2016

ANNUAL REPORT

PENNSYLVANIA INSURANCE DEPARTMENT
Medical Care Availability and
Reduction of Error Fund

February 28, 2017

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

Honorable Sharif Street, Minority Chair
Banking and Insurance Committee
Senate of Pennsylvania
535 Main Capitol
Harrisburg, PA 17120

Honorable Tina Pickett, Chair
Insurance Committee
Pennsylvania House of Representatives
315-A Main Capitol
Harrisburg, PA 17120

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

Dear Senators and Representatives:

We are pleased to provide this Annual Report on the Medical Care Availability and Reduction of Error Fund which includes information on Pennsylvania's patient compensation fund from inception through December 31, 2016.

Newly reported excess claims during the claims year 2016 were 3,005 compared to 2,960 in 2015. Total payments for claims finalized during claims year 2016 were $174 million as compared to $160 million for claims finalized in claims year 2015.

The annual actuarial study, prepared by an outside actuarial firm, concludes that an unfunded liability of $1.00 billion exists as of December 31, 2015. This amount is a decrease over the prior year's estimate of $1.08 billion.

If you have any questions about this report, please feel free to contact me, Deputy Insurance Commissioner Laura Slaymaker at 717-787-6009 or Mcare Executive Director Theodore Otto at 717-783-7657.

Sincerely,

Teresa D. Miller
Insurance Commissioner

Enclosure

Office of the Insurance Commissioner
1326 Strawberry Square | Harrisburg, Pennsylvania 17120 | Phone: 717.783.0442 | Fax: 717.772.1969
www.insurance.pa.gov | in-commissioner@pa.gov

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I. Executive Summary

During 2016, 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 $174 million in covered medical malpractice claims. Mcare also had significant interactions with insurers, self-insureds, and health care providers (HCPs), providing them with valuable information about Mcare operations as well as developments in the medical malpractice insurance market in Pennsylvania.

Key Accomplishments for 2016

Successful implementation of the assessment calculation settlement

In late 2014, Mcare entered into a settlement with the Pennsylvania Medical Society (PAMED), the Hospital and Healthsystem Association of Pennsylvania (HAP) and the Pennsylvania Podiatric Medical Association (PPMA) regarding the calculation of the Mcare assessment. The settlement required Mcare to calculate refunds for over 63,000 HCPs over a five year period. During 2015, Mcare worked closely with the parties and successfully addressed innumerable planning and implementation challenges. During this time, Mcare kept the HCPs informed about the progress and sent a letter to each HCP with an itemization of the amounts due to them along with instructions on how to secure their refund. In late 2015, Mcare was preparing to have the checks issued. In 2016, Mcare issued a total of 23,589 checks valued at $138,132,957. Any remaining refunds will be escheated.

Advocacy for use of alternative dispute resolution techniques

Medical malpractice litigation is stressful for all parties involved. Mcare was effective in its advocacy efforts to have medical malpractice cases resolved by alternative dispute resolution techniques such as mediation and arbitration rather than trial. Mcare also provided a neutral, unbiased, and standardized platform for parties. This improves efficiency, removes unpredictability, reduces costs, and allows all parties a forum for effective resolution.

GO-TIME Savings

Mcare participated in the Governor's Office of Transformation, Innovation, Management and Efficiency (GO-TIME) initiative identifying savings of over $70,000 per year. The projects were right sizing the mail operations and bringing the annual assessment calculation and hospital experience modification programs in-house which was accomplished with no additional staff.

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, significant revisions were made to how the CAT Fund operated by Act 135 of 1996. The basis of the assessment collected from HCPs switched 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 Mcare. The Mcare Act also provided for the eventual phase out of Mcare. Also new in the Mcare Act was a patient safety authority established to share information on how to improve health care. Patients were required to be informed if a serious event happened in their care. The Mcare Act included reasonable tort reforms, including reducing the mandatory insurance coverage to $1 million per occurrence, which brought Pennsylvania in line with nationwide limits.

III. Mcare Financial Highlights

Appendix A.1 is the Mcare Cash Basis Statement of Operations as of December 31, 2016. The reporting is consistent with the settlement terms of the assessment litigation that required Mcare to separately account for the $139 million to be returned to certain HCPs. The Reserve Fund included in the settlement is also accounted for separately. Excluding these funds, Mcare ended calendar year 2016 with a positive balance of $12.1 million. As reported in footnote 5 on the statement of operations and consistent with the settlement agreement, Mcare projected a year-end balance of $13.7 million when calculating the assessment percentage for 2017. The difference between these numbers will be included in the calculation of the 2018 assessment percentage in the latter part of 2017.

Appendix A.2 is the Mcare Summary of Financials from CY 2007 to 2016. This document reflects the volatility of Mcare's claims payments. Mcare provides coverage only on catastrophic medical malpractice cases. While these are a subset of all medical malpractice cases, they typically involve larger amounts of money. This "law of small numbers" results in payments on a relatively small number of cases resulting in significant swings in annual payments. Mcare is protected from these swings by the 10% buffer that is built into each year's assessment calculation as well as the $30 million Reserve Fund provided for in the settlement of the assessment litigation.

Additional information on Financials can be found in Appendix A.

IV. Mcare Program Review

A. Claims Program

The Mcare Fund adjusts claims that are submitted by primary insurers for excess coverage provided by Mcare to HCPs and for first dollar defense and indemnity coverage under Section 715 of the Mcare Act. Mcare claims staff is comprised of examiners, geographic territory managers, and support personnel.

Excess Claims Opened/Closed

Mcare received 3,005 claim reports from primary insurers between September 1, 2015 and August 31, 2016 (claims period). This compares to 2,960 received in the prior claims period. Pending excess claims that were closed in 2016 and prior year claims period totaled 2,980 and 3,653 respectively. These numbers include claims closed with and without payment. A total of 91 primary insurers reported claims to Mcare in the 2016 claims period.

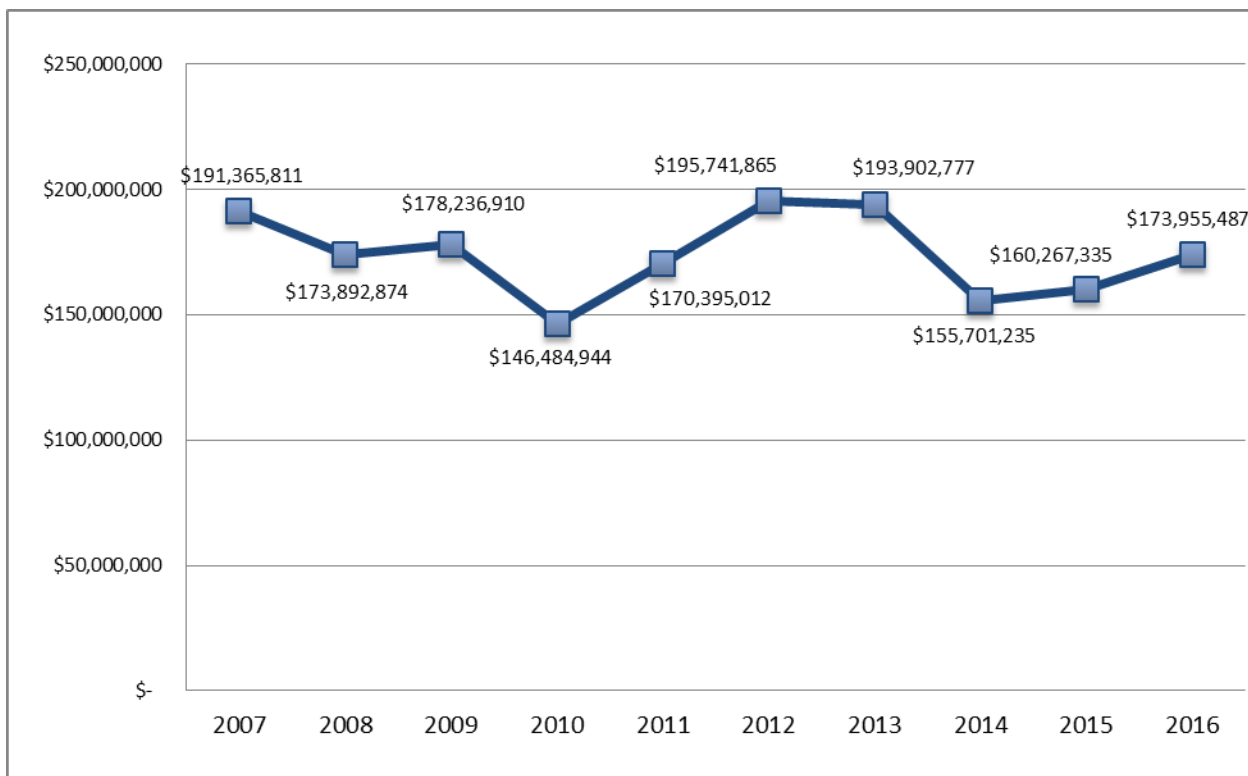
Section 715 Claims Opened/Closed

In claims period 2016, Mcare opened 34 and closed 54 Section 715 claims. These claims arise from medical malpractice incidents that occurred on or before December 31, 2005, which is the date that the Mcare Act began a phase out of Section 715. Section 715 absolves the primary insurer from defense and indemnity obligations and shifts the mandatory occurrence limit of $1,000,000 to Mcare. This shifting was part of the original patient compensation fund program started in 1975. With the phase out of Section 715, primary insurers and self-insurers in Pennsylvania are now subject to risks consistent with insurers writing in other states.

Claims Payments

Claims payments for 2016 rose by 8.5% from 2015. In 2016, Mcare paid $174 million as compared to $160 million in 2015. Mcare's 2016 payments combined with insurers' payments totaled $623 million as compared to $575 million in 2015. The following graph shows Mcare's total payments for the last 10 claims period years.

Chart 1: Claims Payments by Claims Year for 2007-2016



Mcare adjusts solely catastrophic injury medical malpractice claims. Because of this, Mcare's annual claims payment statistics reflect the inherent volatility associated with a relatively small number of indemnity payments which individually involve significant payments. The 8.5% variance in claims payments between 2015 and 2016 is in line with historical experience.

<u>Alternative Dispute Resolution (ADR)</u>

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 since 2003. The unique position of Mcare allows for fair and objective analysis of claims circumstances in order to bring parties to consensus. The Mcare program has resulted in ADR being used in over 1,600 medical malpractice matters, which is more than any other program in Pennsylvania.

In the 2016 claims period, 141 ADR processes were completed. This is comprised of 35 arbitrations, 102 mediations, and 4 monetary cap trial agreements. The prior five year

averages are 36 arbitrations, 94 mediations, and 4 monetary cap trial agreements.

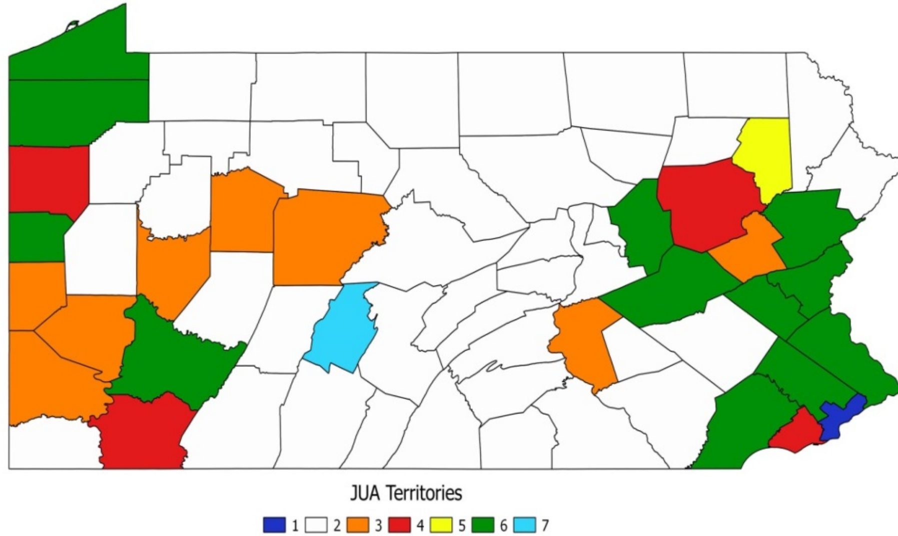
Regional Statistics

Mcare claims payments also vary by county. Chart 2 below is a map of the Commonwealth indicating the claims payments allocated by the venue of the claims litigation and Pennsylvania Professional Liability Joint Underwriting Association (JUA) territory.

The largest percentage of payments, 46.5% arose from the highest concentration of statewide health care delivery located in the Philadelphia and five county surrounding area. The Central area of the state followed at 33.5% and Western comprising 20% of payments. Central payments were higher than the historical average due to a greater number of dated matters coming to fruition.

Additional information on claims can be found in Appendix B.

Chart 2: 2016 Mcare Paid Claims by JUA Territory



JUA Territory	Territory Total	County(ies) Within Territory
Territory 1	$48,654,906	Philadelphia
Territory 2	$18,665,050	Remainder of State
Territory 3	$15,925,000	Allegheny
Territory 3	$8,368,947	Armstrong, Beaver, Carbon, Clearfield, Dauphin, Jefferson, Washington
Territory 3	$24,293,947	Territory 3 Total
Territory 4	$26,600,480	Delaware, Fayette, Luzerne, Mercer
Territory 5	$14,060,401	Lackawanna
Territory 6	$39,180,703	Bucks, Chester, Columbia, Crawford, Erie, Lawrence, Lehigh, Monroe, Montgomery, Northampton, Schuylkill, Westmoreland
Territory 7	$2,500,000	Blair
Total Paid	**$173,955,487**	

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 operations and defense and indemnity of claims. The second is maintaining records of HCPs securing insurance from a private insurance company or self-insuring and enforcing the Commonwealth's mandatory medical malpractice insurance laws.

<u>Assessment Collection</u>

Coverage from Mcare is financed by assessments collected from HCPs as defined in the Mcare Act and interest on these funds. For 2016, the assessment revenue is $165 million as compared to the assessment revenue of $124 million for 2015. The increase in assessment collection is partially due to there being a lower year-end balance to offset spending as further discussed below.

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 loaned 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. Interest Mcare earned during the year, and
6. The projected year-end balance.

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 the JUA. Mcare engaged an actuarial firm in 2015 to project what amount would be raised if every HCP required to participate in the Fund paid the PPP amount. The firm then determines what percentage of the PPP will 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 in which Mcare agreed to recalculate the assessment percentage for the five years in which there were funds remaining at year end. It was the difference in the Original and After Settlement Percentages that was refunded to HCPs. Beginning in 2015, the remaining funds were included in the original calculation. (The Mcare Act requires the JUA to make annual rate filings. Assessment percentages are not generally calculated using the exact same base, however from 2015 to 2017 the JUA PPP remained the same.)

Chart 3: Assessment Percentage for 10 Most Recent Years

Year	Original Percentage	After Settlement
2007	23%	
2008	20%	
2009	19%	18%
2010	21%	15%
2011	19%	13%
2012	23%	22%
2013	25%	n/c
2014	23%	19%
2015	12%	
2016	17%	
2017	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 compares how this provision affected the hospitals in 2016 as compared to 2015.

Chart 4: Hospitals paying the base Mcare assessment and those receiving a discount or increase.

Range	Between (less than)	2016	2015
Discount	80.0% - 95.0%	160	162
Base	95.0% - 105.0%	7	18
Increase	105.0% - 120.0%	44	30
Total of all rated hospitals		211	210

There is a corresponding experience rating plan contained in the Mcare Act to adjust physicians' assessments. The Mcare Act provides that if Mcare makes three payments on behalf of a physician in five years, the physician will pay a 10% surcharge. If Mcare makes four or more payments in the same period of time, the surcharge is 20%. Mcare will also impose a 20% surcharge if it has made two limits payments on behalf of a HCP in the last five years.

Additional information on the assessment, including the calculation of the 2016 assessment, can be found in Appendix C.

Coverage Analysis

Mcare's coverage program is responsible for receiving and analyzing reports from private insurance companies and self-insurers regarding who has medical professional liability insurance coverage, 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.

Acting as a repository for this information makes Mcare an especially reliable source of the number of physicians practicing in the Commonwealth, as well as their specialty and location of practice. As of February 14, 2017, coverage has already been reported and processed for 42,192 physicians for the 2016 coverage year (carriers have 60 days to report coverage so policies beginning toward the end of 2016 may not have been reported yet) as compared to 43,715 for the 2015 coverage year.

Mcare is also a reliable source of information regarding the number of hospitals in the Commonwealth. For 2016, 211 hospitals reported coverage, as compared to 221 in 2015.

Additional information on Mcare coverage statistics can be found in Appendix C.

C. Compliance Program

The Mcare compliance program is based on the Mcare Act's provision requiring HCPs to submit proof of insurance to Mcare within 60 days of the policy being issued. The process used to implement this statutory provision is that the private insurer or self-insurer reports the coverage to Mcare as part of the assessment payment process. Mcare then evaluates the information received and notifies HCPs of coverage issues. If a HCP does not remedy the coverage issue, they are referred to the HCP's licensing authority for license suspension or revocation as provided for in the Mcare Act.

Historically, Mcare received reports from HCPs that they had trouble finding the coverage they needed to become compliant in the traditional medical malpractice market. Mcare worked with another entity created by the Mcare Act, the JUA, to make coverage available at prices that reflected the exposure being insured. This coverage option was used by HCPs in 2016 to become compliant.

Mcare also focused on evaluating its compliance program to maximize the amount of time HCPs and their staffs have to treat patients or otherwise do what is needed to provide health care services and leverage Mcare staff's expertise with insurance producers and the coverages. During 2016, a new analytical tool was provided that better focused the data provided and allowed more efficient enforcement of legal requirements.

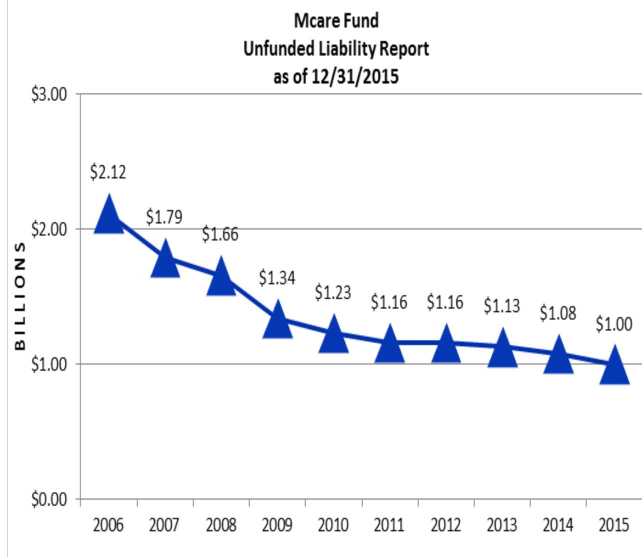
V. Mcare Unfunded Liability

Mcare operates on what has been characterized as a "pay-as-you-go" model since it holds no reserves like a traditional insurance company would. 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 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.

Based on this change, the limits being provided by private insurers increasing to $500,000, the overall coverage limit going from $1.2 million to $1 million, the Mcare unfunded liability projection has generally decreased. The annual actuarial study, prepared in 2016 by PricewaterhouseCoopers LLP, concludes that an unfunded liability of $1.00 billion exists as of December 31, 2015. This amount represents a decrease of 53% over the prior 10 years when it was $2.12 billion in 2006. Chart 5 below reflects the projected unfunded liability for 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 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 last study, conducted in 2015, 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 was no increase to the current basic primary insurance limits for calendar years 2016 and 2017.

The next capacity study will be conducted in 2017 for a potential step up in limits effective January 1, 2018.

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. Although dialogue has been maintained with the podiatrists, as of this time a mutually desirable retirement plan has not been identified.

APPENDIX

Additional Financials — Appendix A

- A.1 Statement of Operations - 2016
- A.2 Summary of Financials - 10 Most Recent Years

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- B.1 Paid Claims by Region - 5 Most Recent Years
- B.2 Claim and Case Payment - 5 Most Recent Years
- B.3 Summary of Annual Fund Claim Payments By Health Care Provider Group - 10 Most Recent Years
- B.4 Claim Payments by Primary Carrier and Self-Insurer - 5 Most Recent Years

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- C.1 Pennsylvania Medical Care Availability and Reduction of Error Fund 2016 Year Assessment Calculation - Executive Summary
- C.2 Pennsylvania Medical Care Availability and Reduction of Error Fund 2016 Experience Modification Factors (In Accordance with Act 13 of 2002) - Executive Summary
- C.3 Amount of Assessment Received by Provider Type by Assessment Year - 10 Most Recent Years
- C.4 Yearly Average Assessment by Provider Group - 10 Most Recent Years
- C.5 Assessment Remitted by Commercial Carrier and Self-Insurer - 10 Most Recent Years
- C.6 Count of Unique Health Care Providers by Provider Type by Assessment Year - 10 Most Recent Years

Additional Mcare Unfunded Liability Information — Appendix D

- D.1 Pennsylvania Medical Care Availability and Reduction of Error Fund Estimation of 12/31/2015 Unfunded Liability prepared by PricewaterhouseCoopers LLP - Executive Summary

Appendix A

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

CASH BASIS STATEMENT OF OPERATIONS

Calendar Year 2016

JANUARY 1, 2016 TO DECEMBER 31, 2016

SETTLEMENT AGREEMENT FUNDS		
Reserve Fund Balance	**$ 30,000,000** [#1]	
Assessment Relief Fund (Refund Account) Balance	**$ 879,962** [#2]	
MCARE FUND BALANCE JANUARY 1, 2016		**$ 27,733,268**
Receipts:		
ASSESSMENT REVENUE	$ 165,214,439	
INTEREST ON SECURITIES	$ 885,106	
INTEREST ON RESERVE FUND	$ 260,466 [#3]	
INTEREST ON ASSESSMENT RELIEF FUND	$ 257,391 [#4]	
MISCELLANEOUS REVENUE	$ 811,685	
REDEPOSIT OF CHECKS	$ -	
TRANSIT & PAYABLES SUMMARY	$ 127,102	
TOTAL RECEIPTS	**$ 167,556,189**	$ 167,556,189
TOTAL FUNDS AVAILABLE		**$ 195,289,457**
Claims Deductions:		
2016 CLAIMS PAID - DEC, 2016	$ 173,955,487	
CLAIMS DEDUCTIONS	**$ 173,955,487**	
Operating Expenses:		
SALARIES	$ 2,356,817	
PAYROLL TAXES & BENEFITS	$ 1,743,814	
DATA PROCESSING SERVICES	$ 261,798	
LEGAL FEES	$ 3,106,528	
OFFICE SUPPLIES & EQUIPMENT	$ 29,911	
CONSULTANTS	$ 1,155,296	
TELECOMMUNICATIONS	$ 74,108	
REAL ESTATE	$ 340,821	
OTHER OPERATIONAL EXPENSES	$ 162,837	
TOTAL OPERATING EXPENSES	**$ 9,231,928**	
TOTAL DEDUCTIONS AND EXPENSES:		**$ (183,187,415)**
MCARE FUND BALANCE DECEMBER 31, 2016		**$ 12,102,042** [#5]

FINACIAL SUMMARY of Settlement Agreement Effective 10/03/14

	SETTLEMENT AGREEMENT		
#1	Reserve Fund Balance (Not to exceed $30 M)		$ 30,000,000
	Assessment Relief Fund (Refund Account) Balance 01/01/16		$ 139,012,919
	1st Round Relief Payment	$ (33,187,610)	
	2nd Round Relief Payment	$ (104,095,616)	
	3rd Round Relief Payment	$ (849,731)	
#2	Assessment Relief Fund (Refund Account) Balance 12/31/16		$ 879,962
#3	Interest on Reserve Fund		$ 260,466
#4	Interest on Assessment Relief Fund		$ 257,391
#5	ACTUAL ENDING BALANCE 12/31/16		$ 12,102,042

On 09/30/16 the projected 2016 ending balance of $13.7 M was included in the 2017 Assessment Calculation

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

Mcare Fund

Summary of Financials from CY 2007 to 2016

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
1	Beginning Balance [1]	58	34	104	61	124	130	130	169	73	28
2	Settlement Agreement [2]								(169)		
3	**ADJUSTED BEGINNING BALANCE**	58	34	104	61	124	130	130	0	73	28
	Receipts:										
4	Assessment Revenue	119	229	218	218	184	209	239	233	124	165
5	Interest Earned	12	4	3	9	2	2	2	2	2	1
6	Auto CAT Fund	45	47	22	0	0	0	0	0	0	0
7	Abatement Repayment/Credits	4	4	2	0	0	0	0	0	0	0
8	Transfer from Other Funds	0	0	0	0	0	0	0	0	0	0
9	Loan from Other Funds	0	0	0	0	0	0	0	0	0	0
10	Misc. Other	1	1	2	0	0	1	4	1	0	1
11	Net Increase/Decrease in Fair Value of Investments	0	0	0	0	0	0	0	4	(1)	0
12	Subtotal Receipts without Beginning Balance (4+5+6+7+8+9+10+11)	181	285	247	227	186	212	245	240	125	167
13	**Grand Total Receipts with Beginning Balance** (3+4+5+6+7+8+9+10+11)	239	319	351	288	310	342	375	240	198	195
		2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
	Expenditures:										
14	Salaries & Benefits	5	5	5	5	4	4	4	4	4	4
15	Loan Repayment	0	0	0	0	0	0	0	0	0	0
16	Transfer to HCPRA for Abatement Repayments	0	14	0	0	0	0	0	0	0	0
17	Interagency Transfer	0	0	100	0	0	0	0	0	0	0
18	Loss on Investments	0	12	0	0	0	0	0	0	0	0
19	Legal Fees	4	4	3	9	6	6	6	6	4	3
20	Liability Claims Paid	191	174	178	146	170	196	194	156	160	174
21	Misc. Other [3]	5	6	4	4	0	6	2	1	2	2
22	**Grand Total Expenditures** (14+15+16+17+18+19+20+21)	205	215	290	164	180	212	206	167	170	183
23	**Year End Balance (13-22)**	**34**	**104**	**61**	**124**	**130**	**130**	**169**	**73**	**28**	**12**

[1] In millions

[2] 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 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 remaining $30 million 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.

[3] 4.9/M Credit Refunds issued in 2012

Appendix B

PA Department of Insurance

Mcare Fund

Paid Claims by Region 2012 - 2016*

		Eastern		Central		Western		Other	
	Total Annual Claim Payment	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
2012	$195,741,865	$124,106,482	63.40%	$27,675,000	14.14%	$43,160,383	22.05%	$800,000	0.41%
2013	$193,902,777	$108,502,306	55.96%	$39,770,471	20.51%	$45,630,000	23.53%	$0	0.00%
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	$83,120,211	51.86%	$34,728,429	21.67%	$39,968,695	24.94%	$2,450,000	1.53%
2016	$173,955,487	$80,324,997	46.18%	$58,425,451	33.59%	$34,705,039	19.95%	$500,000	0.29%

Regional County Definition:

Eastern	Bucks, Chester, Delaware, Lehigh, Montgomery, Northampton, Philadelphia
Central	Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, 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.

PA Insurance Department

Mcare Fund

Claim and Case Payment - 5 Most Recent Years

Year	Fund Money	**Claim** Count	Average **Claim Value**	**Case** Count	Average **Case Value**
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	268	$598,012
2016	$ 173,955,487	372	$ 467,622	289	$601,922

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

PA Department of Insurance

Mcare Fund

Summary of Annual Fund Claim Payments by Health Care Provider Group

2007-2016

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

Mcare Fund

2012 - 2016 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2012	2013	2014	2015	2016
S01		$ 4,000,000			
S07					
S10	$ 1,630,000	$ 1,625,000	$ 1,483,000	$ 3,790,000	$ 3,450,000
S11					
S12	$ 1,500,000	$ 1,532,357	$ 1,650,000	$ 1,000,000	$ 1,150,000
S14					
S23	$ 50,000				
S24					
S32					
S34					
S35				$ 1,000,000	
S36					
S40	$ 450,000				$ 300,000
S41	$ 1,000,000				
S43			$ 400,000		
S45			$ 700,000		
S48					
S49		$ 1,000,000	$ 131,138	$ 500,000	$ 500,000
S51	$ 500,000		$ 1,000,000	$ 1,825,000	$ 1,000,000
S53	$ 500,000		$ 500,000		$ 1,500,000
S54				$ 500,000	
S57			$ 500,000		
S60		$ 1,000,000			$ 1,900,000
S62	$ 1,500,000	$ 1,500,000			
S63	$ 404,990			$ 500,000	
S66		$ 254,000			
003	$ 16,700,000	$ 13,170,000	$ 15,750,000	$ 9,362,500	$ 11,877,500
011	$ 500,000	$ 2,350,000	$ 2,276,207	$ 5,400,000	$ 1,000,000
020					
031	$ 10,980,409	$ 19,113,834	$ 12,526,320	$ 15,041,192	$ 13,371,493
032	$ 4,030,000	$ 2,100,000	$ 4,150,000	$ 3,568,695	$ 500,000
039	$ 250,000				
045		$ 1,000,000	$ 87,500		
052					
055					
067	$ 20,503,076	$ 13,253,500	$ 9,559,462	$ 9,592,500	$ 11,215,050
086	$ 11,075,331	$ 1,127,470	$ 1,500,000	$ 1,050,000	$ 1,000,000
088					
093	$ 875,000	$ 2,875,000	$ 1,300,000		
102					
103	$ 800,000				$ 1,000,000
112			$ 500,000		
119	$ 1,000,000				
121	$ 1,700,000	$ 1,000,000			

Mcare Fund

2012 - 2016 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2012	2013	2014	2015	2016
124	$ 10,000			$ 300,000	
126	$ 2,000,000		$ 570,000		$ 1,000,000
127					$ 500,000
129	$ 5,450,000	$ 3,100,000	$ 8,100,000	$ 5,622,983	$ 2,800,000
130					$ 400,000
131					
135	$ 110,189		$ 1,000,000		$ 2,000,000
136	$ 3,700,000	$ 2,385,000	$ 1,675,000		$ 1,000,000
138			$ 500,000	$ 950,000	
139		$ 800,000			
143			$ 350,000		
144	$ 12,895,000	$ 14,750,000	$ 8,875,000	$ 15,900,000	$ 18,425,000
145	$ 3,925,000	$ 2,411,644	$ 5,562,000	$ 4,700,000	$ 9,225,000
155	$ 9,695,000	$ 11,535,000	$ 12,015,342	$ 11,987,500	$ 10,752,500
156	$ 11,841,622	$ 7,050,000	$ 1,925,000	$ 4,900,000	$ 4,925,480
157					
159		$ 232,000			
160	$ 125,000				
161					
162				$ 200,000	$ 187,500
164					
166					
167					
169					
181					$ 1,000,000
183					
184	$ 2,700,000	$ 1,600,000		$ 450,000	$ 2,750,000
185		$ 375,000			
194					$ 500,000
196		$ 1,700,000	$ 2,000,000	$ 500,000	$ 1,000,000
197	$ 3,400,000	$ 5,559,421	$ 2,427,245	$ 3,325,000	$ 5,933,947
199	$ 2,633,501	$ 8,775,000	$ 2,631,138	$ 2,750,000	$ 1,500,000
201					
202	$ 7,260,000	$ 9,490,000	$ 5,260,000	$ 4,375,000	$ 1,960,000
203	$ 500,000		$ 1,414,438	$ 1,330,929	$ 500,000
207	$ 17,422,747	$ 13,731,250	$ 10,077,342	$ 11,442,078	$ 6,882,922
208		$ 500,000	$ 500,000	$ 1,261,667	$ 525,000
210		$ 1,000,000			$ 350,000
211	$ 8,250,000	$ 5,740,000	$ 6,374,809	$ 2,500,000	$ 4,587,111
212		$ 500,000	$ 500,000		
219	$ 1,800,000	$ 2,775,000	$ 1,850,000	$ 500,000	$ 1,350,000
220	$ 2,875,000	$ 1,575,000		$ 1,750,000	$ 800,000
221	$ 2,550,000	$ 2,509,608	$ 3,875,000	$ 2,509,904	$ 4,625,000
222	$ 1,400,000	$ 500,000		$ 1,750,000	$ 3,500,000

Mcare Fund

2012 - 2016 Claim Payments by Primary Carrier and Self-Insurer

Carrier Code	2012	2013	2014	2015	2016
223	$ 5,000,000	$ 2,450,000	$ 1,400,000	$ 2,400,000	$ 2,500,000
224	$ 300,000	$ 1,000,000	$ 30,000	$ 2,000,000	$ 500,000
228	$ 1,150,000		$ 2,000,000	$ 2,000,000	$ 975,000
229	$ 700,000			$ 200,000	
234					
239		$ 500,000		$ 1,000,000	$ 1,000,000
241	$ 900,000	$ 1,000,000	$ 500,000	$ 130,000	$ 500,000
243					$ 375,000
245	$ 1,500,000	$ 6,082,693	$ 6,500,000	$ 5,225,000	$ 8,250,000
246	$ 500,000	$ 3,025,000	$ 825,000	$ 950,000	$ 2,675,000
248					
250			$ 500,000		
251	$ 500,000				
253	$ 3,050,000	$ 5,050,000	$ 3,365,000	$ 2,827,387	$ 4,150,000
256					
258	$ 500,000	$ 1,000,000	$ 1,860,294	$ 1,500,000	$ 1,675,000
261	$ 500,000	$ 500,000	$ 250,000		$ 500,000
262	$ 1,500,000			$ 250,000	
271	$ 400,000	$ 2,300,000	$ 1,000,000	$ 1,950,000	$ 3,275,000
275			$ 500,000		
276	$ 1,400,000	$ 2,100,000	$ 600,000	$ 800,000	$ 1,200,000
279		$ 150,000			$ 200,000
285	$ 500,000	$ 500,000			
286	$ 350,000		$ 150,000		
293					
297				$ 250,000	
308				$ 700,000	
310	$ 500,000	$ 2,750,000	$ 4,725,000	$ 3,525,000	$ 4,936,984
320				$ 500,000	$ 500,000
333				$ 425,000	$ 500,000
338				$ 1,500,000	$ 1,500,000
Totals	$ 195,741,865	$ 193,902,777	$ 155,701,235	$ 160,267,335	$ 173,955,487

Appendix C

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Pennsylvania medical care availability and reduction of error fund

2016 Assessment Rate Calculation

Philadelphia, PA

October 2015

(in accordance with Act 13 of 2002 and the Settlement Agreement effective October 3, 2014)

Appendix C.1

Mr. Theodore Otto
Executive Director
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, Pennsylvania 17102

October 9, 2015

Dear Mr. Otto:

Enclosed is our DRAFT report describing the methods we have used to estimate the 2016 prevailing primary premium projection of $980 million, indicating an assessment rate of 16.50% for the 2016 year, in accordance with Act 13 of 2002, also known as the Mcare Act, and as prescribed by the Settlement Agreement effective October 3, 2014. We understand that Mcare will round the assessment rate to 17%.

Please call Lela Patrik at (267) 330-2237 or Tim Landick at (267) 330-6608 should you have any questions or require anything further.

Sincerely,

Lela Patrik
Director
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Timothy Landick
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Enclosure

cc: R. Waeger, Mcare Fund

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Introduction

Purpose

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

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

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

PricewaterhouseCoopers LLP (PwC) was engaged to assist the Fund in the determination of the assessment rate to be applied for the 2016 year, in accordance with the provisions of Act 13 and as prescribed by the Settlement Agreement effective October 3, 2014[5] ("Settlement Agreement").

Distribution and use

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

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

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

[2] Namely, Section 715 of Act 13. These were previously known as Section 605 claims. Fund coverage for these claims ceased for claims occurring after December 31, 2005, and is subject to a number of other conditions, such as the "continuing course of treatment" provision.

[3] Notably, Act 111 of 1976 and Act 135 of 1996.

[4] Although increases in the basic insurance coverage are scheduled, the actual timing of the increases will be determined after an assessment of market conditions by the Insurance Commissioner.

[5] The Settlement Agreement effective October 3, 2014 is between the Commonwealth of Pennsylvania ("Commonwealth") and the "Petitioners" – the Hospital & Healthsystem Association of Pennsylvania ("HAP"), the Pennsylvania Medical Society ("PAMED"), and the Pennsylvania Podiatric Medical Association ("PPMA"). The Settlement Agreement sets forth the terms with respect to (1) the Mcare Assessment Case and (2) the Mcare Fund Transfer Case.

Conditions and limitations

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

- Discussions with the Fund and the Department regarding Act 13 and the legislative intent of provisions relevant to the assessment calculation, including the limits of coverage to be provided by the Fund for 2016;
- The calculation of the assessment amount as prescribed by the Settlement Agreement and related discussions with the Fund regarding the application of the Settlement Agreement;
- Policy year 2012, 2013, and 2014 assessments, segregated by primary policy type, product code, county code, and specialty code;
- JUA filings, JUA underwriting manuals, and Fund assessment manuals effective January 1 of 2012, 2013, 2014, 2015, and 2016;
- Claim Year Ending 8/31/2015 Claims Settled;
- Claim Year Ending 8/31/2015 Operating Expense;
- Claim Year Ending 8/31/2015 Principal and Interest Paid or Payable;
- Claim Year Ending 8/31/2015 Borrowing Transfers;
- Projected Starting Balance as of January 1, 2016; and
- Knowledge obtained through our prior experience with the Fund.

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

The projected 2016 prevailing primary premium, which is a primary component of the 2016 assessment rate, is an estimate. As such, this value is subject to variability. While we believe the estimate is reasonable based on the information provided, there can be no assurance that the actual prevailing primary premium will not differ materially from what we have projected, generating either more or less assessment revenue than that projected herein.

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

Qualifications of PwC actuaries

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

Executive summary

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

2016 Assessment Rate

Exhibit 2 shows that our selected primary prevailing premium for 2016 of $980 million generates an indicated assessment rate of 16.50%, which rounds to 17% as shown on Exhibit 1. In accordance with Act 13 and the Settlement Agreement, our calculation contemplates the areas of expense to be recouped, the Projected Starting Balance, and a projection of the 2016 prevailing primary premium.

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

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

The Settlement Agreement prescribes that "beginning with the 2015 Mcare Assessment and for each annual Assessment thereafter, the Mcare Fund shall compute the Assessment by subtracting the full amount of the Projected Starting Balance from" the sum of items (i) through (iv) above.

The resulting "Assessment Amount" of $162 million is to be collected via the application of an assessment rate to the policy year 2016 prevailing primary premium. Hence the projection of 2016 prevailing primary premium is a key component of the recommended assessment rate. There are numerous external factors that will affect both the 2016 payment obligations of the Fund and the 2016 prevailing primary premium base, from which the Fund will derive its financing. We have considered actual 2012, 2013, and 2014 assessments as the basis for our estimate of the 2016 prevailing primary premium.

To the extent that the 2016 claims payments and net expenses of the Fund differ from the assessment collected during 2016, the Fund may have a significant positive or negative balance as of year-end 2016. This positive or negative year-end balance may be impacted by other factors as well, including but not necessarily limited to:

- The amount of external funding, if any, made available to the Fund during 2016;
- The level of assessment abatement or other discounts provided during 2016. Current calculations assume no abatements or discounts; and
- Differences between projected 2016 prevailing primary premium and actual 2016 prevailing primary premium, which would result in a difference between projected and actual assessment revenue.

These variables contribute additional uncertainty regarding the degree to which the amount assessed in 2016 that are collected in 2016 will be sufficient to meet the Fund's 2016 obligations. To the extent the amounts collected in 2016 are insufficient to meet the Fund's 2016 obligations, use of the Reserve Fund or borrowing may be required.

Analysis

Approach

The Act outlines the four cost categories to be funded via the assessment. The aggregate assessment for 2016[6] must cover the following: claim settlements, operating expenses, principal and interest on moneys transferred to the Fund, and a target reserve amount. In addition, the Settlement Agreement prescribes consideration of the Projected Starting Balance in the assessment calculation. In particular, this calculation reduces the assessment amount by the Projected Starting Balance.

The resulting Assessment Amount is recouped by applying an appropriate assessment rate to the 2016 prevailing primary premium.

Claim Settlements

The largest cost to be funded by the 2016 assessment is the amount of claim settlements for the Fund's 2015 claim year ending August 31, 2015. These claims are payable on or about December 31, 2015. The Fund expects that payments for the 2015 claim year will total $160 million.

Fund Operating Expenses

The amount of operating expenses paid of $11 million for the claim year ending August 31, 2015 was provided by the Fund, which includes Fund overhead expenses and legal expenses largely associated with the defense costs of Section 715 claims.

Principal and Interest on Money Transferred

The Fund had no money outstanding during the claim year ending August 31, 2015, and does not currently expect to require borrowing to meet its 2015 obligations.

Target Reserve

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

Projected Starting Balance

Per the Settlement Agreement, the Projected Starting Balance is the "balance in the Mcare Fund as of January 1 of the applicable assessment year, as projected as of on or about October 15 of the prior calendar year, including interest and other income in the Assessment Relief Fund. The Assessment Relief Fund and the Reserve Fund shall not be included in the calculation of the Projected Starting Balance."

The Fund has estimated a Projected Starting Balance as of January 1, 2016 to be $27 million.

Reserve Fund

Per the Settlement Agreement, the Reserve Fund is "the portion of the Settlement Funds that Mcare is permitted to retain as a one-time, non-replenishing reserve." The starting balance of the Reserve Fund as of the effective date of the Settlement Agreement (October 3, 2014) is $30 million, and the Reserve Fund shall never exceed that amount; interest and other income earned on amounts in the Reserve Fund may be retained in the Reserve Fund as long as the

[6] We interpret this to mean the aggregate assessment imposed for policies written in calendar year 2016.

balance does not exceed the $30 million limit. The Insurance Commissioner may choose to reduce the Assessment Amount for a given year using all or a portion of the remaining Reserve Fund.

The Insurance Commissioner has not chosen to reduce the Assessment Amount for 2016 by an amount from the Reserve Fund. It is our understanding that the Reserve Fund continues to be maintained at its $30 million threshold and that associated interest and other income was considered in the calculation of the Projected Starting Balance as of January 1, 2016.

Prevailing Primary Premium

The Fund provided assessment and policy count data for policies effective in 2012, 2013, and 2014. Data was provided for each unique set of the following variables: primary policy type, product code, county code, and specialty code.

A general description of these variables follows below.

Primary Policy Type

This field contains either CM (claims-made) or OC (occurrence). Assessment collections for tail policies are not expected to be material in the aggregate for policy year 2016. Our projections of policy year 2016 assessments exclude assessments collected from tail policies in 2012 ($0.7 million), 2013 (less than $0.1 million), and 2014 (less than $0.1 million).

Product Code

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

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

County Code

The field indicates the rating county of the exposure; there are 67 county codes (e.g., Allegheny and Chester).

Specialty Code

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

The projected 2016 prevailing primary premium has been estimated by adjusting historical assessments for the changes in the underlying JUA class assignments, territory assignments, and rates. Namely, the 2012 assessments have been adjusted for changes effective 01/01/2013, 01/01/2014, 01/01/2015, and 01/01/2016. This calculation is included in its entirety under separate cover in Appendix A. An excerpt of this calculation is attached as Excerpt A. The 2013 assessments have been adjusted for changes effective 01/01/2014, 01/01/2015, and 01/01/2016. This calculation is included in its entirety under separate cover in Appendix B. An excerpt of this calculation is attached as Excerpt B. The 2014 assessments have been adjusted for changes effective 01/01/2015 and 01/01/2016. This calculation is included in its entirety under separate cover in Appendix C. An excerpt of this calculation is attached as Excerpt C.

The relevant changes effective 01/01/2013, 01/01/2014, 01/01/2015, and 01/01/2016 are as follows below.

Changes Effective 01/01/2013

Rate Change

The JUA increased its base rates by 6.8%. Combined with other changes to the rate plan, the expected impact to the overall rate level is an increase of 6.9%, based on the JUA's mix of policies (occurrence, 1st year claims-made, 2nd year claims-made, 4th year claims-made, and mature claims-made). For occurrence policies only, the estimated impact is an increase of 7.6%, per the JUA filing. The indicated rate change varies by class and territory. For example, the indicated rate changes by class and territory range from -7.8% to 23.0% (note: for occurrence policies only and not considering the implied rate changes due to the territory movements of certain counties). Based on Mcare's mix of exposures, the overall impact of the JUA rate change on Mcare's 2013 primary prevailing premium is an increase of approximately 5.9%.

Class Rate Changes

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

County / Territory Changes

Modifications to the mapping of county to rating territory are as follows:

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

Specialty Changes

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

Specialty Code	Specialty	Change
01037	Endocrinology	move to class 00737
01074	Geriatrics	move to class 00674
01142	Nephrology	move to class 00741
01144	Pulmonary Medicine	move to class 01545
01199	Physicians Not Otherwise Classified - No Surgery (NOC)	move to class 00799
02006	Gastroenterology - Excluding Major Surgery	move to class 02206
07026	Vascular Surgery	move to class 09026
07085	Peripheral Vascular Surgery	move to class 09085

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

Changes Effective 01/01/2014

Rate Change

The JUA increased its base rates by 1.6%. Combined with other changes to the rate plan, the expected impact to the overall rate level is an increase of 3.4%, based on the JUA's mix of policies (occurrence, 1st year claims-made, 2nd year claims-made, 4th year claims-made, and mature claims-made). For occurrence policies only, the estimated impact is an increase of 3.1%, per the JUA filing. The indicated rate change varies by class and territory. For example, the indicated rate changes by class and territory range from -5.2% to 17.3% (note: for occurrence policies only and not considering the implied rate changes due to the territory movements of certain counties). Based on Mcare's mix of exposures, the overall impact of the JUA rate change on Mcare's 2014 primary prevailing premium is an increase of 3.3%.

Class Rate Changes

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

County / Territory Changes

Modifications to the mapping of county to rating territory are as follows:

County(County Code)	Change
Blair (07)	chg from Terr 6 to Terr 7
Delaware (23)	chg from Terr 5 to Terr 4
Lackawanna (35)	chg from Terr 4 to Terr 5
Westmoreland (65)	chg from Terr 3 to Terr 6

For 2014, the JUA assigned Blair County to a new territory (Territory 7). No changes were made to territorial relativities.

Specialty Changes

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

Changes Effective 01/01/2015

Rate Changes

The JUA filed no rate increase for 2015.

Class Rate Changes

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

County / Territory Changes

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

Specialty Changes

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

Changes Effective 01/01/2016

Rate Changes

The JUA filed no rate increase for 2015.

Class Rate Changes

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

County / Territory Changes

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

Specialty Changes

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

Results

The indications for the 2016 prevailing primary premium are $983 million based on 2012 remittances, $978 million based on 2013 remittances, and $989 million based on 2014 remittances. Excerpts of the calculation described above are included in this report as Excerpt A (2012), Excerpt B (2013), and Excerpt C (2014). The entire calculation is included under separate cover as Appendix A, Appendix B, and Appendix C, respectively.

Note that the estimates of the primary prevailing premium are generally consistent for 2012, 2013, and 2014. Based on these observations and considerations, our selected 2016 prevailing primary premium is $980 million. Note that this projection may vary from the actual 2016 prevailing primary premium due to numerous factors including, but not limited to:

- Possible changes in the relative size of Pennsylvania's health care industry during 2016 relative to recent years;
- Shifts in the mix (e.g., by specialty and territory) of health care provider exposures during 2015 and 2016;
- Changes in the average effective date of primary policies (i.e., cancel / rewrite distortions) during 2015 and 2016; and
- Additional recording of data, notably for 2014, where policy adjustments and late reported assessments will cause the assessment data to change. The year-over-year increase in 2012 and 2013 data was less than 1%.

2016 Assessment Rate

The cost components of the assessment total $189 million; reducing this by the Projected Starting Balance as of January 1, 2016 of $27 million, as prescribed by the Settlement Agreement, the assessment amount is $162 million. Given the 2016 prevailing primary premium projection of $980 million, the indicated 2016 assessment rate is 16.50%. We understand that Mcare will round the assessment rate to 17%.

Change from Prior

The indicated rounded 2016 assessment rate of 17% is 5% higher than the 2015 assessment rate of 12%. As the chart below indicates, this is driven by three key components of the assessment rate calculation.

- 2015 Assessment Costs – The prior claim year (ending 08/31/2015) assessment costs showed a slight increase year over year (0.5% change), driven by the increase in the cost of claims settled (0.5% change).

- Projected Starting Balance – As prescribed by the Settlement Agreement, beginning in 2015, the assessment costs will be reduced by the Projected Starting Balance to calculate the Assessment Amount for the same year. The 2016 Projected Starting Balance ($27 million) is less than the 2015 Projected Starting Balance ($61 million), resulting in a 3.5% increase in the assessment rate calculation.

- Projected Prevailing Primary Premium – The projected prevailing primary premium selected for policy year 2016 reflects no change from the prior policy year (2015) selection (0% change). Therefore, the increase in the Fund's Assessment Amount causes the assessment rate to increase. The remaining change is attributable to rounding of the assessment rate by the Fund.

The 2015 and 2016 assessment rate calculations are summarized below.

	2016	2015	Assessment Rate Impact
(1) Claim Year Ending 08/31/2015 Claims Settled	160,267,335	155,701,235	0.5%
(2) Claim Year Ending 08/31/2015 Operating Expenses	11,098,196	11,450,000	0.0%
(3) Target Reserve	17,136,553	16,715,124	0.0%
(4) 2015 Assessment Costs, (1)+(2)+(3)	188,502,084	183,866,359	0.5%
(5) Projected Starting Balance	(26,791,145)	(61,442,765)	3.5%
(6) Contribution from Reserve Fund	-	-	0.0%
(7) 2016 Assessment Amount, (4)+(5)+(6)	161,710,939	122,423,594	4.0%
(8) Projected Prevailing Primary Premium	980,000,000	980,000,000	0.0%
(9) Indicated assessment Rate, (7)/(8) *	17%	12%	5%

**reflects rounding of the assessment rate*

Exhibits

Pennsylvania Medical Care Availability and Reduction of Error Fund

Indicated 2016 Assessment Rate

(1)	Claim Year Ending 08/31/2015 Claims Settled	160,267,335
(2)	Claim Year Ending 08/31/2015 Operating Expenses	11,098,196
(3a)	Claim Year Ending 08/31/2015 Principal and Interest Paid or Payable	-
(3b)	Claim Year Ending 08/31/2015 Borrowing Transfers	-
(4)	Target Reserve	17,136,553
(5)	2015 Assessment Costs	188,502,084
(6)	Projected Starting Balance as of January 1, 2016	26,791,145
(7)	Contribution from Reserve Fund	-
(8)	2016 Assessment Amount	161,710,939
(9)	Projected Policy Year 2016 Prevailing Primary Premium	980,000,000
(10)	Indicated 2016 Assessment Rate	17%

Notes

(1) Provided by Fund.
(2) Provided by Fund.
(3a) Provided by Fund, including principal and interest paid or payable for moneys transferred.
(3b) Provided by Fund, including transfers outstanding or received during the claim year.
(4) 10% of (1) through (3), per Section 712(d)(1)(iv) of Act 13 of 2002.
(5) = (1) + (2) + (3a) + (3b) + (4)
(6) Provided by Fund.
(7) Provided by Fund.
(8) = (5) - (6) - (7). Assessment calculation is as presented in Exhibit A of the Settlement Agreement dated October 3, 2014.
(9) Exhibit 2.
(10) = (8) / (9)

Pennsylvania Medical Care Availability and Reduction of Error Fund

Projected 2016 Prevailing Primary Premium

	Projected Prevailing Primary Premium	Implied Assessment Rate
(1) Projection Based on 2012 Assessment Remittances	983,473,443	16.4%
(2) Projection Based on 2013 Assessment Remittances	978,457,334	16.5%
(3) Projection Based on 2014 Assessment Remittances	988,808,118	16.4%
(4) Projected 2016 Prevailing Primary Premium	980,000,000	16.5%

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

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Pennsylvania medical care availability and reduction of error fund

2016 experience modification factors

Philadelphia, PA

December 2015

(in accordance with act 13 of 2002)

Appendix C.2

Mr. Theodore Otto
Executive Director
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, Pennsylvania 17102

December 10, 2015

Dear Mr. Otto:

Enclosed is our report describing the Experience Rating Plan (the Experience Modification Plan or the Plan) and the resulting 2016 Experience Modification Factors, developed pursuant to Section 712(g)(4) of Act 13. The factors contained herein are expected to produce results that are "revenue neutral" to the Fund in total and our recommendations for application of the Plan are included in the report text.

It has been our pleasure to work with you and your team on this analysis; thank you for your assistance. Please call Lela Patrik at (267) 330-2237 or Tim Landick at (267) 330-6608 should you have any questions or require anything further.

Sincerely,

Lela Patrik
Director
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Timothy Landick
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Enclosure

cc: R. Waeger, Mcare Fund

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Introduction

Purpose

The Commonwealth of Pennsylvania established the Medical Care Availability and Reduction of Error Fund[1] (the Fund) on January 13, 1976 as part of its effort to make professional liability insurance available at a reasonable cost and to provide for prompt and fair compensation to persons sustaining injury due to the negligence of a health care provider. Section 712(g)(4) of Act 13 of 2002 (Act 13), amends Section 701 of the October 1975 Act (as amended) such that:

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

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

Distribution and use

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

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

Conditions and limitations

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

- Fund payment information by hospital by claim year for the claim years ending 2011 through 2014; and
- Assessment by hospital by policy year for the policy years ending 2012 through 2015, separately identified by policy type (occurrence, claims-made, claims-made plus[3], or tail).

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

---

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

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

[3] A claims-made plus policy is one in which the tail exposure is pre-funded through the annual policy premium.

The 2015 assessment has been estimated[4] for the 36 hospitals (17% of all hospitals) that have not yet remitted. As estimates, these values are subject to variability. While we believe the projections herein are reasonable based on the information available, there can be no assurance that the actual 2015 assessment will not differ from what we have projected. Please see Appendix A for further description of the 2015 assessment estimation process for the hospitals that have not yet remitted.

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

Database

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

Within our analysis, hospitals are sorted into bands according to the average implied prevailing primary premium (AIPPP) at 2015 levels, based on 2013, 2014, and (if available) 2015 baseline policy year assessments[5]. This increases the extent to which the Plan is normalized for "*class, size, risk, and kind*". The bands are defined as follows[6]:

1. Band 1 Hospitals (AIPPP less than $330,000)
2. Band 2 Hospitals (AIPPP between $330,000 and $640,000)
3. Band 3 Hospitals (AIPPP between $640,000 and $1,300,000)
4. Band 4 Hospitals (AIPPP between $1,300,000 and $2,760,000)
5. Band 5 Hospitals (AIPPP greater than $2,760,000)

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

Based on information provided by the Fund, the assessment and payment information has been combined for hospitals that have merged. Data for hospitals that have simply closed is excluded from the analysis. Data for hospitals with insufficient years of experience has also been excluded from the analysis. The result is 211 hospitals for which experience modification factors were determined.

Qualifications of PwC actuaries

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

---

[4] The procedure used to estimate the 2015 assessment for those who have not yet remitted is described in the *Analysis* section below. A list of additional data adjustments is included as Appendix B.

[5] Historical baseline policy year assessments (defined in the *Analysis* section below) are adjusted to a 2015 level by dividing the assessment by the appropriate assessment rate and applying base rate changes as filed by the JUA.

[6] Note that these band definitions are consistent with those selected for 2015 (based on 2014 AIPPP). The JUA filed a 0% rate change for 2015.

Executive summary

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

Spread of experience modification factors

The 211 experience modification factors as calculated in Exhibit 1 fall into the following ranges:

Distribution			
From	To (less than)	2016 Mods Count	2015 Mods Count
80.0%	82.5%	10	15
82.5%	90.0%	136	128
90.0%	97.5%	21	21
97.5%	105.0%	8	16
105.0%	112.5%	9	8
112.5%	117.5%	5	1
117.5%	120.0%	2	3
120.0%		20	18
Total all rated hospitals		211	210

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

Revenue impact

The 211 experience modification factors are expected to be revenue neutral to the Fund in total. Namely, the factors are determined such that they are revenue neutral when applied to the 2014 baseline assessments. When applied to the 2015 baseline assessments, many of which are estimates, the 2015 modified assessment is less than 1% lower than the 2015 baseline assessment. We do not expect a significant revenue impact when these factors are applied in 2016.

Comparison to 2015 experience modification factors

Of the 211 experience modification factors computed herein, 1 is for a hospital that has been rated for the first time. Of the remaining 210 modification factors, 172 are within 5.0% and 180 are within 7.5% of the 2015 filed experience modification factors. Of the 205 filed experience modification factors computed herein for hospitals whose band assignment has not changed, 170 are within 5.0% and 177 are within 7.5% of their 2015 filed experience modification factors.

There are 38 hospitals with experience modification factor changes greater than 5.0%, all but 4 hospitals[7] of which are in Band 3, Band 4, or Band 5. Similarly, there are 30 hospitals with experience modification factor changes greater than 7.5%, all but 2 hospitals[8] of which are in Band 3, Band 4, or Band 5. Hospitals in these higher bands receive

[7] 1 hospital is in Band 1 and the remaining 3 are in Band 2.
[8] 1 hospital is in Band 1 and 1 hospital is in Band 2.

relatively higher credibility and therefore changes in the experience modification factors are driven by changes in the underlying experience.

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

A comparison of the 2016 experience modification factors to the 2015 experience modification factors for hospitals that have been experience rated for 2016 is included in the attached Summary Exhibit.

Analysis

Methodology

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

1. Compiling the Fund payment data for each hospital for each claim year 2011 through 2014;
2. Estimating and compiling the baseline assessments for each hospital for each policy year 2012 through 2015;
3. Calculating a rate of recoupment[9] for each hospital for each year and for each hospital band for each year;
4. Calculating the four relative rates of recoupment for each hospital showing the ratio of the hospital rate of recoupment to the total hospital rate of recoupment for each year and weighting these four relative rates of recoupment together to estimate an average relative rate of recoupment (weighted rate) for the individual hospital;
5. Determining appropriate a priori modification factors;
6. Determining an appropriate credibility weighting procedure and credibility weighting the hospital weighted rate with its band's a priori modification factor; and
7. Computing experience modification factors that lie within the bounds prescribed by Act 13 and that are revenue neutral.

Each of these steps is described below.

Compiling fund payment data (Exhibits 5 and 9)

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

Compiling policy year assessment data (Exhibits 4 and 8)

The Fund provided information by hospital and type of policy (occurrence, claims-made plus, claims-made, or tail). Policy year non-tail assessment data for 2012 through 2015 is used in this analysis. In Exhibit 8, an adjustment is made to the assessments provided by the Fund in order to derive the baseline assessment that is used in the experience modification computation. Namely, the assessments are adjusted to remove the impact of the charged experience modification factors. This adjustment is required because the experience modification factor is applied to the unmodified assessment; as such, it is necessary to compute each hospital's experience relative to its historical unmodified assessment.

This baseline assessment data is then sorted on Exhibit 4 by hospital by policy year for policy years 2012 through 2015[10]. For policy year 2015, information was provided by the Fund for those hospitals who have remitted their 2015 assessments. The actual non-tail baseline assessment for those hospitals is shown in Exhibit 4. For those hospitals that have not yet remitted their 2015 assessment, the 2015 baseline assessment is estimated as the average of the 2013 and 2014 baseline assessments, modified according to changes in the assessment rate and JUA filed base rate changes.

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

[10] Note that tail assessments are also removed.

Calculating yearly rates of recoupment (Exhibit 3)

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

Rates of recoupment are established as the ratio of the Fund payment data for each claim year (ending 2011 through 2014) to the baseline policy year assessment data for the subsequent policy year (2012 through 2015). The band rates of recoupment are calculated as the ratio of the sum of the Fund payments for each claim year to the sum of the baseline policy year assessments for the subsequent policy year for each hospital within the band.

Calculating the weighted average relative rate of recoupment (Exhibit 2)

A hospital's yearly experience is measured relative to the overall hospital experience for that particular year. This "relative rate of recoupment" provides a measure as to whether the particular hospital is "better" or "worse" than average for the particular year. The four measures across 2011/2012 through 2014/2015 are weighted together to provide a weighted average relative rate of recoupment or "weighted rate" (WR). We have judgmentally chosen weights of 20/25/25/30 for 2011/2012 through 2014/2015, respectively, in order to give slightly more weight to the experience of more recent years as shown in Exhibit 2.

Determining a priori modification factors (Exhibit 6)

A review of several statistics by band indicates that relative rates of recoupment and relative frequencies tend to increase as the band increases. In addition, the projected 2015/2016 relative rate of recoupment by band also tends to increase with the "size" of the band. Since an individual hospital's experience is not fully credible, we have calculated experience modification factors that are a combination of the individual hospital experience and the band experience.

In combining these components, we have sought to balance actuarial and practical considerations in a plan that meets the aforementioned requirements of Act 13. A primary consideration is the degree of credibility that is associated with the apparent differences in experience by band. In Exhibit 6.2, the relative recoupment rate by band is shown by year and for the four-year average. In Exhibit 6.3, the relative frequency by band is similarly displayed. Exhibit 6.4 contains the details of the actuarial methodology we have employed in an attempt to measure the credibility associated with a given year's band indicated relativity to the "average"; the method employs the relationship of the dispersion of relativities within each band and the dispersion of relativities between the bands to determine the credibility of the band experience.

Exhibit 6.1 summarizes the band indications. Our selected band a priori 2015/2016 modification factor is based on a review of the various indications. As was the case in prior years, we have kept our selected relativities in a tighter range than would otherwise be indicated for a number of reasons. First of all, the large number of observations for some bands may cause the calculated credibility to be higher than the "true" credibility. Furthermore, the Plan should produce relatively stable results from year-to-year while being responsive to changes in the underlying experience. Since experience from one year to the next may vary, too much emphasis on the raw indications may tend to emphasize responsiveness at the sacrifice of stability. Lastly, since Act 13 requires final modification factors not to exceed +/-20%, we have selected a priori modification factors within this range.

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

Band	*Current* A Priori Factors	*Prior* A Priori Factors
1	-17.5%	-17.5%
2	-17.5%	-17.5%
3	-5.0%	-5.0%
4	5.0%	2.5%
5	7.5%	10.0%

Determining an individual hospital credibility weighting procedure (Exhibit 7)

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

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

We have used a traditional credibility formula of the form:

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

P is typically some measure of the exposure represented by the risk. To establish a credibility procedure sensitive to the "*class, size, risk, and kind*" of each hospital, we have chosen P equal to the hospitals' 2014 policy year prevailing primary premiums, adjusted for the JUA's 2015 base rate change. Namely, we divided the Fund's 2014 baseline policy year assessment by the Fund's 2014 assessment rate of 23.0%, then adjusted the resulting amount to reflect the JUA's filed base rate change of 0.0% for policy year 2015. Policy periods were annualized where we observed that the 2014 policy year data did not represent an annual policy term.

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

1. 2011/2012, 2012/2013, and 2013/2014 to predict 2014/2015
2. 2011/2012, 2012/2013, and 2014/2015 to predict 2013/2014
3. 2011/2012, 2013/2014, and 2014/2015 to predict 2012/2013
4. 2012/2013, 2013/2014, and 2014/2015 to predict 2011/2012

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

Band	*Current* Calculations		*Prior* Calculations	
	Selected K	Implied Avg Z	Selected K	Implied Avg Z
1	25,000,000	0.5%	30,000,000	0.4%
2	15,000,000	3.1%	15,000,000	3.2%
3	4,000,000	17.6%	5,000,000	15.5%
4	4,000,000	32.1%	5,000,000	27.2%
5	5,000,000	46.2%	5,000,000	46.8%

As shown above, the average credibility is generally similar to that of last year. Individual hospital experience, particularly for smaller hospitals, is generally given limited credibility as the average Band 1 hospital receives 0.5% credibility. The average Band 5 hospital receives 46.2% credibility.

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

Computing experience modification factors (Exhibit 1)

To achieve a revenue neutral impact on 2016 assessments, we estimated modification factors that are revenue neutral based on the 2014 baseline policy year assessments under the assumption that a similar overall impact will result in application of the modification factors to the 2016 assessments[11]. These factors are determined through a recursive process whereby initial boundaries are selected so that after the off-balance[12] adjustment, all modifiers fall within 80% and 120%, as prescribed by Act 13.

[11] As a test, we applied the modification factors to the 2015 baseline policy year assessments, 17% of which are estimates. The resulting modified assessments were approximately revenue neutral.

[12] The adjustment is required to achieve a revenue neutral impact.

Appendix A

Application of the Experience Modification Plan

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

The actual 2015 assessment is different from that estimated in the report

As discussed in the *Analysis* section, the 2015 assessment for those hospitals that have not yet remitted has been estimated; 17% of the 211 rated hospitals have required such estimation. To the extent that the actual 2015 assessments differ from that included in this report, the experience modification factors are impacted, as follows:

1. the individual hospitals' 2014/2015 rates of recoupment will change;
2. the band 2014/2015 rates of recoupment will change;
3. the overall hospital 2014/2015 rate of recoupment will change, impacting each hospital's and each band's relative rate of recoupment;
4. the individual hospitals' weighted average relative rate of recoupment will change;
5. a priori modification factors may be impacted;
6. the credible experience modifiers will change; and
7. the off balance will be impacted.

While the final experience modification factors would change with differences between the actual and the expected 2015 assessments, we expect the end result of these changes to be relatively insignificant, based on the observations below.

1. The individual hospitals' 2014/2015 rates of recoupment will change according to the amount of misestimation of the 2015 assessment, but only for those hospitals with Fund payments in 2014. Any hospital with $0 of 2014 Fund payments will maintain its 0% recoupment rate.
2. The band 2014/2015 rates of recoupment will change, but this change will be tempered by the band members whose data has not changed.
3. The overall hospital 2014/2015 rate of recoupment will change, but this change will also be tempered by the hospitals whose data has not changed.
4. The individual hospital's weighted average relative rate of recoupment will change, but the impact is mitigated since 2014/2015 comprises only 30% of the weighted average rate.
5. It is unlikely that the a priori modification factors will be impacted since our selections have been based on several years of data and generally lie within the range of the raw indications.
6. The individual hospital data is given generally little credibility. This will further mitigate any change to the individual hospital weighted rate. This, combined with the unlikelihood of a change to the a priori modification factors, should result in only minor impacts on the "credible modifiers".
7. Since the Plan is revenue neutral, any impact on the "credible modifiers" will impact the off balance. The change in the off-balance will offset any change in the expected aggregate 2016 revenue change resulting from the change in (6).

Based on these observations, we do not believe a recalculation of the experience modification factor is likely to be needed for those hospitals whose actual 2015 assessment differs from that estimated in this analysis. If the actual 2015 assessment for an individual hospital does differ significantly from that estimated in this analysis, the Fund could consider recomputing the individual hospital's experience modification factor.

Non-annual assessment included in the computation

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

Individual vs. multi-hospital assessment payment

We have combined the historical experience of those hospitals that have merged so that the experience modification factor is based on the experience of the current operation. Potential issues that may arise as a result of this are described below.

Members of a group pay separately

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

Separately rated hospitals remit together

If several separate hospitals (with separate license numbers and limits of coverage) remit a combined assessment, there may be multiple modifiers applicable to the prevailing primary premium. The applied modifier would ideally be the weighted average modifier, using the prevailing primary premium of each hospital as the weights. This produces the same result as would the separate application of each modifier. In the unlikely event that it is impossible to determine the weighted average modifier as described above, the Fund should determine a proxy weighting that would be expected to produce a similar result. This proxy weighting should consider the hospital exposures and territory to the extent such information are available.

Other merger issues

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

Appendix B

Data adjustments

As mentioned in the text, assessments associated with tail policies are removed. In addition, where we observed instances of policy year data that did not represent an annual policy term, we annualized the assessment data (rather than adjusting the underlying data) for purposes of assigning hospitals to band, calculating non-zero rates of recoupment, and calculating the credibility associated with the hospitals' historical experience.

Adjustments were made to assessment data for purposes of calculating rates of recoupment, assigning hospitals to band, and (as regards the 2014 assessments) calculating the credibility associated with the hospitals' historical experience. The following list identifies the hospital assessment data that was subject to adjustment; all adjustments made were to annualize the assessment, unless specified otherwise.

- Hospital license code 84215016: The 2012 assessment is for a 9-month policy period.
- Hospital license code 16653089: The 2012 assessment is for a 17-month policy period.
- Hospital license code 38852021: The 2015 assessment is for an 8-month policy period.
- Hospital license code 98191036: The 2013 assessment is for a 19-month policy period.
- Hospital license code 19326120: The 2012 assessment is for a 184-day policy period.
- Hospital license code 82747178: The 2012 assessment is for a 314-day policy period.
- Hospital license code 70177120: The 2013 assessment is for a 7-month policy period.
- Hospital license code 96212204: The 2012 assessment is for a 700-day policy period.
- Hospital license code 59218247: The 2013 assessment is for an 8-month policy period.
- Hospital license code 64627271: The 2015 assessment is for a 15-month policy period.
- Hospital license code 29542393: The 2015 assessment is for a 17-month policy period.

Adjustments were made to annualize the non-annual policy period assessment data for purposes of assigning hospitals to band and (as regards the 2014 assessments) calculating the credibility associated with the hospitals' historical experience. The following list identifies the hospital assessment data that was subject to adjustment; all adjustments made were to annualize the assessment, unless specified otherwise.

- Hospital license code 84215016: The 2014 assessment is for an 18-month policy period.
- Hospital license code 58417030: The 2015 assessment is for a 495-day policy period.
- Hospital license code 52821043: The 2013 assessment is for an 18-month policy period.
- Hospital license code 14438032: The 2013 assessment is for an 8-month policy period.
- Hospital license code 75450028: The 2013 assessment is for a 19-month policy period.
- Hospital license code 64874036: The 2014 assessment is for a 6-month policy period.
- Hospital license code 59478030: The 2013 and 2015 assessments are for non-annual (1.5-month and 17-month, respectively) policy periods.
- Hospital license code 57285037: The 2013 assessment is for a 125-day policy period.
- Hospital license code 89082059: The 2014 assessment is for an 11-month policy period.
- Hospital license code 54197023: The 2012, 2013, and 2014 assessments are for non-annual (122-day, 9-month, and 9-month, respectively) policy periods.
- Hospital license code 96705102: The 2015 assessment is for an 18-month policy period.
- Hospital license code 55411180: The 2012 assessment is for a 6-month policy period.
- Hospital license code 70324114: The 2013 assessment is for an 8-month policy period.
- Hospital license code 37028198: The 2014 assessment is for an 18-month policy period.
- Hospital license code 36346152: The 2013 assessment is for a 7-month policy period.
- Hospital license code 67147123: The 2013 assessment is for a 7-month policy period.
- Hospital license code 31858157: The 2012 assessment is for a 16-month policy period.

- Hospital license code 55454189: The 2015 assessment is for an 8-month policy period.
- Hospital license code 18756162: The 2015 assessment is for an 8-month policy period.
- Hospital license code 49968179: The 2015 assessment is for an 8-month policy period.
- Hospital license code 78171185: The 2013 assessment is for overlapping claims-made policies (1/1/2013-1/1/2014 and 8/29/2013-1/1/2014) that total to a 490-day policy period.
- Hospital license code 98982162: The 2015 assessment is for a 16-month policy period.
- Hospital license code 71791165: The 2012 assessment is for a 700-day policy period.
- Hospital license code 32616260: The 2013 assessment is for an 8-month policy period.
- Hospital license code 90823268: The 2014 assessment is for a 6-month policy period.
- Hospital license code 38524204: The 2013 assessment is for an 8-month policy period.
- Hospital license code 14133227: The 2013 assessment is for a 7-month policy period.
- Hospital license code 13248233: The 2013 and 2014 assessments are for non-annual (7-month and 17-month, respectively) policy periods.
- Hospital license code 44245254: The 2012 assessment is for a 16-month policy period.
- Hospital license code 65644235: The 2013 assessment is for a 242-day policy period.
- Hospital license code 33567281: The 2015 assessment is for an 18-month policy period.
- Hospital license code 77777214: The 2014 assessment is for a 6-month policy period.
- Hospital license code 79705368: The 2012, 2013, and 2014 assessments are for non-annual (684-day, 47-day, and 17-months respectively) policy periods.
- Hospital license code 10111389: The 2012 and 2014 assessments are for non-annual (16-month and 8-month, respectively) policy periods.
- Hospital license code 53413392: The 2012 assessment is for a 700-day policy period.
- Hospital license code 62832354: The 2012, 2013, 2015 assessments are for non-annual (684-day, 47-day, and 17-month, respectively) policy periods.
- Hospital license code 56747389: The 2013 and 2015 assessments are for non-annual (47-day and 17-month, respectively) policy periods.
- Hospital license code 29542393: The 2013 assessment is for a 47-day policy period.
- Hospital license code 30457304: The 2012 assessment is for a 653-day policy period.
- Hospital license code 21310101: The 2015 assessment is for an 8-month policy period.
- Hospital license code 21310101: The 2015 assessment is for an 8-month policy period.
- Hospital license code 20780101: The 2015 assessment is for a 3-month policy period.
- Hospital license code 21700101: The 2014 assessment is for a 7-month policy period.
- Hospital license code 22430101: The 2012 assessment is for a 653-day policy period.
- Hospital license code 22620101: The 2015 assessment is for a 3-month policy period.
- Hospital license code 22560101: The 2015 assessment is for a 138-day policy period.
- Hospital license code 22630101: The 2015 assessment is for a 15-month policy period.
- Hospital license code 22980101: The 2013 and 2015 assessments are for non-annual (47-day and 17-month, respectively) policy periods.
- Hospital license code 22800101: The 2012 assessment is for a 23-month policy period.

Exhibits

Medical Care Availability and Reduction of Error Fund

Comparison of 2016 and 2015 Experience Modification Factors

Group Code	2016 Final Mod	2015 Final Mod	Change	Group Code	2016 Final Mod	2015 Final Mod	Change	Group Code	2016 Final Mod	2015 Final Mod	Change
41402044	88.2%	91.9%	-4%	31814126	90.5%	89.4%	1%	31641292	86.8%	85.6%	1%
62801025	85.4%	84.3%	1%	82110167	86.9%	86.6%	0%	13248233	85.7%	84.7%	1%
73903086	120.0%	120.0%	0%	43614198	120.0%	120.0%	0%	44245254	85.5%	85.3%	0%
47003060	120.0%	120.0%	0%	55411180	87.2%	87.0%	0%	65644235	85.6%	84.6%	1%
68204091	80.7%	86.9%	-7%	67116132	85.7%	84.7%	1%	27042217	85.3%	87.5%	-2%
11516013	88.7%	101.9%	-13%	09718133	97.1%	101.4%	-4%	78644208	85.4%	84.4%	1%
12915004	85.9%	84.7%	1%	70324114	86.2%	85.3%	1%	11156261	84.9%	84.0%	1%
83615085	106.3%	97.7%	9%	71128195	92.8%	104.5%	-11%	82151272	120.0%	120.0%	0%
84215016	102.6%	109.8%	-7%	52221176	85.9%	87.9%	-2%	83851273	85.8%	84.7%	1%
25312057	88.1%	82.1%	7%	37028198	82.8%	83.2%	0%	64254244	85.0%	84.0%	1%
36713058	85.6%	84.5%	1%	28326129	85.5%	84.4%	1%	65858275	86.2%	85.2%	1%
87517049	83.2%	81.9%	2%	19326120	117.4%	109.1%	8%	38152296	102.8%	106.6%	-4%
58417030	85.6%	84.5%	1%	30637131	85.3%	84.2%	1%	99356277	118.8%	119.7%	-1%
70420061	85.1%	84.1%	1%	61636162	120.0%	120.0%	0%	20668278	120.0%	120.0%	0%
81322082	85.0%	84.0%	1%	65637123	82.8%	83.9%	-1%	21465279	102.1%	100.6%	1%
52821043	88.1%	85.3%	3%	96831164	82.5%	81.3%	1%	33567281	84.9%	83.9%	1%
25725085	90.9%	84.1%	8%	79931165	113.4%	119.5%	-5%	55064242	86.5%	94.5%	-8%
17720096	85.4%	85.5%	0%	11447157	85.7%	84.6%	1%	49766243	85.8%	84.7%	1%
19324078	118.2%	101.5%	17%	82747178	120.0%	107.6%	11%	77777214	84.8%	93.0%	-9%
30638079	85.2%	84.3%	1%	83448149	85.1%	84.1%	1%	38976225	83.5%	84.7%	-1%
21336020	84.4%	85.4%	-1%	24549170	85.2%	84.2%	1%	49271246	94.6%	97.2%	-3%
32834061	87.7%	84.2%	4%	95645131	85.3%	86.0%	-1%	81787227	85.1%	84.0%	1%
14438032	85.8%	86.9%	-1%	36346152	80.0%	80.0%	0%	74598228	113.8%	83.7%	36%
87633084	98.8%	101.3%	-2%	67147123	90.9%	81.5%	12%	46598239	88.3%	88.8%	-1%
29032075	91.9%	106.1%	-13%	80553166	109.0%	99.3%	10%	19194290	85.9%	84.7%	1%
10247016	87.1%	86.1%	1%	31858157	105.7%	91.0%	16%	50605341	85.7%	84.6%	1%
71147027	80.0%	80.1%	0%	55454189	85.6%	84.7%	1%	81908302	85.6%	84.5%	1%
02842078	120.0%	120.0%	0%	77158191	120.0%	120.0%	0%	02503353	85.7%	84.6%	1%
24240009	89.7%	85.5%	5%	18756162	85.6%	84.6%	1%	55605314	86.7%	85.5%	1%
45945070	120.0%	120.0%	0%	44261155	85.5%	84.5%	1%	76406315	85.5%	84.5%	1%
88841063	85.2%	84.2%	1%	75660176	100.9%	87.7%	15%	68705327	91.9%	93.4%	-2%
59241014	83.6%	82.3%	2%	17665167	88.0%	89.6%	-2%	79705368	85.3%	84.3%	1%
33558066	107.7%	99.1%	9%	28467168	85.6%	84.5%	1%	10111389	85.5%	84.3%	1%
75450028	85.4%	84.4%	1%	49968179	85.5%	84.6%	1%	53413392	86.7%	85.5%	1%
16653089	120.0%	118.4%	1%	70177120	120.0%	120.0%	0%	45815344	85.9%	84.7%	1%
17152000	102.8%	88.5%	16%	53878122	84.7%	81.6%	4%	46518325	112.8%	94.1%	20%
38852021	120.0%	120.0%	0%	14377183	83.7%	92.0%	-9%	47816316	87.3%	84.8%	3%
39153062	85.4%	84.4%	1%	25277194	92.2%	93.5%	-1%	30324381	85.7%	84.6%	1%
40366053	80.0%	84.9%	-6%	78171185	87.8%	84.3%	4%	22428368	85.7%	84.6%	1%
21167074	89.8%	96.5%	-7%	89976106	84.5%	82.9%	2%	33025309	85.8%	84.7%	1%
74163037	85.4%	84.3%	1%	21585108	109.1%	120.0%	-9%	76826324	85.9%	84.8%	1%
87768000	92.7%	94.8%	-2%	14286150	93.2%	92.7%	1%	79829326	85.8%	84.7%	1%
88668081	80.0%	84.0%	-5%	17987151	94.3%	90.8%	4%	80433362	85.9%	84.7%	1%
60671062	81.0%	83.6%	-3%	98982162	83.0%	82.4%	1%	21834383	85.8%	84.7%	1%
61677083	87.1%	101.2%	-14%	79785153	97.7%	82.5%	18%	62832354	85.5%	84.5%	1%
23370015	85.3%	84.2%	1%	30495154	96.6%	98.3%	-2%	55130345	85.8%	84.7%	1%
64874036	91.3%	91.0%	0%	71791165	83.0%	81.8%	2%	36538334	85.8%	84.7%	1%
96775028	84.1%	83.9%	0%	72296106	120.0%	108.3%	11%	28831342	85.9%	84.8%	1%
97276059	85.7%	88.9%	-4%	23494157	85.7%	84.6%	1%	40846315	87.3%	86.1%	1%
59478030	84.9%	83.9%	1%	74295158	85.8%	84.7%	1%	11243319	86.7%	85.5%	1%
01181011	120.0%	120.0%	0%	86398149	94.6%	96.1%	-2%	72444327	85.8%	84.7%	1%
42183052	83.2%	86.4%	-4%	47392180	89.8%	90.0%	0%	44845378	85.9%	84.8%	1%
53189093	85.2%	84.4%	1%	49293142	83.0%	81.8%	1%	56747389	85.3%	84.3%	1%
44788024	106.5%	111.2%	-4%	54605294	120.0%	120.0%	0%	08141319	83.7%	82.8%	1%
45083045	108.0%	113.5%	-5%	15107295	86.9%	87.2%	0%	29542393	88.2%	84.5%	4%
57285037	88.2%	83.8%	5%	32616260	83.2%	82.1%	1%	30457304	85.3%	84.6%	1%
88183058	83.5%	84.7%	-1%	83912221	87.8%	88.7%	-1%	21310101	85.9%	84.7%	1%
89082059	83.5%	82.4%	1%	96212204	106.5%	103.0%	3%	20780101	85.8%	84.7%	1%
20592050	87.5%	86.1%	2%	77315235	98.9%	90.9%	9%	21210101	87.5%	86.1%	2%
73796092	88.9%	96.5%	-8%	59218247	93.1%	101.0%	-8%	20690101	85.9%	84.7%	1%
54197023	85.1%	85.6%	-1%	90823268	80.0%	93.4%	-14%	21700101	85.8%	84.7%	1%
95597054	91.9%	93.4%	-2%	72529229	94.6%	90.8%	4%	22180101	85.8%	84.7%	1%
27394085	120.0%	104.9%	14%	64627271	116.8%	120.0%	-3%	22430101	85.3%	84.7%	1%
98191036	120.0%	120.0%	0%	67621243	90.1%	86.2%	4%	22620101	85.8%	84.7%	1%
79898097	82.4%	81.7%	1%	38524204	85.3%	83.4%	2%	22660101	85.2%	84.2%	1%
80103168	85.5%	85.4%	0%	89927235	84.0%	83.0%	1%	22460101	85.8%	84.7%	1%
94606100	85.1%	84.1%	1%	14133227	95.4%	102.0%	-7%	22560101	85.8%	84.7%	1%
65706161	120.0%	107.4%	12%	96131289	85.5%	84.4%	1%	22531501	85.6%	84.6%	1%
96705102	80.0%	81.7%	-2%	89530290	120.0%	120.0%	0%	22630101	85.8%	84.7%	1%
30817115	106.2%	120.0%	-12%	40843261	95.3%	99.7%	-4%	22980101	85.6%	84.5%	1%
								22800101	83.1%	new for 2016	

Notes:
2016 Final Mod is derived on Exhibit 1.
2015 Final Mod is from the prior year's report.
"Change" shows the year-over-year percentage change.

PA Department of Insurance

Mcare Fund

Amount of Assessment Received by Provider Type by Assessment Year

Assessment Year	Rate[2]	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Ctrs	Birth Centers
2007	23%	$ 184,561,157	$ 3,692,160	$ 965,951	$ 49,303,712	$ 5,377,104	$ 767,941	$ 18,061
2008	20%	$ 171,318,038	$ 2,990,281	$ 996,867	$ 45,912,137	$ 5,231,463	$ 825,196	$ 20,708
2009	18%	$ 159,225,911	$ 2,819,565	$ 896,034	$ 42,502,505	$ 4,770,358	$ 776,744	$ 19,991
2010	15%	$ 161,796,137	$ 2,913,844	$ 980,820	$ 41,484,095	$ 4,487,694	$ 784,659	$ 24,203
2011	13%	$ 133,419,589	$ 2,417,219	$ 814,723	$ 34,060,659	$ 3,756,234	$ 665,985	$ 21,712
2012	22%	$ 152,554,067	$ 3,065,845	$ 1,065,859	$ 40,423,379	$ 4,099,402	$ 831,401	$ 34,245
2013	25%	$ 176,074,403	$ 3,709,954	$ 1,267,572	$ 44,051,366	$ 5,532,965	$ 927,072	$ 34,509
2014	19%	$ 169,749,676	$ 3,942,537	$ 1,312,783	$ 41,820,603	$ 4,847,413	$ 917,792	$ 36,080
2015	12%	$ 89,753,638	$ 2,068,862	$ 773,223	$ 22,858,085	$ 2,552,914	$ 492,162	$ 18,226
2016 [1]	17%	$ 124,325,089	$ 2,795,456	$ 1,011,299	$ 31,715,113	$ 3,545,709	$ 726,980	$ 22,858

[1] Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2017. Coverage for policies that has been reported and processed as of February 14, 2017 is included in the counts.

[2] For years 2009, 2010, 2011, 2012, 2013 and 2014 the assessment rate reflects the after settlement percentage.

PA Department of Insurance

Mcare Fund

Yearly Average Unabated Assessment by Provider Group

		Physicians			Podiatrists			Hospitals			Nursing Homes		
	Assessment Rate[1]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2007 to 2016[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2007 to 2016[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2007 to 2016[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2007 to 2016[2]
2007 [3]	23%	$4,861	-17%		$3,326	-26%		$220,234	-20%		$7,516	-17%	
2008	20%	$4,405	-9%		$2,656	-20%		$204,567	-7%		$7,387	-2%	
2009	18%	$4,023	-9%		$2,477	-7%		$192,233	-6%		$6,671	-10%	
2010	15%	$4,006	0%		$2,506	1%		$189,086	-2%		$6,561	-2%	
2011	13%	$3,320	-17%		$2,074	-17%		$160,254	-15%		$5,384	-18%	
2012	22%	$3,627	9%		$2,354	14%		$185,290	16%		$6,384	19%	
2013	25%	$4,195	16%		$2,546	8%		$202,949	10%		$6,521	2%	
2014	19%	$4,023	-4%		$3,210	26%		$196,027	-3%		$7,033	8%	
2015	12%	$2,053	-49%		$1,678	-48%		$103,430	-47%		$3,716	-47%	
2016	17%	$2,949	44%	-39%	$2,434	45%	-27%	$155,861	51%	-29%	$5,267	42%	-30%

[1] For years 2009, 2010, 2011, 2012, 2013 and 2014 the assessment rate reflects the after settlement percentage.

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

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

PA Department of Insurance

Mcare Fund

Assessments Remitted by Commercial Carrier for 2007 - 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Carrier Code	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
001	$ 26,450	$ 18,923	$ 17,490	$ 12,880	$ 10,341	$ 11,721	$ 12,712	$ 15,384		
003	$ 16,320,565	$ 16,184,813	$ 14,646,003	$ 14,222,774	$ 11,611,179	$ 12,841,431	$ 16,162,029	$ 16,377,603	$ 8,561,525	$ 10,815,311
011	$ 3,093,966	$ 3,227,203	$ 2,465,129	$ 2,730,107	$ 2,460,337	$ 2,371,383	$ 3,266,394	$ 3,698,126	$ 1,583,525	$ 2,568,186
021	$ 101,967	$ 92,290	$ 82,229	$ 81,444	$ 69,248	$ 82,237	$ 87,430			
023	$ 105,614	$ 65,366	$ 51,034	$ 57,250	$ 58,602	$ 101,281	$ 113,314	$ 95,281	$ 38,811	$ 29,369
026	$ 55,443	$ 9,870								
031	$ 26,106,849	$ 23,320,832	$ 21,572,773	$ 21,276,762	$ 17,186,612	$ 18,763,644	$ 19,998,192	$ 17,429,803	$ 8,487,718	$ 11,989,457
032	$ 3,941,745	$ 2,358,328	$ 1,640,523	$ 1,289,616	$ 865,976	$ 852,573	$ 887,549	$ 681,269	$ 331,630	$ 379,962
038										$ 38,051
035									$ 21,082	$ 30,021
052	$ 180,934	$ 119,473	$ 203,452	$ 115,870	$ 93,642	$ 71,237	$ 132,046	$ 64,126	$ 21,556	$ 18,110
055								$ 89,425	$ 41,805	$ 55,682
067	$ 17,232,813	$ 15,474,041	$ 15,815,478	$ 15,192,037	$ 11,624,705	$ 12,658,645	$ 13,922,436	$ 13,592,356	$ 6,925,763	$ 9,393,912
090	$ 165,092	$ 139,276	$ 124,663	$ 70,966	$ 69,784	$ 66,940	$ 81,584	$ 80,774	$ 40,467	$ 56,382
103	$ 555,045	$ 544,718	$ 451,262	$ 416,908	$ 329,765	$ 274,772	$ 728,021	$ 1,223,862	$ 685,782	$ 1,318,613
110	$ 26,465	$ 31,004	$ 35,085	$ 39,745	$ 37,335	$ 52,843	$ 75,359	$ 39,898	$ 1,291	$ 1,828
112	$ 253,378	$ 227,379	$ 180,419	$ 113,931	$ 96,636	$ 8,661	$ 10,064	$ 9,573	$ 4,995	$ 7,076
113				$ 2,434	$ 8,969	$ 10,868	$ 15,394	$ 17,432	$ 7,030	$ 12,350
118			$ 7,157			$ 18,269	$ 9,171	$ 8,738	$ 8,918	$ 12,657
121	$ 882,765	$ 776,633	$ 678,834	$ 678,970	$ 549,636	$ 491,566	$ 515,043	$ 453,844	$ 291,794	$ 573,243
124	$ 1,147,023	$ 916,065	$ 885,896	$ 830,255	$ 678,519	$ 788,364	$ 830,074	$ 783,419	$ 372,965	$ 506,006
127	$ 233,085	$ 242,147	$ 331,553	$ 360,052	$ 316,702	$ 376,394	$ 246,674	$ 541,576	$ 612,369	$ 877,141
129	$ 7,285,274	$ 5,986,165	$ 5,249,232	$ 5,348,398	$ 4,152,203	$ 4,358,661	$ 3,053,635	$ 4,457,342	$ 2,224,673	$ 2,876,532
130	$ 39					$ 19,970	$ 74,714	$ 43,833	$ 6,162	$ 13
137	$ 156,052	$ 136,705	$ 118,536	$ 118,127	$ 79,619	$ 95,517	$ 114,141	$ 277,059	$ 145,743	$ 194,690
138	$ 589,153	$ 616,309	$ 596,813	$ 717,329	$ 767,426	$ 745,968	$ 850,573	$ 934,886	$ 499,036	$ 747,582
139	$ 163,506	$ 149,005	$ 56,086							
144	$ 20,326,526	$ 18,699,003	$ 16,864,194	$ 18,023,412	$ 15,900,663	$ 18,959,261	$ 23,526,444	$ 22,370,249	$ 11,596,095	$ 16,991,049
145	$ 4,064,368	$ 4,095,438	$ 4,092,878	$ 4,162,160	$ 3,679,225	$ 4,749,814	$ 5,422,506	$ 5,133,278	$ 2,770,370	$ 2,944,021
155	$ 15,193,657	$ 15,775,505	$ 14,724,440	$ 14,960,854	$ 12,384,028	$ 13,824,304	$ 15,925,204	$ 15,438,241	$ 8,138,205	$ 11,681,820
156	$ 10,557,816	$ 8,189,173	$ 10,275,742	$ 9,119,695	$ 7,134,927	$ 7,930,512	$ 8,659,201	$ 7,591,294	$ 5,167,447	$ 5,545,345
162	$ 90,671	$ 53,423	$ 36,978	$ 17,535	$ 17,843	$ 69,802	$ 120,908	$ 118,044	$ 80,361	$ 170,180
165			$ 184	$ 22,085	$ 198,288	$ 259,445	$ 272,372	$ 76,617	$ 69,798	$ 78,422
169				$ 4,180						
173							$ 1,242			$ 416,185
179	$ 176,742	$ 79,223	$ 37,368	$ 36,539	$ 30,926	$ 35,611	$ 35,955	$ 33,506	$ 17,254	$ 10,485
182	$ 11,369	$ 4,368								
186	$ 147,557	$ 147,828	$ 113,095	$ 105,611	$ 60,230	$ 34,101	$ 22,421			
191	$ 92,138	$ 54,711	$ 20,188							
194	$ 552,999	$ 113,328	$ 21,707	$ 106,244	$ 94,753	$ 48,581	$ 11,573	$ 10,750	$ 6,430	$ 6,145
196	$ 1,338,800	$ 1,152,322	$ 1,260,810	$ 1,186,669	$ 1,061,362	$ 979,269	$ 1,038,089	$ 898,586	$ 424,731	$ 434,516
197	$ 6,000,516	$ 5,680,051	$ 4,926,472	$ 4,957,888	$ 4,277,301	$ 5,610,095	$ 6,872,008	$ 5,961,363	$ 2,984,350	$ 5,295,426
198	$ 8,144	$ 6,734	$ 6,218	$ 76,675	$ 74,078	$ 103,003	$ 118,884			
199	$ 4,568,319	$ 4,774,694	$ 4,587,769	$ 4,849,906	$ 4,066,367	$ 4,610,605	$ 5,392,354	$ 5,329,961	$ 2,901,439	$ 4,253,496
200	$ 905	$ 241								

Assessments Remitted by Commercial Carrier for 2007 - 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Carrier Code	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
202	$ 9,201,173	$ 8,573,179	$ 7,791,910	$ 8,064,521	$ 6,638,291	$ 6,456,603	$ 7,752,483			
203	$ 1,530,507	$ 1,304,080	$ 1,294,032	$ 1,369,529	$ 1,317,844	$ 1,324,129	$ 1,747,218	$ 1,794,879	$ 933,125	$ 1,420,152
206	$ 50,555	$ 41,631	$ 54,164	$ 24,312	$ 28,762	$ 23,432				
207	$ 21,058,161	$ 20,761,244	$ 19,085,429	$ 14,794,610	$ 12,769,476	$ 14,147,817	$ 15,991,773	$ 15,281,398	$ 6,676,570	$ 9,736,899
208	$ 2,582,444	$ 2,051,039	$ 1,869,269	$ 1,970,116	$ 1,669,532	$ 1,862,098	$ 2,125,547	$ 2,035,408	$ 1,045,619	$ 1,276,096
210	$ 407,700	$ 567,407	$ 788,053	$ 879,944	$ 895,795	$ 1,574,771	$ 901,695	$ 892,473	$ 444,525	$ 124,384
211	$ 9,471,696	$ 9,612,577	$ 8,350,530	$ 8,935,740	$ 6,967,934	$ 7,627,800	$ 8,661,482	$ 7,357,394	$ 1,548,641	$ -
212	$ 214,146	$ 197,423	$ 185,955	$ 199,165	$ 234,820	$ 269,253	$ 392,633	$ 649,432	$ 427,673	$ 769,857
215	$ 60,933									
216	$ 10,985	$ 7,052	$ 7,039	$ 7,392	$ 5,448	$ 5,644	$ 6,893			
217	$ 514,874	$ 459,023	$ 384,630	$ 357,590	$ 288,634	$ 332,970	$ 378,859	$ 292,845	$ 145,666	$ 246,912
218	$ 241,409	$ 232,387	$ 258,318	$ 285,174	$ 259,598	$ 297,256	$ 385,246	$ 369,694	$ 208,964	$ 304,410
219	$ 5,489,265	$ 5,219,972	$ 4,347,059	$ 3,992,115	$ 3,348,451	$ 3,505,084	$ 4,236,274	$ 3,809,573	$ 2,013,611	$ 2,756,857
220	$ 2,192,072	$ 2,103,498	$ 2,087,079	$ 2,061,850	$ 1,779,618	$ 2,194,540	$ 1,873,290	$ 1,369,254	$ 450,873	$ 627,112
221	$ 6,094,179	$ 4,865,330	$ 4,409,132	$ 4,457,088	$ 3,369,688	$ 3,473,170	$ 4,345,005	$ 4,468,454	$ 2,416,512	$ 2,214,798
222	$ 3,663,769	$ 3,497,115	$ 3,299,424	$ 3,455,919	$ 3,071,859	$ 3,603,862	$ 4,552,606	$ 4,717,641	$ 2,585,657	$ 3,653,716
223	$ 3,967,074	$ 3,849,643	$ 3,500,761	$ 3,420,200	$ 680,542	$ 5,717,928	$ 3,790,788	$ 3,743,490	$ 2,111,663	$ 3,116,060
224	$ 1,903,762	$ 1,815,565	$ 1,714,821	$ 1,771,228	$ 1,537,149	$ 1,890,197	$ 2,297,211	$ 2,551,243	$ 1,507,942	$ 2,338,699
225	$ 48,129	$ 48,020	$ 47,223	$ 55,395	$ 58,234	$ 70,114	$ 80,901	$ 77,034	$ 40,020	
226	$ 96,197	$ 90,967	$ 82,373	$ 81,390	$ 64,177	$ 75,865	$ 77,175	$ 75,123	$ 39,308	$ 1,151
227	$ 4,010	$ 3,675	$ 3,338	$ 3,360	$ 2,755	$ 3,225				
228	$ 1,768,490	$ 1,703,895	$ 1,605,407	$ 1,633,760	$ 1,297,886	$ 1,470,236	$ 1,052,576			
229	$ 3,752,155	$ 2,422,927	$ 2,324							
230	$ 15,416	$ 22,103	$ 20,715	$ 20,859	$ 7,414					
232	$ 54,951	$ 32,884	$ 60,383	$ 101,537	$ 124,590	$ 122,349	$ 136,670	$ 201,846	$ 152,450	$ 190,474
233	$ 43,869	$ 4,592	$ 617	$ 119	$ 1,339	$ 1,504				
234	$ 219,645	$ 211,825	$ 225,656	$ 211,684	$ 171,751	$ 196,256	$ 217,077	$ 226,606	$ 128,959	$ 171,953
235	$ 86,273	$ 81,046	$ 73,644	$ 73,290	$ 60,010	$ 69,698	$ 81,258	$ 76,906	$ 39,742	$ 57,102
236	$ 59,594	$ 49,931	$ 77,890	$ 53,065	$ 14,613	$ 17,106	$ 36,456	$ 58,055	$ 28,097	$ 17,643
237	$ 6,774	$ 25,463	$ 37,613	$ 18,081	$ 37,038	$ 20,319	$ 21,057	$ 18,694	$ 10,590	$ 17,505
239	$ 2,850,125	$ 2,862,069	$ 2,544,367	$ 2,501,619	$ 2,327,394	$ 2,308,816	$ 2,282,374	$ 2,321,286	$ 1,431,417	$ 2,082,214
241	$ 1,112,562	$ 1,011,930	$ 927,277	$ 936,689	$ 780,430	$ 841,842	$ 973,242	$ 973,897	$ 485,036	$ 774,617
242	$ 43,943	$ 41,115	$ 37,341	$ 37,599	$ 30,820	$ 36,079	$ 41,922	$ 39,879	$ 20,806	$ 29,476
243	$ 32,439	$ 30,088	$ 26,843	$ 23,892	$ 19,320	$ 22,679	$ 26,343	$ 26,156	$ 13,873	$ 21,363
244	$ 82,420	$ 104,665	$ 93,843	$ 92,656	$ 73,106	$ 43,307	$ 56,157	$ 67,363	$ 36,284	$ 5,652
245	$ 5,505,853	$ 5,229,282	$ 5,082,741	$ 5,428,849	$ 4,995,186	$ 6,501,002	$ 7,878,484	$ 7,923,310	$ 4,526,579	$ 7,065,805
246	$ 3,017,049	$ 2,872,355	$ 2,398,723	$ 2,154,129	$ 1,663,726	$ 1,726,585	$ 1,960,684	$ 610,356		
247	$ 100,909	$ 98,780	$ 25,672	$ 33,807	$ 30,579	$ 41,704	$ 108,481	$ 56,497	$ 36,357	$ 57,978
248	$ 472,406	$ 375,191	$ 302,166	$ 314,244	$ 289,671	$ 370,397	$ 443,530	$ 405,018	$ 209,820	$ 81,999
249	$ 1,584	$ 11,495	$ 11,427	$ 21,289	$ 15,689	$ 14,768	$ 22,767	$ 6,897	$ 4,692	
250	$ 657,154	$ 612,257	$ 549,842	$ 482,819	$ 51,022					
251	$ 285,173	$ 178,568	$ 73,792	$ 53,983	$ 44,006					
252	$ 100,293	$ 84,861	$ 78,382	$ 67,892	$ 53,245	$ 54,800	$ 58,348	$ 20,063	$ 10,632	$ 14,341
253	$ 4,207,896	$ 4,117,837	$ 3,963,999	$ 4,120,407	$ 3,483,392	$ 4,130,535	$ 4,779,252	$ 4,570,871	$ 2,265,885	$ 3,217,234
257	$ 35,491	$ 35,638	$ 69,671	$ 48,673	$ 38,693	$ 17,602				

Assessments Remitted by Commercial Carrier for 2007 - 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Carrier Code	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
258	$ 2,916,917	$ 2,594,752	$ 2,105,917	$ 1,916,725	$ 1,591,372	$ 1,686,363	$ 1,780,722	$ 1,509,318	$ 768,068	$ 950,220
261	$ 1,305,617	$ 1,225,646	$ 1,326,180	$ 1,196,930	$ 1,282,512	$ 1,179,904	$ 981,214	$ 858,942	$ 459,688	$ 678,861
262	$ 24,994	$ 21,229	$ 26,752	$ 33,772	$ 36,892	$ 62,788	$ 68,836	$ 59,488	$ 25,076	$ 28,240
263			$ 3,080							
264	$ 2,692	$ 1,161	$ 1,075	$ 920	$ 949	$ 1,066	$ 1,308	$ 1,207	$ 630	
265	$ 107,210	$ 104,788	$ 28,958	$ 13,756	$ 66,711	$ 140,669	$ 146,164	$ 138,607	$ 70,576	$ 119,691
266	$ 45,041	$ 23,553	$ 21,106	$ 21,252	$ 31,786	$ 33,962	$ 46,564	$ 44,295	$ 1,675	$ 2,374
267	$ 970	$ 1,038	$ 536	$ 573	$ 470	$ 633	$ 807	$ 741	$ 387	
268	$ 7,111	$ 6,439	$ 5,204	$ 1,752	$ 1,674	$ 2,043				
271	$ 445,181	$ 957,861	$ 1,670,604	$ 2,509,786	$ 2,162,136	$ 2,508,055	$ 2,533,312	$ 4,155,039	$ 2,547,912	$ 1,648,867
272	$ 7,177	$ 8,822								
274	$ 211,445	$ 174,291	$ 164,117	$ 181,037	$ 145,726	$ 175,616	$ 193,020	$ 167,227	$ 85,539	$ 110,739
275	$ 611,980	$ 539,368	$ 471,145	$ 551,696	$ 401,488	$ 544,901	$ 18,100	$ 21,501	$ 33,860	$ 24,131
276	$ 672,192	$ 598,144	$ 538,114	$ 538,184	$ 437,079	$ 512,402	$ 597,451	$ 563,886	$ 290,947	$ 398,471
277				$ 31,687	$ 59,623	$ 77,756	$ 89,387	$ 139,269	$ 90,233	$ 33,647
278		$ 566								
279	$ 175,728	$ 228,393	$ 216,826	$ 540,063	$ 470,105	$ 593,152	$ 563,997	$ 136,277		
281	$ 1,176	$ 943	$ 949							
282	$ 51,329	$ 67,019	$ 70,584	$ 41,605	$ 24,332					
285		$ 98,668	$ 273,106	$ 420,044	$ 281,021					
286		$ 38,594	$ 50,081	$ 78,039	$ 119,105	$ 157,730	$ 120,817	$ 124,559	$ 80,648	$ 103,615
287		$ 28,721								
289				$ 13,782	$ 11,298	$ 59,699	$ 74,364	$ 55,565	$ 31,858	$ 63,191
290		$ 3,929	$ 113,197	$ 64,152	$ 59,224	$ 64,324	$ 76,356	$ 74,558	$ 39,054	$ 55,670
291						$ 19,927	$ 5,520			
292	$ 286		$ 37,934	$ 11,491	$ 13,718	$ 71,920	$ 7,992	$ 20,418	$ 4,999	$ 6,354
293			$ 50,314	$ 53,367	$ 46,060	$ 47,614	$ 21,814	$ 17,178	$ 7,252	$ 843
294			$ 2,944	$ 7,299	$ 5,982	$ 4,734	$ 1,813	$ 3,472	$ 4,032	$ 4,814
296	$ 3,048	$ 4,270	$ 2,682	$ 2,814	$ 7,908	$ 2,797	$ 3,324	$ 3,449	$ 1,799	$ 2,549
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
303				$ 19,540	$ 29,308	$ 30,070	$ 40,121	$ 48,304	$ 27,066	$ 33,720
305			$ 2,678	$ 45,945	$ 38,857	$ 36,547	$ 39,130			
307				$ 1,272	$ 1,147	$ 2,633	$ 3,155	$ 7,208	$ 4,005	$ 5,473
308				$ 360,392	$ 568,835	$ 791,283	$ 1,082,553	$ 525,390	$ 579,823	$ 90,166
309								$ 4,675	$ 2,439	$ 112,755
310			$ 6,264	$ 4,765,557	$ 3,871,097	$ 5,288,515	$ 5,789,251	$ 5,486,924	$ 3,121,444	$ 4,593,505
312						$ 34,459	$ 20,797	$ 25,161	$ 32,280	$ 25,084
313			$ 572	$ 882	$ 723	$ 904	$ 1,242	$ 1,140	$ 595	$ 843
314				$ 25,112	$ 43,592	$ 107,938	$ 121,336	$ 218,223	$ 112,271	$ 131,407
315				$ 53,824	$ 44,083	$ 41,374	$ 52,256	$ 43,491	$ 8,309	$ 22,633
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

Assessments Remitted by Commercial Carrier for 2007 - 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Carrier Code	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
322					$ 5,224	$ 30,874	$ 45,692	$ 22,319	$ 8,879	$ 76,437
323						$ 62,024	$ 64,842			
324		$ 2,041	$ 408			$ 25,623	$ 32,452	$ 29,512	$ 99,264	$ 1,072,828
325						$ 20	$ 31,562	$ 47,118	$ 36,088	$ 53,300
326						$ 9,404	$ 54,729	$ 71,617	$ 50,146	$ 70,471
327							$ 179,962	$ 47,961	$ 22,241	$ 33,635
328						$ 330	$ 595,609	$ 503,488	$ 263,617	$ 391,495
329						$ 97,845	$ 128,862	$ 164,086	$ 172,805	$ 93,961
330						$ 502	$ 461,626	$ 479,291	$ 76,662	$ 107,276
331							$ 548,451	$ 79,176	$ 52,334	$ 39,505
332					$ 20	$ 735		$ 4,942		$ 3,162
333							$ 213,686	$ 597,202	$ 267,156	$ 40,969
334							$ 229,235	$ 601,547	$ 300,039	$ 267,500
335									$ 2,245	$ 10,222
336							$ 3,747	$ 3,564	$ 1,860	
338					$ 4,676	$ 31,297	$ 1,692,410	$ 6,892,644	$ 4,330,983	$ 6,318,380
339							$ 24,230	$ 16,187		
340							$ 161	$ 60,581	$ 28,454	$ 51,229
341								$ 1,404,521	$ 783,310	$ 1,176,491
342								$ 2,391	$ 5,095	$ 7,217
343								$ 14,795	$ 9,012	$ 12,767
344								$ 2,944		
345							$ 3,101	$ 2,074		$ 12,417
346									$ 26,462	$ 55,783
347									$ 15,377	$ 120,802
348									$ 3,233	$ 6,558
349								$ 836	$ 56,199	$ 28,846
350									$ 18,350	$ 369,683
351									$ 2,489,385	$ 4,250,656
353										$ 30,991
354										$ 218,822
355										$ 1,991,836
900	$ 5,337	$ 3,242	$ 6,278	$ 2,428	$ 1,486	$ 1,032				
Totals	$ 241,664,685	$ 223,717,689	$ 207,265,164	$ 209,471,367	$ 172,704,786	$ 199,832,265	$ 227,540,336	$ 216,534,558	$ 114,658,613	$ 158,930,166

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 15, 2017.

PA Insurance Department

Mcare Fund

Assessments Remitted by Self-Insurer for 2007 - 2016

Carrier	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
S10	$ 4,692,818	$ 4,515,980	$ 4,401,573	$ 4,581,217	$ 3,845,277	$ 3,925,897	$ 5,086,715	$ 4,883,058	$ 2,596,208	
S12	$ 1,579,563	$ 1,533,370	$ 1,442,094	$ 1,497,885	$ 1,447,174	$ 1,701,974	$ 2,119,427	$ 2,127,528	$ 1,095,316	$ 1,715,808
S34	$ 149,334									
S40	$ 425,328	$ 405,479	$ 398,985	$ 422,801	$ 320,702	$ 408,489	$ 536,411	$ 548,490	$ 290,537	$ 444,644
S41	$ 102,625	$ 98,300	$ 84,109	$ 75,339	$ 61,967	$ 68,635	$ 75,056	$ 77,831	$ 40,570	$ 58,952
S43	$ 201,996	$ 276,166	$ 265,791							
S46	$ 14,279	$ 12,820	$ 11,331							
S47	$ 145,913	$ 135,249								
S49	$ 790,576	$ 778,995	$ 661,673	$ 639,358	$ 515,432					
S51	$ 713,553	$ 687,254	$ 661,708	$ 540,122	$ 291,594					
S53	$ 340,490	$ 201,167	$ 190,741	$ 182,191	$ 76,434					
S54	$ 367,418	$ 340,441	$ 343,321	$ 372,268	$ 342,107	$ 393,845	$ 483,422	$ 455,435	$ 260,698	$ 411,462
S57	$ 63,396	$ 55,414	$ 49,877	$ 52,078	$ 39,633	$ 21,273				
S58	$ 17,387	$ 12,503	$ 13,637	$ 16,372	$ 10,656	$ 12,482	$ 15,481	$ 15,492	$ 8,881	$ 9,245
S59	$ 27,285	$ 24,514	$ 22,223	$ 11,932						
S60	$ 459,988	$ 412,089	$ 419,605	$ 399,292	$ 387,342	$ 480,035	$ 545,819	$ 538,398	$ 307,303	$ 185,366
S61	$ 13,766	$ 12,516	$ 11,367	$ 11,445	$ 9,306	$ 10,805	$ 12,555	$ 11,943	$ 6,231	$ 8,900
S62	$ 387,338	$ 806,096								
S63	$ 269,323	$ 285,887	$ 250,675	$ 244,193	$ 154,020	$ 178,381	$ 216,347	$ 216,499	$ 67,749	
S64	$ 18,134	$ 16,912	$ 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
S68								$ 1,586,950	$ 843,002	$ 1,136,423
S69										$ 4,201,956
Totals	$ 10,780,510	$ 10,611,152	$ 9,711,303	$ 9,064,696	$ 7,528,664	$ 7,226,221	$ 9,119,293	$ 10,488,416	$ 5,525,129	$ 8,197,527

[1] The "Amount" is based on the gross rated undiscounted assessment remitted and processed as of February 15, 2017.

PA Department of Insurance

Mcare Fund

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

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Total Annual Count of Unique Providers
2007	37,981	1,110	267	227	716	4	4	40,309
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	40,339	1,162	271	223	702	5	4	42,706
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	43,295	1,239	315	223	690	5	6	45,773
2015	43,715	1,233	321	221	687	5	5	46,187
*2016	42,192	1,148	302	211	673	5	5	44,536

*Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2017. Coverage for policies that has been reported and processed as of February 14, 2017 is included in the counts.

Appendix D

www.pwc.com

Pennsylvania medical care availability and reduction of error fund

Estimation of 12/31/2015 unfunded liability and future years' claims payments pursuant to Act 13 of 2002

Philadelphia, PA

June 22, 2016

Appendix D.1

Mr. Theodore Otto
Executive Director
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, Pennsylvania 17102

Dear Mr. Otto:

Enclosed is our report on the Fund's unpaid claim liabilities as of December 31, 2015. We appreciate the assistance provided by the Mcare team throughout the course of our analysis, and look forward to working with you in the future.

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

Sincerely,

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

Timothy Landick
Principal
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

Enclosure

cc: Laura Lyon Slaymaker, Deputy Insurance Commissioner

PricewaterhouseCoopers LLP, 2 Commerce Square, Suite 1800, 2001 Market Street, Philadelphia, PA 19103-7042
T: (267) 330 3000, F:(267) 330 3300, www.pwc.com/us

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Introduction

Background

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

The Fund currently provides excess coverage (to varying historical limits) for health care providers that have exhausted their primary limits (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[2]). The historical mandatory primary and Fund limits of medical malpractice coverage (000's) are included in the following table:

Policy year effective	Mandatory primary occ / agg limits		Mcare fund excess occ / agg limits	Section 605/715 limits[3]
	Hospital	Physician		
1996 & Prior	200 / 1,000	200 / 600	1,000 / 3,000	1,000
1997 & 1998	300 / 1,500	300 / 900	900 / 2,700	1,000
1999 & 2000	400 / 2,000	400 / 1,200	800 / 2,400	1,000
2001 & 2002	500 / 2,500	500 / 1,500	700 / 2,100	1,000
2003 - 2005	500 / 2,500	500 / 1,500	500 / 1,500	1,000
2006 - 2015	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)

The mandatory primary coverage limits may increase in the future (with corresponding decreases in the Fund coverage limits), subject to the Commissioner's assessment of basic insurance coverage capacity. The estimates contained herein assume that basic coverage limits increase in 2018 and 2021, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2021. The limits of insurance assumed herein are shown in the table on the following page (000's).

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

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

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

Policy year effective	Mandatory primary occ / agg limits		Mcare fund excess occ / agg limits	Section 605 / 715 limits
	Hospital	Physician		
2016 - 2017	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)
2018 - 2020	750 / 3,750	750 / 2,250	250 / 750	250 (excess)
2021 & Sub	1,000 / 4,500	1,000 / 3,000	0 / 0	0

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

i. Reimburse the Fund for the payment of reported claims which became final during the preceding claims period[4];
ii. Pay expenses of the Fund incurred during the preceding claims period;
iii. Pay principal and interest on moneys transferred into the Fund; and
iv. Provide a reserve that shall be 10% of the sum of (i), (ii), and (iii) above.

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 (i) through (iv) above[5]. 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[6]; however, the Fund does require regular actuarial evaluations of its projected unfunded liability.

PricewaterhouseCoopers LLP (PwC) was engaged to provide the Fund with an actuarial central estimate of its unpaid claims expense (i.e., the unfunded liability) as of December 31, 2015. This report is neither intended nor necessarily suitable for any other purpose. The estimates contained herein are meant to represent an expected value over the range of reasonably possible outcomes.

Distribution and use

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

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

[5] Per the "Settlement Agreement" effective October 3, 2014 between the Commonwealth of Pennsylvania and the "Petitioners" – the Hospital & Healthsystem Association of Pennsylvania ("HAP"), the Pennsylvania Medical Society ("PAMED"), and the Pennsylvania Podiatric Medical Association ("PPMA").

[6] In any given year, the Fund may have a shortage or an excess of assessments collected relative to the claims payments and operating costs for the year, resulting in corresponding year-end shortfall or surplus. The estimate of the unfunded liability contained herein includes no adjustment for the Fund's cumulative surplus of $28 million as of December 31, 2015.

Conditions and limitations

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

- By-claim information, including data such as: claim type (Excess[7] or Section 715), open date, claim status, coverage limit, breast implant/pedicle screw claims, "no exposure" claims, primary report date, Fund payment information, etc.;
- The Fund's interpretation of Act 13 provisions;
- Historical surcharge collections by policy type; and
- Information contained in PwC's previous estimates of the Fund's liability.

The calculations in this report rely on the accuracy of the paid loss and claim count data provided. We have not audited this data but have reviewed the data provided for reasonableness. Any changes to the data may require modification to the estimates in this report. In this report, paid loss and claim count triangles have been restated according to each claim's current status (e.g., Excess vs. Section 715) in order to provide for a historical database that is more reflective of the Fund's current procedures. The updated triangles were compared to last year's triangles for reasonableness and consistency; differences observed were not significant.[8]

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

The calculations in this report also rely on information provided by the Fund. Any changes to the data provided or in the application of legislation relative to the historical application may necessitate modification to the estimates in this report.

The projected ultimate losses, calendar year claims payments, and unfunded liability shown in this report are estimates and as such, are subject to variability. This variability arises from the fact that not all factors affecting the ultimate liability have taken place nor can they be evaluated with absolute certainty. Such factors include, but are not limited to, tort reform, expected future inflationary trends and jury awards. The absence of case reserve information may also subject our projections to a higher degree of uncertainty, as do the uncertain impacts associated with the Patient Protection and Affordable Care Act and recent changes to joint and several liability in Pennsylvania as a result of Senate Bill 1131. Our projection of liabilities is based on the Fund's historical payment experience, the projected effect of changes in the Fund's limits of coverage, and our estimate of the impact of changes in Pennsylvania-filed cases over time[9] on the Fund's claims obligations. We have not anticipated additional extraordinary changes to the various factors that might impact the future costs of claims. We have however used methods of estimating the unpaid claim liability that we believe produce reasonable results given current information. No guarantee, either expressed or implied, should be inferred that losses will develop as shown in this report. Furthermore, since the projections contained herein include projections of future years' incidents (i.e., incidents that will not occur until sometime in the future), the uncertainty surrounding these estimates is

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

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

[9] http://www.pacourts.us/assets/files/setting-2929/file-4474.pdf?cb=ac4839

significantly increased. The process of resolving medical malpractice claims, through both settlements and verdicts, is a fluid process that may change over time. Furthermore, changes in handling, processing, negotiating, adjudicating, or otherwise resolving these claims that tend to occur over time could influence the impact of these provisions.

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

The procedures performed throughout this engagement were advisory in nature and were performed under the American Academy of Actuaries Code of Professional Conduct and Actuarial Standards of Practice. The procedures performed did not constitute an audit, a review, examination, or other form of attestation or assurance as those terms are defined by the AICPA. Accordingly we do not express any form of assurance. Any use of the term "review" within this report should be interpreted in the common use of that term, and not in the definition of "review" promulgated by the AICPA. Also, this report/work product does not constitute a legal opinion or advice.

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.

Note that defense is provided by the primary insurers for those claims where the Fund's coverage is provided on an excess basis.

Reinsurance recoverables

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

Severity codes

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

Qualifications of PwC actuaries

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

Executive summary

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

Total unfunded liability

We estimate the Fund's unfunded liability as of December 31, 2015, excluding breast implant and pedicle screw exposure, to be approximately $1.00 billion. The estimates contained herein assume that basic coverage limits increase in 2018 and 2021, and that the Fund provides no "new" coverage beginning with policies issued or renewed in 2021. If the basic coverage limits are not increased in 2018 and 2021, Fund coverage will continue into and beyond 2022 and the total Fund payout (i.e., our estimates of the unfunded liability) would increase. We have not estimated the amount of the increase in the unfunded liability should the basic coverage limits not increase in 2018 and 2021.

During the course of our review, the Fund provided us with a projection of 2016 claim payments of approximately $165 million. We have incorporated this projected claim payment information into our estimate of the unfunded liability of $1.00 billion.

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

Fund / Accident Year	Jan-1 Unfunded Liability	Cost of New Covered Claims	Projected Claims Payments	Dec-31 Unfunded Liability
2015				1,003,086
2016	1,003,086	172,627	165,000	1,010,712
2017	1,010,712	152,067	180,000	982,780
2018	982,780	104,803	183,765	903,817
2019	903,817	74,438	181,678	796,577
2020	796,577	54,655	174,171	677,061
2021	677,061	12,772	156,676	533,157
2022	533,157		131,753	401,404
2023	401,404		106,054	295,349
2024	295,349		82,071	213,279
2025	213,279		59,213	154,065
2026	154,065		41,263	112,803
2027	112,803		29,446	83,357
2028	83,357		21,469	61,888
2029	61,888		15,904	45,984
2030	45,984		11,549	34,435
2031	34,435		8,450	25,985
2032	25,985		6,439	19,546
2033	19,546		4,867	14,680
2034	14,680		3,764	10,915
2035	10,915		2,973	7,942
2036	7,942		2,337	5,605
2037	5,605		1,769	3,837
2038	3,837		1,305	2,532
2039	2,532		921	1,611
2040	1,611		612	999
2041	999		388	611
2042	611		232	379
2043	379		127	252
2044	252		79	173
2045	173		55	119
2046	119		38	81
2047	81		28	53
2048	53		20	32
2049	32		13	20
2050	20		7	13
2051	13		5	7
2052	7		3	5
2053	5		1	4
2054	4		1	4
2055	4		0	3
2056	3		0	3
2057	3		0	2
2058	2		0	2
2059	2		0	1
2060	1		0	1
2061	1		0	1
2062	1		0	0
2063	0		0	0
2064	0		0	0
2065	0		0	0
		571,363	1,574,448	

Our projections of calendar year claims payments gives consideration to longer-term trends in claims payments, and the application of projected payment patterns to the projected unfunded liability resulted in an initial estimate of 2016 claims payments that is higher than the $165 million projection provided by the Fund. As such, we have adjusted our initial projected payout of the unfunded liability to reflect the Fund's projection of the 2016 payments of $165 million. We have also assumed that a reduced level of payments, as observed during recent years, will continue into 2017, and have adjusted the projected 2017 payments to $180 million, which falls between the Fund's expected 2016 payments of $165 million and our initial projection of the 2017 payments of $185 million (Summary Exhibit 8, Sheet 2 of Technical Appendix).

The adjusted payment pattern assumes that the recent decrease in payments has effectively "pushed" the projected payments out in time. As such, the projected 12/31/2015 unfunded liability is unchanged on a nominal basis, but the stream of payments and future years-ending unfunded liability differ as a result of this adjustment.

Separate projections of liability are performed for Philadelphia County and the remainder of the State (ROS), as well as for Excess and Section 715 claims, all excluding breast implant and pedicle screw claims. Our findings for the projections, separately for Excess and Section 715 claims, are discussed separately below.

Comparison to the projections as of 12/31/2014

The total expected unfunded liability of $1.00 billion has decreased 6.9% from our December 31, 2014 estimate of $1.08 billion. A roll-forward of the unfunded liability estimated as of December 31, 2014 to December 31, 2015 is shown in the following table.

Roll-forward of Estimated Unfunded Liability (000's) from 12/31/2014 to 12/31/2015

		Excess	Section 715		Total
(1)	Prior Estimated Liability	894,318	183,385		1,077,703
(2)	Less Prior Estimated DD & PJI	8,855	1,816		10,670
(3)	Prior Estimated Liability Ex. DD & PJI	885,463	181,569		1,067,032
(4)	Plus Change in Prior Accident Year Ultimate	(77,609)	(22,426)		(100,035)
(5)	Less Paid During Year	143,249	16,723		159,972
(6)	Plus Accident Year 2015 Ultimate	173,833	12,296	(a)	186,129
(7)	Current Estimated Liability Ex. DD & PJI	838,438	154,716		993,154
(8)	Current Estimated DD & PJI	8,384	1,547		9,932
(9)	Current Estimated Liability	846,822	156,263		1,003,086

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

During the year, we continued to observe favorable emergence in our projections for both excess and Section 715 claims driven in part by the beneficial impact of Act 13 legislation. Based on information gathered by the Administrative Office of Pennsylvania Courts (AOPC), the number of medical malpractice cases filed in Pennsylvania in recent post-Act 13 years (2003 and subsequent) is significantly lower than pre-Act 13 experience (2000/2001). The Fund has also experienced a reduction in the number of claims that are closing with payment. Given the consistency and persistency of the reduction in cases filed observed by the AOPC and in the number of claims closed with payment by the Fund, we have included an explicit adjustment to recognize these anticipated savings within our estimates. Further discussion is included in the *Reduction in Claim Activity* section below.

The following table summarizes the changes in our ultimate loss projections since the prior valuation.

Fund / Accident Year	Current Selected Ultimate	Prior Selected Ultimate	Change in Selection
1976	47,637,682	47,647,996	(10,314)
1977	59,955,048	59,968,254	(13,206)
1978	86,363,880	86,372,746	(8,866)
1979	98,718,247	98,727,133	(8,886)
1980	135,897,686	135,904,167	(6,481)
1981	150,565,949	150,580,853	(14,904)
1982	173,501,731	173,512,162	(10,431)
1983	178,253,149	178,291,628	(38,479)
1984	166,183,154	166,223,927	(40,773)
1985	178,944,794	178,994,556	(49,762)
1986	171,360,649	171,415,364	(54,715)
1987	196,286,499	196,354,080	(67,581)
1988	215,712,711	215,786,366	(73,655)
1989	215,699,661	215,779,980	(80,319)
1990	255,758,142	255,852,272	(94,130)
1991	294,668,485	294,870,147	(201,662)
1992	269,714,926	269,913,314	(198,388)
1993	258,771,983	257,972,818	799,165
1994	293,618,652	294,151,430	(532,779)
1995	321,883,362	322,782,641	(899,279)
1996	309,419,628	306,943,117	2,476,512
1997	325,027,154	326,221,262	(1,194,108)
1998	300,140,895	302,101,076	(1,960,181)
1999	229,739,764	230,786,724	(1,046,960)
2000	231,564,950	231,997,633	(432,683)
2001	197,896,994	199,128,780	(1,231,786)
2002	149,328,808	150,848,258	(1,519,450)
2003	164,779,463	167,821,279	(3,041,816)
2004	148,296,335	150,819,082	(2,522,747)
2005	162,901,264	161,604,564	1,296,700
2006	135,625,322	136,256,049	(630,728)
2007	170,124,194	172,515,538	(2,391,344)
2008	160,106,554	163,670,376	(3,563,822)
2009	158,968,130	166,628,068	(7,659,938)
2010	160,787,608	171,020,738	(10,233,130)
2011	172,000,390	181,164,583	(9,164,193)
2012	172,974,129	188,722,744	(15,748,616)
2013	180,902,959	198,523,999	(17,621,041)
2014	185,367,076	207,607,793	(22,240,717)
Total	7,485,448,007	7,585,483,496	(100,035,489)

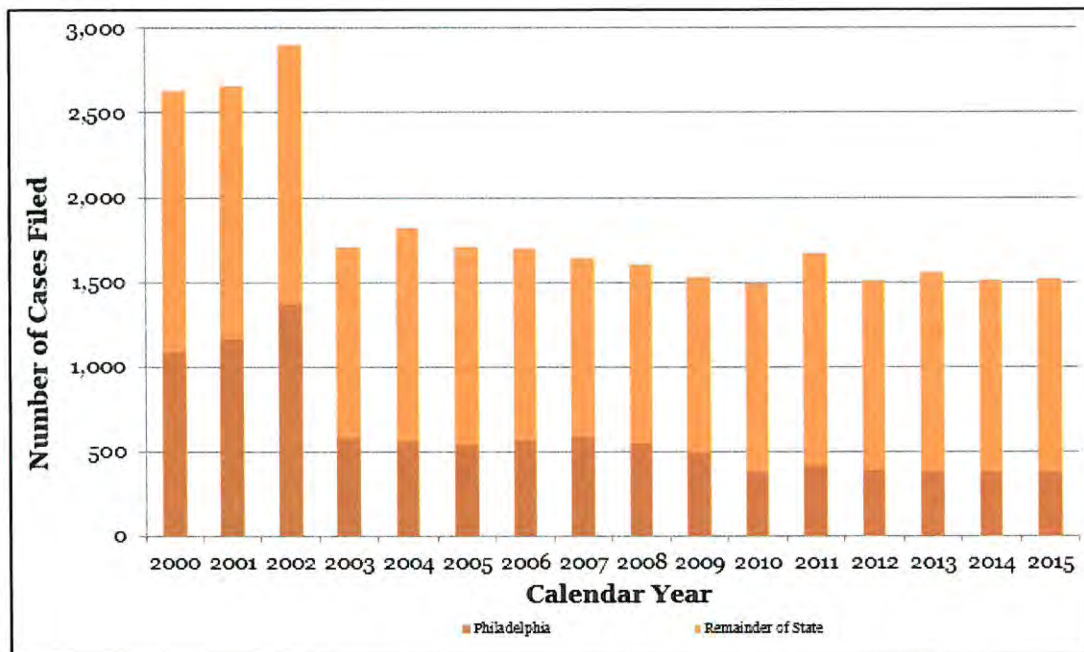
Within our unfunded liability report as of December 31, 2014, we assumed that basic insurance limits would increase from $500,000 to $750,000 during calendar year 2018 and again from $750,000 to $1,000,000 in 2021. As noted above, the estimates herein assume that basic insurance limits will increase in the same fashion, thus the change in ultimate losses shown above are on the same limits basis.

Reduction in claim activity

Information collected by the Administrative Office of Pennsylvania Courts (AOPC) indicates that there has been a reduction in claims filed during 2003 through 2015 as compared to the pre-Act 13 years 2000 through 2001, with particular concentration in Philadelphia County. The average statewide decrease in cases filed is approximately 45%, with Philadelphia County experiencing an average decrease of approximately 65% and ROS experiencing an average decrease of approximately 25%, as shown below:

Number of cases filed per year

Based on Administrative Office of PA Courts (AOPC) Information

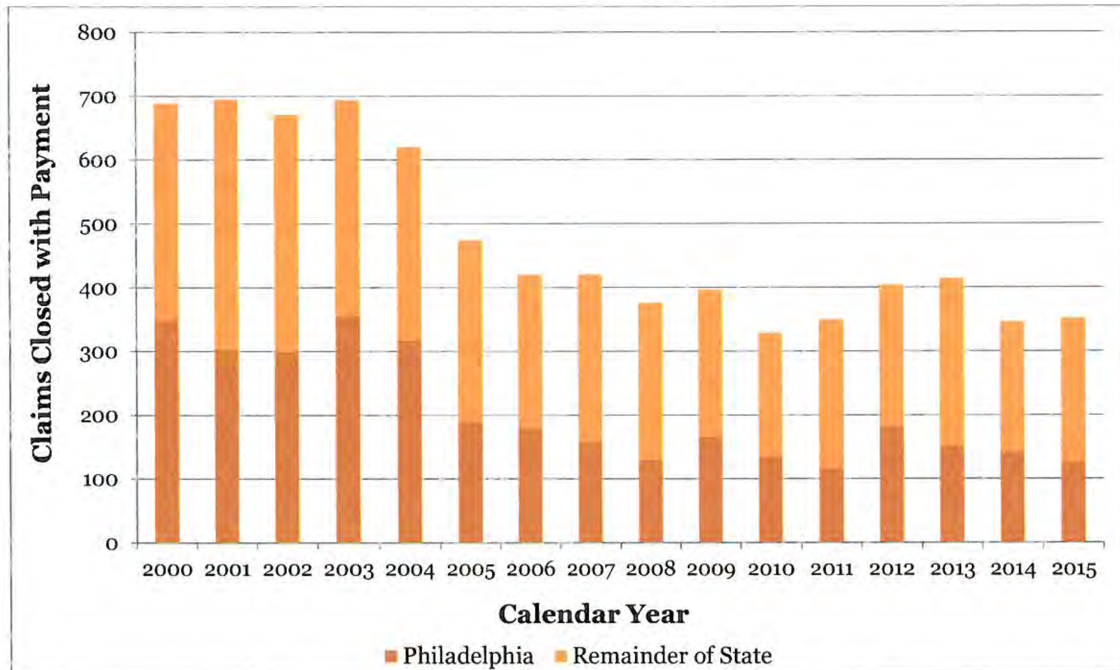


Possible causes for the decrease in claims activity for post-Act 13 years include venue reform (Section 3 of Act 27 of 2002), certificate of merit procedures (Rule of Civil Procedure 1042.3, 2003), and changes in social attitudes toward compensability of medical malpractice. Furthermore, the reduced number of case filings, with a particular concentration in Philadelphia County, is likely a combination of some cases that would have been brought in Philadelphia previously that are now being brought outside Philadelphia (as a result of venue reform) or not at all.

Closed-with-payment Fund claim statistics corroborate the information observed by the AOPC, allowing for a time delay between case filing and claim payment. Namely, the number of Fund claims closing with payment fell dramatically in 2005 through 2015 as compared to calendar years 2000 through 2004. The average statewide decrease in claims closed with payment is approximately 40%, with Philadelphia County experiencing an average decrease of approximately 50% and ROS experiencing an average decrease of approximately 30%, as shown below:

Mcare fund - Closed with payment claims by calendar year

Total Excess and Section 715 Claims



The data compiled by the AOPC and recent Fund claims payment activity are indicative of savings to be realized by the Fund. We reviewed the Fund closed-with-payment activity, making adjustments to reflect the expected effect of changes in the Fund limits of coverage over time for Excess claims. Based on this review, as well as in consideration of the AOPC data and our prior projections, we included an "AOPC Credit" of 37% and 65% within our Philadelphia projections for Excess claims and Section 715 claims, respectively, and an "AOPC Credit" of 1% and 25% within our ROS projections for Excess claims and Section 715 claims, respectively. These AOPC credits are consistent with those used in our prior projections.

Other legislative provisions

Other legislative provisions contained in Act 13 and Act 135 not specifically mentioned above may have an impact on the Fund's obligations. These other provisions include Patient Safety initiatives (Chapter 3 of Act 13), Remittitur (Section 515 of Act 13), Statute of Repose (Section 513 of Act 13), Collateral Sources (Section 508 of Act 13), Payment of Damages/Reduction to Present Value (Sections 509/510 of Act 13), and the "180-day rule" and "continuing course of treatment" provision (Act 135). Although the impact of these elements has not been explicitly estimated herein, these provisions have been in place for several years and our projections implicitly reflect the impact of these provisions.

Other elements of legislation are expected to have a less direct or less significant effect on the Fund's future payments, are more difficult to estimate, or lack sufficient information to actuarially quantify at this point in time, including but not limited to: potential impacts associated with the Patient Protection and Affordable Care Act and recent changes to joint and several liability in Pennsylvania as a result of Senate Bill 1131. The potential for future challenge and changes in interpretation by the courts contributes additional uncertainty to the estimates contained herein.

Analysis

Methodology

Our analysis of liabilities was completed separately for Excess claims and Section 715 claims. Supporting calculations are included in the Technical Appendix, Section 1 and Section 2, respectively. Within each section, separate projections are provided for Philadelphia and ROS, based on the venue county of the claim. Data was organized by year of occurrence. To estimate the unfunded liability as of 12/31/2015, losses paid to date are subtracted from the projected ultimate losses for accident periods 2015 and prior.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- First, an initial estimate of accident year 2015 loss is selected and adjusted to prior accident years for loss trend and changes in Fund attachments and limits. The estimated impact of the "AOPC Credit" is also considered in determining the initial estimates of accident year losses.
- Next, calendar year claim payments are estimated by applying the paid loss pattern underlying the paid loss development method to the estimate of ultimate loss by accident year calculated in the first step.
- Then, the projected calendar year claim payments from the second step are compared with the actual calendar year claim payments provided by the Fund.
- Finally, the process is repeated by adjusting the initial estimate of accident year 2015 loss until the projected calendar year claim payments equal the actual calendar year claim payments.

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

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

Selections (Exhibit 5, Sheet 3 [ROS] and Exhibit 13, Sheet 3 [Philadelphia])

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

Future year projections

The Fund is scheduled to provide coverage (to varying limits) for health care providers beyond 2015. Projections of Excess losses for future years 2016 through 2021 assume an underlying trend of 3.0% per annum at 2015 limits of coverage, based on the trend of projections for recent accident years. Projections of Section 715 losses for future years 2016 through 2021 assume an underlying pre-Act trend of 3.0% per annum at 2015 limits of coverage, based on the trend of projections for recent accident years. The overall trend in the projections of the future excess coverage provided by the Fund is approximately 3.0% per annum. These projections, and the resulting estimates adjusted for changes in the limits of coverage provided by the Fund, are shown in Exhibit 5, Sheet 2 (ROS) and Exhibit 13, Sheet 2 (Philadelphia).

The selected overall trend rate of 3.0% has decreased from the 4.0% assumption underlying our estimate of the unfunded liability as of December 31, 2014. The reduction of our prior assumption from 4% to 3% results from our observation that claim cost trends have been lower than 4% (generally, industry medical malpractice frequency trends have been flat or slightly negative and industry-wide severity trends have been 3-5% resulting from a low general inflationary environment).

Delay damages and post-judgment interest

Prior to Act 135 of 1996, delay damages and post-judgment interest were generally included within the limits of coverage provided by the Fund. Pursuant to Act 135, these costs are now shared with other carriers in proportion to the share of loss and outside the Fund limits of coverage. Data for recent calendar years indicate that Fund costs for delay damages and post-judgment interest have ranged from approximately 0.2% to approximately 2.0%. 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.

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End of Report