pennsylvania
INSURANCE DEPARTMENT

2018

ANNUAL REPORT

PENNSYLVANIA INSURANCE DEPARTMENT
Medical Care Availability and
Reduction of Error Fund

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I. Executive Summary

During 2018, Mcare continued to serve the Commonwealth health care provider community and injured persons by providing coverage and claims payments for medical malpractice. Mcare paid out $211 million in covered medical malpractice claims. Mcare also communicated with insurers, self-insureds, and health care providers (HCPs), providing them information about Mcare operations as well as other items of interest to those in the medical malpractice insurance market in Pennsylvania.

Key Accomplishments for 2018

Enhancements to Insurer Reporting Materials to Save Time and Improve Accuracy

All insurers reporting coverage information and remitting assessments use reporting materials available on the Mcare website. This year enhancements were added that automatically transfer information from worksheets that calculate the assessment due to the summary document that is submitted to Mcare. Previously the insurers had to manually transfer the information which led to errors. In addition, a "Submit" button automatically fills out the email address of the Mcare resource account and properly formats the subject line to efficiently direct the submissions for processing. A tools manual was developed and put on the Mcare website to assist insurers with getting the maximum benefit of these enhancements.

Assistance to carriers improving their Mcare reporting processes

At their own initiative some carriers updated their processes to make them more efficient and less prone to errors. Mcare staff assisted in these efforts by providing subject matter expertise and lessons learned from Mcare's own similar efforts. In some cases, the carriers will also see better data maintained in their core business information systems as well.

Support for use of alternative dispute resolution techniques

Medical malpractice litigation is stressful for all parties involved. Mcare continued to be effective in its support for medical malpractice cases to be resolved by alternative dispute resolution techniques such as mediation and arbitration rather than trial if that is what the parties want. Mcare provides a neutral, unbiased, and standardized platform for parties. This improves efficiency, removes unpredictability, reduces costs, and allows all parties a forum for effective resolution.

Mcare can be reached at 717-783-3770, via e-mail at ra-in-mcare-exec-web@pa.gov, or by visiting our website at www.insurance.pa.gov.

II. Mcare Background

A patient compensation fund has been part of the Commonwealth's medical malpractice insurance landscape since 1975. At that time, when private carriers were seeking triple-digit rate increases or leaving the medical professional liability insurance market, the legislature developed a solution that required participating HCPs to purchase $1.2 million of medical malpractice coverage. This consisted of insurance from the private market and excess coverage from the Medical Professional Liability Catastrophe Loss Fund (CAT Fund).

Due to issues in the medical malpractice environment in 1995, Act 135 of 1996 made significant revisions to how the CAT Fund operated. For example, the basis of the assessment collected from HCPs changed from the actual amount they paid for their private medical malpractice insurance to one that was based on uniformity by specialty and territory. This provided the Fund with significantly more predictability in the funds raised by the assessment. Also, the insurance limits written by the private market increased from $200,000 per occurrence to $500,000 per occurrence over a number of years in $100,000 increments. The overall mandatory insurance coverage requirement remained at $1.2 million.

In late 2001 and into 2002, there was again turmoil in the Commonwealth's medical malpractice market including the rehabilitation and eventual liquidation of the largest Pennsylvania domiciled hospital insurer. This, coupled with other market disruptions, including a key physician insurer closing its doors to new business and others raising their underwriting standards, resulted in executive and legislative branch attention.

The CAT Fund legislation was repealed in 2002 and the Mcare Act ushered in a new approach to addressing medical malpractice in the Commonwealth. The Insurance Department was given responsibility for the administration of the fund. The Mcare Act also provided for the eventual phaseout of Mcare when the timing was right. The Mcare Act included reducing the mandatory insurance coverage to $1 million per occurrence, which is in line with other states.

In 2014 the Commonwealth settled litigation brought by health care providers. The return of funds required under the settlement was completed in 2017. Mcare has separately accounted for the $30 million Reserve Fund and used part of it in lieu of borrowing as required by the settlement in 2018. Since 2014, Mcare has incorporated any projected year-end balance to reduce the amount collected in the following year's assessment.

III. Mcare Financial Highlights

Appendix A contains Mcare financial information. Appendix A.1 is the Mcare Cash Basis Statement of Operations as of December 31, 2018. The reporting is consistent with the settlement terms of the assessment litigation that required Mcare to separately account for the Reserve Fund. Mcare used $15,120,452 of the Reserve Fund in lieu of borrowing to pay claims in 2018 as is required under the settlement. The remaining Reserve Fund of $14,879,548 will continue to be accounted for separately and replenished only by the investment proceeds it generates as required by the settlement. Excluding these funds, Mcare ended calendar year 2018 on a break-even basis.

Appendix A.2 is the Mcare Summary of Financials from CY 2009 to 2018. This document reflects the volatility of Mcare's claims payments with a range of payments of $146 million in 2010 and a $211 million payment in 2018. Decreases in claim payments of over $30 million took place between claim years 2009 to 2010 (-$32 million) and again between 2013 to 2014 (-$38 million). Increases in claims payments took place between claim years 2010 to 2011 (+$24 million), 2011 to 2012 (+25 million) and between 2017 and 2018 (+$30 million). This experience is to be expected because Mcare provides coverage solely on catastrophic medical malpractice cases.

Mcare is protected from these swings by the 10% buffer which is built into each year's assessment calculation as required by the Mcare Act. Also, Mcare has the Reserve Fund as provided for in the settlement of the assessment litigation that was partially used in 2018 to pay claims.

Additional information on Financials can be found in Appendix A.

IV. Mcare Program Review

A. Claims Program

The Mcare Fund adjusts two types of claims. One type is claims submitted by primary insurers on behalf of HCPs for excess coverage. In these claims, the primary insurer is responsible for securing the defense and the first $500,000 of indemnity. The other type is claims submitted to Mcare for both defense and "first dollar" indemnity coverage under Section 715 of the Mcare Act.

Mcare claims staff includes examiners, geographic territory managers, and support personnel. It also uses physician reviewers.

Excess Claims Opened/Closed

Mcare opened 3,253 claims reported by primary insurers between September 1, 2017 and August 31, 2018 (Mcare's claims period as defined in the Mcare Act). This compares to 2,889 claims opened in the prior claims period. Mcare closed 3,558 claims in 2018 compared to 3,268 claims closed in 2017. These numbers include claims closed with and without indemnity payment. A total of 105 primary insurers reported claims to Mcare in the 2018 claims period, up from 91 in 2017.

Section 715 Claims Opened/Closed

Section 715 is a remnant from the original patient compensation fund legislation. The purpose was to insulate primary carriers writing in Pennsylvania from the impact of claims filed four or more years after the medical care. The Mcare Act provided for an end to these types of claims. It did so by requiring a Section 715 claim to arise from medical malpractice incidents that occurred on or before December 31, 2005. For medical malpractice incidents occurring January 1, 2006 and subsequent, primary insurers and self-insurers are responsible for defense and indemnity as they are for other claims.

In claims period 2018, Mcare opened 34 and closed 55 Section 715 claims. This compares to 32 opened and 57 closed in claims period 2017.

Alternative Dispute Resolution (ADR)

Claims examiners and managers provide full investigation and disposition of reported claims. Within these functions, Mcare has actively promoted global resolution through settlement, arbitration, and mediation, as appropriate, to the benefit of the involved HCPs and plaintiffs. The unique position of Mcare allows for fair and objective analysis of the entire case and when appropriate, can facilitate bringing parties to consensus. Since the Mcare ADR program's inception in 2003 it has been used in over 1,700 medical malpractice matters.

In the 2018 claims period, 147 ADR processes were completed as agreed to by the parties. This is comprised of 27 arbitrations, 112 mediations, and 8 monetary cap trial agreements. This compares with a total of 142 processes consisting of 43 arbitrations, 91 mediations and 8 monetary caps for claims period 2017.

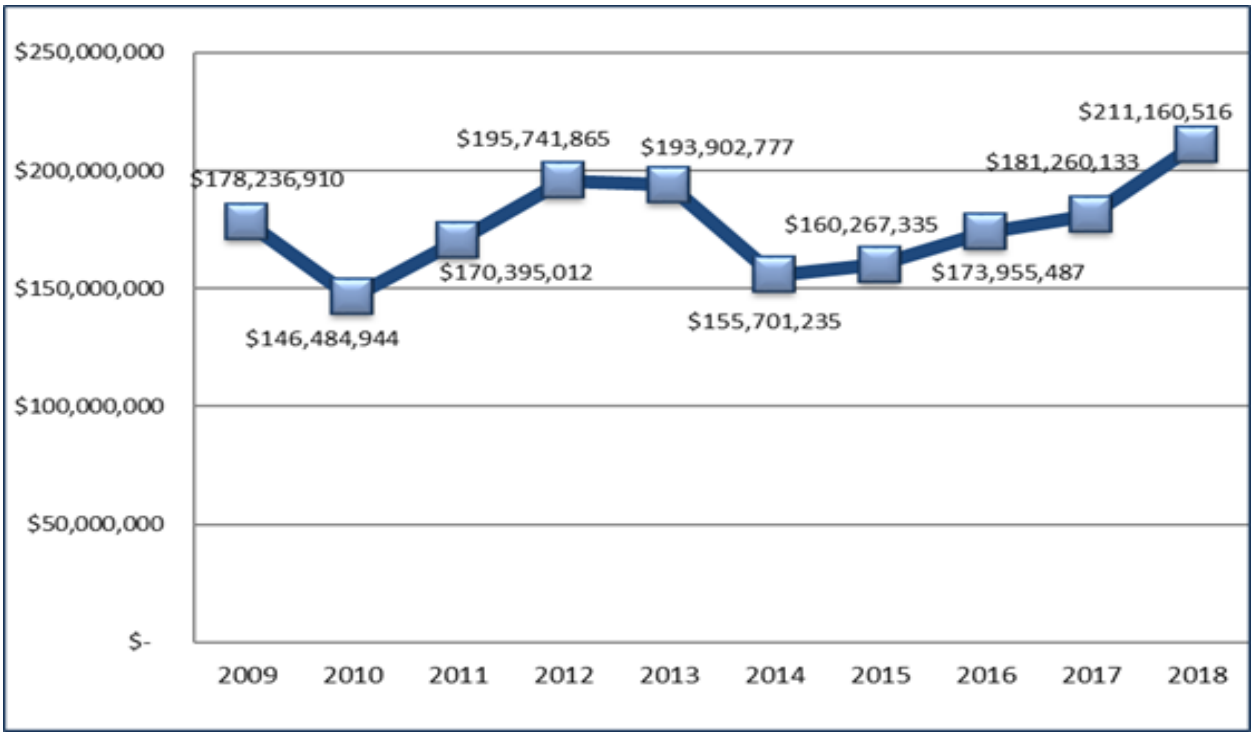
Claims Payments

In 2018, Mcare paid $211 million as compared to $181 million in 2017. Mcare's 2018 payments combined with insurers' payments on claims adjusted by Mcare totaled $777 million as compared to $663 million in 2017.

Mcare adjusts catastrophic injury medical malpractice claims. Its annual claims payment statistics reflect the volatility associated with a relatively small number of high value indemnity payments. The difference in claims payments between 2017 and 2018 is in line with historical experience.

The following graph shows Mcare's total payments for the last 10 claims period years.

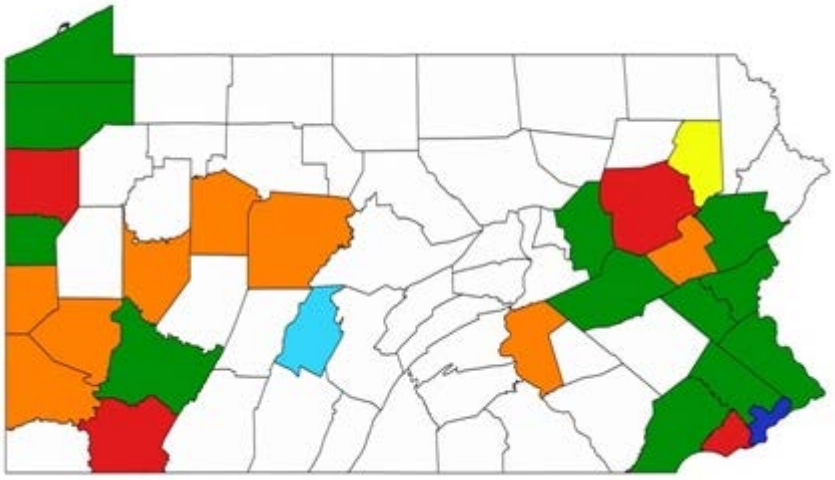
Chart 1: Claims Payments by Claims Year for 2009-2018



Regional Statistics

Mcare claims payments also vary by territory. Chart 2 on the following page shows the 2018 claims payments allocated by territory.

Chart 2: 2018 Mcare Paid Claims by Territory



Territory	Territory Total	County(ies) Within Territory
Territory 1	$74,285,354	Philadelphia
Territory 2	$41,842,735	Remainder of State
Territory 3	$25,547,000	Allegheny
Territory 3	$7,000,000	Armstrong, Beaver, Carbon, Clearfield, Dauphin, Jefferson, Washington
Territory 3	$32,547,000	Territory 3 Total
Territory 4	$16,700,000	Delaware, Fayette, Luzerne, Mercer
Territory 5	$4,550,000	Lackawanna
Territory 6	$40,735,427	Bucks, Chester, Columbia, Crawford, Erie, Lawrence, Lehigh, Monroe, Montgomery, Northampton, Schuylkill, Westmoreland
Territory 7	$500,000	Blair
Total Paid	**$211,160,516**	

Additional information on claims can be found in Appendix B.

B. Coverage Program

The Mcare Coverage Program consists of two major components. The first is collection of assessments from HCPs to provide the funding for Mcare's claims payments, defense of HCPs, and operations. The second is maintaining records of HCPs securing insurance from a private insurance company or by self-insuring. This information assists Mcare in enforcing the Commonwealth's mandatory medical malpractice insurance laws.

Assessment Collection

Coverage from Mcare is financed by assessments collected from HCPs as defined in the Mcare Act and interest on these funds. For 2018, the assessment revenue is $184 million as compared to the assessment revenue of $192 million for 2017. The variance is primarily due to adjustments in effective dates of coverage due to financial transactions by health systems since the assessment rate was the same for both years.

The statutory assessment formula, as modified by the PAMED/HAP/PPMA settlement has the following components:

1. The amount Mcare paid in claims;
2. The administrative costs of Mcare;
3. Repayment of any funds borrowed if claims payments and administrative expenses exceed the amount collected in any given year, and
4. A 10% buffer to protect against a funding deficit if claims payments increase year over year, **minus**
5. The projected year-end balance which includes interest income.

The collection of the assessment is based on a statutorily defined base, the Prevailing Primary Premium (PPP). The PPP is defined as the schedule of occurrence rates approved for use by another Mcare Act agency. Consistent with prior year calculations, Mcare projected what amount would be raised if every HCP required to participate in the fund paid the PPP amount. Mcare then determined what percentage of the PPP would raise the amount to be collected using the statutory assessment formula.

Chart 3 below reflects the assessment percentage over the last 10 years and the impact of the assessment litigation settlement wherein Mcare agreed to recalculate the assessment percentage for the five years in which there were funds remaining at year end. It was the difference between the original percentages and settlement adjusted percentages that was refunded to HCPs. Starting in the 2015 assessment year, the remaining funds were included in the calculation of the assessment percentage.

Chart 3: Assessment Percentage for 10 Most Recent Years

Year	Original Percentage	Settlement Adjusted Percentage
2010	21%	15%
2011	19%	13%
2012	23%	22%
2013	25%	no change
2014	23%	19%
2015	12%	
2016	17%	
2017	19%	
2018	19%	
2019	19%	

The Mcare Act provides for adjustments to hospitals' assessments based on loss experience. The range as provided for by statute is a 20% discount to a 20% increase. Chart 4 below shows how this provision affected the hospitals in 2018.

Chart 4: Hospitals Experience Modification Factors

	Adjustment	2018
Largest Discount	80.0%	93
Off-Balance Only	87.5%	38
Intermediate	87.6%-119.9%	15
Maximum Upward	120%	64
Total of all rated hospitals		**210**

Coverage Analysis

Mcare receives reports of coverage on physicians practicing in the Commonwealth, as well as their specialty and location of practice. It also receives reports of coverage on podiatrists and nurse midwives. Reports of coverage are also made by hospitals, nursing homes, primary health centers, birth centers and medical corporations. Under the Mcare Act, carriers have 60 days from when their coverage began to report coverage to Mcare. Thus, for the first two months of each calendar year, Mcare receives reports of coverage that are for the previous calendar year.

Additional information on the Mcare Coverage Program can be found in Appendix C.

C. Compliance Program

Mcare is responsible for receiving and analyzing reports of coverage from private insurance companies and self-insurers regarding HCPs' medical professional liability insurance coverage. These reports include what type of coverage it is, the periods of coverage, whether a reporting endorsement has been purchased upon the termination of a claims made policy, and the assessment amount being paid per HCP.

Mcare reviews each of these reports for compliance with Pennsylvania's mandatory insurance laws. For 2018, Mcare continued using a special initiative focused on the compliance of hospitals and other facilities. This was due to the acceleration of ownership and affiliation changes in the past few years. The initiative successfully provided support to these hospitals and other facilities by giving them information about differences in what had been reported by the previous owner and what was being reported by the new owner. Mcare was also able to provide information to those involved in an acquisition or other major change in their insurance program on how to most effectively and efficiently report the changes to Mcare.

Mcare also continued its focus on exploring ways to minimize the amount of time insurers, HCPs, and their staffs spend in Mcare compliance activities.

V. Mcare Unfunded Liability

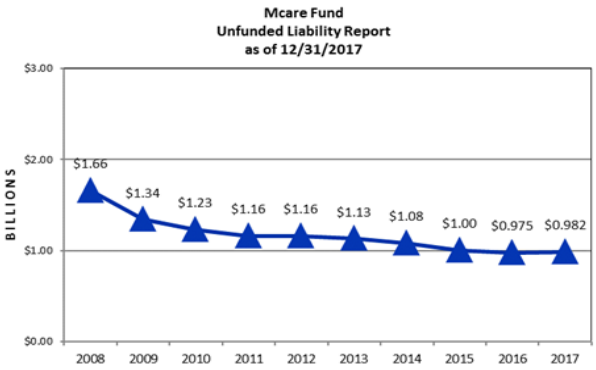
Mcare operates on what has been characterized as a "pay-as-you-go" model since it holds no reserves unlike a traditional insurance company. The HCPs required to participate in Mcare are mandated as a condition of licensure to pay their Mcare assessment. Thus, in a very real sense, the funds that a traditional private insurance company would have already collected remain in the possession of the HCPs until the funds are needed by Mcare to pay claims or other expenses.

One step taken in 2002 to reduce Mcare's unfunded liability was the change in the Mcare Act to place the responsibility for claims reported more than four (4) years from the incident back on the private insurers or self-insureds effective January 1, 2006. This "long tail" portion of the medical professional liability exposure had been the responsibility of a patient compensation fund in Pennsylvania since 1975.

This change, coupled with the limits being provided by private insurers increasing to $500,000 and the overall coverage limit going from $1.2 million to $1 million, has resulted in the Mcare unfunded liability projection trending downward. The annual actuarial study, prepared in 2018 by Deloitte Consulting LLP, concludes that an unfunded liability of $982 million exists as of December 31, 2017.

Below is a chart reflecting the projected unfunded liability over the last 10 years.

Chart 5: Mcare Projected Unfunded Liability over the last 10 years



Additional information on the Mcare Unfunded Liability can be found in Appendix D.

VI. Limits Step Up and Podiatrists' Exit

Limits Step Up

The Mcare Act has a provision that requires a study of the private insurance market's capacity to write increased coverage limits with a corresponding decrease in the coverage limits provided by Mcare. The statute further provides that unless the Insurance Commissioner finds that additional basic insurance coverage capacity is not available, the limits written by the market will increase.

The first time this analysis was conducted, in 2005, the Commissioner did not allow the limits to increase or "step-up." Subsequent studies on a two-year cycle as provided for in the Mcare Act have made similar findings so that the limits have not changed.

The study conducted in 2017 found that it cannot be determined that additional basic insurance capacity is currently available. Reasons for this determination included the large market share of risk retention groups in the market, the changing health care landscape, and the financial impact on health care providers. Thus, there is no increase to the current basic primary insurance limits for calendar years 2018 and 2019.

The next capacity study is being conducted in 2019 for a potential step up in limits effective January 1, 2020.

Podiatrists' Exit

Another provision of the Mcare Act provides for the exit of the podiatrist class of HCPs from the Mcare Fund upon the satisfaction of an arrangement for the class to retire the fund's liabilities associated with podiatrists. Mcare has maintained a dialogue with the podiatrists, however, as of this time, a mutually desirable plan to retire their Mcare liabilities has not been identified.

APPENDIX

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- C.3 Amount of Assessment Received by Provider Type by Assessment Year - 10 Most Recent Years
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- D.1 Pennsylvania Medical Care Availability and Reduction of Error Fund Estimation of 12/31/2017 Unfunded Liability prepared by Deloitte Consulting LLP – Summary of Results

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

CASH BASIS STATEMENT OF OPERATIONS

JANUARY 1, 2018 TO DECEMBER 31, 2018

MCARE FUND BALANCE JANUARY 1, 2018			**$ 16,545,303**
Receipts:			
ASSESSMENT REVENUE	$ 184,483,428		
INVESTMENT INCOME ON ASSESSMENTS	$ 2,147,210		
INVESTMENT INCOME ON RESERVE FUND	$ 584,510		
MISCELLANEOUS REVENUE	$ 330,806		
TRANSIT & PAYABLES SUMMARY	$ (656,443)		
TOTAL RECEIPTS	**$ 186,889,511**		**$ 186,889,511**
TOTAL FUNDS AVAILABLE			**$ 203,434,814**
Claims Deductions:			
2018 CLAIMS PAYMENTS	$ 210,506,924 [#1]		
CLAIMS DEDUCTIONS	**$ 210,506,924**		
Operating Expenses:			
SALARIES	$ 2,422,272		
PAYROLL TAXES & BENEFITS	$ 1,764,424		
DATA PROCESSING SERVICES	$ 278,757		
LEGAL FEES & EXPENSES	$ 2,226,441 [#2]		
COMMONWEALTH SHARED SERVICES	$ 141,635		
CONSULTANTS	$ 652,642		
TELECOMMUNICATIONS	$ 97,944		
REAL ESTATE	$ 362,628		
OTHER OPERATIONAL EXPENSES	$ 101,600		
TOTAL OPERATING EXPENSES	**$ 8,048,343**		
TOTAL DEDUCTIONS AND EXPENSES:			**$ (218,555,267)**
MCARE FUND BALANCE BEFORE TRANSFER			**$ (15,120,452)**
TRANSFER FROM MCARE RESERVE FUND			**$ 15,120,452** [#3]
MCARE FUND BALANCE DECEMBER 31, 2018			**$ (0)**

FINANCIAL FOOTNOTES:

[#1] 2018 Claim Commitments		$ 211,160,516	
Expense adjustment due to Court Orders	$ (653,592)		
2018 Claims Payments		$ 210,506,924	
[#2] Legal Fees & Expenses		$ 2,226,441	
Amount paid to defend Health Care Providers under §715			
[#3] Reserve Fund Balance 01/01/2018		$ 30,000,000	
Transfer to Mcare Operations in lieu of borrowing per	$ 15,120,452		
HAP/PAMED/PPMA Settlement Agreement paragraph 4.A.			
Reserve Fund Balance 12/31/2018		$14,879,548	

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

Mcare Fund

Summary of Financials from CY 2009 to 2018

*** In Millions ***

		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
1	Beginning Balance	104	61	124	130	130	169	73	28	12	17
2	Settlement Agreement [1]						(169)				
3	**ADJUSTED BEGINNING BALANCE**	104	61	124	130	130	0	73	28	12	17
	Receipts:										
4	Assessment Revenue	218	218	184	209	239	233	124	165	192	184
5	Investment Income Earned	3	9	2	2	2	2	2	1	2	3
6	Auto CAT Fund	22	0	0	0	0	0	0	0	0	0
7	Abatement Repayment/Credits	2	0	0	0	0	0	0	0	0	0
8	Transfer from Other Funds [2]	0	0	0	0	0	0	0	0	0	15
9	Loan from Other Funds	0	0	0	0	0	0	0	0	0	0
10	Misc. Other	2	0	0	1	4	1	0	1	1	-1
11	Net Increase/Decrease in Fair Value of Investments	0	0	0	0	0	4	(1)	0	0	0
12	Subtotal Receipts without Beginning Balance (4+5+6+7+8+9+10+11)	247	227	186	212	245	240	125	167	195	201
13	**Grand Total Receipts with Beginning Balance** (3+4+5+6+7+8+9+10+11)	351	288	310	342	375	240	198	195	207	218

		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	Expenditures:										
14	Salaries & Benefits	5	5	4	4	4	4	4	4	4	4
15	Loan Repayment	0	0	0	0	0	0	0	0	0	0
16	Interagency Transfer	100	0	0	0	0	0	0	0	0	0
17	Loss on Investments	0	0	0	0	0	0	0	0	0	0
18	Legal Fees & Expenses	3	9	6	6	6	6	4	3	2	2
19	Liability Claims Paid	178	146	170	196	194	156	160	174	181	211
20	Misc. Other [3]	4	4	0	6	2	1	2	2	3	1
21	**Grand Total Expenditures** (14+15+16+17+18+19+20)	290	164	180	212	206	167	170	183	190	218
22	**Year End Balance (13-21)**	**61**	**124**	**130**	**130**	**169**	**73**	**28**	**12**	**17**	**0**

[1] Settlement Agreement - Pursuant to the Settlement Agreement effective October 3, 2014 between the Pennsylvania Medical Society, the Hospital & Healthsystem Association of Pennsylvania and the Pennsylvania Podiatric Medical Association, $139 million (Relief Fund) of the 2013 Year End Balance is to be returned to the Eligible Health Care Providers who paid assessments during the years of 2009, 2010, 2011, 2012 and 2014. The return of funds was completed by year-end 2017. The remaining $30 million (Reserve Fund) is to be held by Mcare separately and only used to pay claims or other Mcare expenses where other Mcare revenues, including statutory buffer, are insufficient and in lieu of borrowing.

[2] Transfer from Other Funds - transferred $15 million from Reserve Fund in lieu of borrowing in 2018

[3] Misc. Other - includes rounding adjustments and $4.9 million Credit Refunds issued in 2012

Pennsylvania Insurance Department

Mcare Fund

Paid Claims by Region 2014 - 2018*

Year	Total Annual Claim Payment	Eastern		Central		Western		Other	
		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
2014	$155,701,235	$87,078,232	55.93%	$33,328,883	21.41%	$35,294,120	22.67%	$0	0.00%
2015	$160,267,335	$85,070,211	53.08%	$34,728,429	21.67%	$39,968,695	24.94%	$500,000	0.31%
2016	$173,955,487	$80,324,997	46.18%	$58,425,451	33.59%	$34,705,039	19.95%	$500,000	0.29%
2017	$181,260,133	$81,406,418	44.91%	$48,480,436	26.75%	$51,373,279	28.34%	$0	0.00%
2018	$211,160,516	$105,871,615	50.14%	$58,900,723	27.89%	$45,938,178	21.76%	$450,000	0.21%

Regional County Definition:

Eastern	Bucks, Chester, Delaware, Montgomery, Northampton, Philadelphia
Central	Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York
Western	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland
Other	Includes all other states and the United States District Courts where an Mcare defendant was involved.

*County designation within region is for Mcare claims handling purposes only.

Pennsylvania Insurance Department

Mcare Fund

Claim and Case Payments - 10 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	265	$643,000
2012	$195,741,865	404	$484,509	268	$730,380
2013	$193,902,777	414	$468,364	295	$657,298
2014	$155,701,235	346	$450,003	257	$605,841
2015	$160,267,335	352	$455,304	269	$595,789
2016	$173,955,487	372	$467,622	290	$599,847
2017	$181,260,133	402	$450,895	295	$614,441
2018	$211,160,516	439	$481,003	296	$713,380

Note: One "case" consists of 1 to many "claims"

Pennsylvania Insurance Department

Mcare Fund

Summary of Annual Fund Claim Payments by Health Care Provider Group

2009-2018

	Individuals MD's, DO's, Podiatrists Certified Nurse Midwives				Medical Corporations				Institutions Hospitals, Nursing Homes Birth Center, Primary Care Centers				Totals	
Year	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
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
2014	225	65%	$103,366,679	66%	12	3%	$6,050,000	4%	109	32%	$46,284,556	30%	346	$155,701,235
2015	241	68%	$108,303,790	68%	5	1%	$2,675,000	2%	106	30%	$49,288,545	31%	352	$160,267,335
2016	229	62%	$106,235,581	61%	12	3%	$6,112,500	4%	131	35%	$61,607,406	35%	372	$173,955,487
2017	244	61%	$113,657,457	63%	19	5%	$9,179,486	5%	139	35%	$58,423,190	32%	402	$181,260,133
2018	269	61%	$132,674,414	63%	23	5%	$12,485,866	6%	147	33%	$66,000,236	31%	439	$211,160,516

Pennsylvania Insurance Department

Mcare Fund

2014 - 2018 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2014	2015	2016	2017	2018
S01					
S07					
S10	$ 1,483,000	$ 3,790,000	$ 3,450,000	$ 2,500,000	$ 2,000,000
S11					
S12	$ 1,650,000	$ 1,000,000	$ 1,150,000	$ 1,945,952	$ 1,500,000
S14					
S23					
S24					
S32					
S34					
S35		$ 1,000,000			
S36					
S40			$ 300,000		$ 500,000
S41					
S43	$ 400,000				
S45	$ 700,000				
S48					
S49	$ 131,138	$ 500,000	$ 500,000		
S51	$ 1,000,000	$ 1,825,000	$ 1,000,000	$ 1,500,000	
S53	$ 500,000		$ 1,500,000		
S54		$ 500,000			$ 250,000
S57	$ 500,000				
S60			$ 1,900,000		$ 300,000
S62					
S63		$ 500,000			
S66					
S68				$ 500,000	$ 1,025,000
S69					$ 1,500,000
003	$ 15,750,000	$ 9,362,500	$ 11,877,500	$ 10,600,000	$ 16,283,334
011	$ 2,276,207	$ 5,400,000	$ 1,000,000	$ 2,000,000	$ 1,950,000
020					
031	$ 12,526,320	$ 15,041,192	$ 13,371,493	$ 14,343,972	$ 18,905,548
032	$ 4,150,000	$ 3,568,695	$ 500,000	$ 2,450,000	$ 1,000,000
039				$ 560,000	
045	$ 87,500				
052					$ 400,000
055					
067	$ 9,559,462	$ 9,592,500	$ 11,215,050	$ 12,863,755	$ 15,586,000
086	$ 1,500,000	$ 1,050,000	$ 1,000,000	$ 3,800,000	$ 2,000,000
088					
090					$ 500,000
093	$ 1,300,000			$ 1,840,000	$ 50,000
102					
103			$ 1,000,000	$ 500,000	
112	$ 500,000				
119					$ 1,000,000

Pennsylvania Insurance Department

Mcare Fund

2014 - 2018 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2014	2015	2016	2017	2018
121				$ 1,000,000	
124		$ 300,000		$ 250,000	
126	$ 570,000		$ 1,000,000		$ 2,000,000
127			$ 500,000	$ 563,544	$ 1,650,000
129	$ 8,100,000	$ 5,622,983	$ 2,800,000	$ 2,500,000	$ 6,650,197
130			$ 400,000		
131					
135	$ 1,000,000		$ 2,000,000		
136	$ 1,675,000		$ 1,000,000	$ 3,000,000	$ 2,000,000
138	$ 500,000	$ 950,000			$ 1,500,000
139					
143	$ 350,000				
144	$ 8,875,000	$ 15,900,000	$ 18,425,000	$ 15,475,000	$ 16,760,000
145	$ 5,562,000	$ 4,700,000	$ 9,225,000	$ 4,450,000	$ 4,775,000
155	$ 12,015,342	$ 11,987,500	$ 10,752,500	$ 10,325,000	$ 11,650,000
156	$ 1,925,000	$ 4,900,000	$ 4,925,480	$ 4,025,000	$ 3,863,869
157					
159					
160					
161					$ 750,000
162		$ 200,000	$ 187,500		
164					
166					
167					
169					
179					$ 250,000
181			$ 1,000,000		
183					
184		$ 450,000	$ 2,750,000		
185					
194			$ 500,000		
196	$ 2,000,000	$ 500,000	$ 1,000,000	$ 400,000	$ 2,500,000
197	$ 2,427,245	$ 3,325,000	$ 5,933,947	$ 5,996,484	$ 4,000,000
199	$ 2,631,138	$ 2,750,000	$ 1,500,000	$ 4,000,000	$ 3,342,391
201					
202	$ 5,260,000	$ 4,375,000	$ 1,960,000	$ 3,976,350	$ 3,632,500
203	$ 1,414,438	$ 1,330,929	$ 500,000	$ 900,000	$ 1,900,000
207	$ 10,077,342	$ 11,442,078	$ 6,882,922	$ 11,704,487	$ 8,820,361
208	$ 500,000	$ 1,261,667	$ 525,000	$ 544,207	$ 500,000
210			$ 350,000	$ 150,000	
211	$ 6,374,809	$ 2,500,000	$ 4,587,111	$ 4,572,391	$ 7,958,669
212	$ 500,000				$ 500,000
217					$ 400,000
219	$ 1,850,000	$ 500,000	$ 1,350,000	$ 3,000,000	$ 5,226,723
220		$ 1,750,000	$ 800,000	$ 1,850,000	$ 1,000,000
221	$ 3,875,000	$ 2,509,904	$ 4,625,000	$ 2,350,000	$ 1,980,579

Pennsylvania Insurance Department

Mcare Fund

2014 - 2018 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2014	2015	2016	2017	2018
222		$ 1,750,000	$ 3,500,000	$ 850,000	$ 2,500,000
223	$ 1,400,000	$ 2,400,000	$ 2,500,000	$ 1,800,000	$ 4,000,000
224	$ 30,000	$ 2,000,000	$ 500,000	$ 1,200,000	$ 500,000
228	$ 2,000,000	$ 2,000,000	$ 975,000	$ 950,000	
229		$ 200,000			
232				$ 500,000	
234					
239		$ 1,000,000	$ 1,000,000	$ 2,974,590	$ 1,500,000
241	$ 500,000	$ 130,000	$ 500,000	$ 500,000	$ 375,000
243			$ 375,000		$ 500,000
245	$ 6,500,000	$ 5,225,000	$ 8,250,000	$ 19,253,000	$ 11,775,000
246	$ 825,000	$ 950,000	$ 2,675,000	$ 1,000,000	$ 350,000
248					
250	$ 500,000				
251					
253	$ 3,365,000	$ 2,827,387	$ 4,150,000	$ 1,500,000	$ 4,666,667
256					
258	$ 1,860,294	$ 1,500,000	$ 1,675,000	$ 500,000	$ 1,175,000
261	$ 250,000		$ 500,000		$ 2,000,000
262		$ 250,000			
271	$ 1,000,000	$ 1,950,000	$ 3,275,000	$ 2,950,000	$ 2,783,678
275	$ 500,000				
276	$ 600,000	$ 800,000	$ 1,200,000	$ 1,550,000	$ 150,000
279			$ 200,000	$ 500,000	$ 1,000,000
285				$ 500,000	
286	$ 150,000				
290				$ 283,385	
293					
297		$ 250,000			
308		$ 700,000		$ 1,000,000	
310	$ 4,725,000	$ 3,525,000	$ 4,936,984	$ 2,463,016	$ 8,550,000
312				$ 150,000	$ 500,000
314					$ 1,000,000
320		$ 500,000	$ 500,000	$ 500,000	
331				$ 250,000	
333		$ 425,000	$ 500,000	$ 500,000	$ 300,000
338		$ 1,500,000	$ 1,500,000	$ 2,150,000	$ 7,875,000
341				$ 500,000	$ 800,000
350					$ 500,000
351				$ 500,000	
Totals	$ 155,701,235	$ 160,267,335	$ 173,955,487	$ 181,260,133	$ 211,160,516

pennsylvania
INSURANCE DEPARTMENT

2018

ASSESSMENT RATE CALCULATION

PENNSYLVANIA INSURANCE DEPARTMENT
Medical Care Availability and
Reduction of Error Fund

Appendix C.1

TABLE OF CONTENTS

I. Executive Summary

The Medical Care Availability and Reduction of Error Fund (Mcare) is funded by annual assessments collected from health care providers (HCPs) providing health care services in Pennsylvania. Mcare calculates the assessment rate in the fall of each year and informs the HCP community and their insurers of the assessment rate percentage by November 1. The insurers use the Mcare Assessment Manual to learn what amount they should collect from each of their insured HCPs and forward to Mcare when a policy is issued.

The assessment rate calculation process is set by the Mcare Act as well as a settlement with HCP representatives that Mcare entered in 2014. These provisions detail how both the numerator and denominator of the calculation are determined and are discussed below.

Calculation of the Numerator

The numerator of the calculation consists of claim payments, operating expenses and principal and interest Mcare paid on borrowed funds (if any) during the claims period. These numbers all come from Mcare's records. A reserve of 10% is added as required by the Mcare Act. Mcare agreed in the settlement to reduce the total by Mcare management's projection of what the year's starting balance, if any, will be. This forms the numerator of the assessment rate calculation.

Calculation of the Denominator

The denominator of the calculation is based on the "Prevailing Primary Premium". This is a term defined in the Mcare Act as the occurrence rates of the Pennsylvania Professional Liability Joint Underwriting Association (PPLJUA).

The Prevailing Primary Premium (PPP) is used, rather than the amount the HCP pays for their private insurance, to provide a fair methodology to allocate the amount collected by the assessment among HCPs based on their specialty and area of practice (territory). It also provides a more stable base to predict what the actual assessment proceeds will be. The denominator is calculated based on data from Mcare's records about how many HCPs there are in a particular specialty and territory and the amount they would pay if they paid the full PPLJUA premium.

Assessment Rate Calculation

The assessment rate calculation divides the numerator by the denominator. The percentage derived by the calculation is then reviewed by Mcare for a determination whether to round the percentage up or down based on three decimal places.

Assessment Implementation

Mcare applies the assessment percentage to each of the PPP specialty and territory cells and generates a rate chart. This chart, as well as other assessment reporting information, is made available in the annual assessment manual which is available on the Mcare website at www.insurance.pa.gov.

II. Mcare Assessment Rate Calculation

The Mcare Act lists four categories of expenses to be included in the assessment rate calculation, the sum of which is divided by the PPP to determine the assessment percentage. Each component of the calculation is discussed in more detail below.

Final Claims During the Claims Period

To provide sufficient lead time for Mcare to make the assessment rate calculation and to provide the HCP community the assessment rate to use in the following year, the Mcare Act defines the "claims period" as September 1 – August 31. For a claim to be considered "final" during the claims period, Mcare must have received a signed release or a final judgment by August 31.

For claims year 2017, the final claims payments are $181 million, up from $174 million in the previous year.

Mcare Expenses in the Claims Period

In addition to Mcare staff and office expenses, Mcare incurs defense expenses for certain types of claims as required by the Mcare Act. For claims period 2017, the operating expenses are $9.1 million which is consistent with $9.1 million in the previous year.

Principal and Interest on Money Borrowed

The Mcare Act provides for the borrowing of funds by Mcare if it experiences a funding shortfall. This did not occur in this claims period nor is it expected to be needed in the upcoming claims period.

Reserve

The Mcare Act provides for a 10% reserve of all the expense amounts. Historically, claims payments increased year-over-year and the purpose of the reserve was to provide Mcare sufficient additional funds for the upcoming claims period. Recently, the claims payments have been less predictable and without a clear trend. Appendix A has a graph showing claims payments over the last 10 claims periods.

Projected Starting Balance

Prior to the 2014 assessment calculation, Mcare accumulated funds not used at the end of a calendar year. HCP representatives sued Mcare arguing that the funds should be used to reduce the following year's assessment rate calculation. The litigation settled in October 2014 which included Mcare agreeing to reduce the assessment collection by remaining funds. Below is a table reflecting how much per year, including this year, the amount to be collected has been reduced.

Assessment Year	Amount (in millions)
2015	$61
2016	$27
2017	$14
2018	$14
Total	**$116**

Selection of PPP

The Mcare Act's definition of the PPP requires taking the current occurrence rates of the PPLJUA, using Mcare's specialty and territory specific HCP data and calculating a number that equals what the assessment would collect if all the HCPs paid the full PPLJUA rate. Mcare has historically also taken the actual assessment collected in the prior three years and adjusted it to the current PPLJUA rates for comparison purposes. The results of these calculations and analysis for the current year and the past three years are in Appendix B. The selection of the PPP is a management decision by Mcare, not purely an acceptance of one or more calculations or averaging numbers. Mcare selected a PPP of $1.002 billion for 2018.

Appendix C breaks out the tipping points between each assessment percentage based on collecting the $195 million for 2018 as required by the Mcare Act.

Appendix D provides information on the assessment rates for the last 10 years. For the previous three years, a PPP of $980 million was selected. However, the analysis for 2018 supports a PPP of $1.002 billion.

Appendix E shows the HCP count by provider type. There is a general upward trend that provides assurance that the calculated rate should produce the projected amount.

The 2018 assessment rate calculation incorporating these factors is provided on the following page. The assessment rate without rounding is 19.49% which is rounded to 19%.

The chart also provides a comparison with the 2017 calculation to provide information on why the assessment has remained flat year over year.

Summary of 2018 and 2017 Assessment Rate Calculations

	Assessment Rate Factors	2018	2017	Difference	Assessment Rate Impact
(1)	Claim Year Ending 8/31 Claims Settled	$181,260,133	$173,955,487	$7,304,646	1.0%
(2)	Claim Year Ending 8/31 Operating Expenses	$9,100,882	$9,162,344	(61,462)	0.0%
(3)	Target Reserve (10% of (1) + (2))	$19,036,102	$18,311,783	$724,319	0.0%
(4)	Assessment Costs ((1) +(2) +(3))	$209,397,117	$201,429,614	$7,967,503	1.0%
(5)	Projected Starting Balance	($14,073,706)	($13,712,900)	($360,806)	0.0%
(5a)	**Assessment Refund Remainder**	**($6.92)**	$0	**($6.92)**	0.0%
(6)	Contribution from Reserve Fund	$0	$0	$0	0.0%
(7)	Assessment Amount, (4) +(5) +(5a) +(6)	$195,323,403	$187,716,714	$7,606,690	1.0%
(8)	Projected Prevailing Primary Premium	$1,002,000,000	$980,000,000	$22,000,000	-0.5%
(9)	Indicated Assessment Rate, (7)/(8)*	19%	19%	0.0%	0.0%
	**reflects rounding*				

The rounded assessment percentage for 2018 is 19%, the same as last year. The increase in paid claims that carries down to increase the assessment costs and assessment amount was offset by an increase in the projected prevailing primary premium. This rounds to a 0.0% overall change. The remaining $6.92 from the assessment refund program is explicitly included in the 2018 assessment rate calculation thus fulfilling Mcare's promise to return $139,012,919.00.

III. Conclusion

The Mcare Act clearly states what should be done to calculate the assessment rate. Mcare is to take the current claims period expenses (claims payments and its operating expenses) and add the costs of the principal and interest of any borrowing plus a 10% reserve. The litigation settlement requires Mcare to reduce that sum with the projected starting balance.

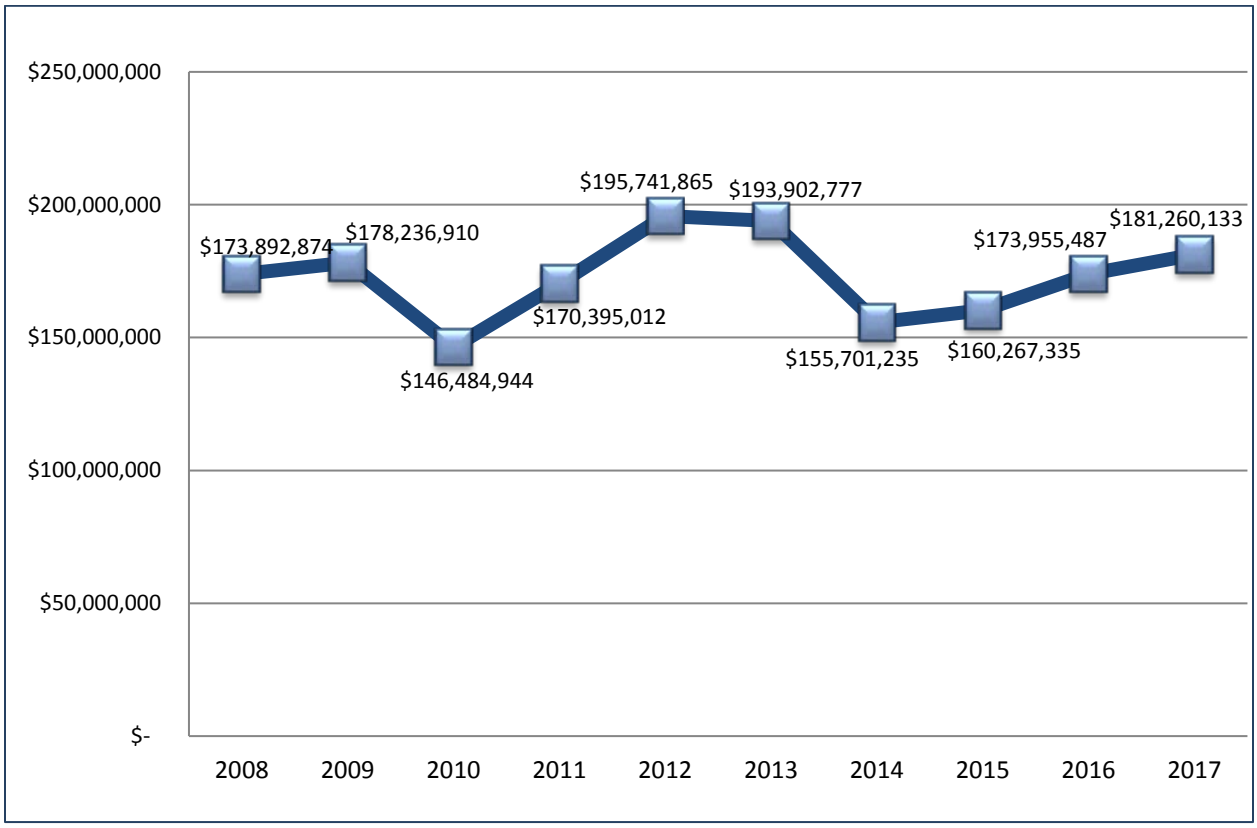
The remaining amount is then divided by the selected PPP to determine the assessment percentage, which is rounded for ease of implementation.

Mcare can be reached at 717-783-3770, via e-mail at ra-in-mcare-exec-web@pa.gov, or by visiting our website at www.insurance.pa.gov.

APPENDICES

APPENDIX A

Claims Payments by Claims Period for 2008-2017



APPENDIX B

PPP Ranges and Mcare Selection

PWC PPP Range 2015 Calculation*			
Collecting	$122 Million		
	Projected PPP	Assessment %	% Used
Based on 2011 Remittances	$956,422,051	12.80%	
Based on 2012 Remittances	$983,191,107	12.50%	
Based on 2013 Remittances	$977,845,422	12.50%	
Mcare Selected 2015	*$980,000,000*	*12.49%*	**12%**

PWC PPP Range 2016 Calculation*			
Collecting	$160 Million		
	Projected PPP	Assessment %	% Used
Based on 2012 Remittances	$983,473,443	16.40%	
Based on 2013 Remittances	$978,457,334	16.50%	
Based on 2014 Remittances	$988,808,118	16.40%	
Mcare Selected 2016	*$980,000,000*	*16.50%*	**17%**

Mcare PPP Range 2017 Calculation			
Collecting	$188 Million		
	Projected PPP	Assessment %	% Used
Based on 2013 Remittances	$977,596,442	19.20%	
Based on 2014 Remittances	$987,407,178	19.01%	
Based on 2015 Remittances	$1,001,555,043	18.74%	
Mcare Selected 2017	*$980,000,000*	*19.15%*	**19%**

Mcare PPP Range 2018 Calculation			
Collecting	$195,323,403		
	Projected PPP	Assessment %	% Used
Based on 2014 Remittances	$986,675,774	19.80%	
Based on 2015 Remittances	$1,000,510,724	19.52%	
Based on 2016 Remittances	$1,001,714,363	19.50%	
Mcare Selected 2018	*$1,002,000,000*	*19.49%*	**19%**

*Information excerpted from previous calculations done by PriceWaterhouseCoopers.

APPENDIX C

Selected PPP Assessment Percentage Impact

	2018 Assessment Expenses		PPP		%	% Rounded
	$195,323,403		$1,056,300,000		18.49%	18%
	$195,323,403		$1,055,500,000		18.51%	19%
Selected	**$195,323,403**		**$1,002,000,000**		**19.49%**	**19%**
	$195,323,403		$1,001,945,000		19.49%	19%
	$195,323,403		$1,001,100,000		19.51%	20%

APPENDIX D

Assessment Percentage
10 Most Recent Years

Year	Percentage
2008	20%
2009	18%*
2010	15%*
2011	13%*
2012	22%*
2013	25%
2014	19%*
2015	**12%**
2016	**17%**
2017	**19%**

*Percentages shown are after recalculation by use of projected starting balance as required by the settlement.

Bolded percentages include use of the projected starting balance during the calculation process.

APPENDIX E

Health Care Provider Count for 2008-2017

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Total Annual Count of Unique Providers
2008	38,890	1,126	267	224	713	5	4	41,229
2009	39,585	1,138	256	222	714	5	4	41,924
2010	40,340	1,162	271	223	702	5	4	42,707
2011	41,127	1,174	286	223	701	5	5	43,521
2012	42,208	1,201	309	222	699	5	5	44,649
2013	42,859	1,221	315	220	698	5	5	45,323
2014	43,294	1,239	315	223	690	5	6	45,772
2015	43,714	1,232	321	221	689	5	5	46,187
2016	43,348	1,204	333	220	681	5	6	45,797
*2017	31,885	858	244	165	483	4	3	33,642

* Coverage for policies that has been reported and processed as of September 14, 2017 is included in the counts.

pennsylvania
INSURANCE DEPARTMENT

2018

HOSPITAL EXPERIENCE MODIFICATION FACTOR CALCULATION

PENNSYLVANIA INSURANCE DEPARTMENT
Medical Care Availability and
Reduction of Error Fund

Appendix C.2

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I. Executive Summary

The Medical Care Availability and Reduction of Error Fund (Mcare) is funded by annual assessments collected from health care providers (HCPs) providing services in Pennsylvania. Mcare calculates the assessment percentage in the fall of each year and informs the HCP community and their insurers of the assessment rate by November 1.

Mcare's enabling statute (Mcare Act) also provides for a hospital experience modification (HEM) program. The purpose of the program is to provide appropriate financial incentives to encourage effective risk management practices and to promote quality care.

Each hospital may receive a +/- 20% adjustment to the assessment they pay based on the claims payments Mcare has made on their behalf as compared to what they have paid to Mcare in assessments. The Mcare Act directs that the five most recent claims periods are to be used. In addition, a hospital's experience is to be compared to its peers. The following report provides information on how the 2018 HEM factors were calculated and distributed.

II. Mcare HEM Factor Calculation and Distribution

The Mcare HEM factor calculation is like a paid loss retrospective rating plan. It directly correlates the hospital's claims experience at the Mcare layer of coverage with what the hospital has paid in to Mcare.

The first step in calculating the HEM factors is identifying which hospitals will be included. Closed hospitals are excluded as they are no longer paying an assessment. New hospitals must be in operation for five years to be eligible for a HEM factor. Prior to that their HEM factor is 1.0.

Once those hospitals eligible for a HEM factor have been identified, their individual Mcare loss ratio is calculated (Mcare Hospital Loss Ratio). As provided for in the Mcare Act, five years of data is used. Five years of claims payments is divided by five years of assessment payments.

For the 2018 HEM calculation, claims payments made in claims years 2012 to 2016 were used. Under the Mcare Act, claims payments are made on the last business day of the year. The HEM calculation is completed in the fall so the 2017 claims payments had not yet been made.

Assessment payments made from 2013 to 2017 were used in the calculation. The overwhelming bulk of hospital assessment payments are for coverage effective either in January or July. Thus, the number of hospitals for which Mcare must advance calculate their projected assessment payment for 2017 using the previous year's bed and visit count is not material.

If a hospital has no Mcare paid claims during the five-year evaluation period, their HEM factor is 80%. This is the maximum discount allowed by the Mcare Act. If a hospital has one or more Mcare paid claims, additional analysis is needed to determine its HEM factor.

To compare a hospital's Mcare Hospital Loss Ratio to its peers, hospitals are placed in one of five bands. A hospital's band is determined by its Annualized Prevailing Primary Premium (APPP). APPP is calculated by taking the hospital's annual bed and visit counts and multiplying them by the unadjusted Prevailing Primary Premium as defined in the Mcare Act (PPP).

The bands are as follows:

Band based on APPP	
Band #	Band Range
1	$0 to $330,000
2	$330,001 to $640,000
3	$640,001 to $1,300,000
4	$1,300,001 to $2,760,000
5	$2,760,001 and greater

The band loss ratio is developed by taking the five years of Mcare claims payments on behalf of all the hospitals in the band and dividing it by five years of assessments paid to Mcare by all hospitals in the band. This produces the Mcare Band Loss Ratio.

Each hospital's Mcare Hospital Loss Ratio is compared to the Mcare Band Loss Ratio to determine whether the hospital's ratio is better, the same or worse than others in the band. It is

this difference that forms the foundation of the HEM factor. The results of this comparison may indicate a HEM factor that is outside the +/-20% allowed by the statute so the results of this initial analysis is called the Uncapped HEM Factor.

Since its inception in the 1990's, the Mcare HEM program has been "revenue neutral". Revenue neutral in this context means that the hospitals as a provider group will pay the same with the HEM program as they would have without it. By doing so other health care providers do not benefit from reduced assessment payments nor have to subsidize the hospital provider group assessment payments.

To determine whether the HEM program is revenue neutral, Mcare calculates how much hospitals as a group would pay into Mcare if there was not a HEM program (Baseline Assessment). Then the amount the hospitals would pay once the HEM factors are applied (Modified Assessment) is calculated. The Baseline Assessment is compared to the Modified Assessment and the difference is the Off-Balance Target. The Off-Balance Target is generally a positive number which means the initial HEM factor calculation generates less assessment than if there were no HEM program. Thus, a factor (Off-Balance Factor) is applied to the Modified Assessment so that it is increased to generate the additional assessment needed to match the Baseline Assessment.

The use of the Off-Balance Factor on the Uncapped HEM Factor must be done together with the application of the +/- 20% statutory restriction. Multiple calculations are needed because as a hospital's HEM factor is increased with the application of the Off-Balance Factor, it has the possible impact of taking the factor to the statutory maximum of 120%. Once this happens, no additional assessment may be collected from the hospital. Successive calculations limit the hospitals new HEM Factor at the maximum until the Off-Balance Target is reached. This process results in the Capped HEM which is the hospital's final HEM.

The Mcare Act requires that frequency be incorporated into the HEM calculation process. Mcare addresses this mandate by including all hospitals with one or more claims in calculating the Off-Balance Factor. It is possible for a hospital to have one or more Mcare paid claims but their Mcare Hospital Loss Ratio as compared to their peers still be under the statutory minimum of 80%. For these hospitals, their loss ratio is brought to 80% and then the Off-Balance Factor is applied to it.

Below are the results of the HEM calculation for the 2018 assessment year.

2018 HEM Distribution	
80% (No Mcare Claims Paid)	93
87.5% (Off-Balance only)	38
87.6%-119.9% (Intermediate)	15
120% (Maximum)	64
Rated Hospitals	210

To distribute the HEM factors, Mcare prepares a document for each individual hospital that communicates its HEM factor and how to use it when calculating the hospital's assessment. Hospitals with no Mcare claims payments during the five-year

evaluation period receive a slightly different document which confirms that they are receiving the largest discount permitted under the Mcare Act of 80%.

The transmittal document also gives the Executive Director's direct dial telephone number, email address and a dedicated email account if there are any questions regarding the hospital's HEM calculation or if they need it to be resent. Responses to hospitals are generally accomplished within an hour with a service standard of same day communications.

Using email to distribute these documents allows Mcare to get the information directly to the person(s) responsible for using the HEM factor. In addition, documents for hospital systems or those with the same producer can be grouped together for greater efficiency.

III. Conclusion

The 2018 HEM factor calculation provides hospitals with an understandable methodology of how their factor is determined. The process is intuitive as it directly compares what a hospital paid in with what Mcare paid out on their behalf. Hospitals without an Mcare paid claim during the 5-year evaluation period are assured of the maximum discount permitted by the Mcare Act. Hospitals can also keep track of their Mcare claims payments and determine when the payment(s) will be outside the evaluation period.

Hospitals who want more detail on how their HEM factor is calculated are responded to by Mcare quickly because Mcare staff have materials already prepared to convey the relevant data elements and calculations. In addition to providing information by telephone, Mcare encourages an email follow up which contains all the information the hospital needs to first confirm that the data used by Mcare is consistent with the hospital's records and how to explain the calculation to others in hospital management.

If there are any questions on this report or the HEM program, Mcare can be reached at 717-783-3770 or via e-mail at ra-in-mcare-exec-web@pa.gov. Frequently asked questions and their answers are available on the Mcare website at www.insurance.pa.gov.

Pennsylvania Insurance Department

Mcare Fund

Amount of Assessment Received by Provider Type and Assessment Year

Assessment Year	Rate[2]	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Medical Corporations
2009	18%	$159,225,581	$2,819,145	$896,034	$42,501,737	$4,770,358	$776,744	$19,991	$5,537,568
2010	15%	$161,796,219	$2,913,844	$980,820	$41,474,745	$4,487,694	$784,659	$24,203	$5,301,037
2011	13%	$133,412,581	$2,417,219	$814,723	$34,052,259	$3,756,234	$665,985	$21,712	$4,307,149
2012	22%	$152,540,795	$3,065,651	$1,065,859	$40,416,868	$4,099,402	$831,401	$34,245	$4,616,815
2013	25%	$176,075,568	$3,709,954	$1,267,572	$44,045,124	$5,532,965	$927,072	$34,509	$5,019,754
2014	19%	$169,577,303	$3,938,854	$1,312,783	$41,779,458	$4,821,131	$917,792	$35,630	$4,387,956
2015	12%	$89,477,577	$2,067,666	$769,996	$22,837,130	$2,556,454	$492,162	$18,676	$2,310,332
2016	17%	$127,446,146	$2,943,439	$1,061,980	$31,235,829	$3,582,110	$726,980	$27,829	$3,267,257
2017	19%	$135,274,924	$3,252,007	$1,144,310	$32,795,513	$3,999,873	$865,740	$31,919	$3,411,622
2018[1]	19%	$141,303,783	$3,074,675	$1,309,660	$34,870,548	$3,535,114	$940,752	$27,077	$2,930,974

[1] Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2019. Coverage for 2018 policies that have been reported and processed as of January 29, 2019 is included in the counts and subject to additional development.

[2] For years 2009, 2010, 2011, 2012, 2013 and 2014 the assessment rate reflects the after settlement percentage; however, the dollars reflected are based on the presettlement assessment percentages.

Pennsylvania Insurance Department

Mcare Fund

Yearly Average Assessment by Provider Group

Assessment Year	Assessment Rate[1]	Physicians			Podiatrists			Hospitals			Nursing Homes		
		Yearly Average[2]	% Change over Prior Year[2]	% Change from 2009 to 2018[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2009 to 2018[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2009 to 2018[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2009 to 2018[2]
2009	18%	$4,022	-9%		$2,478	-7%		$191,449	-7%		$6,681	-9%	
2010	15%	$4,011	0%		$2,508	1%		$185,985	-3%		$6,393	-4%	
2011	13%	$3,244	-19%		$2,059	-18%		$152,701	-18%		$5,358	-16%	
2012	22%	$3,614	11%		$2,553	24%		$182,058	19%		$5,865	9%	
2013	25%	$4,108	14%		$3,038	19%		$200,205	10%		$7,927	35%	
2014	19%	$3,915	-5%		$3,179	5%		$187,352	-6%		$6,977	-12%	
2015	12%	$2,047	-48%		$1,680	-47%		$103,335	-45%		$3,705	-47%	
2016	17%	$2,887	41%		$2,423	44%		$141,981	37%		$5,207	41%	
2017	19%	$3,301	14%		$2,747	13%		$166,316	17%		$5,631	8%	
2018	19%	$3,313	0%	-18%	$2,723	-1%	10%	$174,353	5%	-9%	$5,638	0%	-16%

[1] For years 2009, 2010, 2011, 2012, 2013 and 2014 the assessment rate reflects the after settlement percentage; however, the dollars reflected are based on the presettlement assessment percentages.

[2] The reporting of coverage adjustments throughout the year may impact yearly average and percent change.

Assessments Remitted by Primary Carrier for 2009 - 2018

Carrier Code	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
001	$ 17,490	$ 12,880	$ 10,341	$ 11,721	$ 12,712	$ 15,384				
003	$ 14,646,003	$ 14,222,774	$ 11,611,146	$ 12,830,163	$ 16,146,419	$ 16,349,876	$ 8,340,366	$ 10,759,485	$ 10,693,555	$ 10,176,505
011	$ 2,465,129	$ 2,730,107	$ 2,460,337	$ 2,371,383	$ 3,272,132	$ 3,691,475	$ 1,586,454	$ 2,585,199	$ 3,231,436	$ 3,404,318
021	$ 82,229	$ 81,444	$ 69,248	$ 82,237	$ 87,430					
023	$ 51,034	$ 57,250	$ 58,602	$ 101,281	$ 113,314	$ 95,281	$ 38,811	$ 29,639	$ 28,160	$ 27,637
026										
031	$ 21,572,773	$ 21,276,762	$ 17,186,612	$ 18,763,571	$ 19,998,192	$ 17,427,943	$ 8,485,302	$ 11,769,295	$ 12,103,886	$ 11,810,090
032	$ 1,640,523	$ 1,289,616	$ 865,976	$ 852,573	$ 887,549	$ 681,269	$ 331,630	$ 379,837	$ 408,819	$ 362,336
035								$ 45,583		$ 1,994
038							$ 21,082	$ 30,021	$ 33,750	$ 29,109
052	$ 203,452	$ 115,870	$ 93,642	$ 71,237	$ 132,046	$ 64,126	$ 22,820	$ 32,438	$ 110,781	$ 106,364
055						$ 89,425	$ 41,805	$ 55,682	$ 62,238	$ 60,227
067	$ 15,815,478	$ 15,192,037	$ 11,624,705	$ 12,658,645	$ 13,922,436	$ 13,591,144	$ 6,925,014	$ 9,330,723	$ 11,017,152	$ 9,714,111
090	$ 124,663	$ 70,966	$ 69,784	$ 66,940	$ 81,584	$ 80,774	$ 40,467	$ 56,382	$ 64,524	$ 40,322
103	$ 450,494	$ 407,558	$ 321,365	$ 268,261	$ 721,779	$ 1,212,476	$ 682,136	$ 2,201,623	$ 1,309,917	$ 288,480
110	$ 35,085	$ 39,745	$ 37,335	$ 52,843	$ 75,359	$ 39,898	$ 1,291	$ 1,828	$ 2,043	$ 31,114
112	$ 180,419	$ 113,931	$ 96,636	$ 8,661	$ 10,064	$ 9,573	$ 4,995	$ 7,076	$ 7,908	$ 7,908
113		$ 2,434	$ 8,969	$ 10,868	$ 15,394	$ 17,432	$ 7,030	$ 14,166	$ 12,845	$ 14,938
118	$ 7,157			$ 18,269	$ 9,171	$ 8,738	$ 8,918	$ 12,657		
121	$ 678,834	$ 678,970	$ 549,636	$ 491,566	$ 515,043	$ 453,844	$ 291,999	$ 566,281	$ 536,323	$ 408,677
124	$ 885,896	$ 830,255	$ 678,519	$ 788,170	$ 830,074	$ 783,419	$ 375,219	$ 503,243	$ 1,769,310	$ 1,786,933
127	$ 331,553	$ 360,052	$ 316,702	$ 376,394	$ 246,674	$ 541,576	$ 611,065	$ 939,636	$ 1,018,760	$ 875,515
129	$ 5,249,232	$ 5,348,398	$ 4,152,203	$ 4,358,661	$ 3,053,635	$ 4,457,342	$ 2,199,200	$ 2,827,030	$ 3,174,269	$ 3,360,277
130				$ 19,970	$ 74,714	$ 43,833	$ 6,162	$ 8		
137	$ 118,536	$ 118,127	$ 79,619	$ 95,517	$ 114,141	$ 277,059	$ 145,743	$ 206,289	$ 48,100	$ 37,632
138	$ 596,813	$ 717,329	$ 767,426	$ 745,968	$ 850,573	$ 934,886	$ 499,036	$ 745,370	$ 1,044,818	$ 802,326
139	$ 56,086									
144	$ 16,864,194	$ 18,023,412	$ 15,900,663	$ 18,959,413	$ 23,529,925	$ 22,371,254	$ 11,610,694	$ 17,145,183	$ 8,560,732	$ 20,142,836
145	$ 4,092,878	$ 4,162,160	$ 3,679,225	$ 4,749,814	$ 5,422,506	$ 5,133,278	$ 2,770,731	$ 2,944,042	$ 2,402,606	$ 2,605,534
155	$ 14,724,440	$ 14,962,605	$ 12,384,028	$ 13,822,587	$ 15,924,552	$ 15,401,727	$ 8,127,291	$ 11,675,012	$ 14,867,867	$ 14,950,814
156	$ 10,275,742	$ 9,119,695	$ 7,134,927	$ 7,930,512	$ 8,659,201	$ 7,590,581	$ 5,166,850	$ 5,538,402	$ 6,319,986	$ 6,277,106
162	$ 36,978	$ 17,535	$ 17,843	$ 69,802	$ 120,908	$ 118,044	$ 80,415	$ 178,883	$ 195,235	$ 508,195
165	$ 184	$ 22,195	$ 197,936	$ 259,445	$ 272,372	$ 76,537	$ 70,824	$ 87,293	$ 98,284	$ 86,794
169		$ 4,180								
173					$ 1,242			$ 405,707	$ 472,742	$ 97,253
179	$ 37,368	$ 36,539	$ 30,926	$ 35,611	$ 35,955	$ 36,917	$ 19,318	$ 24,830	$ 51,423	$ 74,006
182										
186	$ 113,095	$ 105,611	$ 60,230	$ 34,101	$ 22,421					
191	$ 20,188									
194	$ 21,287	$ 106,244	$ 94,753	$ 48,581	$ 11,573	$ 10,750	$ 6,430	$ 7,001	$ 8,058	$ 3,584
196	$ 1,260,810	$ 1,186,669	$ 1,061,362	$ 979,269	$ 1,038,089	$ 898,586	$ 425,638	$ 543,061	$ 642,478	$ 340,684
197	$ 4,926,472	$ 4,957,888	$ 4,277,301	$ 5,610,095	$ 6,872,008	$ 5,961,363	$ 2,983,724	$ 4,003,268	$ 4,411,876	$ 4,291,827
198	$ 6,218	$ 76,675	$ 74,078	$ 103,003	$ 118,884					
199	$ 4,587,769	$ 4,849,906	$ 4,066,367	$ 4,610,605	$ 5,392,354	$ 5,329,961	$ 2,901,439	$ 4,271,173	$ 5,027,296	$ 5,235,306
200										
202	$ 7,791,910	$ 8,064,521	$ 6,638,291	$ 6,456,603	$ 7,752,483					
203	$ 1,294,032	$ 1,369,529	$ 1,317,844	$ 1,324,129	$ 1,747,218	$ 1,794,879	$ 932,468	$ 1,416,957	$ 1,935,345	$ 2,434,871
206	$ 54,164	$ 24,312	$ 28,762	$ 23,432					$ 124,452	$ 131,269
207	$ 19,085,429	$ 14,794,610	$ 12,769,476	$ 14,147,817	$ 15,991,773	$ 15,264,229	$ 6,652,058	$ 9,655,284	$ 10,954,774	$ 11,417,627

Pennsylvania Insurance Department

Mcare Fund

Assessments Remitted by Primary Carrier for 2009 - 2018

Carrier Code	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
208	$ 1,869,269	$ 1,970,116	$ 1,669,532	$ 1,862,098	$ 2,125,547	$ 2,033,677	$ 1,045,518	$ 1,387,832	$ 286,584	$ 12,624
210	$ 788,053	$ 879,944	$ 895,795	$ 1,524,156	$ 901,695	$ 892,473	$ 444,628	$ 128,071	$ 733	$ 2,576
211	$ 8,350,530	$ 8,935,740	$ 6,967,934	$ 7,627,800	$ 8,661,482	$ 7,357,394	$ 1,548,641			
212	$ 185,955	$ 199,165	$ 234,820	$ 269,253	$ 392,633	$ 649,432	$ 427,673	$ 769,857		
216	$ 7,039	$ 7,392	$ 5,448	$ 5,644	$ 6,893					
217	$ 384,630	$ 357,590	$ 288,634	$ 332,970	$ 378,859	$ 289,646	$ 145,666	$ 246,912	$ 353,284	$ 217,192
218	$ 258,318	$ 285,174	$ 259,598	$ 297,256	$ 385,246	$ 369,694	$ 208,964	$ 318,772	$ 412,875	$ 425,842
219	$ 4,347,059	$ 3,992,115	$ 3,347,922	$ 3,505,084	$ 4,236,274	$ 3,809,231	$ 2,013,611	$ 2,739,939	$ 3,051,061	$ 2,878,012
220	$ 2,087,079	$ 2,061,850	$ 1,779,618	$ 2,194,869	$ 1,874,925	$ 1,368,891	$ 449,627	$ 626,572	$ 572,267	$ 615,411
221	$ 4,409,132	$ 4,457,088	$ 3,368,454	$ 3,472,968	$ 4,345,005	$ 4,468,244	$ 2,417,119	$ 2,216,238	$ 1,348,052	$ 1,196,890
222	$ 3,299,424	$ 3,455,919	$ 3,071,859	$ 3,603,862	$ 4,552,750	$ 4,716,852	$ 2,597,293	$ 4,022,646	$ 5,108,647	$ 5,379,241
223	$ 3,500,761	$ 3,420,200	$ 680,542	$ 5,717,928	$ 3,790,788	$ 3,743,490	$ 2,107,802	$ 3,158,914	$ 4,110,801	$ 436,972
224	$ 1,714,715	$ 1,770,644	$ 1,536,620	$ 1,890,108	$ 2,296,493	$ 2,548,110	$ 1,498,224	$ 2,329,348	$ 2,854,239	$ 2,901,353
225	$ 47,223	$ 55,395	$ 58,234	$ 70,114	$ 80,901	$ 77,034	$ 40,020			
226	$ 82,373	$ 81,390	$ 64,177	$ 75,865	$ 77,175	$ 75,123	$ 39,308	$ 1,151		
227	$ 3,338	$ 3,360	$ 2,755	$ 3,225						
228	$ 1,605,407	$ 1,633,760	$ 1,297,886	$ 1,470,236	$ 1,052,576					
229	$ 2,324									
230	$ 20,715	$ 20,859	$ 7,414							
232	$ 60,383	$ 101,537	$ 124,590	$ 122,274	$ 136,670	$ 174,369	$ 154,431	$ 193,872	$ 245,750	$ 141,422
233	$ 617	$ 119	$ 1,339	$ 1,504						
234	$ 225,656	$ 211,684	$ 171,751	$ 196,256	$ 217,077	$ 226,606	$ 128,959	$ 171,953	$ 177,735	$ 193,054
235	$ 73,644	$ 73,290	$ 60,010	$ 69,698	$ 81,258	$ 76,906	$ 39,742	$ 57,102	$ 65,495	$ 69,533
236	$ 77,890	$ 53,065	$ 14,613	$ 17,106	$ 36,456	$ 58,055	$ 28,097	$ 17,643	$ 14,270	$ 14,503
237	$ 37,613	$ 18,081	$ 37,038	$ 20,319	$ 21,057	$ 18,694	$ 10,590	$ 17,505	$ 23,638	$ 21,029
239	$ 2,544,367	$ 2,501,619	$ 2,327,394	$ 2,308,816	$ 2,282,374	$ 2,321,286	$ 1,437,860	$ 2,083,778	$ 2,409,712	$ 2,345,180
241	$ 927,277	$ 936,689	$ 780,430	$ 841,842	$ 973,242	$ 974,336	$ 485,175	$ 768,648	$ 885,737	$ 883,322
242	$ 37,341	$ 37,599	$ 30,820	$ 36,079	$ 41,922	$ 39,879	$ 20,806	$ 29,476	$ 32,944	$ 27,162
243	$ 26,843	$ 23,892	$ 19,320	$ 22,679	$ 26,343	$ 26,156	$ 13,873	$ 21,605	$ 21,723	$ 20,877
244	$ 93,843	$ 92,656	$ 73,106	$ 43,307	$ 56,157	$ 67,363	$ 34,033	$ 5,652	$ 6,318	$ 6,842
245	$ 5,082,741	$ 5,428,849	$ 4,995,186	$ 6,501,002	$ 7,878,484	$ 7,923,310	$ 4,526,608	$ 7,064,504	$ 8,339,264	$ 9,315,796
246	$ 2,398,499	$ 2,154,129	$ 1,663,726	$ 1,726,585	$ 1,960,684	$ 610,356				
247	$ 25,672	$ 33,807	$ 30,579	$ 41,704	$ 108,481	$ 56,497	$ 36,331	$ 66,805	$ 79,262	$ 69,323
248	$ 302,166	$ 314,244	$ 289,671	$ 370,397	$ 443,530	$ 405,018	$ 209,820	$ 82,171		
249	$ 11,427	$ 21,289	$ 15,689	$ 14,768	$ 22,767	$ 6,897	$ 4,692			
250	$ 549,842	$ 482,819	$ 51,022							
251	$ 73,792	$ 53,983	$ 44,006							
252	$ 78,382	$ 67,892	$ 53,245	$ 54,800	$ 58,348	$ 20,063	$ 10,632	$ 14,341	$ 18,017	$ 19,063
253	$ 3,963,999	$ 4,120,407	$ 3,483,392	$ 4,130,535	$ 4,783,081	$ 4,571,137	$ 2,265,845	$ 3,254,848	$ 2,235,252	
257	$ 69,671	$ 48,673	$ 38,693	$ 17,602						
258	$ 2,105,917	$ 1,916,725	$ 1,591,372	$ 1,686,363	$ 1,780,722	$ 1,510,059	$ 767,746	$ 935,301	$ 951,351	$ 901,017
261	$ 1,326,180	$ 1,196,930	$ 1,282,512	$ 1,179,670	$ 981,214	$ 858,640	$ 458,924	$ 700,283	$ 690,779	$ 751,299
262	$ 26,752	$ 33,772	$ 36,892	$ 62,788	$ 68,836	$ 59,488	$ 25,076	$ 28,240	$ 38,404	$ 39,816
263	$ 3,080									
264	$ 1,075	$ 920	$ 949	$ 1,066	$ 1,308	$ 1,207	$ 630	$ 892	$ 997	$ 997
265	$ 28,958	$ 13,756	$ 66,711	$ 140,669	$ 146,164	$ 138,607	$ 70,576	$ 122,115	$ 125,178	$ 141,302
266	$ 21,106	$ 21,252	$ 31,786	$ 33,962	$ 46,564	$ 44,295	$ 1,675	$ 2,374	$ 28,808	$ 33,213
267	$ 536	$ 573	$ 470	$ 633	$ 807	$ 741	$ 387			
268	$ 5,204	$ 1,752	$ 1,674	$ 2,043						

Pennsylvania Insurance Department

Mcare Fund

Assessments Remitted by Primary Carrier for 2009 - 2018

Carrier Code	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
271	$ 1,670,604	$ 2,508,591	$ 2,157,805	$ 2,508,055	$ 2,533,213	$ 4,121,948	$ 2,561,603	$ 3,294,627	$ 4,307,166	$ 4,619,548
272										
274	$ 164,117	$ 181,037	$ 145,726	$ 175,616	$ 193,020	$ 167,227	$ 84,043	$ 112,858	$ 122,030	$ 117,659
275	$ 471,145	$ 551,696	$ 401,488	$ 544,901	$ 18,100	$ 21,501	$ 33,860	$ 25,686	$ 26,007	$ 24,670
276	$ 538,114	$ 538,184	$ 437,079	$ 512,402	$ 597,451	$ 563,886	$ 290,947	$ 368,373	$ 287,662	$ 272,926
277		$ 31,687	$ 59,623	$ 77,665	$ 89,387	$ 138,816	$ 90,233	$ 36,433	$ 33,147	
278										
279	$ 216,826	$ 540,063	$ 470,105	$ 593,152	$ 563,997	$ 136,277				
280									$ 2,797	$ 4,427
281	$ 949									
282	$ 70,584	$ 41,605	$ 24,332							
285	$ 273,106	$ 420,044	$ 281,021							
286	$ 50,081	$ 78,039	$ 119,105	$ 157,730	$ 120,817	$ 124,559	$ 80,916	$ 110,675	$ 161,621	$ 173,362
287										
289		$ 13,782	$ 11,298	$ 59,699	$ 74,364	$ 55,565	$ 31,938	$ 68,500	$ 39,694	$ 40,931
290	$ 113,197	$ 64,152	$ 59,224	$ 64,324	$ 76,356	$ 74,558	$ 39,054	$ 55,670	$ 59,283	
291				$ 19,927	$ 5,520					
292	$ 37,934	$ 11,491	$ 13,718	$ 71,920	$ 7,992	$ 19,965	$ 4,999	$ 5,179		
293	$ 50,314	$ 53,367	$ 46,060	$ 47,614	$ 21,814	$ 17,178	$ 7,260	$ 843	$ 942	
294	$ 2,944	$ 7,299	$ 5,982	$ 4,734	$ 1,813	$ 3,472	$ 4,032	$ 4,814	$ 5,380	
296	$ 2,682	$ 2,814	$ 7,908	$ 2,797	$ 3,324	$ 3,449	$ 1,799	$ 2,549	$ 2,849	
297	$ 33,500	$ 18,398	$ 8,824	$ 11,047						
298	$ 5,495	$ 24,403	$ 25,482	$ 26,560	$ 32,910	$ 32,527	$ 18,997	$ 26,913	$ 30,080	$ 30,080
303		$ 19,540	$ 29,308	$ 30,070	$ 40,121	$ 48,304	$ 27,066	$ 33,720	$ 40,418	$ 47,724
305	$ 2,678	$ 45,945	$ 38,857	$ 36,547	$ 39,130					
307		$ 1,272	$ 1,147	$ 2,633	$ 3,155	$ 7,208	$ 4,005	$ 5,429	$ 5,256	$ 2,682
308		$ 360,392	$ 568,835	$ 791,283	$ 1,082,553	$ 525,390	$ 581,624	$ 94,102	$ 62,101	$ 7,597
309						$ 4,675	$ 2,439	$ 111,890	$ 137,295	$ 42,035
310	$ 6,264	$ 4,765,557	$ 3,871,097	$ 5,288,515	$ 5,789,251	$ 5,489,944	$ 3,113,702	$ 4,600,030	$ 5,211,904	$ 5,363,906
312				$ 34,459	$ 20,797	$ 25,161	$ 32,280	$ 25,084		
313	$ 572	$ 882	$ 723	$ 904	$ 1,242	$ 1,140	$ 595	$ 208		
314		$ 25,112	$ 43,592	$ 107,938	$ 121,336	$ 218,223	$ 112,271	$ 129,078	$ 19,279	
315		$ 53,824	$ 44,083	$ 41,374	$ 52,256	$ 43,491	$ 8,309	$ 21,250	$ 33,299	$ 39,773
316			$ 12,325	$ 29,157						
318			$ 7,288	$ 4,435		$ 85				
320			$ 137,894	$ 472,986	$ 298,395	$ 1,236				
321				$ 5,926	$ 36,484	$ 29,869	$ 19,247	$ 20,428	$ 13,241	
322			$ 5,224	$ 30,874	$ 45,692	$ 22,319	$ 8,879	$ 80,208	$ 74,993	$ 85,490
323				$ 62,024	$ 64,842					
324	$ 408			$ 25,623	$ 32,452	$ 29,512	$ 99,264	$ 1,404,245	$ 1,822,567	$ 1,922,057
325				$ 20	$ 31,562	$ 47,118	$ 36,088	$ 52,979	$ 17,810	
326				$ 9,404	$ 54,729	$ 71,617	$ 50,683	$ 71,882	$ 16,402	$ 11,102
327					$ 179,962	$ 47,961	$ 22,241	$ 33,635	$ 35,094	$ 37,289
328				$ 330	$ 597,683	$ 504,122	$ 270,612	$ 398,494	$ 451,577	$ 390,667
329				$ 97,845	$ 128,862	$ 164,086	$ 172,805	$ 93,961	$ 329,842	$ 321,615
330				$ 502	$ 463,142	$ 485,066	$ 80,266	$ 127,831	$ 48,231	$ 30,561
331					$ 548,451	$ 78,726	$ 52,784	$ 49,922	$ 42,040	$ 35,117
332			$ 20	$ 735		$ 4,942	$ 3	$ 4,183	$ 6,814	$ 5,694
333					$ 213,686	$ 597,202	$ 267,156	$ 49,478	$ 149,218	$ 180,988

Pennsylvania Insurance Department

Mcare Fund

Assessments Remitted by Primary Carrier for 2009 - 2018

Carrier Code	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
334					$ 229,235	$ 601,547	$ 300,039	$ 274,790	$ 289,690	$ 298,058
335							$ 2,245	$ 10,222	$ 11,424	$ 16,791
336					$ 3,747	$ 3,564	$ 1,860			
337									$ 919	$ 612
338			$ 4,676	$ 31,297	$ 1,692,242	$ 6,812,484	$ 4,281,786	$ 6,232,471	$ 6,981,870	$ 7,197,034
339					$ 24,230	$ 16,187				
340					$ 161	$ 60,581	$ 28,454	$ 51,229	$ 3,099	$ 249
341						$ 1,404,521	$ 783,310	$ 1,174,183	$ 1,378,743	$ 1,394,898
342						$ 2,391	$ 5,095	$ 7,217	$ 8,067	$ 5,984
343						$ 14,795	$ 9,012	$ 12,767	$ 4,668	$ 9,810
344						$ 2,944			$ 188,697	$ 223,860
345					$ 3,101	$ 2,074		$ 12,417	$ 21,822	$ 13,087
346							$ 26,462	$ 57,467	$ 55,888	$ 41,577
347							$ 15,377	$ 124,740	$ 299,984	$ 314,848
348							$ 3,233	$ 8,317	$ 100,593	$ 106,505
349						$ 836	$ 56,996	$ 33,510	$ 28,738	$ 59,134
350							$ 18,350	$ 365,133	$ 524,664	$ 639,725
351							$ 2,490,143	$ 5,350,398	$ 5,648,921	$ 3,753,452
353								$ 30,991		$ 13,734
354								$ 220,198	$ 351,292	$ 356,215
355								$ 1,972,111	$ 2,427,532	$ 2,473,826
357										$ 12,000
359									$ 1,034,805	$ 1,049,599
360								$ 19,663	$ 70,807	$ 62,169
361									$ 153,192	$ 139,780
362								$ 3,766		
363									$ 6,699	
364										$ 245,511
365									$ 1,276,893	$ 3,279,375
368										$ 3,546,104
370										$ 4,175
371										$ 20,830
900	$ 6,278	$ 2,428	$ 1,486	$ 1,032						
Totals	$ 207,263,646	$ 209,462,099	$ 172,689,378	$ 199,761,677	$ 227,535,264	$ 216,294,384	$ 114,365,389	$ 162,063,694	$ 171,705,971	$ 180,092,224

Note: The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of January 29, 2019.

Pennsylvania Insurance Department

Mcare Fund

Assessments Remitted by Self-Insurer for 2009 - 2018

Carrier Code	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
S10	$ 4,401,573	$ 4,581,217	$ 3,845,277	$ 3,925,897	$ 5,086,715	$ 4,881,939	$ 2,596,208			
S12	$ 1,442,094	$ 1,497,885	$ 1,447,174	$ 1,701,974	$ 2,119,427	$ 2,127,528	$ 1,095,316	$ 1,719,125	$ 1,960,885	$ 460,048
S40	$ 398,985	$ 422,801	$ 320,702	$ 408,489	$ 536,411	$ 548,490	$ 290,537	$ 444,667	$ 519,142	$ 539,753
S41	$ 84,109	$ 75,339	$ 61,967	$ 68,635	$ 75,056	$ 77,831	$ 40,570	$ 58,952	$ 79,101	$ 96,066
S43	$ 265,791									
S46	$ 11,331									
S47										
S49	$ 661,673	$ 639,358	$ 515,432							
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	$ 455,435	$ 260,698	$ 410,417	$ 478,963	$ 475,799
S57	$ 49,877	$ 52,078	$ 39,633	$ 21,273						
S58	$ 13,637	$ 16,372	$ 10,656	$ 12,482	$ 15,481	$ 15,492	$ 8,881	$ 9,245	$ 10,262	$ 12,761
S59	$ 22,223	$ 11,932								
S60	$ 419,605	$ 399,292	$ 387,342	$ 480,035	$ 545,819	$ 538,398	$ 307,303	$ 185,366		
S61	$ 11,367	$ 11,445	$ 9,306	$ 10,805	$ 12,555	$ 11,943	$ 6,231	$ 8,900	$ 9,947	$ 9,785
S62										
S63	$ 250,675	$ 244,193	$ 154,020	$ 178,381	$ 216,347	$ 216,499	$ 67,749			
S64	$ 15,095	$ 15,199	$ 12,459	$ 14,663	$ 16,946	$ 16,121				
S66	$ 467,498									
S67		$ 3,004	$ 14,561	$ 9,742	$ 11,114	$ 10,671	$ 8,634	$ 24,771	$ 28,574	$ 28,574
S68						$ 1,586,950	$ 843,002	$ 1,128,113	$ 1,149,591	$ 1,178,141
S69								$ 4,166,919	$ 4,835,517	$ 4,939,206
Totals	$ 9,711,303	$9,064,696	$7,528,664	$7,226,221	$9,119,293	$10,487,297	$5,525,129	$ 8,156,475	$9,071,982	$7,740,133

Note: The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of January 29, 2019.

Pennsylvania Insurance Department

Mcare Fund

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

2009 - 2018

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Total Annual Count[1, 2]
2009	39,585	1,138	256	222	714	5	4	41,924
2010	40,341	1,162	271	223	702	5	4	42,708
2011	41,128	1,174	286	223	701	5	5	43,522
2012	42,207	1,201	309	222	699	5	5	44,648
2013	42,865	1,221	315	220	698	5	5	45,329
2014	43,321	1,239	315	223	691	5	5	45,799
2015	43,734	1,231	321	221	690	5	6	46,208
2016	44,089	1,220	334	220	689	5	6	46,563
2017	44,050	1,232	351	218	688	4	6	46,549
2018	42,655	1,129	344	200	627	4	4	44,963[3]

[1] Medical corporations are excluded as they are not health care providers.

[2] Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2019. Coverage for 2018 policies that have been reported and processed as of January 29, 2019 is included in the counts and subject to additional development.

[3] Applying an experience based development factor of 1.04% to the current 2018 health care provider count results in a projected 2018 health care provider count of 46,719.

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

Unfunded Liability Analysis as of December 31, 2017;

Rollforward Analysis to June 30, 2018 (based on actual loss activity)

Deloitte Consulting LLP
July 11, 2018

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July 11, 2018

Mr. Theodore G. Otto, III
Executive Director – MCare Fund
Pennsylvania Insurance Department – Bureau of MCare
1010 North 7th Street, Suite 201
Harrisburg, PA 17102

Dear Mr. Otto:

Deloitte Consulting LLP is pleased to submit the actuarial report regarding our analysis of Pennsylvania Insurance Department ("Department") unfunded liability associated with the Medical Care Availability and Reduction of Error Fund as of June 30, 2018. This report is based on an analysis of data through December 31, 2017. Results are presented as of December 31, 2017 and again as of June 30, 2018, based on actual payments and claim emergence between December 31, 2017 and June 30, 2018.

We are members of the Casualty Actuarial Society and the American Academy of Actuaries and meet the qualification standards to issue this actuarial report.

We have enjoyed working with Pennsylvania Insurance Department on this analysis. If you have any questions after reviewing this report, please do not hesitate to contact us.

Sincerely,

Kevin Bingham, ACAS, MAAA
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Table of Contents

I. Overview

Deloitte Consulting LLP ("Deloitte Consulting", "us", "we" or "our") was retained by the Pennsylvania Insurance Department to provide an independent actuarial analysis regarding the Department's unfunded liability of the Medical Care Availability and Reduction of Error Fund ("MCare" or "the Fund") as of June 30, 2018. This report has been created to support and document the analysis.

This report discusses our approach and presents the results of our December 31, 2017 review, which was also rolled forward to June 30, 2018. Our unpaid claim liability estimates are presented on an undiscounted basis. All information presented in this report is as of December 31, 2017 and June 30, 2018, displayed in thousands of US dollars unless otherwise stated.

Fund Background

The Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") was created on January 13, 1976 to ensure reasonable compensation for persons injured due to medical negligence. As a successor to CAT Fund, the Medical Care Availability and Reduction of Error Fund was created by Act 13 of 2002, and signed into law on March 20, 2002.

The Fund provides excess coverage (to varying historical limits) for health care providers who have exhausted their primary limits ("Excess Claims"), and previously provided 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 Claims").

Per Section 715 of Act 13, a provision was created to eliminate the Fund's first-dollar coverage of late reported claims. Prior to Act 13, these late reported claims were known as Section 605 claims. All medical professional liability insurance policies issued on or after January 1, 2006 provide coverage within the primary policy limit for breach of contract or tort occurring after December 31, 2005 regardless of when reported. However, the Fund still provides first dollar coverage for certain late reported claims under Section 715, including injuries to minors and for foreign objects in accordance with the Statute of repose at Section 513 of Act 13, when the first date of occurrence was prior to January 1, 2006 and the last date(s) of criticized treatment is more than four years before the claim was made.

The mandatory medical professional liability primary coverage limits are scheduled to increase (with corresponding decreases in the Fund coverage limits), subject to the Commissioner's assessment of the basic insurance coverage capacity. Per our discussions with the Department, the estimates contained in this report assume that the basic coverage limits will increase to $750,000 in 2020 through 2022 and then to $1 million in 2023, and that the Fund provides no new coverage beginning with policies issued or renewed in 2023.

Policy Year	Hospital: Mandatory Primary Occurrence / Aggregate Limits	Physician: Mandatory Primary Occurrence / Aggregate Limits	MCare Fund Excess Occurrence / Aggregate Limits	Section 605/715 Limits
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 – 2019	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)
2020 – 2022	750 / 2,750	750 / 1,750	250 / 1,250	250 (excess)
2023 & Subs.	1,000 / 3,000	1,000 / 2,000	0 / 1,000	0 (excess)

The Fund is supported by an assessment collected from each participating health care provider. The annual assessment percentage for calendar year 2017 is 19%.[1] Act 13 requires an assessment that will, in the aggregate, produce an amount sufficient to accomplish the following:

1) Reimburse the Fund for payments of reported claims which became final during the preceding claims period;[2]
2) Pay expenses of the Fund incurred during the preceding claims period;
3) Pay principal and interest on moneys transferred into the Fund; and
4) Provide a reserve that should be 10% of the sum of (1), (2) and (3).

Beginning with the 2015 assessment and for each annual assessment thereafter, the Fund computes the assessment by subtracting any projected starting balance from the sum of items (1) through (4) above.[3] The assessment is collected via the application of an assessment rate to the policy year prevailing primary premium, which is based on the Joint Underwriting Association (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 paid; however, the fund does require regular actuarial evaluations of its projected unfunded liability.

[1] http://www.insurance.pa.gov/Pages/2017-Coverage-Rating.aspx

[2] The Funds fiscal year for claim payments ends on August 31st, with actual payments on the claims settled within the fiscal year being made on or about December 31st

[3] Per the "settlement agreement" effective October 3, 2014 between the Commonwealth of Pennsylvania and the "Petitioners" – the Hospital & Health System Association of Pennsylvania ("HAP"), the Pennsylvania Medical Society ("PAMED"), and the Pennsylvania Podiatric Medical Association ("PPMA").

REPORT SECTIONS

This report is comprised of the following sections:

- **Overview** – general introduction and overview of the engagement;
- **Scope** – describes the work and reports that Deloitte Consulting has been requested to perform and produce;
- **Summary of Results** – results of our estimates of the unpaid claim liabilities;
- **Conditions and Limitations** – details the limitations that apply to this engagement's work product, report and results;
- **Actuarial Methodology** – describes the approach underlying the results of our estimates of unpaid claim liabilities;
- **ASOP 43 Disclosures** – discusses certain disclosures required by Actuarial Standard of Practice #43 pertaining to the estimation of unpaid claims liabilities;
- **Exhibits** – describes the contents of the exhibits included in this report.

II. SCOPE

Deloitte Consulting serves as an independent consultant to Pennsylvania Insurance Department under an agreement between Pennsylvania Insurance Department and Deloitte Consulting. Our role under such engagement is to provide an actuarial analysis of the MCare's unfunded liability.

The scope of work is to provide the following:

- An estimate of the Department's unfunded liability as of December 31, 2017 for covered claims from January 1, 1976 through December 31, 2017.
- Considerations impacting the unfunded liability and future calendar year payment projections, including but not limited to: principal drivers of the projections, typical time horizons over which experience is considered for projection purposes, and historical variability of these drivers.
- A roll-forward estimate of the Department's unfunded liability from December 31, 2017 to June 30, 2018, calculated by adding 6 months of the actual cost of new covered claims for 2018 to the unfunded liability as of December 31, 2017.

Kevin Bingham is a Member of the American Academy of Actuaries (MAAA) and an Associate of the Casualty Actuarial Society (ACAS). Greg Chrin is a Member of the American Academy of Actuaries (MAAA) and a Fellow of the Casualty Actuarial Society (FCAS). Mr. Bingham and Mr. Chrin prepared and supervised the various analyses contained in this report that supports the findings expressed in our opinions, conclusions and observations. Mr. Bingham, ACAS, MAAA and Mr. Chrin, FCAS, MAAA, have met the qualification standards as promulgated by the American Academy of Actuaries and are appropriately qualified to perform this analysis. Mr. Bingham and Mr. Chrin have also attested compliance with the Casualty Actuarial Society's Continuing Education Policy. These organizations have professional standards that, among other provisions, require an actuary perform only assignments for which he/she is qualified. Mr. Chrin is the immediate past chairperson of the American Academy of Actuaries Medical Professional Liability Committee. Mr. Bingham is also a past chairperson of the American Academy of Actuaries Medical Professional Liability Committee.[4] [5]

During the course of our analysis, Deloitte Consulting considered the following:

- Historical paid loss development patterns by coverage and any recent changes in these patterns;
- Historical closed with payment claim count development patterns and any recent changes in these patterns; and
- Industry information where needed to supplement the Fund's own data.

[4] https://actuary.org/category/site-section/public-policy/casualty/medical-professional-liability
[5] https://actuary.org/committees/dynamic/AAAMEDMAL

The estimates contained in this report provide for losses and do not include any provisions for:

- Breast Implant and Pedicle Screw Claims
- Defense Costs
- Administrative expenses
- Brokerage or reinsurance costs including commissions
- Risk management fees
- Loss control fees
- Legal Fees (other than claim defense costs)
- Actuarial fees
- Assessments

Our reasonable loss unpaid claim liability estimates provided in this report are intended to represent an "actuarial central estimate". "Actuarial central estimate" is defined by actuarial literature as "an estimate that represents an expected value over the range of reasonably possible outcomes."

Any use of the word "review" within this report should be interpreted in the common use of that term, and not in the definition of "review" promulgated by the American Institute of Certified Public Accountants ("AICPA").

III. Summary of Results

Conclusions

A summary of our estimated unfunded liability excluding breast implant and pedicle screw exposure as of December 31, 2017 is displayed in the table below. We have included a 1% load to account for the unfunded liability associated with delay damages and post judgment interest ("DD & PJI") costs.

Summary of Unfunded Liability (000's) as of December 31, 2017	
Coverage	**Undiscounted Estimates**
Excess Claims	$838,098
Section 715 Claims (First Dollar Coverage)	$28,242
Section 715 Claims (Excess Coverage)	$106,245
Total Excluding DD & PJI	**$972,584**
DD & PJI Load	1.0%
Total Including DD & PJI	**$982,310**

Furthermore, a summary of our estimated unfunded liability excluding breast implant and pedicle screw exposure derived from data valued as of December 31, 2017, and rolled forward to June 30, 2018 using actual loss emergence from January through June 2018 is displayed in the table below.

Summary of Unfunded Liability (000's) as of June 30, 2018	
Coverage	**Undiscounted Estimates**
Excess Claims	$844,573
Section 715 Claims (First Dollar Coverage)	$24,727
Section 715 Claims (Excess Coverage)	$108,279
Total Excluding DD & PJI (Using Projected Payments)	**$977,579**
Actual – Expected Paid (1/1/18 – 6/30/18)	$15,833
Total Excluding DD & PJI (Adjusted for Actual Payments)	**$961,746**
DD & PJI Load	1.0%
Total Including DD & PJI	**$971,364**

A more detailed display of our unfunded liability estimates is presented on the Summary of the supporting exhibits.

The unpaid unfunded liability estimates provided above make provisions for:

- Case outstanding; claim adjusters' estimates of outstanding unpaid loss for known, reported claims.
- Incurred but not reported claims ("IBNR"); claims not yet reported and not recorded in the loss system, which are expected to arise from accidents that have already occurred
- "Pipeline" claims; claims known but not yet recorded in the loss system.
- Case development; future development on known, recorded claims.
- Reopened claims; future reopened claims which should be coded to the year the claim was originally incurred.

The last four components listed above are commonly referred to collectively as bulk IBNR.

RELEVANT COMMENTS

- **Breast Implant and Pedicle Screw Claims**
  The Fund has been able to identify reported claims with exposure to breast implant or pedicle screw liability. These exposures have 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). Therefore, 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.

- **Delay Damages and Post Judgment Interest**
  Prior to Act 135 of 1996, delay damages and post-judgment interest costs were generally included within the limits of coverage provided by the Fund. Pursuant to Act 135, these costs are now shared with other carriers in proportion to the share of loss and outside the Fund limits of coverage. Data for recent calendar years indicate that Fund costs for delay damages and post-judgment interest have ranged from approximately 0.2% to approximately 1.8%. We have selected 1.0% as the estimated ratio of these costs to loss and have increased our estimates of the unfunded liability projections accordingly.

- **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. Similarly, our estimates do not include a provision for the cost of claims administration nor for the Fund's other operating costs. We understand that defense is provided by the primary insurers for those claims where the Fund's coverage is provided on an excess basis.

- **Actual versus Expected Development**

  By using prior-year assumptions and selections from our independent testing, we estimated expected paid losses to emerge since the prior valuation. We then compared these expectations by year to the actual loss activity and noted any adverse or favorable development. Details on actual versus expected emergence are displayed in the tables below:

Summary of Actual versus Expected Emergence (000's)			
Line of Business	**Expected Emergence**	**Actual Emergence**	**Actual vs. Expected**
Excess Claims SW excl. Philadelphia	$101,686	$118,951	$17,264
Excess Claims Philadelphia	$54,538	$49,931	$(4,607)
Section 715 Claims SW excl. Philadelphia (First Dollar)	$6,525	$8,800	$2,275
Section 715 Claims Philadelphia (First Dollar)	$3,621	$0	$(3,621)
Section 715 Claims SW excl. Philadelphia (Excess)	$5,738	$1,750	$(3,988)
Section 715 Claims Philadelphia (Excess)	$4,876	$0	$(4,876)
Total	**$176,984**	**$179,432**	**$2,447**

We do not consider these variances to necessarily indicate there was any error in the prior-year Estimated Actuarial Liabilities. We have considered the loss emergence described above (as well as the loss emergence for previous years) when reselecting our loss development pattern assumptions. We also consider this information when we reselect our ultimate loss estimates, as described below.

- **Change in Ultimate Loss Estimates**

  Our ultimate loss selections for common accident years decreased by $2.5 million. Details on changes in our ultimate loss selections are displayed in the table below:

Summary of Change in Ultimate Loss Selections (000's)	
Line of Business	**Ultimate Change**
Excess Claims SW excl. Philadelphia	$40,179
Excess Claims Philadelphia	$(22,972)
Section 715 Claims SW excl. Philadelphia (First Dollar)	$1,983
Section 715 Claims Philadelphia (First Dollar)	$(4,353)
Section 715 Claims SW excl. Philadelphia (Excess)	$(2,770)
Section 715 Claims Philadelphia (Excess)	$(14,591)
Total	**$(2,524)**

The overall decrease in ultimates is majorly driven by favorable emergence on Excess Claims (primarily AYs 2008 and 2009) and Section 715 Excess Claims for Philadelphia (primarily AYs 2013 and 2015), which is mostly offset by significant adverse emergence across recent years on Excess Claims for SW excl. Philadelphia. Refer to the analysis exhibits for more details on the actual versus expected development and change in ultimate loss selections by accident year.

- **Runoff of Liabilities**

  We have projected our estimated unfunded liability as of December 31, 2017 for each of the upcoming accident years by rolling forward our estimates based on the projected newly asserted claims and expected payment activity by calendar year. Refer to Summary Appendix, Sheet 2 for the respective details.

IV. Conditions and Limitations

Due to the inherent uncertainty in projecting the ultimate costs of claims, no assurance can be offered that any particular range of estimates of ultimate losses or unpaid claim liabilities will be adequate. We believe, however, that the actuarial techniques and assumptions used in our analysis are reasonable.

In estimating unpaid unfunded liability, it is necessary to project the future payments of unfunded liability. It is certain that actual future payments of unfunded liability will not develop exactly as projected and may, in fact, vary significantly from the projections. No warranty is expressed or implied that such variance will not occur.

Further, our projections make no provision for the broadening of coverage by legislative action or judicial interpretation or for extraordinary future emergence of new classes of losses or types of losses not sufficiently represented in the Department's historical database or which are not yet quantifiable.

Distribution and Use

This analysis has been prepared solely for the internal use of Pennsylvania Insurance Department and as documentation supporting our estimates related to unpaid claim liabilities as of December 31, 2017 and June 30, 2018. We understand that the Pennsylvania Insurance Department may release this report to the Pennsylvania Medical Society, the Hospital and Health System Association of Pennsylvania, and the Pennsylvania Podiatric Medical Association. In addition, the Fund may use this report as part of MCare's Annual Report. Limited distribution of this report is permitted to the Department's external auditors to support their audit process, provided that it is made available on a confidential basis and that any further distribution by auditors to third parties is prohibited without Deloitte Consulting's prior written consent. This report may be made available to applicable state insurance regulatory agencies when required who shall use the report solely in connection with the discharge of their regulatory oversight responsibilities and for no other purpose.

Any other distribution of this report is not permitted without the prior written consent of Deloitte Consulting. The supporting data, analysis and tables contained in our exhibits are provided to clearly document the assumptions which support the results stated herein and are integral parts of this study. It is our intention that this report be used in its entirety, as a whole, and not segmented for other purposes.

Deloitte Consulting shall have no liability, regardless of form, to any person or entity other than the Pennsylvania Insurance Department for any action taken or omitted to be taken by such parties in respect of this report. Third parties should recognize that the furnishing of this report is not a substitute for their own due diligence and may not place any reliance on this report or data contained herein that would result in the creation of any duty or liability by Deloitte Consulting to any third party.

DATA RELIANCE

Deloitte Consulting has relied upon data provided by the Department for this review. A specific audit to verify the accuracy or completeness of the data is beyond the scope of this engagement. While we have reviewed the data in regard to its reasonableness and consistency for our review, we have relied on such data without audit or verification and our conclusions are based on the assumption that it is accurate and complete. If the underlying information provided is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

V. Actuarial Methodology

Unfunded Liability

Several actuarial methods may be used for estimating ultimate losses. The methods used by each line of business are applied based on the credibility of the historical data, changes in Department operations affecting the historical data (e.g., changes in case reserving or claim reporting), the characteristics of that line of business (e.g., long versus short tail of development), and actuarial judgment. The paragraphs below describe the mechanics of the various methodologies and outline the underlying assumptions for each method.

General assumptions may include, but not be limited to, the following items:

- Loss development factors, including age-to-age, age-to-ultimate, and "tail" development factors
- Loss trends, including severity trend, frequency trend, and loss cost trend
- Loss cost amounts
- Rate changes

Loss Methodologies

- **Paid Loss Development Method**
  This method projects losses to ultimate based upon historical changes in the valuation of paid losses at given points in time (e.g., 12 months, 24 months). This method is particularly appropriate when loss development patterns have been historically stable and can be predicted with reasonable accuracy.

- **Expected Loss Rate Method**
  The Expected Loss Rate Method adjusts the historical loss rates to a current year on-level basis to reflect changes in the claim cost inflation, frequency, rate change and retention levels. Loss rates are defined as the estimated losses per unit of premium. An on-level loss rate is selected and then unadjusted to each appropriate year. The selected unadjusted loss rates are then multiplied by the premium to calculate ultimate losses.

- **Paid Bornhuetter-Ferguson (B-F) Method**
  This method is essentially a combination of two other reserving techniques: the Paid Loss Development Method and the Expected Loss Rate Method. The B-F Method blends these two methods by splitting expected losses into two distinct pieces: expected paid losses and expected unpaid losses. As an accident year matures, the expected paid losses are replaced with actual paid losses plus expected unpaid losses to produce ultimate losses. Thus, as the accident year matures, the initial expected paid loss estimate becomes less important while the actual paid loss experience becomes more important. To calculate this method, one must estimate initial expected losses and a loss payment pattern. The initial expected losses are calculated by

selecting an average loss rate and multiplying by the exposure. The payment pattern is taken from the Paid Loss Development Method.

- **Frequency-Severity Method**
  The Frequency-Severity methodology begins with selecting initial expected loss severities, after consideration of the results from the loss development approaches. The initial loss severities are representative of the ultimate costs per claim. These expected loss severities are then applied to estimated ultimate claim counts to estimate ultimate losses.

We note that 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 claim adjuster's assessment of the relevant case-specific facts and circumstances. Therefore, we have not leveraged actuarial methods that rely upon case reserve estimates (e.g., Reported Loss Development Method, Reported B-F Method, etc.).

For our analysis of Section 715 excess claims (AY 2006 & Subs.) excluding breast implant and pedicle screw exposure (Section III of the analysis exhibits), we relied on the loss development factor selections for Excess claims (Section I of the analysis exhibits) assuming a lag of four years, given the nature of Section 715 excess claims and since the Department's historical claims experience was not sufficiently statistically credible.

Base Premium estimates utilized in our procedures are updated based on periodic assessment studies and loss and exposure trends. We have reviewed these trends and held them flat in light of the market conditions.

SELECTED ULTIMATE LOSSES AND UNPAID LOSS CALCULATION

The estimates of ultimate losses for the direct business by accident year is selected based on the indications of the reserving methodologies described above. More weight is applied to the Bornhuetter-Ferguson methods in more recent periods and the loss development method in older periods. We calculated unpaid loss by subtracting paid losses from these ultimate selections.

OTHER CONSIDERATIONS

ROLL-FORWARD ANALYSIS

We forecasted the undiscounted December 31, 2017 unpaid claim liability indications to June 30, 2018 using our selected payment patterns produced by our analysis of the supporting data. Incremental payments between January 1, 2018 and June 30, 2018 are added to the cumulative payments made through December 31, 2017 to determine the cumulative payments as of June 30, 2018. The cumulative payments as of June 30, 2018 are then subtracted from the ultimate loss estimates to result in a reasonable range of undiscounted unpaid claim liabilities as of June 30, 2018.

REINSURANCE COLLECTIBILITY

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.

PENNSYLVANIA PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION (PPCIGA)

For insurers who become insolvent, the PPCIGA provides coverage for primary policy limits up to $300,000. The Fund currently provides coverage in excess of $500,000. This could create a gap between the protection of the PPCIGA and the Fund which is not explicitly covered by the Fund. However, the gap may impact the amount of payments provided by the Fund which adds to the uncertainty of the estimates. We do not expect this uncertainty to materially impact our estimates.

VI. ASOP 43 Disclosures

Actuarial Standard of Practice 43: *"Property/Casualty Unpaid Claim Estimates"* requires certain disclosures to accompany actuarial estimates of unpaid losses. The following disclosures are applicable to our analysis of the Department's unfunded liability as of December 31, 2017 and June 30, 2018.

- **Terminology**: The terms "Estimates of Unpaid Claim Liabilities", and "Unpaid Claim Estimates" are used interchangeably and are meant to convey the same meaning.

- **Purpose or Use of Unpaid Claim Estimates**: The purpose of the unpaid claim estimates is to provide the Department's Management with an independent analysis and estimates of unfunded liability associated with the Department's MCare programs.

- **Scope of the Unpaid Claim Estimates**: The intended measure of the unpaid claim estimates provided is an actuarial central estimate (an estimate that represents an expected value over the range of reasonably likely outcomes). Our estimates are shown on an undiscounted basis.

- **Constraints on the Unpaid Claim Estimates**: There were certain constraints in the performance of this actuarial analysis. These constraints stem from substantial uncertainties in estimating the loss for unpaid claims. Examples include but are not limited to the rate of inflation inherent in losses during observable development periods, the projected development for losses as they age beyond the observable development periods, changes in full and final settlement practices, and the inherent variability in losses over time.

- **Uncertainty**: We have not attempted to measure the uncertainty in the estimates.

- **Applicable Dates**: These unpaid claim estimates as of December 31, 2017 and June 30, 2018 were based on loss, and premium data evaluated as of December 31, 2017, and additional information provided to us through the date of this report.

- **Updates of Previous Estimates**: These unpaid claim estimates include updates of previous estimates. The assumptions underlying these estimates are generally based on our evaluation of the Entity's historical experience, and these assumptions in some cases have changed since our last evaluation of the unpaid claim liabilities as of June 30, 2017.

- **Documentation**: This report, along with the accompanying exhibits, provides documentation supporting our unpaid claim estimates as of December 31, 2017 and June 30, 2018.

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End of Report