Medical Care Availability and
Reduction of Error Fund

2020

ANNUAL REPORT

pennsylvania
INSURANCE DEPARTMENT

March 1, 2021

Honorable John DiSanto, Chair
Banking and Insurance Committee
Senate of Pennsylvania
168 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, 2020.

Newly opened excess claims during the claims year 2020 were 2,676 compared to 2,952 in 2019. Total payments for claims finalized during claims year 2020 were $169 million as compared to $191 million for claims finalized in claims year 2019.

The annual actuarial study, prepared by an outside actuarial firm, concludes that an unfunded liability of $1.025 billion exists as of December 31, 2019. This amount is slightly higher over the prior year's estimate of $999 million.

If you have any questions about this report, please feel free to contact me, Deputy Insurance Commissioner Laura Slaymaker at 717-903-1823 or Mcare Executive Director Tawny Mummah at 717-350-5545.

Sincerely,

Jessica K. Altman
Insurance Commissioner

Enclosure

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I. Executive Summary

During 2020, 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 $169 million in covered medical malpractice claims. Mcare also communicated with insurers, self-insurers, and health care providers, about Mcare operations and the medical malpractice insurance market.

Key Accomplishments for 2020

Highly Efficient and Effective Transition to Remote Environment

Prior to the Governor's March 2020 Order for remote work, all Mcare operations were conducted within the physical office. A significant portion of the claims functions was in hard copy claims files and the operating system held file notes. The coverage, claims and fiscal processes quickly and efficiently transitioned to a remote environment using available software and technologies, including VPN connections. As a result, 98% of staff is seamless in all essential and secondary operations.

Transition to Virtual Dispute Resolution Methods

Mcare Claims Administration has been at the forefront of innovative Alternative Dispute Resolution (ADR) in catastrophic medical malpractice claims handling for the past 17 years. In 2020, Mcare once again lead the medical malpractice insurer and legal community by assisting in their acceptance of virtual environment meetings to conduct mediations and binding arbitration sessions for earlier resolution of cases. Mcare advocated for the use of Zoom and Microsoft Teams platforms and they were rapidly endorsed by mediators and arbitrators as dependable, effective, and secure ways to meet online as opposed to physical face-to-face negotiations.

Enhancements to Online Coverage Reporting Materials to Improve Efficiency and Accuracy

In 2020, Mcare released an updated e-216 form that included several revisions and user submission tools. The e-216 Review Tool performs a line by line completeness and accuracy check on the coverage entered in order to reduce the potential for inaccurate submissions that would create outstanding issues. Also, the e-216 Submit Tool reduces possible resubmissions by ensuring that the e-216 header is filled out completely, and it automatically generates an email to Mcare for ease of transmission. These enhancements were so impressive that they were chosen to be featured in the Office of Administration's December 2020 LEAN Showcase.

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 https://www.insurance.pa.gov/SpecialFunds/Pages/MCARE.

II. Mcare Background

A patient compensation fund has been part of the Commonwealth's medical malpractice insurance landscape since 1975. At that time, when insurers were seeking triple-digit rate increases or leaving the medical professional liability insurance market, the legislature developed a solution that required participating health care providers 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).

The CAT Fund legislation was repealed in 2002 by the Medical Care Availability and Reduction of Error (Mcare) Act ("Act 13 of 2002"), which created the Mcare Fund as a special fund within the Pennsylvania Insurance Department. Act 13 of 2002 mandates participation in Mcare for hospitals, nursing homes, birth centers, and primary health centers, and for licensed physicians, podiatrists and certified nurse midwives conducting 50% or more of their health care business within this Commonwealth. Most professional corporations, professional associations and partnerships owned entirely by health care providers may elect to insure their primary liability. If they elect to purchase primary coverage, then their participation in Mcare is mandatory.

Health care providers required to obtain excess professional liability coverage from Mcare must first obtain primary coverage from a Pennsylvania Insurance Department licensed primary insurer or approved self-insurance plan. The primary insurer invoices, collects and remits the assessment to Mcare on behalf of each health care provider they insure. The assessment paid to Mcare is a specified percentage of the prevailing primary premium (PPP) that the Pennsylvania Professional Liability Joint Underwriting Association (JUA) would have charged if each health care provider had obtained primary coverage from the JUA. This assessment percentage varies from year to year and is determined under a formula that considers the prior year's annual Mcare claim payments, annual operating expenses, a 10% buffer, any projected year-end balance, and whether Mcare has any loan repayment obligations.

While efforts began in the mid-1990s to phase-out Mcare's predecessor and have all mandatory professional liability coverage provided by medical malpractice insurance entities, this has not yet occurred. Pursuant to Act 13 of 2002, after a phase-out of Mcare, health care providers obligated to participate in Mcare would obtain 100% of their mandatory medical malpractice coverage from a private insurance entity, but still continue to pay annual Mcare assessments to pay for Mcare's incurred liabilities at the time of the phase-out (i.e., Mcare's unfunded liability or "tail"). In the past, Pennsylvania provider organizations have opposed stepping-up primary medical malpractice limits, as provided in Act 13 of 2002. In 2007 and 2008, they made their support of a step-up conditional on a commitment of public funds both to pay off Mcare's unfunded liabilities and to cap annual increases in private medical malpractice premium increases. The estimate of Mcare's unfunded liability was $1.025 billion as of December 31, 2019.

III. Mcare Financial Highlights

Appendix A contains Mcare's financial information. Appendix A.1 is the Mcare Cash Basis Statement of Operations as of December 31, 2020. The reporting is consistent with the assessment litigation settlement that required Mcare to separately account for the Reserve Fund. Mcare did not use any monies from the Reserve Fund to pay claims in 2020. The remaining Reserve Fund of $13,902,392 will continue to be separately accounted for and replenished only by the investment proceeds it generates. Excluding these funds, Mcare realized a calendar year 2020 balance of $13 million.

Appendix A.2 is the Mcare Summary of Financials from calendar years 2011 to 2020. This document reflects the volatility of Mcare's claims payments with a range of payments from $156 million in 2014 to $211 million in 2018. Decreases in claim payments of $38 million occurred between 2013 to 2014 and $42 million occurred between 2018 to 2020. Increases in claims payments of $26 million occurred between 2011 to 2012 and $30 million occurred between 2017 and 2018.

Additional information on Financials can be found in Appendix A.

IV. Mcare Program Review

A. Claims Program

The Mcare Fund has a fully functional claims administration unit comprised of geographic territory managers, examiners, and support personnel. Claims are submitted by primary insurers on behalf of health care providers as notice of potential triggering of Mcare excess indemnity coverage. In these claims, the primary insurer is responsible for providing the defense and the first $500,000 of indemnity. Mcare also has a declining number of claims submitted for defense and "first dollar" indemnity coverage based upon an occurrence date of incidents prior to January 1, 2006, under Section 715 of the Mcare Act.

Excess Claims Opened/Closed

Mcare opened 2,676 claims reported by primary insurers between September 1, 2019 and August 31, 2020 (the 2020 statutory claims period). This compares to 2,952 claims opened in the prior claims period. Mcare closed 3,173 claims in the 2020 claims period compared to 3,946 claims closed in the prior claims period. These numbers include claims closed with and without Mcare indemnity payment. A total of 107 primary insurers reported claims to Mcare in the 2020 claims period, compared to 105 in 2019.

Section 715 Claims Opened/Closed

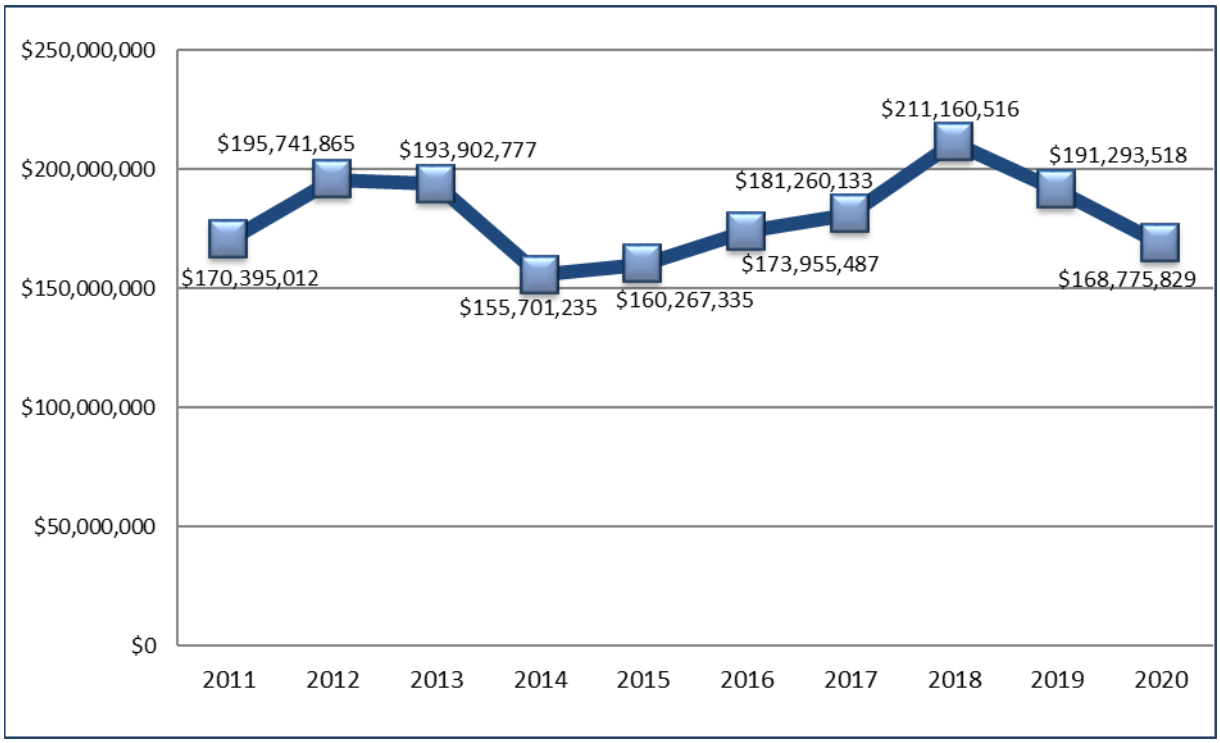
Section 715 of the Mcare Act is a remnant from the 1975 original compensation fund legislation. The purpose was to insulate primary insurers writing in Pennsylvania from the impact of claims filed four or more years after the medical care was rendered. The Mcare Act provided for an end to these claims by requiring that application be restricted to occurrences on or before December 31, 2005. For medical malpractice incidents occurring January 1, 2006 and subsequent, primary insurers are responsible for defense and indemnity, as they are for other claims. In the 2020 claims period, Mcare opened 14 and closed 32 Section 715 claims. This compares to 17 opened and 47 closed in the 2019 claims period.

Alternative Dispute Resolution (ADR)

Claims examiners and managers provide full investigation and disposition of reported claims. Within these functions and as appropriate, Mcare has actively promoted global resolution through settlement, arbitration, and mediation, to the benefit of the involved health care providers and plaintiffs. The unique position of Mcare allows for fair and objective analysis of the entire case and, when appropriate, can facilitate bringing parties to consensus. Since the Mcare ADR program's inception in 2003, it has been used in over 2,000 medical malpractice matters.

Chart 1 below shows Mcare's total payments for the last 10 claims period years.

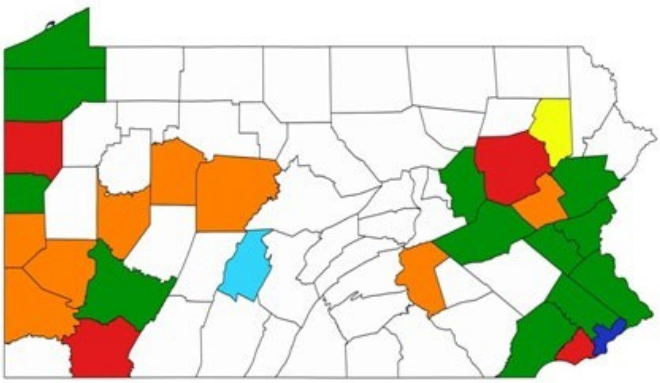
Chart 1: Claims Payments by Claims Year for 2011-2020



Regional Statistics

Mcare claims payments also vary by JUA territory. Chart 2 below shows the 2020 claims payments allocated by territory.

Chart 2: 2020 Mcare Paid Claims by Territory



Territory	Territory Total	County(ies) Within Territory
Territory 1	$38,451,125	Philadelphia
Territory 2	$25,575,000	Remainder of State
Territory 3	$21,280,000	Allegheny
Territory 3	$14,876,121	Armstrong, Beaver, Carbon, Clearfield, Dauphin, Jefferson, Washington
Territory 3	$36,056,121	Territory 3 Total
Territory 4	$23,800,000	Delaware, Fayette, Luzerne, Mercer
Territory 5	$6,039,000	Lackawanna
Territory 6	$36,354,583	Bucks, Chester, Columbia, Crawford, Erie, Lawrence, Lehigh, Monroe, Montgomery, Northampton, Schuylkill, Westmoreland
Territory 7	$2,500,000	Blair
Total Paid	**$168,775,829**	

Additional information on claims can be found in Appendix B.

B. Coverage Program

The Mcare Coverage Program consists of two major components. The first is the collection of assessments from health care providers to provide the funding for claims indemnity and expense payments and Mcare operations. The second is the maintenance of records submitted by insurers or self-insurers on behalf of health care providers. This information assists Mcare in enforcing the Commonwealth's mandatory medical malpractice insurance laws.

Assessment Collection

Mcare coverage is funded by assessments collected from health care providers as defined in the Mcare Act and interest earned on these funds. For 2020, the assessment revenue is $190 million as compared to the assessment revenue of $195 million for 2019. Since the assessment rate was the same for both years, the variance is primarily due to adjustments by health systems in effective dates of coverage.

The collection of the assessment is based on the PPP as defined in the schedule of occurrence rates approved for use by the JUA. The statutory assessment formula, as modified by the settlement of Hospital & Healthsystem of Pennsylvania, Pennsylvania Medical Society and Pennsylvania Podiatric Medical Association, 5 MAP 2014 (Pa. Supreme Ct.), is to produce an amount sufficient to do all of the following:

1. Reimburse Mcare for paid claims,
2. Pay expenses Mcare incurred,
3. Pay principle and interest on any funds borrowed,
4. Provide a 10% buffer of the sum of items 1-3, and
5. Minus the projected year-end balance, which includes interest income from the sum of items 1-4.

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

Chart 3: Assessment Percentage for 10 Most Recent Years

Assessment Year	Original Percentage	Settlement Adjusted Percentage
2012	23%	22%
2013	25%	no change
2014	23%	19%
2015	12%	
2016	17%	
2017	19%	
2018	19%	
2019	19%	
2020	19%	
2021	19%	

Hospital Experience Modification

The Mcare Act provides for adjustments to the Mcare assessments paid by hospitals based upon loss experience. The maximum range as provided for by statute is a 20% decrease to a 20% increase. Chart 4 below shows the experience modification factors provided to hospitals that are applied to the calculated assessment with the loss experience adjustment to determine the actual amount owed and how this provision affected the hospitals in 2020.

Chart 4: Hospitals Experience Modification Factors

	Factors	**2020**
Maximum Decrease	80.0%	91
Off-Balance Only	85.0%	38
Intermediate	85.01%-119.9%	13
Maximum Increase	120%	57
Total of Rated Hospitals		199

Coverage Analysis

Mcare receives reports of coverage from licensed insurers and approved self-insurance entities on behalf of physicians, podiatrists, and nurse midwives practicing in the Commonwealth, as well as their specialty and location of practice. It also receives reports of coverage on hospitals, nursing homes, primary health centers, birth centers and medical corporations. Under the Mcare Act, insurers have 60 days from when coverage begins to report coverage to Mcare.

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

C. Compliance Program

Mcare is responsible for receiving and analyzing reports of coverage from insurers and self-insurers regarding health care providers' medical professional liability insurance coverage. These reports include the type of coverage, 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 health care provider.

Mcare reviews each of these reports for compliance with Pennsylvania's mandatory insurance laws. In 2020, Mcare reinvigorated its compliance efforts, focusing on the compliance of hospitals and nursing homes.

V. Unfunded Liability

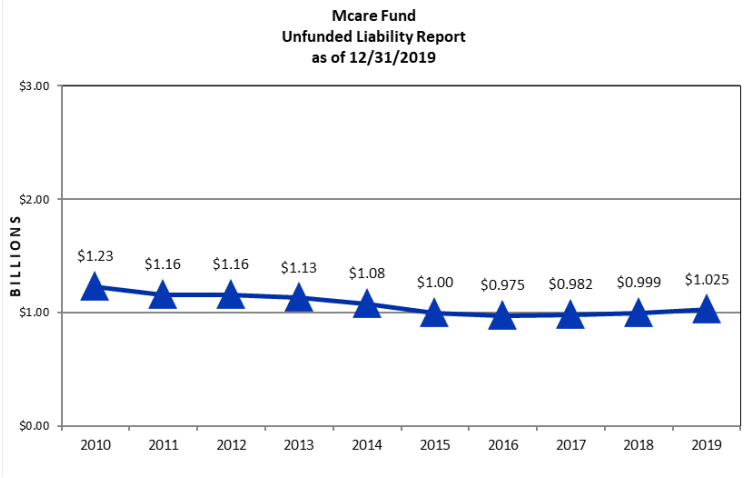
Mcare operates on a funding scheme characterized as a "pay-as-you-go" system since it holds no reserves, unlike a traditional insurance company. Mcare does not maintain a reserve dedicated to support the liability or claims that have been incurred but not yet paid. This constitutes the unfunded liability of Mcare.

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

This change, coupled with the limits being provided by insurers increasing to $500,000 and the overall coverage limit going from $1.2 million to $1 million, has previously resulted in the Mcare unfunded liability projection trending downward. The annual actuarial study, prepared in 2020 by Deloitte Consulting LLP ("Deloitte"), concludes that an unfunded liability of $1.025 billion exists as of December 31, 2019. According to Deloitte, the increase is due to cost projections on previous accident years caused by severity estimates in the medical malpractice market in Pennsylvania with recognized suppression of current claims due to extended period of court closures caused by COVID-19.

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

Chart 5: Mcare Projected Unfunded Liability over the Last 10 Years



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

VI. Limits Step Up and Podiatrists' Exit

Limits Step Up

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

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

The study conducted in 2019 found that it cannot be determined that additional basic insurance capacity was currently available. Reasons for this determination included the large market share of risk retention groups, 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 2020 and 2021. The next capacity study will be conducted in 2021 for a potential step up in limits effective January 1, 2022.

Podiatrists' Exit

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

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MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

CASH BASIS STATEMENT OF OPERATIONS

JANUARY 1, 2020 TO DECEMBER 31, 2020

MCARE FUND BALANCE JANUARY 1, 2020		**$ 0**
Receipts:		
ASSESSMENT REVENUE	$ 190,206,034	
INVESTMENT INCOME ON ASSESSMENTS	$ 611,013	
MISCELLANEOUS REVENUE	$ 0	
TRANSIT & PAYABLES SUMMARY	$ (1,174,602)	
TOTAL RECEIPTS	**$ 189,642,445**	**$ 189,642,445**
TOTAL FUNDS AVAILABLE		**$ 189,642,445**
Claims Deductions:		
2020 CLAIMS PAYMENTS	$ 169,525,829 [#1]	
CLAIMS DEDUCTIONS	**$ 169,525,829**	
Operating Expenses:		
SALARIES	$ 2,509,752	
PAYROLL TAXES & BENEFITS	$ 1,791,671	
DATA PROCESSING SERVICES	$ 4,506	
LEGAL FEES & EXPENSES	$ 1,740,130 [#2]	
COMMONWEALTH SHARED SERVICES	$ 252,082	
CONSULTANTS	$ 277,769	
TELECOMMUNICATIONS	$ 48,665	
REAL ESTATE	$ 370,202	
OTHER OPERATIONAL EXPENSES	$ 160,530	
TOTAL OPERATING EXPENSES	**$ 7,155,307**	
TOTAL DEDUCTIONS AND EXPENSES:		**$ (176,681,136)**
MCARE FUND BALANCE BEFORE TRANSFER		**$ 12,961,309**
TRANSFER FROM MCARE RESERVE FUND		**$ 0** [#3]
MCARE FUND BALANCE DECEMBER 31, 2020		**$ 12,961,309**

FINANCIAL FOOTNOTES:

[#1] 2020 Claim Commitments	$ 168,775,829
2019 Claims paid in 2020	$ 750,000
Total Claims Paid in 2020	$ 169,525,829
[#2] Legal Fees & Expenses	$ 1,740,130
Amount paid to defend Health Care Providers under §715	
[#3] Reserve Fund Balance 01/01/2020	$ 13,787,549
Transfer to Mcare Operations in lieu of borrowing per HAP/PAMED/PPMA Settlement Agreement paragraph 4.A.	$ 0
Reserve Fund Investment Income	$ 113,843
Reserve Fund Balance 12/31/2020	$ 13,901,392

Mcare Fund

Summary of Financials from CY 2011 to 2020

* In Millions *

		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1	Beginning Balance	124	130	130	169	73	28	12	17	0	0
2	Settlement Agreement [1]				**(169)**						
3	**ADJUSTED BEGINNING BALANCE**	124	130	130	0	73	28	12	17	0	0
	Receipts:										
4	Assessment Revenue	184	209	239	233	124	165	192	184	195	190
5	Investment Income Earned	2	2	2	2	2	1	2	3	3	0
6	Auto CAT Fund	0	0	0	0	0	0	0	0	0	0
7	Abatement Repayment/Credits	0	0	0	0	0	0	0	0	0	0
8	Transfer from Other Funds [2]	0	0	0	0	0	0	0	15	1	0
9	Loan from Other Funds	0	0	0	0	0	0	0	0	0	0
10	Misc. Other	0	1	4	1	0	1	1	(1)	0	0
11	Net +/- in Fair Value of Investments	0	0	0	4	(1)	0	0	0	0	0
12	Subtotal Receipts without Beginning Balance (4+5+6+7+8+9+10+11)	186	212	245	240	125	167	195	201	199	190
13	**Grand Total Receipts with Beginning Balance** (3+4+5+6+7+8+9+10+11)	310	342	375	240	198	195	207	218	199	190

		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
	Expenditures:										
14	Salaries & Benefits	4	4	4	4	4	4	4	4	4	4
15	Loan Repayment	0	0	0	0	0	0	0	0	0	0
16	Interagency Transfer	0	0	0	0	0	0	0	0	0	0
17	Loss on Investments	0	0	0	0	0	0	0	0	0	0
18	Legal Fees & Expenses	6	6	6	6	4	3	2	2	2	2
19	Liability Claims Paid	170	196	194	156	160	174	181	211	191	170
20	Misc. Other [3]	0	6	2	1	2	2	3	1	2	1
21	**Grand Total Expenditures** (14+15+16+17+18+19+20)	180	212	206	167	170	183	190	218	199	177
22	**Year End Balance (13-21)**	**130**	**130**	**169**	**73**	**28**	**12**	**17**	**0**	**0**	**13**

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

[2] Transfer from Other Funds - transferred $15 million from Reserve Fund in lieu of borrowing in 2018. Transferred $1.4 million from Reserve Fund in lieu of borrowing in 2019.

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

Pennsylvania Insurance Department

Mcare Fund

Paid Claims by Region 2016 - 2020*

Year	Total Annual Claim Payment	Eastern		Central		Western		Other	
		Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims	Region Paid Claims	Percent of Region to Total Paid Claims
2016	$173,955,487	$80,324,997	46.17%	$58,425,451	33.58%	$34,705,039	19.95%	$500,000	0.28%
2017	$181,260,133	$81,406,418	44.91%	$48,480,436	26.74%	$51,373,279	28.34%	$0	0.00%
2018	$211,160,516	$105,871,615	50.13%	$58,900,723	27.89%	$45,938,178	21.75%	$450,000	0.21%
2019	$191,293,518	$84,718,761	44.28%	$51,225,982	26.77%	$54,848,775	28.67%	$500,000	0.26%
2020	$168,775,829	$68,850,708	40.79%	$49,724,000	29.46%	$49,736,121	29.46%	$465,000	0.27%

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, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York
Western	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland
Other	Includes all other states and the United States District Courts where an Mcare defendant was involved.

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

Pennsylvania Insurance Department

Mcare Fund

Claim and Case Payments - 10 Most Recent Years

Year	Fund Money	**Claim** Count	Average **Claim Value**	**Case** Count	Average **Case Value**
2011	$170,395,012	353	$482,705	263	$647,890
2012	$195,741,865	404	$484,510	265	$738,649
2013	$193,902,777	414	$468,364	291	$666,333
2014	$155,701,235	346	$450,004	253	$615,420
2015	$160,267,335	352	$455,305	263	$609,382
2016	$173,955,487	372	$467,622	286	$608,236
2017	$181,260,133	402	$450,896	291	$622,887
2018	$211,160,516	439	$481,003	291	$725,638
2019	$191,293,518	413	$463,180	278	$688,106
2020	$168,775,829	352	$479,477	247	$683,303

Note: One “case” consists of 1 to many “claims”.

Pennsylvania Insurance Department

Mcare Fund

Summary of Annual Fund Claim Payments by Health Care Provider Group

2011-2020

	Individuals MD's, DO's, Podiatrists Certified Nurse Midwives				**Medical Corporations**				**Institutions** Hospitals, Nursing Homes Birth Center, Primary Care Centers				**Totals**	
Year	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Count of Claims	% of Total Claims	Amount of Fund Payment	% of Annual Fund Claims Payment	Total Claim Count	Total Annual Fund Claims Payment
2011	230	65%	$110,890,028	65%	18	5%	$8,543,331	5%	105	30%	$50,961,653	30%	353	$170,395,012
2012	256	63%	$128,473,897	66%	16	4%	$8,912,666	5%	132	33%	$58,355,302	30%	404	$195,741,865
2013	267	64%	$125,139,084	65%	21	5%	$9,230,191	5%	126	30%	$59,533,502	31%	414	$193,902,777
2014	225	65%	$103,366,679	66%	12	3%	$6,050,000	4%	109	32%	$46,284,556	30%	346	$155,701,235
2015	241	68%	$108,303,790	68%	5	1%	$2,675,000	2%	106	30%	$49,288,545	31%	352	$160,267,335
2016	229	62%	$106,235,581	61%	12	3%	$6,112,500	4%	131	35%	$61,607,406	35%	372	$173,955,487
2017	244	61%	$113,657,457	63%	19	5%	$9,179,486	5%	139	35%	$58,423,190	32%	402	$181,260,133
2018	269	61%	$132,674,414	63%	23	5%	$12,485,866	6%	147	33%	$66,000,236	31%	439	$211,160,516
2019	255	62%	$117,731,905	62%	17	4%	$7,975,000	4%	141	34%	$65,586,613	34%	413	$191,293,518
2020	208	58%	$99,461,246	59%	9	3%	$5,250,000	3%	135	38%	$64,064,583	38%	352	$168,775,829

Pennsylvania Insurance Department

Mcare Fund

Claim Payments by Self-Insurer and Insurer

Carrier Code	2016	2017	2018	2019	2020
S10	$ 3,450,000	$ 2,500,000	$ 2,000,000	$ 3,500,000	$ 3,000,000
S12	$ 1,150,000	$ 1,945,952	$ 1,500,000	$ 500,000	$ 500,000
S23	$ -	$ -	$ -	$ 3,000,000	$ -
S35	$ -	$ -	$ -	$ -	$ 1,000,000
S40	$ 300,000	$ -	$ 500,000	$ 1,000,000	$ -
S41	$ -	$ -	$ -	$ -	$ 500,000
S49	$ 500,000	$ -	$ -	$ -	$ -
S51	$ 1,000,000	$ 1,500,000	$ -	$ 500,000	$ 500,000
S53	$ 1,500,000	$ -	$ -	$ -	$ -
S54	$ -	$ -	$ 250,000	$ -	$ -
S60	$ 1,900,000	$ -	$ 300,000	$ -	$ 750,000
S62	$ -	$ -	$ -	$ -	$ 1,000,000
S68	$ -	$ 500,000	$ 1,025,000	$ 3,100,000	$ -
S69	$ -	$ -	$ 1,500,000	$ -	$ 1,000,000
003	$ 11,877,500	$ 10,600,000	$ 16,283,334	$ 11,718,077	$ 11,922,246
011	$ 1,000,000	$ 2,000,000	$ 1,950,000	$ 2,950,000	$ 4,024,000
031	$ 13,371,493	$ 14,343,972	$ 18,905,548	$ 13,856,800	$ 9,400,000
032	$ 500,000	$ 2,450,000	$ 1,000,000	$ 1,000,000	$ 900,000
039	$ -	$ 560,000	$ -	$ -	$ -
052	$ -	$ -	$ 400,000	$ -	$ -
067	$ 11,215,050	$ 12,863,755	$ 15,586,000	$ 14,126,801	$ 8,355,000
086	$ 1,000,000	$ 3,800,000	$ 2,000,000	$ -	$ 1,000,000
090	$ -	$ -	$ 500,000	$ -	$ -
093	$ -	$ 1,840,000	$ 50,000	$ -	$ 1,000,000
103	$ 1,000,000	$ 500,000	$ -	$ 750,000	$ 1,000,000
119	$ -	$ -	$ 1,000,000	$ -	$ 55,000
121	$ -	$ 1,000,000	$ -	$ 500,000	$ 1,000,000
124	$ -	$ 250,000	$ -	$ -	$ -
126	$ 1,000,000	$ -	$ 2,000,000	$ -	$ -
127	$ 500,000	$ 563,544	$ 1,650,000	$ 500,000	$ 1,725,000
129	$ 2,800,000	$ 2,500,000	$ 6,650,197	$ 3,600,000	$ 6,300,000
130	$ 400,000	$ -	$ -	$ -	$ -
135	$ 2,000,000	$ -	$ -	$ -	$ -
136	$ 1,000,000	$ 3,000,000	$ 2,000,000	$ 100,000	$ 1,000,000
137	$ -	$ -	$ -	$ -	$ 500,000
138	$ -	$ -	$ 1,500,000	$ 1,000,000	$ 400,000
144	$ 18,425,000	$ 15,475,000	$ 16,760,000	$ 20,895,000	$ 19,075,000
145	$ 9,225,000	$ 4,450,000	$ 4,775,000	$ 6,825,000	$ 3,100,000
155	$ 10,752,500	$ 10,325,000	$ 11,650,000	$ 10,150,000	$ 7,250,000
156	$ 4,925,480	$ 4,025,000	$ 3,863,869	$ 5,638,000	$ 5,260,000
161	$ -	$ -	$ 750,000	$ -	$ -
162	$ 187,500	$ -	$ -	$ -	$ 2,000,000
173	$ -	$ -	$ -	$ 500,000	$ -
179	$ -	$ -	$ 250,000	$ -	$ -
181	$ 1,000,000	$ -	$ -	$ -	$ -
184	$ 2,750,000	$ -	$ -	$ -	$ -

Pennsylvania Insurance Department

Mcare Fund

Claim Payments by Self-Insurer and Insurer

Carrier Code	2016	2017	2018	2019	2020
194	$ 500,000	$ -	$ -	$ -	$ -
196	$ 1,000,000	$ 400,000	$ 2,500,000	$ -	$ -
197	$ 5,933,947	$ 5,996,484	$ 4,000,000	$ 3,000,000	$ 6,350,000
199	$ 1,500,000	$ 4,000,000	$ 3,342,391	$ 3,100,000	$ 500,000
202	$ 1,960,000	$ 3,976,350	$ 3,632,500	$ 4,000,000	$ 600,000
203	$ 500,000	$ 900,000	$ 1,900,000	$ 2,000,000	$ 500,000
207	$ 6,882,922	$ 11,704,487	$ 8,820,361	$ 5,000,000	$ 4,250,000
208	$ 525,000	$ 544,207	$ 500,000	$ -	$ -
210	$ 350,000	$ 150,000	$ -	$ -	$ -
211	$ 4,587,111	$ 4,572,391	$ 7,958,669	$ 8,800,000	$ 6,000,000
212	$ -	$ -	$ 500,000	$ 1,500,000	$ 950,000
217	$ -	$ -	$ 400,000	$ -	$ -
218	$ -	$ -	$ -	$ 500,000	$ -
219	$ 1,350,000	$ 3,000,000	$ 5,226,723	$ 2,475,000	$ 500,000
220	$ 800,000	$ 1,850,000	$ 1,000,000	$ 1,000,000	$ 195,000
221	$ 4,625,000	$ 2,350,000	$ 1,980,579	$ 4,150,000	$ 1,750,000
222	$ 3,500,000	$ 850,000	$ 2,500,000	$ 5,275,982	$ 2,509,583
223	$ 2,500,000	$ 1,800,000	$ 4,000,000	$ 1,000,000	$ 1,500,000
224	$ 500,000	$ 1,200,000	$ 500,000	$ -	$ -
228	$ 975,000	$ 950,000	$ -	$ -	$ -
232	$ -	$ 500,000	$ -	$ -	$ 300,000
234	$ -	$ -	$ -	$ 500,000	$ -
239	$ 1,000,000	$ 2,974,590	$ 1,500,000	$ 2,363,093	$ 1,500,000
241	$ 500,000	$ 500,000	$ 375,000	$ 1,100,000	$ -
243	$ 375,000	$ -	$ 500,000	$ -	$ -
245	$ 8,250,000	$ 19,253,000	$ 11,775,000	$ 10,050,000	$ 18,875,000
246	$ 2,675,000	$ 1,000,000	$ 350,000	$ -	$ 500,000
253	$ 4,150,000	$ 1,500,000	$ 4,666,667	$ 2,233,333	$ 4,600,000
258	$ 1,675,000	$ 500,000	$ 1,175,000	$ 695,000	$ 925,000
261	$ 500,000	$ -	$ 2,000,000	$ 2,775,000	$ 1,150,000
262	$ -	$ -	$ -	$ 500,000	$ -
271	$ 3,275,000	$ 2,950,000	$ 2,783,678	$ 4,275,000	$ 1,950,000
275	$ -	$ -	$ -	$ -	$ -
276	$ 1,200,000	$ 1,550,000	$ 150,000	$ 1,725,000	$ 380,000
277	$ -	$ -	$ -	$ -	$ 500,000
279	$ 200,000	$ 500,000	$ 1,000,000	$ -	$ -
285	$ -	$ 500,000	$ -	$ -	$ -
286	$ -	$ -	$ -	$ -	$ 250,000
289	$ -	$ -	$ -	$ -	$ 500,000
290	$ -	$ 283,385	$ -	$ -	$ -
308	$ -	$ 1,000,000	$ -	$ -	$ 250,000
310	$ 4,936,984	$ 2,463,016	$ 8,550,000	$ 6,066,432	$ 6,860,000
312	$ -	$ 150,000	$ 500,000	$ -	$ -
314	$ -	$ -	$ 1,000,000	$ -	$ -
320	$ 500,000	$ 500,000	$ -	$ -	$ -
324	$ -	$ -	$ -	$ 1,500,000	$ 500,000
329	$ -	$ -	$ -	$ 1,400,000	$ -
331	$ -	$ 250,000	$ -	$ 800,000	$ -
333	$ 500,000	$ 500,000	$ 300,000	$ -	$ -

Pennsylvania Insurance Department

Mcare Fund

Claim Payments by Self-Insurer and Insurer

Carrier Code	2016	2017	2018	2019	2020
334	$ -	$ -	$ -	$ -	$ 1,500,000
338	$ 1,500,000	$ 2,150,000	$ 7,875,000	$ 3,900,000	$ 6,700,000
341	$ -	$ 500,000	$ 800,000	$ 1,500,000	$ 950,000
350	$ -	$ -	$ 500,000	$ -	$ 500,000
351	$ -	$ 500,000	$ -	$ 2,400,000	$ 965,000
Total	$ 173,955,487	$ 181,260,133	$ 211,160,516	191,293,518	$ 168,775,829

pennsylvania
INSURANCE DEPARTMENT

Pennsylvania Medical Care Availability

and Reduction of Error Fund

2020

Assessment Rate Calculation

19%

Executive Summary

As required by Act 13 of 2002 ("the Act"), the Pennsylvania Medical Care Availability and Reduction of Error Fund ("Mcare") calculates the annual assessment rate to be used on behalf of eligible Pennsylvania health care providers. In addition, the 2020 assessment calculation reflects the provisions prescribed by the 2014 Settlement Agreement.

2020 Assessment Rate

The 2020 selected prevailing primary premium (PPP) of $951,353,607 generates an assessment rate of 19.21%, which rounds to 19% as shown in Exhibit 1. Section 712(d)(1) of the Act requires an assessment that will, in the aggregate, produce an amount of revenue sufficient to do all 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 required 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 $182,777,968 is to be collected per the application of an assessment rate to the policy year 2020's PPP. Therefore, the projection of 2020 PPP is a vital component of the calculated assessment rate. Numerous external factors will affect both the 2020 payment obligations of Mcare and the 2020 PPP base, from which Mcare derives its revenue. We have considered actual assessment revenue from years 2016, 2017 and 2018 as our basis for our estimate of the 2020 PPP.

To the extent that the 2020 claims payments and net expenses of Mcare differ from the assessment collected during 2020, Mcare may have a significant positive or negative balance as of year-end 2019. This balance may be impacted by other variables, including but not limited to, the amount of supplemental funding, if any, made available to Mcare during 2020. In addition, the differences between projected 2020 PPP and actual 2020 PPP may result in a difference between projected and actual assessment revenue.

These variables may impact whether the amount of 2020 assessment collected in 2020 will be sufficient to meet Mcare's 2020 obligations. Use of the Reserve Fund and/or supplemental funding would be required if the assessment collected in 2020 is insufficient to meet Mcare's 2020 obligations.

Basis of the Calculation

Section 712(d)(1) of the Act mandates that the aggregate assessment for 2020 produces an amount sufficient to pay the claims expenses, operating expenses, principal and interest on moneys transferred into Mcare, and 10% buffer amount. In addition, the Settlement Agreement requires Mcare to reduce the assessment amount by the Projected Starting Balance.

Claims Payments

The claims commitment of Mcare's 2019 claims year ending August 31, 2019 with payment on or before December 31, 2019 is the principal component of the 2020 assessment. The claims payment for the 2019 year is $191.3 million.

Operating Expenses

The operating expenses for claim year end August 31, 2019 were $8.2 million. These expenses include Mcare administrative costs, including legal expenditures mainly related to the defense of Section 715 claims.

Principal and Interest on Money Transferred, if Any

It was not necessary for Mcare to borrow any monies in order to meet its 2019 obligations.

Buffer Reserve Amount

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

Projected Starting Balance

The Settlement Agreement defines the Projected Starting Balance to be 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." Mcare's Projected Starting Balance as of January 1, 2020 is $0.

Settlement Reserve Fund

The Settlement Agreement defines the Reserve Fund as "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 (October 3, 2014) is $30 million, and the Reserve Fund shall never exceed that amount. Interest and other income earned on the amounts in the Reserve Fund may be retained in the Reserve Fund unless retention of such interest and other income would result in the Reserve Fund exceeding $30 million…." 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 projected Reserve Fund balance as of December 31, 2019 is $13,787,549.

Prevailing Primary Premium (PPP)

The assessment and policy count data for policies effective in 2016, 2017 and 2018 was used to calculate the PPP. This data includes primary policy type (claims-made or occurrence), product code, county code, and specialty code.

Product Code

The product code is one of eight as listed below:

1. BC Birth Center;
2. HS Hospital;
3. MC Professional Corporation;
4. MD Physician, Resident, or Fellow;
5. MW Nurse Midwife;
6. NC Nursing Home;
7. PC Primary Health Center; and
8. SC Podiatrist.

County Code

The assigned rating county of the exposure in one of the 67 Pennsylvania counties (e.g. Allegheny, Luzerne, Philadelphia).

Specialty Code

The specialty code is provided in the JUA (Pennsylvania Professional Liability Joint Underwriting Association) annual rating schedule, as well as ISO codes for certified nurse midwives and podiatrists.

Rate Change

The JUA made no rating changes effective January 1, 2020. Therefore, the projected 2020 PPP did not require Mcare to factor in any adjustments to the JUA class, county/territory, or specialty.

Selected 2020 PPP

Mcare selected $951 million as the 2020 PPP based on remittances received and processed by Mcare as of August 26, 2019 for the following three policy years: $1 billion in 2016 remittances, $951 million in 2017 remittances, and $970 million in 2018 remittances (see Exhibit 2). This PPP may vary from the actual 2020 PPP due to numerous factors including, but not limited to:

- Possible changes in the relative size of Pennsylvania's health care industry during 2020 relative to recent years;
- Possible changes in the specialty and/or territory of a health care provider's exposure during 2019 and 2020;
- Possible changes in the effective date of primary policies (i.e., cancel/rewrite distortions) during 2019 and 2020; and

- Additional data, such as policy adjustments, late reported assessment, and mergers and closings that will cause the assessment data to change.

2020 Assessment Rate

The cost components of the assessment total $182 million. There was $0 Projected Starting Balance as of January 1, 2020, as prescribed by the Settlement Agreement, to reduce the assessment amount of $182 million. Given the 2020 PPP projection of $951 million, the calculated 2020 assessment rate is 19.21%, which Mcare rounded down to 19%.

Assessment Rate Factors	2020
(1) Claim Year Ending 08/31/2019 Claims Payments*	$157,977,086
(2) Claim Year Ending 08/31/2019 Operating Expenses	$8,184,703
(3) Buffer Reserve of 10% (1) + (2)	$16,616,179
(4) 2019 Assessment Costs (1) + (2) + (3)	$182,777,968
(5) Projected Starting Balance as of 01/01/2020	$0
(6) Settlement Reserve Fund	$0
(7) 2020 Assessment Amount (4) + (5) + (6)	$182,777,968
(8) Projected 2020 Prevailing Primary Premium (PPP)	$951,353,607
(9) Calculated 2020 Assessment Rate (7) ÷ (8) Rounded	19%

*The 2019 committed claims payments used to calculate the 2020 assessment are $191,293,518; however, on the date the assessment calculation was completed, $33,316,432 in payment were awaiting a court approval of the payment and thus they were excluded from the calculation. As the court orders were received, the payment was authorized.

Exhibit 1

Prior Year Comparison

The calculated rounded 2020 assessment rate of 19% is the same as the 2019 assessment rate of 19%. The 2019 and 2020 assessment rate calculations are summarized below:

Assessment Rate Factors	**2020**	**2019**
(1) Claim Year Ending 08/31 Claims Payments*	$157,977,086	$163,243,190
(2) Claim Year Ending 08/31 Operating Expenses	$8,184,703	$8,814,617
(3) Buffer Reserve of 10% (1) + (2)	$16,616,179	$17,205,781
(4) Assessment Costs (1) + (2) + (3)	$182,777,968	$189,263,588
(5) Projected Starting Balance as of 01/01	$0	$0
(6) Settlement Reserve Fund	$0	$0
(7) Assessment Amount (4) + (5) + (6)	$182,777,968	$189,263,588
(8) Projected Prevailing Primary Premium (PPP)	$951,353,607	$995,773,108
(9) Calculated Assessment Rate (7) ÷ (8) Rounded	19%	19%

*The 2019 committed claims payments used to calculate the 2020 assessment are $191,293,518; however, on the date the assessment calculation was completed, $33,316,432 in payment were awaiting a court approval of the payment and thus they were excluded from the calculation. As the court orders were received, the payment was authorized.

The 2018 committed claims payments used to calculate the 2019 assessment were $211,160,516; however, on the date the assessment calculation was completed, $47,917,326 in payment were awaiting a court approval of the payment and thus they were excluded from the calculation. As the court orders were received, the payment was authorized.

Exhibit 2

Projected 2020 Prevailing Primary Premium (PPP)

Annual Assessment Remittances	Projected PPP	Implied Assessment Rate
Projection Based on 2016 Assessment Remittances	$1,001,188,535	18.26%
Projection Based on 2017 Assessment Remittances	$ 951,353,607	19.16%
Projection Based on 2018 Assessment Remittances	$ 969,576,344	18.86%
Projection Based on 2019 Assessment Remittances*	$ 951,353,607	19.21%

* Selected PPP based on the remittances of 2016, 2017 and 2018.

* * *

pennsylvania
INSURANCE DEPARTMENT

Medical Care Availability and Reduction of Error Fund

2020

Calculation of the Hospital Experience Modification Factor

Executive Summary

As per Section 712(g)(4) of Act 13 of 2002 ("the Act"), Mcare experience rates each eligible hospital through its Hospital Experience Modification ("HEM") program. The purpose of the HEM program is to provide appropriate financial incentives to encourage effective risk management practices and to promote quality care. The Act requires:

> "The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustments 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."

The 2020 HEM factor calculation provides hospitals with an understandable methodology of how their factor is determined.

HEM Factor Calculation

Each year, the Mcare HEM factor calculation directly correlates the hospital's claims experience at the Mcare layer of coverage with what the hospital has paid into Mcare; similar to a paid loss retrospective rating plan. The first step in calculating the HEM factors is to identify those hospitals which hold a current license with the PA Department of Health and have at least five years of claims experience (claims period).

New hospitals that do not meet the five-year claims experience requirement may not be rated, and, therefore, will have an annual HEM factor of 1.0 or 100%. Hospitals that surrendered their license, but are still providing services under a merged license, will be rated under the merged hospital's current license.

Closed hospitals are excluded as they no longer hold a current license and they are no longer paying an assessment.

Once the hospitals eligible for a 2020 HEM factor have been identified, their individual Mcare loss ratio is calculated (Mcare Hospital Loss Ratio). As required by the Act, five years of claims and assessment data is used to calculate the HEM factor. The aggregate of five years of claims payments is divided by the aggregate of five years of assessment payments. For the 2020 HEM calculation, the following data was used in the calculation.

Claims Payments

Claims payments made in claims years 2014 to 2018 were used in the calculation. Because the 2020 HEM calculation is completed in the fall of 2019, claims payments for 2019 are not included, as these payments are scheduled to be made on or before December 31, 2019.

Assessment Payments

Assessments received and processed as of September 9, 2019 for years 2015 to 2019 were used in the calculation. Historically, most hospital's assessment payments are for coverage effective either in January or July. Therefore, any hospital whose assessment has not been received and processed prior to September 9, 2019 must be advance calculated. The advance calculation is based on the hospital's most recent bed and visit counts, assessment rate, and related HEM year factor.

Band and Loss Ratio Analysis

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

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

Each band loss ratio is developed by taking the aggregate five years of claims payments on behalf of all the hospitals in the band and dividing it by the aggregate five years of assessments paid by all hospitals in the band. This produces the Band Loss Ratio. Each hospital's Loss Ratio is compared to its Band Loss Ratio to determine whether the hospital's ratio is better, the same or worse than others in the same band. It is this difference that forms the foundation of the HEM factor. The results of this comparison may indicate a HEM factor that is outside the +/-20% allowed by the statute. Accordingly, the results of this initial analysis is called the Uncapped HEM Factor.

Revenue Neutral and Off-Balance Analysis

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

a group would pay into Mcare if there was not a HEM program (Baseline Assessment). Then the amount the hospitals would pay once the HEM factors are applied (Modified Assessment) is calculated. The Baseline Assessment is compared to the Modified Assessment and the difference is the Off-Balance Target. The Off-Balance Target is generally a positive number, which means the initial HEM factor calculation generates less assessment than if there was no HEM program. Thus, a factor (Off-Balance Factor) is applied to the Modified Assessment so that it is increased to generate the additional assessment needed to match the Baseline Assessment. The use of the Off-Balance Factor on the Uncapped HEM Factor must be done together with the application of the +/- 20% statutory restriction.

Multiple calculations are needed because as a hospital's HEM factor is increased with the application of the Off-Balance Factor, it has the possible impact of taking the factor to the statutory maximum of 120%. Once this happens, no additional assessment may be collected from the hospital. Successive calculations limit the hospital's new HEM Factor at the maximum until the Off-Balance Target is reached. This process results in the Capped HEM, which is the hospital's final HEM. The Mcare Act requires that frequency be incorporated into the HEM calculation process. Mcare addresses this mandate by including all hospitals with one or more Mcare paid claims in calculating the Off-Balance Factor. It is possible for a hospital to have one or more Mcare paid claims but for the Mcare Hospital Loss Ratio as compared to their peers, and still be under the statutory minimum of 80%. For these hospitals, their Loss Ratio is brought to 80% and then the Off-Balance Factor is applied to it (Off Balance Only).

If a hospital has no Mcare paid claims during the five-year evaluation period, their HEM factor is 80%. This is the maximum discount allowed by the Mcare Act.

2020 HEM Breakdown

Below is a breakdown of the HEM factor calculation for the 2020 assessment year.

Count	Factor	Description
84	80.0%	Claims Free
38	85.9%	Off Balance Only
13	86.0% - 119.9%	Intermediate
57	120.0%	Max Rate
199 Rated		

Distribution of HEM Factor

Mcare emails the HEM factor to each individual hospital's contact. In addition, contact information for Mcare is provided should there be any questions regarding Mcare's calculation of the hospital's HEM factor or to request additional information.

* * *

Pennsylvania Insurance Department

Mcare Fund

Amount of Assessment Received by Provider Type and Assessment Year

Assessment Year	Rate[2]	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Medical Corporations
2011	19%	$133,389,204	$2,417,218	$814,722	$33,357,796	$3,755,398	$665,985	$21,712	$4,247,233
2012	23%	$152,494,244	$3,065,651	$1,065,859	$40,059,126	$4,099,402	$831,401	$34,245	$4,612,059
2013	25%	$176,005,481	$3,709,951	$1,267,572	$44,045,124	$5,532,965	$927,072	$34,509	$5,015,326
2014	23%	$169,399,771	$3,938,854	$1,309,333	$41,779,456	$4,816,068	$917,792	$35,630	$4,379,681
2015	12%	$89,391,022	$2,067,654	$689,398	$22,274,479	$2,556,765	$492,162	$18,676	$2,308,889
2016	17%	$127,328,014	$2,943,431	$986,634	$31,240,251	$3,574,746	$726,980	$27,829	$3,263,177
2017	19%	$135,054,683	$3,252,451	$1,138,573	$32,801,513	$3,974,949	$865,740	$31,919	$3,417,735
2018	19%	$145,703,260	$3,227,805	$1,282,130	$35,975,060	$3,927,142	$940,752	$32,633	$3,162,391
2019	19%	$146,987,816	$3,163,264	$1,312,743	$35,814,327	$3,927,995	$931,536	$27,294	$3,115,201
2020[1]	19%	$137,480,240	$2,662,838	$1,300,764	$32,999,176	$3,554,412	$971,516	$24,030	$2,692,535

[1] Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2020. Coverage for 2020 policies that have been reported and processed as of January 20, 2020 is included in the amounts and is subject to additional development.

[2] For years 2011, 2012, 2013, and 2014 the assessment rate and assessment received reflects the pre-settlement percentage and the actual dollars collected.

Pennsylvania Insurance Department

Mcare Fund

Yearly Average Assessment by Provider Group													
		Physicians			Podiatrists			Hospitals			Nursing Homes		
Assessment Year	Assessment Rate[1]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2011 to 2020[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2011 to 2020[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2011 to 2020[2]	Yearly Average[2]	% Change over Prior Year[2]	% Change from 2011 to 2020[2]
2011	19%	$3,246	-20%		$2,058	-18%		$149,586	-20%		$5,357	-17%	
2012	23%	$3,615	11%		$2,552	24%		$181,263	21%		$5,864	9%	
2013	25%	$4,112	13%		$3,038	19%		$200,205	10%		$7,926	35%	
2014	23%	$3,917	-5%		$3,179	4%		$187,351	-7%		$6,969	-13%	
2015	12%	$2,047	-48%		$1,679	-48%		$100,789	-47%		$3,700	-47%	
2016	17%	$2,889	41%		$2,412	43%		$142,001	40%		$5,188	40%	
2017	19%	$3,066	6%		$2,635	9%		$150,465	5%		$5,769	11%	
2018	19%	$3,226	5%		$2,639	0%		$166,551	10%		$5,708	-2%	
2019	19%	$3,214	-1%		$2,590	-2%		$173,016	3%		$5,734	0%	
2020	19%	$3,229	0%	-1%	$2,623	-1%	27%	$178,373	3%	19%	$5,459	-5%	1%

[1] For years 2011, 2012, 2013 and 2014 the assessment rate reflects the pre-settlement percentages and the yearly average is based on the actual dollars collected.

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

Pennsylvania Insurance Department

Mcare Fund

Assessment Remitted by Self-Insurer and Insurer

Carrier Code	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020[1]
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
S10	$ 3,845,264	$ 3,925,883	$ 5,086,685	$ 4,881,913	$ 2,596,183	$ -	$ -	$ -	$ -	$ -
S12	$ 1,447,157	$ 1,701,951	$ 2,119,413	$ 2,127,826	$ 1,095,774	$ 1,719,098	$ 1,962,165	$ 460,715	$ -	$ -
S40	$ 320,699	$ 408,487	$ 536,409	$ 548,488	$ 290,538	$ 444,667	$ 519,132	$ 541,188	$ 551,911	$ 579,797
S41	$ 61,967	$ 68,635	$ 75,056	$ 77,831	$ 40,570	$ 58,952	$ 79,101	$ 96,066	$ 41,916	$ -
S49	$ 515,429	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
S51	$ 8,770	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
S53	$ 76,433	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
S54	$ 329,419	$ 393,845	$ 480,575	$ 455,416	$ 260,685	$ 410,403	$ 478,947	$ 475,057	$ 479,950	$ 463,468
S57	$ 39,633	$ 21,274	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
S58	$ 10,656	$ 12,482	$ 15,481	$ 15,492	$ 8,881	$ 9,245	$ 10,262	$ 12,761	$ 8,529	$ 6,461
S60	$ 387,341	$ 480,034	$ 545,819	$ 538,397	$ 307,302	$ 185,365	$ -	$ -	$ -	$ -
S61	$ 9,306	$ 10,805	$ 12,555	$ 11,943	$ 6,231	$ 8,900	$ 9,947	$ 9,785	$ 9,785	$ 9,623
S63	$ 154,020	$ 178,381	$ 216,346	$ 216,499	$ 67,749	$ -	$ -	$ -	$ -	$ -
S64	$ 12,459	$ 14,663	$ 16,946	$ 16,121	$ -	$ -	$ -	$ -	$ -	$ -
S67	$ 14,561	$ 9,742	$ 11,114	$ 10,671	$ 8,634	$ 24,771	$ 28,574	$ 28,574	$ 28,574	$ 28,574
S68	$ -	$ -	$ -	$ 1,586,947	$ 843,000	$ 1,128,109	$ 1,149,585	$ 1,183,689	$ 631,253	$ 109,375
S69	$ -	$ -	$ -	$ -	$ -	$ 4,165,559	$ 4,833,776	$ 4,949,255	$ 5,219,071	$ 5,499,673
001	$ 10,341	$ 11,721	$ 12,712	$ 15,382	$ -	$ -	$ -	$ -	$ -	$ -
003	$ 11,596,880	$ 12,782,156	$ 16,119,315	$ 16,346,152	$ 8,335,034	$ 10,760,138	$ 10,661,785	$ 10,115,016	$ 9,754,905	$ 10,114,620
011	$ 2,439,958	$ 2,370,323	$ 3,272,081	$ 3,691,410	$ 1,586,401	$ 2,586,464	$ 3,228,759	$ 2,928,634	$ 1,921,523	$ 1,877,012
021	$ 69,248	$ 82,237	$ 87,430	$ -	$ -	$ -	$ -	$ -	$ -	$ -
023	$ 58,602	$ 101,281	$ 113,314	$ 95,281	$ 38,811	$ 30,345	$ 28,636	$ 29,011	$ 26,296	$ 24,779
031	$ 17,019,350	$ 18,721,825	$ 19,998,071	$ 17,427,777	$ 8,485,127	$ 11,769,445	$ 12,102,504	$ 11,522,036	$ 10,550,560	$ 9,564,928
032	$ 865,973	$ 852,571	$ 887,543	$ 681,267	$ 331,629	$ 379,835	$ 408,819	$ 342,835	$ 372,321	$ 550,312
035	$ -	$ -	$ -	$ -	$ -	$ 45,583	$ -	$ 3,262	$ 308	$ -
038	$ -	$ -	$ -	$ -	$ 21,082	$ 30,021	$ 33,750	$ 29,109	$ 30,629	$ 27,651
052	$ 93,642	$ 71,237	$ 132,046	$ 64,126	$ 22,820	$ 36,368	$ 116,122	$ 136,186	$ 283,461	$ 352,645
055	$ -	$ -	$ -	$ 89,425	$ 41,805	$ 55,682	$ 62,238	$ 60,227	$ 64,201	$ 62,776
056	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,124
067	$ 11,501,386	$ 12,578,990	$ 13,912,613	$ 13,531,061	$ 6,910,095	$ 9,306,870	$ 11,027,414	$ 9,848,614	$ 9,262,862	$ 8,406,020
090	$ 69,784	$ 66,940	$ 81,584	$ 80,774	$ 40,778	$ 57,267	$ 65,423	$ 41,311	$ -	$ -
103	$ 321,320	$ 268,261	$ 721,750	$ 1,212,483	$ 682,114	$ 2,202,262	$ 1,319,642	$ 305,698	$ 231,543	$ 162,204
110	$ 37,333	$ 52,843	$ 75,357	$ 39,896	$ 1,291	$ 1,828	$ 2,043	$ 31,114	$ 16,276	$ 82,182
112	$ 91,872	$ 8,661	$ 10,064	$ 9,573	$ 4,995	$ 7,076	$ 7,908	$ 7,908	$ 163,268	$ 162,760
113	$ 8,969	$ 10,868	$ 15,394	$ 17,432	$ 7,030	$ 14,166	$ 12,845	$ 18,656	$ 43,988	$ 24,204
118	$ -	$ 18,269	$ 9,171	$ 8,738	$ 8,918	$ 12,657	$ -	$ -	$ -	$ -
121	$ 541,757	$ 488,452	$ 508,436	$ 453,832	$ 291,976	$ 567,915	$ 505,392	$ 464,311	$ 3,744,918	$ 4,972,204
124	$ 678,518	$ 788,170	$ 830,071	$ 783,419	$ 375,219	$ 503,243	$ 1,769,309	$ 1,926,942	$ 1,775,441	$ 1,285,182
127	$ 316,698	$ 376,388	$ 246,670	$ 541,574	$ 611,060	$ 939,628	$ 999,787	$ 889,086	$ 1,122,081	$ 1,776,742
129	$ 3,874,511	$ 4,358,655	$ 3,053,578	$ 4,457,301	$ 2,199,179	$ 2,827,020	$ 3,173,850	$ 3,346,188	$ 238,298	$ 623,176
130	$ -	$ 19,970	$ 74,714	$ 43,833	$ 6,160	$ 7	$ -	$ -	$ -	$ -
137	$ 79,619	$ 95,517	$ 114,141	$ 277,059	$ 145,743	$ 206,289	$ 48,100	$ 37,632	$ 33,538	$ 26,967
138	$ 746,129	$ 739,112	$ 850,570	$ 934,882	$ 499,036	$ 745,370	$ 1,045,122	$ 1,081,823	$ 1,093,190	$ 963,692
144	$ 15,867,259	$ 18,958,871	$ 23,529,330	$ 22,370,815	$ 11,610,202	$ 17,156,835	$ 8,576,903	$ 20,217,295	$ 20,563,791	$ 19,785,959
145	$ 3,633,646	$ 4,749,815	$ 5,422,499	$ 5,133,275	$ 2,770,722	$ 2,945,947	$ 2,412,948	$ 3,311,606	$ 2,797,118	$ 891,391
155	$ 12,328,905	$ 13,816,272	$ 15,931,152	$ 15,401,536	$ 8,127,065	$ 11,681,500	$ 14,886,076	$ 15,189,835	$ 16,225,694	$ 16,933,433
156	$ 7,082,079	$ 7,921,906	$ 8,659,189	$ 7,590,570	$ 5,166,860	$ 5,526,119	$ 6,264,391	$ 6,139,241	$ 6,127,105	$ 6,655,256
162	$ 17,843	$ 69,802	$ 120,527	$ 118,044	$ 80,415	$ 178,877	$ 195,235	$ 504,935	$ 395,931	$ 382,593
165	$ 197,936	$ 259,444	$ 272,371	$ 76,134	$ 70,766	$ 87,281	$ 103,888	$ 92,699	$ 49,601	$ 23,404
173	$ -	$ -	$ 1,242	$ -	$ -	$ 405,704	$ 503,423	$ 456,476	$ 473,100	$ 40,217
179	$ 30,926	$ 35,611	$ 35,955	$ 36,917	$ 19,318	$ 24,830	$ 51,423	$ 67,154	$ 70,579	$ 39,616
186	$ 60,230	$ 34,101	$ 22,421	$ -	$ -	$ -	$ -	$ -	$ -	$ -
194	$ 94,753	$ 48,581	$ 11,573	$ 10,750	$ 6,430	$ 7,001	$ 8,058	$ 2,673	$ 2,305	$ 489
196	$ 1,057,211	$ 970,662	$ 1,038,084	$ 898,586	$ 425,636	$ 543,060	$ 643,801	$ 400,840	$ 258,817	$ 259,227

Pennsylvania Insurance Department

Mcare Fund

Assessment Remitted by Self-Insurer and Insurer

Carrier Code	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020[1]
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
197	$ 4,267,462	$ 5,506,331	$ 6,872,008	$ 5,961,345	$ 2,983,701	$ 4,003,266	$ 4,410,037	$ 4,275,519	$ 4,221,062	$ 4,119,653
198	$ 74,078	$ 103,003	$ 118,884	$ -	$ -	$ -	$ -	$ -	$ -	$ -
199	$ 4,066,329	$ 4,610,572	$ 5,392,324	$ 5,329,903	$ 2,901,373	$ 4,271,121	$ 5,027,183	$ 5,242,478	$ 5,494,778	$ 5,569,741
202	$ 6,631,146	$ 6,449,223	$ 7,749,522	$ -	$ -	$ -	$ -	$ -	$ -	$ -
203	$ 1,315,694	$ 1,320,779	$ 1,745,055	$ 1,794,847	$ 932,436	$ 1,416,924	$ 1,934,620	$ 2,430,468	$ 2,721,114	$ 2,879,255
206	$ 28,762	$ 23,432	$ -	$ -	$ -	$ -	$ 124,441	$ 131,544	$ 94,225	$ 71,025
207	$ 12,757,889	$ 14,147,779	$ 15,991,743	$ 15,263,721	$ 6,651,781	$ 9,649,099	$ 10,942,758	$ 11,216,308	$ 11,873,015	$ 12,140,974
208	$ 1,643,666	$ 1,862,092	$ 2,125,544	$ 2,033,677	$ 1,045,518	$ 1,387,829	$ 286,584	$ 12,624	$ 4,356	$ 3,733
210	$ 895,765	$ 1,524,122	$ 901,685	$ 892,463	$ 444,621	$ 128,062	$ 732	$ 2,576	$ -	$ -
211	$ 6,967,834	$ 7,622,953	$ 8,661,328	$ 7,357,292	$ 1,548,345	$ -	$ -	$ -	$ -	$ -
212	$ 234,814	$ 269,253	$ 392,620	$ 649,370	$ 427,633	$ 769,809	$ -	$ -	$ -	$ -
216	$ 5,448	$ 5,644	$ 6,893	$ -	$ -	$ -	$ -	$ -	$ -	$ -
217	$ 288,634	$ 332,970	$ 378,859	$ 289,646	$ 145,666	$ 246,912	$ 353,284	$ 217,192	$ 199,049	$ 196,089
218	$ 259,598	$ 297,256	$ 385,246	$ 376,913	$ 213,513	$ 325,227	$ 420,094	$ 436,101	$ 450,312	$ 450,578
219	$ 3,303,889	$ 3,500,473	$ 4,236,273	$ 3,809,186	$ 2,013,599	$ 2,739,925	$ 3,046,379	$ 2,836,663	$ 2,714,224	$ 2,721,338
220	$ 1,772,866	$ 2,189,191	$ 1,874,510	$ 1,367,918	$ 449,037	$ 625,747	$ 570,213	$ 616,197	$ 692,847	$ 752,878
221	$ 3,317,929	$ 3,467,253	$ 4,344,956	$ 4,468,210	$ 2,417,018	$ 2,216,260	$ 1,348,271	$ 1,138,019	$ 495,372	$ -
222	$ 3,067,783	$ 3,603,829	$ 4,552,699	$ 4,716,792	$ 2,597,229	$ 4,014,347	$ 5,099,247	$ 5,328,800	$ 5,448,782	$ 5,935,523
223	$ 679,167	$ 5,711,742	$ 3,790,754	$ 3,742,316	$ 2,105,356	$ 3,152,892	$ 4,094,828	$ 4,765,303	$ 5,046,530	$ 526,944
224	$ 1,525,887	$ 1,882,426	$ 2,296,212	$ 2,548,582	$ 1,498,596	$ 2,330,169	$ 2,855,566	$ 2,891,268	$ 2,880,042	$ 2,982,044
225	$ 58,234	$ 70,114	$ 80,901	$ 77,034	$ 40,020	$ -	$ -	$ -	$ -	$ -
226	$ 64,177	$ 75,865	$ 77,175	$ 75,123	$ 39,308	$ 1,151	$ -	$ -	$ -	$ -
227	$ 2,755	$ 3,225	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
228	$ 1,297,885	$ 1,470,230	$ 1,052,570	$ -	$ -	$ -	$ -	$ -	$ -	$ -
230	$ 7,414	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
232	$ 124,576	$ 122,273	$ 136,670	$ 174,369	$ 154,431	$ 193,866	$ 245,750	$ 184,143	$ 99,047	$ 93,439
233	$ 1,339	$ 1,504	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
234	$ 171,751	$ 196,256	$ 217,077	$ 226,605	$ 128,959	$ 171,953	$ 177,735	$ 193,055	$ 214,939	$ 199,954
235	$ 60,010	$ 69,698	$ 81,258	$ 76,906	$ 39,742	$ 57,102	$ 65,495	$ 69,533	$ 68,563	$ 66,875
236	$ 14,613	$ 17,106	$ 36,456	$ 58,055	$ 28,097	$ 17,643	$ 14,270	$ 14,503	$ 16,945	$ 16,945
237	$ 37,038	$ 20,319	$ 21,057	$ 18,694	$ 10,590	$ 17,505	$ 23,638	$ 26,570	$ 24,505	$ 15,287
239	$ 2,327,347	$ 2,308,781	$ 2,282,363	$ 2,321,204	$ 1,440,787	$ 2,083,762	$ 2,408,615	$ 2,161,090	$ 2,637,582	$ 3,180,773
241	$ 759,421	$ 840,404	$ 973,243	$ 974,321	$ 484,333	$ 768,631	$ 885,717	$ 874,363	$ 895,784	$ 921,664
242	$ 30,820	$ 36,079	$ 41,922	$ 39,879	$ 20,806	$ 29,476	$ 32,944	$ 27,162	$ 27,162	$ 26,874
243	$ 19,320	$ 22,679	$ 26,343	$ 26,156	$ 13,873	$ 21,605	$ 21,723	$ 20,877	$ 26,028	$ 27,812
244	$ 73,104	$ 43,306	$ 56,156	$ 67,363	$ 34,033	$ 5,652	$ 6,318	$ 6,842	$ 6,318	$ 11,010
245	$ 4,844,857	$ 6,496,178	$ 7,878,415	$ 7,923,153	$ 4,526,535	$ 7,064,405	$ 8,341,353	$ 9,267,371	$ 9,783,277	$ 9,945,386
246	$ 1,663,710	$ 1,726,568	$ 1,960,678	$ 610,352	$ -	$ -	$ -	$ -	$ -	$ -
247	$ 30,579	$ 41,704	$ 108,459	$ 56,479	$ 36,329	$ 66,805	$ 79,262	$ 79,166	$ 61,430	$ 31,593
248	$ 289,669	$ 370,396	$ 443,530	$ 405,018	$ 209,820	$ 82,171	$ -	$ -	$ -	$ -
249	$ 15,689	$ 14,768	$ 22,767	$ 6,897	$ 4,692	$ -	$ -	$ -	$ -	$ -
250	$ 51,022	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
251	$ 44,006	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
252	$ 53,245	$ 54,800	$ 58,348	$ 20,063	$ 10,632	$ 14,341	$ 18,017	$ 19,158	$ 21,629	$ 22,004
253	$ 3,483,275	$ 4,130,445	$ 4,783,029	$ 4,568,471	$ 2,265,702	$ 3,254,773	$ 2,235,165	$ -	$ -	$ -
257	$ 38,693	$ 17,602	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
258	$ 1,583,866	$ 1,686,361	$ 1,780,720	$ 1,493,302	$ 767,745	$ 935,301	$ 951,349	$ 877,381	$ 529,965	$ -
261	$ 1,282,507	$ 1,177,343	$ 981,276	$ 851,200	$ 451,974	$ 680,371	$ 672,122	$ 728,490	$ 696,597	$ 849,896
262	$ 36,891	$ 62,788	$ 68,834	$ 59,482	$ 25,075	$ 28,238	$ 38,403	$ 39,816	$ 35,737	$ 35,691
264	$ 949	$ 1,066	$ 1,308	$ 1,207	$ 630	$ 892	$ 997	$ 997	$ 997	$ 997
265	$ 66,711	$ 140,669	$ 146,164	$ 138,607	$ 70,567	$ 122,108	$ 125,178	$ 144,308	$ 230,530	$ 259,827
266	$ 31,786	$ 33,962	$ 46,564	$ 44,295	$ 1,675	$ 2,374	$ 28,808	$ 33,213	$ 40,122	$ 37,780
267	$ 470	$ 633	$ 807	$ 741	$ 387	$ -	$ -	$ -	$ -	$ -
268	$ 1,674	$ 2,043	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Assessment Remitted by Self-Insurer and Insurer

Carrier Code	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020[1]
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
269	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,329	$ 41,120
270	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,637	$ 35,808
271	$ 2,111,938	$ 2,500,738	$ 2,525,481	$ 4,120,407	$ 2,578,700	$ 3,298,728	$ 4,336,381	$ 4,844,388	$ 4,064,700	$ 1,373,223
274	$ 145,726	$ 175,615	$ 193,020	$ 167,227	$ 83,804	$ 112,520	$ 121,652	$ 120,635	$ 117,221	$ 110,446
275	$ 401,488	$ 528,789	$ 18,100	$ 21,501	$ 33,860	$ 25,686	$ 26,007	$ 32,139	$ 5,454	$ 4,293
276	$ 437,079	$ 512,402	$ 597,451	$ 563,886	$ 290,947	$ 368,373	$ 287,662	$ 272,926	$ 268,383	$ 270,216
277	$ 59,622	$ 77,665	$ 89,378	$ 138,806	$ 90,233	$ 36,433	$ 33,147	$ -	$ -	$ -
279	$ 470,088	$ 593,150	$ 563,997	$ 136,277	$ -	$ -	$ -	$ -	$ -	$ 683,185
280	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,797	$ 4,427	$ 4,427	$ -
282	$ 24,332	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
285	$ 281,021	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
286	$ 119,105	$ 157,730	$ 120,817	$ 124,559	$ 80,914	$ 110,675	$ 161,621	$ 212,812	$ 302,970	$ 146,711
289	$ 11,298	$ 59,699	$ 74,358	$ 55,548	$ 31,937	$ 68,495	$ 39,688	$ 37,435	$ 49,748	$ 191,868
290	$ 59,224	$ 64,324	$ 76,356	$ 74,558	$ 39,054	$ 55,670	$ 59,283	$ 59,116	$ 59,006	$ 57,451
291	$ -	$ 19,927	$ 5,520	$ -	$ -	$ -	$ -	$ -	$ -	$ -
292	$ 13,718	$ 71,916	$ 7,992	$ 19,965	$ 4,999	$ 5,179	$ -	$ -	$ -	$ -
293	$ 46,060	$ 47,614	$ 21,814	$ 17,178	$ 7,260	$ 843	$ 942	$ -	$ -	$ -
294	$ 5,982	$ 4,734	$ 1,813	$ 3,472	$ 4,032	$ 4,814	$ 5,380	$ 8,678	$ 18,225	$ 15,357
296	$ 7,908	$ 2,797	$ 3,324	$ 3,449	$ 1,799	$ 2,549	$ 2,849	$ 2,849	$ -	$ -
297	$ 8,824	$ 11,047	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
298	$ 25,482	$ 26,560	$ 32,910	$ 32,527	$ 18,997	$ 26,913	$ 30,080	$ 30,080	$ 22,511	$ 64,465
300	$ -	$ -	$ -	$ -	$ -	$ -	$ 881	$ 2,254	$ 4,751	$ 6,524
303	$ 29,308	$ 30,070	$ 40,121	$ 48,304	$ 27,066	$ 33,720	$ 40,418	$ 47,724	$ 40,783	$ 43,424
305	$ 38,857	$ 36,547	$ 39,130	$ -	$ -	$ -	$ -	$ -	$ -	$ -
307	$ 1,147	$ 2,633	$ 3,155	$ 7,208	$ 4,005	$ 5,429	$ 5,256	$ 2,820	$ 1,626	$ 2,120
308	$ 568,806	$ 791,271	$ 1,082,547	$ 525,385	$ 581,522	$ 94,101	$ 62,101	$ 7,793	$ 29,919	$ 12,472
309	$ -	$ -	$ -	$ 4,675	$ 2,439	$ 111,880	$ 137,793	$ 161,698	$ 57,364	$ 811
310	$ 3,845,109	$ 4,948,242	$ 5,724,914	$ 5,392,537	$ 3,049,475	$ 4,443,674	$ 4,919,035	$ 5,048,413	$ 5,221,789	$ 5,321,577
311	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,149
312	$ -	$ 34,459	$ 20,797	$ 25,161	$ 32,280	$ 25,084	$ -	$ -	$ -	$ -
313	$ 723	$ 903	$ 1,242	$ 1,140	$ 595	$ 208	$ -	$ -	$ -	$ -
314	$ 43,592	$ 107,938	$ 121,335	$ 218,223	$ 112,271	$ 129,076	$ 19,279	$ -	$ -	$ -
315	$ 44,083	$ 41,374	$ 52,256	$ 43,491	$ 8,309	$ 21,250	$ 34,926	$ 39,773	$ 4,776	$ 514
316	$ 12,325	$ 29,157	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
318	$ 7,288	$ 4,435	$ -	$ 85	$ -	$ -	$ -	$ -	$ 7,548	$ 11,778
320	$ 137,894	$ 472,985	$ 298,395	$ 1,232	$ -	$ -	$ -	$ -	$ -	$ -
321	$ -	$ 5,926	$ 36,484	$ 29,869	$ 19,247	$ 20,428	$ 13,241	$ 7,548	$ -	$ -
322	$ 5,224	$ 30,874	$ 45,687	$ 22,317	$ 8,879	$ 80,208	$ 74,993	$ 85,490	$ -	$ -
323	$ -	$ 62,024	$ 64,842	$ -	$ -	$ -	$ -	$ -	$ -	$ -
324	$ -	$ 25,617	$ 32,452	$ 29,512	$ 99,378	$ 1,488,791	$ 1,967,565	$ 2,345,516	$ 1,858,064	$ 733,041
325	$ -	$ 20	$ 31,562	$ 47,118	$ 36,088	$ 52,979	$ 17,810	$ -	$ -	$ -
326	$ -	$ 9,404	$ 54,700	$ 71,589	$ 50,683	$ 71,882	$ 16,402	$ 14,598	$ 15,575	$ 17,101
327	$ -	$ -	$ 179,962	$ 47,961	$ 22,241	$ 33,635	$ 35,094	$ 37,289	$ 51,159	$ 55,871
328	$ -	$ 330	$ 597,682	$ 504,099	$ 271,394	$ 400,377	$ 454,319	$ 441,247	$ 317,854	$ 226,945
329	$ -	$ 97,844	$ 128,861	$ 164,064	$ 172,773	$ 93,865	$ 329,834	$ 321,787	$ 339,444	$ 59,527
330	$ -	$ 502	$ 463,115	$ 485,036	$ 80,249	$ 128,072	$ 49,451	$ 40,395	$ 1,223	$ -
331	$ -	$ -	$ 548,448	$ 78,726	$ 52,795	$ 49,976	$ 42,040	$ 24,970	$ 36,044	$ 735
332	$ 20	$ 735	$ -	$ 4,940	$ 3	$ 4,183	$ 6,814	$ 11,352	$ 22,731	$ 31,292
333	$ -	$ -	$ 213,686	$ 597,201	$ 267,156	$ 48,673	$ 149,137	$ 187,024	$ 263,635	$ 238,843
334	$ -	$ -	$ 229,182	$ 601,491	$ 300,028	$ 274,788	$ 279,322	$ 290,964	$ 202,790	$ 139,439
335	$ -	$ -	$ -	$ -	$ 2,245	$ 10,222	$ 11,424	$ 16,791	$ 58,657	$ 52,288
336	$ -	$ -	$ 3,747	$ 3,564	$ 1,860	$ -	$ -	$ -	$ -	$ -
337	$ -	$ -	$ -	$ -	$ -	$ -	$ 919	$ 3,378	$ 5,755	$ 1,446
338	$ 4,676	$ 31,776	$ 1,695,310	$ 6,794,582	$ 4,263,538	$ 6,216,317	$ 6,956,050	$ 7,104,832	$ 7,206,117	$ 7,671,701

Assessment Remitted by Self-Insurer and Insurer

Carrier Code	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020[1]
	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
339	$ -	$ -	$ 24,230	$ 16,187	$ -	$ -	$ -	$ -	$ -	$ -
340	$ -	$ -	$ 154	$ 60,580	$ 28,454	$ 51,229	$ 3,099	$ 3,348	$ -	$ -
341	$ -	$ -	$ -	$ 1,403,904	$ 782,114	$ 1,170,833	$ 1,371,363	$ 1,368,302	$ 1,256,507	$ 1,308,345
342	$ -	$ -	$ -	$ 2,391	$ 5,095	$ 7,217	$ 8,067	$ 5,984	$ 3,483	$ 3,447
343	$ -	$ -	$ -	$ 14,795	$ 9,012	$ 12,767	$ 4,668	$ 9,810	$ 48,172	$ 54,902
344	$ -	$ -	$ -	$ 2,943	$ -	$ -	$ 188,697	$ 223,860	$ 31,061	$ -
345	$ -	$ -	$ 3,101	$ 2,074	$ -	$ 12,417	$ 20,722	$ 11,987	$ 23,551	$ 24,687
346	$ -	$ -	$ -	$ -	$ 26,462	$ 57,467	$ 56,044	$ 100,826	$ 128,676	$ 49,925
347	$ -	$ -	$ -	$ -	$ 15,377	$ 124,740	$ 299,034	$ 326,327	$ 221,856	$ 161,238
348	$ -	$ -	$ -	$ -	$ 3,233	$ 8,317	$ 100,593	$ 109,584	$ 117,666	$ 109,217
349	$ -	$ -	$ -	$ 836	$ 56,984	$ 33,506	$ 28,738	$ 48,375	$ 85,202	$ 16,012
350	$ -	$ -	$ -	$ -	$ 18,350	$ 365,131	$ 524,577	$ 636,690	$ 907,214	$ 961,766
351	$ -	$ -	$ -	$ -	$ 2,489,481	$ 5,350,272	$ 5,643,898	$ 4,592,539	$ 5,041,578	$ 4,297,567
353	$ -	$ -	$ -	$ -	$ -	$ 30,991	$ -	$ 25,503	$ 12,657	$ 5,612
354	$ -	$ -	$ -	$ -	$ -	$ 219,523	$ 350,542	$ 350,767	$ 341,864	$ 320,936
355	$ -	$ -	$ -	$ -	$ -	$ 1,972,111	$ 2,417,153	$ 2,443,919	$ 2,880,316	$ 2,568,043
357	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,000	$ -	$ -
359	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,043,963	$ 1,009,675	$ 275,675	$ 231,219
360	$ -	$ -	$ -	$ -	$ -	$ 19,663	$ 70,807	$ 67,619	$ 59,501	$ -
361	$ -	$ -	$ -	$ -	$ -	$ -	$ 151,350	$ 178,268	$ 267,732	$ 205,293
362	$ -	$ -	$ -	$ -	$ -	$ 3,766	$ -	$ -	$ -	$ -
363	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,699	$ 8,025	$ 8,774	$ 8,774
364	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 249,824	$ 378,026	$ 375,460
365	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,263,344	$ 3,308,538	$ 4,425,477	$ 4,325,979
367	$ -	$ -	$ -	$ -	$ -	$ -	$ 28,433	$ 21,067	$ 14,783	$ 26,174
368	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,538,550	$ 2,607,469	$ -
369	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 787,605	$ 229,026
370	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,637	$ 12,525	$ 148,100
371	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 105,467	$ 16,670	$ -
372	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 617,793	$ 653,331
373	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,748	$ 20,397
374	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,462,750	$ -
375	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,819
376	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 86,294	$ 73,584
377	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,834	$ 76,030
378	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,233
379	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 918,336
900	$ 1,486	$ 1,032	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Totals	$178,669,268	$206,261,987	$236,538,000	$226,576,585	$119,799,045	$170,091,062	$180,537,563	$194,251,173	$195,280,176	$181,685,511

Note: The Amount is based on the gross rated undiscounted assessment remitted and processed as of January 20, 2020 and is subject to additional development.

Pennsylvania Department of Insurance

Mcare Fund

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

1991 - 2020

Assessment Year	Physicians (MD/DO)	Podiatrists	Nurse Midwives	Hospitals	Nursing Homes	Primary Health Centers	Birth Centers	Total Annual Count
1991	31,179	1,112	112	247	686	34	5	33,375
1992	31,963	1,101	121	248	707	34	5	34,179
1993	32,550	1,088	130	242	712	33	7	34,762
1994	33,309	1,098	156	240	726	28	5	35,562
1995	34,086	1,102	174	241	746	28	4	36,381
1996	34,302	1,096	192	235	775	23	4	36,627
1997	34,112	1,095	207	234	788	16	5	36,457
1998	34,243	1,063	209	232	785	14	5	36,551
1999	34,140	1,058	201	231	776	13	4	36,423
2000	34,127	1,087	218	232	768	12	4	36,448
2001	35,111	1,096	231	232	742	10	4	37,426
2002	35,379	1,099	225	236	736	6	3	37,684
2003	35,587	1,098	231	233	729	6	4	37,888
2004	35,542	1,104	233	231	716	5	4	37,835
2005	36,321	1,090	244	225	720	5	3	38,608
2006	37,227	1,111	253	225	712	5	3	39,536
2007	37,982	1,110	267	226	716	4	4	40,309
2008	38,890	1,126	267	224	713	5	4	41,229
2009	39,585	1,138	256	221	714	5	4	41,923
2010	40,307	1,162	271	223	702	5	4	42,674
2011	41,091	1,174	285	223	701	5	5	43,484
2012	42,173	1,201	309	221	699	5	5	44,613
2013	42,798	1,221	315	220	698	5	5	45,262
2014	43,240	1,239	315	223	691	5	5	45,718
2015	43,653	1,231	321	221	691	5	6	46,128
2016	44,060	1,220	335	220	689	5	6	46,535
2017	44,043	1,234	352	218	689	4	6	46,546
2018	45,159	1,223	365	216	688	4	5	47,660
2019	45,726	1,221	384	207	685	3	5	48,231
2020	42,568	1,015	354	185	651	3	5	44,781

Coverage for policies that have been reported and processed as of January 20, 2021 are included in the counts.

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

[2] Coverage for policies that incept or renew during the month of December is due to Mcare on or before March 1, 2021. Coverage for 2020 policies that have been reported and processed as of January 20, 2021 is included in the counts and subject to additional development.

[3] Applying an experience based development factor of 1.04% to the current 2019 health care provider count results in a projected 2020 health care provider count of 46,572.

PENNSYLVANIA MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND

Unfunded Liability Analysis as of December 31, 2019;

Rollforward Analysis to June 30, 2020 (based on actual loss activity)

Deloitte Consulting LLP

July 24, 2020

Deloitte.

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July 24, 2020

Ms. Beth Persun
Acting Executive Director – Mcare Fund
Pennsylvania Insurance Department – Bureau of Mcare
1010 North 7th Street, Suite 201
Harrisburg, PA 17102

Dear Ms. Persun:

Deloitte Consulting LLP is pleased to submit the actuarial report regarding our analysis of Pennsylvania Insurance Department ("Department") unfunded liability associated with the Medical Care Availability and Reduction of Error Fund as of June 30, 2020. This report supports our analysis of data through December 31, 2019, including a roll-forward to calculate the unfunded balance as of June 30, 2020 based on actual loss payments.

Michael D. Green and Gregory R. Chrin are members of the Casualty Actuarial Society and the American Academy of Actuaries and meet the qualification standards to issue this actuarial report.

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

Sincerely,

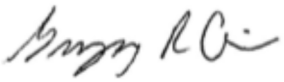

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Table of Contents

I. Overview

Deloitte Consulting LLP ("Deloitte Consulting", "us", "we" or "our") was retained by the Pennsylvania Insurance Department to provide an independent actuarial analysis regarding the Department's unfunded liability of the Medical Care Availability and Reduction of Error Fund ("Mcare" or "the Fund") as of June 30, 2020. This report has been created to support and document our independent analysis.

This report discusses our approach and presents the results of our December 31, 2019 review, which was also rolled forward to June 30, 2020. Our unpaid claim estimates are presented on an undiscounted basis. All information presented in this report is as of December 31, 2019 and June 30, 2020, displayed in thousands of US dollars unless otherwise stated.

Fund Background

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

The Fund provides excess coverage (to varying historical limits) for health care providers who have exhausted their primary limits ("Excess Claims"), and previously provided first dollar coverage, including defense, for claims that are reported within the statute of limitations, but four or more years after the occurrence event ("Section 715 Claims").

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

The mandatory medical professional liability primary coverage limits are scheduled to increase (with corresponding decreases in the Fund coverage limits), subject to the Commissioner's assessment of the basic insurance coverage capacity. Per our discussions with the Department, the estimates contained in this report assume that the primary coverage limits will increase to $750,000 in 2021 through 2023 and then to $1 million in 2024, and that the Fund provides no excess coverage beginning with policies issued or renewed in 2024.

Policy Year	Hospital: Mandatory Primary Occurrence / Aggregate Limits	Physician: Mandatory Primary Occurrence / Aggregate Limits	Mcare Fund Excess Occurrence / Aggregate Limits	Section 605/715 Limits
1996 & Prior	200 / 1,000	200 / 600	1,000 / 3,000	1,000
1997 – 1998	300 / 1,500	300 / 900	900 / 2,700	1,000
1999 – 2000	400 / 2,000	400 / 1,200	800 / 2,400	1,000
2001 – 2002	500 / 2,500	500 / 1,500	700 / 2,100	1,000
2003 – 2005	500 / 2,500	500 / 1,500	500 / 1,500	1,000
2006 – 2020	500 / 2,500	500 / 1,500	500 / 1,500	500 (excess)
2021 – 2023	750 / 3,750	750 / 2,250	250 / 750	250 (excess)
2024 & Subs.	1,000 / 4,500	1,000 / 3,000	0 / 0	0 (excess)

The Fund is supported by an assessment collected from each participating health care provider. The annual assessment percentage for calendar year 2019 is 19%.[1] Act 13 requires an assessment that will, in the aggregate, produce an amount sufficient to accomplish the following:

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

Beginning with the 2015 assessment and for each annual assessment thereafter, the Fund computes the assessment by subtracting any projected starting balance from the sum of items (1) through (4) above.[3] The assessment is collected via the application of an assessment rate to the policy year prevailing primary premium, which is based on the Joint Underwriting Association (JUA) occurrence rates applicable to the health care provider. Given that the assessments are primarily designed to reimburse the Fund for claims and expenses paid during the preceding claims period, the Fund effectively operates on a pay-as-you-go basis. The Fund does not maintain a reserve dedicated to support the liability for claims that have been incurred but not yet paid; however, the fund does require regular actuarial evaluations of its projected unfunded liability.

[1] https://www.insurance.pa.gov/SpecialFunds/MCARE/Pages/2019.aspx

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

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

REPORT SECTIONS

This report is comprised of the following sections:

- **Overview** – provides a general introduction and overview of the engagement;
- **Scope** – describes the work and reports that Deloitte Consulting has performed and produced;
- **Conditions and Limitations** – details the limitations that apply to this engagement's work product, report and results;
- **Summary of Results** – provides our estimates of the unpaid claims including relevant comments that discuss the areas of note observed throughout our analysis;
- **Actuarial Methodology** – describes the approach underlying the results of our estimates of unpaid claims;
- **ASOP 43 Disclosures** – discusses certain disclosures required by Actuarial Standard of Practice No. 43 pertaining to the estimation of property/casualty unpaid claims;
- **Exhibits** – describes the contents of the exhibits included in this report.

II. Scope

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

The scope of work is to provide the following:

- An estimate of the Department's unfunded liability as of December 31, 2019 for covered claims from January 1, 1976 through December 31, 2019.
- Considerations impacting the unfunded liability and future calendar year payment projections, including but not limited to principal drivers of the projections, typical time horizons over which experience is considered for projection purposes, and historical variability of these drivers.
- A roll-forward estimate of the Department's unfunded liability from December 31, 2019 to June 30, 2020, calculated by adding 6 months of the actual cost of new covered claims for 2020 to the unfunded liability as of December 31, 2019.

Gregory R. Chrin, is a Member of the American Academy of Actuaries (MAAA) and a Fellow of the Casualty Actuarial Society (FCAS). Greg Chrin prepared and supervised the various analyses contained in this report. Greg Chrin meets the definition of a Qualified Actuary per the NAIC Annual Statement Instructions – Property and Casualty, Actuarial Opinion. Michael D. Green, MAAA, ACAS, performed a peer review of this work. Greg Chrin and Michael Green have also attested compliance with the Casualty Actuarial Society's Continuing Education Policy as of December 31, 2019 to perform actuarial services in 2020. These organizations have professional standards that, among other provisions, require an actuary perform only assignments for which he/she is qualified.

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

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

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

The services we performed in this actuarial analysis do not constitute an audit, review, examination, or other form of attestation as those terms are defined by the American Institute of Certified Public Accountants (AICPA). Any use of the word "review" within this report should be interpreted in the common use of that term, and not the definition of "review" promulgated by the AICPA.

Deloitte Consulting affirms, to the best of our knowledge, that it presently has no interest, direct or indirect, which would conflict with the performance of services for this analysis.

III. Conditions and Limitations

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

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

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

In particular, the COVID-19 pandemic will likely impact the number and severity of future reported claims and the development of previously reported claims, as early expectations would suggest that:

- The pandemic may directly or indirectly result in more and/or larger claims being incurred than expected based on historical information for some coverages, or fewer claims for other coverages; and

- The effect of the pandemic on medical treatment, legal processes and business operations may cause the development of losses for previously reported claims to be understated for the period starting with the pandemic's inception through the evaluation date of the data for this report.

The volume of data affected by the pandemic which was available at the time of this analysis is small and immature. In our analysis we have incorporated estimated adjustments to our actuarial assumptions in consideration of the effects of the pandemic. However, we caution that the volatility and uncertainty of our projections are increased due to the lack of sufficiently credible data.

Please refer to the "Roll-forward Analysis" description on p.14 of this report for specific details around the adjusted approach.

Distribution and Use

This analysis has been prepared solely for the internal use of Pennsylvania Insurance Department and as documentation supporting our estimates related to unpaid claim liabilities as of December 31, 2019 and June 30, 2020. We understand that the Pennsylvania Insurance Department may release this report to the Pennsylvania Medical Society, the Hospital and Health System Association of Pennsylvania, and the Pennsylvania Podiatric Medical Association. In addition, the Fund may use this report as a part of the Mcare's Annual Report. Limited distribution of this report is permitted to the Department's external auditors to support their audit process, provided that it is made available on a confidential basis and

that any further distribution by auditors to third parties is prohibited without Deloitte Consulting's prior written consent. This report may be made available to applicable state insurance regulatory agencies when required who shall use the report solely in connection with the discharge of their regulatory oversight responsibilities and for no other purpose.

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

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

DATA RELIANCE

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

IV. SUMMARY OF RESULTS

A summary of our estimated unfunded liability excluding breast implant and pedicle screw exposure as of December 31, 2019 is displayed in the table below. We have included a 0.9% load to account for the unfunded liability associated with delay damages and post judgment interest ("DD & PJI") costs.

Summary of Unfunded Liability (000's) as of December 31, 2019	
Coverage	**Undiscounted Estimates**
Excess Claims	$881,480
Section 715 Claims (First Dollar Coverage)	$20,009
Section 715 Claims (Excess Coverage)	$114,519
Total Excluding DD & PJI	**$1,016,008**
DD & PJI Load	0.9%
Total Including DD & PJI	**$1,025,152**

Furthermore, a summary of our estimated unfunded liability excluding breast implant and pedicle screw exposure derived from data valued as of December 31, 2019 and rolled forward to June 30, 2020 using actual loss emergence from January 1, 2020 through June 30, 2020 is displayed in the table below.

Summary of Unfunded Liability (000's) as of June 30, 2020	
Coverage	**Undiscounted Estimates**
Excess Claims	$889,450
Section 715 Claims (First Dollar Coverage)	$17,246
Section 715 Claims (Excess Coverage)	$117,019
Total Excluding DD & PJI (Using Projected Payments)	**$1,023,715**
Estimated Payments (1/1/2020 – 6/30/2020)	$91,541
Actual Payments (1/1/2020 – 6/30/2020)	$76,616
Total Excluding DD & PJI (Based on Actual Payments)	**$1,038,640**
DD & PJI Load	0.9%
Total Including DD & PJI	**$1,047,988**

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

The unfunded liability estimates provided above make provisions for:

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

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

RELEVANT COMMENTS

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

- **Delay Damages and Post Judgment Interest**
  Prior to Act 135 of 1996, delay damages and post-judgment interest costs were generally included within the limits of coverage provided by the Fund. Pursuant to Act 135, these costs are now shared with other carriers in proportion to the share of loss and outside the Fund limits of coverage. Data for the most recent 15 calendar years indicate that Fund costs for delay damages and post-judgment interest have ranged from approximately 0.2% to approximately 1.8%. We have selected 0.9% as the estimated ratio of these costs to loss and have increased our estimates of the unfunded liability projections accordingly.

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

- **Actual versus Expected Development**

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

Summary of Actual versus Expected Emergence – Paid Loss (000's) 12/31/2018 – 12/31/2019			
Line of Business	**Expected Emergence**	**Actual Emergence**	**Actual vs. Expected**
Excess Claims SW excl. Philadelphia	112,050	138,161	26,111
Excess Claims Philadelphia	53,248	42,915	(10,332)
Section 715 Claims SW excl. Philadelphia (First Dollar)	3,886	7,875	3,989
Section 715 Claims Philadelphia (First Dollar)	1,725	1,000	(725)
Section 715 Claims SW excl. Philadelphia (Excess)	6,470	600	(5,870)
Section 715 Claims Philadelphia (Excess)	3,895	100	(3,795)
Total	**$181,272**	**$190,651**	**$9,379**

It is important to note that variances between actual and expected losses are not unexpected due to the inherently random nature of the insurance claim process (both in timing and amount of payments). Our prior-year estimates, as well as our expectation of loss development during the past 12 months, were based on the Entity's history of data up through that point in time only. Therefore, the actual versus expected differences displayed above are intended to be construed as loss activity in the current year above and beyond (either positive or negative) what the previous historical loss development patterns had implied.

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

- **Change in Ultimate Loss Estimates**

  Our ultimate loss selections for common accident years increased by $24.3 million. Details on changes in our ultimate loss selections are displayed in the table below:

Summary of Change in Ultimate Loss (000's)	
Line of Business	**Ultimate Change**
Excess Claims SW excl. Philadelphia	50,926

Excess Claims Philadelphia	(23,873)
Section 715 Claims SW excl. Philadelphia (First Dollar)	7,268
Section 715 Claims Philadelphia (First Dollar)	(639)
Section 715 Claims SW excl. Philadelphia (Excess)	(2,880)
Section 715 Claims Philadelphia (Excess)	(6,470)
Total	**$24,332**

The overall increase in ultimate loss is majorly driven by higher than expected severity and loss rate indications for Excess claims due to increased settlement and court activity through December 31, 2019. The activity is expected to slow down with the courts in Pennsylvania being potentially closed through the end of year 2020, and general delays in settlements caused by the COVID-19 pandemic. Please refer to the analysis exhibits for more details on the loss rate and severity selections, actual versus expected development and the change in ultimate loss selections by accident year.

- **Runoff of Liabilities**

  We have estimated the unfunded liability as of December 31, 2019 for each of the future accident years by rolling forward our estimates based on the projected newly asserted claims and expected payment activity by calendar year. Refer to Summary Appendix, Sheet 2 for the respective calculations.

V. Actuarial Methodology

Unfunded Liability

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

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

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

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

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

Loss Methods

- **Paid Loss Development Method**
  This method projects losses to ultimate based upon historical changes in the valuation of paid losses at given points in time (e.g., 12 months, 24 months). This method is particularly appropriate when loss development patterns have been historically stable and can be predicted with reasonable accuracy. This method is appropriate when claim handling processes have been stable but are independent of the case reserving methods used by the company given the reliance only on paid losses.

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

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

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

We note that the Fund does not establish a provision for case reserves on open claims. Case reserves represent an estimate of the case value based on a claim adjuster's assessment of the relevant case-specific facts and circumstances. Therefore, we have not leveraged actuarial methods that rely upon case reserve estimates (e.g., reported loss development method, reported B-F method, etc.).

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

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

SELECTED ULTIMATE LOSSES AND UNPAID LOSS CALCULATION

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

OTHER CONSIDERATIONS

ROLL-FORWARD ANALYSIS

The loss data that we used to estimate the unfunded liability amount was valued as of December 31, 2019. Therefore, in order to compute the estimated unfunded liability as of June 30, 2020, we had calculated a projection in June based on estimated loss payments. We have now revisited our analysis and made certain adjustments as described below.

Our estimated loss payments from January 1, 2020 to June 30, 2020 are approx. $91.5 million for all segments combined. The actual loss payments for the same period and all segments combined are provided to be $76.6 million which compare favorably to our expectation. In light of the uncertainty caused by COVID-19 and the unknown actual vs. expected differential of loss payments, we have held our ultimate loss estimates and subtracted loss payments of $76.6 million resulting in a higher estimate of unfunded liability as of June 30, 2020.

REINSURANCE COLLECTIBILITY

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

PENNSYLVANIA PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION (PPCIGA)

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

VI. ASOP 43 Disclosures

Actuarial Standard of Practice No. 43: *"Property/Casualty Unpaid Claim Estimates"* requires certain disclosures to accompany actuarial estimates of unpaid claims. The following disclosures are applicable to our analysis of the Department's unfunded liability as of December 31, 2019 and June 30, 2020.

- **Terminology**: The terms "Unfunded Liability", "Estimates of Unpaid Claims", and "Unpaid Claim Estimates" are used interchangeably and are meant to convey the same meaning. The term "Reserve" is limited to its strict definition as an amount recorded in financial statements.

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

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

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

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

- **Applicable Dates**: These unpaid claim estimates as of December 31, 2019 and June 30, 2020 were based on loss, and premium data evaluated as of December 31, 2019, and additional information provided to us through the date of this report.

- **Updates of Previous Estimates**: These unpaid claim estimates include updates of previous estimates. The assumptions underlying these estimates are generally based on our evaluation of the Entity's historical experience, and these assumptions in some cases have changed since our last evaluation of the unpaid claim liabilities as of June 30, 2019.

- **Documentation**: This report, along with the accompanying exhibits, provides documentation supporting our unpaid claim estimates as of December 31, 2019 and June 30, 2020.

VII. EXHIBITS

Pennsylvania Medical Care Availability and Reduction of Error Fund Summary 1

Total Excess and Section 715 Claims, Excluding Breast Implant & Pedicle Screw Claims

Unfunded Liability Analysis as of 12/31/2019
(000)'s

Summary Exhibit

	Selected Ultimate Loss @ 12/31/2019	Paid Loss @ 12/31/2019	Indicated Unpaid Loss @ 12/31/2019
	(1)	(2)	(3)
Excess Claims (1990 - 2019)			
SW excl. Philadelphia	3,324,609	2,666,491	658,119
Philadelphia	2,326,457	2,103,096	223,362
Excess Claims (1989 & Prior)	1,640,549	1,640,549	0
Sub-Total (A)	7,291,616	6,410,136	881,480
Section 715 Claims (First Dollar Coverage: 2005 & Prior)			
SW excl. Philadelphia	593,911	578,350	15,561
Philadelphia	434,565	430,118	4,448
Sub-Total (B)	1,028,476	1,008,468	20,009
Section 715 Claims (Excess Coverage: 2006 - 2019)			
SW excl. Philadelphia	91,464	8,915	82,549
Philadelphia	35,440	3,470	31,970
Sub-Total (C)	126,904	12,385	114,519
Total (D = A + B + C)	**8,446,996**	**7,430,988**	**1,016,008**
DD & PJI Load (E)			**0.9%**
Total incl. DD & PJI (D * (1+E))			**1,025,152**

Footnotes:

(1) Deloitte Selected Ultimate Loss @ 12/31/2019
(2) Provided by Entity @ 12/31/2019
(3) Deloitte Indicated Unpaid Loss @ 12/31/2019

Total Excess and Section 715 Claims, Excluding Breast Implant & Pedicle Screw Claims

Unfunded Liability Analysis as of 06/30/2020
(000)'s

Summary Exhibit

	Selected Ultimate Loss @ 06/30/2020	Paid Loss @ 06/30/2020	Indicated Unpaid Loss @ 06/30/2020
	(1)	(2)	(3)
Excess Claims (1990 - 2020)			
SW excl. Philadelphia	3,458,301	2,725,315	666,140
Philadelphia	2,376,357	2,128,097	223,310
Excess Claims (1989 & Prior)	1,640,549	1,640,549	0
Sub-Total (A)	7,475,207	6,493,961	889,450
Section 715 Claims (First Dollar Coverage: 2005 & Prior)			
SW excl. Philadelphia	593,911	580,405	13,507
Philadelphia	434,565	430,826	3,739
Sub-Total (B)	1,028,476	1,011,231	17,246
Section 715 Claims (Excess Coverage: 2006 - 2020)			
SW excl. Philadelphia	102,417	12,233	84,708
Philadelphia	39,392	5,105	32,311
Sub-Total (C)	141,809	17,337	117,019
Total (D = A + B + C)	**8,645,492**	**7,522,529**	**1,023,715**
Expected Paid (1/1/2020 - 06/30/2020) (E)			91,541
Actual Paid (1/1/2020 - 06/30/2020) (F)			76,616
Total (G = D + E - F)			**1,038,640**
DD & PJI Load (H)			**0.9%**
Total incl. DD & PJI (G * (1+H))			**1,047,988**

Footnotes:

(1) Deloitte Selected Ultimate Loss @ 06/30/2020
(2) Provided by Entity @ 12/31/2019 + Projected Payments through 06/30/2020
(3) Deloitte Indicated Unpaid Loss @ 06/30/2020; Latest Year Adjusted for Partial Period

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End of Report