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Act 13 of 2002

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Medical Care Availability and Reduction of Error Fund

Joel Ario  
Acting Insurance Commissioner  
PA Department of Insurance

Annual Report  
of Operations  
2007

Issued March 1, 2008

# Office of Mcare

## 2007 Annual Report of Operations

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## **About Mcare**

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

### **PURPOSE**

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

### **REVENUE STREAM**

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

“...the fund shall be funded by an assessment on each participating health care provider. Assessments shall be levied by the department on or after January 1 of each year. The assessment shall be based on the prevailing primary premium for each participating health care provider and shall, in the aggregate, produce an amount sufficient to do all of the following:

- (i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.
- (ii) Pay expenses of the fund incurred during the preceding claims period.
- (iii) Pay principal and interest on moneys transferred into the fund in accordance with section 713(c).
- (iv) Provide a reserve that shall be 10% of the sum of subparagraphs (i), (ii) and (iii).”

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



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

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

## **PARTICIPATION**

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

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

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



## **COVERAGE REQUIREMENTS**

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

### **A. Primary Coverage for Participating Health Care Providers**

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

### **B. Mcare Coverage for Participating Health Care Providers**

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

### **C. Primary Coverage for Nonparticipating Health Care Providers**

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

### **D. Mcare Coverage for Nonparticipating Health Care Providers**

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



**Medical Care Availability and Reduction of Error Fund**  
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E. Mcare Coverage for Nonparticipating Health Care Providers Electing to Participate in Mcare

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

**REPORTING COVERAGE TO MCARE**

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

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

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

**CLAIMS REPORTING**

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



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

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

**SUMMARY**

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

Medical Care Availability and Reduction of Error Fund  
30 North 3<sup>rd</sup> Street, 8<sup>th</sup> Floor  
P.O. Box 12030  
Harrisburg, PA 17108-2030  
(717) 783-3770  
or  
[www.mcare.state.pa.us](http://www.mcare.state.pa.us)

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

**CASH BASIS**

STATEMENT OF OPERATIONS

JANUARY 1, 2007 TO DECEMBER 31, 2007

<b>FUND BALANCE JANUARY 1, 2007</b>		<b>58,194,528.65</b>
ADD:		
ASSESSMENT REVENUE FROM HCP'S	119,808,500.94	
M.V. VIOLATIONS - AUTO CAT FUND	45,148,775.69	
HCP EXPERIENCE RATED ADJ - PER	270,716.00	
INTEREST ON SECURITIES	9,113,026.20	
ABATEMENT REPAYMENT	4,413,105.30	
MISCELLANEOUS - ANNUITIES	114,183.71	
REFUNDS OF EXPENDITURES	1,136,141.00	
TOTAL ADDITIONS		<b>180,004,448.84</b>
<b>TOTAL FUNDS AVAILABLE</b>		<b><u>238,198,977.49</u></b>
DEDUCT:		
2007 CLAIMS PAID - DEC, 2007	191,365,811.00	
TOTAL DEDUCTIONS	<u>191,365,811.00</u>	
OPERATING EXPENSES:		
SALARIES	3,472,879.74	
PAYROLL TAXES & BENEFITS	1,397,354.81	
SPECIALIZED SERVICES - CONTRACTED	606,195.48	
DATA PROCESSING SERVICES	304,403.05	
LEGAL & CONSULTING FEES	6,291,971.03	
OFFICE SUPPLIES	86,376.51	
TELECOMMUNICATIONS	152,354.43	
REAL ESTATE	538,447.80	
TRAVEL, DUES, LEGAL/MED. SUBSCRIPTIONS	40,975.02	
TREASURY REPLACEMENT CHECKS	45,644.36	
TOTAL OPERATING EXPENSES	<u>12,936,602.23</u>	
<b>TOTAL DEDUCTIONS:</b>		<b>204,302,413.23</b>
<b>FUND BALANCE DECEMBER 31, 2007</b>		<b><u><u>33,896,564.26</u></u></b>

Office of Mcare  
PA Department of Insurance

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

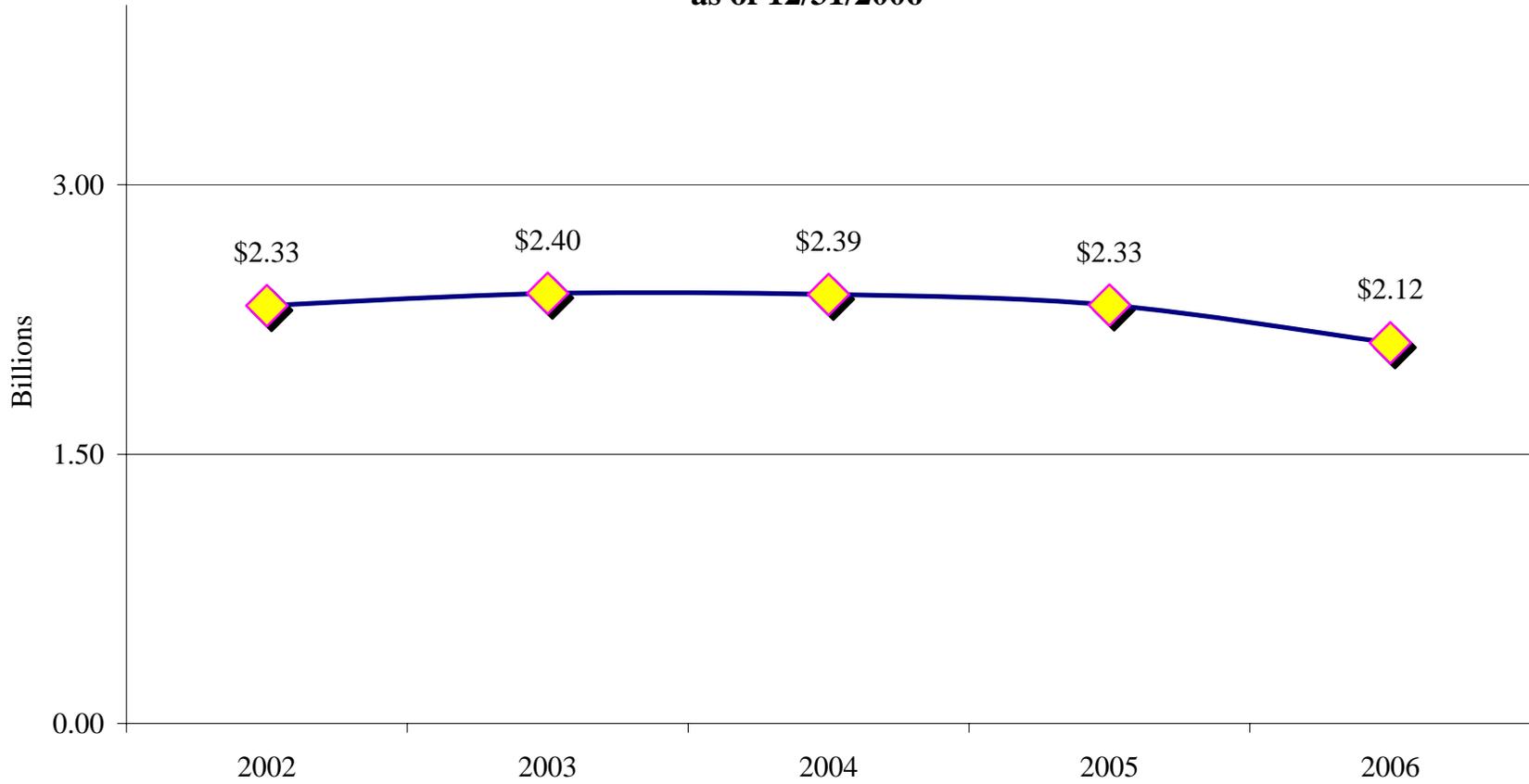
**Estimates of Mcare Fund's Unfunded Liability and  
Future Claims as of 12/31/2006**

The attached report by PricewaterhouseCoopers LLP's is an analysis of the Mcare Fund's unfunded liability and future claim payments. Note that it was completed by PricewaterhouseCoopers under the assumptions that the scheduled changes in the basic or primary coverage limits would occur on January 1, 2008 and January 1, 2011 per section 711 of Act 13 of 2002, thereby reducing the Fund's future coverage. Subsequent to the completion of this analysis, the Insurance Department made the following determination:

"...because of the still relatively new entries into the Pennsylvania market... an additional two years to study developing marketplace trends, RRG stability, and the positive effects of Act 13 in general, is needed for the Department to determine whether a step-up in the basic insurance limits is appropriate."

The attached graphical representation of the Mcare Fund's unfunded liability from 2002 through 2006 likewise was developed under the assumptions that the scheduled changes in the basic or primary coverage limits would occur on January 1, 2008 and on January 1, 2011 per section 711 of Act 13 of 2002, thereby reducing the Fund's future coverage.

**Office of Mcare  
Unfunded Liability Report  
as of 12/31/2006**



\*From 2000 forward, the report includes provisions for delay damages  
March 1, 2008

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

ESTIMATION OF 12/31/2006 UNFUNDED LIABILITY

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

**Prepared by**

**Actuarial and Insurance Management Solutions**

**PricewaterhouseCoopers LLP**

**Philadelphia, Pennsylvania**

**July 2007**

## 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 outstanding liability as of December 31, 2006, excluding breast implant and pedicle screw exposure, to be approximately \$2.12 billion, after adjustments for Act 13, including those for:

- Scheduled changes in the limits of coverage;
- Continuing Course of Treatment provision; and,
- Section 513 (Statute of Repose).

Our projections also include an adjustment to reflect the recent apparent shift in claims from Philadelphia to other venues, including an adjustment to reflect the reduced propensity for Fund claims to close with payment and the reduced average Fund severity per claim closing with payment.

The mandatory primary coverage limits are scheduled to increase (with corresponding decreases in the Fund coverage limits) in 2008 and 2011, 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 2011. If the coverage capacity does not exist to increase the mandatory primary limits as scheduled in 2008 and 2011, Fund coverage will continue into and beyond 2012 and the total Fund payout would increase accordingly.

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

Accident <u>Year</u>	Beginning Unfunded <u>Liability</u>	Cost of Covered <u>Claims</u>	Projected Claims <u>Payments</u>	Ending Unfunded <u>Liability</u>	Discounted (4%) Ending <u>Unfunded</u>
2006				2,123,125	1,756,531
2007	2,123,125	265,306	316,826	2,071,605	1,717,867
2008	2,071,605	191,617	306,985	1,956,237	1,630,115
2009	1,956,237	142,620	304,941	1,793,916	1,502,087
2010	1,793,916	115,571	302,431	1,607,056	1,349,476
2011	1,607,056	29,172	293,042	1,343,186	1,132,991
2012	1,343,186		271,470	1,071,716	906,841
2013	1,071,716		237,939	833,777	705,176
2014	833,777		197,967	635,810	535,416
2015	635,810		153,359	482,451	403,474
2016	482,451		113,218	369,233	306,395
2017	369,233		83,411	285,822	235,240
2018	285,822		61,182	224,640	183,467
2019	224,640		45,749	178,891	145,057
2020	178,891		34,763	144,129	116,096
2021	144,129		26,763	117,365	93,977
2022	117,365		21,338	96,027	76,398
2023	96,027		16,724	79,303	62,729
2024	79,303		13,159	66,144	52,080
2025	66,144		10,719	55,425	43,444
2026	55,425		8,776	46,649	36,406
2027	46,649		7,114	39,535	30,748
2028	39,535		5,675	33,860	26,303
2029	33,860		4,469	29,391	22,886
2030	29,391		3,665	25,726	20,136
2031	25,726		3,064	22,661	17,877
2032	22,661		2,562	20,099	16,030
2033	20,099		2,286	17,814	14,386
2034	17,814		2,100	15,713	12,860
2035	15,713		1,960	13,753	11,415
2036	13,753		1,891	11,862	9,981
2037	11,862		1,809	10,054	8,571
2038	10,054		1,711	8,343	7,203
2039	8,343		1,589	6,754	5,903
2040	6,754		1,449	5,305	4,690
2041	5,305		1,300	4,005	3,577
2042	4,005		1,120	2,885	2,601
2043	2,885		919	1,966	1,786
2044	1,966		705	1,262	1,153
2045	1,262		477	785	722
2046	785		311	474	440
2047	474		208	265	249
2048	265		138	127	120
2049	127		86	40	39
2050	40		35	6	5
2051	6		6	0	0
		744,286	2,867,411		

The projections summarized above do not explicitly reflect information available-to-date for claim year 2007. We have projected 2007 payments to be \$317 million based on the methods and assumptions contained herein. Currently, the Fund is projecting 2007 claim year payments to be approximately \$225 million. Fund payments in 2005 and 2006 were also markedly lower than our original projections. Although the reason for this difference is not entirely clear at this time, the apparent reduction in claims payments from that which we have projected could be a result of claims shifting toward non-Philadelphia venues, inherent fluctuation in excess medical malpractice payments, or a culmination of a number of factors.

Our current projections of the unfunded liability incorporate the actual 2006 payments into our projection methodologies, and include a projection of the impact of an apparent claims shift toward non-Philadelphia venues. We have also implicitly considered the apparent decrease in 2007 payments in our assessment of the overall reasonableness of the projections.

Given the apparent decrease in Fund payment activity during 2007, we have attempted to provide an adjusted estimate of payout of the projected Unfunded Liability assuming the Fund's projection of the 2007 payments of \$225 million. We have also assumed that the reduced level of payments observed during 2005 through 2007 will continue into 2008, and have adjusted the projected 2007 payments to \$260 million, which is roughly the average of the Fund's expected 2007 payments of \$225 million and our unadjusted projection of the 2008 payments of \$307 million.

The adjusted payment pattern assumes that the recent decrease in payments has effectively "pushed" the payments out in time. As such, the projected 12/31/2006 unfunded liability is

unchanged on a nominal basis, but the stream of payments, future years-ending unfunded liability, and present value of the unfunded liability differ, as shown below:

Accident <u>Year</u>	Beginning Unfunded <u>Liability</u>	Cost of Covered <u>Claims</u>	Projected Claims <u>Payments</u>	Ending Unfunded <u>Liability</u>	Discounted (4%) Ending <u>Unfunded</u>
2006				2,123,125	1,727,476
2007	2,123,125	265,306	225,000	2,163,431	1,779,476
2008	2,163,431	191,617	260,000	2,095,048	1,741,174
2009	2,095,048	142,620	308,360	1,929,308	1,614,169
2010	1,929,308	115,571	312,329	1,732,550	1,456,143
2011	1,732,550	29,172	315,109	1,446,613	1,221,858
2012	1,446,613		297,501	1,149,112	973,232
2013	1,149,112		257,811	891,302	754,350
2014	891,302		213,688	677,614	570,837
2015	677,614		163,684	513,930	429,986
2016	513,930		120,792	393,138	326,393
2017	393,138		88,874	304,263	250,575
2018	304,263		65,179	239,084	195,418
2019	239,084		49,295	189,789	153,940
2020	189,789		36,875	152,913	123,222
2021	152,913		28,151	124,762	100,000
2022	124,762		22,520	102,242	81,480
2023	102,242		17,904	84,337	66,834
2024	84,337		14,250	70,087	55,258
2025	70,087		11,606	58,481	45,862
2026	58,481		9,370	49,111	38,326
2027	49,111		7,608	41,504	32,252
2028	41,504		6,117	35,387	27,425
2029	35,387		4,715	30,672	23,807
2030	30,672		3,819	26,853	20,941
2031	26,853		3,185	23,668	18,593
2032	23,668		2,655	21,012	16,681
2033	21,012		2,342	18,671	15,007
2034	18,671		2,151	16,520	13,457
2035	16,520		2,005	14,516	11,990
2036	14,516		1,910	12,606	10,560
2037	12,606		1,830	10,776	9,152
2038	10,776		1,758	9,018	7,760
2039	9,018		1,645	7,372	6,425
2040	7,372		1,515	5,857	5,168
2041	5,857		1,375	4,483	4,000
2042	4,483		1,203	3,280	2,957
2043	3,280		1,009	2,271	2,066
2044	2,271		801	1,470	1,348
2045	1,470		579	891	823
2046	891		389	502	467
2047	502		235	267	251
2048	267		141	127	120
2049	127		86	40	39
2050	40		35	6	5
2051	6		6	0	0
2052	0		0	0	0
		744,286	2,867,411		

Estimates of the liability reflecting the time value of money contained herein employ a discount rate assumption of 4%; however, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. Estimates at other discount rates are included below. Discounted estimates contained herein assume that the Fund's payments continue to be made at the end of each calendar year.

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

### **Excess Unfunded Liability**

The projected ultimate losses and the loss reserve requirements for Excess losses are shown in Section 2, Exhibit 1. Our estimate of the outstanding liability as of 12/31/2006 for Excess claims is approximately \$1.51 billion, including delay damages and post-judgment interest. Projected ultimate losses by accident year are lower than our prior projections, primarily attributable to the effect of favorable differences between actual and expected paid loss emergence over the past 12 months and by a decrease in the projected number of claims that will close with payment. These favorable effects are offset in part by an increase in the estimated cost of claims subject to Section 715's continuing course of treatment provision, which increases Excess costs as claims that no longer receive first-dollar Section 715 coverage may be instead eligible for Excess coverage (adjusted to reflect the expected impact of differences in the limits of Fund coverage).

### **Section 715 Unfunded Liability**

The projected ultimate losses and the loss reserve requirements for Section 715 losses are shown in Section 3, Exhibit 1. Our estimate of the outstanding liability as of 12/31/2006 for Section

715 claims is approximately \$0.61 billion, including delay damages and post-judgment interest. Projected ultimate losses by accident year are lower than our prior projections, primarily attributable to the effect of favorable differences between actual and expected paid loss emergence over the past 12 months, by a decrease in the projected number of claims that will close with payment, and by an increase in the estimate of claims subject to the continuing course of treatment provision.

### **Comparison to Prior Estimates**

Section 1, Exhibit 5, Sheet 2 presents a comparison of the post-Act 13 results of the current analysis to the prior analysis. Compared to our 12/31/2005 analysis, our overall estimate of ultimate loss for accident years 2005 and prior, after Act 13 adjustments, has decreased by \$261 million (3.6%).

The estimate of the post-Act 13 12/31/2006 unfunded liability of \$2.12 billion, including delay damages and post-judgment interest, represents a decrease of approximately 12.4% (\$301 million) from our 12/31/2006 projection of \$2.42 billion prepared as of 12/31/2005. The decrease in the projection is due to a combination of effects, primarily the additional year of Fund paid loss information as cited above. Other changes also contributing to the decrease in the estimate include: decreases in the projected number of claims that will close with Fund payment, an increase in the net savings attributable to the continuing course of treatment provision, a slight reduction in the estimate of delay damages and post judgment interest (currently estimated as 2% of the liability projections based on historical payment activity).

Based on current projection of ultimate loss, our current best estimate of the post-Act 13 unfunded liability as of 12/31/2005, including delay damages and post-judgment interest but excluding breast implant and pedicle screw claims, is roughly \$2.07 billion.

The estimates contained herein include the estimated impact of recent legislation and other considerations, as discussed below.

## Recent Legislation

### *Changes in Limits of Coverage for Excess Losses*

The changes in the mandatory primary occurrence and aggregate limits that health care providers must carry are described in the following table (in thousands):

Calendar Year Effective	Mandatory Primary Occ / Agg Limits		Mcare Fund Occ / Agg Limits
	Hospital	Physician	Hospital or Physician
1996 & Prior	200 / 1,000	200 / 600	1,000 / 3,000
1997 & 1998	300 / 1,500	300 / 900	900 / 2,700
1999 & 2000	400 / 2,000	400 / 1,200	800 / 2,400
2001 & 2002	500 / 2,500	500 / 1,500	700 / 2,100
2003 – 2007	500 / 2,500	500 / 1,500	500 / 1,500
2008 <sup>6</sup> – 2010	750 / 3,750	750 / 2,250	250 / 750
2011 <sup>7</sup> & Sub	1,000 / 4,500	1,000 / 3,000	0 / 0

Changes in the limits of coverage provided by the Fund reduce the Fund's liability from what it otherwise would have been. Our calculations include projections of the savings resulting from

<sup>6</sup> Limits may change beginning in 2008, depending on the Insurance Commissioner's assessment of market conditions. However, if the Commissioner determines that additional basic insurance capacity is not available, current primary and Fund coverage will remain in effect until such capacity is available. The estimates herein assume that limits of coverage change beginning in 2008.

<sup>7</sup> Limits may again change three years after the initial change described above. This is also contingent upon the Commissioner's assessment of basic insurance capacity. The estimates herein assume that limits of coverage again change in 2011.

the reduced coverage afforded by the Fund, assuming such reductions in coverage proceed as currently scheduled under Act 13.

*Changes in Limits of Coverage for Section 715 Losses not Subject to CCoT*

Act 135 of 1996 began the process of reducing the amount of coverage provided by the Fund gradually from \$1,000,000 to \$700,000. Act 13 reestablished Section 715 Fund coverage limits at \$1,000,000. Although a window of time exists during which reduced Fund coverage may exist for Section 715 claims<sup>8</sup>, the impact of this is not expected to be significant and the estimates contained herein assume that Fund coverage for all Section 715 claims has been restored to \$1,000,000 per claim for all accident years prior to 2006.

Act 13 of 2002 included a provision for eliminating the Fund's first-dollar coverage of late reported claims. More specifically, all medical professional liability insurance policies issued on or after January 1, 2006 are required to provide coverage for claims arising four or more years after the breach of contract or tort occurred and after December 31, 2005. The projections contained herein assume Fund limits of coverage per the table above accordingly.

*Continuing Course of Treatment*

The “continuing course of treatment” provision states that where any related treatment or consultation between a claimant and a health care provider took place less than four years before the date on which the health care provider or the primary insurer received notice of a claim, the claim shall be deemed to have occurred less than four years prior to the date of notice and thus not be considered a Section 715 claim. As such, adjustments to the Section 715 estimates are

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<sup>8</sup> 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.

required because some claims that would have previously qualified for Section 715 coverage will now be denied Section 715 coverage under CCoT. These claims must be “removed” from the Section 715 estimates and be included in the Excess experience, modified for changes in the limits of coverage accordingly.

Section 715 reported claim activity over the past four years (i.e., the period impacted by the application of the CCoT provision) has been approximately 50% lower than historical levels. The extent to which this reduction in reported claims will result in a corresponding reduction in costs is highly uncertain, and there are some signs of recent increases in the average severity of Section 715 claims that are closing with payment. However, based on the continued reduced level of reported claim activity, we have increased our estimate of the portion of Section 715 losses that are subject to the CCoT provision from 20% to 35% of the pre-CCoT losses. This has a favorable impact on the Section 715 projections (the decrease in losses that are eligible for Section 715 coverage), which is partially offset by an adverse impact on the Excess projections (the increase in losses that are potentially subject to Excess coverage).

#### *Other Act 13 Provisions*

Act 13 contains other provisions that may impact costs, notably those related to Section 508 (Collateral Sources), Sections 509/510 (Payment of Damages / Reduction to Present Value), and Section 513 (Statute of Repose).

Based on the work supporting PwC's report entitled *Common Wealth of Pennsylvania, Estimate of the Impact of Act 13, Pursuant to Section 745(a)(2)*, dated June 30, 2005 (the “Act 13 analysis”), including a review of responses to the state-wide data call issued in support of that review, we believe the impact of Section 508 and Sections 509/510 cannot be separated from other recent measures or separately assessed actuarially. The unfunded liability projections

include no explicit additional savings for these provisions. The estimates contained herein include projected savings of 3.5% for Section 513 (applicable to Section 715 claims only), also based on the results of the Act 13 analysis.

### *Other Considerations*

Section 3 of Act 127 of 2002 specifies that a medical professional liability action may be brought against a health care provider for a medical professional liability claim only in the county in which the cause of action arose (Venue Reform). Pennsylvania Supreme Court Rule of Civil Procedure 1042.3 states that a certificate of merit be filed within 60 days of filing a complaint<sup>9</sup>, representing that a written statement of merit has been supplied by an appropriate professional, that expert testimony is unnecessary for prosecution of the claim, or that the claim is based solely on allegations that other licensed professionals for whom the defendant is responsible deviated from an acceptable professional standard. These recent developments appear to have changed the mix of claims by venue in the Commonwealth, as discussed below.

Information collected by the Administrative Office of Pennsylvania Courts (AOPC) indicates that there has been a reduction in claims filed during 2003 through 2006, with particular concentration in Philadelphia County. The incentive for plaintiffs to file in Philadelphia versus other venues relates to a higher percentage of plaintiff's verdicts as well a larger number of higher jury verdicts in Philadelphia County. According to statistics compiled by the AOPC, 37% of total verdicts in Philadelphia County were plaintiff verdicts for the period from January 2000 through December 2006; 17% of total verdicts in the remainder of the state were plaintiff verdicts for the same period. Of the plaintiff verdicts, Philadelphia County has a greater portion of large verdicts compared to the remainder of Pennsylvania. Recent AOPC statistics indicate that roughly 40% of medical malpractice plaintiff verdicts in Philadelphia County have resulted

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<sup>9</sup> Subject to some exceptions, and extensions may be requested.

in awards greater than \$1 million, compared with roughly 30% in the remainder of the state during the period January 2000 through December 2006. While several other counties have had large jury awards, the number of large jury verdicts is significantly higher in Philadelphia County than any other venue in Pennsylvania.

Additional information from the AOPC indicates that the number of medical malpractice cases filed in Pennsylvania fell dramatically in 2003 through 2006 as compared to 2000 through 2002. The average statewide decrease in cases filed is roughly 38%, with Philadelphia County experiencing an average decrease of over 50%.

The magnitude and duration of the decrease as indicated by the latest AOPC is also generally consistent with our review of aggregate frequency statistics included in the Act 13 analysis, where an average improvement of roughly 20% was observed based on data gathered from insurance companies writing medical malpractice business in the Commonwealth.

We do not believe it is possible to separate the impact of venue reform from the impact of the certificate of merit measures at this time. Other measures may also be impacting the number of cases filed. 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 or not at all. We observe a relatively similar shift toward non-Philadelphia venues in claims reported to the Fund.

Although it does appear that recent reforms have had a significant initial impact on the number of cases filed and in the claims reported to the Fund, the extent to which this reduction in the number of claims results in a reduction in the total costs to the Fund is uncertain for several reasons:

- The reduced number of cases may be a reduction in less meritorious cases, in which case a

reduction in the number of cases may not lead to a commensurate decrease in costs, particularly in the excess layers of coverage provided by the Fund.

- Certain counties or areas may have a tendency for higher awards or settlements because those areas see the most complicated medical cases. To some degree, a higher average award or settlement may be indicative of a higher degree of alleged damage associated with more complicated medical cases. The movement of cases out of Philadelphia and into surrounding counties may simply increase the average award of the surrounding counties.
- As claims have moved to other counties, the process of disposing of those claims may have slowed. Fund payments for recent years have been 25% to 35% lower than we have projected based on historical payment patterns. If this is partially due to a temporary slow-down in payment resulting from venue reform, any resulting savings may be offset, at least partially, by the inflationary impact of delaying the resolution of these claims.

Nonetheless, we believe the data compiled by the AOPC and recent Fund reported claims activity is indicative of a potential savings to be realized by the Fund. Although the possibility exists, as cited above, that the reduced number of filings and apparent shift of claims away from Philadelphia may not result in a commensurate level of cost savings, we believe that two potential aspects of savings should be reflected in our estimates:

- Savings attributable to a reduced propensity to close Fund claims with payment outside Philadelphia compared to the propensity to close Fund claims with payment within Philadelphia; and
- Savings attributable to a reduced average severity of Fund claims that close with payment outside Philadelphia compared to the average severity of Fund claims that close with payment within Philadelphia.

Based on current Fund data, included in Appendix A, we believe an estimate of the resulting savings due to this apparent shift of claims toward non-Philadelphia venues of 5% is reasonable

at this time, and has been incorporated into our estimates. Actual savings may be more or less than currently projected depending on the extent to which the reduction of total claims and shift in claims outside of Philadelphia result in a commensurate level of savings to the Fund. Note that these savings are in addition to the significant implicit savings generated by the inclusion of recent Fund payment activity in our analysis. As compared to our estimates as of 12/31/2004, our loss projections have developed favorably by over \$400 million.

Other elements of recent legislation are expected to have a less direct 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) and Remittitur (Section 515 of Act 13). Although not explicitly estimated herein, these other elements of recent legislation may also have an impact on the Fund's obligations.

**Other Comments**

As summarized in Section 1, Exhibit 1, the indicated post-Act 13 liability after discounting the Fund's liabilities at a 4% annual rate of interest is approximately \$1.76 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%	\$1.89 billion
3%	\$1.84 billion
4%	\$1.76 billion
5%	\$1.65 billion

The attached exhibits employ a discount rate assumption of 4%; however, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose.

The Fund has recently begun to capture data relating to its delay damage and post-judgment interest costs. Prior to Act 135, these costs 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 roughly ranged from 1% to 3%. We have selected 2.0% as the estimated ratio of these costs to loss and have increased our post-Act 13 unfunded liability projections accordingly.

## **Calculation of 2007 Mcare Assessment Rate**

The attached is the Executive Summary of a study by PricewaterhouseCoopers LLP that was the basis for setting the 2007 Mcare Assessment rate at 23 percent.

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

**2007 YEAR ASSESSMENT CALCULATION**  
(In Accordance with Act 13 of 2002)

**Prepared by**

**Actuarial and Insurance Management Solutions**

**PricewaterhouseCoopers LLP**

**Philadelphia, Pennsylvania**

**October 2006**

## 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.

### 2007 Assessment Rate

Exhibit 1 presents the indicated 2007 assessment rate of 23%. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2007 prevailing primary premium.

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

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

These amounts are to be collected via the application of an assessment rate to the policy year 2007 prevailing primary premium. Hence the projection of 2007 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2007 payment obligations of the Fund and the 2007 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2003, 2004, and 2005 assessments as the basis for our estimate of the 2007 prevailing primary premium.

Note that there is some uncertainty surrounding the source and amount of funds that will be made available to pay the Fund's 2006 obligations, as a portion of the 2006 assessment has been abated and additional amounts may yet be received from external funding sources (e.g., Auto Cat Fund) during the remainder of the year. However, the Fund does not currently expect to require borrowing to meet its cash flow obligations for 2006.

Since the 2007 assessment rate is based largely on the Fund's obligations for the 2006 claim year, any significant change in Fund's claim or expense obligations from 2006 to 2007 may result in a significant actual year-end 12/31/2007 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2007. To the extent the funds available in 2007 are insufficient to meet the Fund's 2007 obligations, additional funding or borrowing may be required.

Differences between projected 2007 prevailing primary premium and actual 2007 prevailing primary premium will result in a difference between projected and actual assessment revenue. This variable contributes additional uncertainty to degree to which the funds available to the Fund will be sufficient to meet its 2007 obligations.

## ANALYSIS

### 2007 Assessment Rate

The Act outlines the four categories to be funded via the assessment. The aggregate assessment for 2007<sup>5</sup> must cover: claim settlements, operating expenses, principal and interest on moneys transferred to the Fund, and a target reserve amount. These costs are recouped by applying an appropriate assessment rate to the 2007 prevailing primary premium.

#### *Claim Settlements*

The largest component of the 2007 assessment is the amount of claim settlements for the Fund's 2006 claim year ending August 31, 2006. These claims are payable on or about December 31, 2006. The Fund expects that payments for the 2006 claim year will total approximately \$209.5 million.

#### *Fund Operating Expenses*

Operating expenses paid of \$10.1 million for claim year ending 08/31/2006 was provided by the Fund, which includes Fund overhead expenses and legal expenses largely associated with the defense costs of Section 715 claims. Note that the Fund operating expenses exclude roughly \$2.5 million of accrued operating expense liability as of 08/31/2006. However, the inclusion of this amount would not alter the indicated assessment rate.

#### *Principal and Interest on Moneys Transferred*

The Fund had no moneys outstanding during the claim year ending 08/31/2006, and does not currently expect to require borrowing to meet its 2006 obligations.

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<sup>5</sup> We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2007.

### *Target Reserve*

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

### *Prevailing Primary Premium*

The Fund provided assessment and policy count data for policies effective in 2003, 2004 and 2005. Note that the Fund captures unabated assessments that are discounted to the extent the discount was actually applied. Based on the discounted unabated assessment, the Fund computes the undiscounted unabated assessment, which is employed in our analysis. In examining the discounted and undiscounted unabated data provided, we observed instances where it appeared that the undiscounted unabated assessment was not properly computed from the discounted unabated assessment. However, based on our review of the discounted and undiscounted assessment data provided, we believe any distortion arising from those instances where the undiscounted unabated assessment is not properly captured would not have a material effect on our projection of the 2007 projected prevailing premium.

Data was provided for each unique set of the following variables: primary policy type, product code, county code, and specialty code.

A general description of these variables follows:

#### Primary Policy Type

This field contains either CM (claims-made), OC (occurrence), or OP (occurrence-plus<sup>6</sup>). Assessment collections for tail policies are not expected to be material in the aggregate for policy

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

year 2007. As such, our projections of policy year 2007 assessments exclude assessments collected in 2003, 2004 and 2005 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 2007 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 2003 assessments have been adjusted for changes effective 01/01/2004, 01/01/2005, 01/01/2006, and 01/01/2007. This calculation is included in its entirety under

separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2004 assessments have been adjusted for changes effective 01/01/2005, 01/01/2006, and 01/01/2007. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2005 assessments have been adjusted for changes effective 01/01/2006 and 01/01/2007. 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 01/01/2004, 01/01/2005, 01/01/2006, and 01/01/2007 are as follows:

***Changes Effective 01/01/2004***

Note that the changes effective 01/01/2004 discussed below apply only to the calculation based on 2003 assessments (Appendix A / Excerpt A). The 2004 and 2005 assessments implicitly reflect these changes and do not require modification for changes effective 01/01/2004.

Base Rate Change

The JUA increased its base rates 4.2% for institutional healthcare providers and decreased its base rates 1.4% for non-institutional healthcare providers.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
010	-5.4%
035	+12.2%
070	+0.9%
080	+3.8%
090	-9.1%

JUA Class	Impact
900	+20.0%

County / Territory Changes

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

<i>Non-Institutional Changes</i>		
County (County Code)	Change	Impact
Delaware (23), Philadelphia (51)	no Territory 1 change	+0.0%
Allegheny (02), Mercer (43), Washington (63), Westmoreland (65)	change Territory 3 rel.	+9.1%
Bucks (09), Montgomery (46), Schuylkill (54)	change Territory 4 rel.	+6.3%
Chester (15), Lackawanna (35), Monroe (45)	change Territory 5 rel.	+6.3%
Berks (06), Blair (07), Cumberland (21), Dauphin (22), Erie (25), Lehigh (39), Luzerne (40), Northampton (48), York (67)	no Territory 6 change	+0.0%
All Other	change Territory 2 rel.	+10.0%

Specialty Changes

Nine specialty changes were implemented, for the specialties listed below. Note that the impact is relative to the 2004 rates for Territory 1. The impact includes the impact of any class changes filed, but excludes any filed changes to territory relativities.

Specialty Code	Specialty	Change	Impact
00638	Geriatrics - No Surgery	move to 00738	+21.5%
00642	Nephrology - No Surgery	move to 00742	+21.5%
00721	Rehabilitation / Physiatry - No Surgery	move to 00621	-17.7%
01006	Gastroenterology - No Surgery	move to 01206	+30.8%
01015	Pathology - No Surgery	move to 01215	+30.8%

Specialty Code	Specialty	Change	Impact
01022	Radiology - No Surgery	move to 01222	+30.8%
01516	Pediatrics - No Surgery	move to 01216	-15.0%
07030	Plastic Surgery	move to 06030	-13.0%
07047	Colon-Rectal Surgery when 26% or more is non-colon-rectal surgery	move to 06047	-13.0%

*Changes Effective 01/01/2005*

Note that the changes effective 01/01/2005 discussed below apply only to the calculation based on 2003 and 2004 assessments (Appendices A and B / Excerpts A and B). The 2005 assessments implicitly reflect these changes and do not require modification for changes effective 01/01/2005.

Base Rate Change

The JUA increased its base rates 0.6% for institutional healthcare providers and decreased its base rates 7.4% for non-institutional healthcare providers.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	-21.1%
007	+24.5%
010	-7.7%
012	+11.8%
020	+10.6%
022	+16.7%

JUA Class	Impact
070	+15.2%
080	+7.3%
090	-10.0%
100	+11.1%
130	+13.1%
900	+31.0%

County / Territory Changes

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

<i>Non-Institutional Changes</i>		
County (County Code)	Change	Impact
Bucks (09), Montgomery (46)	change Territory 4 rel.	+5.9%
Blair (07), Dauphin (22), Erie (25), Lehigh (39), Luzerne (40), Northampton (48)	change Territory 6 rel.	+8.3%
Mercer (43)	move from T3 to T6	+8.3%
Berks (06), Cumberland (21), York (67)	move from T6 to T2, offsets Terr 6 rel chg	+0.0%
Columbia (19), Crawford (20)	change Territory 5 rel.	+18.2%
Fayette (26), Lawrence (37)	move from T2 to T3	+9.1%
Lackawanna (35)	move from T5 to T4	+5.9%
Schuylkill (54)	move from T4 to T6	-23.5%
All Other	no change	+0.0%

Specialty Changes

Numerous specialty changes were implemented, including changes that simply clarified the class plan. Those specialty changes that resulted in a class change are listed below. Note that the impact is relative to the 2005 rates for Territory 1. The impact includes the impact of any class changes filed, but is net of any filed changes to territory relativities.

Specialty Code	Specialty	Change	Impact
00738	Geriatrics – No Surgery	move to 01074	-13.0%
01058	Hematology/Oncology – No Surgery	move to 00758	+15.0%
01216	Pediatrics – No Surgery	move to 01067	-36.8%
02001	General Practice – Minor Surgery	combine into 02221	+13.6%
02033	Family Practice – Minor Surgery		
02010	Internal Medicine – Minor Surgery	move to 02210	+13.6%
02227	Anesthesiology - Pain Management – NS	move to 02283 <sup>7</sup>	-45.7%
03014	Otolaryngology - Major Surgery	combine into 03565	+24.1%
03087	Otorhinolaryngology – Major Surgery		
03023	Urology	move to 03545	+24.1%
03085	Rhinology – Major Surgery	move to 03570	+24.1%
03088	Otology – Major Surgery	move to 03590	+24.1%
03089	Laryngology – Major Surgery	move to 03591	+24.1%
03547	Colon-Rectal Surgery if 75% or more of total Surgical Practice	move to 05015	+8.4%
08033	Family Practice – Major Surgery	move to 07017	-10.2%
08088	Plastic Surgeons Specializing in Hand Surgery	move to 06030	-32.2%

*Changes Effective 01/01/2006*

Base Rate Change

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

Class Rate Changes

The JUA modified the class rates for the following classes:

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

County / Territory Changes

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

<i>Non-Institutional Changes</i>		
County (County Code)	Change	Impact
Bucks (09), Lackwanna (35), Montgomery (46)	change Territory 4 rel.	-5.6%

<sup>7</sup> Note that some exposures may move to classification Anesthesiology - Pain Management Only -- No Surgery (01283). We have assumed that providers remained in current class 022.

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

Specialty Changes

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

*Changes Effective 01/01/2007*

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

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
007	+5.1%

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

County / Territory Changes

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

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

Specialty Changes

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

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

Results

The indications for the 2007 prevailing primary premium are \$1.046 billion based on 2003 remittances, \$1.048 billion based on 2004 remittances, and \$1.040 billion based on 2005 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2003), Excerpt B (2004), and Excerpt C (2005). The entire calculation is included under separate cover as Appendix A, Appendix B, and Appendix C, respectively. Based on these indications, we have projected a 2007 prevailing primary premium of \$1.045 billion.

Note, however, that this projection may vary from the actual 2007 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 2006 and 2007;

- shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2006 and 2007; and
- changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2006 and 2007.
- additional recording of data, notably for 2005, where policy adjustments and late reported assessments will cause the assessment data to change. Historically, assessments increase roughly 1% to 2% beyond the last quarter of the subsequent year.

Furthermore, it is not clear at this time what impact assessment abatements, which have not yet been extended to 2007, have on the size, mix, and average effective date of the provider population, and in turn, the 2007 prevailing primary premium. Any significant changes to the abatement program could result in reduced 2007 prevailing primary premium; this subjects the prevailing primary premium estimate for 2007 to additional uncertainty.

Act 13 also instituted other changes that may impact the prevailing primary premium, including the provisions of Section 712(g), which allow the Fund to increase the prevailing primary premium of a health care providers based on the health care provider's Fund claims experience. The Fund has previously implemented experience rating of hospitals, but will adjust the prevailing primary premium of non-hospitals for the first time during 2007. Based on our discussions with the Fund, we understand that the Fund expects the non-hospital experience rating to apply to a relatively limited number of health care providers, and we have not attempted to measure the impact of this change at this time.

#### *2007 Assessment Rate*

The cost components of the assessment total \$241.6 million. Given the 2007 prevailing primary premium projection of \$1.045 billion, the indicated 2007 assessment rate is 23%.

Since the 2007 assessment rate is based largely on the Fund's obligations for the 2006 claim year, any significant change in Fund's claim or expense obligations from 2006 to 2007 may result in a significant actual year-end 12/31/2007 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2007 and the degree to which 2007 assessments are abated. To the extent that funds available in 2007 are insufficient to meet the Fund's 2007 obligations, additional funding or borrowing will be required.

## **Calculation and Application of 2007 Hospital Experience Modification Factors**

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

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

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

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

**2007 EXPERIENCE MODIFICATION FACTORS**  
(In Accordance with Act 13 of 2002)

**Prepared by**

**Actuarial and Insurance Management Solutions**

**PricewaterhouseCoopers LLP**

**Philadelphia, Pennsylvania**

**December 2006**

## EXECUTIVE SUMMARY

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

### Spread of Experience Modification Factors

The 216 experience modification factors as calculated in Exhibit 1 fall into the following ranges:

Distribution		
From	To	Count
	80.0%	0
80.0%	85.0%	94
85.0%	90.0%	55
90.0%	95.0%	18
95.0%	100.0%	13
100.0%	105.0%	9
105.0%	110.0%	3
110.0%	115.0%	8
115.0%	120.0%	6
120.0%		10
Total All Rated Hospitals		216

### Revenue Impact

The 216 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 2005 baseline assessments. When applied to the 2006 baseline assessments, many of which are estimates, the 2006 modified assessment is approximately 0.3% lower than the 2006 baseline assessment. As such, we do not expect a significant revenue impact when these factors are applied in 2007.

### **Comparison to 2006 Experience Modification Factors**

Of the 216 experience modification factors computed herein, five are for hospitals that have been rated for the first time. Of the remaining 211 modification factors, 168 are within 5% and 187 are within 7.5% of the 2006 filed experience modification factors. Of the 201 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 164 are within 5% and 179 are within 7.5% of their 2006 filed experience modification factors.

Of the 43 experience modification factor changes greater than 5%, six arise from those hospitals whose band assignments have changed from last year. Similarly, of the 24 experience modification factor changes greater than 7.5%, two arise from hospitals whose band assignment has changed from last year. As mentioned above, steps were taken to ensure that unwarranted changes in the band assignment did not occur. However, some fluctuation in band assignment is normally expected to occur for hospitals lying near the endpoints of a given band's range and for hospitals that have merged.

## ANALYSIS

### Methodology

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

- 1) Compiling the Fund payment data for each hospital for each claim year 2002 through 2005;
- 2) Estimating and compiling the baseline assessments for each hospital for each policy year 2003 through 2006;
- 3) Calculating a rate of recoupment<sup>7</sup> 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.

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<sup>7</sup> The rate of recoupment is defined as the ratio of one claim year's Fund payments to the subsequent policy year's baseline assessments.

### **Compiling Fund Payment Data (Exhibits 5 and 9)**

The Fund provided payment data by hospital by claim year for Excess and Section 605 claims. As mentioned previously, combined data was used in our analysis in order to fully reflect the *"frequency and severity of claims paid by the Fund"*. The total payment data (included as Exhibit 9) is sorted by hospital by claim year as shown in Exhibit 5.

### **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 data for 2003 through 2006 is employed in this analysis. Note that the Fund captures unabated assessments that are discounted to the extent the discount was actually applied. Based on the discounted unabated assessment, the Fund computes the undiscounted unabated assessment, which is employed in our analysis. In examining the discounted and undiscounted unabated data provided, we observed instances in the data where it appeared that the undiscounted unabated assessment was not properly computed from the discounted unabated assessment. However, based on our review of the discounted and undiscounted assessment data provided, we believe any distortion arising from those instances where the undiscounted unabated assessment is not properly captured would not have a significant effect on our projection of the 2007 experience modification factors.

In Exhibit 8, an adjustment is made to the undiscounted 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 2003 through 2006<sup>8</sup>. For policy year 2006, information was provided by the Fund for those hospitals who have remitted their 2006 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2006 assessment, the 2006 baseline assessment is estimated as the average of the 2004 and 2005 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes. Note that a majority of the 2006 assessments have been estimated herein.

#### **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.

We have interpreted the Act 13 provision that the experience modification factors be "*based on the ... past five most recent claims periods*" to include claim years ending 2002 through 2006. However, given the expected relationship between a claim year's payments and the *subsequent* policy year's assessments, use of the claim year ending 2006 data would require estimation of each individual hospital's 2007 assessment. We did not feel that it would be appropriate to estimate the 2007 assessments for each of the 216 rated hospitals, especially in light of the degree of estimation required for the 2006 assessments. As such, the expected 2006/2007 rate of recoupment is not included in the statistics of Exhibits 1 through 5. However, as shown on

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<sup>8</sup> Note that tail assessments are also removed.

Exhibit 6, we have reviewed the expected 2006/2007 experience when selecting the *a priori* experience modification factors (described below) for each band, assuming that the relative differences between the 2006 and 2007 assessments will be equal for each band.

Rates of recoupment are established as the ratio of the Fund payment data for each claim year (ending 2002 through 2005) to the baseline policy year assessment data for the subsequent policy year (2003 through 2006). 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 2002/2003 through 2005/2006, 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 2006/2007 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 2006/2007 modification factor is based on a review of the various indications. We have kept our selected relativities in a tighter range than would otherwise be indicated for a number of reasons. The large number of observations for some bands may cause the calculated credibility to be higher than the "true" credibility. Furthermore, the Plan should produce relatively stable results from year-to-year in addition to being responsive to changes in the underlying experience. Since experience from one year to the next may vary, too much emphasis on the raw indications may tend to emphasize responsiveness at the sacrifice of stability.

The selected a priori modification factors are summarized below:

Band	A Priori Factor
Band 1	-17.5%
Band 2	-12.5%
Band 3	-7.5%
Band 4	0.0%
Band 5	12.5%

**Determining an Individual Hospital Credibility Weighting Procedure** (Exhibit 7)

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

- a. produce results that are reasonable in the professional judgment of the actuary,
- b. do not tend to bias the results in any material way,
- c. are practical to implement, and
- d. give consideration to the need to balance responsiveness and stability."

We have used a traditional credibility formula of the form:

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

P is typically some measure of the exposure represented by the risk. To establish a credibility procedure sensitive to the "class, size, risk, and kind" of each hospital, we have used the 2005 baseline policy year assessments for P.

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) 2002/2003, 2003/2004, and 2004/2005 to predict 2005/2006
- 2) 2002/2003, 2003/2004, and 2005/2006 to predict 2004/2005
- 3) 2002/2003, 2004/2005, and 2005/2006 to predict 2003/2004
- 4) 2003/2004, 2004/2005, and 2005/2006 to predict 2002/2003

The results of these analyses are shown in Exhibit 7. The indications vary, but do support credibility at the individual hospital level, particularly for hospitals in Band 2 through Band 5. Since we expect that the predictive value of the data be relatively stable over time, the selected K considers current indications as well as the prior selection. As last year, we continue to utilize a K of \$10,000,000 for Band 1 hospitals, and a K of \$7,000,000 for Band 2 hospitals. We have lowered the K for hospitals in Band 3 from \$4,000,000 to \$3,500,000, the K for hospitals in Band 4 from \$3,500,000 to \$3,000,000, and the K for hospitals in Band 5 from \$3,000,000 to 2,500,000.

The reductions in the selected K for Band 3, Band 4, and Band 5 result in relatively more credibility given to individual hospital experience for hospitals in these bands. However, the average credibility is generally similar to that of last year, since the average P in the credibility formula is lower than last year as a result of decreases in the Fund assessment. Despite the decrease in K for hospitals in Band 3, Band 4, and Band 5, individual hospital experience is still generally given limited credibility: the average Band 1 hospital receives 0.5% credibility and the average Band 5 hospital receives 42.5% credibility.

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

### Computing Experience Modification Factors (Exhibit 1)

To achieve a revenue neutral impact on 2007 assessments, we estimated modification factors that are revenue neutral based on the 2005 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2007 assessments<sup>9</sup>. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance<sup>10</sup> adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

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<sup>9</sup> As a test, we applied the modification factors to the [largely estimated] 2006 baseline policy year assessments. The resulting modified assessments were approximately revenue neutral.

<sup>10</sup> The adjustment required to achieve a revenue neutral impact.

### 2007 Mcare Paid Claims by Region

Eastern			Central			Western			Other		
County			County			County					
Bucks	Lehigh	Philadelphia	Adams	Lancaster	Tioga	Allegheny	Elk	Potter	Includes all other states and the United States District Courts where an Mcare defendant was involved.		
Chester	Montgomery		Berks	Lebanon	Union	Armstrong	Erie	Somerset			
Delaware	Northampton		Bradford	Luzerne	Wayne	Beaver	Fayette	Venango			
			Carbon	Lycoming	Wyoming	Bedford	Forest	Warren			
			Centre	Mifflin	York	Blair	Greene	Washington			
			Clinton	Monroe		Butler	Indiana	Westmoreland			
			Columbia	Montour		Cambria	Jefferson				
			Cumberland	Northumberland		Cameron	Lawrence				
			Dauphin	Perry		Clarion	McKean				
			Franklin	Pike		Clearfield	Mercer				
			Fulton	Schuylkill		Crawford					
			Huntingdon	Snyder							
			Juniata	Sullivan							
			Lackawanna	Susquehanna							
Region Paid Claims		\$102,902,187				\$32,262,814				1,275,000	
Percent of Region to Total Paid Claims		53.77%				16.86%				28.70%	
										0.67%	

<b>Total Paid Claims:</b>	<b>\$191,365,811</b>
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PA Department of Insurance

Office of Mcare

**Claim and Case Payment - 5 Most Recent Years**

Year	Fund Money	Claim Count	Average Claim Value	Case Count	Average Case Value
2003	\$ 378,720,772	701	\$ 540,258	543	\$ 697,460
2004	\$ 320,339,689	620	\$ 516,677	475	\$ 674,399
2005	\$ 232,588,740	471	\$ 493,819	373	\$ 623,562
2006	\$ 209,522,349	423	\$ 495,325	322	\$ 650,691
2007	\$ 191,365,811	422	\$ 453,473	308	\$ 621,318

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

PA Department of Insurance

Office of Mcare

**Summary of Annual Fund Claim Payments by Health Care Provider Group  
1998 - 2007**

<u>Individuals</u>					<u>Medical Corps</u>				<u>Institutions</u>				<u>Totals</u>	
MD's, DO's, Podiatrists Certified Nurse Midwives									Hospitals, Nursing Homes, Birth Centers, Care Centers			Primary		
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
1998	487	78%	\$204,901,310	76%	15	2%	\$ 6,336,468	2%	123	20%	\$ 58,623,990	22%	625	\$ 269,861,768
1999	569	81%	\$230,401,064	77%	30	4%	\$ 16,580,781	6%	107	15%	\$ 52,300,535	17%	706	\$ 299,282,380
2000	550	79%	\$256,516,538	75%	30	4%	\$ 16,681,399	5%	119	17%	\$ 68,146,290	20%	699	\$ 341,344,227
2001	529	76%	\$237,838,807	74%	26	4%	\$ 17,586,312	5%	137	20%	\$ 66,244,013	21%	692	\$ 321,669,132
2002	496	74%	\$242,058,227	70%	21	3%	\$ 15,287,490	4%	157	23%	\$ 90,702,013	26%	674	\$ 348,047,730
2003	495	71%	\$261,420,315	69%	33	5%	\$ 21,360,127	6%	173	25%	\$ 95,940,330	25%	701	\$ 378,720,772
2004	450	73%	\$235,449,423	73%	18	3%	\$ 10,448,473	3%	153	25%	\$ 74,441,793	23%	620	\$ 320,339,689
2005	337	72%	\$171,099,732	74%	20	4%	\$ 10,068,307	4%	114	24%	\$ 51,420,701	22%	471	\$ 232,588,740
2006	304	72%	\$151,833,293	72%	27	6%	\$ 14,186,262	7%	92	22%	\$ 43,502,794	21%	423	\$ 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

## Office of Mcare

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

<b>Company Code</b>	<b>Total Fund Payments</b>
S01	\$ 1,175,000
S12	\$ 70,000
S48	\$ 500,000
S49	\$ 200,000
S62	\$ 700,000
003	\$ 9,453,248
011	\$ 3,109,150
031	\$ 15,019,312
032	\$ 7,825,000
045	\$ 162,500
067	\$ 34,215,389
086	\$ 15,463,599
093	\$ 2,525,000
119	\$ 5,325,000
121	\$ 675,000
126	\$ 2,967,496
129	\$ 2,700,000
135	\$ 250,000
136	\$ 7,996,750
143	\$ 1,000,000
144	\$ 11,175,000
145	\$ 2,800,000
155	\$ 13,489,405
156	\$ 5,980,000
159	\$ 240,000
160	\$ 800,000
161	\$ 1,231,250
162	\$ 2,360,013
164	\$ 5,050,000
169	\$ 500,000
183	\$ 500,000
184	\$ 5,625,000
194	\$ 500,000
196	\$ 1,400,000
197	\$ 1,550,000
199	\$ 3,100,000
202	\$ 1,225,000
203	\$ 600,000
207	\$ 8,670,000
211	\$ 1,000,000
219	\$ 500,000

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

<b>Company Code</b>	<b>Total Fund Payments</b>
220	\$ 725,000
221	\$ 1,150,000
222	\$ 452,699
224	\$ 500,000
228	\$ 1,500,000
229	\$ 500,000
241	\$ 810,000
245	\$ 3,850,000
246	\$ 1,675,000
250	\$ 325,000
253	\$ 250,000
<hr/>	
Totals	\$ 191,365,811

Office of Mcare  
**2007 Assessment Remitted by  
Commercial Carrier**

Company Code	Amount <sup>1</sup>
001	\$23,152
003	\$ 16,239,131
011	\$ 2,830,674
021	\$ 101,967
023	\$ 3,266
026	\$ 55,443
031	\$ 25,928,808
032	\$ 3,747,678
052	\$ 98,989
067	\$ 17,087,614
090	\$ 122,425
103	\$ 482,620
110	\$ 26,465
112	\$ 150,743
121	\$ 738,126
124	\$ 1,157,801
127	\$ 234,872
129	\$ 2,421,568
130	\$ 39
137	\$ 129,451
138	\$ 597,956
139	\$ 163,506
144	\$ 19,746,132
145	\$ 3,996,023
155	\$ 15,127,467
156	\$ 8,855,475
160	\$ 1,244
162	\$ 89,264
179	\$ 101,275
182	\$ 11,369
186	\$ 88,078
191	\$ 85,048
194	\$ 542,450
196	\$ 1,174,349
197	\$ 5,975,497
198	\$ 8,144
199	\$ 4,533,631
200	\$ 905
202	\$ 9,261,882

Office of Mcare  
**2007 Assessment Remitted by  
Commercial Carrier**

Company Code	Amount <sup>1</sup>
203	\$ 1,527,803
207	\$ 21,181,967
208	\$ 2,100,137
210	\$ 161,456
211	\$ 7,623,896
212	\$ 214,182
215	\$ 44,485
216	\$ 10,985
217	\$ 514,874
218	\$ 241,409
219	\$ 5,589,576
220	\$ 2,161,751
221	\$ 5,519,459
222	\$ 3,642,995
223	\$ 3,005,032
224	\$ 1,865,478
225	\$ 48,129
226	\$ 87,012
228	\$ 1,735,806
229	\$ 3,660,087
230	\$ 15,416
232	\$ 54,951
233	\$ 5,232
234	\$ 218,084
235	\$ 86,273
236	\$ 51,184
237	\$ 6,665
239	\$ 2,535,089
241	\$ 1,085,003
242	\$ 43,943
243	\$ 32,439
244	\$ 20,990
245	\$ 5,473,901
246	\$ 2,422,638
247	\$ 100,772
248	\$ 456,481
250	\$ 649,735
251	\$ 285,761
252	\$ 59,226

Office of Mcare  
2007 Assessment Remitted by  
Commercial Carrier

<b>Company Code</b>	<b>Amount</b> <sup>1</sup>
253	\$ 4,220,244
257	\$ 35,491
258	\$ 2,611,968
261	\$ 1,091,289
262	\$ 24,994
264	\$ 2,894
265	\$ 100,213
266	\$ 23,859
267	\$ 970
268	\$ 7,111
271	\$ 381,990
272	\$ 7,177
274	\$ 206,093
275	\$ 394,832
276	\$ 672,192
279	\$ 234,238
281	\$ 1,176
<b>Total</b>	<b>\$ 226,497,560</b>

<sup>1</sup>The "Amount" is based on the gross unabated, undiscounted assessment remitted and processed as of January 30, 2008.

## Office of Mcare

**2007 Assessment Remitted by  
Self-Insurer**

<b>Company Code</b>	<b>Amount <sup>1</sup></b>
S10	\$ 4,674,369
S12	\$ 1,551,835
S34	\$ 147,258
S40	\$ 425,328
S41	\$ 102,625
S43	\$ 201,996
S46	\$ 14,279
S49	\$ 791,476
S51	\$ 312,763
S53	\$ 386,226
S54	\$ 368,948
S57	\$ 63,396
S58	\$ 19,197
S59	\$ 27,285
S60	\$ 445,573
S61	\$ 13,766
S62	\$ 387,338
S63	\$ 271,416
<b>Total</b>	<b>\$ 10,205,074</b>

<sup>1</sup>The "Amount" is based on the gross unabated, undiscounted assessment remitted and processed as of January 30, 2008.