

Act 13 of 2002

Medical Care Availability and Reduction of Error Fund

Michael F. Consedine
Insurance Commissioner
Department of Insurance

Annual Report of Operations 2013



COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG

THE COMMISSIONER

March 3, 2014

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

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

Honorable Tina Pickett, Chair
Insurance Committee
Pennsylvania House of Representatives
314-C Main Capitol Building
Harrisburg, PA 17120

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

Dear Senators and Representatives:

Enclosed please find the Department of Insurance, Bureau of Medical Care Availability and Reduction of Error Fund's (Mcare) Annual Report of Operations for 2013. This report is prepared annually, as a service to the legislature, by Mcare. Among the many tabs, the report includes data regarding the total amount of claims paid and expenses incurred from 2002 through December 31, 2013, as well as the unique count of providers participating in Mcare.

If you have any questions about these reports, please feel free to contact me, Deputy Insurance Commissioner for Mcare Joe DiMemmo, Mcare Executive Director Todd Rittle at 717-783-3770, or Legislative Director Kristen Erway at 717-783-3501.

Sincerely,

A handwritten signature in blue ink that reads "Michael F. Consedine".

Michael F. Consedine
Insurance Commissioner

Enclosure

Mcare Fund

2013 Annual Report of Operations

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About Mcare

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

PURPOSE

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

REVENUE STREAM

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

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

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

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

PARTICIPATION

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

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

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

COVERAGE REQUIREMENTS

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

For hospitals, the required total coverage amounts are \$1,000,000 per occurrence, and \$4,000,000 per annual aggregate. The current total coverage amounts required for health care providers participating in Mcare are as follows:

A. Primary Coverage for Participating Health Care Providers

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

B. Mcare Coverage for Participating Health Care Providers

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

C. Primary Coverage for Nonparticipating Health Care Providers

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

D. Mcare Coverage for Nonparticipating Health Care Providers

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

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

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

REPORTING COVERAGE TO MCARE

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

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.

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
1010 N. 7th Street, Suite 201
P.O. Box 12030
Harrisburg, PA 17108-2030
(717) 783-3770
or
visit our website at
www.insurance.pa.gov/mcare

MEDICAL CARE AVAILABILITY AND REDUCTION OF EFFOR FUND
CASH BASIS
STATEMENT OF OPERATIONS
JANUARY 1, 2013 TO December 31, 2013

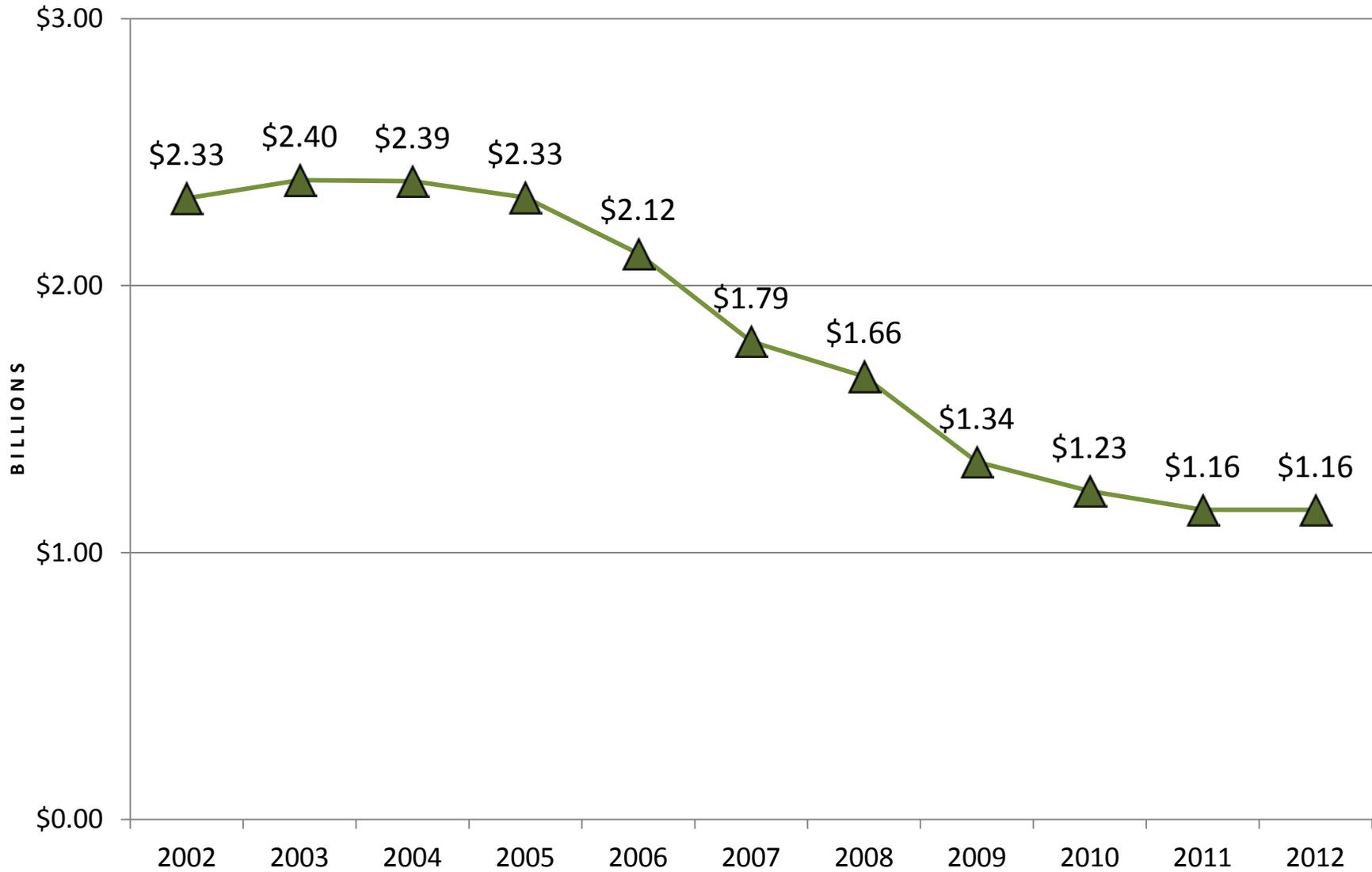
FUND BALANCE JANUARY 1, 2013		129,805,739
ADD:		
ASSESSMENT REVENUE	239,374,627	
INTEREST ON SECURITIES	1,702,377	
OTHER REVENUES	2,917,105	
ABATEMENT REPAYMENT REC'D	0	
CASH IN TRANSIT 12/31/13	1,108,294	
REDEPOSIT OF CHECKS	0	
ACCOUNTS PAYABLE	0	
TOTAL FUNDS AVAILABLE		245,102,403
SUB TOTAL		<u>374,908,142</u>
OTHER DEDUCTIONS		
CLAIMS PAID DECEMBER 31, 2013	193,902,777	193,902,777
OPERATING EXPENSES		
SALARIES	2,572,359	
PAYROLL TAXES & BENEFITS	1,388,225	
DATA PROCESSING SERVICES	50,400	
LEGAL FEES & SERVICES	6,468,734	
OFFICE SUPPLIES	29,000	
CONSULTANTS (IT, Physicians, Actuary)	711,870	
TELECOMMUNICATIONS	78,336	
REAL ESTATE	442,508	
MOVING EXPENSES	202,200	
MISC	48,816	
<u>TOTAL OPERATING EXPENSES</u>	<u>11,992,448</u>	11,992,448
TOTAL DEDUCTIONS	<u>205,895,225</u>	205,895,225
FUND BALANCE DECEMBER 31, 2013		<u>169,012,917</u>

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

PA Department of Insurance
Mcare Fund

History of Assessment Rates and Coverage Limits			Coverage Limits (per Occurrence/per Annum) in Millions					
			Non-hospital			Hospital		
			Mcare Limit	Basic Limit	Total Aggregate Limits for Mcare & Non-hospital	Mcare Limit	Basic Limit	Total Aggregate Limits for Mcare & Hospital
Year	Percentage	Policy Effective Date						
1976	Greater of 10% or \$100	01/13/76 - 12/31/82	\$1.0/\$3.0	\$0.1/\$0.3	\$1.1/\$3.3	\$1.0/\$3.0	\$0.1/\$1.0	\$1.1/\$4.0
1977	Greater of 10% or \$100							
1978	nil							
1979	nil							
1980	Greater of 10% or \$100							
1981	22%							
1982	38%	01/01/83 - 12/31/83	\$1.0/\$3.0	\$0.15/\$0.45	\$1.15/\$3.45	\$1.0/\$3.0	\$0.15/\$1.0	\$1.15/\$4.0
1983	41%							
1984	52%							
1985	70%							
1986	87%							
1987	87%							
1988	61%							
1989	59.5%							
1990	50%							
1991	68%							
1992	90%							
1993	91%							
1994	93%							
1995	170% (102% & 68%)							
1996	164%							
1997	75%							
1998	64%							
1999	59%							
2000	61%							
2001	61%							
2002	50%							
2003	43%							
2004	46%							
2005	39%							
2006	29%							
2007	23%							
2008	20%							
2009	19%							
2010	21%							
2011	19%							
2012	23%							
2013	25%							
		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
		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
		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
		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

**Mcare Fund
Unfunded Liability Report
as of 12/31/2012**



Estimation of 2012 Unfunded Liability

The Executive Summary of a report by PricewaterhouseCoopers LLP that was the basis for determining the value of the Fund's unfunded liability at \$1.16 billion as of December 31, 2012.

Pennsylvania medical care availability and reduction of error fund

Estimation of 12/31/2012 unfunded liability

Philadelphia, PA

July 2013

Estimate of future years' claims payments pursuant to act 13 of 2002



Mr. Todd Rittle
Executive Director
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, Pennsylvania 17102
July 26, 2013

Dear Mr. Rittle:

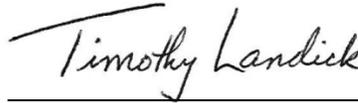
Enclosed is an updated draft report on the Fund's unpaid claim liabilities as of December 31, 2012, reflecting modifications to the narrative we've recently discussed. Please review this updated draft at your convenience and we can discuss any further questions or comments you may have.

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

Sincerely,



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



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



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

Enclosure

cc: R. Waeger, Mcare Fund

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Introduction

Background

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

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

Policy year effective	Mandatory primary occ / agg limits		Mcare fund excess occ / agg limits	Section 605/715 limits ³
	Hospital	Physician		
1996 & Prior	200 / 1,000	200 / 600	1,000 / 3,000	1,000
1997 & 1998	300 / 1,500	300 / 900	900 / 2,700	1,000
1999 & 2000	400 / 2,000	400 / 1,200	800 / 2,400	1,000
2001 & 2002	500 / 2,500	500 / 1,500	700 / 2,100	1,000
2003 - 2005	500 / 2,500	500 / 1,500	500 / 1,500	1,000
2006 - 2011	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)

The mandatory primary coverage limits may increase (with corresponding decreases in the Fund coverage limits) in 2014 and 2017, subject to the Commissioner's assessment of basic insurance coverage capacity. The estimates contained herein assume that basic coverage limits increase as scheduled, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2017. The limits of insurance assumed herein are shown in the table below (000's).

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

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

³ A window of time exists during which reduced Fund coverage may exist for Section 715 (late reported) claims. In general, Section 715 claims reported to the primary carrier on or after November 26, 2000 and on or before March 19, 2002 may be subject to reduced limits of coverage.

Policy year effective	Mandatory primary occ / agg limits		Mcare fund excess occ / agg limits	Section 605 / 715 limits
	Hospital	Physician		
2012 - 2013	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)
2014 - 2016	750 / 3,750	750 / 2,250	250 / 750	250 (excess)
2017 & Sub	1,000 / 4,500	1,000 / 3,000	0 / 0	0

The Fund is supported by an assessment collected from each participating health care provider. Act 13 requires an assessment that will, in the aggregate, produce an amount sufficient to accomplish the following:

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

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

PricewaterhouseCoopers LLP (PwC) was engaged to provide the Fund with an actuarial central estimate of its unpaid claims expense (i.e., the unfunded liability) as of December 31, 2012. This report is neither intended nor necessarily suitable for any other purpose. The estimates contained herein are meant to represent an expected value over the range of reasonably possible outcomes.

Distribution and use

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

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

⁵ In any given year, the Fund may have a shortage or an excess of assessments collected relative to the claims payments and operating costs for the year, resulting in corresponding year-end shortfall or surplus. The estimate of the unfunded liability contained herein includes no adjustment for the Fund’s cumulative surplus of \$130 million as of December 31, 2012.

Conditions and limitations

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

- By-claim information, including data such as: claim type (Excess⁶ or Section 715), open date, claim status, coverage limit, breast implant/pedicle screw claims, “no exposure” claims, primary report date, Fund payment information, etc.;
- The Fund’s interpretation of Act 13 provisions;
- Historical surcharge collections by policy type; and
- Information contained in PwC’s previous estimates of the Fund’s liability.

The calculations in this report rely on the accuracy of the paid loss and claim count data provided. We have not audited this data but have reviewed the data provided for reasonableness. Any changes to the data may require modification to the estimates in this report. In this report, paid loss and claim count triangles have been restated according to each claim’s current status (e.g., Excess vs. Section 715) in order to provide for a historical database that is more reflective of the Fund’s current procedures. The updated triangles were compared to last year’s triangles for reasonableness and consistency; differences observed were not significant.⁷

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

The calculations in this report also rely on information provided by the Fund and on the Fund’s interpretation of recent legislation, of which many provisions are neither time-tested nor court-tested. Any changes to the data provided or in the “application” of recent legislation relative to the interpretation assumed herein may necessitate modification to the estimates in this report.

The projected ultimate losses, calendar year claims payments, and unfunded liability shown in this report are estimates and as such, are subject to variability. This variability arises from the fact that not all factors affecting the ultimate liability have taken place nor can they be evaluated with absolute certainty. Such factors include, but are not limited to, tort reform, expected future inflationary trends and jury awards. The absence of case reserve information may also subject our projections to a higher degree of uncertainty, as do the uncertain impacts associated with the Patient Protection and Affordable Care Act and recent changes to joint and several liability in Pennsylvania as a result of Senate Bill 1131. Our projection of liabilities is based on the Fund’s historical payment experience, the projected effect of changes in the Fund’s limits of coverage, and our estimate of the impact of changes in Pennsylvania-filed cases over time⁸ on the Fund’s claims obligations. We have not anticipated additional extraordinary changes to the various factors that might impact the future costs of claims. We have however used methods of estimating the unpaid claim liability that we believe produce reasonable results given current information. No guarantee, either expressed or implied, should be inferred that losses will develop as shown in this report. Furthermore, since the projections contained herein include projections of future years’ incidents (i.e.,

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

⁷ The Fund has been able to identify reported claims with exposure to breast implant or pedicle screw liability. These exposures resulted in significant historical reported claim activity. However, nearly all breast implant and pedicle screw claims are closed with relatively minor historical Fund payment activity (less than \$10 million). Consistent with our analyses in previous years, we have excluded these claims from the data used in our analysis to avoid the potential distortive effects on our projections. The unpaid claim estimates shown herein do not include a provision for these exposures.

⁸ <http://www.pacourts.us/NR/rdonlyres/068DFFE8-84BF-4EC2-8F29-A40627D43697/0/Fig1MedMalCaseFilings200011.pdf>

incidents that will not occur until sometime in the future), the uncertainty surrounding these estimates is significantly increased.

Act 13 provisions and other recent legislation and rules of civil procedure contribute additional uncertainty to the estimates contained herein. The process of resolving medical malpractice claims, through both settlements and verdicts, is a fluid process that may change over time. Furthermore, changes in handling, processing, negotiating, adjudicating, or otherwise resolving these claims that tend to occur over time could influence the impact of these provisions.

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

Defense and other costs

Our estimates do not include a provision for the costs of providing defense for Section 715 claims. These costs, which have averaged approximately 20% per year of the Section 715 claims paid over recent years, have historically been included in the Fund’s operating (rather than claims) budget. Note that defense is provided by the primary insurers for those claims where the Fund’s coverage is provided on an excess basis. Similarly, our estimates do not include a provision for the cost of claims administration nor for the Fund’s other operating costs.

Reinsurance recoverables

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

Severity codes

For the past several years, the Fund has been more thoroughly capturing severity information for certain claims. This information provides a rough indication of the severity of a plaintiff’s alleged injury. The nine indicators range from “Emotional” to “Grave”. Injuries of different severity codes may have different characteristics, such as different average costs and different paid loss development patterns. During the course of our review, we investigated whether there appeared to be any significant changes in the distribution of claims, in particular for codes with a similar average cost. At this time, shifts in the distribution of claims appear to be largely attributable to changes in the Fund layer of coverage - increases in the primary coverage increase the likelihood of less severe cases being fully captured by the primary layer. Conversely, there is an increased likelihood for a proportionally greater amount of Fund claims to arise from more severe injuries. We would not expect other shifts in the distribution of claims to materially distort our analysis at this time. We will continue to monitor severity code information and adjust our estimates of the unfunded liability as warranted in the future.

Qualifications of PwC actuaries

David Kaye and Marc Oberholtzer, and the peer reviewer for this assignment, Tim Landick, are members of the American Academy of Actuaries and Fellows of the Casualty Actuarial Society and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Executive summary

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

Total unfunded liability

We estimate the Fund's unfunded liability as of December 31, 2012, excluding breast implant and pedicle screw exposure, to be approximately \$1.16 billion, assuming the limits of Fund coverage proceed as currently contemplated under Act 13. Namely, the estimates contained herein assume that basic coverage limits increase in 2014 and 2017, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2017. If the basic coverage limits are not increased in 2014 and 2017, Fund coverage will continue into and beyond 2018 and the total Fund payout (i.e., our estimates of the unfunded liability) would increase. We have not estimated the amount of the increase in the unfunded liability should the basic coverage limits not increase in 2014 and 2017.

During the course of our review, the Fund provided us with a projection of 2013 claim payments of approximately \$195 million. We have incorporated this projected claim payment information into our estimate of the unfunded liability of \$1.16 billion.

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

Fund / Accident Year	Jan-1 Unfunded Liability	Cost of New Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability	Discounted (2%) Dec-31 Unfunded
2012				1,160,787	1,069,020
2013	1,160,787	179,511	201,627	1,138,670	1,049,192
2014	1,138,670	128,593	203,515	1,063,748	981,705
2015	1,063,748	92,359	201,885	954,222	881,955
2016	954,222	70,066	194,690	829,598	767,199
2017	829,598	16,977	179,499	667,076	618,110
2018	667,076		156,514	510,562	473,958
2019	510,562		129,421	381,142	354,017
2020	381,142		102,702	278,440	258,396
2021	278,440		75,886	202,554	187,678
2022	202,554		53,396	149,158	138,035
2023	149,158		38,485	110,673	102,311
2024	110,673		28,040	82,633	76,317
2025	82,633		20,577	62,056	57,266
2026	62,056		15,040	47,016	43,371
2027	47,016		10,953	36,063	33,286
2028	36,063		8,417	27,646	25,535
2029	27,646		6,528	21,118	19,517
2030	21,118		5,027	16,091	14,881
2031	16,091		3,946	12,145	11,232
2032	12,145		3,109	9,036	8,348
2033	9,036		2,414	6,622	6,101
2034	6,622		1,818	4,804	4,405
2035	4,804		1,306	3,499	3,188
2036	3,499		918	2,581	2,334
2037	2,581		628	1,953	1,753
2038	1,953		416	1,537	1,371
2039	1,537		270	1,267	1,128
2040	1,267		197	1,070	954
2041	1,070		161	909	812
2042	909		136	772	692
2043	772		114	658	592
2044	658		101	557	503
2045	557		88	469	425
2046	469		76	393	358
2047	393		67	326	298
2048	326		57	270	247
2049	270		45	225	207
2050	225		38	187	173
2051	187		34	153	142
2052	153		31	122	115
2053	122		28	94	89
2054	94		25	69	65
2055	69		21	48	46
2056	48		17	31	29
2057	31		13	18	17
2058	18		8	9	9
2059	9		6	4	4
		487,506	1,648,289		

The estimated payments shown above consider longer-term trends in experience and payment patterns, and result in a projected 2013 Fund payment of \$202 million, which differs slightly from the current Fund projection of \$195 million. However, given the proximity of the projected payment to the Fund's current expectation in the context of the overall estimate of the unfunded liability, we have not made an explicit adjustment to our projected payout pattern at this time.

Estimates of the liability reflecting the time value of money contained herein employ a discount rate assumption of 2%; however, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. Estimates at other discount rates are included in the Discounting section below. Discounted estimates contained herein assume that the Fund's payments continue to be made at the end of each calendar year. Note that the Fund does not currently maintain assets in support of the liability.

Separate projections of liability 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 12/31/2011

The total expected unfunded liability of \$1.16 billion has increased 0.1% from our December 31, 2011 estimate of \$1.16 billion. The breakdown of the change in the undiscounted estimate since December 31, 2011 is shown in the following table:

Rollforward of Estimated Unfunded Liability (000's) from 12/31/2011 to 12/31/2012				
		<u>Excess</u>	<u>Section 715</u>	<u>Total</u>
(1)	Prior Estimated Liability	925,694	234,209	1,159,902
(2)	<u>Less Prior Estimated DD & PJI</u>	<u>13,680</u>	<u>3,461</u>	<u>17,141</u>
(3)	Prior Estimated Liability Ex. DD & PJI	912,013	230,748	1,142,761
(4)	Plus Change in Prior Accident Year Ultimate	(38,250)	39,610	1,360
(5)	Less Paid During Year	146,757	47,840	194,597
(6)	<u>Plus Accident Year 2012 Ultimate</u>	<u>177,386</u>	<u>16,723</u> (a)	<u>194,108</u>
(7)	Current Estimated Liability Ex. DD & PJI	904,392	239,240	1,143,632
(8)	<u>Current Estimated DD & PJI</u>	<u>13,566</u>	<u>3,589</u>	<u>17,154</u>
(9)	Current Estimated Liability	917,958	242,829	1,160,787

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

During the year, we observed favorable emergence in our projections for excess claims driven in part by the beneficial impact of Act 13 legislation. Based on information gathered by the Administrative Office of Pennsylvania Courts (AOPC), the number of medical malpractice cases filed in Pennsylvania in recent post-Act 13 years (2003 and subsequent) is significantly lower than pre-Act 13 experience (2000/2001). The Fund has also experienced a reduction in the number of claims that are closing with payment. Given the consistency and persistency of the reduction in cases filed observed by the AOPC and in the number of claims closed with payment by the Fund, we have included an explicit adjustment to recognize anticipated savings. Further discussion is included in the *Reduction in Claim Activity* section below.

The favorable emergence in our projections for excess claims was offset by adverse emergence in our estimate for Section 715 claims. The adverse emergence observed for Section 715 claims resulted from increased claim payment activity and an associated increase in certain actuarial assumptions underlying our estimates following a 2010 court decision that eliminated the aggregate limit that had previously capped Mcare's exposure to Section 715 claims⁹. Following the court decision, the Fund has received several claims that would have been capped at the annual

⁹ WEST PENN ALLEGHENY SYS. v. MCARE FUND, see 11 A.3d 598 (2010)

aggregate limit. Although the runoff nature of the Fund's Section 715 coverage should serve to mitigate the potential for increases in cost that otherwise could arise from the loss of aggregate protection, the uncertain long-term impact of this change does increase the potential variability in our estimate.

Fund / Accident Year	Current Selected Ultimate	Prior Selected Ultimate	Change in Selection
1976	47,668,227	47,674,839	(6,612)
1977	59,999,133	60,013,253	(14,120)
1978	86,406,868	86,427,056	(20,189)
1979	97,762,282	97,783,249	(20,968)
1980	135,952,342	135,994,145	(41,803)
1981	150,653,387	150,699,829	(46,442)
1982	173,604,712	173,659,197	(54,485)
1983	178,418,894	178,490,288	(71,395)
1984	166,332,182	166,397,788	(65,605)
1985	179,152,365	179,073,254	79,112
1986	171,558,502	171,649,257	(90,755)
1987	196,523,800	196,650,341	(126,541)
1988	215,968,584	216,106,614	(138,031)
1989	215,439,650	215,420,027	19,623
1990	254,850,665	255,150,495	(299,831)
1991	292,957,848	291,233,760	1,724,088
1992	270,721,125	271,509,881	(788,756)
1993	258,947,587	259,674,157	(726,571)
1994	294,698,142	294,008,272	689,870
1995	322,762,351	322,563,665	198,686
1996	308,506,835	309,942,718	(1,435,884)
1997	325,645,618	327,143,077	(1,497,459)
1998	304,815,032	281,251,675	23,563,357
1999	232,976,163	235,425,123	(2,448,960)
2000	233,286,500	227,840,765	5,445,735
2001	197,673,650	195,780,694	1,892,956
2002	150,055,973	151,862,099	(1,806,125)
2003	169,333,249	167,604,173	1,729,075
2004	154,580,434	159,981,829	(5,401,394)
2005	172,034,578	172,037,456	(2,878)
2006	151,164,354	153,908,128	(2,743,774)
2007	171,794,250	174,459,976	(2,665,726)
2008	174,471,908	180,362,268	(5,890,360)
2009	186,102,347	192,800,674	(6,698,327)
2010	203,897,481	204,399,524	(502,043)
2011	211,853,508	212,231,289	(377,781)
Total	7,118,570,525	7,117,210,835	1,359,690

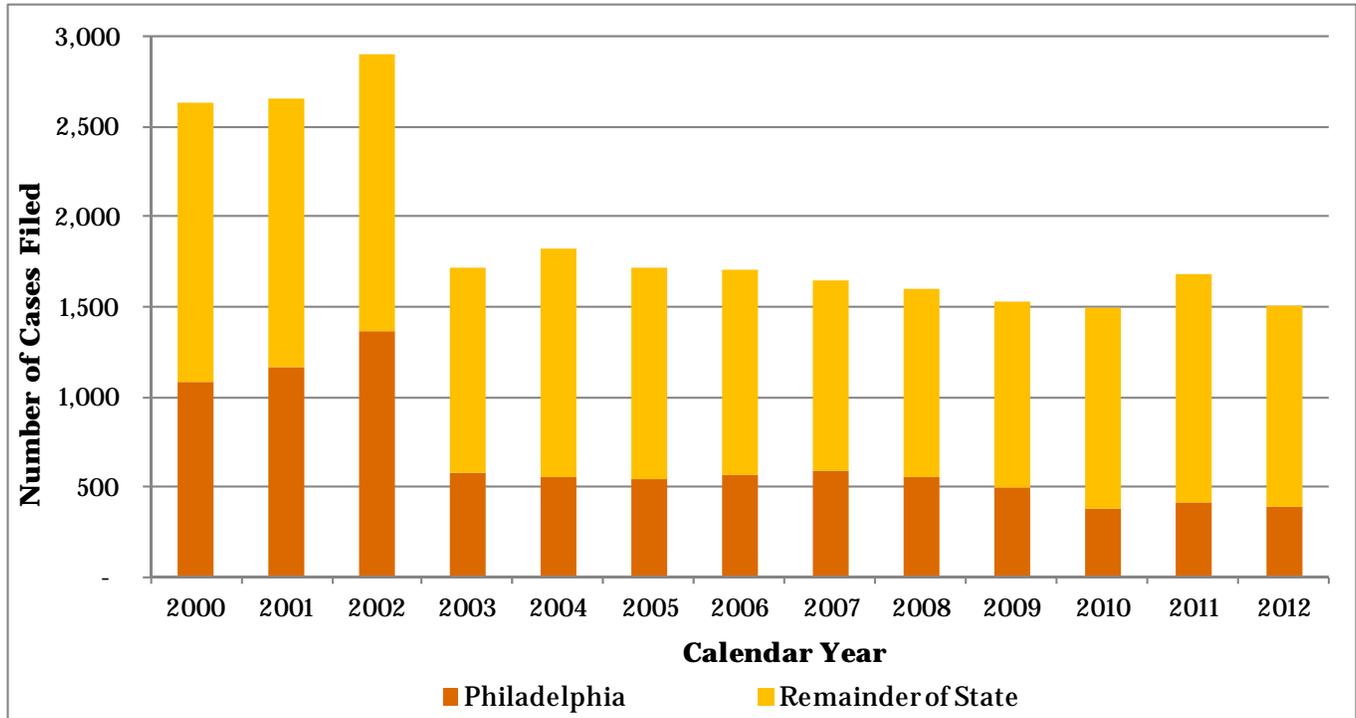
We note that the prior selected ultimate column in the table above has been adjusted to include approximately \$16 million of Section 715 claims that were not captured in our prior year report. We have estimated the impact of the inclusion of these claims in the prior year report to be relatively minor; for purposes of year-over-year comparisons, we have assumed that the inclusion of these claims in the prior report would have resulted in a corresponding increase in the projected ultimate loss.

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 2012 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 44%, with Philadelphia County experiencing an average decrease of approximately 60% and the remainder of the state (ROS) experiencing an average decrease of approximately 30%, as shown below:

Number of cases filed per year

Based on Administrative Office of PA Courts (AOPC) Information

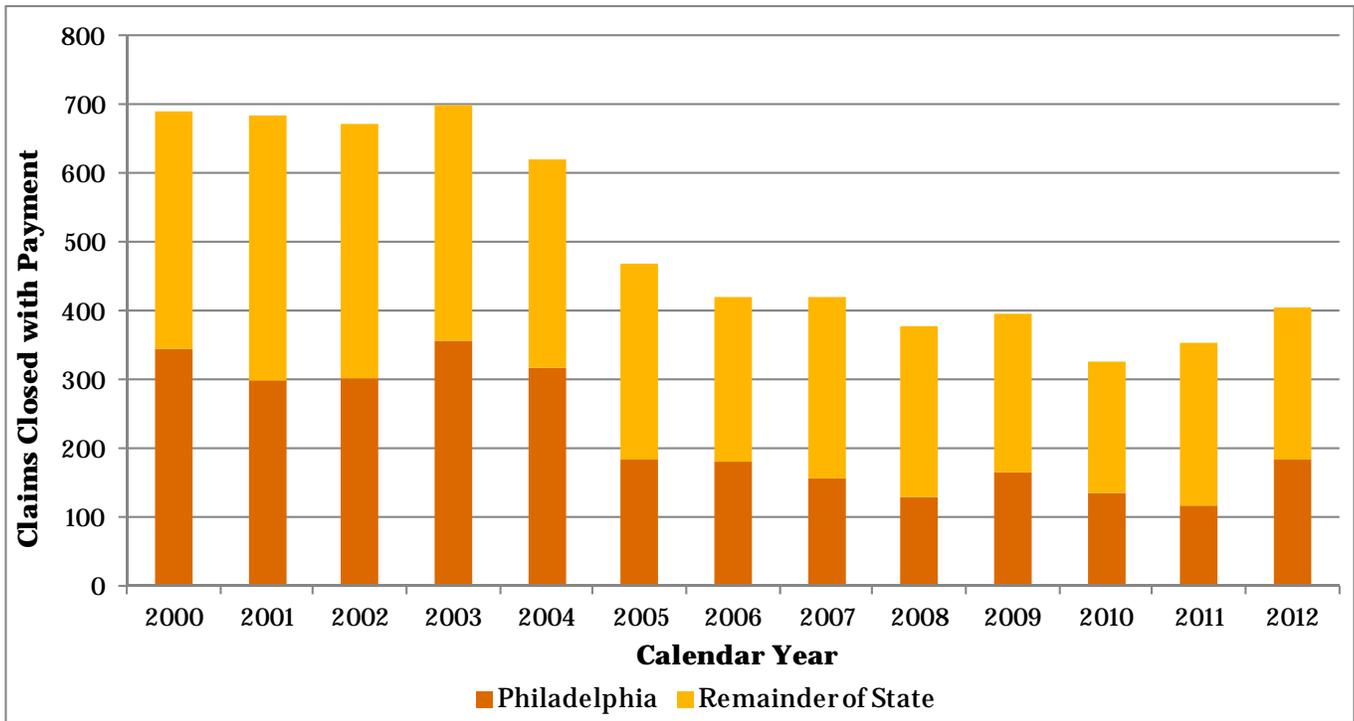


Possible causes for the decrease in claims activity for recent years include venue reform (Section 3 of Act 27 of 2002), certificate of merit procedures (Rule of Civil Procedure 1042.3, 2003), and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number 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 corroborate the information observed by the AOPC, allowing for a time delay between case filing and claim payment. Namely, the number of Fund claims closing with payment fell dramatically in 2005 through 2012 as compared to calendar years 2004 and prior. 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:

Mcare fund - Closed with payment claims by calendar year

Total Excess and Section 715 Claims



The data compiled by the AOPC and recent Fund claims payment activity are indicative of savings to be realized by the Fund. Although the possibility exists that the reduced number of filings and apparent shift of claims away from Philadelphia may not result in a commensurate level of cost savings, we concluded that the consistency and persistency of the change in claims activity warrants reflection in our estimates. To that end, we reviewed the Fund closed-with-payment activity, making adjustments to reflect the expected effect of changes in the Fund limits of coverage over time for Excess claims. Based on this review, as well as in consideration of the AOPC data and our prior projections, we included an "AOPC Credit" of 37% and 60% within our Philadelphia projections for Excess claims and Section 715 claims, respectively, and an "AOPC Credit" of 1% and 25% within our ROS projections for Excess claims and Section 715 claims, respectively. These AOPC credits are generally consistent with those used in our prior projections.

Other legislative provisions

Other elements of legislation are expected to have a less direct or less significant effect on the Fund's future payments, are more difficult to estimate, or lack sufficient information to actuarially quantify at this point in time, including but not necessarily limited to: Patient Safety initiatives (Chapter 3 of Act 13), Remittitur (Section 515 of Act 13), Statute of Repose (Section 513 of Act 13), Collateral Sources (Section 508 of Act 13), Payment of Damages/Reduction to Present Value (Sections 509/510 of Act 13), and the "180-day rule" and "continuing course of treatment" provision (Act 135). These other elements of the legislation may also have an impact on the Fund's obligations, although the impact of these elements has not been explicitly estimated herein. These provisions have generally been in place for several years; to the extent paid loss or claim activity has been impacted, our projections implicitly reflect the impact of these provisions. That said, these provisions may be subject to future challenge and interpretation by the courts, which contributes additional uncertainty to the estimates contained herein. As noted above, the impacts associated with the Patient Protection and Affordable Care Act and recent changes to joint and several liability in Pennsylvania as a result of Senate Bill 1131 may also subject our projections to a higher degree of uncertainty.

Discounting

As summarized in Summary, Exhibit 1, Sheet 1, the indicated post-Act 13 liability after discounting the Fund's liabilities at a 2% annual rate of interest is approximately \$1.06 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%	\$1.07 billion
3%	\$1.03 billion
4%	\$0.99 billion
5%	\$0.95 billion

The attached exhibits employ a discount rate assumption of 2%; however, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. The Fund does not currently maintain assets in support of the liability.

Analysis

Methodology

Our analysis of liabilities was completed separately for Excess claims and Section 715 claims. Supporting calculations are included in the Technical Appendix, Section 1 and Section 2, respectively. Within each section, separate projections are provided for Philadelphia and Remainder of State (ROS), based on the venue county of the claim. Data was organized by year of occurrence. To estimate the unfunded liability as of 12/31/2012, losses paid to date are subtracted from the projected ultimate losses for accident periods 2012 and prior.

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

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

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

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

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

The paid loss development method assumes that losses are paid at a consistent rate. It is especially useful for coverages where losses develop early and are paid quickly, such as automobile physical damage, or in instances where case reserves are not established (i.e., in preparing estimates for the Fund). In our estimates for Excess, separate paid loss development factors have been estimated assuming the Fund coverage attaches at \$200,000 limits (as it does for policies effective prior to 1997) and assuming the Fund coverage attached at \$500,000 limits (as it does for policies effective in 2001 and subsequent). For each year, the paid loss development pattern employed is based on these patterns, adjusted to reflect the estimated average Fund attachment point for the accident year.

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

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

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

If loss development methods produce erratic or unreliable estimates for the more recent periods, the future cost per closed-with-payment claim method can provide more stable results while maintaining consistency with historical

loss experience. However, a substantial number of unusual claims can distort claim averages or make them very volatile.

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

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

The Paid Bornhuetter-Ferguson method is a combination of the paid loss development method and a loss per exposure method. The amount of losses yet to be paid is based on initial expected loss estimates. These expected losses are then modified to the extent paid losses to date differ from what would have been expected based on the selected paid loss development pattern.

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

- First, an initial estimate of accident year 2012 loss is selected and adjusted to prior accident years for loss trend and changes in Fund attachments and limits. The estimated impact of the "AOPC Credit" is also considered in determining the initial estimates of accident year losses.
- Next, calendar year claim payments are estimated by applying the paid loss pattern underlying the paid loss development method to the estimate of ultimate loss by accident year calculated in the first step.
- Then, the projected calendar year claim payments from the second step are compared with the actual calendar year claim payments provided by the Fund.
- Finally, the process is repeated by adjusting the initial estimate of accident year 2012 loss until the projected calendar year claim payments equal the actual calendar year claim payments.

This methodology is often used to align expected and actual paid loss over a period of several *accident* years, rather than *calendar* years. We believe the calendar year approach of our projection methodology increases the extent to which the projections directly reflect emerging experience, and we have "matched" the experience over seven calendar years for Excess claims and six years for Section 715 claims. As a result of the continuing favorable development of recent years, the current projections give greater weight to recent favorable emerging experience. We will continue to monitor emerging experience in future projections and adjust the span of years included accordingly.

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

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

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

Discounting

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

The unpaid claims estimated herein have been discounted to reflect the investment income that could be earned from 12/31/2012 until the final date of payment. While post-Act 13 experience can be expected to have a slightly different payment pattern than pre-Act 13 experience, we expect that the relative effect on the discount would not be significant.

The attached discounted estimates assume a 2% rate of return and the paid loss pattern underlying the paid loss development method. However, as discussed above, this discount rate and the resulting estimate of the discounted liability may not be suitable for every purpose. Estimates of the discounted unfunded liability can be produced under various discount rate assumptions.

Future year projections

The Fund is scheduled to provide coverage (to varying limits) for health care providers beyond 2012. Projections of Excess losses for future years 2013 through 2017 assume an underlying trend of 6.0% per annum at 2012 limits of coverage, based on the trend of projections for recent accident years. Projections of Section 715 losses for future years 2013 through 2017 assume an underlying pre-Act trend of 6.0% per annum at 2012 limits of coverage, based on the trend of projections for recent accident years. The overall trend in the projections of the future excess coverage provided by the Fund is approximately 6.0% per annum. These projections, and the resulting estimates adjusted for changes in the limits of coverage provided by the Fund, are shown in Exhibit 5, Sheet 2 (ROS) and Exhibit 13, Sheet 2 (Philadelphia).

Delay damages and post-judgment interest

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

Calculation of 2013 Mcare Assessment Rate

The report by PricewaterhouseCoopers LLP that describes the methods used and the basis for setting the 2013 Mcare Assessment rate at 25% in order to generate an estimated \$230,522,452 in assessment revenue.

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

**2013 YEAR ASSESSMENT CALCULATION
(In Accordance with Act 13 of 2002)**

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

October 2012



October 10, 2012

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

Dear Mr. DiMemmo:

Enclosed is our report describing the methods we have used to estimate the 2013 prevailing primary premium projection of \$925 million, indicating an assessment rate of 24.9% for the 2013 year, in accordance with Act 13 of 2002, also known as the Mcare Act. We understand that Mcare will round the assessment rate to 25%.

Please call Mark at (267) 330-6612 should you have any questions or require anything further.

Sincerely,

A handwritten signature in black ink that reads "Mark R. Proska".

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

A handwritten signature in black ink that reads "Marc Oberholtzer".

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

cc: R. Waeger, Pennsylvania Mcare Fund

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INTRODUCTION

Purpose

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

The Fund currently provides excess coverage (to varying historical limits) for health care providers that have exhausted their primary limits. 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 715² coverage). The Fund is supported by an assessment collected from each participating health care provider.

In March of 2002, Act 13 was enacted which amended existing legislation³ regarding the Fund. Act 13 instituted numerous changes, including but not limited to: scheduling increases in basic insurance coverage limits⁴, scheduling decreases in the amount of excess coverage afforded by the Fund, and providing for assessment discounts in 2002, 2003, and 2004.

PricewaterhouseCoopers LLP (PwC) was engaged to assist the Fund in the determination of the assessment rate to be applied for the 2013 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 2012;
- claim year 2012 loss payments expected to be made on or about December 31, 2012;
- policy year 2009, 2010, and 2011 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 2013 prevailing primary premium, which is a primary component of the 2013 assessment rate, is an estimate. As such, this value is subject to variability. While we believe the estimate is reasonable based on the information provided, there can be no assurance that the actual prevailing primary premium will not differ materially from what we have projected, generating either more or less assessment revenue than that projected herein.

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 eligible⁵ 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 2013, the net 2013 assessment remittances may be less, perhaps significantly so, than that needed for operating expenses and claim payments during 2013.

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

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

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.

2013 Assessment Rate

Exhibit 2 shows that our selected primary prevailing premium for 2013 of \$925 million generates an indicated assessment rate of 24.9%, which rounds to the 25% shown on Exhibit 1. In accordance with Act 13, our calculation contemplates the areas of expense to be recouped and a projection of the 2013 prevailing primary premium.

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

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

These amounts are to be collected via the application of an assessment rate to the policy year 2013 prevailing primary premium. Hence the projection of 2013 prevailing primary premium is a key component of the recommended assessment rate.

There are numerous external factors that will affect both the 2013 payment obligations of the Fund and the 2013 prevailing primary premium base, from which the Fund will derive its

financing. We have used actual 2009, 2010, and 2011 assessments as the basis for our estimate of the 2013 prevailing primary premium.

Since the 2013 assessment rate is based largely on the Fund's obligations for the 2012 claim year, any significant change in Fund's claim or expense obligations from 2012 to 2013 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 2013. To the extent the funds available in 2013 are insufficient to meet the Fund's 2013 obligations, additional funding or borrowing may be required.

Differences between projected 2013 prevailing primary premium and actual 2013 prevailing primary premium will result in a difference between projected and actual assessment revenue. This variable contributes additional uncertainty regarding the degree to which the funds available will be sufficient to meet the Fund's 2013 obligations.

ANALYSIS

2013 Assessment Rate

The Act outlines the four categories to be funded via the assessment. The aggregate assessment for 2013⁶ 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 2013 prevailing primary premium.

Claim Settlements

The largest expense to be recorded by the 2013 assessment is the amount of claim settlements for the Fund's 2012 claim year ending August 31, 2012. These claims are payable on or about December 31, 2012. The Fund expects that payments for the 2012 claim year will total \$195.7 million.

Fund Operating Expenses

Operating expenses paid of \$13.8 million for the claim year ending August 31, 2012 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, 2012, and does not currently expect to require borrowing to meet its 2012 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 2013.

Prevailing Primary Premium

The Fund provided unabated assessment and policy count data for policies effective in 2009, 2010, and 2011. Data was provided for each unique set of the following variables: primary policy type, product code, county code, and specialty code.

A general description of these variables follows:

Primary Policy Type

This field contains either CM (claims-made), OC (occurrence), or OP (occurrence-plus⁷). Assessment collections for tail policies are not expected to be material in the aggregate for policy year 2013. Our projections of policy year 2013 assessments exclude assessments collected in 2009, 2010, and 2011 arising from tail policies.

Product Code

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

- BC – birth center;
- HS – hospital;
- MC – professional corporation;
- MD – other doctor , resident, or fellow;
- MW – nurse midwife;
- NC – nursing home;
- PC – primary health center; and
- SC – podiatrist.

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

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 2013 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 2009 assessments have been adjusted for changes effective 01/01/2010, 01/01/2011, 01/01/2012, and 01/01/2013. This calculation is included in its entirety under separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2010 assessments have been adjusted for changes effective 01/01/2011, 01/01/2012, and 01/01/2013. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2011 assessments have been adjusted for changes effective 01/01/2012 and 01/01/2013. 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 01/01/2010, 01/01/2011, 01/01/2012, and 01/01/2013 are as follows:

Changes Effective 01/01/2010

Rate Change

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

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

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

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

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

Class Rate Changes

The JUA modified the class rates for the following classes:

JUA Class	Impact
006	+4.9%
007	+5.0%
010	-3.9%
011	+9.9%
012	+5.0%
020	+5.0%
022	-4.3%
030	-5.0%
035	+5.0%
050	-5.0%
060	-5.0%
070	-5.0%
080	-5.0%
090	-5.0%
100	+5.0%
120	-5.0%
900	+5.0%

County / Territory Changes

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

<i>Non-Institutional Changes</i>		
County (County Code)	Change	Impact
Philadelphia (51)	no change Terr 1	0.0%
Allegheny (02), Armstrong (03), Jefferson (33), Washington (63), Westmoreland (65)	no change Terr 3 rel.	0.0%
Bucks (09), Chester (15), Fayette (26), Montgomery (46)	change Terr 4 rel.	-9.9%
Delaware (23)	change Terr 5 rel.	-6.7%
Blair (07), Columbia (19), Crawford (20), Dauphin (22), Erie (25), Lackawanna (35), Lawrence (37), Lehigh (39), Luzerne (40), Mercer (43), Monroe (45), Northampton (48), Schuylkill (54)	change Terr 6 rel.	-3.0%
All Other	change Terr 2 rel.	-5.4%

Specialty Changes

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

Specialty Code	Specialty	Change	Impact
00608	Hematology - No Surgery	move to class 00508	-25.4%
00656	Utilization Review	move to class 00556	-25.4%
00634	Administrative Medicine - No Surgery	move to class 00534	-25.4%

Specialty Code	Specialty	Change	Impact
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	move to class 01142	-14.2%
01049	Nuclear Medicine - No Surgery	move to class 00649	-37.7%
01034	Occupational Medicine - Including MRO or Employment Physicals	move to class 00624	-37.7%
01013	Orthopedics - No Surgery	move to class 00613	-37.7%
02055	Ophthalmology - Surgery	move to class 01755	-5.7%
02011	Neurology - Excluding Major Surgery	move to class 02511	+9.4%
02040	Infectious Disease - Excluding Major Surgery	move to class 02540	+9.4%
03022	Cardiology - Including Right Heart or Left Heart Catheterization	move to class 02223	-9.6%

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

Changes Effective 01/01/2011

Rate Change

The JUA decreased its base rates by 9.4%.

Class Rate Changes

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

County / Territory Changes

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

Specialty Changes

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

Changes Effective 01/01/2012

Rate Change

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

Class Rate Changes

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

County / Territory Changes

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

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

We note that the overall rate change for these counties includes the impact of the territory change in addition to the overall indicated rate change.

No changes were made to territorial relativities.

Specialty Changes

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

Changes Effective 01/01/2013

Rate Change

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

certain counties). Based on Mcare's mix of exposures, the overall impact of the JUA rate change on Mcare's 2013 primary prevailing premium is an increase of approximately 5.9%.

Class Rate Changes

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

County / Territory Changes

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

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

We note that the overall rate change for these counties includes the impact of the territory change in addition to the overall indicated rate change.

No changes were made to territorial relativities.

Specialty Changes

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

Specialty Code	Specialty	Change
01037	Endocrinology	move to class 00737
01074	Geriatrics	move to class 00674
01142	Nephrology	move to class 00741
01144	Pulmonary Medicine	move to class 01545

Specialty Code	Specialty	Change
01199	Physicians Not Otherwise Classified - No Surgery (NOC)	move to class 00799
02006	Gastroenterology - Excluding Major Surgery	move to class 02206
07026	Vascular Surgery	move to class 09026
07085	Peripheral Wascular Surgery	move to class 09085

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

Results

The indications for the 2013 prevailing primary premium are \$912.6 million based on 2009 remittances, \$925.6 million based on 2010 remittances, and \$925.4 million based on 2011 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2009), Excerpt B (2010), and Excerpt C (2011). The entire calculation is included under separate cover as Appendix A, Appendix B, and Appendix C, respectively.

Note that the estimates of the primary prevailing premium increased moderately from 2009 to 2010, but are relatively flat from 2010 to 2011. This overall increase appears to be driven by a moderately increasing number of physicians covered by Mcare over the 2009 to 2011 period. Based on discussions with Mcare, we understand that the number of physicians is likely to remain relatively flat in 2012. Based on these observations and considerations, our selected 2013 prevailing primary premium is \$925 million. This selection is consistent with the prevailing primary premium level in 2010 and 2011 as Mcare believes that the previous upward trend has leveled off. Note that this projection may vary from the actual 2013 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 2012 and 2013;
- shifts in the mix (e.g., by specialty, territory, etc.) of health care provider exposures during 2012 and 2013;
- changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2012 and 2013; and
- additional recording of data, notably for 2011, where policy adjustments and late reported assessments will cause the assessment data to change. The year-over-year increase in 2009 and 2010 data was less than 1%.

Note that an abatement program has not yet been extended beyond 2007. 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 2013 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.

2013 Assessment Rate

The cost components of the assessment total \$230.5 million. Given the 2013 prevailing primary premium projection of \$925 million, the indicated 2013 assessment rate is 24.9%. We understand that Mcare will round the assessment rate to 25%.

Since the 2013 assessment rate is based largely on the Fund's obligations for the 2012 claim year, any significant change in the Fund's claim or expense obligations from 2012 to 2013 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 2013 and the degree to which 2013 assessments are abated, if at all. To the extent that funds available in 2013 are insufficient to meet the Fund's 2013 obligations, additional funding or borrowing will be required.

Change from Prior

The indicated rounded 2013 assessment rate of 25% is higher than the 2012 assessment rate of 23%. As the chart below indicates, the claims obligations increased by a greater rate than the projected prevailing primary premium. All else being equal, an increase in the Fund's claims obligations causes the assessment rate to increase (3%, for 2013), but an increase in the projected prevailing primary premium will cause the assessment rate to decrease (1%, for 2013).

The 2012 and 2013 assessment rate calculations are summarized as follows:

	<u>2013</u>	<u>2012</u>	<u>Assessment Rate Impact</u>
(1) Prior Claim Year Claims Settled	195,741,865	170,395,012	3%
(2) Prior Claim Year Operating Expenses	13,824,000	14,900,000	0%
(3) Target Reserve	<u>20,956,587</u>	<u>18,529,501</u>	<u>0%</u>
(4) Assessment Costs, (1)+(2)+(3)	<u>230,522,452</u>	<u>203,824,513</u>	<u>3%</u>
(5) Projected Prevailing Primary Premium	925,000,000	870,000,000	-1%
(6) Indicated Assessment Rate, (4) / (5)	25%	23%	2%

QUALIFICATIONS of PwC ACTUARIES

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

EXHIBITS

Pennsylvania Medical Care Availability and Reduction of Error Fund

Indicated 2013 Assessment Rate

(1)	Claim Year Ending 08/31/2012 Claims Settled	195,741,865
(2)	Claim Year Ending 08/31/2012 Operating Expenses	13,824,000
(3a)	Claim Year Ending 08/31/2012 Principal and Interest Paid or Payable	-
(3b)	Claim Year Ending 08/31/2012 Borrowing Transfers	-
(4)	Target Reserve	<u>20,956,587</u>
(5)	2012 Assessment Costs	<u>230,522,452</u>
	(5) = (1)+(2)+(3a)+(3b)+(4)	
(6)	Projected Policy Year 2013 Prevailing Primary Premium	925,000,000
(7)	Indicated 2013 Assessment Rate	25%
	(7) = (5) / (6)	

Notes:

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

Pennsylvania Medical Care Availability and Reduction of Error Fund

Projected 2013 Prevailing Primary Premium

	<u>Projected Prevailing Primary Premium</u>	<u>Implied Assessment Rate</u>
(1) Projection Based on 2009 Assessment Remittances	912,556,039	25.3%
(2) Projection Based on 2010 Assessment Remittances	925,594,279	24.9%
<u>(3) Projection Based on 2011 Assessment Remittances</u>	<u>925,409,558</u>	<u>24.9%</u>
(4) Projected 2013 Prevailing Primary Premium	925,000,000	24.9%

Notes

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

Calculation and Application of 2013 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**

2013 EXPERIENCE MODIFICATION FACTORS
(In Accordance with Act 13 of 2002)

Prepared by

Actuarial and Insurance Management Solutions

PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania

December 2012



December 10, 2012

Mr. Todd Rittle
Executive Director
Pennsylvania Mcare Fund
30 North Third Street
8th Floor, Suite 800
Harrisburg, Pennsylvania 17108

Dear Mr. Rittle:

Enclosed is our report describing the Experience Rating Plan and the resulting 2013 Experience Modification Factors, developed pursuant to Section 712(g)(4) of Act 13. The factors contained herein are expected to produce results that are "revenue neutral" to the Fund in total and our recommendations for application of the plan are included in the report text.

Please call me at (267) 330-6612 should you have any questions or require anything further.

Sincerely,

A handwritten signature in black ink that reads "Mark R. Proska".

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

A handwritten signature in black ink that reads "Marc Oberholtzer".

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

cc: R. Waeger, Pennsylvania Mcare Fund

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INTRODUCTION

Purpose

The Commonwealth of Pennsylvania established the Medical Professional Liability Catastrophe Loss Fund¹ 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 premium² of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustment shall be based on the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk, and kind within the same defined region during the past five most recent claims periods."

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

Distribution and Use

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

The supporting exhibits are an integral part of this report; as such, the report must only be released in its entirety. Third parties reviewing this report should recognize that the furnishing

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.

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 2008 through 2012;
- Assessment by hospital by policy year for the policy years ending 2009 through 2012, separately identified by policy type (occurrence, claims-made, claims-made plus³, 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 2012 assessment has been estimated⁴ for the 40 hospitals (19% of all hospitals) that have not yet remitted. As estimates, these values are subject to variability. While we believe the projections herein are reasonable based on the information available, there can be no assurance that the actual 2012 assessment will not differ, perhaps significantly, from what we have projected. Please see Appendix A for further description of the 2012 assessment estimation process for the hospitals that have not yet remitted.

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

Database

Given the constraints on the data to be used in the Plan, such that *"Any adjustment shall be based on the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk, and kind within the same defined region during the past five most*

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 2012 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.

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 2012 levels, based on 2010, 2011, and (if available) 2012 baseline policy year assessments⁵. This increases the extent to which the Plan is normalized for *"class, size, risk, and kind"*. The bands are defined as follows⁶:

1. Band 1 Hospitals (AIPPP less than \$305,000)
2. Band 2 Hospitals (AIPPP between \$305,000 and \$590,000)
3. Band 3 Hospitals (AIPPP between \$590,000 and \$1,210,000)
4. Band 4 Hospitals (AIPPP between \$1,210,000 and \$2,450,000)
5. Band 5 Hospitals (AIPPP greater than \$2,450,000)

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

Based on information provided by the Fund, the assessment and payment information has been combined for hospitals that have merged. Data for hospitals that have simply closed is excluded from the analysis. Data for hospitals with insufficient years of experience has also been excluded from the analysis. The result is 208 hospitals for which experience modification factors were determined.

⁵ Historical baseline policy year assessments (defined in the ANALYSIS section below) are adjusted to a 2012 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 2012 (based on 2011 AIPPP), adjusted for JUA changes filed for 2012.

Qualifications of PwC Actuaries

The preparer of this report, Mark R. Proska, Director, and the peer reviewer, Marc Oberholtzer, 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 208 experience modification factors as calculated in Exhibit 1 fall into the following ranges:

Distribution		
From	To (Less Than)	Count
80.0%	85.0%	49
85.0%	90.0%	88
90.0%	95.0%	12
95.0%	100.0%	18
100.0%	105.0%	13
105.0%	110.0%	7
110.0%	115.0%	5
115.0%	120.0%	1
120.0%		15
Total All Rated Hospitals		208

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

Revenue Impact

The 208 experience modification factors are expected to be revenue neutral to the Fund in total. Namely, the factors are determined such that they are revenue neutral when applied to the 2011 baseline assessments. When applied to the 2012 baseline assessments, many of which are estimates, the 2012 modified assessment is less than 0.1% higher than the 2012 baseline assessment. We do not expect a significant revenue impact when these factors are applied in 2013.

Comparison to 2012 Experience Modification Factors

Of the 208 experience modification factors computed herein, 2 are for hospitals that have been rated for the first time. Of the remaining 206 modification factors, 168 are within 5% and 180 are within 7.5% of the 2012 filed experience modification factors. Of the 198 filed experience

modification factors computed herein for hospitals whose band assignment has not changed, 164 are within 5% and 174 are within 7.5% of their 2012 filed experience modification factors.

Of the 34 experience modification factor changes greater than 5%, 11 are Band 3 hospitals and 16 are Band 4 hospitals. Similarly, of the 24 experience modification factor changes greater than 7.5%, 9 are Band 3 hospitals and 10 are Band 4 hospitals.

We reviewed the data to ensure that unsupported changes in the band assignment did not occur. However, some fluctuation in band assignment is normally expected to occur for hospitals lying near the endpoints of a given band's range and for hospitals that have merged.

A comparison of the 2013 experience modification factors to the 2012 experience modification factors for hospitals that have been experience rated for 2013 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 2008 through 2011;
2. Estimating and compiling the baseline assessments for each hospital for each policy year 2009 through 2012;
3. Calculating a rate of recoupment⁷ for each hospital for each year and for each hospital band for each year;
4. Calculating the four relative rates of recoupment for each hospital showing the ratio of the hospital rate of recoupment to the total hospital rate of recoupment for each year and weighting these four relative rates of recoupment together to estimate an average relative rate of recoupment (weighted rate) for the individual hospital;
5. Determining appropriate a priori modification factors;
6. Determining an appropriate credibility weighting procedure and credibility weighting the hospital weighted rate with its band's a priori modification factor; and
7. Computing experience modification factors that lie within the bounds prescribed by Act 13 and that are revenue neutral.

Each of these steps is described below.

Compiling Fund Payment Data (Exhibits 5 and 9)

The Fund provided payment data by hospital by claim year for Excess and Section 715 claims. We used combined data in our analysis in order to fully reflect the *"frequency and severity of claims paid by the Fund"*. The total payment data (included as Exhibit 9) is sorted by hospital by claim year as shown in Exhibit 5.

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 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 2009 through 2012 is used in this analysis. In Exhibit 8, an adjustment is made to the assessments provided by the Fund in order to derive the baseline assessment that is used in the experience modification computation. Namely, the assessments are adjusted to remove the impact of the charged experience modification factors. This adjustment is required because the experience modification factor is applied to the unmodified assessment; as such, it is necessary to compute each hospital's experience relative to its historical unmodified assessment.

This baseline assessment data is then sorted on Exhibit 4 by hospital by policy year for policy years 2009 through 2012⁸. For policy year 2012, information was provided by the Fund for those hospitals who have remitted their 2012 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2012 assessment, the 2012 baseline assessment is estimated as the average of the 2010 and 2011 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes.

Calculating Yearly Rates of Recoupment (Exhibit 3)

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

Rates of recoupment are established as the ratio of the Fund payment data for each claim year (ending 2008 through 2011) to the baseline policy year assessment data for the subsequent policy year (2009 through 2012). 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.

⁸ Note that tail assessments are also removed.

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 2008/2009 through 2011/2012, 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 2012/2013 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 2012/2013 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	<i>Current</i> A Priori Factors	<i>Prior</i> A Priori Factors
1	-17.5%	-17.5%
2	-17.5%	-17.5%
3	-5.0%	-7.5%
4	0.0%	0.0%
5	12.5%	12.5%

Determining an Individual Hospital Credibility Weighting Procedure (Exhibit 7)

Actuarial Standard of Practice No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property / Casualty Coverages*, states, “Credibility procedures should be used in ... prospective experience rating,” and that, “the actuary should select credibility procedures that do the following:

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

We have used a traditional credibility formula of the form:

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

P is typically some measure of the exposure represented by the risk. To establish a credibility procedure sensitive to the "class, size, risk, and kind" of each hospital, we have chosen P equal to the hospitals' 2011 policy year prevailing primary premiums, adjusted for the JUA's 2012 rate change. To calculate P, we divided the Fund's 2011 baseline policy year assessment by the Fund's 2011 assessment rate of 19.0%. We then adjusted the total to reflect the JUA's filed rate change of -3.3% for policy year 2012. Policy periods were annualized where we observed that the 2011 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. 2008/2009, 2009/2010, and 2010/2011 to predict 2011/2012
2. 2008/2009, 2009/2010, and 2011/2012 to predict 2010/2011
3. 2008/2009, 2010/2011, and 2011/2012 to predict 2009/2010
4. 2009/2010, 2010/2011, and 2011/2012 to predict 2008/2009

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

Band	<i>Current</i> Calculations		<i>Prior</i> Calculations	
	Selected K	Implied Avg Z	Selected K	Implied Avg Z
1	40,000,000	0.3%	40,000,000	0.3%
2	20,000,000	2.3%	20,000,000	2.1%
3	8,000,000	9.5%	8,500,000	9.4%
4	6,500,000	20.6%	6,500,000	21.0%
5	5,000,000	44.9%	5,000,000	45.7%

As shown above, the average credibility is generally similar to that of last year. Individual hospital experience is generally given limited credibility: the average Band 1 hospital receives 0.3% credibility and the average Band 5 hospital receives 44.9% credibility.

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

Computing Experience Modification Factors (Exhibit 1)

To achieve a revenue neutral impact on 2013 assessments, we estimated modification factors that are revenue neutral based on the 2011 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2013 assessments⁹. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance¹⁰ adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

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

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

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 2012 Assessment is Different from that Estimated in the Report

As discussed in the ANALYSIS section, the 2012 assessment for those hospitals that have not yet remitted has been estimated; 19% of the 208 rated hospitals have required such estimation. To the extent that the actual 2012 assessments differ from that included in this report, the experience modification factors are impacted, as follows:

1. the individual hospitals' 2011/2012 rates of recoupment will change;
2. the band 2011/2012 rates of recoupment will change;
3. the overall hospital 2011/2012 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 2012 assessments, we expect the end result of these changes to be relatively insignificant, based on the observations below.

1. The individual hospitals' 2011/2012 rates of recoupment will change according to the amount of misestimation of the 2012 assessment, but only for those hospitals with Fund payments in 2011. Any hospital with \$0 of 2011 Fund payments will maintain its 0% recoupment rate.
2. The band 2011/2012 rates of recoupment will change, but this change will be tempered by the band members whose data has not changed.
3. The overall hospital 2011/2012 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 2011/2012 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 2013 revenue change resulting from the change in (6).

Based on these observations, we do not believe a recalculation of the experience modification factor is likely to be needed for those hospitals whose actual 2012 assessment differs from that estimated in this analysis. If the actual 2012 assessment for an individual hospital does differ significantly from that estimated in this analysis, please let us know and we can discuss this further.

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. 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 appear to be supported.

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.

2013 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		\$108,502,306				\$39,770,471				\$45,630,000	\$ -
Percent of Region to Total Paid Claims		55.96%				20.51%				23.53%	0.00%

Total Paid Claims:	\$193,902,777
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Mcare Fund - Paid Claims by Region 2009 - 2013

	Total Annual Claim Payment	<u>Eastern</u>		<u>Central</u>		<u>Western</u>		<u>Other</u>	
		Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims
2009	\$178,236,910	\$81,095,486	45.50%	\$28,147,236	15.79%	\$27,259,161	15.29%	\$3,150,000	1.77%
2010	\$146,484,944	\$88,496,871	60.41%	\$15,151,943	10.34%	\$37,501,130	25.60%	\$5,335,000	3.64%
2011	\$170,395,012	\$88,321,177	51.83%	\$34,110,670	20.02%	\$43,513,165	25.54%	\$4,450,000	2.61%
2012	\$195,741,865	\$124,106,482	63.40%	\$27,675,000	14.14%	\$43,160,383	22.05%	\$800,000	0.41%
2013	\$193,902,777	\$108,502,306	55.96%	\$39,770,471	20.51%	\$45,630,000	23.53%	\$0	0.00%

PA Department of Insurance

Mcare Fund

Claim and Case Payment - 5 Most Recent Years

Year	Fund Money	Claim Count	Average Claim Value	Case Count	Average Case Value
2009	\$ 178,236,910	396	\$ 450,093	292	\$610,400
2010	\$ 146,484,944	329	\$ 445,243	255	\$574,451
2011	\$ 170,395,012	353	\$ 482,705	264	\$645,436
2012	\$ 195,741,865	404	\$ 484,510	267	\$733,116
2013	\$ 193,902,777	414	\$ 468,364	294	\$659,533

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

Mcare Fund

Summary of Annual Fund Claim Payments by Health Care Provider Group 2004-2013

Year	<u>Individuals</u>				<u>Medical Corps</u>				<u>Institutions</u>				<u>Totals</u>	
	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
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	49%	\$ 151,833,293	72%	26	4%	\$ 14,186,262	7%	92	15%	\$ 43,502,794	21%	620	\$ 209,522,349
2007	273	65%	\$ 123,762,853	65%	25	6%	\$ 12,560,972	7%	124	29%	\$ 55,041,986	29%	422	\$ 191,365,811
2008	256	61%	\$ 116,967,358	67%	16	4%	\$ 8,165,387	5%	105	25%	\$ 48,760,129	28%	422	\$ 173,892,874
2009	285	72%	\$ 127,713,538	72%	14	4%	\$ 9,012,513	5%	97	24%	\$ 41,510,859	23%	396	\$ 178,236,910
2010	194	59%	\$ 87,936,023	60%	10	3%	\$ 5,592,973	4%	125	38%	\$ 52,955,948	36%	329	\$ 146,484,944
2011	230	65%	\$ 110,890,028	65%	18	5%	\$ 8,543,331	5%	105	30%	\$ 50,961,653	30%	353	\$ 170,395,012
2012	256	63%	\$ 128,473,897	66%	16	4%	\$ 8,912,666	5%	132	33%	\$ 58,355,302	30%	404	\$ 195,741,865
2013	267	64%	\$ 125,139,084	65%	21	5%	\$ 9,230,191	5%	126	30%	\$ 59,533,502	31%	414	\$ 193,902,777

Mcare Fund

**2013 Claims Payments by Primary
Carrier and Self-Insurer**

Company Code	Total Fund Payments
S01	\$ 4,000,000
S10	\$ 1,625,000
S12	\$ 1,532,357
S49	\$ 1,000,000
S60	\$ 1,000,000
S62	\$ 1,500,000
S66	\$ 254,000
003	\$ 13,170,000
011	\$ 2,350,000
031	\$ 19,113,834
032	\$ 2,100,000
045	\$ 1,000,000
067	\$ 13,253,500
086	\$ 1,127,470
093	\$ 2,875,000
121	\$ 1,000,000
129	\$ 3,100,000
136	\$ 2,385,000
139	\$ 800,000
144	\$ 14,750,000
145	\$ 2,411,644
155	\$ 11,535,000
156	\$ 7,050,000
159	\$ 232,000
184	\$ 1,600,000
185	\$ 375,000
196	\$ 1,700,000
197	\$ 5,559,421
199	\$ 8,775,000
202	\$ 9,490,000
207	\$ 13,731,250
208	\$ 500,000
210	\$ 1,000,000
211	\$ 5,740,000
212	\$ 500,000
219	\$ 2,775,000
220	\$ 1,575,000
221	\$ 2,509,608
222	\$ 500,000
223	\$ 2,450,000
224	\$ 1,000,000
239	\$ 500,000
241	\$ 1,000,000
245	\$ 6,082,693
246	\$ 3,025,000
253	\$ 5,050,000
258	\$ 1,000,000
261	\$ 500,000
271	\$ 2,300,000
276	\$ 2,100,000
279	\$ 150,000
285	\$ 500,000
310	\$ 2,750,000
Totals	\$ 193,902,777

Mcare Fund**2009 - 2013 Claim Payments by Primary Carrier and Self-Insurer**

Carrier Code	2009	2010	2011	2012	2013
S01	\$ 700,000				\$ 4,000,000
S07					
S10	\$ 2,500,000	\$ 3,000,000	\$ 3,700,000	\$ 1,630,000	\$ 1,625,000
S11	\$ 750,000				
S12	\$ 700,000	\$ 500,000	\$ 1,375,000	\$ 1,500,000	\$ 1,532,357
S14					
S23				\$ 50,000	
S24			\$ 500,000		
S32			\$ 950,000		
S34					
S36	\$ 750,000				
S40				\$ 450,000	
S41		\$ 500,000	\$ 500,000	\$ 1,000,000	
S43		\$ 750,000			
S45					
S48			\$ 1,000,000		
S49					\$ 1,000,000
S51			\$ 1,000,000	\$ 500,000	
S53	\$ 1,200,000		\$ 500,000	\$ 500,000	
S54					
S57		\$ 500,000			
S60		\$ 400,000	\$ 1,000,000		\$ 1,000,000
S62		\$ 500,000		\$ 1,500,000	\$ 1,500,000
S63				\$ 404,990	
S66					\$ 254,000
003	\$ 20,094,627	\$ 11,007,385	\$ 12,407,633	\$ 16,700,000	\$ 13,170,000
011	\$ 5,340,251	\$ 1,600,000	\$ 1,975,000	\$ 500,000	\$ 2,350,000
020		\$ 500,000			
031	\$ 17,861,959	\$ 9,520,502	\$ 12,962,642	\$ 10,980,409	\$ 19,113,834
032	\$ 5,600,000	\$ 2,130,000	\$ 2,275,000	\$ 4,030,000	\$ 2,100,000
039				\$ 250,000	
045	\$ 100,000	\$ 700,000	\$ 205,000		\$ 1,000,000
052			\$ 100,000		
055		\$ 125,000			
067	\$ 13,458,485	\$ 7,770,531	\$ 17,993,170	\$ 20,503,076	\$ 13,253,500
086	\$ 4,340,859	\$ 675,000	\$ 5,407,500	\$ 11,075,331	\$ 1,127,470
088					
093	\$ 4,025,000	\$ 2,325,000	\$ 1,600,000	\$ 875,000	\$ 2,875,000
102					
103			\$ 500,000	\$ 800,000	
112					
119	\$ 675,000	\$ 394,917	\$ 855,083	\$ 1,000,000	
121	\$ 2,147,661	\$ 700,000	\$ 200,000	\$ 1,700,000	\$ 1,000,000
124			\$ 425,000	\$ 10,000	

Mcare Fund**2009 - 2013 Claim Payments by Primary Carrier and Self-Insurer**

Carrier Code	2009	2010	2011	2012	2013
126	\$ 1,800,000	\$ 661,031	\$ 1,000,000	\$ 2,000,000	
129	\$ 5,250,000	\$ 7,700,000	\$ 2,750,000	\$ 5,450,000	\$ 3,100,000
131					
135	\$ 3,630,987			\$ 110,189	
136	\$ 4,797,784	\$ 2,325,000	\$ 1,550,000	\$ 3,700,000	\$ 2,385,000
139		\$ 500,000			\$ 800,000
143	\$ 1,425,000		\$ 139,261		
144	\$ 11,875,000	\$ 5,675,000	\$ 12,324,000	\$ 12,895,000	\$ 14,750,000
145	\$ 1,792,500	\$ 7,200,000	\$ 2,425,000	\$ 3,925,000	\$ 2,411,644
155	\$ 14,544,463	\$ 13,200,000	\$ 13,953,751	\$ 9,695,000	\$ 11,535,000
156	\$ 6,120,000	\$ 5,860,000	\$ 5,375,000	\$ 11,841,622	\$ 7,050,000
157					
159	\$ 25,000				\$ 232,000
160	\$ 500,000		\$ 1,313,804	\$ 125,000	
161	\$ 1,555,000				
162	\$ 700,000	\$ 5,693,463	\$ 1,200,000		
164					
166					
167	\$ 150,000				
169					
183	\$ 500,000				
184	\$ 1,500,000	\$ 2,500,000	\$ 1,818,092	\$ 2,700,000	\$ 1,600,000
185					\$ 375,000
194	\$ 550,000	\$ 1,000,000	\$ 500,000		
196	\$ 1,500,000	\$ 1,200,000			\$ 1,700,000
197	\$ 2,699,000	\$ 3,700,000	\$ 2,537,500	\$ 3,400,000	\$ 5,559,421
199	\$ 2,950,000	\$ 1,765,000	\$ 1,850,000	\$ 2,633,501	\$ 8,775,000
201	\$ 300,000				
202	\$ 4,200,000	\$ 5,075,000	\$ 7,845,426	\$ 7,260,000	\$ 9,490,000
203	\$ 200,000		\$ 500,000	\$ 500,000	
207	\$ 14,675,834	\$ 12,209,500	\$ 12,832,067	\$ 17,422,747	\$ 13,731,250
208		\$ 912,615	\$ 120,000		\$ 500,000
210					\$ 1,000,000
211	\$ 1,512,500	\$ 3,750,000	\$ 7,236,287	\$ 8,250,000	\$ 5,740,000
212		\$ 400,000			\$ 500,000
219		\$ 450,000	\$ 2,000,000	\$ 1,800,000	\$ 2,775,000
220	\$ 1,125,000	\$ 1,950,000	\$ 1,590,000	\$ 2,875,000	\$ 1,575,000
221	\$ 3,500,000	\$ 3,050,000	\$ 3,585,275	\$ 2,550,000	\$ 2,509,608
222		\$ 1,010,000	\$ 500,000	\$ 1,400,000	\$ 500,000
223		\$ 800,000	\$ 618,521	\$ 5,000,000	\$ 2,450,000
224	\$ 650,000	\$ 500,000	\$ 1,000,000	\$ 300,000	\$ 1,000,000
228	\$ 2,250,000	\$ 300,000	\$ 1,250,000	\$ 1,150,000	
229	\$ 300,000	\$ 950,000	\$ 2,500,000	\$ 700,000	
234		\$ 200,000			

Mcare Fund**2009 - 2013 Claim Payments by Primary Carrier and Self-Insurer**

Carrier Code	2009	2010	2011	2012	2013
239	\$ 500,000	\$ 800,000			\$ 500,000
241	\$ 550,000	\$ 400,000	\$ 650,000	\$ 900,000	\$ 1,000,000
243			\$ 500,000		
245	\$ 500,000	\$ 1,000,000	\$ 2,900,000	\$ 1,500,000	\$ 6,082,693
246	\$ 1,255,000	\$ 1,850,000	\$ 2,700,000	\$ 500,000	\$ 3,025,000
248	\$ 160,000	\$ 500,000			
250			\$ 1,000,000		
251	\$ 200,000			\$ 500,000	
253	\$ 2,000,000	\$ 6,000,000	\$ 1,650,000	\$ 3,050,000	\$ 5,050,000
256			\$ 500,000		
258	\$ 250,000	\$ 300,000	\$ 250,000	\$ 500,000	\$ 1,000,000
261		\$ 1,000,000	\$ 500,000	\$ 500,000	\$ 500,000
262				\$ 1,500,000	
271			\$ 500,000	\$ 400,000	\$ 2,300,000
276		\$ 500,000	\$ 1,000,000	\$ 1,400,000	\$ 2,100,000
279					\$ 150,000
285				\$ 500,000	\$ 500,000
286				\$ 350,000	
293			\$ 500,000		
310				\$ 500,000	\$ 2,750,000
Totals	\$ 178,236,910	\$ 146,484,944	\$ 170,395,012	\$ 195,741,865	\$ 193,902,777

Mcare Fund
**2013 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
001	\$ 11,760
003	\$ 16,066,203
011	\$ 2,906,597
021	\$ 84,370
023	\$ 108,706
031	\$ 20,068,991
032	\$ 855,787
052	\$ 117,847
067	\$ 13,874,470
090	\$ 80,808
103	\$ 663,145
110	\$ 73,128
112	\$ 10,064
113	\$ 15,394
118	\$ 9,171
121	\$ 518,419
124	\$ 836,211
127	\$ 238,298
129	\$ 4,718,221
130	\$ 63,002
137	\$ 114,141
138	\$ 847,793
144	\$ 23,388,153
145	\$ 5,328,576
155	\$ 15,918,045
156	\$ 8,748,288
162	\$ 123,672
165	\$ 230,964
173	\$ 1,242
179	\$ 15,187
186	\$ 22,421
194	\$ 11,449
196	\$ 1,240,910
197	\$ 6,871,460
198	\$ 118,884
199	\$ 5,391,293
202	\$ 7,752,674
203	\$ 1,748,119
207	\$ 16,094,411
208	\$ 2,160,918
210	\$ 227,732
211	\$ 7,406,958
212	\$ 392,633
216	\$ 6,893
217	\$ 380,113
218	\$ 383,799
219	\$ 4,268,560
220	\$ 1,841,231
221	\$ 4,319,574

Mcare Fund
**2013 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
222	\$ 4,552,026
223	\$ 3,756,310
224	\$ 2,297,908
225	\$ 80,901
226	\$ 79,396
228	\$ 1,660,508
232	\$ 136,305
234	\$ 217,077
235	\$ 81,258
236	\$ 28,596
237	\$ 21,057
239	\$ 2,273,518
241	\$ 983,431
242	\$ 41,922
243	\$ 26,343
244	\$ 52,383
245	\$ 7,868,578
246	\$ 1,811,159
247	\$ 27,567
248	\$ 448,322
249	\$ 23,353
252	\$ 57,281
253	\$ 4,760,749
258	\$ 1,799,155
261	\$ 966,078
262	\$ 68,836
264	\$ 1,308
265	\$ 149,389
266	\$ 46,564
267	\$ 807
271	\$ 2,401,360
274	\$ 193,293
275	\$ 18,100
276	\$ 597,600
277	\$ 99,773
279	\$ 653,840
286	\$ 120,817
289	\$ 75,015
290	\$ 76,356
291	\$ 5,520
292	\$ 7,992
293	\$ 17,484
294	\$ 1,813
296	\$ 3,324
298	\$ 32,910
303	\$ 39,587
305	\$ 39,130
307	\$ 3,155
308	\$ 1,075,403

Mcare Fund
**2013 Assessment Remitted by
Commercial Carrier**

Company Code	Amount ¹
310	\$ 6,134,442
312	\$ 20,797
313	\$ 1,242
314	\$ 124,933
315	\$ 52,256
320	\$ 297,410
321	\$ 36,116
322	\$ 45,692
323	\$ 50,630
324	\$ 32,452
325	\$ 31,562
326	\$ 42,926
327	\$ 23,441
328	\$ 547,285
329	\$ 127,517
330	\$ 443,262
331	\$ 550,482
333	\$ 215,352
334	\$ 229,235
336	\$ 3,747
338	\$ 1,670,126
339	\$ 24,230
340	\$ 148
Total	\$ 227,162,525

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 28, 2014.

PA Department of Insurance

Mcare Fund

Assessment Remitted by Commercial Carrier for 2009 - 2013

	2009	2010	2011	2012	2013
Carrier Code	Amount ¹				
001	\$ 17,490	\$ 12,880	\$ 10,341	\$ 11,721	\$ 11,760
003	\$ 14,640,077	\$ 14,228,746	\$ 11,622,126	\$ 12,917,797	\$ 16,066,203
011	\$ 2,465,129	\$ 2,732,389	\$ 2,463,761	\$ 2,344,444	\$ 2,906,597
021	\$ 82,229	\$ 81,444	\$ 69,248	\$ 82,237	\$ 84,370
023	\$ 51,034	\$ 58,538	\$ 58,602	\$ 101,056	\$ 108,706
031	\$ 21,572,773	\$ 21,276,762	\$ 17,187,441	\$ 18,768,756	\$ 20,068,991
032	\$ 1,640,523	\$ 1,289,616	\$ 865,976	\$ 852,366	\$ 855,787
052	\$ 203,452	\$ 115,870	\$ 93,634	\$ 71,237	\$ 117,847
067	\$ 15,815,478	\$ 15,192,037	\$ 11,626,874	\$ 12,669,595	\$ 13,874,470
090	\$ 124,663	\$ 70,966	\$ 69,784	\$ 66,940	\$ 80,808
103	\$ 450,346	\$ 416,908	\$ 332,931	\$ 274,654	\$ 663,145
110	\$ 35,085	\$ 39,745	\$ 37,335	\$ 52,843	\$ 73,128
112	\$ 180,419	\$ 113,931	\$ 96,636	\$ 8,661	\$ 10,064
113		\$ 2,434	\$ 8,969	\$ 10,868	\$ 15,394
118	\$ 7,157			\$ 18,269	\$ 9,171
121	\$ 678,834	\$ 678,970	\$ 549,636	\$ 491,566	\$ 518,419
124	\$ 885,896	\$ 830,255	\$ 678,519	\$ 788,364	\$ 836,211
127	\$ 331,553	\$ 360,052	\$ 316,702	\$ 376,317	\$ 238,298
129	\$ 5,249,232	\$ 5,348,398	\$ 4,152,203	\$ 4,359,356	\$ 4,718,221
130				\$ 19,970	\$ 63,002
137	\$ 118,536	\$ 118,127	\$ 79,619	\$ 95,517	\$ 114,141
138	\$ 596,813	\$ 717,329	\$ 765,894	\$ 742,567	\$ 847,793
139	\$ 56,086				
144	\$ 16,864,092	\$ 18,023,416	\$ 15,900,676	\$ 18,955,347	\$ 23,388,153
145	\$ 4,092,820	\$ 4,215,232	\$ 3,679,569	\$ 4,759,242	\$ 5,328,576
155	\$ 14,716,471	\$ 14,960,854	\$ 12,372,742	\$ 13,785,689	\$ 15,918,045
156	\$ 10,275,742	\$ 9,119,695	\$ 7,134,927	\$ 7,941,147	\$ 8,748,288
162	\$ 36,978	\$ 17,535	\$ 17,843	\$ 69,802	\$ 123,672
165	\$ 184	\$ 22,085	\$ 196,389	\$ 253,964	\$ 230,964
169		\$ 4,180			
173					\$ 1,242
179	\$ 37,368	\$ 36,539	\$ 30,926	\$ 35,611	\$ 15,187
186	\$ 113,095	\$ 105,611	\$ 60,230	\$ 34,101	\$ 22,421
191	\$ 20,188				
194	\$ 21,707	\$ 106,244	\$ 94,753	\$ 48,581	\$ 11,449
196	\$ 1,260,810	\$ 1,186,669	\$ 1,061,362	\$ 979,269	\$ 1,240,910
197	\$ 4,925,958	\$ 4,958,432	\$ 4,276,861	\$ 5,609,581	\$ 6,871,460
198	\$ 6,218	\$ 107,345	\$ 87,992	\$ 103,003	\$ 118,884
199	\$ 4,587,769	\$ 4,849,906	\$ 4,066,367	\$ 4,610,605	\$ 5,391,293
202	\$ 7,791,910	\$ 8,064,521	\$ 6,638,291	\$ 6,456,603	\$ 7,752,674

PA Department of Insurance

Mcare Fund

Assessment Remitted by Commercial Carrier for 2009 - 2013

	2009	2010	2011	2012	2013
Carrier Code	Amount ¹				
203	\$ 1,294,032	\$ 1,369,529	\$ 1,317,791	\$ 1,324,022	\$ 1,748,119
206	\$ 54,164	\$ 24,312	\$ 28,762	\$ 23,432	
207	\$ 19,106,824	\$ 14,794,610	\$ 12,769,476	\$ 14,143,163	\$ 16,094,411
208	\$ 1,869,667	\$ 1,970,565	\$ 1,669,842	\$ 1,862,427	\$ 2,160,918
210	\$ 787,745	\$ 878,320	\$ 893,358	\$ 1,568,812	\$ 227,732
211	\$ 8,350,530	\$ 8,935,740	\$ 6,973,924	\$ 7,628,094	\$ 7,406,958
212	\$ 185,955	\$ 199,165	\$ 234,820	\$ 269,399	\$ 392,633
216	\$ 7,039	\$ 7,392	\$ 5,448	\$ 5,644	\$ 6,893
217	\$ 384,630	\$ 357,590	\$ 288,634	\$ 332,970	\$ 380,113
218	\$ 258,318	\$ 285,174	\$ 259,598	\$ 297,256	\$ 383,799
219	\$ 4,348,616	\$ 3,994,216	\$ 3,351,000	\$ 3,530,970	\$ 4,268,560
220	\$ 2,096,701	\$ 2,171,582	\$ 1,859,360	\$ 2,185,498	\$ 1,841,231
221	\$ 4,409,132	\$ 4,458,489	\$ 3,369,688	\$ 3,472,821	\$ 4,319,574
222	\$ 3,299,424	\$ 3,456,560	\$ 3,071,859	\$ 3,603,862	\$ 4,552,026
223	\$ 3,500,761	\$ 3,418,202	\$ 675,817	\$ 5,712,969	\$ 3,756,310
224	\$ 1,714,927	\$ 1,771,812	\$ 1,537,678	\$ 1,890,286	\$ 2,297,908
225	\$ 47,223	\$ 55,395	\$ 58,234	\$ 70,114	\$ 80,901
226	\$ 82,373	\$ 81,390	\$ 64,177	\$ 75,865	\$ 79,396
227	\$ 3,338	\$ 3,360	\$ 2,755	\$ 3,225	
228	\$ 1,607,351	\$ 1,633,760	\$ 1,297,886	\$ 1,470,236	\$ 1,660,508
229	\$ 2,324				
230	\$ 20,715	\$ 20,859	\$ 7,414		
232	\$ 60,383	\$ 101,537	\$ 124,590	\$ 122,349	\$ 136,305
233	\$ 617	\$ 119	\$ 1,339	\$ 1,504	
234	\$ 225,656	\$ 211,684	\$ 171,751	\$ 196,256	\$ 217,077
235	\$ 73,644	\$ 73,290	\$ 60,010	\$ 69,698	\$ 81,258
236	\$ 77,890	\$ 53,065	\$ 14,613	\$ 17,106	\$ 28,596
237	\$ 37,613	\$ 18,081	\$ 37,038	\$ 20,319	\$ 21,057
239	\$ 2,544,367	\$ 2,501,599	\$ 2,327,394	\$ 2,308,847	\$ 2,273,518
241	\$ 927,277	\$ 936,689	\$ 780,430	\$ 841,842	\$ 983,431
242	\$ 37,341	\$ 37,599	\$ 30,820	\$ 36,079	\$ 41,922
243	\$ 26,843	\$ 23,892	\$ 19,320	\$ 22,679	\$ 26,343
244	\$ 93,843	\$ 92,656	\$ 73,106	\$ 43,307	\$ 52,383
245	\$ 5,082,741	\$ 5,428,849	\$ 4,995,085	\$ 6,501,002	\$ 7,868,578
246	\$ 2,391,723	\$ 2,147,574	\$ 1,658,352	\$ 1,722,352	\$ 1,811,159
247	\$ 25,672	\$ 33,744	\$ 30,528	\$ 40,213	\$ 27,567
248	\$ 302,166	\$ 314,244	\$ 289,671	\$ 370,397	\$ 448,322
249	\$ 11,427	\$ 21,289	\$ 15,689	\$ 14,768	\$ 23,353
250	\$ 549,842	\$ 482,819	\$ 51,022		
251	\$ 73,792	\$ 53,983	\$ 44,006		

PA Department of Insurance

Mcare Fund

Assessment Remitted by Commercial Carrier for 2009 - 2013

	2009	2010	2011	2012	2013
Carrier Code	Amount ¹				
252	\$ 78,382	\$ 67,892	\$ 53,245	\$ 54,571	\$ 57,281
253	\$ 3,965,972	\$ 4,122,858	\$ 3,485,401	\$ 4,136,508	\$ 4,760,749
257	\$ 69,671	\$ 48,673	\$ 38,693	\$ 17,602	
258	\$ 2,105,917	\$ 1,916,725	\$ 1,589,848	\$ 1,684,841	\$ 1,799,155
261	\$ 1,326,180	\$ 1,197,276	\$ 1,282,394	\$ 1,180,151	\$ 966,078
262	\$ 26,752	\$ 33,772	\$ 36,892	\$ 62,788	\$ 68,836
263	\$ 3,080				
264	\$ 1,075	\$ 920	\$ 949	\$ 1,066	\$ 1,308
265	\$ 28,958	\$ 13,756	\$ 66,711	\$ 140,669	\$ 149,389
266	\$ 25,919	\$ 26,099	\$ 35,759	\$ 38,691	\$ 46,564
267	\$ 536	\$ 573	\$ 470	\$ 633	\$ 807
268	\$ 5,204	\$ 1,752	\$ 1,674	\$ 2,043	
271	\$ 1,670,191	\$ 2,509,786	\$ 2,162,136	\$ 2,507,596	\$ 2,401,360
274	\$ 164,117	\$ 181,037	\$ 145,726	\$ 175,616	\$ 193,293
275	\$ 471,145	\$ 550,538	\$ 401,488	\$ 543,147	\$ 18,100
276	\$ 538,114	\$ 538,184	\$ 437,079	\$ 512,402	\$ 597,600
277		\$ 31,687	\$ 58,541	\$ 70,830	\$ 99,773
279	\$ 216,826	\$ 540,063	\$ 470,105	\$ 593,152	\$ 653,840
281	\$ 949				
282	\$ 70,584	\$ 41,605	\$ 24,332		
285	\$ 273,106	\$ 420,044	\$ 218,021		
286	\$ 50,081	\$ 78,039	\$ 119,105	\$ 157,730	\$ 120,817
289		\$ 13,782	\$ 11,298	\$ 59,699	\$ 75,015
290	\$ 113,197	\$ 64,152	\$ 59,224	\$ 64,324	\$ 76,356
291				\$ 19,927	\$ 5,520
292	\$ 37,934	\$ 11,491	\$ 13,718	\$ 71,920	\$ 7,992
293	\$ 50,314	\$ 53,367	\$ 46,060	\$ 47,614	\$ 17,484
294	\$ 2,944	\$ 7,299	\$ 5,982	\$ 4,734	\$ 1,813
296	\$ 2,682	\$ 2,814	\$ 7,908	\$ 2,797	\$ 3,324
297	\$ 33,500	\$ 18,398	\$ 8,824	\$ 11,047	
298	\$ 5,495	\$ 24,403	\$ 25,482	\$ 26,560	\$ 32,910
303		\$ 19,540	\$ 29,308	\$ 30,070	\$ 39,587
305	\$ 2,678	\$ 45,945	\$ 38,857	\$ 36,547	\$ 39,130
307		\$ 1,272	\$ 1,147	\$ 2,633	\$ 3,155
308		\$ 360,392	\$ 569,135	\$ 798,903	\$ 1,075,403
310	\$ 3,225	\$ 4,836,527	\$ 3,968,241	\$ 5,458,490	\$ 6,134,442
312				\$ 34,459	\$ 20,797
313	\$ 572	\$ 882	\$ 723	\$ 904	\$ 1,242
314		\$ 25,112	\$ 43,592	\$ 111,025	\$ 124,933
315		\$ 53,824	\$ 44,083	\$ 41,374	\$ 52,256

PA Department of Insurance

Mcare Fund

Assessment Remitted by Commercial Carrier for 2009 - 2013

	2009	2010	2011	2012	2013
Carrier Code	Amount ¹				
316			\$ 12,325	\$ 29,157	
318			\$ 7,288	\$ 4,435	
320			\$ 137,894	\$ 471,640	\$ 297,410
321				\$ 5,926	\$ 36,116
322			\$ 5,224	\$ 30,874	\$ 45,692
323				\$ 62,024	\$ 50,630
324	\$ 408			\$ 25,623	\$ 32,452
325				\$ 20	\$ 31,562
326				\$ 9,725	\$ 42,926
327					\$ 23,441
328				\$ 330	\$ 547,285
329				\$ 97,845	\$ 127,517
330				\$ 46	\$ 443,262
331					\$ 550,482
332			\$ 20	\$ 735	
333					\$ 215,352
334					\$ 229,235
336					\$ 3,747
338					\$ 1,670,126
339					\$ 24,230
340					\$ 148
900	\$ 6,278	\$ 2,428	\$ 1,486	\$ 1,032	
Total	\$ 207,280,727	\$ 209,747,303	\$ 172,833,832	\$ 200,009,904	\$ 227,162,525

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 24, 2014.

Mcare Fund

**2013 Assessment Remitted by
Self-Insurer**

Company Code	Amount ¹
S10	\$ 5,096,289
S12	\$ 2,124,755
S40	\$ 536,361
S41	\$ 75,056
S54	\$ 483,422
S58	\$ 14,445
S60	\$ 553,601
S61	\$ 12,555
S63	\$ 216,347
S64	\$ 16,946
S67	\$ 11,114
TOTALS	\$ 9,140,891

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 24, 2014.

Mcare Fund					
Assessments Remitted by Self-Insurer 2009 - 2013					
Carrier	2009	2010	2011	2012	2013
S10	\$ 4,401,573	\$ 4,580,935	\$ 3,846,617	\$ 3,925,897	\$ 5,096,289
S12	\$ 1,442,094	\$ 1,497,885	\$ 1,447,174	\$ 1,701,255	\$ 2,124,755
S40	\$ 398,985	\$ 421,831	\$ 320,702	\$ 408,489	\$ 536,361
S41	\$ 84,109	\$ 75,339	\$ 61,967	\$ 68,635	\$ 75,056
S43	\$ 265,791				
S46	\$ 11,331				
S49	\$ 661,673	\$ 639,790	\$ 519,316		
S51	\$ 661,708	\$ 540,122	\$ 291,594		
S53	\$ 190,741	\$ 182,191	\$ 76,434		
S54	\$ 343,321	\$ 372,268	\$ 342,107	\$ 393,845	\$ 483,422
S57	\$ 49,877	\$ 52,078	\$ 39,633	\$ 21,273	
S58	\$ 13,637	\$ 16,372	\$ 10,656	\$ 12,482	\$ 14,445
S59	\$ 22,223	\$ 11,932			
S60	\$ 419,605	\$ 399,292	\$ 387,342	\$ 481,557	\$ 553,601
S61	\$ 11,367	\$ 11,445	\$ 9,306	\$ 10,805	\$ 12,555
S63	\$ 250,675	\$ 244,193	\$ 154,020	\$ 178,381	\$ 216,347
S64	\$ 15,095	\$ 15,199	\$ 12,459	\$ 14,663	\$ 16,946
S66	\$ 467,498				
S67		\$ 3,004	\$ 14,561	\$ 9,742	\$ 11,114
TOTALS	\$ 9,711,303	\$ 9,063,876	\$ 7,533,888	\$ 7,227,024	\$ 9,140,891

¹ The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 24, 2014.

Mcare Fund

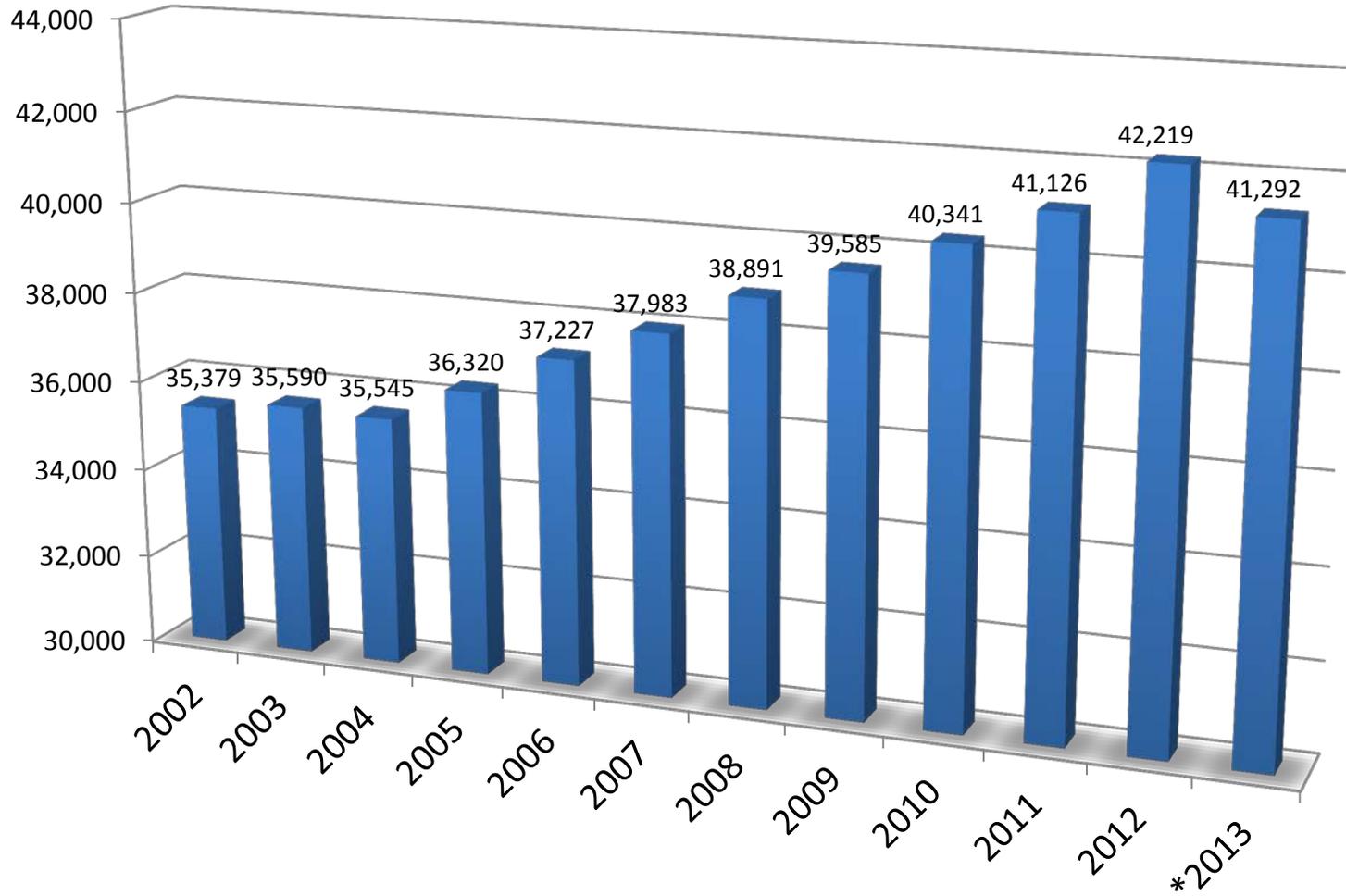
Count of Unique Health Care Providers by Provider Type by Assessment Year

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Total Annual Count of Unique Providers
2002	35,379	1,099	225	236	736	6	3	37,684
2003	35,590	1,097	231	233	728	6	4	37,889
2004	35,545	1,104	231	231	716	5	4	37,836
2005	36,320	1,090	244	225	720	5	3	38,607
2006	37,227	1,111	253	225	711	5	3	39,535
2007	37,983	1,110	266	226	715	4	4	40,308
2008	38,891	1,126	266	224	712	5	4	41,228
2009	39,585	1,138	255	221	712	5	4	41,920
2010	40,341	1,162	271	223	700	5	4	42,706
2011	41,126	1,175	285	223	699	5	5	43,518
2012	42,219	1,201	309	221	697	5	5	44,657
*2013	41,292	1,194	311	211	678	5	4	43,695

*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that has been reported and processed as of February 24, 2014, are included in the counts.

Mcare Fund

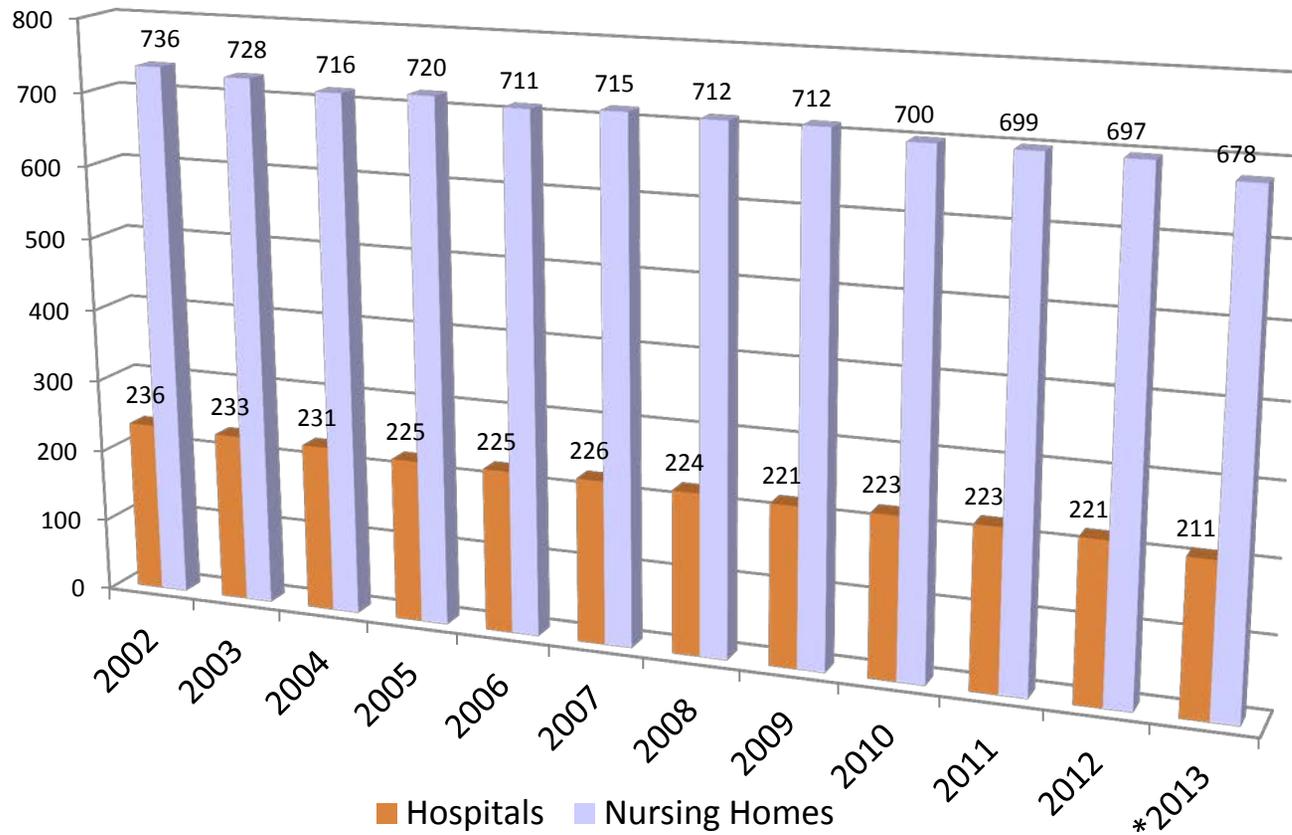
Unique Count of Physicians (MD/DO)



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

Unique Count of Hospitals and Nursing Homes



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

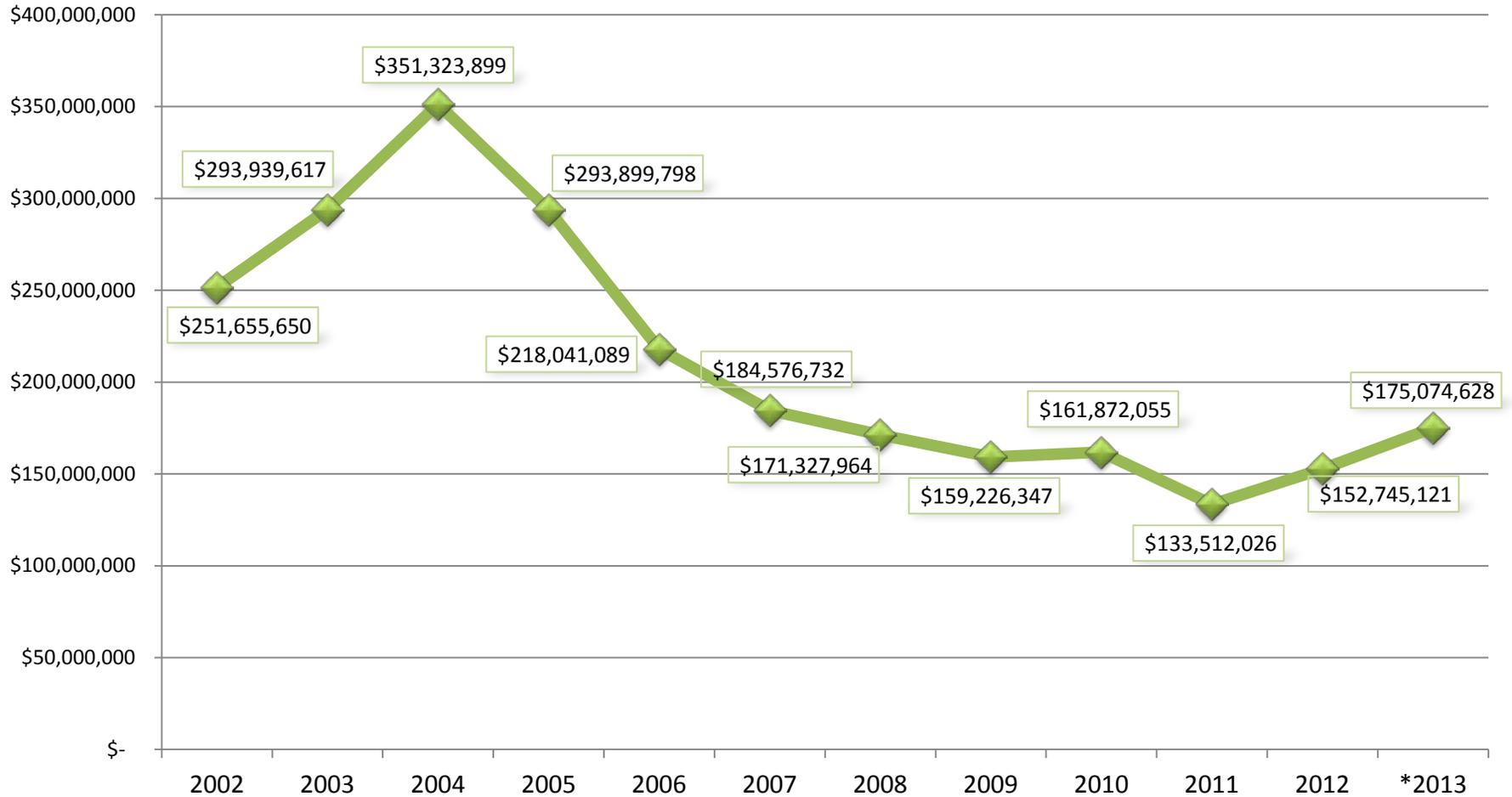
Mcare Fund**Amount of Assessment Received by Provider Type by Assessment Year**

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Ctrs	Birth Centers
2002	\$ 251,655,650	\$ 4,932,582	\$ 514,318	\$ 64,779,436	\$ 4,061,429	\$ 915,800	\$ 6,212
2003	\$ 293,939,617	\$ 5,919,908	\$ 825,749	\$ 73,105,848	\$ 8,777,237	\$ 880,037	\$ 14,632
2004	\$ 351,323,899	\$ 6,480,906	\$ 1,210,251	\$ 76,947,309	\$ 9,890,247	\$ 947,025	\$ 20,432
2005	\$ 293,899,798	\$ 6,170,358	\$ 1,280,876	\$ 75,094,669	\$ 8,957,666	\$ 885,526	\$ 20,382
2006	\$ 218,041,089	\$ 5,019,667	\$ 1,074,833	\$ 61,334,521	\$ 6,437,525	\$ 897,225	\$ 15,572
2007	\$ 184,576,732	\$ 3,692,160	\$ 965,769	\$ 49,332,452	\$ 5,374,291	\$ 767,941	\$ 18,061
2008	\$ 171,327,964	\$ 2,990,281	\$ 996,867	\$ 45,417,759	\$ 5,233,582	\$ 813,838	\$ 20,708
2009	\$ 159,226,347	\$ 2,819,565	\$ 890,670	\$ 41,915,063	\$ 4,765,624	\$ 776,744	\$ 19,991
2010	\$ 161,872,055	\$ 2,915,572	\$ 980,820	\$ 41,545,120	\$ 4,572,332	\$ 784,659	\$ 24,203
2011	\$ 133,512,026	\$ 2,421,547	\$ 814,723	\$ 33,445,821	\$ 3,772,982	\$ 665,985	\$ 21,712
2012	\$ 152,745,121	\$ 3,070,687	\$ 1,068,855	\$ 40,058,689	\$ 4,106,178	\$ 831,401	\$ 33,191
*2013	\$ 175,074,628	\$ 3,738,367	\$ 1,314,550	\$ 45,041,927	\$ 5,270,285	\$ 927,072	\$ 25,405

*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

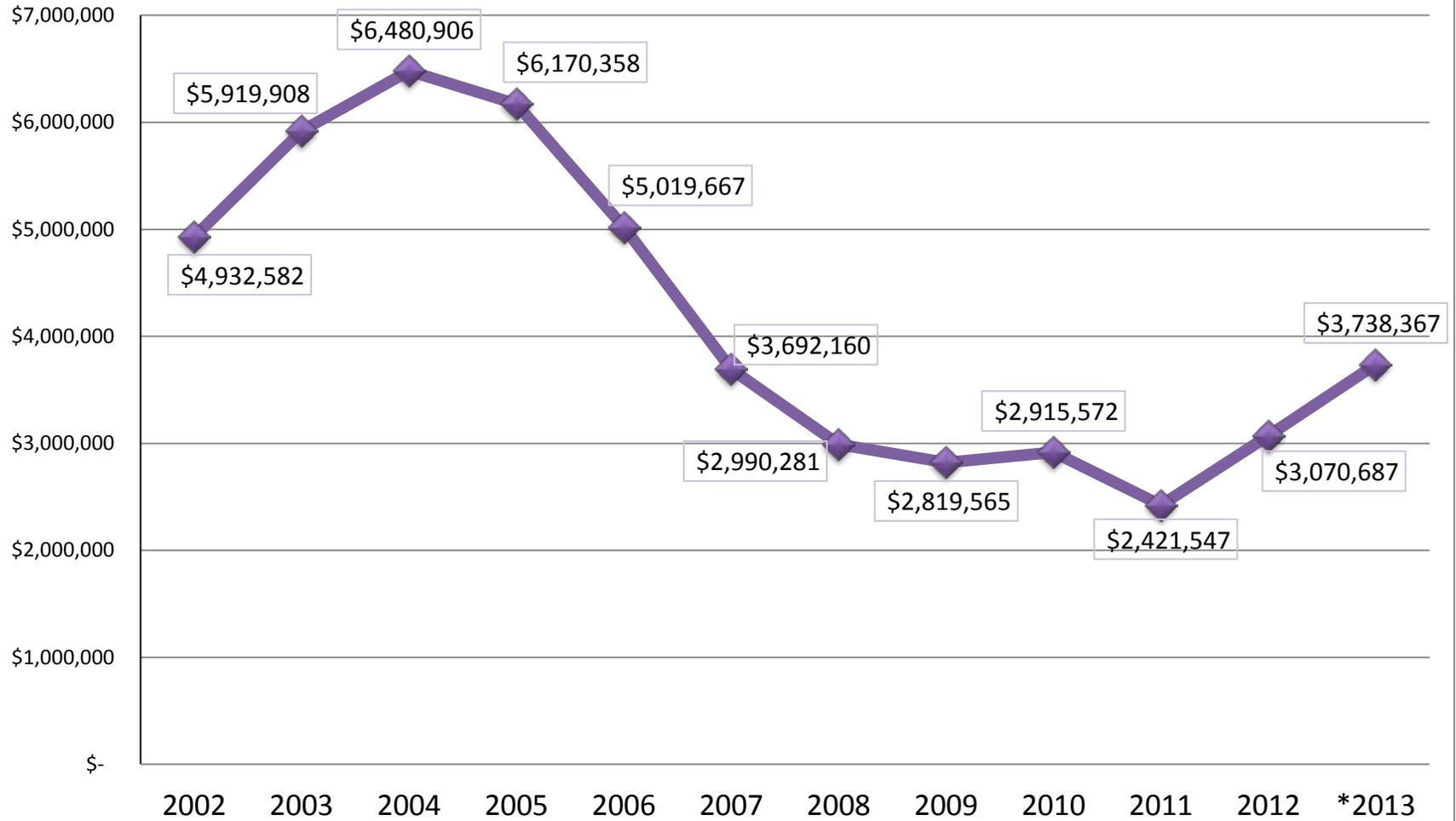
Assessment Remitted on Behalf of Physicians (MD/DO)



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

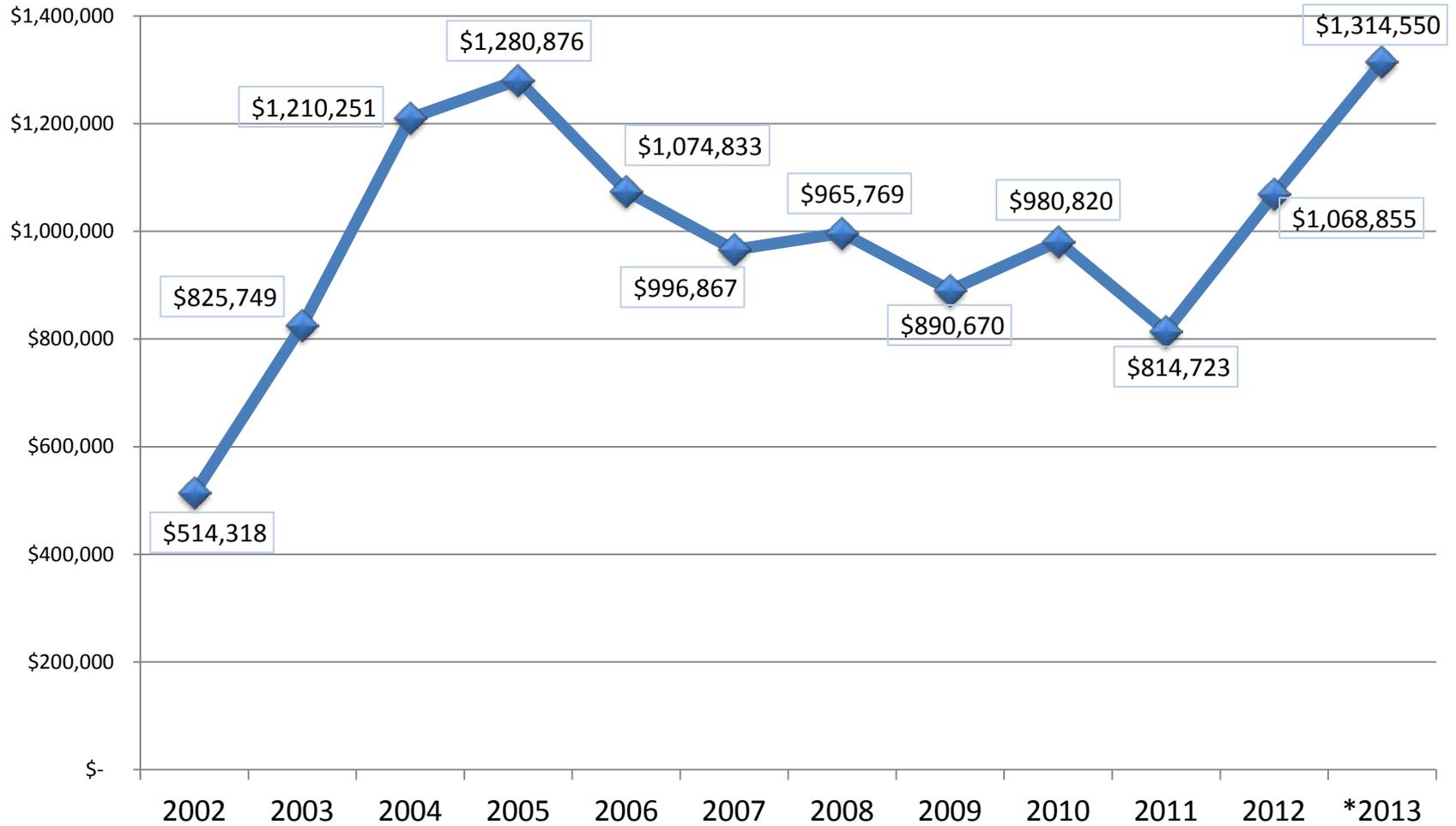
Assessment Remitted on Behalf of Podiatrists



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

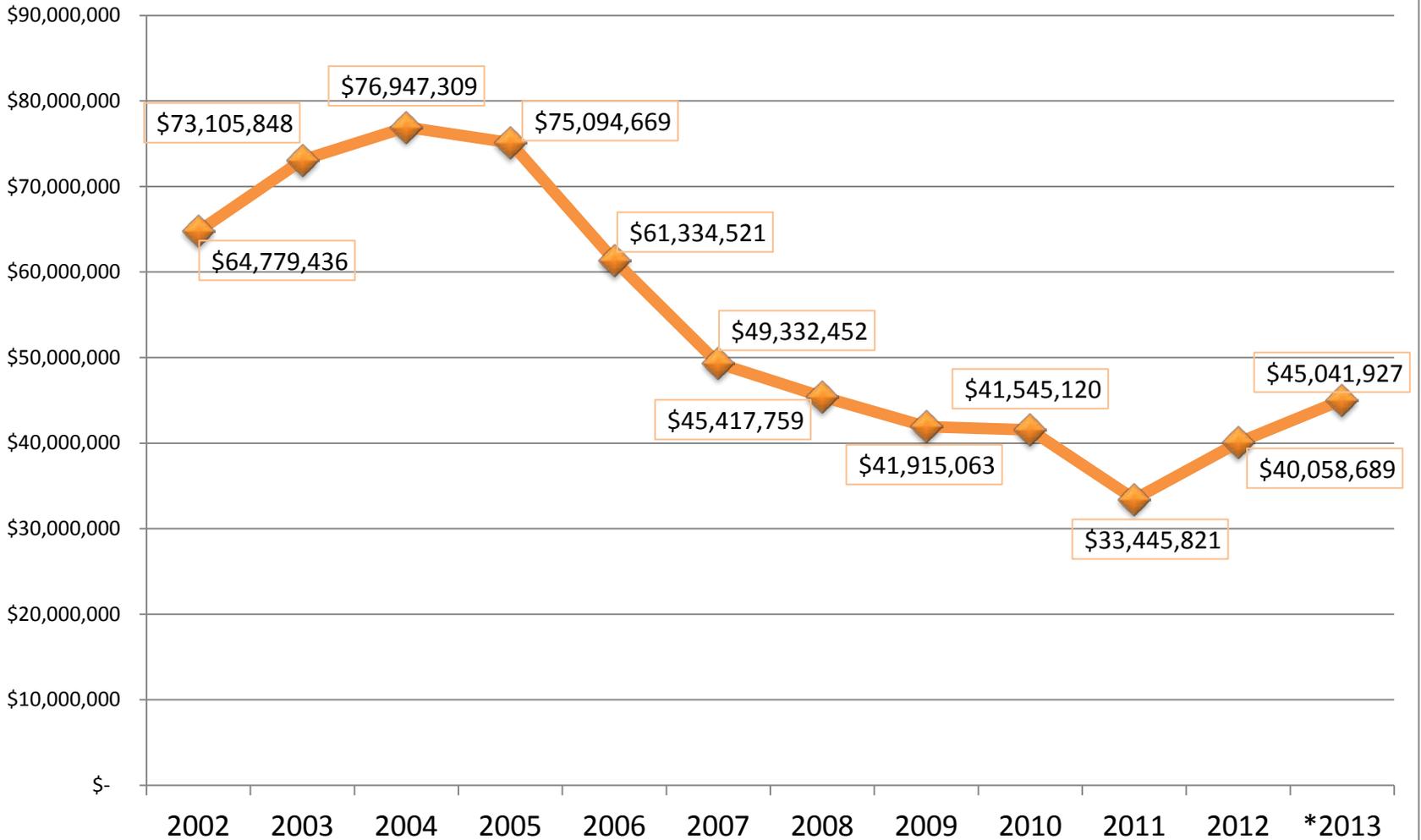
Assessment Remitted on Behalf of Certified Nurse-Midwives



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

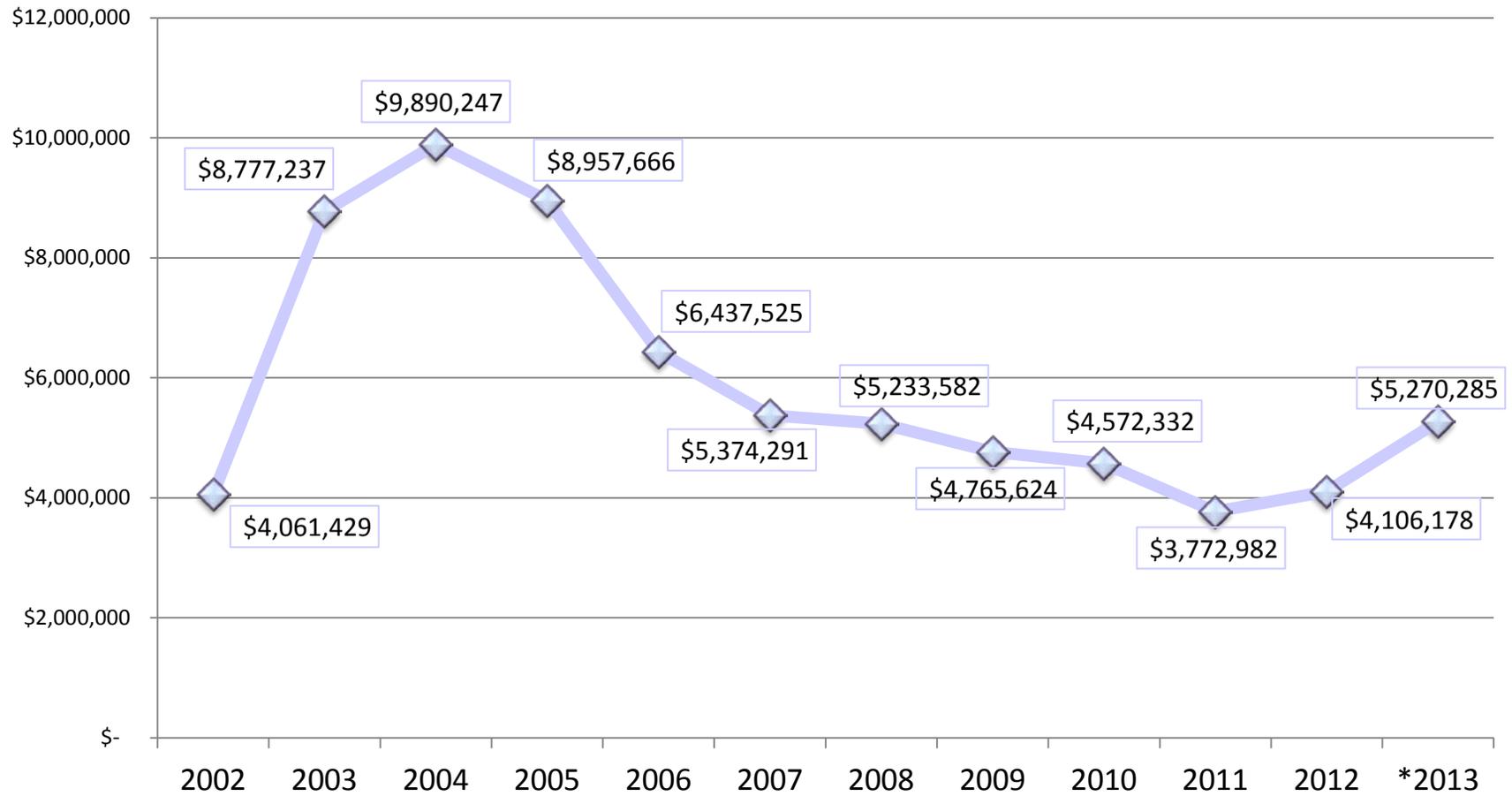
Assessment Remitted on Behalf of Hospitals



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

Assessment Remitted on Behalf of Nursing Homes



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Mcare Fund

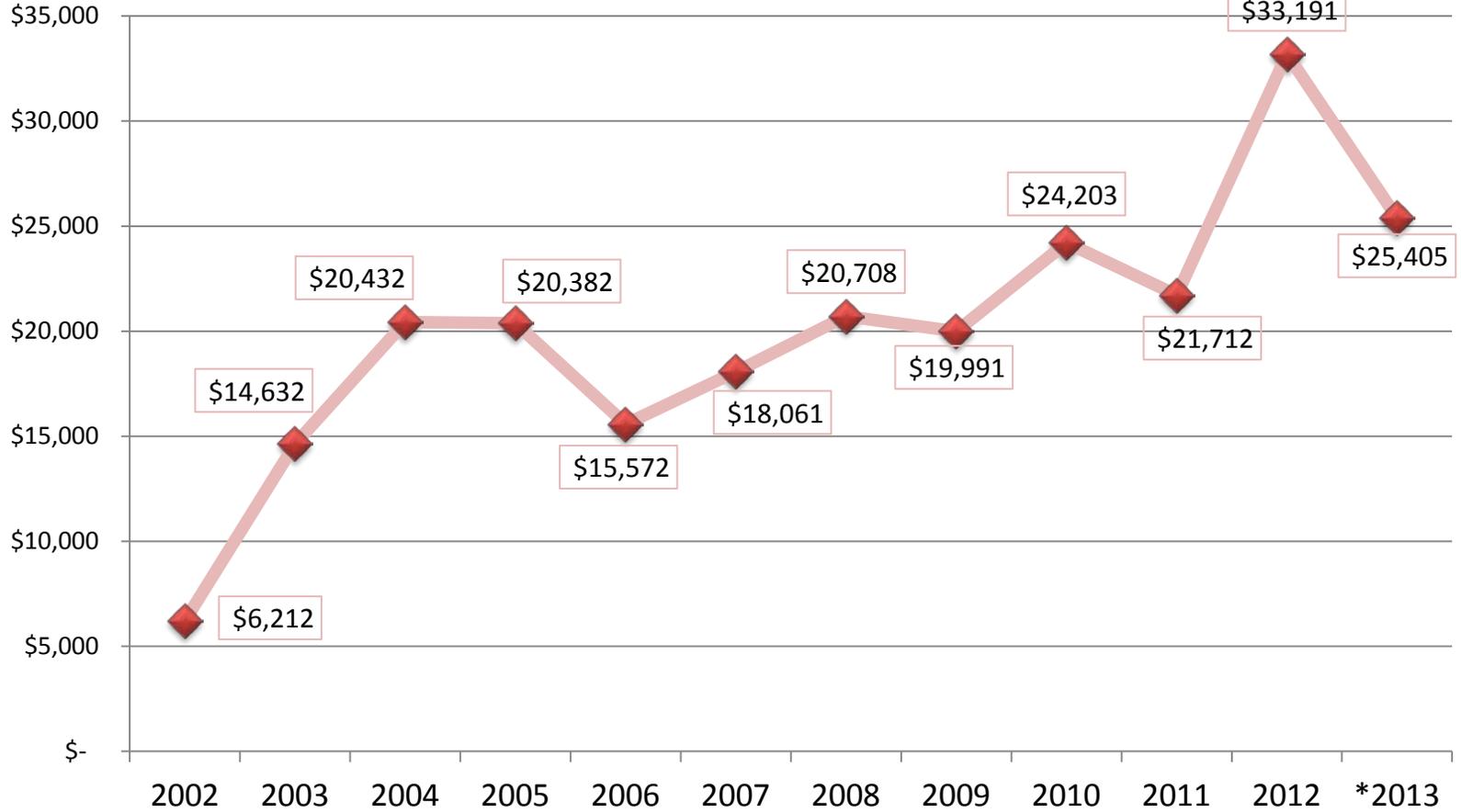
Assessment Remitted on Behalf of Primary Health Care Centers



* Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

Mcare Fund

Assessment Remitted on Behalf of Birth Centers



*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2014. Coverage for policies that have been reported and processed as of February 24, 2014 is included in the counts.

PA Department of Insurance

Mcare Fund

Yearly Average Unabated Assessment by Provider Group

	Physicians			Podiatrists			Hospitals			Nursing Homes		
	Yearly Average	% Change over Prior Year	% Change from 2002 to 2013	Yearly Average	% Change over Prior Year	% Change from 2002 to 2013	Yearly Average	% Change over Prior Year	% Change from 2002 to 2013	Yearly Average	% Change over Prior Year	% Change from 2002 to 2012
2002	\$7,113			\$4,490			\$274,489			\$5,518		
2003*	\$8,259	16%		\$5,403	20%		\$313,755	14%		\$12,056	118%	
2004*	\$9,881	20%		\$5,870	9%		\$333,103	6%		\$13,808	15%	
2005*	\$8,091	-18%		\$5,657	-4%		\$333,751	0%		\$12,440	-10%	
2006*	\$5,858	-28%		\$4,520	-20%		\$273,812	-18%		\$9,064	-27%	
2007*	\$4,861	-17%		\$3,326	-26%		\$220,234	-20%		\$7,516	-17%	
2008	\$4,405	-9%		\$2,656	-20%		\$204,567	-7%		\$7,387	-2%	
2009	\$4,023	-9%		\$2,477	-7%		\$192,233	-6%		\$6,671	-10%	
2010	\$4,006	0%		\$2,506	1%		\$189,086	-2%		\$6,561	-2%	
2011	\$3,320	-17%		\$2,074	-17%		\$160,254	-15%		\$5,384	-18%	
2012	\$3,627	9%		\$2,354	14%		\$185,290	16%		\$6,384	19%	
2013	\$4,195	16%	-41%	\$2,546	8%	-43%	\$202,949	10%	-26%	\$6,521	2%	18%

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