FINAL REPORT
AND
RECOMMENDATIONS
OF THE
PENNSYLVANIA COMMISSION
ON THE
MEDICAL CARE AVAILABILITY
AND REDUCTION OF ERROR
FUND

November 2006

Final Report and Recommendations of the Pennsylvania Commission on the Medical Care Availability and Reduction of Error Fund

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Senate of Pennsylvania
Lancaster, Pennsylvania

Honorable Steven R. Nickol
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INTRODUCTION

On December 22, 2005, Governor Edward G. Rendell signed Act 88 of 2005 into law, which extended the Health Care Provider Retention Program through 2006. In addition, Act 88 provided for the establishment of a Commission on the Medical Care Availability and Reduction of Error Fund ("Mcare Fund") "… for the purpose of reviewing and making recommendations regarding appropriate and effective methods to address any future unfunded liabilities of the Mcare Fund." 40 P.S. § 5103.1(b). The specific charge of the Mcare Commission is as follows:

> The Commission shall undertake a study of the future scope and obligations of the Fund and shall submit its report to the Governor and General Assembly, by November 15, 2006. The Commission shall make recommendations concerning continuation of the Mcare abatement; the elimination or phaseout of the Fund; and other provisions for providing adequate medical professional liability insurance, including, at a minimum, an evaluation and actuarial analysis of the projected scope of the Fund's future unfunded liability and any reasonable and available financing options for retiring those unfunded liabilities. 40 P.S. § 5103.1(b)(3).

The Mcare Commission expires on November 30, 2006. 40 P.S. § 5103.1(b)(5). See Exhibit 1 for the text of the applicable sections of Act 88. In accordance with Act 88, the Mcare Commission submits the following report.

THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND (Mcare)

The Medical Care Availability and Reduction of Error Fund ("Mcare") was created by Act 13 of 2002 and is administered by the Pennsylvania Insurance Department. Mcare is the successor to the Medical Professional Liability Catastrophe Loss Fund, which was established in 1976 in response to the first of several medical malpractice insurance crises, and is better known as the "CAT Fund." Mcare's purpose is to ensure reasonable compensation for persons injured due to medical negligence. Mcare accomplishes this by administering various sources of funds to pay for final judgments, awards or settlements in medical malpractice claims against participating health care providers and eligible entities, which exceed the primary limits of coverage. Participation in Mcare is mandatory for:

- physicians
- osteopathic physicians
- podiatrists
- nurse-midwives
- hospitals
- nursing homes
- birth centers
- primary health centers
- professional corporations, professional associations or partnerships owned entirely by health care providers may choose to insure their basic (primary) layer of liability; if they so choose, then their participation in Mcare is mandatory.

Participation in Mcare is not mandatory for:

- providers who practice less than 50% in PA
- providers who practice exclusively as federal government employees
- providers who practice exclusively as Commonwealth or City of Philadelphia employees
- providers who are exclusively forensic pathologists
- providers who are retired, but who provide limited care for his or herself and immediate family members
- providers who practice exclusively as members of the PA or U.S. military forces
- providers who practice exclusively under a volunteer license
- providers who practice exclusively with coverage under the Federal Tort Claims Act.

Since the Fund's creation in 1976, most health care providers have been required to insure their liability by purchasing medical professional liability insurance as follows:

- Primary Layer from an insurance carrier licensed or approved by the PA Insurance Department or with an approved self-insurance plan
  and an
- Mcare Layer

Both the amount of coverage from each of the two layers and the total required coverage has varied since 1976. Currently, hospitals are required to have minimum total coverage of $1 million per incident and $4 million in aggregate coverage per year. The first $500,000 per incident and $2.5 million of the annual aggregate for hospitals are the primary layer, and the coverage above the primary layer is the Mcare layer. Non-hospital providers are required to have minimum total coverage of $1 million per incident and $3 million in aggregate per year; the first $500,000 per incident and $1.5 million of the annual aggregate for non-hospitals are the primary layer, and coverage above the primary layer is the Mcare layer.

The expenses of the Mcare Fund were funded until recent years exclusively by assessments paid by health care providers participating in the Mcare Fund. Mcare's assessment rates increased or decreased to reflect the changes in Mcare's coverage, claims payouts and operational expenses. Until 1996, Mcare's annual assessment rate was simply a percentage of health care providers' primary premiums. Since 1997, Mcare assessment rates have been a percentage of the base rates of the Pennsylvania Professional Liability Joint Underwriting Association's (JUA) that would be applicable to each Mcare participating provider. Mcare's assessment rates have decreased from 61% for policies with effective dates in 2000 to 23% for policies with effective dates in 2007.

In 2003, the General Assembly and Governor Edward G. Rendell enacted Act 44, thus establishing the Health Care Provider Retention Program ("HCPRA"), also commonly referred to as the "Abatement Program" whereby making Pennsylvania the first state in the nation to help defray the cost of malpractice insurance liability coverage with abatements. This program was established to encourage physicians and other providers to continue practicing in Pennsylvania so that residents of Pennsylvanians would have continued availability of and access to quality health care. The Abatement Program defrays providers' professional insurance expenses until legislative and judicial reforms have time to take effect on medical malpractice liability costs.

Act 44 provides public funding for the Abatement Program from a 25 cent per pack tax on cigarettes[1], which provides approximately $180 million annually, and under Act 13 of 2002 approximately $42 million annually from the Auto CAT Fund through 2013. From 2003 through 2006, more than $830 million in taxpayer dollars has been committed to the Abatement Program. Act 128 of 2006 extends the Abatement Program through 2007 and will bring the total of public funds committed to the Abatement Program to almost $1 billion. Approximately 14% of all physicians participating in the Mcare program are eligible for 100% abatements of their Mcare assessments, as are certified midwives. Physicians who are not eligible for 100% abatements are eligible for 50% abatements, as are podiatrists (as of 2005) and nursing homes (as of 2006). Each health care provider participating in the Abatement Program commits to continue practicing in the Commonwealth for the year of his/her abatement and the following calendar year. In part due to the Abatement Program, the number of physicians paying Mcare assessments remained fairly constant over the past few years at more than 35,000; therefore, indicating there has not been a mass exodus of physicians from Pennsylvania.

Mcare's claim expenses decreased each year since 2003, and Mcare's assessment rates decreased each year since 2001. Total Mcare assessments paid by providers (net of abatements) have declined each year since 2001. However, the financing of the Mcare Fund since 1976 has been on a "pay-as-you-go" basis. This has resulted in Mcare accruing "unfunded liabilities" that are commonly referred to as the "tail." Mcare's unfunded liability is the amount of money Mcare is projected to pay for claims against the Mcare Fund reported to date as well as claims against the Mcare Fund that were incurred but are not yet reported. PricewaterhouseCoopers, Mcare's outside consulting actuary, estimated Mcare's unfunded liability to be $2.33 billion as of December 31, 2005.

ESTABLISHMENT OF THE COMMISSION ON THE MCARE FUND

As noted in the introduction, Act 88 of 2005 provided for the establishment of the Commission on the Mcare Fund and charged the Commission with responsibility for studying, reviewing and making recommendations regarding appropriate and effective methods to address any future unfunded liabilities of the Mcare Fund and other aspects of Mcare, including continuation of the Abatement Program. The Commission was specifically charged with undertaking a study of the future scope and obligations of the Fund and submitting its report to the Governor and General Assembly by November 15, 2006.

Act 88 requires the Commission consist of the following members: The Insurance Commissioner, Chairperson, 40 P.S. § 5103.1(b)(1)(i); the Secretary of the Budget, 40 P.S. § 5103.1(b)(1)(ii); the Secretary of Revenue 40 P.S. § 5103.1(b)(1)(iii); two members appointed by the President Pro Tempore of the Senate and two members appointed by the Minority Leader of the Senate, 40 P.S. § 5103.1(b)(1)(iv); and two members appointed by the Speaker of the House of Representatives and two members appointed by the Minority Leader of the House of Representatives, 40 P.S. § 5103.1(b)(1)(v). The members of the Mcare Commission are:

[1] The approximately 25 cents per package of cigarettes comes from the commitment of 18.52% of the tax imposed by Section 1206 of Tax Reform Code of 1971, as amended.

- Honorable M. Diane Koken, Chairperson
  Insurance Commissioner
- Honorable Michael Masch
  Secretary of the Budget
- Honorable Gregory C. Fajt
  Secretary of Revenue

Appointed by Senate President Pro Tempore:

- Honorable Gibson E. Armstrong
  Senate of Pennsylvania
- Joshua Port, M.D.

Appointed by Senate Minority Leader:

- Joseph Cesare, M.D.
- Lisa Thomas, M.D.

Appointed by House Speaker:

- Honorable Steven Nickol
  Pennsylvania House of Representatives
- David F. Simon, Esquire

Appointed by House Minority Leader:

- Don Matusow, Esquire
- Steven A. Shapiro, M.D.

APPROACH USED BY THE COMMISSION ON THE MCARE FUND

The Commission first met on April 12, 2006. Subsequently, the Commission held six meetings. The agendas, minutes, presentations to the Commission and handouts at each Commission meeting are now available at Mcare's web site[2]. The Commission also held a public hearing on November 2, 2006, at which the Commission received oral and written testimony from interested persons, which is available at Mcare's web site. The Commission also held several executive sessions regarding the process to be used to finalize the recommendations and report.

The Commission reviewed its charge under Act 88 and identified both the focus for the Commission's activities and appropriate limits. For example, the Commission determined that tort reform and health care quality were issues outside the scope of the Commission's responsibilities. The Commission then agreed to a set of principles to guide the Commission in determining how best to address issues, prioritize the work of the Commission, and decide on the recommendations of the Commission. The Commission also developed a series of work tasks and retained PricewaterhouseCoopers for actuarial services. The principles approved by the Commission were:

- Ensure adequate numbers of health care providers for access to quality health care by Pennsylvanians
- Encourage health care providers to practice in Pennsylvania
- Maintain a healthy medical malpractice marketplace

[2] This material is available at Mcare's web site at: www.mcare.state.pa.us. This material will be available on Mcare's web site for six months after the publication of this report.

- Continue the Abatement Program in some form
- Phase-out Mcare
- Mitigate impact of Mcare phase-out on health care providers
- Evaluate financing options for addressing Mcare's unfunded liabilities
- Determine who should pay, and how much, for the abatement and the unfunded liability
- Minimize taxpayer costs
- Seek ways of beginning to pre-fund Mcare obligations

The Commission's work tasks were:

- Update actuarial estimates of the unfunded liabilities of the Mcare Fund
- Assess trends in medical malpractice rates and project rates annually through 2010 as well as long term
- Develop annual estimates through 2010, as well as long term trends, by specialty and geographic area, of the costs to health care providers of phasing-out Mcare
- Estimate the options and costs for continuing abatements through 2009
- Identify and evaluate alternatives for financing Mcare's unfunded liabilities
- Identify rating factors for health care providers used by the JUA
- Identify barriers to recruitment of health care providers to Pennsylvania through interviews with physician recruiters and other recruiters
- Physicians' primary coverage by carrier, by region or county, separately for hospital-related

To support the work of the Commission, and as required by Section 5103.1(b)(2) of Act 88, an Advisory Committee was appointed, compromised of the following members:

- George Huber, Senior Vice President, Corporate Relations and Regional Programming, UPMC
- Roosevelt Hairston, Jr., Esquire, Vice President, Government Affairs & Community Relations, Children's Hospital of Philadelphia
- Craig G. Kriza, D.P.M., J.D., Practicing Podiatrist and Widener University School of Law
- Beth Koob, Esquire, Chief Counsel and Corporate Secretary, Temple University Health System
- Peter A. Schwartz, M.D., Chair of Reading Hospital's OB/GYN Department
- Ken Jones, Esquire, General Counsel, Pennsylvania Medical Society
- Angela Bontempo, President and CEO, Saint Vincent Health System
- Norman Epstein, President and CEO, Summit Health System
- Frank Trembulak, Executive Vice President and COO, Geisinger Health System
- Scot D. Paris, M.D., Chair, Pottstown Memorial Medical Center's Department of Surgery and President of Pa. Physicians for the Protection of Specialty Care
- Robert Muscalus, D.O., Medical Director for Clinical Client Relationships, Highmark
- Theodore G. Otto, III, Esquire, CPCU, ARM, Are, VP, Secretary and General Counsel of PMSLIC
- Chester J. Szcaepanski, FCAS, MAAA, VP and Chief Actuary, Donegal Insurance Group
- Cliff Rieders, Esquire, Rieders, Travis, Humphrey, Harris, Waters & Waffenschmidt
- Dianne Salter, Vice President for Insurance, Jefferson Health System

The Mcare Commission was also supported by many other people. In particular, the Commission would like to acknowledge the following persons for their support and assistance:

- Peter J. Adams, Deputy Insurance Commissioner, Office of Mcare
- Timothy J. Landick, Director, PricewaterhouseCoopers, LLP
- Dee Ann McHugh, Assistant to Deputy Insurance Commissioner for Mcare
- Arthur F. McNulty, Esquire, Acting Chief Counsel, Insurance Department
- Beth C. Persun, Director, Bureau of Claims Administration, Office of Mcare
- Jason C. Riley, Chief, Division of Policy Administration, Office of Mcare
- Cindy E. Sheaffer, Esquire, Department Counsel, Office of Mcare

The Commission reviewed numerous reports and proposals, which were prepared by Mcare staff, PricewaterhouseCoopers, members of the Commission, members of the Advisory Committee, and representatives of trade and provider organizations. These reports and proposals included Mcare's Annual Report of Operations for 2005; PricewaterhouseCoopers' Estimate and Overview of Mcare's Unfunded Liabilities; a proposal by the Hospital and Health System Association of Pennsylvania, the Pennsylvania Medical Society and other provider organizations, proposals by Dr. Scot Paris and Mr. Cliff Rieders, and a survey of the importance of Pennsylvania' malpractice environment on physician recruiting[3].

To organize the many alternatives and allow systematic evaluation of these alternatives by the Commission on a comparable basis, PricewaterhouseCoopers developed a financial model, which used information obtained by PricewaterhouseCoopers from a variety of national and Pennsylvania sources, as well as internal risk management information obtained by PricewaterhouseCoopers by surveying health systems affiliated with members of the Commission and the Advisory Committee. More than 150 alternative proposals and scenarios were thus modeled in a systematic manner. Many were determined to be financially infeasible with the public funds committed to date and the projections by PricewaterhouseCoopers of future Mcare claim payments and related operational expenses, as well as projected increases in primary malpractice premium expenses. However, certain scenarios were projected to be financially feasible. Please refer to Exhibit 2 for a compilation of the work prepared by PricewaterhouseCoopers. The PricewaterhouseCoopers report includes discussion of the projected unfunded liability (as Appendix A), information compiled to assist the Commission in its assessment of trends in medical malpractice rates and projection of future rates (as Appendix B), and details of the model created to estimate the impact of various proposals (as Appendix C).

RECOMMENDATIONS TO THE GOVERNOR AND GENERAL ASSEMBLY

After reviewing actuarial information about the unfunded liabilities of the Mcare Fund, systematically analyzing the results of financial modeling for more than 150 alternative approaches, and considering numerous proposals and recommendations regarding the Mcare Fund, the members of the Commission make the following recommendations to the Governor and General Assembly. These recommendations should be considered together, rather than

[3] The reports and analyses are all posted on Mcare's web site at www.mcare.state.pa.us, and will continue to be available on Mcare's web site for six months after publication of this report.

separately, because many of the recommendations are meaningful only as part of an overall approach:

1. The phase-out of Mcare's coverage going forward should be done, with no change in providers' mandatory malpractice insurance coverage requirements, as soon as possible to conserve the public funds that have been committed to pay off the Mcare Fund's unfunded liabilities and to mitigate health care providers' total medical malpractice insurance coverage expenses; the current Mcare abatement program should be continued until Mcare's coverage going forward has been phased-out, at which time Mcare assessments will end, thereby reducing health care providers' costs;

2. Continue to devote those sources and levels of public funds already committed to medical malpractice relief and health care provider retention (that is, 25 cents per package of cigarette tax revenues dedicated to the HCPRA, assuming this would be available if needed up until 2025 and the Auto CAT Fund surcharge, assuming it to be available if needed through 2013);

3. The currently committed public funds will be used for the abatement program and then to pay Mcare's claim payments and operating expenses while Mcare is in run-off; the Mcare Abatement Program will be phased-out as the Mcare coverage layer is reduced and then eliminated;

4. To the extent that currently committed public funds exceed the requirements for the abatement program and then to pay Mcare's claim payments and operating expenses, including an appropriate reserve in the Health Care Provider Retention Account and, if necessary, a coverage ratio for any borrowing against future public funds to pay current Mcare's claim payments and operating expenses, residual public funds should be used to further mitigate through 2025 health care providers' total out-of-pocket expenses for medical malpractice insurance;

5. The currently committed public funds shall be used for the purposes stated in these recommendations to achieve a target of no more than 10 percent annual aggregate increases for mandatory coverage on a year-over-year basis;

6. Dedicate any remaining unobligated public funds in the HCPRA to supporting state programs and services related to healthcare;

7. Aggressively promote health care quality, which will, among other things, reduce future malpractice expenses and maximize the residual public funds that can be dedicated to healthcare services;

8. Implement this approach as soon as private malpractice insurers and self-insurers have capacity to fully serve the market;

9. Borrow to shift money through time as necessary to cover the financial obligations of this approach particularly during the next few years when Mcare claim payments will be

larger than they will be closer to 2025, and use unobligated public funds from the HCPRA and the Auto CAT Fund surcharge to repay these borrowings; and,

10. Make appropriate arrangements in 2025 to respond to any remaining Mcare claims and borrowing obligations using reserves established for these obligations.

* * *

Exhibit 1

Act 88 of 2005, Section 5103.1. Commission on the Mcare Fund

(A) Declaration of Policy.-- The General Assembly recognizes that changes in the medical professional liability insurance market have necessitated the need for a plan to address the unfunded liabilities of the Medical Care Availability and Reduction of Error (Mcare) Fund.

(B) Establishment of Commission on the Mcare Fund.-- There is established a Commission on the Mcare Fund for the purpose of reviewing and making recommendations regarding appropriate and effective methods to address any future unfunded liabilities of the Mcare Fund.

(1) The Commission shall consist of the following members:

(i) the Insurance Commissioner or designee of the Insurance Commissioner, who shall serve as the chairperson of the Commission.

(ii) the Secretary of the Budget or designee of the Office of the Budget.

(iii) the Secretary of Revenue or a designee of the Secretary of Revenue.

(iv) two members appointed by the President Pro Tempore of the Senate and two members appointed by the Minority Leader of the Senate.

(v) two members appointed by the Speaker of the House of Representatives and two members appointed by the Minority Leader of the House of Representatives.

(2) The Commission shall establish an Advisory Committee composed of no more than 15 individuals with expertise in areas including: health care, medical professional liability insurance, the law, finance and actuarial analysis. The members of the Advisory Committee shall serve without compensation, but shall be reimbursed for their actual and necessary expenses for attendance at meetings.

(3) The Commission shall undertake a study of the future scope and obligations of the Fund and shall submit its report to the Governor and General Assembly by November 15, 2006. The Commission shall make recommendations concerning continuation of the Mcare abatement; the elimination or phase-out of the Fund; and other provisions for providing adequate medical professional liability insurance, including, at a minimum, an evaluation and actuarial analysis of the projected scope of the Fund's future unfunded liability and any reasonable and available financing options for retiring those unfunded liabilities.

(4) The Commission is authorized to incur expenses deemed necessary to implement this section. Expenses incurred for this purpose shall be paid by the Fund.

(5) The Commission shall expire November 30, 2006.

Exhibit 2
Report prepared by PricewaterhouseCoopers LLP

See attached
Actuarial Analyses and Support of the Mcare Commission, Pursuant to Act 88 of 2005

and

Addendum to Appendix C