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Act 13 of 2002

Medical Care Availability and Reduction of Error Fund

Joel Ario
Insurance Commissioner
PA Department of Insurance

Annual Report
of Operations
2008

Issued March 2, 2009

Office of Mcare
2008 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

PENNSYLVANIA INSURANCE DEPARTMENT

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
PENNSYLVANIA INSURANCE DEPARTMENT

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 3rd Street, 8th Floor
P.O. Box 12030
Harrisburg, PA 17108-2030
(717) 783-3770
or
www.mcare.state.pa.us

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

CASH BASIS

STATEMENT OF OPERATIONS

JANUARY 1, 2008 TO DEC 31, 2008

FUND BALANCE JANUARY 1, 2008		33,896,564.26
ADD:		
ASSESSMENT REVENUE	228,501,222.12	
AUTO CAT FUND	47,436,066.70	
INTEREST ON SECURITIES	4,017,285.91	
MISCELLANEOUS REVENUE	564,939.04	
HCP EXPERIENCE RATED ADJ	319,396.00	
ABATEMENT REPAYMENT	4,461,115.50	
TOTAL ADDITIONS		285,300,025.27
TOTAL FUNDS AVAILABLE		319,196,589.53
DEDUCT:		
TRANSFER TO HEALTHCARE RETENTION ACCOUNT		
FROM ABATEMENT REPAYMENT RECEIPTS	13,806,045.59	
2008 CLAIMS PAID - DEC, 2008	173,892,874.00	
LOSS ON INVESTEMENTS	12,449,055.16	
TREASURY REFUNDS & ADJ.	1,687,322.82	
TOTAL DEDUCTIONS		201,835,297.57
OPERATING EXPENSES:		
SALARIES & BENEFITS	4,548,354.41	
LEGAL SERVICES/FEES	3,521,382.84	
OPERATING EXPENSES	4,940,117.99	
TOTAL OPERATING EXPENSES		13,009,855.24
TOTAL DEDUCTIONS:		214,845,152.81
FUND BALANCE DECEMBER 31, 2008		104,351,436.72

History of Assessment Rates and Coverage Limits			Coverage Limits (per Occurrence/per Annum) in Millions					
			Non-hospital			Hospital		
			Mcare Limit	Basic Limit	Total Aggregate Limits for Mcare & Non-hospital	Mcare Limit	Basic Limit	Total Aggregate Limits for Mcare and Hospital
Year	Percentage	Policy Effective Date						
1976	Greater of 10% or \$100	01/13/76 - 12/31/82	\$1.0/\$3.0	\$0.1/\$0.3	\$1.1/\$3.3	\$1.0/\$3.0	\$0.1/\$1.0	\$1.1/\$4.0
1977	Greater of 10% or \$100							
1978	nil							
1979	nil							
1980	Greater of 10% or \$100							
1981	22%							
1982	38%	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%							
1985	70%							
1986	87%							
1987	87%							
1988	61%							
1989	59.5%							
1990	50%							
1991	68%							
1992	90%							
1993	91%							
1994	93%							
1995	170%							
1996	164%							
1997	75%							
1998	64%							
1999	59%							
2000	61%							
2001	61%							
2002	50%							
2003	43%							
2004	46%							
2005	39%							
2006	29%							
2007	23%							
2008	20%							

**Office of Mcare
Unfunded Liability Report
as of 12/31/2007**



*From 2000 forward, the report includes provisions for delay damages
March 2, 2009

Estimation of 2007 Unfunded Liability

The attached is the Executive Summary of a report by PricewaterhouseCoopers LLP that was the basis for determining the value of the unfunded liability at \$1.79 billion as of December 31, 2007.

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

ESTIMATION OF 12/31/2007 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

June 2008

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, 2007, excluding breast implant and pedicle screw exposure, to be approximately \$1.79 billion, assuming the limits of Fund coverage proceed as currently scheduled under Act 13.

Namely, the mandatory primary coverage limits are scheduled to increase (with corresponding decreases in the Fund coverage limits) in 2010 and 2013, subject to the Commissioner's assessment of basic insurance coverage capacity. The estimates contained herein assume that basic coverage limits increase as scheduled, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2013. If the coverage capacity does not exist to increase the mandatory primary limits as scheduled in 2010 and 2013, Fund coverage will continue into and beyond 2014 and the total Fund payout would increase accordingly.

Pennsylvania Mcare Fund
 Estimation of 12/31/2007 Unfunded Liability and
 Estimate of Future Years' Claims Payments
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Assuming changes in the Fund coverage limits proceed as scheduled, the projected year-beginning unfunded liability, cost of covered “new” occurrences, calendar year claims payments, and resulting year-ending unfunded liability are included in the table below:

Accident Year	Beginning Unfunded Liability	Cost of Covered Claims	Projected Claims Payments	Ending Unfunded Liability	Discounted (4%) Ending Unfunded
2007				1,788,913	1,470,844
2008	1,788,913	265,237	243,712	1,810,438	1,495,490
2009	1,810,438	249,912	252,349	1,808,001	1,499,442
2010	1,808,001	181,589	264,927	1,724,662	1,437,794
2011	1,724,662	134,558	274,885	1,584,335	1,326,197
2012	1,584,335	107,170	276,418	1,415,088	1,186,045
2013	1,415,088	26,842	264,343	1,177,588	989,898
2014	1,177,588		238,566	939,022	790,928
2015	939,022		204,300	734,722	618,265
2016	734,722		169,147	565,575	473,849
2017	565,575		131,414	434,161	361,389
2018	434,161		96,880	337,281	278,965
2019	337,281		72,131	265,150	217,992
2020	265,150		55,295	209,855	171,417
2021	209,855		42,733	167,122	135,541
2022	167,122		32,568	134,554	108,394
2023	134,554		24,707	109,847	88,023
2024	109,847		19,674	90,174	71,870
2025	90,174		15,816	74,358	58,930
2026	74,358		12,455	61,903	48,832
2027	61,903		10,052	51,851	40,734
2028	51,851		8,198	43,653	34,165
2029	43,653		6,653	37,000	28,878
2030	37,000		5,311	31,689	24,722
2031	31,689		4,337	27,352	21,375
2032	27,352		3,550	23,802	18,680
2033	23,802		2,948	20,855	16,479
2034	20,855		2,492	18,362	14,646
2035	18,362		2,174	16,188	13,058
2036	16,188		1,976	14,212	11,604
2037	14,212		1,885	12,328	10,183
2038	12,328		1,752	10,575	8,839
2039	10,575		1,623	8,952	7,569
2040	8,952		1,496	7,456	6,375
2041	7,456		1,380	6,075	5,250
2042	6,075		1,241	4,834	4,219
2043	4,834		1,091	3,744	3,297
2044	3,744		943	2,800	2,485
2045	2,800		761	2,039	1,824
2046	2,039		561	1,479	1,336
2047	1,479		446	1,033	944
2048	1,033		363	669	618
2049	669		276	393	367
2050	393		183	210	198
2051	210		121	89	85
2052	89		70	19	18
2053	19		18	1	1
		965,308	2,754,221		

As shown in the table above, we have projected 2008 claims payments to be \$244 million based on the methods and assumptions contained herein. Currently, the Fund is projecting 2008 claim year payments to be broadly similar to those for 2007, approximately \$190 million. Fund payments in 2005 through 2007 were also lower than our original projections. We have tried to incorporate the apparent continued reduction in payment activity into our selection of the unfunded liability; however, our payment patterns assume longer-term trends and result in an estimated 2008 claims payment that is higher than expected by the Fund based on information available to date.

Given the apparent decrease in Fund payment activity during 2008, we have attempted to provide an adjusted estimate of payout of the projected Unfunded Liability assuming the Fund's projection of the 2008 payments of \$190 million. We have also assumed that the reduced level of payments observed during 2005 through 2008 will continue into 2009, and have adjusted the projected 2009 payments to \$220 million, which is roughly the average of the Fund's expected 2008 payments of \$190 million and our unadjusted projection of the 2009 payments of \$252 million.

The adjusted payment pattern assumes that the recent decrease in payments has effectively "pushed" the payments out in time. As such, the projected 12/31/2007 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:

Pennsylvania Mcare Fund
 Estimation of 12/31/2007 Unfunded Liability and
 Estimate of Future Years' Claims Payments
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Accident Year	Beginning Unfunded Liability	Cost of Covered Claims	Projected Claims Payments	Ending Unfunded Liability	Discounted (4%) Ending Unfunded
2007				1,788,913	1,452,280
2008	1,788,913	265,237	190,000	1,864,150	1,529,895
2009	1,864,150	249,912	220,000	1,894,062	1,567,573
2010	1,894,062	181,589	264,126	1,811,525	1,509,451
2011	1,811,525	134,558	279,872	1,666,211	1,395,733
2012	1,666,211	107,170	291,721	1,481,660	1,243,059
2013	1,481,660	26,842	282,565	1,225,937	1,030,971
2014	1,225,937		250,275	975,663	821,935
2015	975,663		212,903	762,760	641,909
2016	762,760		175,054	587,706	492,532
2017	587,706		136,585	451,121	375,648
2018	451,121		101,209	349,912	289,465
2019	349,912		75,017	274,894	226,026
2020	274,894		57,296	217,598	177,771
2021	217,598		44,304	173,294	140,578
2022	173,294		33,663	139,631	112,538
2023	139,631		25,678	113,953	91,361
2024	113,953		20,458	93,495	74,557
2025	93,495		16,514	76,981	61,026
2026	76,981		12,967	64,014	50,500
2027	64,014		10,459	53,555	42,061
2028	53,555		8,555	45,000	35,188
2029	45,000		6,940	38,060	29,656
2030	38,060		5,471	32,590	25,372
2031	32,590		4,438	28,151	21,948
2032	28,151		3,639	24,512	19,187
2033	24,512		3,013	21,500	16,942
2034	21,500		2,534	18,966	15,086
2035	18,966		2,217	16,749	13,472
2036	16,749		2,010	14,739	12,001
2037	14,739		1,894	12,845	10,587
2038	12,845		1,777	11,068	9,234
2039	11,068		1,646	9,422	7,958
2040	9,422		1,540	7,883	6,736
2041	7,883		1,429	6,454	5,577
2042	6,454		1,294	5,160	4,506
2043	5,160		1,147	4,013	3,539
2044	4,013		1,004	3,009	2,676
2045	3,009		827	2,182	1,957
2046	2,182		629	1,552	1,406
2047	1,552		488	1,065	974
2048	1,065		391	673	622
2049	673		280	393	367
2050	393		183	210	198
2051	210		121	89	85
2052	89		70	19	18
2053	19		18	1	1
		965,308	2,754,221		

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

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

Comparison to Projection as of 12/31/2006

The total expected unfunded liability of \$1.79 billion has decreased 16% from our December 31, 2006 estimate of \$2.12 billion. The breakdown of the change in the undiscounted estimate since December 31, 2007 is shown in the following table:

Rollforward of Estimated Unfunded Liability (000's) from 12/31/2006 to 12/31/2007					
			<u>Excess</u>	<u>Section 715</u>	<u>Total</u>
(1)	Prior Estimated Liability		1,510,098	613,027	2,123,125
(2)	Less Prior Estimated DD & PJI		<u>29,610</u>	<u>12,020</u>	<u>41,630</u>
(3)	Prior Estimated Liability Ex. DD & PJI	(1)-(2)	1,480,488	601,007	2,081,495
(4)	Plus Change in Prior Accident Year Ultimate		(454,891)	55,945	(398,946)
(5)	Less Paid During Year		155,079	35,412	190,491
(6)	Plus Accident Year 2007 Ultimate		<u>239,329</u>	<u>31,090</u>	<u>270,419</u>
(7)	Current Estimated Liability Ex. DD & PJI	(3)+(4)-(5)+(6)	1,109,847	652,629	1,762,476
(8)	Current Estimated DD & PJI	1.5% * (7)	<u>16,648</u>	<u>9,789</u>	<u>26,437</u>
(9)	Current Estimated Liability	(7)+(8)	1,126,495	662,418	1,788,913

The decrease in the projection is primarily due to the continuation of favorable Fund claim payment trends; our projections give increasing weight to the favorable emerging experience. Based on information gathered by the Administrative Office of Pennsylvania Courts (AOPC), the number of medical malpractice cases filed in Pennsylvania in recent post-Act 13 years (2003 and subsequent) is significantly lower than pre-Act 13 experience (2000/2001). The Fund has also experienced a recent reduction in the number of claims that are closing with payment, and our projections of the number of claims that will close with payment now explicitly recognize a savings based on the reduction in cases filed. Our prior projections were more cautionary in this regard; however, 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 believe it is appropriate to include a more explicit and significant adjustment. Further discussion is included in the *Reduction in Claim Activity* section below.

The adjustment to more explicitly recognize favorable claims activity has had a more significant impact on our projection of Excess claims than on our projection of Section 715 claims, compared to our projections of last year. Our prior projections for Section 715 claims included an adjustment for the Continuing Course of Treatment Provision (CCoT) of -35% for recent years, based in large part of the reduction in recent Fund claims activity. Since actual loss experience is increasingly impacted by post-CCoT experience and our current projections include an "AOPC Credit" averaging approximately 20% based on the recent AOPC experience (corroborated by recent Fund claims payment activity), an additional CCoT adjustment no longer appears necessary and has therefore been removed.

The projected ultimate losses and the loss reserve requirements for Excess losses are shown in Summary, Exhibit 7. Our estimate of the unfunded liability as of 12/31/2007 for Excess claims is approximately \$1.13 billion, including delay damages and post-judgment interest. The projected ultimate losses and the loss reserve requirements for Section 715 losses are shown in

Summary, Exhibit 8. Our estimate of the unfunded liability as of 12/31/2007 for Section 715 claims is approximately \$0.66 billion, including delay damages and post-judgment interest.

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 – 2009	500 / 2,500	500 / 1,500	500 / 1,500
2010 ⁶ – 2013	750 / 3,750	750 / 2,250	250 / 750
2014 ⁷ & 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

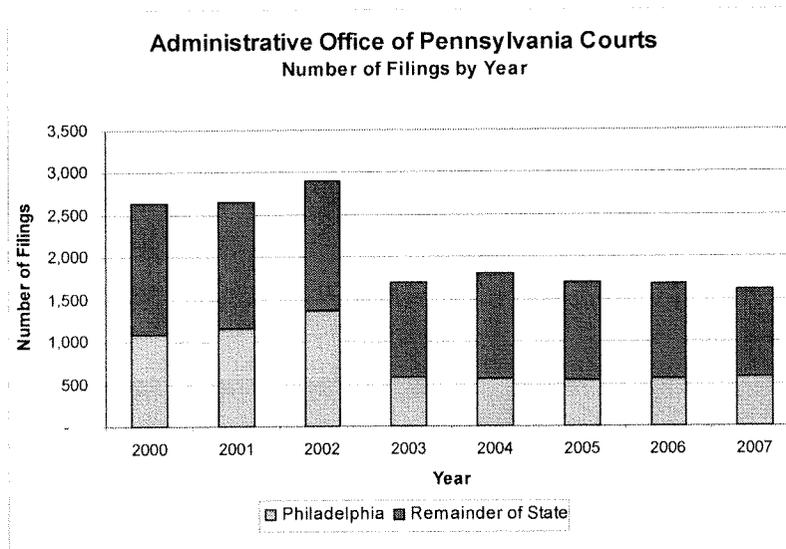
⁶ Limits may change beginning in 2010, depending on the Insurance Commissioner's assessment of market conditions. However, if the Commissioner determines that additional basic insurance capacity is not available, current primary and Fund coverage will remain in effect until such capacity is available. The estimates herein assume that limits of coverage change beginning in 2010.

⁷ 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 2014.

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

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 2007, with particular concentration in Philadelphia County. The average statewide decrease in cases filed is approximately 35%, with Philadelphia County experiencing an average decrease of approximately 50% and the remainder of the state (ROS) experiencing an average decrease of approximately 25%, as shown below:



Where possible to do so, incentives to bring suit in Philadelphia versus other venues include 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, 32% of total verdicts in

Philadelphia County were plaintiff verdicts for the period from July 2003 through December 2007; 14% of total verdicts in the remainder of the state were plaintiff verdicts for the same period. Of the plaintiff verdicts, Philadelphia County has a greater portion of large verdicts compared to the remainder of Pennsylvania. Recent AOPC statistics indicate that roughly 40% of medical malpractice plaintiff verdicts in Philadelphia County have resulted in awards greater than \$1 million, compared with roughly 30% in the remainder of the state during the period July 2003 through December 2007. While several other counties have had large jury awards, the number of large jury verdicts is significantly higher in Philadelphia County than any other venue in Pennsylvania.

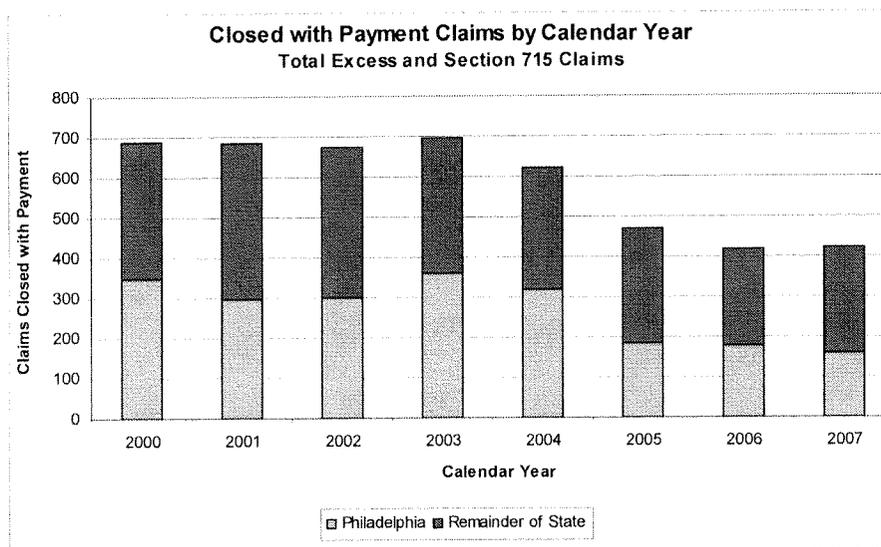
It is not entirely clear what is causing the decrease in claims activity for recent years, although possibilities include venue reform, certificate of merit procedures, and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number of case filings, with a particular concentration in Philadelphia County, is likely a combination of some cases that would have been brought in Philadelphia previously that are now being brought outside Philadelphia (as a result of venue reform) or not at all. The extent to which this reduction in the number of claims results in a reduction in the total costs to the Fund is uncertain for several reasons:

- The reduced number of cases may be a reduction in less meritorious cases, in which case a reduction in the number of cases may not lead to a commensurate decrease in costs, particularly in the excess layers of coverage provided by the Fund.
- Certain counties or areas may have a tendency for higher awards or settlements because those areas see the most complicated medical cases. To some 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.

Closed-with-Payment Fund claim statistics provide some corroboration of the information observed by the AOPC, allowing for a time delay between case filing and claim payment. Namely, the number of Fund claims closing with payment fell dramatically in 2005 through 2007 as compared to prior years. The average statewide decrease in claims closed with payment is approximately 35%, with Philadelphia County experiencing an average decrease of nearly 50% and ROS experiencing an average decrease of approximately 25%, as shown below:



A portion of this decrease is likely attributable to the changes in the limit of Excess coverage provided by the Fund over time. Nonetheless, we believe the data compiled by the AOPC and recent Fund claims payment activity are indicative of savings to be realized by the Fund. Although the possibility exists, as cited above, that the reduced number of filings and apparent shift of claims away from Philadelphia may not result in a commensurate level of cost savings, we believe that the consistency and persistency of the change in claims activity warrants reflection in our estimates, and have included an "AOPC Credit" of 30% within our Philadelphia projections and 15% within our ROS projections. These credits are broadly consistent with the reduction in Fund closed-with-payment activity during 2005 through 2007 as compared to recent prior experience, adjusted for changes in the limits of coverage.

Changes in Limits of Coverage for Section 715 Losses

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 claims⁸, 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

⁸ 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.

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.

Other Act 13 Provisions

Other elements of recent legislation are expected to have a less direct or less significant effect on the Fund's future payments, are more difficult to estimate, or lack sufficient information to actuarially quantify at this point in time, including but not necessarily limited to: Patient Safety initiatives (Chapter 3 of Act 13), Remittitur (Section 515 of Act 13), Statute of Repose (Section 513), Collateral Sources (Section 508), and Payment of Damages / Reduction to Present Value (Sections 509/510). Although not explicitly estimated herein, these other elements of recent legislation may also have an impact on the Fund's obligations. Note, however, that these provisions have generally been in place for a few years; to the extent paid loss or claim activity has been impacted, our projections implicitly reflect the impact of these provisions.

Other Comments

As summarized in Summary, Exhibit 1, the indicated post-Act 13 liability after discounting the Fund's liabilities at a 4% annual rate of interest is approximately \$1.47 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%	\$1.62 billion

Discount Rate	Discounted Unfunded Liability
3%	\$1.54 billion
4%	\$1.47 billion
5%	\$1.41 billion

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

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 1.5% as the estimated ratio of these costs to loss and have increased our post-Act 13 unfunded liability projections accordingly.

Calculation of 2008 Mcare Assessment Rate

The attached is the Executive Summary of a study by PricewaterhouseCoopers LLP that was the basis for setting the 2008 Mcare Assessment rate at 20 percent.

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

2008 YEAR ASSESSMENT CALCULATION
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

October 2007

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.

2008 Assessment Rate

Exhibit 1 presents the indicated 2008 assessment rate of 20%. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2008 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 2008 prevailing primary premium. Hence the projection of 2008 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2008 payment obligations of the Fund and the 2008 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2004, 2005, and 2006 assessments as the basis for our estimate of the 2008 prevailing primary premium.

Since the 2008 assessment rate is based largely on the Fund's obligations for the 2007 claim year, any significant change in Fund's claim or expense obligations from 2007 to 2008 may result in a significant actual year-end 12/31/2008 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2008. To the extent the funds available in 2008 are insufficient to meet the Fund's 2008 obligations, additional funding or borrowing may be required.

Differences between projected 2008 prevailing primary premium and actual 2008 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 2008 obligations.

ANALYSIS

2008 Assessment Rate

The Act outlines the four categories to be funded via the assessment. The aggregate assessment for 2008⁵ 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 2008 prevailing primary premium.

Claim Settlements

The largest component of the 2008 assessment is the amount of claim settlements for the Fund's 2007 claim year ending August 31, 2007. These claims are payable on or about December 31, 2007. The Fund expects that payments for the 2007 claim year will total approximately \$191.4 million.

Fund Operating Expenses

Operating expenses paid of \$14.6 million for claim year ending 08/31/2007 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 include roughly \$2.5 million for claim year 2006 legal fees paid subsequent to 08/31/2006. However, the inclusion of this amount does not alter the indicated assessment rate.

Principal and Interest on Moneys Transferred

The Fund had no moneys outstanding during the claim year ending 08/31/2007, and does not currently expect to require borrowing to meet its 2007 obligations.

⁵ We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2008.

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 2004, 2005 and 2006. 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 for 2004, 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 the distortion arising from those instances where the undiscounted unabated assessment is not properly captured is less than 0.3% of the 2004 assessment, and would not have a material effect on our projection of the 2008 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-plus⁶). Assessment collections for tail policies are not expected to be material in the aggregate for policy

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

year 2008. As such, our projections of policy year 2008 assessments exclude assessments collected in 2004, 2005 and 2006 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 2008 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 2004 assessments have been adjusted for changes effective 01/01/2005, 01/01/2006, 01/01/2007, and 01/01/2008. This calculation is included in its entirety under

separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2005 assessments have been adjusted for changes effective 01/01/2006, 01/01/2007, and 01/01/2008. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2006 assessments have been adjusted for changes effective 01/01/2007 and 01/01/2008. 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 01/01/2005, 01/01/2006, 01/01/2007, and 01/01/2008 are as follows:

Changes Effective 01/01/2005

Note that the changes effective 01/01/2005 discussed below apply only to the calculation based on the 2004 assessment (Appendices A / Excerpts A). The 2005 and 2006 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%

JUA Class	Impact
020	+10.6%
022	+16.7%
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%

<i>Non-Institutional Changes</i>		
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 ⁷	-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%

⁷ 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.

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

Specialty Changes

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

Changes Effective 01/01/2007

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

Class Rate Changes

The JUA modified the class rates for the following classes:

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

County / Territory Changes

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

<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%

Changes Effective 01/01/2008

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

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	-11.1%
012	+4.5%
020	-1.3%
022	+2.9%
030	-2.2%

JUA Class	Impact
035	-3.0%
060	-2.0%
070	-1.9%
080	-1.7%
100	+5.0%
130	-15.0%
900	+5.0%

County / Territory Changes

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

<i>Non-Institutional Changes</i>		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	change Terr 3 rel.	-8.0%
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-8.0%
Delaware (23)	change Terr 5 rel.	-8.0%
Blair (07), Columbia (19), Crawford (20), Dauphin (22), Erie (25), Lackawanna (35), Lawrence (37), Lehigh (39), Luzerne(40), Mercer (43), Monroe (45), Northampton (48), Schuylkill (54)	change Terr 6 rel.	-8.0%
All Other	change Terr 2 rel.	-8.0%

Specialty Changes

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

Results

The indications for the 2008 prevailing primary premium are \$1.098 billion based on 2004 remittances, \$1.097 billion based on 2005 remittances, and \$1.142 billion based on 2006 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2004), Excerpt B (2005), and Excerpt C (2006). 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 2008 prevailing primary premium of \$1.120 billion.

Note, however, that this projection may vary from the actual 2008 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 2007 and 2008;
- shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2007 and 2008; and

- changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2007 and 2008.
- additional recording of data, notably for 2006, 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 2008, have on the size, mix, and average effective date of the provider population, and in turn, the 2008 prevailing primary premium. Any significant changes to the abatement program could result in reduced 2008 prevailing primary premium; this subjects the prevailing primary premium estimate for 2008 to additional uncertainty.

Act 13 also instituted other changes that may impact the prevailing primary premium, including the provisions of Section 712(g), which allow the Fund to increase the prevailing primary premium of a health care providers based on the health care provider's Fund claims experience. The Fund has previously implemented experience rating of hospitals, but adjusted the prevailing primary premium of non-hospitals for the first time during 2007. Based on our discussions with the Fund, we understand that the non-hospital experience rating adjustments applied to a relatively limited number of health care providers, and will be applied similarly in 2008. We have not attempted to measure the impact of this program at this time.

2008 Assessment Rate

The cost components of the assessment total \$226.5 million. Given the 2008 prevailing primary premium projection of \$1.120 billion, the indicated 2008 assessment rate is 20%.

Since the 2008 assessment rate is based largely on the Fund's obligations for the 2007 claim year, any significant change in Fund's claim or expense obligations from 2007 to 2008 may

result in a significant actual year-end 12/31/2008 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2008 and the degree to which 2008 assessments are abated. To the extent that funds available in 2008 are insufficient to meet the Fund's 2008 obligations, additional funding or borrowing will be required.

Calculation and Application of 2008 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**

2008 EXPERIENCE MODIFICATION FACTORS
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

December 2007

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

Distribution		
From	To	Count
	80.0%	0
80.0%	85.0%	91
85.0%	90.0%	48
90.0%	95.0%	20
95.0%	100.0%	15
100.0%	105.0%	15
105.0%	110.0%	8
110.0%	115.0%	2
115.0%	120.0%	3
120.0%		11
Total All Rated Hospitals		213

Revenue Impact

The 213 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 2006 baseline assessments. When applied to the 2007 baseline assessments, many of which are estimates, the 2007 modified assessment is approximately 0.3% higher than the 2007 baseline assessment. As such, we do not expect a significant revenue impact when these factors are applied in 2008.

Comparison to 2007 Experience Modification Factors

Of the 213 experience modification factors computed herein, two are for hospitals that have been rated for the first time. Of the remaining 211 modification factors, 179 are within 5% and 189 are within 7.5% of the 2007 filed experience modification factors. Of the 203 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 175 are within 5% and 184 are within 7.5% of their 2007 filed experience modification factors.

Of the 28 experience modification factor changes greater than 5%, four arise from those hospitals whose band assignments have changed from last year. Similarly, of the 19 experience modification factor changes greater than 7.5%, three 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 2003 through 2006;
- 2) Estimating and compiling the baseline assessments for each hospital for each policy year 2004 through 2007;
- 3) Calculating a rate of recoupment⁷ for each hospital for each year and for each hospital band for each year;
- 4) Calculating the four relative rates of recoupment for each hospital showing the ratio of the hospital rate of recoupment to the total hospital rate of recoupment for each year and weighting these four relative rates of recoupment together to estimate an average relative rate of recoupment (weighted rate) for the individual hospital;
- 5) Determining appropriate *a priori* modification factors;
- 6) Determining an appropriate credibility weighting procedure and credibility weighting the hospital weighted rate with its band's *a priori* modification factor; and
- 7) Computing experience modification factors that lie within the bounds prescribed by Act 13 and that are revenue neutral.

Each of these steps is described below.

Compiling Fund Payment Data (Exhibits 5 and 9)

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

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

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

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 2004 through 2007 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 2008 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 2004 through 2007⁸. For policy year 2007, information was provided by the Fund for those hospitals who have remitted their 2007 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2007 assessment, the 2007 baseline assessment is estimated as the average of the 2005 and 2006 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.

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 2003 through 2007. However, given the expected relationship between a claim year's payments and the *subsequent* policy year's assessments, use of the claim year ending 2007 data would require estimation of each individual hospital's 2008 assessment. We did not feel that it would be appropriate to estimate the 2008 assessments for each of the 213 rated hospitals, especially in light of the estimation required for the 2007 assessments. As such, the expected 2007/2008 rate of recoupment is not included in the statistics of Exhibits 1 through 5. However, as shown on Exhibit 6, we have reviewed the expected 2007/2008 experience when selecting the *a priori* experience modification factors (described below) for each band, assuming that the relative

⁸ Note that tail assessments are also removed.

differences between the 2007 and 2008 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 2003 through 2006) to the baseline policy year assessment data for the subsequent policy year (2004 through 2007). 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 2003/2004 through 2006/2007, 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 2007/2008 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 2007/2008 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 chosen P equal to the hospitals' 2006 policy year prevailing primary premiums, adjusted for the JUA's 2007 rate change. To calculate P, we divided the Fund's 2006 baseline policy year assessment by the Fund's 2006 assessment rate of 29.0%. We then adjusted the total to reflect the JUA's filed rate change of +7.7% for policy year 2007. Policy periods were annualized where we observed that the 2006 policy year data did not represent an annual policy term. In prior calculations, P was equal to the baseline policy year Fund assessments. This year's use of prevailing primary premiums is expected to increase the stability of P over time by removing the impact of changing assessment rates. Since the credibility assigned to an average hospital in each band is similar to that of last year (as shown on the next page), we do not believe this refinement represents a significant change to the experience modification factor calculation.

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) 2003/2004, 2004/2005, and 2005/2006 to predict 2006/2007
- 2) 2003/2004, 2004/2005, and 2006/2007 to predict 2005/2006
- 3) 2003/2004, 2005/2006, and 2006/2007 to predict 2004/2005
- 4) 2004/2005, 2005/2006, and 2006/2007 to predict 2003/2004

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

Band	Current Calculations		Prior Calculations	
	Selected K	Implied Avg Z	Selected K	Implied Avg Z
Band 1	30,000,000	0.5%	10,000,000	0.5%
Band 2	20,000,000	2.7%	7,000,000	2.7%
Band 3	10,000,000	9.2%	3,500,000	9.4%
Band 4	8,000,000	20.3%	3,000,000	20.1%
Band 5	7,000,000	41.8%	2,500,000	42.5%

As shown above, the average credibility is generally similar to that of last year despite the large increases in selected K. Since the average P in this year's calculations is much larger than in prior years, the increase in K was necessary to maintain consistent credibility levels for each

band. 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 41.8% 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 2008 assessments, we estimated modification factors that are revenue neutral based on the 2006 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2008 assessments⁹. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance¹⁰ adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

⁹ As a test, we applied the modification factors to the 2007 baseline policy year assessments, approximately 20% of which are estimates. The resulting modified assessments were approximately revenue neutral.

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

2008 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		\$94,374,144				\$28,566,309				\$ 5,350,000	
Percent of Region to Total Paid Claims		54.27%				16.43%				26.22%	
										3.08%	

Total Paid Claims:	\$173,892,874
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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
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
2008	\$ 173,892,874	377	\$ 461,254	279	\$ 623,272

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

Office of Mcare

Summary of Annual Fund Claim Payments by Health Care Provider Group

1999 - 2008

Year	<u>Individuals</u> MD's, DO's, Podiatrists Certified Nurse Midwives				<u>Medical Corps</u>				<u>Institutions</u> Hospitals, Nursing Homes Birth Center, Primary Care Centers				<u>Totals</u>	
	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
1999	567	80%	\$ 231,940,685	77%	30	4%	\$ 16,580,781	6%	108	15%	\$ 51,725,385	17%	705	\$ 300,246,851
2000	550	79%	\$ 256,516,538	75%	30	4%	\$ 16,681,399	5%	119	17%	\$ 68,146,290	20%	699	\$ 341,344,227
2001	529	76%	\$ 237,838,807	74%	26	4%	\$ 17,586,312	5%	137	20%	\$ 66,244,013	21%	692	\$ 321,669,132
2002	496	74%	\$ 242,058,227	70%	21	3%	\$ 15,287,490	4%	157	23%	\$ 90,702,013	26%	674	\$ 348,047,730
2003	495	71%	\$ 261,412,315	69%	33	5%	\$ 21,352,127	6%	173	25%	\$ 95,956,330	25%	701	\$ 378,720,772
2004	450	73%	\$ 235,414,423	73%	18	3%	\$ 10,448,473	3%	152	25%	\$ 74,476,793	23%	620	\$ 320,339,689
2005	337	72%	\$ 171,099,732	74%	20	4%	\$ 10,068,307	4%	114	24%	\$ 51,420,701	22%	471	\$ 232,588,740
2006	304	72%	\$ 151,833,293	72%	26	6%	\$ 14,186,262	7%	92	22%	\$ 43,502,794	21%	422	\$ 209,522,349
2007	273	65%	\$ 123,762,853	65%	25	6%	\$ 12,560,972	7%	124	29%	\$ 55,041,986	29%	422	\$ 191,365,811
2008	256	68%	\$ 116,967,358	67%	16	4%	\$ 8,165,387	5%	105	28%	\$ 48,760,129	28%	377	\$ 173,892,874

2008 Claims Payment by Commercial Carrier and Self-Insurer

Company Code	Total Fund Payments
S07	\$ 2,000,000
S10	\$ 3,000,000
S12	\$ 500,000
S14	\$ 1,000,000
S23	\$ 906,250
S34	\$ 1,000,000
S36	\$ 1,500,000
S43	\$ 500,000
S45	\$ 400,000
S48	\$ 1,000,000
S54	\$ 500,000
003	\$ 10,728,436
011	\$ 3,950,000
031	\$ 16,042,750
032	\$ 4,109,736
045	\$ 350,000
067	\$ 18,239,903
086	\$ 13,739,896
093	\$ 1,865,000
112	\$ 500,000
119	\$ 1,750,000
121	\$ 500,000
124	\$ 500,000
126	\$ 2,441,655
129	\$ 6,575,000
131	\$ 557
136	\$ 7,950,000
144	\$ 10,219,400
145	\$ 600,000
155	\$ 6,620,790
156	\$ 6,650,000
160	\$ 700,000
161	\$ 1,465,000
162	\$ 2,214,073
164	\$ 1,250,000
166	\$ 175,000
183	\$ 500,000
184	\$ 9,360,039
196	\$ 250,000
197	\$ 5,550,000
199	\$ 1,575,000

2008 Claims Payment by Commercial Carrier and Self-Insurer

Company Code	Total Fund Payments
201	\$ 500,000
202	\$ 1,200,000
203	\$ 100,000
207	\$ 9,450,000
211	\$ 2,875,000
219	\$ 850,000
220	\$ 940,000
221	\$ 742,559
222	\$ 850,000
224	\$ 300,000
228	\$ 500,000
229	\$ 1,131,830
245	\$ 3,300,000
246	\$ 1,100,000
250	\$ 1,000,000
256	\$ 375,000
Totals	\$ 173,892,874

Office of Mcare
**2008 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
001	\$18,923
003	\$ 15,844,730
011	\$ 3,101,305
021	\$ 87,719
023	\$ 57,679
031	\$ 23,028,856
032	\$ 2,290,064
052	\$ 77,582
067	\$ 15,418,046
090	\$ 111,034
103	\$ 519,065
110	\$ 30,055
112	\$ 219,238
121	\$ 721,228
124	\$ 919,034
127	\$ 249,297
129	\$ 3,548,514
137	\$ 130,520
138	\$ 583,706
139	\$ 149,005
144	\$ 18,629,977
145	\$ 3,903,610
155	\$ 15,761,773
156	\$ 8,138,853
162	\$ 53,423
179	\$ 41,608
182	\$ 4,368
186	\$ 126,511
191	\$ 48,123
194	\$ 77,636
196	\$ 1,092,860
197	\$ 5,666,705
198	\$ 6,734
199	\$ 4,740,885
200	\$ 241
202	\$ 8,608,639
203	\$ 1,299,006
206	\$ 41,631
207	\$ 20,672,829

Office of Mcare
**2008 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
208	\$ 1,792,524
210	\$ 233,155
211	\$ 8,088,546
212	\$ 197,423
216	\$ 8,056
217	\$ 459,023
218	\$ 232,387
219	\$ 5,207,491
220	\$ 2,051,779
221	\$ 4,574,919
222	\$ 3,486,849
223	\$ 3,803,666
224	\$ 1,812,276
225	\$ 48,020
226	\$ 90,967
227	\$ 3,675
228	\$ 1,703,229
229	\$ 2,458,868
230	\$ 22,103
232	\$ 33,214
233	\$ 4,592
234	\$ 210,417
235	\$ 81,046
236	\$ 49,931
237	\$ 3,617
239	\$ 2,607,666
241	\$ 992,191
242	\$ 41,115
243	\$ 30,088
244	\$ 88,579
245	\$ 5,198,343
246	\$ 2,724,816
247	\$ 92,944
248	\$ 357,290
249	\$ 2,993
250	\$ 605,335
251	\$ 178,568
252	\$ 85,384
253	\$ 4,223,692

Office of Mcare
**2008 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
257	\$ 35,638
258	\$ 2,274,644
261	\$ 1,007,252
262	\$ 21,229
264	\$ 1,161
265	\$ 95,615
266	\$ 15,343
267	\$ 1,038
268	\$ 6,439
271	\$ 818,415
272	\$ 8,822
274	\$ 173,673
275	\$ 493,759
276	\$ 598,144
278	\$ 566
279	\$ 228,552
281	\$ 943
282	\$ 39,952
285	\$ 79,804
286	\$ 38,594
287	\$ 28,721
290	\$ 3,929
900	\$ 3,242
Total	\$ 215,883,264

¹The "Amount" is based on the gross unabated, undiscounted assessment remitted and processed as of January 30, 2009.

Office of Mcare

**2008 Assessment Remitted by
Self-Insurer**

Company Code	Amount ¹
S10	\$ 4,520,461
S12	\$ 1,557,830
S40	\$ 402,953
S41	\$ 98,300
S43	\$ 276,166
S46	\$ 12,820
S47	\$ 135,249
S49	\$ 754,297
S51	\$ 318,284
S53	\$ 201,167
S54	\$ 338,803
S57	\$ 55,414
S58	\$ 12,503
S59	\$ 24,514
S60	\$ 408,396
S61	\$ 12,516
S62	\$ 346,651
S63	\$ 276,916
S64	\$ 16,912
Total	\$ 9,770,152

¹The "Amount" is based on the gross unabated, undiscounted assessment remitted and processed as of January 30, 2009.