342	375	240
		2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
	Expenditures:										
15	Salaries & Benefits	4	3	5	5	5	5	4	4	4	4
16	Loan Repayment	215	0	0	0	0	0	0	0	0	0
17	Transfer to HCPRA for Abatement Repayments	0	0	0	14	0	0	0	0	0	0
18	Interagency Transfer	0	0	0	0	100	0	0	0	0	0
19	Loss on Investments	0	0	0	12	0	0	0	0	0	0
20	Legal Fees	10	8	4	4	3	9	6	6	6	6
21	Liability Claims Paid	233	210	191	174	178	146	170	196	194	156
22	Misc. Other [3]	2	1	5	6	4	4	0	6	2	1
23	Subtotal w/o Loan Repayment or Interagency Transfer (15+17+19+20+21+22)	249	222	205	215	190	164	180	212	206	167
24	**Grand Total Expenditures with All Expenditures** (15+16+17+18+19+20+21+22)	464	222	205	215	290	164	180	212	206	167
25	**Year End Balance (14-24)**	**59**	**58**	**34**	**104**	**61**	**124**	**130**	**130**	**169**	**73**

[1] In millions

[2] Settlement Agreement - Pursuant to the Settlement Agreement effective October 3, 2014 between the Pennsylvania Medical Society, the Hospital & Healthsystem Association of Pennsylvania and the Pennsylvania Podiatric Medical Association, $139 million of the 2013 Year End Balance is to be returned to the Eligible Health Care Providers who paid assessments during the years of 2009, 2010, 2011, 2012 and 2014. The remaining $30 million is to be held by Mcare separately and only used to pay claims or other Mcare expenses where other Mcare revenues, including statutory buffer, are insufficient and in lieu of borrowing.

[3] 4.9/M Credit Refunds issued in 2012.

Appendix B

PA Department of Insurance

Mcare Fund

Paid Claims by Region 2010 - 2014*

		Eastern		Central		Western		Other	
	Total Annual Claim Payment	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
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%
2012	$195,741,865	$124,106,482	63.40%	$27,675,000	14.14%	$43,160,383	22.05%	$800,000	0.41%
2013	$193,902,777	$108,502,306	55.96%	$39,770,471	20.51%	$45,630,000	23.53%	$0	0.00%
2014	$155,701,235	$87,078,232	55.93%	$33,328,883	21.41%	$35,294,120	22.67%	$0	0.00%

Regional County Definition:

Eastern	Bucks, Chester, Delaware, Lehigh, Montgomery, Northampton, Philadelphia
Central	Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York
Western	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland
Other	Includes all other states and the United States District Courts where an Mcare defendant was involved.

*County designation within region is for Mcare claims handling purposes only.

PA Insurance Department

Mcare Fund

Claim and Case Payment - 5 Most Recent Years

Year	Fund Money	**Claim** Count	Average **Claim Value**	**Case** Count	Average **Case Value**
2010	$ 146,484,944	329	$ 445,243	255	$574,451
2011	$ 170,395,012	353	$ 482,705	265	$643,000
2012	$ 195,741,865	404	$ 484,510	268	$730,380
2013	$ 193,902,777	414	$ 468,364	295	$657,298
2014	$ 155,701,235	346	$ 450,004	256	$608,208

Note: One "case" consists of 1 to many "claims"

PA Department of Insurance

Mcare Fund

Summary of Annual Fund Claim Payments by Health Care Provider Group

2005-2014

	Individuals MD's, DO's, Podiatrists Certified Nurse Midwives				Medical Corps				Institutions Hospitals, Nursing Homes Birth Center, Primary Care Centers				Totals	
Year	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
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	49%	$ 151,833,293	72%	26	4%	$ 14,186,262	7%	92	15%	$ 43,502,794	21%	620	$ 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	61%	$ 116,967,358	67%	16	4%	$ 8,165,387	5%	105	25%	$ 48,760,129	28%	422	$ 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
2012	256	63%	$ 128,473,897	66%	16	4%	$ 8,912,666	5%	132	33%	$ 58,355,302	30%	404	$ 195,741,865
2013	267	64%	$ 125,139,084	65%	21	5%	$ 9,230,191	5%	126	30%	$ 59,533,502	31%	414	$ 193,902,777
2014	225	65%	$ 103,366,679	66%	12	3%	$ 6,050,000	4%	109	32%	$ 46,284,556	30%	346	$ 155,701,235

Mcare Fund

2010 - 2014 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2010	2011	2012	2013	2014
S01				$ 4,000,000	
S07					
S10	$ 3,000,000	$ 3,700,000	$ 1,630,000	$ 1,625,000	$ 1,483,000
S11					
S12	$ 500,000	$ 1,375,000	$ 1,500,000	$ 1,532,357	$ 1,650,000
S14					
S23			$ 50,000		
S24		$ 500,000			
S32		$ 950,000			
S34					
S36					
S40			$ 450,000		
S41	$ 500,000	$ 500,000	$ 1,000,000		
S43	$ 750,000				$ 400,000
S45					$ 700,000
S48		$ 1,000,000			
S49				$ 1,000,000	$ 131,138
S51		$ 1,000,000	$ 500,000		$ 1,000,000
S53		$ 500,000	$ 500,000		$ 500,000
S54					
S57	$ 500,000				$ 500,000
S60	$ 400,000	$ 1,000,000		$ 1,000,000	
S62	$ 500,000		$ 1,500,000	$ 1,500,000	
S63			$ 404,990		
S66				$ 254,000	
003	$ 11,007,385	$ 12,407,633	$ 16,700,000	$ 13,170,000	$ 15,750,000
011	$ 1,600,000	$ 1,975,000	$ 500,000	$ 2,350,000	$ 2,276,207
020	$ 500,000				
031	$ 9,520,502	$ 12,962,642	$ 10,980,409	$ 19,113,834	$ 12,526,320
032	$ 2,130,000	$ 2,275,000	$ 4,030,000	$ 2,100,000	$ 4,150,000
039			$ 250,000		
045	$ 700,000	$ 205,000		$ 1,000,000	$ 87,500
052		$ 100,000			
055	$ 125,000				
067	$ 7,770,531	$ 17,993,170	$ 20,503,076	$ 13,253,500	$ 9,559,462
086	$ 675,000	$ 5,407,500	$ 11,075,331	$ 1,127,470	$ 1,500,000
088					
093	$ 2,325,000	$ 1,600,000	$ 875,000	$ 2,875,000	$ 1,300,000
102					
103		$ 500,000	$ 800,000		
112					$ 500,000
119	$ 394,917	$ 855,083	$ 1,000,000		
121	$ 700,000	$ 200,000	$ 1,700,000	$ 1,000,000	
124		$ 425,000	$ 10,000		

Mcare Fund

2010 - 2014 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2010	2011	2012	2013	2014
126	$ 661,031	$ 1,000,000	$ 2,000,000		$ 570,000
129	$ 7,700,000	$ 2,750,000	$ 5,450,000	$ 3,100,000	$ 8,100,000
131					
135			$ 110,189		$ 1,000,000
136	$ 2,325,000	$ 1,550,000	$ 3,700,000	$ 2,385,000	$ 1,675,000
138					$ 500,000
139	$ 500,000			$ 800,000	
143		$ 139,261			$ 350,000
144	$ 5,675,000	$ 12,324,000	$ 12,895,000	$ 14,750,000	$ 8,875,000
145	$ 7,200,000	$ 2,425,000	$ 3,925,000	$ 2,411,644	$ 5,562,000
155	$ 13,200,000	$ 13,953,751	$ 9,695,000	$ 11,535,000	$ 12,015,342
156	$ 5,860,000	$ 5,375,000	$ 11,841,622	$ 7,050,000	$ 1,925,000
157					
159				$ 232,000	
160		$ 1,313,804	$ 125,000		
161					
162	$ 5,693,463	$ 1,200,000			
164					
166					
167					
169					
183					
184	$ 2,500,000	$ 1,818,092	$ 2,700,000	$ 1,600,000	
185				$ 375,000	
194	$ 1,000,000	$ 500,000			
196	$ 1,200,000			$ 1,700,000	$ 2,000,000
197	$ 3,700,000	$ 2,537,500	$ 3,400,000	$ 5,559,421	$ 2,427,245
199	$ 1,765,000	$ 1,850,000	$ 2,633,501	$ 8,775,000	$ 2,631,138
201					
202	$ 5,075,000	$ 7,845,426	$ 7,260,000	$ 9,490,000	$ 5,260,000
203		$ 500,000	$ 500,000		$ 1,414,438
207	$ 12,209,500	$ 12,832,067	$ 17,422,747	$ 13,731,250	$ 10,077,342
208	$ 912,615	$ 120,000		$ 500,000	$ 500,000
210				$ 1,000,000	
211	$ 3,750,000	$ 7,236,287	$ 8,250,000	$ 5,740,000	$ 6,374,809
212	$ 400,000			$ 500,000	$ 500,000
219	$ 450,000	$ 2,000,000	$ 1,800,000	$ 2,775,000	$ 1,850,000
220	$ 1,950,000	$ 1,590,000	$ 2,875,000	$ 1,575,000	
221	$ 3,050,000	$ 3,585,275	$ 2,550,000	$ 2,509,608	$ 3,875,000
222	$ 1,010,000	$ 500,000	$ 1,400,000	$ 500,000	
223	$ 800,000	$ 618,521	$ 5,000,000	$ 2,450,000	$ 1,400,000
224	$ 500,000	$ 1,000,000	$ 300,000	$ 1,000,000	$ 30,000
228	$ 300,000	$ 1,250,000	$ 1,150,000		$ 2,000,000
229	$ 950,000	$ 2,500,000	$ 700,000		

Mcare Fund

2010 - 2014 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2010	2011	2012	2013	2014
234	$ 200,000				
239	$ 800,000			$ 500,000	
241	$ 400,000	$ 650,000	$ 900,000	$ 1,000,000	$ 500,000
243		$ 500,000			
245	$ 1,000,000	$ 2,900,000	$ 1,500,000	$ 6,082,693	$ 6,500,000
246	$ 1,850,000	$ 2,700,000	$ 500,000	$ 3,025,000	$ 825,000
248	$ 500,000				
250		$ 1,000,000			$ 500,000
251			$ 500,000		
253	$ 6,000,000	$ 1,650,000	$ 3,050,000	$ 5,050,000	$ 3,365,000
256		$ 500,000			
258	$ 300,000	$ 250,000	$ 500,000	$ 1,000,000	$ 1,860,294
261	$ 1,000,000	$ 500,000	$ 500,000	$ 500,000	$ 250,000
262			$ 1,500,000		
271		$ 500,000	$ 400,000	$ 2,300,000	$ 1,000,000
275					$ 500,000
276	$ 500,000	$ 1,000,000	$ 1,400,000	$ 2,100,000	$ 600,000
279				$ 150,000	
285			$ 500,000	$ 500,000	
286			$ 350,000		$ 150,000
293		$ 500,000			
310			$ 500,000	$ 2,750,000	$ 4,725,000
Totals	$ 146,484,944	$ 170,395,012	$ 195,741,865	$ 193,902,777	$ 155,701,235

Appendix C

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

2014 YEAR ASSESSMENT CALCULATION
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

October 2013

pwc

October 16, 2013

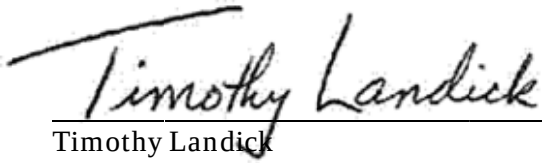
Mr. Todd Rittle
Executive Director
Pennsylvania Insurance Department
Mcare Fund
1010 N. 7th Street, Suite 201
Harrisburg, PA 17102

Dear Mr. Rittle:

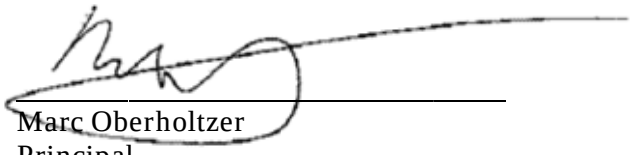
Enclosed is our report describing the methods we have used to estimate the 2014 prevailing primary premium projection of $980 million, indicating an assessment rate of 23.2% for the 2014 year, in accordance with Act 13 of 2002, also known as the Mcare Act. We understand that Mcare will round the assessment rate to 23%.

Please call Tim at (267) 330-6608 should you have any questions or require anything further.

Sincerely,



Timothy Landick
Director
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries



Marc Oberholtzer
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

cc: R. Waeger
J. DiMemmo

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INTRODUCTION

Purpose

The Commonwealth of Pennsylvania established the Medical Care Availability and Reduction of Error Fund[1] ("Mcare" or "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. The Fund also provides first dollar coverage, including defense, for certain claims reported four or more years after the occurrence event (i.e. those that qualify for Section 715[2] coverage). The Fund is supported by an assessment collected from each participating health care provider.

In March of 2002, Act 13 was enacted which amended existing legislation[3] regarding the Fund. Act 13 instituted numerous changes, including but not limited to: scheduling increases in basic insurance coverage limits[4], scheduling decreases in the amount of excess coverage afforded by the Fund, and providing for assessment discounts in 2002, 2003, and 2004.

PricewaterhouseCoopers LLP (PwC) was engaged to assist the Fund in the determination of the assessment rate to be applied for the 2014 year, in accordance with the provisions of Act 13.

[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] Namely, Section 715 of Act 13. These were previously known as Section 605 claims. Fund coverage for these claims ceased for claims occurring after December 31, 2005, and is subject to a number of other conditions, such as the "continuing course of treatment" provision.
[3] Notably, Act 111 of 1976 and Act 135 of 1996.
[4] Although increases in the basic insurance coverage are scheduled, the actual timing of the increases will be determined after an assessment of market conditions by the Insurance Commissioner.

Distribution and Use

This report was prepared for internal use by the Fund's management, including the Pennsylvania Insurance Department (the Department). We understand that the Fund may release this report to the Pennsylvania Medical Society and the Hospital Association of Pennsylvania. Other use or further distribution of this report is not authorized without prior written approval of PwC.

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 to answer questions, subject to the Fund's permission and at the Fund's expense, regarding this report.

Conditions and Limitations

In our analysis, we have relied without audit or further verification on the following data received from the Fund:

- Assessments, operating expenses, and other income and expense information for claim year 2013;
- Claim year 2013 loss payments expected to be made on or about December 31, 2013;
- Policy year 2010, 2011, and 2012 assessments, segregated by primary policy type, product code, county code, and specialty code;
- Several recent JUA filings, JUA underwriting manuals, and Fund assessment manuals;
- Discussions with the Fund and the Department regarding Act 13 and the legislative intent of provisions relevant to the assessment calculation, including the limits of coverage to be provided by the Fund for 2014; and
- Knowledge obtained through our prior experience with the Fund.

The calculations in this report rely heavily on the accuracy of the data provided. We have not audited the data included herein, although we have examined the data for reasonableness and consistency to data previously provided. Any changes to this underlying data may require modification to the estimates in this report.

The projected 2014 prevailing primary premium, which is a primary component of the 2014 assessment rate, is an estimate. As such, this value is subject to variability. While we believe the estimate is reasonable based on the information provided, there can be no assurance that the actual prevailing primary premium will not differ materially from what we have projected, generating either more or less assessment revenue than that projected herein.

As mentioned above, although increases in the basic insurance coverage are scheduled pursuant to Act 13, the actual timing of the increases will be determined after an assessment of market conditions by the Insurance Commissioner. Our calculations assume that the Fund assessment is levied against prevailing primary premium based on the JUA's filed occurrence rates at $500,000 per claim, and do not consider the impact of any legislation that would otherwise affect the operations or assessment revenue of the Fund.

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.

2014 Assessment Rate

Exhibit 2 shows that our selected primary prevailing premium for 2014 of $980 million generates an indicated assessment rate of 23.2%, which rounds to 23% as shown on Exhibit 1. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2014 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; and

(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 2014 prevailing primary premium. Hence the projection of 2014 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2014 payment obligations of the Fund and the 2014 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2010, 2011, and 2012 assessments as the basis for our estimate of the 2014 prevailing primary premium.

Since the 2014 assessment rate is based largely on the Fund's obligations for the 2013 claim year, any significant change in Fund's claim or expense obligations from 2013 to 2014 may result in a significant change to the Fund's year-ending surplus or deficit. This surplus or deficit will be impacted by other factors as well, including but not necessarily limited to:

- The amount of external funding, if any, made available to the Fund during 2014;
- The amount of year-ending 2013 surplus. The projections herein assume that any year-ending 2013 surplus does not impact the 2014 assessment, consistent with the Fund's interpretation of Act 13. The year-ending 2012 surplus was approximately $129 million. While the year-ending 2013 surplus cannot be known with certainty until the final claims payments and operating expenses are known, preliminary projections of the year-ending 2013 surplus are approximately $150 million;
- The level of assessment abatement or other discounts provided during 2014. Current calculations assume no abatements or discounts; and
- Differences between projected 2014 prevailing primary premium and actual 2014 prevailing primary premium, which would result in a difference between projected and actual assessment revenue.

These variables contribute uncertainty regarding the degree to which the amount assessed in 2014 will be sufficient to meet the Fund's 2014 obligations. To the extent the amounts assessed in 2014 are insufficient to meet the Fund's 2014 obligations, the level of Fund surplus will be impacted or additional funding or borrowing may be required.

ANALYSIS

2014 Assessment Rate

The Act outlines the four cost categories to be funded via the assessment. The aggregate assessment for 2014[5] must cover the following: 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 2014 prevailing primary premium.

Claim Settlements

The largest cost to be funded by the 2014 assessment is the amount of claim settlements for the Fund's 2013 claim year ending August 31, 2013. These claims are payable on or about December 31, 2013. The Fund expects that payments for the 2013 claim year will total $194 million.

Fund Operating Expenses

Operating expenses paid of $12 million for the claim year ending August 31, 2013 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, 2013, and does not currently expect to require borrowing to meet its 2013 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. Consistent with the Fund's interpretation of Act 13, Fund surplus does not impact the calculation of the target reserve.

[5] We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2014.

Prevailing Primary Premium

The Fund provided assessment and policy count data for policies effective in 2010, 2011, and 2012. 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 below.

Primary Policy Type

This field contains either CM (claims-made) or OC (occurrence). Assessment collections for tail policies are not expected to be material in the aggregate for policy year 2014. Our projections of policy year 2014 assessments exclude assessments collected in 2010, 2011, and 2012 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;
- 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 2014 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 2010 assessments have been adjusted for changes effective 01/01/2011, 01/01/2012, 01/01/2013, and 01/01/2014. This calculation is included in its entirety under separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2011 assessments have been adjusted for changes effective 01/01/2012, 01/01/2013, and 01/01/2014. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2012 assessments have been adjusted for changes effective 01/01/2013 and 01/01/2014. 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 01/01/2011, 01/01/2012, 01/01/2013, and 01/01/2014 are as follows below.

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.

Changes Effective 01/01/2012

Rate Change

The JUA decreased its base rates by 3.9%. Combined with other changes to the rate plan, the expected impact to the overall rate level is a decrease of 3.3%, based on the JUA's mix of policies (occurrence, 1st year claims-made, 2nd year claims-made, 4th year claims-made, and mature claims-made). For occurrence policies only, the estimated impact is a decrease of roughly 5.2%, per the JUA filing. The indicated rate change varies by class and territory. For example, the indicated rate changes by class and territory range from -17.8% to 11.2% (note: for occurrence policies only and not considering the implied rate changes due to the territory movements of certain counties). Based on the Fund's mix of exposures, the overall impact of the JUA rate change on Mcare's 2012 primary prevailing premium is a decrease of approximately 7.2%.

Class Rate Changes

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

County / Territory Changes

Modifications to the mapping of county to rating territory are as follows:

County (County Code)	Change
Chester (06)	chg from Terr 4 to Terr 6
Dauphin (22)	chg from Terr 6 to Terr 3
Lackawanna (35)	chg from Terr 6 to Terr 4
Luzerne (40)	chg from Terr 6 to Terr 4
Mercer (43)	chg from Terr 6 to Terr 4

No changes were made to territorial relativities.

Specialty Changes

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

Changes Effective 01/01/2013

Rate Change

The JUA increased its base rates by 6.8%. Combined with other changes to the rate plan, the expected impact to the overall rate level is an increase of 6.9%, based on the JUA's mix of policies (occurrence, 1st year claims-made, 2nd year claims-made, 4th year claims-made, and mature claims-made). For occurrence policies only, the estimated impact is an increase of 7.6%, per the JUA filing. The indicated rate change varies by class and territory. For example, the indicated rate changes by class and territory range from -7.8% to 23.0% (note: for occurrence policies only and not considering the implied rate changes due to the territory movements of certain counties). Based on Mcare's mix of exposures, the overall impact of the JUA rate change on Mcare's 2013 primary prevailing premium is an increase of approximately 5.9%.

Class Rate Changes

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

County / Territory Changes

Modifications to the mapping of county to rating territory are as follows:

County (County Code)	Change
Beaver (04)	chg from Terr 2 to Terr 3
Carbon (13)	chg from Terr 2 to Terr 3
Clearfield (17)	chg from Terr 2 to Terr 3
Bucks(09)	chg from Terr 4 to Terr 6
Montgomery (46)	chg from Terr 4 to Terr 6

No changes were made to territorial relativities.

Specialty Changes

Specialty changes that resulted in a class change are listed below.

Specialty Code	Specialty	Change
01037	Endocrinology	move to class 00737
01074	Geriatrics	move to class 00674
01142	Nephrology	move to class 00741
01144	Pulmonary Medicine	move to class 01545
01199	Physicians Not Otherwise Classified - No Surgery (NOC)	move to class 00799

Specialty Code	Specialty	Change
02006	Gastroenterology - Excluding Major Surgery	move to class 02206
07026	Vascular Surgery	move to class 09026
07085	Peripheral Wascular Surgery	move to class 09085

The movement of specialty classes 01142 to 00741, 01199 to 00799, and 01199 to 00799 results in the effective discontinuation of the use of class code 011; therefore, proposed rates were not filed for class code 011.

Changes Effective 01/01/2014

Rate Change

The JUA increased its base rates by 1.6%. Combined with other changes to the rate plan, the expected impact to the overall rate level is an increase of 3.4%, based on the JUA's mix of policies (occurrence, 1st year claims-made, 2nd year claims-made, 4th year claims-made, and mature claims-made). For occurrence policies only, the estimated impact is an increase of 3.1%, per the JUA filing. The indicated rate change varies by class and territory. For example, the indicated rate changes by class and territory range from -5.2% to 17.3% (note: for occurrence policies only and not considering the implied rate changes due to the territory movements of certain counties). Based on Mcare's mix of exposures, the overall impact of the JUA rate change on Mcare's 2014 primary prevailing premium is an increase of 3.3%.

Class Rate Changes

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

County / Territory Changes

Modifications to the mapping of county to rating territory are as follows:

County (County Code)	Change
Blair (07)	chg from Terr 6 to Terr 7
Delaware (23)	chg from Terr 5 to Terr 4
Lackawanna (35)	chg from Terr 4 to Terr 5
Westmoreland (65)	chg from Terr 3 to Terr 6

For 2014, the JUA assigned Blair county to a new territory (Territory 7). No changes were made to territorial relativities.

Specialty Changes

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

Results

The indications for the 2014 prevailing primary premium are $955.5 million based on 2010 remittances, $956.4 million based on 2011 remittances, and $983.3 million based on 2012 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2010), Excerpt B (2011), and Excerpt C (2012). The entire calculation is included under separate cover as Appendix A, Appendix B, and Appendix C, respectively.

Note that the estimates of the primary prevailing premium are similar for 2010 and 2011, but show an increase in 2012. Based on discussions with Mcare, it is our understanding that this increase is predominantly driven by the alignment of individual physicians and small hospitals with the larger healthcare systems, which may result in these exposures moving to higher rated territories. It is our understanding that this alignment activity was concentrated in 2012 and that the 2013 exposure levels to date appear comparable to the 2012 levels.

Based on these observations and considerations, our selected 2014 prevailing primary premium is $980 million. Note that this projection may vary from the actual 2014 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 2014 relative to recent years;
- Shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2013 and 2014;
- Changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2013 and 2014; and
- Additional recording of data, notably for 2012, where policy adjustments and late reported assessments will cause the assessment data to change. The year-over-year increase in 2010 and 2011 data was less than 1%.

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.

2014 Assessment Rate

The cost components of the assessment total $227 million. Given the 2014 prevailing primary premium projection of $980 million, the indicated 2014 assessment rate is 23.2%. We understand that Mcare will round the assessment rate to 23%.

Change from Prior

The indicated rounded 2014 assessment rate of 23% is 2% lower than the 2013 assessment rate of 25%. As the chart below indicates, the assessment costs showed a slight decrease year over year, while the projected prevailing primary premium increased by 3.3%. All else being equal, the slight decrease in the Fund's claims obligations causes the assessment rate to decrease as will the increase in the projected prevailing primary premium (-0.4% and -1.3%, respectively). The remaining change is attributable to rounding of the rate. The 2013 and 2014 assessment rate calculations are summarized below.

	2014	2013	Assessment Rate Impact
(1) Prior Claim Year Claims Settled	193,902,777	195,741,865	-0.2%
(2) Prior Claim Year Operating Expenses	12,387,160	13,824,000	-0.2%
(3) Target Reserve	20,628,994	20,956,587	0.0%
(4) Assessment Costs, (1)+(2)+(3)	226,918,931	230,522,452	-0.4%
(5) Projected Prevailing Primary Premium	980,000,000	925,000,000	-1.3%
(6) Indicated Assessment Rate, (4) / (5)*	**23%**	**25%**	**-2%**

** reflects rounding of the assessment rate*

QUALIFICATIONS of PwC ACTUARIES

Timothy Landick and the peer reviewer for this report, Marc Oberholtzer, 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 2014 Assessment Rate

(1)	Claim Year Ending 08/31/2013 Claims Settled	193,902,777
(2)	Claim Year Ending 08/31/2013 Operating Expenses	12,387,160
(3a)	Claim Year Ending 08/31/2013 Principal and Interest Paid or Payable	-
(3b)	Claim Year Ending 08/31/2013 Borrowing Transfers	-
(4)	Target Reserve	20,628,994
(5)	2013 Assessment Costs (5) = (1)+(2)+(3a)+(3b)+(4)	226,918,931
(6)	Projected Policy Year 2014 Prevailing Primary Premium	980,000,000
(7)	Indicated 2014 Assessment Rate (7) = (5) / (6)	**23%**

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 2014 Prevailing Primary Premium

	Projected Prevailing Primary Premium	Implied Assessment Rate
(1) Projection Based on 2010 Assessment Remittances	955,501,849	23.7%
(2) Projection Based on 2011 Assessment Remittances	956,439,921	23.7%
(3) Projection Based on 2012 Assessment Remittances	983,299,385	23.1%
(4) Projected 2014 Prevailing Primary Premium	980,000,000	23.2%

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).

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Pennsylvania medical care availability and reduction of error fund

2014 experience modification factors

(in accordance with act 13 of 2002)

Philadelphia, PA

December 2013

pwc

Mr. Todd Rittle
Executive Director
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, Pennsylvania 17102
December 11, 2013

Dear Mr. Rittle:

Enclosed is our report describing the Experience Rating Plan and the resulting 2014 Experience Modification Factors, developed pursuant to Section 712(g)(4) of Act 13. The factors contained herein are expected to produce results that are "revenue neutral" to the Fund in total and our recommendations for application of the plan are included in the report text.

Please call Lela Patrik at (267) 330-2237 or Tim Landick at (267) 330-6608 should you have any questions or require anything further.

Sincerely,

Lela Patrik
Manager
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Timothy J. Landick
Director
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Marc Oberholtzer
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Enclosure

cc: R. Waeger, Mcare Fund

Introduction

Purpose

The Commonwealth of Pennsylvania established the Medical Care Availability and Reduction of Error Fund[1] (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. Section 712(g)(4) of Act 13 of 2002 (Act 13), amends Section 701 of the October 1975 Act (as amended) such that:

> *"The applicable prevailing primary premium[2] of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. 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 periods."*

PricewaterhouseCoopers LLP (PwC) was engaged to assist the Fund in establishing an Experience Rating Plan (the Plan) that facilitates modification of the prevailing primary premium pursuant to the Section 712(g)(4) amendment prescribed by Act 13. The methodology employed herein is consistent with that employed in prior Experience Modification Factor computations.

Distribution and use

This report was prepared for internal use by the Fund's management, including the Pennsylvania Insurance Department (the Department). We understand that the Fund may release this report to the Hospital Association of Pennsylvania. Other use or further distribution of this report is not authorized without prior written approval of PwC.

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 to answer questions, subject to the Fund's permission and at the Fund's expense, regarding this report.

Conditions and limitations

In our analysis we have relied, without audit or further verification, on the following data received from the Fund:

- Fund payment information by hospital by claim year for the claim years ending 2009 through 2012; and
- Assessment by hospital by policy year for the policy years ending 2010 through 2013, separately identified by policy type (occurrence, claims-made, claims-made plus[3], or tail).

The calculations in this report rely heavily on the accuracy of the Fund payment and assessment 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.

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[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] Prevailing primary premium is hereafter defined to mean the premium determined by application of JUA-based occurrence rates and applicable rating plan.

[3] A claims-made plus policy is one in which the tail exposure is pre-funded through the annual policy premium.

The 2013 assessment has been estimated[4] for the 43 hospitals (21% of all hospitals) that have not yet remitted. As estimates, these values are subject to variability. While we believe the projections herein are reasonable based on the information available, there can be no assurance that the actual 2013 assessment will not differ, perhaps significantly, from what we have projected. Please see Appendix A for further description of the 2013 assessment estimation process for the hospitals that have not yet remitted.

The attached exhibits should be considered an integral part of this report.

Database

Given the constraints on the data to be used in the Plan, such that "*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 periods*", we have used total Fund payments (Section 605 and Excess) and assessments as the measures of the underlying hospital experience to determine Experience Modification Factors. Total Fund payments have been used to fully reflect the "*frequency and severity of claims paid by the Fund*". Fund payments are measured relative to assessments in order to provide a comparison that is normalized for "*class, size, risk, and kind*" since assessments are driven by the type, exposure (bed and/or visit counts), and territory of the hospital.

Within our analysis, hospitals are sorted into bands according to the average implied prevailing primary premium (AIPPP) at 2013 levels, based on 2011, 2012, and (if available) 2013 baseline policy year assessments[5]. This increases the extent to which the Plan is normalized for "*class, size, risk, and kind*". The bands are defined as follows[6]:

1. Band 1 Hospitals (AIPPP less than $325,000)
2. Band 2 Hospitals (AIPPP between $325,000 and $630,000)
3. Band 3 Hospitals (AIPPP between $630,000 and $1,290,000)
4. Band 4 Hospitals (AIPPP between $1,290,000 and $2,620,000)
5. Band 5 Hospitals (AIPPP greater than $2,620,000)

For those hospitals whose band assignment changed from last year, the underlying policy data was examined to verify that the change in assignment was supported by the data.

Based on information provided by the Fund, the assessment and payment information has been combined for hospitals that have merged. Data for hospitals that have simply closed is excluded from the analysis. Data for hospitals with insufficient years of experience has also been excluded from the analysis. The result is 209 hospitals for which experience modification factors were determined.

Qualifications of PwC actuaries

Lela Patrik and Timothy Landick, and the peer reviewer for this assignment, Marc Oberholtzer, 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.

[4] The procedure used to estimate the 2013 assessment for those who have not yet remitted is described in the *Analysis* section below. A list of additional data adjustments is included as Appendix B.

[5] Historical baseline policy year assessments (defined in the *Analysis* section below) are adjusted to a 2013 level by dividing the assessment by the appropriate assessment rate and applying base rate changes as filed by the JUA.

[6] Note that these band definitions are generally consistent with those selected for 2013 (based on 2012 AIPPP), adjusted for JUA changes filed for 2013.

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.

Spread of experience modification factors

The 209 experience modification factors as calculated in Exhibit 1 fall into the following ranges:

Distribution			
From	To (less than)	2014 Mods Count	2013 Mods Count
80.0%	85.0%	93	49
85.0%	90.0%	47	88
90.0%	95.0%	18	12
95.0%	100.0%	18	18
100.0%	105.0%	3	13
105.0%	110.0%	7	7
110.0%	115.0%	6	5
115.0%	120.0%	3	1
120.0%		14	15
Total all rated hospitals		209	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%.

There has been a shift in the distribution of the experience modification factors calculated this year (for 2014) as compared to last year (for 2013), particularly from the 85.0%-90.0% range down to the 80.0%-85.0% range. We note that of the 137 hospitals that were rated between 80.0% and 90.0% last year, 79 had experience modification factors within the 84.5%-85.5% range; of the 140 hospitals rated between 80.0% and 90.0% this year, 77 have experience modification factors within the 84.5%-85.5% range. Since many hospitals have experience modification factors within a tight range around the 85% cut-off, relatively small shifts in the credibility factors, off-balance, and relative recoupment rates can cause this migration between the 80.0%-85.0% and 85.0%-90.0% range categories.

Revenue impact

The 209 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 2012 baseline assessments. When applied to the 2013 baseline assessments, many of which are estimates, the 2013 modified assessment is less than 0.1% higher than the 2013 baseline assessment. We do not expect a significant revenue impact when these factors are applied in 2014.

Comparison to 2013 experience modification factors

Of the 209 experience modification factors computed herein, 3 are for hospitals that have been rated for the first time. Of the remaining 206 modification factors, 170 are within 5.0% and 189 are within 7.5% of the 2013 filed experience modification factors. Of the 201 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 168 are within 5.0% and 186 are within 7.5% of their 2013 filed experience modification factors.

Of the 36 experience modification factor changes greater than 5.0%, 33 are for hospitals in Band 3, Band 4, or Band 5. Similarly, of the 17 experience modification factor changes greater than 7.5%, 15 are for hospitals in Band 3, Band 4, or Band 5. These hospitals receive relatively higher credibility and therefore changes in the experience modification factors are driven by changes in the underlying experience.

We reviewed the data 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 2014 experience modification factors to the 2013 experience modification factors for hospitals that have been experience rated for 2014 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 2009 through 2012;
2. Estimating and compiling the baseline assessments for each hospital for each policy year 2010 through 2013;
3. Calculating a rate of recoupment[7] for each hospital for each year and for each hospital band for each year;
4. Calculating the four relative rates of recoupment for each hospital showing the ratio of the hospital rate of recoupment to the total hospital rate of recoupment for each year and weighting these four relative rates of recoupment together to estimate an average relative rate of recoupment (weighted rate) for the individual hospital;
5. Determining appropriate a priori modification factors;
6. Determining an appropriate credibility weighting procedure and credibility weighting the hospital weighted rate with its band's a priori modification factor; and
7. Computing experience modification factors that lie within the bounds prescribed by Act 13 and that are revenue neutral.

Each of these steps is described below.

Compiling fund payment data (Exhibits 5 and 9)

The Fund provided payment data by hospital by claim year for Excess and Section 715 claims. We used combined data 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 2010 through 2013 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 2010 through 2013[8]. For policy year 2013, information was provided by the Fund for those hospitals who have remitted their 2013 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2013 assessment, the 2013 baseline assessment is estimated as the average of the 2011 and 2012 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes.

Calculating yearly rates of recoupment (Exhibit 3)

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

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[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.
[8] Note that tail assessments are also removed.

Rates of recoupment are established as the ratio of the Fund payment data for each claim year (ending 2009 through 2012) to the baseline policy year assessment data for the subsequent policy year (2010 through 2013). 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 2009/2010 through 2012/2013, 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 2013/2014 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 2013/2014 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
1	-17.5%	-17.5%
2	-17.5%	-17.5%
3	-5.0%	-5.0%
4	0.0%	0.0%
5	12.5%	12.5%

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' 2012 policy year prevailing primary premiums, adjusted for the JUA's 2013 base rate change. Namely, we divided the Fund's 2012 baseline policy year assessment by the Fund's 2012 assessment rate of 23.0%, then adjusted the resulting amount to reflect the JUA's filed base rate increase of 6.9% for policy year 2013. Policy periods were annualized where we observed that the 2012 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. 2009/2010, 2010/2011, and 2011/2012 to predict 2012/2013
2. 2009/2010, 2010/2011, and 2012/2013 to predict 2011/2012
3. 2009/2010, 2011/2012, and 2012/2013 to predict 2010/2011
4. 2010/2011, 2011/2012, and 2012/2013 to predict 2009/2010

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.

	Current Calculations		*Prior* Calculations	
Band	Selected K	Implied Avg Z	Selected K	Implied Avg Z
1	40,000,000	0.3%	40,000,000	0.3%
2	20,000,000	2.4%	20,000,000	2.3%
3	8,500,000	9.4%	8,000,000	9.4%
4	7,000,000	20.3%	6,500,000	20.6%
5	5,000,000	45.9%	5,000,000	44.9%

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 45.9% 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 2014 assessments, we estimated modification factors that are revenue neutral based on the 2012 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2014 assessments[9]. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance[10] adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

[9] As a test, we applied the modification factors to the 2012 baseline policy year assessments, 20% of which are estimates. The resulting modified assessments were approximately revenue neutral.

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

Medical Care Availability and Reduction of Error Fund

Comparison of 2014 and 2013 Experience Modification Factors

Group Code	2014 Final Mod	2013 Final Mod	Change	Group Code	2014 Final Mod	2013 Final Mod	Change	Group Code	2014 Final Mod	2013 Final Mod	Change
41402044	114.6%	120.0%	-5%	31814126	89.8%	83.1%	8%	40843261	109.4%	104.5%	5%
62801025	84.7%	84.9%	0%	82110167	84.9%	102.5%	-17%	31641292	85.9%	84.8%	1%
73903086	94.8%	101.4%	-7%	43614198	120.0%	105.5%	14%	13248233	84.9%	85.1%	0%
47003060	120.0%	120.0%	0%	55411180	84.4%	84.7%	0%	44245254	85.9%	85.7%	0%
68204091	91.0%	90.0%	1%	67116132	84.8%	85.1%	0%	65644235	84.8%	85.0%	0%
11516013	99.7%	96.7%	3%	09718133	116.9%	111.8%	5%	27042217	84.9%	85.1%	0%
12915004	85.0%	85.2%	0%	70324114	85.5%	86.2%	-1%	78644208	84.7%	84.9%	0%
83615085	86.0%	97.6%	-12%	71128195	108.5%	115.7%	-6%	11156261	84.5%	84.7%	0%
84215016	110.2%	106.9%	3%	52221176	85.3%	86.4%	-1%	82151272	112.3%	95.6%	17%
25312057	83.2%	83.6%	0%	37028198	84.4%	84.6%	0%	83851273	85.0%	85.2%	0%
36713058	85.1%	83.9%	1%	28326129	84.6%	84.8%	0%	64254244	85.6%	86.1%	-1%
87517049	82.9%	83.3%	-1%	19326120	95.3%	102.2%	-7%	65858275	84.6%	85.0%	0%
58417030	84.8%	85.0%	0%	30637131	85.7%	88.1%	-3%	38152296	99.8%	102.7%	-3%
70420061	83.1%	83.6%	-1%	61636162	120.0%	120.0%	0%	99356277	107.9%	105.3%	2%
81322082	84.4%	84.6%	0%	65637123	94.4%	95.7%	-1%	20668278	113.4%	98.1%	16%
52821043	85.6%	85.9%	0%	96831164	82.5%	82.9%	0%	21465279	96.2%	91.0%	6%
25725085	84.5%	84.6%	0%	79931165	115.4%	106.3%	9%	33567281	84.4%	84.5%	0%
17720096	85.9%	86.0%	0%	11447157	84.9%	85.1%	0%	55064242	96.0%	98.7%	-3%
19324078	97.5%	93.6%	4%	82747178	96.0%	97.9%	-2%	49766243	85.0%	85.2%	0%
30638079	84.7%	84.9%	0%	83448149	84.6%	84.7%	0%	77777214	96.9%	101.3%	-4%
21336020	90.7%	84.0%	8%	24549170	84.6%	86.0%	-2%	38976225	86.3%	86.7%	0%
32834061	84.6%	84.8%	0%	95645131	86.7%	84.7%	2%	49271246	92.0%	93.2%	-1%
14438032	87.0%	87.5%	-1%	36346152	80.0%	86.2%	-7%	81787227	85.3%	85.7%	0%
87633084	88.3%	94.9%	-7%	67147123	86.2%	86.3%	0%	74598228	81.6%	87.3%	-6%
29032075	106.3%	100.9%	5%	80553166	108.1%	120.0%	-10%	46598239	86.3%	86.1%	0%
10247016	84.7%	85.9%	-1%	31858157	94.8%	99.2%	-4%	19194290	85.0%	85.2%	0%
71147027	88.8%	85.5%	4%	55454189	84.9%	85.1%	0%	50605341	84.9%	85.1%	0%
02842078	120.0%	120.0%	0%	76153130	84.7%	84.9%	0%	81908302	84.8%	85.0%	0%
24240009	94.0%	102.0%	-8%	77158191	120.0%	120.0%	0%	02503353	84.8%	85.0%	0%
45945070	119.6%	105.9%	13%	18756162	84.9%	85.1%	0%	55605314	85.7%	85.0%	1%
88841063	84.6%	84.8%	0%	44261155	84.8%	85.0%	0%	76406315	84.8%	85.0%	0%
59241014	83.1%	83.3%	0%	75660176	89.9%	91.2%	-1%	68705327	94.9%	96.4%	-2%
33558066	98.8%	100.7%	-2%	17665167	87.9%	92.2%	-5%	79705368	84.6%	84.9%	0%
75450028	84.7%	84.9%	0%	28467168	84.8%	85.0%	0%	10111389	84.5%	84.8%	0%
16653089	120.0%	120.0%	0%	49968179	84.6%	85.9%	-1%	53413392	85.8%	84.8%	1%
17152000	93.9%	87.5%	7%	70177120	115.0%	97.4%	18%	45815344	85.0%	85.2%	0%
38852021	120.0%	120.0%	0%	53878122	83.2%	81.5%	2%	46518325	109.9%	110.6%	-1%
39153062	84.7%	84.9%	0%	14377183	95.3%	95.7%	0%	47816316	85.0%	85.2%	0%
40366053	80.4%	83.3%	-3%	25277194	93.4%	89.0%	5%	30324381	84.9%	85.1%	0%
21167074	90.3%	100.2%	-10%	78171185	84.6%	84.8%	0%	22428368	84.9%	85.1%	0%
74163037	84.7%	84.9%	0%	89976106	87.3%	94.9%	-8%	33025309	85.0%	85.2%	0%
87768000	96.5%	101.6%	-5%	21585108	120.0%	120.0%	0%	76826324	85.0%	85.2%	0%
88668081	89.9%	89.8%	0%	14286150	92.2%	90.7%	2%	57628362	84.9%	85.0%	0%
60671062	89.3%	89.5%	0%	17987151	87.2%	82.1%	6%	79829326	85.0%	85.2%	0%
61677083	99.9%	96.1%	4%	98982162	85.0%	85.8%	-1%	80433362	85.0%	85.2%	0%
23370015	84.6%	84.8%	0%	79785153	87.5%	81.8%	7%	21834383	85.0%	85.2%	0%
64874036	94.8%	89.0%	6%	30495154	96.7%	96.5%	0%	62832354	84.8%	85.0%	0%
96775028	84.4%	85.8%	-2%	71791165	82.8%	83.0%	0%	94433397	85.0%	85.2%	0%
97276059	86.1%	86.2%	0%	72296106	110.7%	113.0%	-2%	55130345	85.0%	85.2%	0%
59478030	83.7%	83.6%	0%	23494157	84.9%	85.1%	0%	36538334	84.9%	85.1%	0%
01181011	120.0%	120.0%	0%	74295158	84.9%	85.1%	0%	28831342	85.0%	85.2%	0%
42183052	87.2%	87.4%	0%	86398149	94.4%	88.3%	7%	40846315	86.0%	86.4%	0%
53189093	86.0%	86.3%	0%	47392180	100.1%	96.6%	4%	11243319	85.7%	85.2%	1%
44788024	90.2%	111.5%	-19%	49293142	85.1%	89.2%	-5%	72444327	85.0%	85.2%	0%
45083045	99.1%	100.4%	-1%	54605294	120.0%	120.0%	0%	44845378	85.0%	85.2%	0%
57285037	84.5%	85.6%	-1%	15107295	89.8%	83.8%	7%	56747389	84.7%	84.9%	0%
88183058	89.9%	90.3%	0%	32616260	83.2%	83.6%	0%	08141319	83.4%	83.9%	-1%
89082059	83.2%	87.4%	-5%	83912221	93.3%	88.8%	5%	29542393	84.8%	85.0%	0%
20592050	86.2%	85.2%	1%	96212204	97.4%	86.9%	12%	30457304	84.9%	85.1%	0%
73796092	99.5%	106.4%	-6%	77315235	98.4%	97.0%	1%	72856377	85.0%	85.2%	0%
54197023	85.5%	85.7%	0%	59218247	100.8%	97.9%	3%	63853356	84.9%	85.1%	0%
95597054	95.4%	104.8%	-9%	90823268	107.3%	110.4%	-3%	35557389	84.9%	85.1%	0%
27394085	120.0%	120.0%	0%	72529229	94.6%	94.8%	0%	76156363	86.2%	85.1%	1%
98191036	120.0%	120.0%	0%	64627271	100.4%	105.0%	-4%	88457398	85.0%	85.2%	0%
79898097	82.5%	82.8%	0%	67621243	84.9%	85.1%	0%	67859383	85.0%	85.2%	0%
80103168	85.6%	85.7%	0%	38524204	84.5%	84.7%	0%	51768395	85.0%	85.2%	0%
94606100	84.4%	84.7%	0%	89927235	83.6%	83.9%	0%	62768395	84.9%	new for 2014	
65706161	89.9%	95.2%	-6%	14133227	93.7%	97.7%	-4%	73768395	85.0%	new for 2014	
96705102	88.8%	86.7%	2%	96131289	84.5%	84.6%	0%	05763355	84.9%	new for 2014	
30817115	120.0%	120.0%	0%	89530290	120.0%	120.0%	0%				

Notes:
2014 Final Mod is derived on Exhibit 1.
2013 Final Mod is from the prior year's report.
"Change" shows the year-over-year percentage change.

PA Department of Insurance

Mcare Fund

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
2005	$ 293,875,477	$ 6,170,358	$ 1,280,876	$ 75,037,060	$ 8,957,666	$ 885,526	$ 20,382
2006	$ 218,020,588	$ 5,019,667	$ 1,074,833	$ 61,324,718	$ 6,437,525	$ 897,225	$ 15,572
2007	$ 184,566,736	$ 3,692,160	$ 965,769	$ 49,303,712	$ 5,374,291	$ 767,941	$ 18,061
2008	$ 171,328,262	$ 2,990,281	$ 996,867	$ 45,433,100	$ 5,228,327	$ 813,838	$ 20,708
2009	$ 159,239,581	$ 2,819,565	$ 890,670	$ 41,912,060	$ 4,760,811	$ 776,744	$ 19,991
2010	$ 161,874,757	$ 2,915,572	$ 980,820	$ 41,468,010	$ 4,567,485	$ 784,659	$ 24,203
2011	$ 133,519,985	$ 2,419,943	$ 814,723	$ 33,398,281	$ 3,769,009	$ 665,985	$ 21,712
2012	$ 152,736,111	$ 3,068,991	$ 1,065,859	$ 40,059,401	$ 4,096,976	$ 831,401	$ 33,721
2013	$ 176,416,493	$ 3,981,254	$ 1,276,132	$ 44,038,347	$ 5,531,553	$ 927,072	$ 34,509
*2014	$ 170,515,174	$ 3,674,692	$ 1,331,779	$ 41,791,461	$ 4,654,582	$ 917,792	$ 35,630

*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2015. Coverage for policies that has been reported and processed as of February 25, 2015 is included in the amount.

PA Department of Insurance

Mcare Fund

Yearly Average Unabated Assessment by Provider Group

	Physicians			Podiatrists			Hospitals			Nursing Homes		
	Yearly Average	% Change over Prior Year	% Change from 2002 to 2013	Yearly Average	% Change over Prior Year	% Change from 2002 to 2013	Yearly Average	% Change over Prior Year	% Change from 2002 to 2013	Yearly Average	% Change over Prior Year	% Change from 2002 to 2012
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%		$2,074	-17%		$160,254	-15%		$5,384	-18%	
2012	$3,627	9%		$2,354	14%		$185,290	16%		$6,384	19%	
2013	$4,195	16%		$2,546	8%		$202,949	10%		$6,521	2%	
2014	$4,023	-4%	-43%	$3,210	26%	-29%	$196,027	-3%	-29%	$7,033	8%	27%

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

Mcare Fund

Assessments Remitted by Self-Insurer 2005 - 2014

Carrier	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
S10	$ 6,640,753	$ 5,109,964	$ 4,692,818	$ 4,515,980	$ 4,401,573	$ 4,581,217	$ 3,845,277	$ 3,925,897	$ 5,086,715	$ 4,909,842
S12	$ 1,656,347	$ 1,525,455	$ 1,579,563	$ 1,533,370	$ 1,442,094	$ 1,497,885	$ 1,447,174	$ 1,701,974	$ 2,119,427	$ 2,136,185
S34	$ 142,448	$ 268,185	$ 149,334	$ -	$ -	$ -	$ -	$ -	$ -	$ -
S40	$ 716,561	$ 563,811	$ 425,328	$ 405,479	$ 398,985	$ 421,831	$ 320,702	$ 408,489	$ 536,411	$ 548,490
S41	$ 170,657	$ 124,224	$ 102,625	$ 98,300	$ 84,109	$ 75,339	$ 61,967	$ 68,635	$ 75,056	$ 77,831
S43	$ 364,425	$ 42,623	$ 201,996	$ 276,166	$ 265,791	$ -	$ -	$ -	$ -	$ -
S45	$ 24,244	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -
S46	$ 20,227	$ 2,860	$ 14,279	$ 12,820	$ 11,331	$ -		$ -	$ -	$ -
S47	$ 228,702	$ 166,829	$ 145,913	$ 135,249	$ -	$ -	$ -	$ -	$ -	$ -
S49	$ 1,316,490	$ 984,784	$ 790,576	$ 778,995	$ 661,673	$ 639,358	$ 515,432	$ -	$ -	$ -
S51	$ 1,400,925	$ 982,385	$ 713,553	$ 687,254	$ 661,708	$ 540,122	$ 291,594	$ -	$ -	$ -
S53	$ 641,655	$ 518,935	$ 340,490	$ 201,167	$ 190,741	$ 182,191	$ 76,434		$ -	$ -
S54	$ 545,307	$ 402,360	$ 367,418	$ 340,441	$ 343,321	$ 372,268	$ 342,107	$ 393,845	$ 483,422	$ 454,589
S57	$ 246,793	$ 78,529	$ 63,396	$ 55,414	$ 49,877	$ 52,078	$ 39,633	$ 21,273	$ -	$ -
S58	$ 30,959	$ 22,910	$ 17,387	$ 12,503	$ 13,637	$ 16,372	$ 10,656	$ 12,482	$ 15,481	$ 15,492
S59	$ 42,377	$ 32,058	$ 27,285	$ 24,514	$ 22,223	$ 11,932	$ -	$ -	$ -	$ -
S60	$ 515,953	$ 465,053	$ 459,988	$ 412,089	$ 419,605	$ 399,292	$ 387,342	$ 480,035	$ 545,783	$ 532,755
S61	$ 21,916	$ 15,987	$ 13,766	$ 12,516	$ 11,367	$ 11,445	$ 9,306	$ 10,805	$ 12,555	$ 11,943
S62	$ 652,260	$ 502,670	$ 387,338	$ 806,096	$ -	$ -	$ -	$ -	$ -	$ -
S63	$ 435,207	$ 320,610	$ 269,323	$ 285,887	$ 250,675	$ 244,193	$ 154,020	$ 178,381	$ 216,347	$ 216,499
S64	$ 28,908	$ 21,230	$ 18,134	$ 16,912	$ 15,095	$ 15,199	$ 12,459	$ 14,663	$ 16,946	$ 16,121
S66	$ -	$ -	$ -	$ -	$ 467,498	$ -	$ -	$ -	$ -	$ -
S67	$ -	$ -	$ -	$ -	$ -	$ 3,004	$ 14,561	$ 9,742	$ 11,114	$ 10,671
S68	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,590,591
TOTALS	**$ 15,843,114**	**$ 12,151,462**	**$ 10,780,510**	**$ 10,611,152**	**$ 9,711,303**	**$ 9,063,726**	**$ 7,528,664**	**$ 7,226,221**	**$ 9,119,257**	**$ 10,521,009**

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 25, 2015.

Mcare Fund

Assessment Remitted by Commercial Carrier for 2005 - 2014

Carrier Code	2005 Amount [1]	2006 Amount	2007 Amount	2008 Amount	2009 Amount	2010 Amount	2011 Amount	2012 Amount	2013 Amount	2014 Amount
001	$ 47,324	$ 33,007	$ 26,450	$ 18,923	$ 17,490	$ 12,880	$ 10,341	$ 11,721	$ 11,760	$ -
003	$ 28,838,265	$ 20,610,870	$ 16,320,565	$ 16,183,237	$ 14,646,003	$ 14,221,278	$ 11,622,512	$ 12,843,082	$ 16,175,835	$ 16,285,186
011	$ 3,519,774	$ 2,373,646	$ 3,088,606	$ 3,227,203	$ 2,465,129	$ 2,730,107	$ 2,460,040	$ 2,364,112	$ 3,266,051	$ 3,704,245
021	$ 212,524	$ 116,340	$ 101,967	$ 92,290	$ 82,229	$ 81,444	$ 69,248	$ 82,237	$ 87,430	$ -
023	$ 95,243	$ 68,430	$ 105,614	$ 65,366	$ 51,034	$ 58,538	$ 58,602	$ 101,281	$ 113,314	$ 95,286
026	$ 18,287	$ 1,382	$ 55,443	$ 9,870	$ -	$ -	$ -	$ -	$ -	$ -
031	$ 40,141,225	$ 29,015,911	$ 26,106,849	$ 23,321,704	$ 21,572,773	$ 21,276,762	$ 17,186,593	$ 18,765,227	$ 19,999,274	$ 17,608,276
032	$ 11,452,219	$ 6,460,037	$ 3,941,745	$ 2,358,328	$ 1,640,523	$ 1,289,616	$ 865,976	$ 852,573	$ 886,928	$ 682,098
052	$ 373,630	$ 197,285	$ 180,934	$ 119,473	$ 203,452	$ 115,870	$ 93,642	$ 71,237	$ 132,089	$ 47,669
055	$ 244,072	$ 103,734	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 89,425
067	$ 32,040,035	$ 21,638,813	$ 17,232,813	$ 15,474,041	$ 15,815,478	$ 15,192,037	$ 11,626,874	$ 12,669,168	$ 13,924,692	$ 13,603,538
086	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,840
090	$ 242,090	$ 197,110	$ 165,092	$ 139,276	$ 124,663	$ 70,966	$ 69,784	$ 66,940	$ 81,584	$ 80,774
103	$ 696,889	$ 445,927	$ 555,681	$ 544,718	$ 450,346	$ 416,908	$ 332,731	$ 274,808	$ 688,522	$ 1,189,369
110	$ 26,047	$ 9,348	$ 26,465	$ 31,004	$ 35,085	$ 39,745	$ 37,335	$ 52,843	$ 75,359	$ 39,898
112	$ 399,101	$ 332,971	$ 253,378	$ 227,379	$ 180,419	$ 113,931	$ 96,636	$ 8,661	$ 10,064	$ 9,573
113	$ -	$ -	$ -	$ -	$ -	$ 2,434	$ 8,969	$ 10,868	$ 15,394	$ 17,432
118	$ -	$ -	$ -	$ -	$ 7,157	$ -	$ -	$ 18,269	$ 9,171	$ 8,738
121	$ 1,468,601	$ 909,349	$ 882,765	$ 776,633	$ 678,834	$ 678,970	$ 549,636	$ 491,566	$ 515,043	$ 450,908
124	$ 1,561,433	$ 1,428,005	$ 1,147,023	$ 916,065	$ 885,896	$ 830,255	$ 678,519	$ 788,364	$ 830,074	$ 788,132
127	$ 140,514	$ 355,965	$ 233,085	$ 242,147	$ 331,553	$ 360,052	$ 316,702	$ 376,394	$ 242,324	$ 517,437
129	$ 10,416,024	$ 15,765,415	$ 7,285,274	$ 5,986,165	$ 5,249,232	$ 5,348,398	$ 4,152,203	$ 4,359,771	$ 3,057,342	$ 4,529,258
130	$ -	$ -	$ 39	$ -	$ -	$ -	$ -	$ 19,970	$ 71,064	$ 22,275
132	$ 21,307	$ 12,021	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
137	$ 270,175	$ 182,854	$ 156,052	$ 136,705	$ 118,536	$ 118,127	$ 79,619	$ 95,517	$ 114,141	$ 259,411
138	$ 949,048	$ 665,057	$ 589,153	$ 616,309	$ 596,813	$ 717,329	$ 765,894	$ 742,567	$ 847,240	$ 932,301
139	$ 213,775	$ 162,613	$ 163,506	$ 149,005	$ 56,086	$ -	$ -	$ -	$ -	$ -
144	$ 30,972,749	$ 23,381,543	$ 20,326,526	$ 18,694,241	$ 16,864,092	$ 18,023,434	$ 15,900,663	$ 18,956,389	$ 23,488,446	$ 22,385,533
145	$ 5,652,473	$ 4,604,584	$ 4,066,871	$ 4,093,690	$ 4,092,820	$ 4,213,562	$ 3,679,569	$ 4,748,241	$ 5,419,089	$ 5,100,032
148	$ 258	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	$ 23,219,031	$ 16,938,250	$ 15,193,657	$ 15,775,505	$ 14,716,471	$ 14,960,854	$ 12,372,784	$ 13,813,562	$ 15,919,072	$ 15,446,322
156	$ 19,206,036	$ 13,316,319	$ 10,557,816	$ 8,189,173	$ 10,275,742	$ 9,119,695	$ 7,134,927	$ 7,936,949	$ 8,672,193	$ 7,624,564
160	$ 34,214	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
162	$ 1,308,419	$ 199,936	$ 90,671	$ 53,423	$ 36,978	$ 17,535	$ 17,843	$ 69,802	$ 121,352	$ 111,918
165	$ -	$ -	$ -	$ -	$ 184	$ 22,085	$ 198,288	$ 259,445	$ 272,372	$ 61,567
169	$ 2,695	$ 2,040	$ -	$ -	$ -	$ 4,180	$ -	$ -	$ -	$ -
173	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,242	$ -
179	$ 11,457	$ 69,573	$ 176,742	$ 79,223	$ 37,368	$ 36,539	$ 30,926	$ 35,611	$ 35,955	$ 14,186
182	$ 78,992	$ 56,333	$ 11,369	$ 4,368	$ -	$ -	$ -	$ -	$ -	$ -
183	$ 613,327	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
186	$ 305,134	$ 190,345	$ 147,557	$ 147,828	$ 113,095	$ 105,611	$ 60,230	$ 34,101	$ 22,421	$ -
191	$ 266,091	$ 206,266	$ 92,138	$ 54,711	$ 20,188	$ -	$ -	$ -	$ -	$ -
194	$ 1,622,993	$ 760,994	$ 552,999	$ 113,328	$ 21,707	$ 106,244	$ 94,753	$ 48,581	$ 11,573	$ 10,750
196	$ 1,824,991	$ 1,505,682	$ 1,338,800	$ 1,152,322	$ 1,260,810	$ 1,186,669	$ 1,061,362	$ 979,269	$ 1,039,187	$ 877,277
197	$ 9,819,619	$ 7,128,106	$ 6,001,678	$ 5,680,512	$ 4,925,958	$ 4,958,432	$ 4,276,861	$ 5,609,581	$ 6,871,401	$ 5,964,147
198	$ 18,868	$ 13,764	$ 8,144	$ 6,734	$ 6,218	$ 107,345	$ 87,992	$ 103,003	$ 118,884	$ -
199	$ 6,952,466	$ 5,182,005	$ 4,568,319	$ 4,774,694	$ 4,587,769	$ 4,849,906	$ 4,066,367	$ 4,610,605	$ 5,392,354	$ 5,327,279
200	$ 1,482	$ 1,122	$ 905	$ 241	$ -	$ -	$ -	0	$ -	$ -
202	$ 13,833,367	$ 10,829,429	$ 9,201,173	$ 8,573,179	$ 7,791,910	$ 8,064,521	$ 6,638,291	$ 6,456,603	$ 7,752,483	$ -
203	$ 2,291,771	$ 1,658,136	$ 1,530,507	$ 1,304,080	$ 1,294,032	$ 1,369,529	$ 1,317,844	$ 1,324,129	$ 1,747,218	$ 1,794,879
206	$ 90,018	$ 63,160	$ 50,555	$ 41,631	$ 54,164	$ 24,312	$ 28,762	$ 23,432	$ -	$ -
207	$ 30,634,792	$ 22,504,336	$ 21,063,317	$ 20,772,601	$ 19,106,824	$ 14,794,610	$ 12,769,476	$ 14,147,817	$ 15,993,696	$ 15,309,647
208	$ 4,417,428	$ 3,437,902	$ 2,582,444	$ 2,051,039	$ 1,869,269	$ 1,970,187	$ 1,669,532	$ 1,862,098	$ 2,392,527	$ 1,766,411
210	$ 307,417	$ 209,112	$ 407,700	$ 567,407	$ 788,053	$ 879,944	$ 895,795	$ 1,573,025	$ 900,515	$ 815,789
211	$ 14,533,257	$ 10,329,786	$ 9,471,805	$ 9,612,577	$ 8,350,530	$ 8,935,740	$ 6,967,934	$ 7,627,800	$ 8,661,830	$ 7,539,580
212	$ 82,654	$ 263,985	$ 214,146	$ 197,423	$ 185,955	$ 199,165	$ 234,820	$ 269,399	$ 392,633	$ 649,432
215	$ 61,762	$ 91,726	$ 60,933	$ -	$ -	$ -	$ -	$ -	$ -	$ -
216	$ 19,466	$ 13,991	$ 10,985	$ 7,052	$ 7,039	$ 7,392	$ 5,448	$ 5,644	$ 6,893	$ -
217	$ 857,909	$ 605,802	$ 514,874	$ 459,023	$ 384,630	$ 357,590	$ 288,634	$ 332,970	$ 378,859	$ 292,845
218	$ 326,379	$ 276,821	$ 241,409	$ 232,387	$ 258,318	$ 285,174	$ 259,598	$ 297,256	$ 385,246	$ 364,147
219	$ 7,547,282	$ 5,955,405	$ 5,489,265	$ 5,219,972	$ 4,348,616	$ 3,994,216	$ 3,351,000	$ 3,530,970	$ 4,392,985	$ 3,940,192
220	$ 3,653,676	$ 2,657,632	$ 2,192,072	$ 2,103,498	$ 2,093,698	$ 2,094,472	$ 1,811,720	$ 2,186,209	$ 1,852,280	$ 1,392,274
221	$ 10,241,825	$ 7,427,839	$ 6,094,179	$ 4,865,330	$ 4,409,132	$ 4,458,489	$ 3,369,688	$ 3,473,170	$ 4,346,848	$ 4,541,633
222	$ 4,868,036	$ 3,885,791	$ 3,663,769	$ 3,497,115	$ 3,299,424	$ 3,456,560	$ 3,071,859	$ 3,603,862	$ 4,552,611	$ 4,670,982
223	$ 5,322,470	$ 4,273,862	$ 3,967,074	$ 3,849,643	$ 3,500,761	$ 3,420,200	$ 680,542	$ 5,717,928	$ 3,789,230	$ 3,674,106
224	$ 2,692,382	$ 2,172,179	$ 1,903,762	$ 1,815,565	$ 1,714,927	$ 1,771,812	$ 1,537,678	$ 1,890,286	$ 2,298,717	$ 2,560,455
225	$ 70,069	$ 51,383	$ 48,129	$ 48,020	$ 47,223	$ 55,395	$ 58,234	$ 70,114	$ 80,901	$ 77,034
226	$ 150,605	$ 114,407	$ 96,197	$ 90,967	$ 82,373	$ 81,390	$ 64,177	$ 75,865	$ 77,175	$ 75,123

Mcare Fund

Assessment Remitted by Commercial Carrier for 2005 - 2014

Carrier Code	2005 Amount [1]	2006 Amount	2007 Amount	2008 Amount	2009 Amount	2010 Amount	2011 Amount	2012 Amount	2013 Amount	2014 Amount
227	$ 6,435	$ 4,694	$ 4,010	$ 3,675	$ 3,338	$ 3,360	$ 2,755	$ 3,225	$ -	$ -
228	$ 2,648,932	$ 1,948,701	$ 1,768,490	$ 1,701,835	$ 1,607,351	$ 1,633,760	$ 1,297,886	$ 1,470,236	$ 1,052,576	$ -
229	$ 7,099,920	$ 4,659,753	$ 3,752,155	$ 2,422,927	$ 2,324	$ -	$ -	0	$ -	$ -
230	$ 13,735	$ 22,197	$ 15,416	$ 22,103	$ 20,715	$ 20,859	$ 7,414	0	$ -	$ -
232	$ 367,966	$ 328,130	$ 54,951	$ 32,884	$ 60,383	$ 101,537	$ 124,590	$ 122,349	$ 136,652	$ 170,539
233	$ 83,297	$ 55,060	$ 43,869	$ 4,592	$ 617	$ 119	$ 1,339	$ 1,504	$ -	$ -
234	$ 340,223	$ 256,604	$ 219,645	$ 211,825	$ 225,656	$ 211,684	$ 171,751	$ 196,256	$ 217,077	$ 226,606
235	$ 134,639	$ 101,397	$ 86,273	$ 81,046	$ 73,644	$ 73,290	$ 60,010	$ 69,698	$ 81,258	$ 76,906
236	$ 150,849	$ 103,174	$ 59,594	$ 49,931	$ 77,890	$ 53,065	$ 14,613	$ 17,106	$ 36,456	$ 51,526
237	$ 18,450	$ 10,624	$ 6,774	$ 25,463	$ 37,613	$ 18,081	$ 37,038	$ 20,319	$ 21,057	$ 20,059
239	$ 3,901,881	$ 3,081,978	$ 2,850,125	$ 2,862,069	$ 2,544,367	$ 2,501,619	$ 2,327,394	$ 2,308,847	$ 2,282,374	$ 2,318,419
241	$ 1,905,980	$ 1,322,833	$ 1,112,562	$ 1,011,930	$ 927,277	$ 936,689	$ 780,430	$ 841,842	$ 973,242	$ 978,356
242	$ 72,851	$ 45,872	$ 43,943	$ 41,115	$ 37,341	$ 37,599	$ 30,820	$ 36,079	$ 41,922	$ 39,879
243	$ 53,759	$ 38,408	$ 32,439	$ 30,088	$ 26,843	$ 23,892	$ 19,320	$ 22,679	$ 26,343	$ 26,156
244	$ 143,971	$ 266,054	$ 82,420	$ 104,665	$ 93,843	$ 92,656	$ 73,106	$ 43,307	$ 55,943	$ 66,351
245	$ 8,060,920	$ 6,287,446	$ 5,505,853	$ 5,229,282	$ 5,082,741	$ 5,428,849	$ 4,995,186	$ 6,501,002	$ 7,878,484	$ 7,903,177
246	$ 7,338,225	$ 4,726,834	$ 3,017,049	$ 2,872,355	$ 2,398,723	$ 2,154,129	$ 1,663,726	$ 1,726,585	$ 1,960,684	$ 610,356
247	$ 135,669	$ 92,695	$ 100,909	$ 98,780	$ 25,672	$ 33,807	$ 30,579	$ 41,677	$ 111,819	$ 44,360
248	$ 825,423	$ 558,983	$ 472,406	$ 375,191	$ 302,166	$ 314,244	$ 289,671	$ 370,397	$ 443,530	$ 405,663
249	$ 1,266	$ -	$ 1,584	$ 11,495	$ 11,427	$ 21,289	$ 15,689	$ 14,768	$ 22,767	$ 4,211
250	$ 825,468	$ 758,085	$ 657,154	$ 613,888	$ 549,842	$ 482,819	$ 51,022	$ -	$ -	$ -
251	$ -	$ 389,786	$ 285,173	$ 178,568	$ 73,792	$ 53,983	$ 44,006	$ -	$ -	$ -
252	$ 73,372	$ 121,543	$ 100,293	$ 84,861	$ 78,382	$ 67,892	$ 53,245	$ 54,800	$ 58,348	$ 20,496
253	$ 7,476,467	$ 5,596,728	$ 4,207,896	$ 4,117,837	$ 3,965,972	$ 4,122,858	$ 3,485,401	$ 4,138,934	$ 4,806,609	$ 4,673,640
254	$ 39,180	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
255	$ 1,482	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
256	$ 155,055	$ 223,649	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
257	$ -	$ 34,910	$ 35,491	$ 35,638	$ 69,671	$ 48,673	$ 38,693	$ 17,602	$ -	$ -
258	$ 551,704	$ 2,674,928	$ 2,916,917	$ 2,594,752	$ 2,105,917	$ 1,916,725	$ 1,591,372	$ 1,686,363	$ 1,780,722	$ 1,510,276
261	$ -	$ 1,342,800	$ 1,305,617	$ 1,225,646	$ 1,326,180	$ 1,196,930	$ 1,282,486	$ 1,180,607	$ 986,365	$ 878,911
262	$ -	$ 19,008	$ 24,994	$ 21,229	$ 26,752	$ 33,772	$ 36,892	$ 62,788	$ 68,836	$ 59,488
263	$ 4,016	$ 2,244	$ -	$ -	$ 3,080	$ -	$ -	$ -	$ -	$ -
264	$ 2,291	$ 2,601	$ 2,692	$ 1,161	$ 1,075	$ 920	$ 949	$ 1,066	$ 1,308	$ 1,207
265	$ -	$ 52,404	$ 107,210	$ 104,788	$ 28,958	$ 13,756	$ 66,711	$ 140,669	$ 146,164	$ 142,135
266	$ 45,660	$ 14,924	$ 45,041	$ 23,553	$ 21,106	$ 21,252	$ 31,786	$ 33,962	$ 46,564	$ 44,295
267	$ -	$ 44,168	$ 970	$ 1,038	$ 536	$ 573	$ 470	$ 633	$ 807	$ 741
268	$ 1,649	$ 2,907	$ 7,111	$ 6,439	$ 5,204	$ 1,752	$ 1,674	$ 2,043	$ -	$ -
271	$ -	$ -	$ 445,181	$ 957,861	$ 1,670,191	$ 2,509,786	$ 2,162,136	$ 2,507,531	$ 2,530,757	$ 5,671,670
272	$ -	$ 2,968	$ 7,177	$ 8,822	$ -	$ -	$ -	$ -	$ -	$ -
274	$ -	$ 306,044	$ 211,445	$ 174,291	$ 164,117	$ 181,037	$ 145,726	$ 175,616	$ 193,020	$ 168,204
275	$ 56,376	$ 222,794	$ 611,980	$ 539,368	$ 471,145	$ 551,696	$ 401,488	$ 544,901	$ 18,100	$ 21,501
276	$ -	$ -	$ 672,192	$ 598,144	$ 538,114	$ 538,184	$ 437,079	$ 512,402	$ 597,451	$ 563,886
277	$ -	$ -	$ -	$ -	$ -	$ 31,687	$ 60,284	$ 73,897	$ 90,978	$ 130,931
278	$ 7,884	$ 5,548	$ -	$ 566	$ -	$ -	$ -	$ -	$ -	$ -
279	$ -	$ -	$ 175,728	$ 228,393	$ 216,826	$ 540,063	$ 470,105	$ 593,152	$ 563,997	$ 136,277
281	$ 1,752	$ 1,326	$ 1,176	$ 943	$ 949	$ -	$ -	$ -	$ -	$ -
282	$ -	$ -	$ 51,329	$ 67,019	$ 70,584	$ 41,605	$ 24,332	$ -	$ -	$ -
285	$ -	$ -	$ -	$ 98,668	$ 273,106	$ 420,044	$ 281,021	$ -	$ -	$ -
286	$ -	$ -	$ -	$ 38,594	$ 50,081	$ 78,039	$ 119,105	$ 157,730	$ 120,817	$ 122,429
287	$ -	$ -	$ -	$ 28,721	$ -	$ -	$ -	$ -	$ -	$ -
289	$ -	$ -	$ -	$ -	$ -	$ 13,782	$ 11,298	$ 59,699	$ 74,364	$ 53,632
290	$ -	$ -	$ -	$ 3,929	$ 113,197	$ 64,152	$ 59,224	$ 64,324	$ 76,356	$ 74,558
291	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,927	$ 5,520	$ -
292	$ -	$ -	$ 286	$ -	$ 37,934	$ 11,491	$ 13,718	$ 71,920	$ 7,992	$ 15,301
293	$ -	$ -	$ -	$ -	$ 50,314	$ 53,367	$ 46,060	$ 47,614	$ 19,438	$ 14,586
294	$ -	$ -	$ -	$ -	$ 2,944	$ 7,299	$ 5,982	$ 4,734	$ 1,813	$ 3,472
296	$ 4,529	$ 3,600	$ 3,048	$ 4,270	$ 2,682	$ 2,814	$ 7,908	$ 2,797	$ 3,324	$ 3,449
297	$ -	$ -	$ -	$ -	$ 33,500	$ 18,398	$ 8,824	$ 11,047	$ -	$ -
298	$ -	$ -	$ -	$ -	$ 5,495	$ 24,403	$ 25,482	$ 26,560	$ 32,910	$ 32,527
303	$ -	$ -	$ -	$ -	$ -	$ 19,540	$ 29,308	$ 30,070	$ 40,121	$ 48,304
305	$ -	$ -	$ -	$ -	$ 2,678	$ 45,945	$ 38,857	$ 36,547	$ 39,130	$ -
307	$ -	$ -	$ -	$ -	$ -	$ 1,272	$ 1,147	$ 2,633	$ 3,155	$ 7,208
308	$ -	$ -	$ -	$ -	$ -	$ 360,392	$ 569,135	$ 795,748	$ 1,087,102	$ 534,601
309	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,675
310	$ -	$ -	$ -	$ -	$ 3,225	$ 4,839,707	$ 3,971,655	$ 5,453,907	$ 6,029,593	$ 5,896,134
312	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 34,459	$ 20,797	$ -
313	$ -	$ -	$ -	$ -	$ 572	$ 882	$ 723	$ 904	$ 1,242	$ 1,140
314	$ -	$ -	$ -	$ -	$ -	$ 25,112	$ 43,592	$ 110,615	$ 123,801	$ 212,319

Mcare Fund

Assessment Remitted by Commercial Carrier for 2005 - 2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Carrier Code	Amount [1]	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
315	$ -	$ -	$ -	$ -	$ -	$ 53,824	$ 44,083	$ 41,374	$ 52,256	$ 43,491
316	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,325	$ 29,157	$ -	$ -
318	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,288	$ 4,435	$ -	$ -
320	$ -	$ -	$ -	$ -	$ -	$ -	$ 137,894	$ 472,581	$ 298,395	$ 1,236
321	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,926	$ 36,484	$ 30,956
322	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,224	$ 30,874	$ 45,692	$ 20,523
323	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 62,024	$ 64,842	$ -
324	$ -	$ -	$ -	$ 2,041	$ 408	$ -	$ -	$ 25,623	$ 32,452	$ 35,845
325	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20	$ 31,562	$ 41,767
326	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,404	$ 56,401	$ 67,231
327	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 179,962	$ 47,961
328	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 330	$ 595,555	$ 484,270
329	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 97,845	$ 128,862	$ 152,710
330	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 502	$ 460,150	$ 476,361
331	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 548,451	$ 78,991
332	$ -	$ -	$ -	$ -	$ -	$ -	$ 20	$ 735	$ -	$ 4,942
333	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 215,890	$ 601,379
334	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 229,235	$ 602,913
336	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,747	$ 3,564
338	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,652,818	$ 6,952,014
339	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,230	$ 16,187
340	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 161	$ 60,581
341	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,404,521
342	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,391
343	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,795
344	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,173
900	$ 77,719	$ 6,018	$ 5,337	$ 3,242	$ 6,278	$ 2,428	$ 1,486	$ 1,032	$ -	$ -
Total	$ 379,930,457	$ 287,206,056	$ 241,668,891	$ 223,721,864	$ 207,285,747	$ 209,667,818	$ 172,855,986	$ 199,988,831	$ 228,119,713	$ 218,498,532

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 25, 2015.

Appendix D

Mcare Fund

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
2005	36,322	1,090	244	225	720	5	3	38,609
2006	37,228	1,111	253	225	711	5	3	39,536
2007	37,983	1,110	266	226	715	4	4	40,308
2008	38,891	1,126	266	224	712	5	4	41,228
2009	39,585	1,138	255	221	712	5	4	41,920
2010	40,346	1,162	271	223	700	5	4	42,711
2011	41,135	1,175	285	223	699	5	5	43,527
2012	42,232	1,202	309	221	697	5	5	44,671
2013	42,811	1,222	316	220	695	5	5	45,274
*2014	41,916	1,151	306	220	657	5	5	44,260

*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2015. Coverage for policies that has been reported and processed as of February 25, 2015 is included in the counts.

Appendix E

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Pennsylvania medical care availability and reduction of error fund

Estimation of 12/31/2013 unfunded liability and future years' claims payments pursuant to Act 13 of 2002

Philadelphia, PA

July 2014

Appendix E.1

Mr. Joseph DiMemmo
Deputy Insurance Commissioner
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, Pennsylvania 17102
July 21, 2014

Dear Mr. DiMemmo:

Enclosed is our report on the Fund's unpaid claim liabilities as of December 31, 2013. We appreciate the assistance provided by the Mcare team throughout the course of our analysis, and look forward to working with you in the future.

Please call David Kaye at (267) 330-1611 or Tim Landick at (267) 330-6608 when you are available to discuss. We look forward to hearing from you.

Sincerely,

David Kaye
Director
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Timothy Landick
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Enclosure

cc: R. Waeger, Mcare Fund

Table of contents

Introduction

Background

The Commonwealth of Pennsylvania established the Medical Care Availability and Reduction of Error Fund[1] (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 previously provided 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 claims[2]). The historical mandatory primary and Fund limits of medical malpractice coverage (000's) are included in the table on the following page:

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 - 2013	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 2016 and 2019, 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 2019. The limits of insurance assumed herein are shown in the table below (000's).

[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 that eliminated 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 provide coverage (within the primary policy limit) for claims brought forth four or more years after the breach of contract or the tort occurred, and which occurred after December 31, 2005. The Fund no longer provides first-dollar coverage for these late reported claims but does provide coverage 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. 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.

[3] A window of time exists during which reduced Fund coverage may exist for Section 715 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.

Policy year effective	Mandatory primary occ / agg limits		Mcare fund excess occ / agg limits	Section 605 / 715 limits
	Hospital	Physician		
2014 - 2015	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)
2016 - 2018	750 / 3,750	750 / 2,250	250 / 750	250 (excess)
2019 & 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 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 period[4];
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 Joint Underwriting Association (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 paid[5]; 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, 2013. 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.

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.

[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 $169 million as of December 31, 2013.

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 (Excess[6] or Section 715), open date, claim status, coverage limit, breast implant/pedicle screw claims, "no exposure" claims, primary report date, Fund payment information, etc.;
- 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.[7]

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. Any changes to the data provided or in the application of legislation relative to the historical application may necessitate modification to the estimates in this report.

The projected ultimate losses, calendar year claims payments, and 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, as do the uncertain impacts associated with the Patient Protection and Affordable Care Act and recent changes to joint and several liability in Pennsylvania as a result of Senate Bill 1131. 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 time[8] 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 sometime in the future), the uncertainty surrounding these estimates is

[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.

[7] 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). Consistent with our analyses in previous years, we have excluded these claims from the data used in our analysis to avoid the potential distortive effects on our projections. The unpaid claim estimates shown herein do not include a provision for these exposures.

[8] http://www.pacourts.us/assets/files/setting-2929/file-2300.pdf?cb=e416ad.pdf

significantly increased. The process of resolving medical malpractice claims, through both settlements and verdicts, is a fluid process 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 20% per year of the Section 715 claims paid over recent years, have historically been included in the Fund's operating (rather than claims) budget. Similarly, our estimates do not include a provision for the cost of claims administration nor for the Fund's other operating costs.

Note that defense is provided by the primary insurers for those claims where the Fund's coverage is provided on an excess basis.

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

For the past several years, the Fund has been 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

David Kaye and the peer reviewer for this assignment, Tim Landick, 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, 2013, excluding breast implant and pedicle screw exposure, to be approximately $1.13 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 2016 and 2019, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2019. If the basic coverage limits are not increased in 2016 and 2019, Fund coverage will continue into and beyond 2020 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 in 2016 and 2019.

During the course of our review, the Fund provided us with a projection of 2014 claim payments of approximately $175 million. We have incorporated this projected claim payment information into our estimate of the unfunded liability of $1.13 billion.

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:

Fund / Accident Year	Jan-1 Unfunded Liability	Cost of New Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability	Discounted (2%) Dec-31 Unfunded
2013				1,126,995	1,037,436
2014	1,126,995	193,792	175,000	1,145,787	1,040,692
2015	1,145,787	173,541	190,000	1,129,327	1,021,026
2016	1,129,327	122,194	199,582	1,051,938	951,917
2017	1,051,938	86,291	200,634	937,595	849,654
2018	937,595	64,394	194,509	807,480	734,391
2019	807,480		177,482	645,320	589,855
2020	645,320		152,033	493,287	451,949
2021	493,287		124,775	368,511	337,827
2022	368,511		98,372	270,139	247,405
2023	270,139		72,406	197,734	180,777
2024	197,734		51,143	146,590	134,087
2025	146,590		36,853	109,737	100,299
2026	109,737		27,259	82,478	75,357
2027	82,478		20,348	62,130	56,737
2028	62,130		15,003	47,126	43,003
2029	47,126		11,033	36,093	32,933
2030	36,093		8,518	27,575	25,170
2031	27,575		6,532	21,043	19,220
2032	21,043		5,069	15,974	14,603
2033	15,974		3,992	11,982	10,948
2034	11,982		3,117	8,865	8,094
2035	8,865		2,407	6,458	5,885
2036	6,458		1,805	4,653	4,223
2037	4,653		1,259	3,394	3,057
2038	3,394		878	2,516	2,246
2039	2,516		602	1,914	1,692
2040	1,914		397	1,517	1,331
2041	1,517		256	1,261	1,104
2042	1,261		189	1,072	939
2043	1,072		157	915	802
2044	915		129	786	691
2045	786		113	674	593
2046	674		98	576	508
2047	576		84	492	435
2048	492		71	421	373
2049	421		62	358	319
2050	358		51	307	275
2051	307		40	267	241
2052	267		38	230	208
2053	230		37	193	176
2054	193		34	159	146
2055	159		31	128	119
2056	128		30	98	92
2057	98		27	72	67
2058	72		23	49	47
2059	49		18	31	30
2060	31		13	18	17
		655,533	1,782,510		

Our projections of calendar year claims payments gives consideration to longer-term trends in claims payments, and the application of projected payment patterns to the projected unfunded liability resulted in an initial estimate of 2014 claims payments that is higher than the $175 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 2014 payments of $175 million. We have also assumed that a reduced level of payments, as observed during recent years, will continue into 2015, and have adjusted the projected 2015 payments to $190 million, which is roughly the average of the Fund's expected 2014 payments of $175 million and our initial projection of the 2015 payments of $195 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 12/31/2013 unfunded liability is unchanged on a nominal basis, but

the stream of payments, future years-ending unfunded liability, and present value of the unfunded liability differ as a result of this adjustment. Estimates of the liability reflecting the time value of money contained herein employ a discount rate assumption of 2%; 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 are performed for Philadelphia County and the remainder of the State (ROS), as well as for Excess and Section 715 claims, all excluding breast implant and pedicle screw claims. Our findings for the projections, separately for Excess and Section 715 claims, are discussed separately below.

Comparison to the projections as of 12/31/2012

The total expected unfunded liability of $1.13 billion has decreased 2.9% from our December 31, 2012 estimate of $1.16 billion. The breakdown of the change in the undiscounted estimate since December 31, 2012 is shown in the following table:

Rollforward of Estimated Unfunded Liability (000's) from 12/31/2012 to 12/31/2013

		Excess	Section 715		Total
(1)	Prior Estimated Liability	917,958	242,829		1,160,787
(2)	Less Prior Estimated DD&PJI	13,566	3,589		17,154
(3)	Prior Estimated Liability Ex. DD&PJI	904,392	239,240		1,143,632
(4)	Plus Change in Prior Accident Year Ultimate	(43,080)	(1,914)		(44,994)
(5)	Less Paid During Year	159,046	33,720		192,766
(6)	Plus Accident Year 2013 Ultimate	191,230	17,029	(a)	208,260
(7)	Current Estimated Liability Ex. DD&PJI	893,497	220,635		1,114,131
(8)	Current Estimated DD&PJI	10,216	2,648		12,864
(9)	Current Estimated Liability	903,713	223,282		1,126,995

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

During the year, we continued to observe favorable emergence in our projections for excess claims driven in part by the beneficial impact of Act 13 legislation. 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 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.

Section 715 claim estimates decreased slightly, driven primarily by favorable claim experience in accident years 2006 to 2012.

Fund / Accident Year	Current Selected Ultimate	Prior Selected Ultimate	Change in Selection
1976	47,668,227	47,668,227	0
1977	59,997,523	59,999,133	(1,610)
1978	86,402,607	86,406,868	(4,261)
1979	98,758,878	98,762,282	(3,404)
1980	135,952,342	135,952,342	0
1981	150,639,166	150,653,387	(14,222)
1982	173,590,418	173,604,712	(14,294)
1983	178,398,604	178,418,894	(20,290)
1984	166,315,013	166,332,182	(17,169)
1985	179,122,224	179,152,365	(30,142)
1986	171,526,894	171,558,502	(31,608)
1987	196,485,601	196,523,800	(38,199)
1988	215,910,990	215,968,584	(57,593)
1989	215,341,675	215,439,650	(97,974)
1990	255,721,206	254,850,665	870,541
1991	295,055,034	292,957,848	2,097,186
1992	270,269,275	270,721,125	(451,850)
1993	258,387,938	258,947,587	(559,649)
1994	294,549,372	294,698,142	(148,770)
1995	321,286,682	322,762,351	(1,475,669)
1996	307,132,889	308,506,835	(1,373,945)
1997	324,126,497	325,645,618	(1,519,121)
1998	302,556,841	304,815,032	(2,258,191)
1999	231,953,565	232,976,163	(1,022,598)
2000	233,342,621	233,286,500	56,121
2001	201,869,094	197,673,650	4,195,443
2002	151,952,882	150,055,973	1,896,909
2003	167,876,400	169,333,249	(1,456,849)
2004	157,370,411	154,580,434	2,789,976
2005	170,075,601	172,034,578	(1,958,977)
2006	140,239,037	151,164,354	(10,925,317)
2007	175,812,874	171,794,250	4,018,623
2008	171,296,966	174,471,908	(3,174,942)
2009	177,119,146	186,102,347	(8,983,201)
2010	186,570,935	203,897,481	(17,326,546)
2011	194,442,835	211,853,508	(17,410,673)
2012	203,566,264	194,108,327	9,457,937
Total	7,268,684,525	7,313,678,851	(44,994,326)

Within our unfunded liability report as of December 31, 2012, we assumed that basic insurance limits would increase from $500,000 to $750,000 during calendar year 2014 and again from $750,000 to $1,000,000 in 2017; however, in October 2013, the Pennsylvania Insurance Commissioner determined that there would be no increase in the basic limits of coverage effective during calendar year 2014. The estimates herein assume that basic insurance limits will increase from $500,000 to $750,000 during calendar year 2016 and again from $750,000 to $1,000,000 in 2019. The amounts in the tables above have not been adjusted to reflect the impact of the Commissioner's decision on our prior ultimate loss estimates. We note that the delay in the timing of the limits increases results in an increase in our ultimate loss estimates given that the Fund is providing coverage for claims in the $500,000 excess of $500,000 layer for a longer period of time (i.e., the costs are retained by the Fund rather

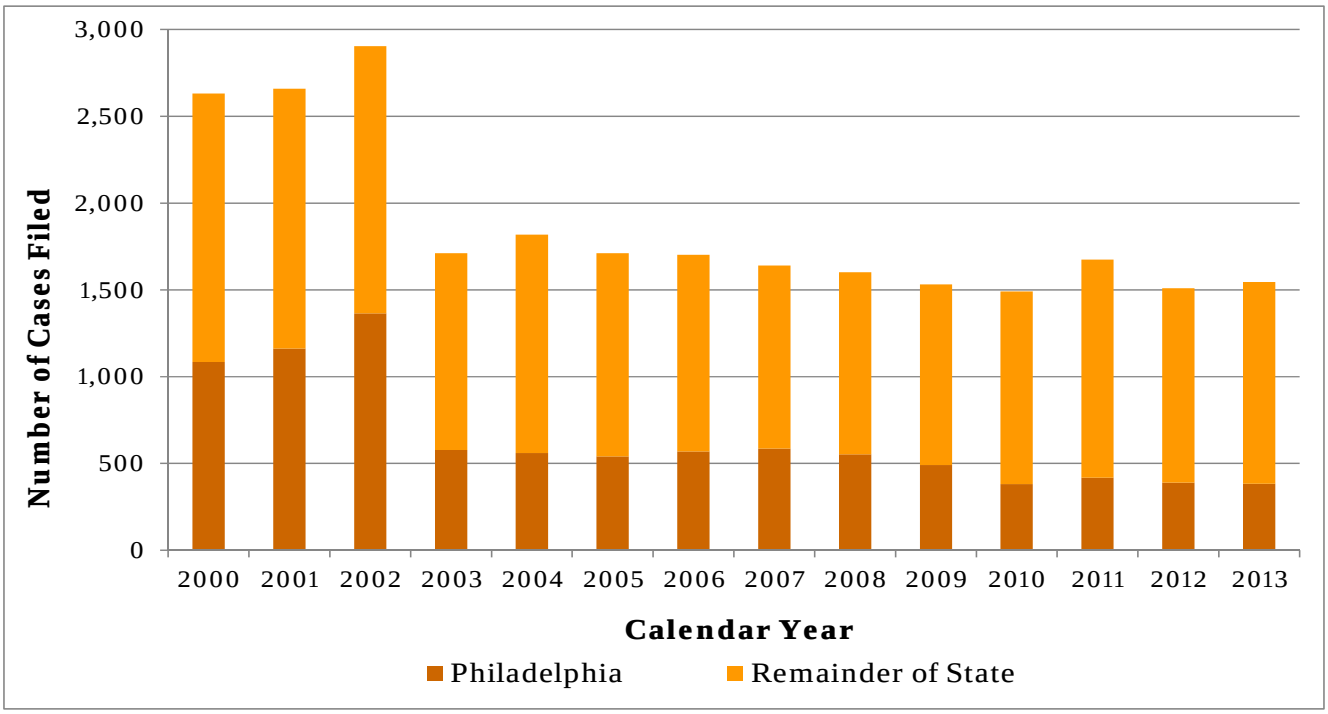
than insured through the primary insurance marketplace.) We have estimated the impact of this additional coverage as a $35 million increase to our unfunded liability estimate as of December 31, 2012.

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 2013 as compared to the pre-Act 13 years 2000 through 2001, with particular concentration in Philadelphia County. The average statewide decrease in cases filed is approximately 41%, with Philadelphia County experiencing an average decrease of approximately 63% and ROS experiencing an average decrease of approximately 25%, as shown below:

Number of cases filed per year

Based on Administrative Office of PA Courts (AOPC) Information

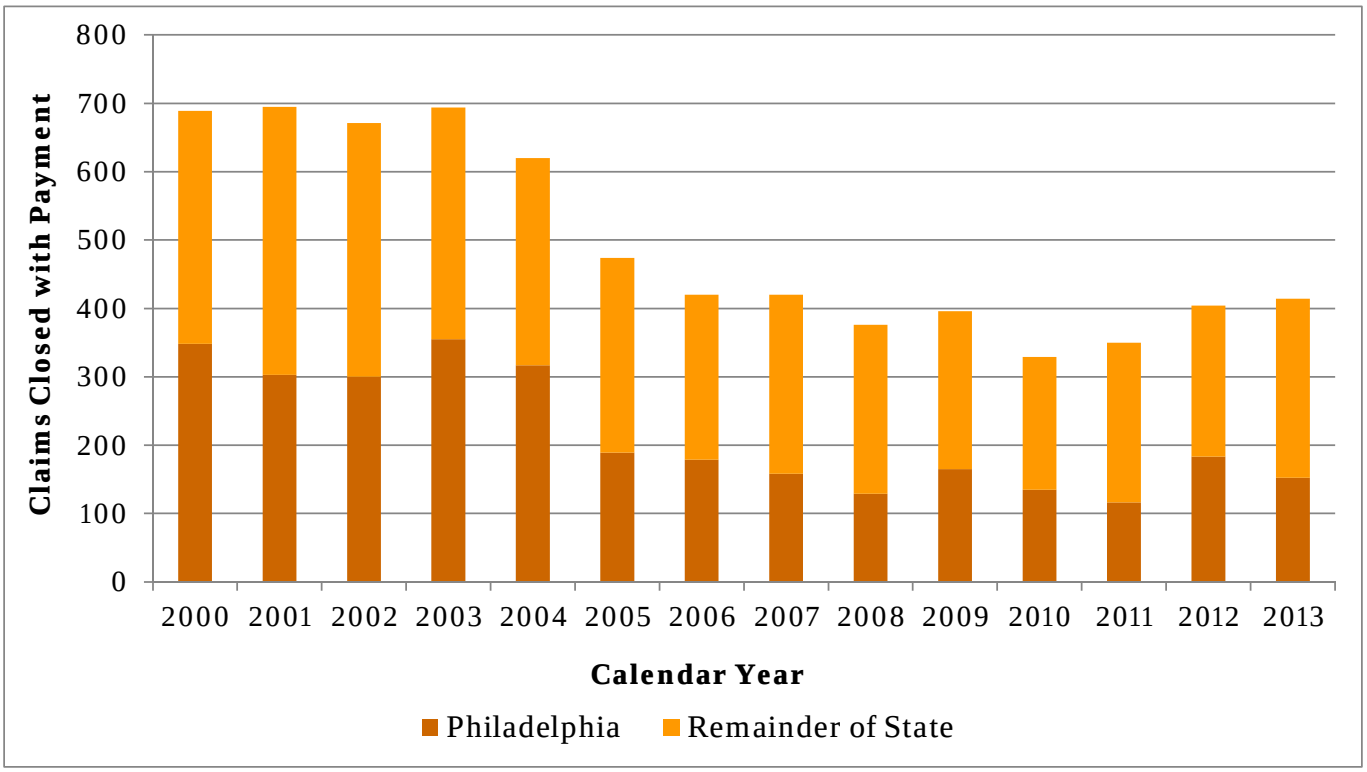


Possible causes for the decrease in claims activity for post-Act 13 years include venue reform (Section 3 of Act 27 of 2002), certificate of merit procedures (Rule of Civil Procedure 1042.3, 2003), and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number of case filings, with a particular 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 corroborate 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 2013 as compared to calendar years 2000 through 2004. The average statewide decrease in claims closed with payment is approximately 40%, with Philadelphia County experiencing an average decrease of approximately 50% and ROS experiencing an average decrease of approximately 30%, as shown below:

Mcare fund - Closed with payment claims by calendar year

Total Excess and Section 715 Claims



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 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 37% and 60% within our Philadelphia projections for Excess claims and Section 715 claims, respectively, and an "AOPC Credit" of 1% and 25% 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 legislative provisions

Other elements of 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 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 be subject to future challenge and interpretation by the courts, which contributes additional uncertainty to the estimates contained herein. As noted above, the impacts associated with the Patient Protection and Affordable Care Act and recent changes to joint and

several liability in Pennsylvania as a result of Senate Bill 1131 may also subject our projections to a higher degree of uncertainty.

Discounting

As summarized in Summary, Exhibit 1, Sheet 1, the indicated post-Act 13 liability after discounting the Fund's liabilities at a 2% annual rate of interest is approximately $1.04 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%	$1.04 billion
3%	$1.00 billion
4%	$0.96 billion
5%	$0.93 billion

The attached exhibits employ a discount rate assumption of 2%; 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 ROS, based on the venue county of the claim. Data was organized by year of occurrence. To estimate the unfunded liability as of 12/31/2013, losses paid to date are subtracted from the projected ultimate losses for accident periods 2013 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 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 (i.e., in preparing estimates for the Fund). 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 2013 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 2013 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 directly reflect emerging experience, and we have "matched" the experience over seven calendar years for Excess claims and six years for Section 715 claims. 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 12/31/2013 until the final date of payment. The attached discounted estimates assume a 2% 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 2013. Projections of Excess losses for future years 2014 through 2019 assume an underlying trend of 4.0% per annum at 2013 limits of coverage, based on the trend of projections for recent accident years. Projections of Section 715 losses for future years 2014 through 2019 assume an underlying pre-Act trend of 4.0% per annum at 2013 limits of coverage, based on the trend of projections for recent accident years. The overall trend in the projections of the future excess coverage provided by the Fund is approximately 4.0% 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 1.2% as the estimated ratio of these costs to loss and have increased our estimates of the unfunded liability projections accordingly.