pennsylvania
INSURANCE DEPARTMENT

10

Act 13 of 2002

Medical Care Availability and Reduction of Error Fund

Michael F. Consedine
Acting Insurance Commissioner
Department of Insurance

Annual Report of Operations 2010

Issued March 1, 2011

Office of Mcare

2010 Annual Report of Operations

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pennsylvania
INSURANCE DEPARTMENT

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.

PARTICIPATION

Act 13, as amended, mandates that each health care provider who renders 50% or more of his or her professional health care business or practice within Pennsylvania ("participating health care provider") must obtain primary coverage with a primary

carrier licensed or approved by the Pennsylvania Insurance Department or with an approved self-insurance plan. In addition, each participating health care provider must obtain statutory excess professional liability coverage with Mcare by paying a certain percentage of the prevailing primary premium charged by the Pennsylvania Professional Liability Joint Underwriting Association (JUA) to Mcare. The appropriate percentage ("assessment") varies each year based upon payments made by Mcare in the previous year.

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

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

COVERAGE REQUIREMENTS

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

A. Primary Coverage for Participating Health Care Providers

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

B. Mcare Coverage for Participating Health Care Providers

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

C. Primary Coverage for Nonparticipating Health Care Providers

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

D. Mcare Coverage for Nonparticipating Health Care Providers

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

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

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

REPORTING COVERAGE TO MCARE

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

Mcare has the authority to determine the amount of the annual assessment that will be levied on each participating health care provider and eligible entity. The assessment is a percentage designated by Mcare of the prevailing primary premium charged by the JUA for health care providers of like class,

size, risk and kind. A health care provider must pay the assessment to their primary carrier in sufficient time for it to forward proof of insurance and the applicable assessment payment to Mcare within 60 days of the effective date of the health care provider's primary policy.

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

CLAIMS REPORTING

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

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

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

SUMMARY

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

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

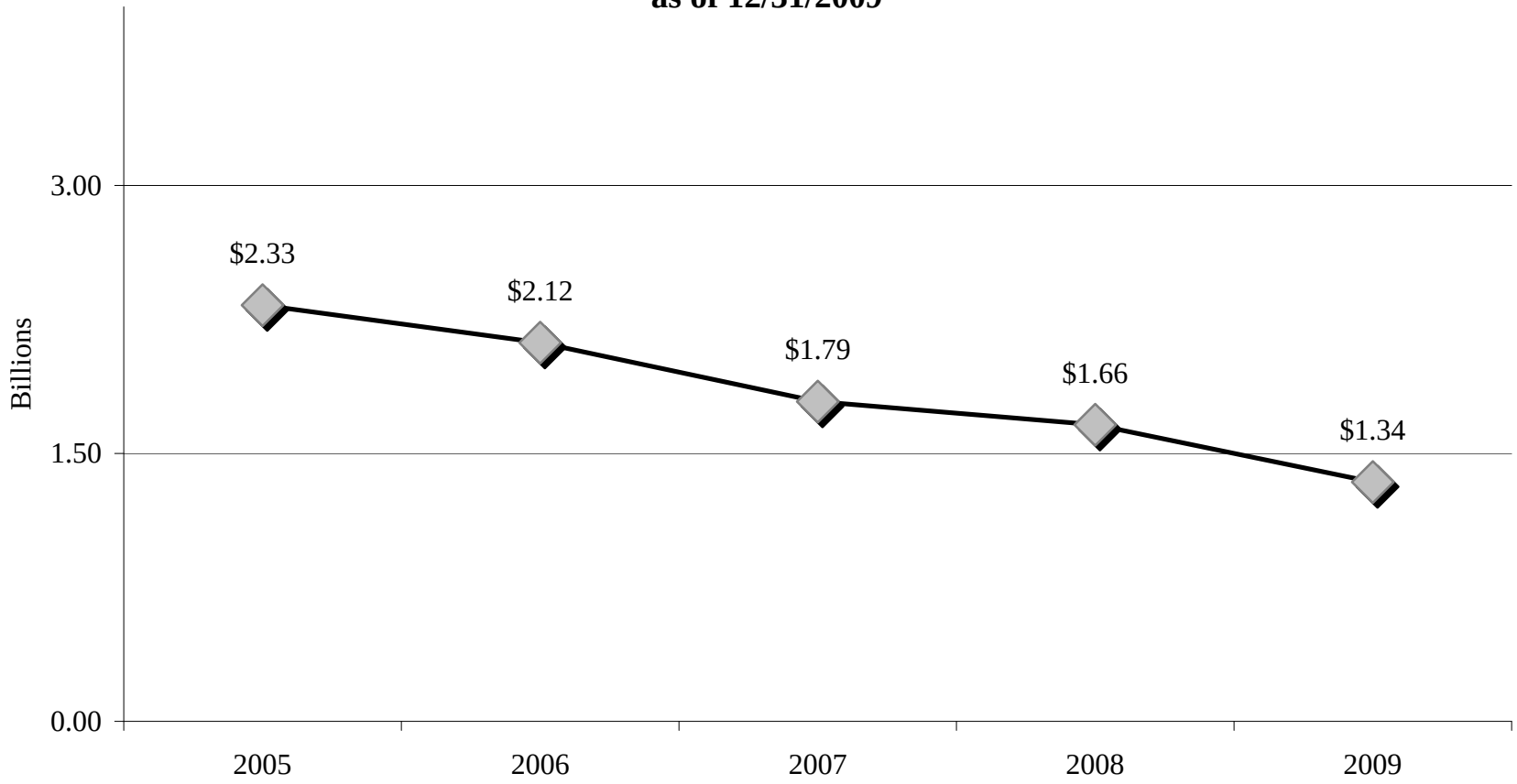
MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND
CASH BASIS
STATEMENT OF OPERATIONS
JANUARY 1, 2010 TO DECEMBER 31, 2010

FUND BALANCE JANUARY 1, 2010			61,394,664.32
ADDITIONS:	HEALTH CARE PROVIDER ASSESSMENT	218,610,576.65	
	INTEREST ON SECURITIES	9,594,741.59	
	ABATEMENT REPAYMENT	2,659.75	
	OTHER REVENUES	523,180.94	
	CASH IN TRANSIT 12/31/10	-2,085,920.00	
	ACCOUNTS PAYABLE @ 12/31/10	259.00	
TOTAL FUNDS AVAILABLE			288,040,162.25
OTHER DEDUCTIONS:			
	2010 CLAIMS PAID - DEC, 2010	146,484,944.00	
	PURCHASE OF ANNUITY	232,383.48	
	CHECK ADJUSTMENT REFUND	37,547.10	
	TOTAL OTHER DEDUCTIONS		146,754,874.58
OPERATING EXPENSES:			
	SALARIES	4,210,540.14	
	PAYROLL TAXES & BENEFITS	1,425,351.91	
	DATA PROCESSING SERVICES	66,811.26	
	LEGAL FEES	8,642,608.09	
	OFFICE SUPPLIES	43,414.34	
	CONSULTANTS (PHYSICIANS & I	615,915.86	
	TELECOMMUNICATIONS	58,455.34	
	REAL ESTATE	565,575.32	
	TRAVEL, TRAINING, DUES, SUBSCRIPTIONS	40,699.73	
	SAP PAYABLES @ 12/31/10	2,010,952.17	
	TOTAL OPERATING EXPENSES	17,680,324.16	
TOTAL DEDUCTIONS:			164,435,198.74
FUND BALANCE DECEMBER 31, 2010			**123,604,963.51**
Carrier Credits Payable			*-1,104,000.00*
2002 Credit Letter Payable			*-4,980,000.00*
Estimated 2011 Fiscal			*117,520,963.51*

History of Assessment Rates and Coverage Limits

Year	Percentage	Policy Effective Date	Coverage Limits (per Occurrence/per Annum) in Millions — Non-hospital: Mcare Limit	Non-hospital: Basic Limit	Non-hospital: Total Aggregate Limits for Mcare & Non-hospital	Hospital: Mcare Limit	Hospital: Basic Limit	Hospital: Total Aggregate Limits for Mcare & Hospital
1976	Greater of 10% or $100	01/13/76 - 12/31/82	$1.0/$3.0	$0.1/$0.3	$1.1/$3.3	$1.0/$3.0	$0.1/$1.0	$1.1/$4.0
1977	Greater of 10% or $100							
1978	nil							
1979	nil							
1980	Greater of 10% or $100							
1981	22%							
1982	38%							
1983	41%	01/01/83 - 12/31/83	$1.0/$3.0	$0.15/$0.45	$1.15/$3.45	$1.0/$3.0	$0.15/$1.0	$1.15/$4.0
1984	52%	01/01/84 - 12/31/96	$1.0/$3.0	$0.2/$0.6	$1.2/$3.6	$1.0/$3.0	$0.2/$1.0	$1.2/$4.0
1985	70%							
1986	87%							
1987	87%							
1988	61%							
1989	59.5%							
1990	50%							
1991	68%							
1992	90%							
1993	91%							
1994	93%							
1995	170% (102% & 68%)							
1996	164%							
1997	75%	01/01/97 - 12/31/98	$0.9/$2.7	$0.3/$0.9	$1.2/$3.6	$0.9/$2.7	$0.3/$1.5	$1.2/$4.2
1998	64%							
1999	59%	01/01/99 - 12/31/00	$0.8/$2.4	$0.4/$1.2	$1.2/$3.6	$0.8/$2.4	$0.4/$2.0	$1.2/$4.4
2000	61%							
2001	61%	01/01/01 - 12/31/02	$0.7/$2.1	$0.5/$1.5	$1.2/$3.6	$0.7/$2.1	$0.5/$2.5	$1.2/$4.6
2002	50%							
2003	43%	01/01/2003 to present	$0.5/$1.5	$0.5/$1.5	$1.0/$3.0	$0.5/$1.5	$0.5/$2.5	$1.0/$4.0
2004	46%							
2005	39%							
2006	29%							
2007	23%							
2008	20%							
2009	19%							
2010	21%							

Office of Mcare
Unfunded Liability Report
as of 12/31/2009



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

Estimation of 2010 Unfunded Liability

The attached is the Executive Summary of a report by PricewaterhouseCoopers LLP that was the basis for determining the value of the unfunded liability at $1.34 billion as of December 31, 2009.

Tab 5

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

ESTIMATION OF 12/31/2009 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 2010

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, 2009, excluding breast implant and pedicle screw exposure, to be approximately $1.34 billion, assuming the limits of Fund coverage proceed as currently contemplated under Act 13. Namely, the mandatory primary coverage limits may increase (with corresponding decreases in the Fund coverage limits) in 2012 and 2015, subject to the Commissioner's assessment of basic insurance coverage capacity. The estimates contained herein assume that basic coverage limits increase in 2012 and 2015, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2015. If the basic coverage limits are not increased in 2012 and 2015, Fund coverage will continue into and beyond 2016 and the total Fund payout would increase accordingly.

During the course of our review, the Fund provided us with a projection of 2010 claim payments of approximately $175 million. The projection is relatively close to the average of the last three claim years, and we have incorporated this information into our projection of the unfunded liability. However, our projections also give some consideration to longer-term trends in claims payments, and the application of projected payment patterns to the projected unfunded liability results in an initial estimate of 2010 claims payment that is higher than expected by the Fund based on information available to date. As such, we have adjusted our initial projected payout of the Unfunded Liability

to reflect the Fund's projection of the 2010 payments of $175 million. We have also assumed that a reduced level of payments, as observed during recent years, will continue into 2011, and have adjusted the projected 2011 payments to $195 million, which is roughly the average of the Fund's expected 2010 payments of $175 million and our initial projection of the 2011 payments of $213 million.

The adjusted payment pattern assumes that the recent decrease in payments has effectively "pushed" the projected payments out in time. As such, the projected 12/31/2009 unfunded liability is unchanged on a nominal basis, but the stream of payments, future years-ending unfunded liability, and present value of the unfunded liability differ.

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

Accident Year	Jan-1 Unfunded Liability	Cost of New Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability	Discounted (4%) Dec-31 Unfunded
2009				1,344,762	1,119,066
2010	1,344,762	206,678	175,000	1,376,440	1,153,582
2011	1,376,440	191,242	195,000	1,372,681	1,156,560
2012	1,372,681	138,878	220,101	1,291,459	1,093,288
2013	1,291,459	101,375	224,944	1,167,891	992,513
2014	1,167,891	78,354	224,429	1,021,816	869,318
2015	1,021,816	19,229	208,481	832,564	710,652
2016	832,564		181,495	651,070	557,583
2017	651,070		152,664	498,406	427,223
2018	498,406		123,409	374,997	320,903
2019	374,997		93,393	281,604	240,346
2020	281,604		68,142	213,462	181,817
2021	213,462		50,585	162,877	138,505
2022	162,877		38,345	124,532	105,700
2023	124,532		29,122	95,410	80,806
2024	95,410		21,709	73,701	62,329
2025	73,701		16,259	57,442	48,564
2026	57,442		12,730	44,712	37,776
2027	44,712		10,028	34,684	29,260
2028	34,684		7,642	27,042	22,788
2029	27,042		5,940	21,102	17,759
2030	21,102		4,729	16,373	13,741
2031	16,373		3,755	12,618	10,535
2032	12,618		2,847	9,770	8,109
2033	9,770		2,107	7,663	6,326
2034	7,663		1,594	6,069	4,985
2035	6,069		1,206	4,863	3,978
2036	4,863		893	3,970	3,244
2037	3,970		671	3,298	2,703
2038	3,298		534	2,765	2,277
2039	2,765		451	2,314	1,917
2040	2,314		383	1,931	1,611
2041	1,931		326	1,604	1,349
2042	1,604		279	1,325	1,124
2043	1,325		242	1,083	926
2044	1,083		211	872	752
2045	872		179	692	603
2046	692		145	547	482
2047	547		122	425	379
2048	425		108	316	286
2049	316		94	222	203
2050	222		78	144	133
2051	144		58	85	80
2052	85		39	47	44
2053	47		26	21	20
2054	21		15	6	5
2055	6		5	1	1
2056	1		1	0	0
		735,757	2,080,518		

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

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

Comparison to Projection as of 12/31/2008

The total expected unfunded liability of $1.34 billion has decreased 18.8% from our December 31, 2008 estimate of $1.66 billion. The breakdown of the change in the undiscounted estimate since December 31, 2008 is shown in the following table:

Rollforward of Estimated Unfunded Liability (000's) from 12/31/2008 to 12/31/2009

		Excess	Section 715		Total
(1)	Prior Estimated Liability	1,078,950	577,100		1,656,051
(2)	Less Prior Estimated DD & PJI	15,945	8,529		24,474
(3)	Prior Estimated Liability Ex. DD & PJI	1,063,005	568,572		1,631,577
(4)	Plus Change in Prior Accident Year Ultimate	(182,160)	(163,563)		(345,723)
(5)	Less Paid During Year	145,584	29,910		175,494
(6)	Plus Accident Year 2009 Ultimate	194,449	20,079	(a)	214,528
(7)	Current Estimated Liability Ex. DD & PJI	929,710	395,178		1,324,888
(8)	Current Estimated DD & PJI	13,946	5,928		19,873
(9)	Current Estimated Liability	943,656	401,106		1,344,762

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

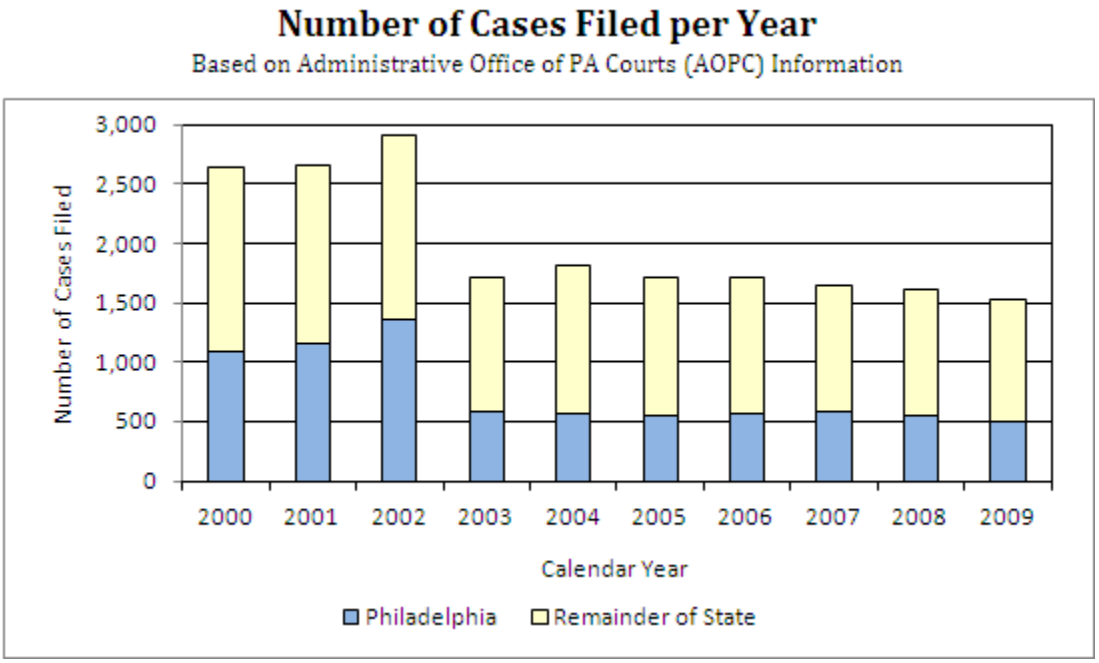
The decrease in the projection is primarily due to the continuation of favorable Fund claim payment trends; our projections give increasing weight to the favorable emerging experience. Based on information gathered by the Administrative Office of Pennsylvania Courts (AOPC), the number of medical malpractice cases filed in Pennsylvania in recent post-Act 13 years (2003 and subsequent) is significantly lower than pre-Act 13 experience (2000/2001). The Fund has also experienced a recent reduction in the number of claims that are closing with payment. Given the consistency and persistency of the reduction in cases filed observed by the AOPC and in the number of claims closed with payment by the Fund, we have included an explicit adjustment to recognize anticipated savings. Further discussion is included in the *Reduction in Claim Activity* section below. Our projections of ultimate loss have decreased by $346 million as compared to the prior projections, as shown in the following table:

Accident Year	Current Selected Ultimate	Prior Selected Ultimate	Change in Selection
1976	47,720,237	47,128,077	592,161
1977	60,082,048	60,320,980	(238,932)
1978	86,485,837	86,890,327	(404,490)
1979	97,835,995	98,051,926	(215,931)
1980	136,059,803	136,361,778	(301,975)
1981	150,794,817	151,199,874	(405,057)
1982	173,765,335	174,254,900	(489,565)
1983	178,675,910	179,400,425	(724,515)
1984	166,928,652	167,599,191	(670,539)
1985	179,481,354	180,443,335	(961,981)
1986	172,113,416	173,019,221	(905,806)
1987	196,821,643	198,049,744	(1,228,101)
1988	217,127,800	218,436,866	(1,309,066)
1989	217,001,458	218,604,177	(1,602,719)
1990	257,042,611	258,408,404	(1,365,793)
1991	294,821,860	294,102,232	719,628
1992	274,678,522	273,144,824	1,533,698
1993	256,319,197	258,144,605	(1,825,407)
1994	295,642,295	296,385,862	(743,566)
1995	324,928,816	325,683,539	(754,723)
1996	313,491,271	317,443,232	(3,951,962)
1997	334,959,523	337,840,920	(2,881,396)
1998	285,903,881	287,220,819	(1,316,938)
1999	247,538,176	254,897,035	(7,358,859)
2000	244,058,020	259,870,076	(15,812,056)
2001	211,527,337	226,259,806	(14,732,470)
2002	172,268,873	192,665,171	(20,396,297)
2003	187,762,461	213,044,232	(25,281,771)
2004	190,594,717	235,499,991	(44,905,274)
2005	206,265,307	261,906,751	(55,641,444)
2006	191,277,108	244,181,434	(52,904,326)
2007	195,297,021	251,387,630	(56,090,609)
2008	206,818,889	239,965,505	(33,146,615)
Total	6,772,090,191	7,117,812,887	(345,722,695)

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 2009 as compared to the pre-Act 13 years 2000 through 2002, with particular concentration in Philadelphia County. The average statewide decrease in cases filed is approximately 40%, with Philadelphia County experiencing an average decrease of approximately

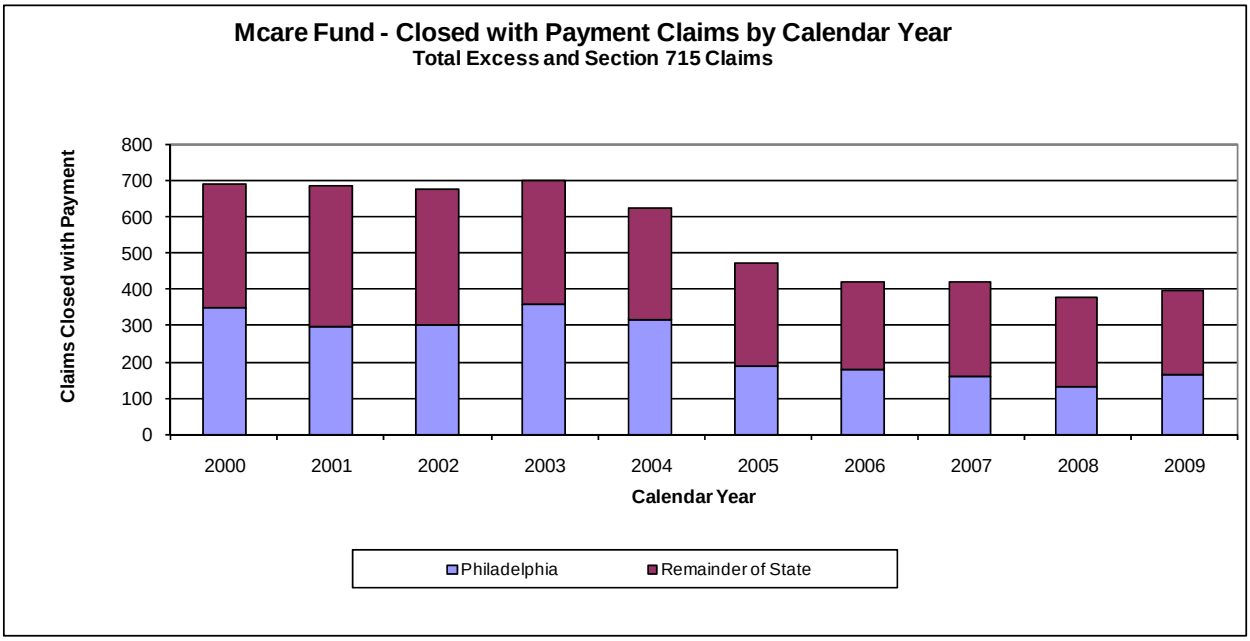
55% and the remainder of the state (ROS) experiencing an average decrease of approximately 30%, as shown below:



Possible causes for the decrease in claims activity for recent years include venue reform (Section 3 of Act 27 of 2002), certificate of merit procedures (Rule of Civil Procedure 1042.3, 2003), and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number of case filings, with a particular concentration in Philadelphia County, is likely a combination of some cases that would have been brought in Philadelphia previously that are now being brought outside Philadelphia (as a result of venue reform) or not at all.

Closed-with-Payment Fund claim statistics provide some corroboration of the information observed by the AOPC, allowing for a time delay between case filing and claim payment. Namely, the number of Fund claims closing with payment fell

dramatically in 2005 through 2009 as compared to prior years. The average statewide decrease in claims closed with payment is approximately 40%, with Philadelphia County experiencing an average decrease of nearly 50% and ROS experiencing an average decrease of approximately 30%, as shown below:



The data compiled by the AOPC and recent Fund claims payment activity are indicative of savings to be realized by the Fund. Although the possibility exists that the reduced number of filings and apparent shift of claims away from Philadelphia may not result in a commensurate level of cost savings, we concluded that the consistency and persistency of the change in claims activity warrants reflection in our estimates. To that end, we reviewed the Fund closed-with-payment activity, making adjustments to reflect the expected effect of changes in the Fund limits of coverage over time for Excess claims. Based on this review, as well as in consideration of the AOPC data and our prior projections, we included an "AOPC Credit" of 35% and 55% within our Philadelphia

projections for Excess claims and Section 715 claims, respectively, and an "AOPC Credit" of 5% and 30% within our ROS projections for Excess claims and Section 715 claims, respectively. These AOPC credits are generally consistent with those used in the prior year for Excess claims and higher than those used in the prior year for Section 715 claims.

Other Recent Legislative Provisions

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

Discounting

As summarized in Summary, Exhibit 1, Sheet 1 the indicated post-Act 13 liability after discounting the Fund's liabilities at a 4% annual rate of interest is approximately $1.12

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%	$1.22 billion
3%	$1.17 billion
4%	$1.12 billion
5%	$1.07 billion

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

Calculation of 2010 Mcare Assessment Rate

The Executive Summary of the study produced by PricewaterhouseCoopers LLP that serves as the basis for setting the 2010 Mcare Assessment rate at 21% in order to collect $208,807,871 in assessment dollars.

Tab 6

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

2010 YEAR ASSESSMENT CALCULATION
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

October 2009

INTRODUCTION

Purpose

The Commonwealth of Pennsylvania established the Medical Care Availability and Reduction of Error Fund[1] (the Fund) on January 13, 1976 as part of its effort to make professional liability insurance available at a reasonable cost and to provide for prompt and fair compensation to persons sustaining injury due to the negligence of a health care provider.

The Fund currently provides excess coverage (to varying historical limits) for health care providers that have exhausted their primary limits. The Fund also provides first dollar coverage, including defense, for certain claims reported four or more years after the occurrence event (i.e. those that qualify for Section 715[2] coverage).

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

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

PricewaterhouseCoopers LLP (PwC) was engaged to assist the Fund in the determination of the assessment rate to be applied for the 2010 year, in accordance with the provisions of Act 13.

[1] Pursuant to the provisions of Act 13 of 2002 (hereafter, "Act 13"), Medical Care Availability and Reduction of Error (Mcare) Fund (hereafter, "the Fund") assumed the rights of the Medical Professional Liability Catastrophe Loss Fund on October 1, 2002.
[2] Namely, Section 715 of Act 13. These were previously known as Section 605 claims. Fund coverage for these claims ceased for claims occurring after December 31, 2005, and is subject to a number of other conditions, such as the "continuing course of treatment" provision.
[3] Notably, Act 111 of 1976 and Act 135 of 1996.
[4] Although increases in the basic insurance coverage are scheduled, the actual timing of the increases will be determined after an assessment of market conditions by the Insurance Commissioner.

Distribution and Use

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

The supporting exhibits are an integral part of this report; as such, the report must only be released in its entirety. Third parties reviewing this report should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein that would result in the creation of any duty or liability by PwC to the third party. PwC is available to answer questions, subject to the Fund's permission and at the Fund's expense, regarding this report.

Conditions and Limitations

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

- assessments, operating expenses, and other income and expense information for claim year 2009;
- claim year 2009 loss payments expected to be made on or about December 31, 2009;
- policy year 2006, 2007, and 2008 assessments, segregated by: primary policy type, product code, county code, and specialty code;
- several recent JUA filings, JUA underwriting manuals, and Fund assessment manuals;
- discussions with the Fund and the Department regarding Act 13 and the legislative intent of provisions relevant to the assessment calculation; and
- knowledge obtained through our prior experience with the Fund.

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

The projected 2010 prevailing primary premium, which is a primary component of the 2010 assessment rate, is an estimate. As such, this value is subject to variability. While we believe the estimate is reasonable based on the information available, there can be no assurance that the actual prevailing primary premium will not differ materially from what we have projected, generating either more or less assessment than that projected herein.

Act 44 of 2003 established the Health Care Provider Retention Program, also known as the Abatement Program, to provide a form of financial relief from the Mcare assessments. The Abatement Program initially provided relief to eligible[5] doctors and certified midwives. Podiatrists were added to the Abatement Program in 2005, and nursing homes were added in 2006. We understand that legislation has not currently been enacted to extend an abatement program beyond 2007. Should an abatement be approved for 2010, the net 2010 assessment remittances may be less, perhaps significantly so, than that needed for operating expenses and claim payments during 2010.

As mentioned above, although increases in the basic insurance coverage are scheduled pursuant to Act 13, the actual timing of the increases will be determined after an assessment of market conditions by the Insurance Commissioner. We understand that a decision regarding the availability of additional medical malpractice basic insurance coverage capacity in Pennsylvania, pursuant to Section 711(d)(3) of Act 13 of 2002, is still pending. Our calculations assume that

[5] Conditions for eligibility are described in the Fund's assessment manuals.

the Fund assessment is levied against prevailing primary premium based on the JUA's filed occurrence rates at $500,000 per claim.

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.

2010 Assessment Rate

Exhibit 1 presents the indicated 2010 assessment rate of 21%. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2010 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 2010 prevailing primary premium. Hence the projection of 2010 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2010 payment obligations of the Fund and the 2010 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2006, 2007, and 2008 assessments as the basis for our estimate of the 2010 prevailing primary premium.

Since the 2010 assessment rate is based largely on the Fund's obligations for the 2009 claim year, any significant change in Fund's claim or expense obligations from 2009 to 2010 may result in a significant change to the Fund's year-ending surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2010. To the extent the funds available in 2010 are insufficient to meet the Fund's 2010 obligations, additional funding or borrowing may be required.

Differences between projected 2010 prevailing primary premium and actual 2010 prevailing primary premium will result in a difference between projected and actual assessment revenue. This variable contributes additional uncertainty regarding the degree to which the funds available to the Fund will be sufficient to meet its 2010 obligations.

ANALYSIS

2010 Assessment Rate

The Act outlines the four categories to be funded via the assessment. The aggregate assessment for 2010[6] 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 2010 prevailing primary premium.

Claim Settlements

The largest component of the 2010 assessment is the amount of claim settlements for the Fund's 2009 claim year ending August 31, 2009. These claims are payable on or about December 31, 2009. The Fund expects that payments for the 2009 claim year will total approximately $178.2 million.

Fund Operating Expenses

Operating expenses paid of $11.6 million for claim year ending August 31, 2009 was provided by the Fund, which includes Fund overhead expenses and legal expenses largely associated with the defense costs of Section 715 claims.

Principal and Interest on Moneys Transferred

The Fund had no moneys outstanding during the claim year ending August 31, 2009, and does not currently expect to require borrowing to meet its 2009 obligations.

Target Reserve

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

[6] We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2010.

Prevailing Primary Premium

The Fund provided unabated assessment and policy count data for policies effective in 2006, 2007 and 2008. 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[7]). Assessment collections for tail policies are not expected to be material in the aggregate for policy year 2010. As such, our projections of policy year 2010 assessments exclude assessments collected in 2006, 2007 and 2008 arising from tail policies.

Product Code

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

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

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

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

County Code

The field indicates the rating county of the exposure.

Specialty Code

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

The projected 2010 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 2006 assessments have been adjusted for changes effective 01/01/2007, 01/01/2008, 01/01/2009, and 01/01/2010. This calculation is included in its entirety under separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2007 assessments have been adjusted for changes effective 01/01/2008, 01/01/2009, and 01/01/2010. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2008 assessments have been adjusted for changes effective 01/01/2009 and 01/01/2010. 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 01/01/2007, 01/01/2008, 01/01/2009, and 01/01/2010 are as follows:

Changes Effective 01/01/2007

Note that the changes effective 01/01/2007 discussed below apply only to the calculation based on the 2006 assessment (Appendices A / Excerpts A). The 2007 and 2008 assessments implicitly reflect these changes and do not require modification for changes effective 01/01/2007.

Base Rate Change

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

Class Rate Changes

The JUA modified the class rates for the following classes:

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

County / Territory Changes

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

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

Specialty Changes

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

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

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

Changes Effective 01/01/2008

Base Rate Change

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

Class Rate Changes

The JUA modified the class rates for the following classes:

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

County / Territory Changes

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

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

Specialty Changes

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

as 01059 in our 2008 projection. Based on our review of 2008 data, we continue to believe this simplifying assumption is reasonable in the context of the prevailing primary premium projection.

Changes Effective 01/01/2009

Base Rate Change

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

Class Rate Changes

The JUA modified the class rates for the following classes:

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

JUA Class	Impact
100	+5.0%
900	+5.0%

County / Territory Changes

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

Non-Institutional Changes		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	change Terr 3 rel.	-5.1%
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-8.0%
Delaware (23)	change Terr 5 rel.	-8.0%
Blair (07), Columbia (19), Crawford (20), Dauphin (22), Erie (25), Lackawanna (35), Lawrence (37), Lehigh (39), Luzerne (40), Mercer (43), Monroe (45), Northampton (48), Schuylkill (54)	no change Terr 6 rel.	0.0%
All Other	change Terr 2 rel.	-8.0%

Specialty Changes

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

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

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

Changes Effective 01/01/2010

Rate Change

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

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

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

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

Our methodology does not explicitly recognize that the rating procedure will be changing for these health care providers. However, given the relative size of the prevailing primary premium for affected health care providers (less than 3% of the total prevailing primary premium), we believe the impact of this change is not significant in the overall context of the prevailing primary premium.

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	+4.9%
007	+5.0%
010	-3.9%
011	+9.9%
012	+5.0%
020	+5.0%
022	-4.3%
030	-5.0%

JUA Class	Impact
035	+5.0%
050	-5.0%
060	-5.0%
070	-5.0%
080	-5.0%
090	-5.0%
100	+5.0%
120	-5.0%
900	+5.0%

County / Territory Changes

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

Non-Institutional Changes		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	No change Terr 3 rel.	0.0%
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-9.9%
Delaware (23)	change Terr 5 rel.	-6.7%
Blair (07), Columbia (19), Crawford (20), Dauphin (22), Erie (25), Lackawanna (35), Lawrence (37), Lehigh (39), Luzerne (40), Mercer (43), Monroe (45), Northampton (48), Schuylkill (54)	change Terr 6 rel.	-3.0%

Non-Institutional Changes		
County (County Code)	Change	Impact
All Other	change Terr 2 rel.	-5.4%

Specialty Changes

Specialty changes that resulted in a class change are listed below. Note that the impact is relative to the 2009 rates for Territory 1. The impact includes the impact of any class changes filed, but excludes any filed changes to territory relativities.

Specialty Code	Specialty	Change	Impact
00608	Hemotology - No Surgery	move to class 00508	-25.4%
00656	Utilization Review	move to class 00556	-25.4%
00634	Administrative Medicine - No Surgery	Move to class 00534	-25.4%
00637	Physicians - Practice Limited to Acupuncture (other than acupuncture anesthesia)	Move to class 00537	-25.4%
00682	Pharmacology - Clinical	Move to class 00582	-25.4%
00742	Nephrology - No Surgery	Mover to class 01142	-14.2%
01049	Nuclear Medicine - No Surgery	Move to class 00649	-37.7%
01034	Occupational Medicine - Including MRO or Employment Physicals	Move to class 00624	-37.7%
01013	Orthopedics - No Surgery	Move to class 00613	-37.7%
02055	Ophthalmology - Surgery	Move to class 01755	-5.7%
02011	Neurology - Excluding Major Surgery	Move to class 02511	+9.4%
02040	Infectious Disease - Excluding Major Surgery	Move to class 02540	+9.4%

Specialty Code	Specialty	Change	Impact
03022	Cardiology - Including Right Heart or Left Heart Catheterization	Move to class 02223	-9.6%

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

Results

The indications for the 2010 prevailing primary premium are $0.996 billion based on 2006 remittances, $0.989 billion based on 2007 remittances, and $1.002 billion based on 2008 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2006), Excerpt B (2007), and Excerpt C (2008). 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 2010 prevailing primary premium of $0.995 billion.

Note, however, that this projection may vary from the actual 2010 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 2009 and 2010;
- shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2009 and 2010; and
- changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2009 and 2010.
- additional recording of data, notably for 2008, where policy adjustments and late reported assessments will cause the assessment data to change. The year-over-year increase in 2007 data was less than 1%.

Note that an abatement program has not yet been extended to 2008 through 2010. It is not clear at this time what impact, if any, assessment abatements have on the size, mix, and average effective date of the provider population, and in turn, the prevailing primary premium. This subjects the prevailing primary premium estimate for 2010 to additional uncertainty.

Act 13 also instituted other changes that may impact the prevailing primary premium, including the provisions of Section 712(g), which allow the Fund to increase the prevailing primary premium of a health care providers based on the health care provider's Fund claims experience. The Fund has previously implemented experience rating of hospitals, but adjusted the prevailing primary premium of non-hospitals for the first time during 2007. Non-hospital experience rating adjustments were applied to a relatively limited number of health care providers, and we understand that the Fund has presently ceased applying experience rating adjustments to non-hospital health care providers. As such, we have not attempted to measure the impact of this program.

2010 Assessment Rate

The cost components of the assessment total $208.8 million. Given the 2010 prevailing primary premium projection of $0.995 billion, the indicated 2010 assessment rate is 21%.

Since the 2010 assessment rate is based largely on the Fund’s obligations for the 2009 claim year, any significant change in Fund’s claim or expense obligations from 2009 to 2010 may result in a significant change in the year-ending December 31 surplus or deficit. This surplus or deficit will also be impacted by the level of external funding made available to the Fund during 2010 and the degree to which 2010 assessments are abated, if at all. To the extent that funds available in 2010 are insufficient to meet the Fund's 2010 obligations, additional funding or borrowing will be required.

Change from Prior

The indicated 2010 assessment rate of 21% is higher than the 2009 assessment rate of 19%. The increase in the assessment rate is primarily the result of the decrease in the projected prevailing primary premium resulting from the decrease in the filed JUA rates. The projected policy year 2010 projected prevailing primary premium of $0.995 billion has decreased from the 2009 projected prevailing primary premium of $1.090 billion, driven by the changes to the JUA rates described above. The 2009 and 2010 assessment rate calculations are summarized below.

		2010	2009	Assessment Rate Impact
(1)	Prior Claim Year Claims Settled	178,236,910	173,892,874	0%
(2)	Prior Claim Year Operating Expenses	11,588,427	11,764,894	0%
(3)	Target Reserve	18,982,534	18,565,777	0%
(4)	Assessment Costs, (1)+(2)+(3)	208,807,871	204,223,545	0%
(5)	Projected Prevailing Primary Premium	995,000,000	1,090,000,000	2%
(6)	Indicated Assessment Rate, (4) / (5)	**21%**	**19%**	**2%**

QUALIFICATIONS of PwC ACTUARY

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

EXHIBITS

Pennsylvania Medical Care Availability and Reduction of Error Fund

Indicated 2010 Assessment Rate

(1)	Claim Year Ending 08/31/2009 Claims Settled	178,236,910
(2)	Claim Year Ending 08/31/2009 Operating Expenses	11,588,427
(3a)	Claim Year Ending 08/31/2009 Principal and Interest Paid or Payable	-
(3b)	Claim Year Ending 08/31/2009 Borrowing Transfers	-
(4)	Target Reserve	18,982,534
(5)	2009 Assessment Costs (5) = (1)+(2)+(3a)+(3b)+(4)	208,807,871
(6)	Projected Policy Year 2010 Prevailing Primary Premium	995,000,000
(7)	Indicated 2010 Assessment Rate (7) = (5) / (6)	**21%**

Notes:

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

Pennsylvania Medical Care Availability and Reduction of Error Fund

Projected 2010 Prevailing Primary Premium

(1) Projection Based on 2006 Assessment Remittances	992,407,801
(2) Projection Based on 2007 Assessment Remittances	985,165,782
(3) Projection Based on 2008 Assessment Remittances	998,514,282
(4) Projected 2010 Prevailing Primary Premium	995,000,000

Notes

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

Calculation and Application of 2010 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

2010 EXPERIENCE MODIFICATION FACTORS
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

December 2009

INTRODUCTION

Purpose

The Commonwealth of Pennsylvania established the Medical Professional Liability Catastrophe Loss Fund[1] through the act of October 15, 1975 (P.L. 390, No. 111) as part of its effort to make professional liability insurance available at a reasonable cost and to provide for prompt and fair compensation to persons sustaining injury due to the negligence of a health care provider. Section 712(g)(4) of Act 13 of 2002 (Act 13), amends Section 701 of the October 1975 Act (as amended) such that:

> *"The applicable prevailing primary premium[2] of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustment shall be based on the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk, and kind within the same defined region during the past five most recent claims periods."*

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

Distribution and Use

This report was prepared for internal use by the Fund's management, including the Pennsylvania Insurance Department (the Department). We understand that the Fund may release this report to

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

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

the Hospital Association of Pennsylvania. Other use or further distribution of this report is not authorized without prior written approval of PwC.

The supporting exhibits are an integral part of this report; as such, the report must only be released in its entirety. Third parties reviewing this report should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein that would result in the creation of any duty or liability by PwC to the third party. PwC is available to answer questions, subject to the Fund's permission and at the Fund's expense, regarding this report.

Conditions and Limitations

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

- Fund payment information by hospital by claim year for the claim years ending 2005 through 2009;
- Assessments by hospital by policy year for the policy years ending 2006 through 2009, separately identified by policy type (occurrence, claims-made plus[3], claims-made, or tail);

The calculations in this report rely heavily on the accuracy of the Fund payment and assessment data provided. We have not audited this data but have reviewed the data provided for reasonableness. Any changes to the data may require modification to the estimates in this report.

The 2009 assessment has been estimated[4] for each of those hospitals that have not yet remitted. As estimates, these values are subject to variability. Approximately 21% of hospitals have

[3] A claims-made plus policy is one in which the tail exposure is pre-funded through the annual policy premium.
[4] The procedure used to estimate the 2009 assessment for those who have not yet remitted is described in the ANALYSIS section below. A list of additional data adjustments is included as Appendix B.

required estimation of their 2009 assessment. While we believe the projections herein are reasonable based on the information available, there can be no assurance that the actual 2009 assessment will not differ, perhaps significantly, from what we have projected.

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

Database

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

Within our analysis, hospitals are sorted into bands according to the average implied prevailing primary premium (AIPPP) at 2009 levels, based on 2007, 2008, and (if available) 2009 baseline policy year assessments[5]. This increases the extent to which the Plan is normalized for *"class, size, risk, and kind"*. The bands are defined as follows[6]:

1) Band 1 Hospitals (AIPPP less than $380,000)
2) Band 2 Hospitals (AIPPP between $380,000 and $736,000)

[5] Historical baseline policy year assessments (defined in the ANALYSIS section below) are adjusted to a 2009 level by dividing the assessment by the appropriate assessment rate and applying increased limits factors and base rate changes as filed by the JUA.

[6] Note that these band definitions are generally consistent with those selected for 2009 (based on 2008 AIPPP), adjusted for JUA changes filed for 2009.

3) Band 3 Hospitals (AIPPP between $736,000 and $1,520,000)
4) Band 4 Hospitals (AIPPP between $1,520,000 and $3,100,000)
5) Band 5 Hospitals (AIPPP greater than $3,100,000)

For those hospitals whose band assignment changed from last year, the underlying policy data was examined to verify that the change in assignment did not appear unwarranted.

Based on information provided by the Fund, the assessment and payment information has been combined for hospitals that have merged. Data for hospitals that have simply closed is excluded from the analysis. Data for hospitals with insufficient years of experience has also been excluded from the analysis. The result is 207 hospitals for which experience modification factors were determined.

Qualifications of PwC Actuaries

Timothy J. Landick, Director, and John F. Gibson, Principal, are members of the American Academy of Actuaries and Fellows of the Casualty Actuarial Society and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

EXECUTIVE SUMMARY

This section provides a synopsis of the key findings 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 207 experience modification factors as calculated in Exhibit 1 fall into the following ranges:

Distribution		
From	To	Count
	80.0%	0
80.0%	85.0%	115
85.0%	90.0%	18
90.0%	95.0%	24
95.0%	100.0%	12
100.0%	105.0%	16
105.0%	110.0%	3
110.0%	115.0%	5
115.0%	120.0%	4
120.0%		10
Total All Rated Hospitals		207

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

Revenue Impact

The 207 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 2008 baseline assessments. When applied to the 2009 baseline assessments, many of which are estimates, the 2009 modified assessment is approximately 0.2% lower than the 2009 baseline

assessment. As such, we do not expect a significant revenue impact when these factors are applied in 2010.

Comparison to 2009 Experience Modification Factors

Of the 207 experience modification factors computed herein, two are for hospitals that have been rated for the first time. Of the remaining 205 modification factors, 153 are within 5% and 183 are within 7.5% of the 2009 filed experience modification factors. Of the 200 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 150 are within 5% and 180 are within 7.5% of their 2009 filed experience modification factors.

Of the 52 experience modification factor changes greater than 5%, 19 are Band 2 hospitals, whose selected a priori modification factor has decreased nearly 6% since the prior review and 1 arises from a hospital whose band assignment has changed from last year. Similarly, of the 22 experience modification factor changes greater than 7.5%, 2 are Band 2 hospitals and one arises from a hospital 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.

A comparison of the 2010 experience modification factors to the 2009 experience modification factors for hospitals that have been experience rated for 2010 is included in the attached Summary Exhibit.

ANALYSIS

Methodology

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

1) Compiling the Fund payment data for each hospital for each claim year 2005 through 2008;
2) Estimating and compiling the baseline assessments for each hospital for each policy year 2006 through 2009;
3) Calculating a rate of recoupment[7] for each hospital for each year and for each hospital band for each year;
4) Calculating the four relative rates of recoupment for each hospital showing the ratio of the hospital rate of recoupment to the total hospital rate of recoupment for each year and weighting these four relative rates of recoupment together to estimate an average relative rate of recoupment (weighted rate) for the individual hospital;
5) Determining appropriate *a priori* modification factors;
6) Determining an appropriate credibility weighting procedure and credibility weighting the hospital weighted rate with its band's *a priori* modification factor; and
7) Computing experience modification factors that lie within the bounds prescribed by Act 13 and that are revenue neutral.

Each of these steps is described below.

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

Compiling Fund Payment Data (Exhibits 5 and 9)

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

Compiling Policy Year Assessment Data (Exhibits 4 and 8)

The Fund provided information by hospital and type of policy (occurrence, claims-made plus, claims-made, or tail). Policy year non-tail assessment data for 2006 through 2009 is employed in this analysis. In Exhibit 8, an adjustment is made to the assessments provided by the Fund in order to derive the baseline assessment that is used in the experience modification computation. Namely, the assessments are adjusted to remove the impact of the charged experience modification factors. This adjustment is required because the experience modification factor is applied to the unmodified assessment; as such, it is necessary to compute each hospital's experience relative to its historical unmodified assessment.

This baseline assessment data is then sorted on Exhibit 4 by hospital by policy year for policy years 2006 through 2009[8]. For policy year 2009, information was provided by the Fund for those hospitals who have remitted their 2009 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2009 assessment, the 2009 baseline assessment is estimated as the average of the 2007 and 2008 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes.

[8] Note that tail assessments are also removed.

Calculating Yearly Rates of Recoupment (Exhibit 3)

The Fund operates on a recoupment basis. Namely, one policy year's assessment is meant to recoup the prior claim year's payments, operating expenses, and other costs. As such, there is an expected relationship between a given claim year's payments and the *subsequent* policy year's assessments.

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 2005 through 2009. However, given the expected relationship between a claim year's payments and the *subsequent* policy year's assessments, use of the claim year ending 2009 data would require estimation of each individual hospital's 2010 assessment. We did not feel that it would be appropriate to estimate the 2010 assessments for each of the 207 rated hospitals, especially in light of the estimation required for the 2009 assessments. As such, the expected 2009/2010 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 2009/2010 experience when selecting the *a priori* experience modification factors (described below) for each band, assuming that the relative differences between the 2009 and 2010 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 2005 through 2008) to the baseline policy year assessment data for the subsequent policy year (2006 through 2009). 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 2005/2006 through 2008/2009, 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 2009/2010 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 2009/2010 modification factor is based on a review of the various indications. As was the case in prior years, we have kept our selected relativities in a tighter range than would otherwise be indicated for a number of reasons. The large number of observations for some bands may cause the calculated credibility to be higher than the "true" credibility. Furthermore, the Plan should produce relatively stable results from year-to-year while being responsive to changes in the underlying experience. Since experience from one year to the next may vary, too much emphasis on the raw indications may tend to emphasize responsiveness at the sacrifice of stability. Lastly, since Act 13 requires final modification factors not to exceed +/-20%, we have selected a priori modification factors within this range.

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

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

For Band 2, we elected to change the a priori modification from -12.5% to -17.5%. Long-term experience for Band 2 hospitals has been favorable relative to indications which led to this change. We will continue to monitor band experience and adjust a priori factors accordingly in future reviews.

Determining an Individual Hospital Credibility Weighting Procedure (Exhibit 7)

Actuarial Standard of Practice No. 25 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' 2008 policy year prevailing primary premiums, adjusted for the JUA's 2009 rate change. To calculate P, we divided the Fund's 2008 baseline policy year assessment by the Fund's 2008 assessment rate of 20.0%. We then adjusted the total to reflect the JUA's filed rate change of -4.4% for policy year 2009. Policy periods were annualized where we observed that the 2008 policy year data did not represent an annual policy term.

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

1) 2005/2006, 2006/2007, and 2007/2008 to predict 2008/2009

2) 2005/2006, 2006/2007, and 2008/2009 to predict 2007/2008

3) 2005/2006, 2007/2008, and 2008/2009 to predict 2006/2007

4) 2006/2007, 2007/2008, and 2008/2009 to predict 2005/2006

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

	Current Calculations		Prior Calculations	
Band	Selected K	Implied Avg Z	Selected K	Implied Avg Z
Band 1	40,000,000	0.4%	40,000,000	0.4%
Band 2	20,000,000	2.7%	30,000,000	1.9%
Band 3	10,000,000	9.3%	10,000,000	9.8%
Band 4	8,000,000	20.9%	8,000,000	21.0%
Band 5	6,000,000	46.4%	7,000,000	43.3%

As shown above, the average credibility is generally similar to that of last year. Individual hospital experience is generally given limited credibility: the average Band 1 hospital receives 0.4% credibility and the average Band 5 hospital receives 46.4% credibility.

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

Computing Experience Modification Factors (Exhibit 1)

To achieve a revenue neutral impact on 2010 assessments, we estimated modification factors that are revenue neutral based on the 2008 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2010 assessments[9]. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance[10] adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

[9] As a test, we applied the modification factors to the 2009 baseline policy year assessments, approximately 21% of which are estimates. The resulting modified assessments were approximately revenue neutral.
[10] The adjustment is required to achieve a revenue neutral impact.

APPENDIX A

Application of the Experience Modification Plan

The following discussion addresses several issues that may arise in applying the experience modification factors calculated in the report and provides our recommendation for resolving these issues.

The Actual 2009 Assessment is Different from that Estimated in the Report

As discussed in the ANALYSIS section, the 2009 assessment for those hospitals that have not yet remitted has been estimated. Approximately 21% of the 207 rated hospitals have required such estimation. To the extent that the actual 2009 assessments differ from that included in this report, the experience modification factors are impacted, as follows:

1) the individual hospitals' 2008/2009 rates of recoupment will change;
2) the band 2008/2009 rates of recoupment will change;
3) the overall hospital 2008/2009 rate of recoupment will change, impacting *each* hospital's and *each* band's relative rate of recoupment;
4) the individual hospitals' weighted average relative rate of recoupment will change;
5) *a priori* modification factors may be impacted;
6) the credible experience modifiers will change; and
7) the off balance will be impacted.

While the final experience modification factors would change with differences between the actual and the expected 2009 assessments, we expect the end result of these changes to be relatively insignificant, based on the observations below.

1) The individual hospitals' 2008/2009 rates of recoupment will change according to the

amount of misestimation of the 2009 assessment, but only for those hospitals with Fund payments in 2008. Any hospital with $0 of 2008 Fund payments will maintain its 0% recoupment rate.

2) The band 2008/2009 rates of recoupment will change, but this change will be tempered by the band members whose data has not changed.
3) The overall hospital 2008/2009 rate of recoupment will change, but this change will also be tempered by the hospitals whose data has not changed.
4) The individual hospitals' weighted average relative rate of recoupment will change, but the impact is mitigated since 2008/2009 comprises only 30% of the weighted average rate.
5) It is unlikely that *a priori* modification factors will be impacted since our selections have been based on several years of data and generally lie within the range of the raw indications.
6) The individual hospital data is given generally little credibility. This will further mitigate any change to the individual hospital weighted rate. This, combined with the unlikelihood of a change to the *a priori* modification factors, should result in only minor impacts to the "credible modifiers".
7) Since the Plan is revenue neutral, any impact on the "credible modifiers" will impact the off balance. The change in the off-balance will offset any change in the expected aggregate 2010 revenue change resulting from the change in (6).

As such, we recommend that the experience modification factor should not be recalculated for those hospitals whose actual 2009 assessment differs from that included in the calculation.

Non-Annual Assessment Included in the Computation

Cases may arise where the baseline policy year assessment for a healthcare provider is based on a non-annual assessment. In these cases, there is a distortion in the rate of recoupment, which can flow through the calculation similarly to the case described above. Like the case described above, we do not expect such distortion to be significant. If the non-annual assessment results in a distortion to the baseline policy year assessment, the additional possibility arises that a hospital may be assigned to a different band than would have otherwise been assigned. As mentioned above, cases where a band assignment changed from last year were investigated to ensure that such changes did not appear to be unwarranted.

Individual vs. Multi-Hospital Assessment Payment

We have attempted to combine the historical experience of those hospitals that have merged so that the experience modification factor is based on the experience of the current operation. Potential issues that may arise as a result of this include:

Members of a Group Pay Separately

In the event that hospitals belong to a group (remitting under a single license number and receiving a single limit of coverage) but the members remit the assessment separately, the experience modification factor of the group should be applied to the prevailing primary premium of each individual member.

Separately Rated Hospitals Remit Together

If several separate hospitals (with separate license numbers and limits of coverage) remit a combined assessment, there may be multiple modifiers applicable to the prevailing primary premium. The applied modifier would ideally be the weighted average modifier, using the prevailing primary premium of each hospital as the weights. This produces the same result as

would the separate application of each modifier. In the unlikely event that it is impossible to determine the weighted average modifier as described above, the Fund should determine a proxy weighting that would be expected to produce a similar result. This proxy weighting should consider the hospital exposures and territory to the extent such information are available.

Other Merger Issues

Entities that merged in or subsequent to the experience period and now remit a single assessment and receive a single limit of coverage, but were not experience rated as such, should be re-rated according to the experience of the merged entity. Similarly, entities rated as a single group that, in fact, remit separate assessments and receive separate limits of coverage should be re-rated according to the experience of the individual entity. Please let us know if these situations arise and we can discuss this further.

2010 Mcare Paid Claims by Region

Eastern			Central			Western			Other
County			County			County			
Bucks	Lehigh	Philadelphia	Adams	Lancaster	Tioga	Allegheny	Elk	Potter	Includes all other states and the United States District Courts where an Mcare defendant was involved.
Chester	Montgomery		Berks	Lebanon	Union	Armstrong	Erie	Somerset	
Delaware	Northampton		Bradford	Luzerne	Wayne	Beaver	Fayette	Venango	
			Carbon	Lycoming	Wyoming	Bedford	Forest	Warren	
			Centre	Mifflin	York	Blair	Greene	Washington	
			Clinton	Monroe		Butler	Indiana	Westmoreland	
			Columbia	Montour		Cambria	Jefferson		
			Cumberland	Northumberland		Cameron	Lawrence		
			Dauphin	Perry		Clarion	McKean		
			Franklin	Pike		Clearfield	Mercer		
			Fulton	Schuylkill		Crawford			
			Huntingdon	Snyder					
			Juniata	Sullivan					
			Lackawanna	Susquehanna					
Region Paid Claims		$88,496,871			$15,151,943			$37,501,130	$ 5,335,000
Percent of Region to Total Paid Claims		60.41%			10.34%			25.60%	3.64%

Total Paid Claims:	$146,484,944

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**
2006	$ 209,522,349	423	$ 495,325	322	$ 650,691
2007	$ 191,365,811	422	$ 453,473	308	$ 621,318
2008	$ 173,892,874	377	$ 461,254	279	$ 623,272
2009	$ 178,236,910	396	$ 450,093	292	$ 610,400
2010	$ 146,484,944	329	$ 445,243	255	$ 574,451

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

Summary of Annual Fund Claim Payments by Health Care Provider Group

2001-2010

	Individuals MD's, DO's, Podiatrists Certified Nurse Midwives				Medical Corps				Institutions Hospitals, Nursing Homes Birth Center, Primary Care Centers				Totals	
Year	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
2001	529	76%	$ 237,838,807	74%	26	4%	$ 17,586,312	5%	137	20%	$ 66,244,013	21%	692	$ 321,669,132
2002	496	74%	$ 242,058,227	70%	21	3%	$ 15,287,490	4%	157	23%	$ 90,702,013	26%	674	$ 348,047,730
2003	495	71%	$ 261,412,315	69%	33	5%	$ 21,352,127	6%	173	25%	$ 95,956,330	25%	701	$ 378,720,772
2004	450	73%	$ 235,414,423	73%	18	3%	$ 10,448,473	3%	152	25%	$ 74,476,793	23%	620	$ 320,339,689
2005	337	72%	$ 171,099,732	74%	20	4%	$ 10,068,307	4%	114	24%	$ 51,420,701	22%	471	$ 232,588,740
2006	304	72%	$ 151,833,293	72%	26	6%	$ 14,186,262	7%	92	22%	$ 43,502,794	21%	422	$ 209,522,349
2007	273	65%	$ 123,762,853	65%	25	6%	$ 12,560,972	7%	124	29%	$ 55,041,986	29%	422	$ 191,365,811
2008	256	68%	$ 116,967,358	67%	16	4%	$ 8,165,387	5%	105	28%	$ 48,760,129	28%	377	$ 173,892,874
2009	285	72%	$ 127,713,538	72%	14	4%	$ 9,012,513	5%	97	24%	$ 41,510,859	23%	396	$ 178,236,910
2010	194	59%	$ 87,936,023	60%	10	3%	$ 5,592,973	4%	125	38%	$ 52,955,948	36%	329	$ 146,484,944

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2010 Claims Payment by Commercial Carrier and Self-Insurer

Company Code	Total Fund Payments	
S10	$	3,000,000
S12	$	500,000
S41	$	500,000
S43	$	750,000
S57	$	500,000
S60	$	400,000
S62	$	500,000
003	$	11,007,385
011	$	1,600,000
020	$	500,000
031	$	9,520,502
032	$	2,130,000
045	$	700,000
055	$	125,000
067	$	7,770,531
086	$	675,000
093	$	2,325,000
119	$	394,917
121	$	700,000
126	$	661,031
129	$	7,700,000
136	$	2,325,000
139	$	500,000
144	$	5,675,000
145	$	7,200,000
155	$	13,200,000
156	$	5,860,000
162	$	5,693,463
184	$	2,500,000
194	$	1,000,000
196	$	1,200,000
197	$	3,700,000
199	$	1,765,000
202	$	5,075,000
207	$	12,209,500
208	$	912,615
211	$	3,750,000
212	$	400,000
219	$	450,000
220	$	1,950,000
221	$	3,050,000

Office of Mcare

2010 Claims Payment by Commercial Carrier and Self-Insurer

Company Code	Total Fund Payments	
222	$	1,010,000
223	$	800,000
224	$	500,000
228	$	300,000
229	$	950,000
234	$	200,000
239	$	800,000
241	$	400,000
245	$	1,000,000
246	$	1,850,000
248	$	500,000
253	$	6,000,000
258	$	300,000
261	$	1,000,000
276	$	500,000
Totals	$	146,484,944

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2010 Assessment Remitted by Commercial Carrier

Company Code	Amount [1]
001	$ 12,880
003	$ 14,329,252
011	$ 2,886,196
021	$ 81,444
023	$ 60,184
031	$ 21,321,350
032	$ 1,277,707
052	$ 97,612
067	$ 15,138,562
090	$ 70,966
103	$ 395,383
110	$ 39,835
112	$ 116,305
113	$ 2,434
121	$ 692,806
124	$ 833,349
127	$ 377,553
129	$ 4,663,917
137	$ 118,127
138	$ 715,634
144	$ 18,005,262
145	$ 4,181,676
155	$ 15,011,995
156	$ 9,043,333
162	$ 16,938
165	$ 21,615
179	$ 36,539
186	$ 89,052
194	$ 102,379
196	$ 1,201,050
197	$ 4,955,403
199	$ 4,847,544
202	$ 8,116,372
203	$ 1,369,529
206	$ 24,120
207	$ 14,841,068
208	$ 1,979,425
210	$ 746,020
211	$ 8,381,607

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2010 Assessment Remitted by Commercial Carrier

Company Code	Amount [1]
212	$ 183,657
216	$ 7,392
217	$ 357,590
218	$ 285,174
219	$ 3,999,907
220	$ 2,158,792
221	$ 4,505,214
222	$ 3,468,920
223	$ 3,363,289
224	$ 1,772,704
225	$ 55,395
226	$ 81,390
227	$ 3,360
228	$ 1,713,283
230	$ 20,859
232	$ 100,436
233	$ 714
234	$ 210,673
235	$ 73,290
236	$ 53,065
237	$ 19,650
239	$ 2,532,553
241	$ 928,650
242	$ 37,599
243	$ 23,892
244	$ 88,545
245	$ 5,421,496
246	$ 2,110,315
247	$ 31,906
248	$ 311,350
249	$ 21,172
250	$ 476,796
251	$ 53,983
252	$ 68,837
253	$ 4,131,544
257	$ 48,673
258	$ 1,875,228
261	$ 1,026,652
262	$ 35,585

Office of Mcare

2010 Assessment Remitted by Commercial Carrier

Company Code	Amount [1]	
264	$	920
265	$	12,098
266	$	26,099
267	$	573
268	$	1,752
271	$	2,406,813
274	$	181,692
275	$	541,522
276	$	538,184
277	$	31,342
278	$	882
279	$	540,842
282	$	43,209
285	$	420,662
286	$	71,574
289	$	13,782
290	$	65,930
292	$	11,491
293	$	33,491
294	$	7,299
296	$	2,814
297	$	18,398
298	$	24,403
303	$	19,540
305	$	41,929
307	$	1,272
308	$	328,234
310	$	4,952,754
313	$	882
314	$	27,633
315	$	50,956
900	$	5,019
Total	$	208,285,944

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 22, 2011.

Office of Mcare

2010 Assessment Remitted by Self-Insurer

Company Code	Amount [1]	
S10	$	4,572,782
S12	$	1,500,519
S40	$	419,049
S41	$	75,339
S49	$	671,307
S51	$	537,233
S53	$	182,191
S54	$	372,268
S57	$	52,078
S58	$	16,372
S59	$	22,335
S60	$	404,098
S61	$	11,445
S63	$	209,263
S64	$	15,199
S67	$	3,004
Total	$	9,064,482

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 22, 2011.