



REPORT ON KEY ISSUES FROM THE
HOUSE APPROPRIATIONS COMMITTEE

BUDGET BRIEFING

DWIGHT EVANS, DEMOCRATIC CHAIRMAN

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2009/10 Proposed Budget: MCARE/Provider Retention

The Governor's 2009/10 proposed budget uses the accumulated balance of the **Health Care Provider Retention Account (HCPRA)** as a revenue stream to accomplish three goals. First, the proposed budget would transfer \$350 million from the Account to the General Fund, in order to help close the budget gap. Second, the proposed budget would use \$280 million from the account to help pay the liability on the **Medical Care Availability and Reduction of Error (MCARE)** fund. Third, the proposed budget would use funds from the Account in 2011/12 (\$19.3 million) and 2012/13 (\$47.1 million) to cover costs associated with expanding the adultBasic health insurance program.

In addition to using the HCPRA balance as a revenue source in his proposed budget, the Governor would redirect the 25 cents per pack cigarette tax, currently dedicated to the HCPRA to the General Fund.

An improved medical liability insurance climate in Pennsylvania has resulted in lower MCARE claims. As a result, the commonwealth has not needed the amount of funds available through the HCPRA to cover assessment abatement costs. This Budget Briefing will examine the history of MCARE and the HCPRA, as well as the Governor's proposal to accelerate the phase-out of MCARE.

Medical Care Availability and Reduction of Error (MCARE) Fund

Mechanics of MCARE

Act 13 of 2002 created the Medical Care Availability of Error (MCARE) Fund. MCARE succeeded the Medical Professional Liability Catastrophe Loss (CAT) Fund. The CAT fund began to accept coverage and accrue unreserved liabilities in calendar year 1976.

MCARE Coverage	
Participating Health Care Providers	Exempt Health Care Providers
Hospitals	Providers not practicing in PA
Nursing Homes	Providers who are exclusively federal government or commonwealth employees
Birth Centers	Providers who are exclusively forensic pathologists
Primary Health Centers	Providers who are retired, whether or not they provide care for themselves or immediate family members
Physicians, podiatrists, and certified nurse midwives licensed by the commonwealth and who conduct 50% or more of their health business in Pennsylvania.	Providers who practice exclusively as members of the armed forces
Professional corporations, associations and partnerships owned entirely by health care providers that have elected to insure their primary liability.	Providers who practice exclusively under a volunteer license

The main purpose of the MCARE Fund is to ensure reasonable compensation for people injured due to medical negligence. Act 13 requires participating health insurers to purchase private medical malpractice insurance for basic insurance coverage or “primary coverage.” Primary coverage must be obtained in the amount of \$500,000 per occurrence and \$1,500,000 per annual aggregate (\$2,500,000 per annual aggregate for hospitals). Money in the MCARE fund is used to pay claims against participating health providers for losses or damages awarded in excess of that primary coverage.

Act 13 provides for the “phase-out” of MCARE, eventually shifting all medical liability coverage to private providers. MCARE is operated on a “pay-as-you-go” basis. When court judgments and settlements occur, MCARE makes annual payments to cover the obligations. Claim payments often occur years after the alleged incident. As a result, even after the shift to private insurance coverage, MCARE will continue to make claims payments, known as a “tail,” for several decades.

MCARE Revenues and Expenditures

Since 2003, the MCARE Fund has received the following revenue sources: (1) assessments on health care providers; (2) transfers from the Health Care Provider Retention Account (HCPRA) to cover assessment abatements; (3) revenue related to traffic moving violations via the AutoCAT Fund; and (4) interest earnings on the MCARE Fund.

Provider assessments are the largest revenue source to the fund.

Assessments are calculated based on a formula outlined in the MCARE Act. The formula examines the number of payout claims in the previous calendar year and any projected operating expenses in the current calendar year.

The formula also accounts for maintaining a 10 percent cushion in the Fund. Due to the nature of the formula, in years where claims are declining,

providers pay more into the Fund than is required to cover claim payouts in the current year.

Health Care Provider Retention Account

The Health Care Provider Retention Account (HCPRA) was originally created under Act 44 of 2003. The purpose of the Account was to fund MCARE assessment abatements for participating health care providers as outlined in the legislation. Act 46 of 2003 raised the cigarette tax and directed the equivalent of 25 cents per pack to the Account, in order to cover the costs of those abatements.

Funding Assessment Abatements

Under Act 44 of 2003 and subsequent related legislation, participating health care providers were eligible to receive abatements equating to either 50 or 100 percent of their MCARE assessments for calendar years 2003 through 2006, depending on the stipulations set forth in law. The program expired in December 2007.

HCPRA Assessment Abatements		
Provider	Abatement %	Calendar Years
Physicians assessed as members of one of the four highest rate classes of the prevailing primary premium	100%	2003-2006
Emergency physicians	100%	2003-2006
Physicians routinely providing obstetrical services in rural areas (as designated by the Insurance Department)	100%	2003-2006
Certified Nurse Midwives	100%	2003-2006
Physicians that do not qualify for a 100% abatement	50%	2003-2006
Licensed podiatrists	50%	2005-2006
Nursing homes	50%	2006

Under the law, the Secretary of the Budget may transfer an amount up to the aggregate amount of abatements granted by the Insurance Department under the Health Care Provider Retention Program. As mentioned in the section “MCARE Revenues and

Expenditures,” when claims decline, assessment revenues exceed the amount necessary to fund claim payouts in the current year. The nature of this formula eventually resulted in lower assessments and a surplus in the MCARE fund. Therefore, transfers from the HCPRA to the MCARE Fund only were necessary in 2004 and 2005 to help cover claim costs.

HCPRA Revenues and Expenditures

As mentioned previously, an amount equivalent to 25 cents per pack of the cigarette tax is deposited into the HCPRA. The Secretary of the Budget may transfer an amount up to the aggregate amount of abatements granted by the Insurance Department under the Health Care Provider Retention Program, if deemed necessary. The Secretary of the Budget transferred funds from the HCPRA to the MCARE Fund in 2004 (\$100 million) and in 2005 (\$230 million). No other transfers for this purpose have been made. As a result, the HCPRA currently has a balance of over \$600 million.

While the program expired in December 2007, the Tax Reform Code provisions dedicating the portion of the cigarette tax to the HCPRA remain in effect. Therefore, those revenues continue to be deposited into the HCPRA.

The Medical Liability Insurance Climate in Pennsylvania

Starting in 2000 and peaking in 2003, the health care providers in Pennsylvania were faced with escalating medical malpractice insurance premiums and the lack of available private insurance companies willing to write new policies. As a result, the commonwealth took various actions, including the Health Care Provider Retention Program and court reforms, in order to improve the medical malpractice insurance climate.

The number of statewide medical malpractice claims payouts was 41 percent lower in 2007 than the base period of 2000 through 2002, before reforms were implemented. In addition, the amount of MCARE claim payments has dropped significantly since 2003 (from \$379 million to below \$200 million).

2009/10 Budget Proposal: Paying the MCARE “Tail”

As mentioned in the subsection “Mechanics of MCARE,” the MCARE fund will continue to make claims payments, known as “paying the tail,” even after coverage shifts to private insurance. The Governor’s proposed budget would address this issue by “pre-paying” the liability of the MCARE fund through the following sources: (1) \$280 million from the HCPRA; (2) continued dedication of AutoCAT Fund revenues (approximately \$44 million annually); (3) the current balance of the MCARE Fund (approximately \$104 million); and the interest earnings on these contributions.

QUESTIONS AND COMMENTS 717-783-1540

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