



About Mcare

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

PURPOSE

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

REVENUE STREAM

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

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

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

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



Medical Care Availability and Reduction of Error Fund

PENNSYLVANIA INSURANCE DEPARTMENT

In addition to the annual assessments, the fund receives supplemental funding under section 712(m), beginning January 1, 2004 and is to set to expire nine calendar years thereafter on December 31, 2013. These funds consist of surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system, also known as the “Auto CAT Fund.”

In addition to the above funding sources, Act 44 of 2003, section 443.7 established within the General Fund a special account known as the Health Care Provider Retention Account. It directs the department to assist in administering funds appropriated under this section. This account is used to provide funding for the Abatement Program.

PARTICIPATION

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

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

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



COVERAGE REQUIREMENTS

Historically, the mandatory coverage limits for health care providers has varied. Currently, the total required amounts of medical professional liability coverage, including primary and Mcare coverage, for health care providers, excluding hospitals, are \$1,000,000 per occurrence and \$3,000,000 per annual policy year aggregate. For hospitals, the required total coverage amounts are \$1,000,000 per occurrence, and \$4,000,000 per annual aggregate. The current total coverage amounts required for health care providers participating in Mcare are as follows:

A. Primary Coverage for Participating Health Care Providers

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

B. Mcare Coverage for Participating Health Care Providers

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

C. Primary Coverage for Nonparticipating Health Care Providers

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

D. Mcare Coverage for Nonparticipating Health Care Providers

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



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

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

REPORTING COVERAGE TO MCARE

The primary insurance carrier must submit proof of insurance to Mcare for each policy issued to a participating health care provider, eligible professional corporation, eligible partnership, and eligible professional association on a Form 216 Remittance Advice (“Form 216”), together with the appropriate assessment payment for each health care provider identified on the Form 216. A copy of the Form 216 may be found on Mcare’s website.

Mcare has the authority to determine the amount of the annual assessment that will be levied on each participating health care provider and eligible entity. The assessment is a percentage designated by Mcare of the prevailing primary premium charged by the JUA for health care providers of like class, size, risk and kind. A health care provider must pay the assessment to their primary carrier in sufficient time for it to forward proof of insurance and the applicable assessment payment to Mcare within 60 days of the effective date of the health care provider’s primary policy.

A participating health care provider’s failure to obtain primary coverage in the amount mandated by Act 13, or to pay the assessment required, will result in Mcare certifying the health care provider’s noncompliance to the appropriate licensure board for possible disciplinary action. In addition, Mcare will not provide coverage to that health care provider in the event of a claim made against him or her.

CLAIMS REPORTING

If all statutory requirements are satisfied, Mcare provides coverage in excess of the applicable primary coverage. If it is anticipated that a judgment, award, or settlement in a particular case will exceed the available primary coverage for a health care provider, the primary carrier must promptly notify Mcare in writing of the medical professional liability claim. This notification must be made through submission of a Form C-416 to Mcare. A copy of the Form C-416 may be found on Mcare’s website.



Medical Care Availability and Reduction of Error Fund
PENNSYLVANIA INSURANCE DEPARTMENT

Section 715 of Act 13 provides an exception to Mcare's role as statutory excess carrier in instances where the claim alleges malpractice prior to January 1, 2006. Under Section 715, Mcare provides first dollar indemnity up to \$1,000,000 and the cost of defense for a claim if certain requirements are met. Specifically, the claim must be filed more than four years after the date the breach of contract or tort occurred, must be filed within the applicable statute of limitations, and the primary carrier must submit a Form C-416 requesting Section 715 status for the claim within 180 days of the date on which notice of the claim was first given to the health care provider or its insurer. In the event of multiple treatments occurring less than four years before the date on which the health care provider or its insurer received notice of the claim, Section 715 coverage will not apply.

Pursuant to Act 13, Section 715 coverage ends as of January 1, 2006. Specifically, primary carriers are required to provide first dollar indemnity and cost of defense for all claims occurring four or more years after the breach of contract or tort and after December 31, 2005.

SUMMARY

This narrative is provided for general informational purposes only and is not inclusive of all Mcare programs, procedures, rules, or regulations. For additional information, please contact Mcare at the following address:

Medical Care Availability and Reduction of Error Fund
30 North 3rd Street, 8th Floor
P.O. Box 12030
Harrisburg, PA 17108-2030
(717) 783-3770
or
www.insurance.pa.gov/mcare