Act 13 of 2002 created the Medical Care Availability and Reduction 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.

Coverage

Mcare is a special fund within the State Treasury with the purpose to ensure reasonable compensation for people injured due to medical negligence. Physicians, hospitals, and other health care providers, as defined by Act 13, are required to have medical professional liability insurance. For 2022, participating health care providers, excluding hospitals, are required to carry medical professional liability insurance, primary coverage, in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate. Hospitals are required to obtain primary coverage in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate.

Mcare funds are used when claims against participating health care providers result in losses or damages being awarded that exceed a provider's primary coverage. Mcare provides participating health care providers with coverage of $500,000 per occurrence and $1,500,000 per annual aggregate in excess of their primary coverage.

Medical Professional Liability Coverage (Occurrence / Aggregate Limits)			
Policy Year	Mandatory Primary Coverage		Mcare Fund Excess Coverage
	Health Care Providers (Excluding Hospitals)	Hospitals	
2022	$500,000 / $1,500,000	$500,000 / $2,500,000	$500,000 / $1,500,000

Phase-out

Act 13 provides for the phase-out of Mcare, eventually shifting all medical liability coverage to private coverage. Mcare is operated on a pay-as-you-go basis. When court judgements and settlements occur, Mcare makes annual payments to cover the obligations. The governor's executive budget estimates that $190 million will be disbursed in 2022/23.

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 for several decades. Providers will still be required to pay annual Mcare assessments to cover Mcare's liabilities incurred at the time of phase-out. Pennsylvania provider organizations have opposed the phase-out and made their support conditional on a commitment of public funds to pay off Mcare's unfunded liabilities and to cap annual increases in medical professional liability insurance. According to the Mcare Annual Report for 2021, the estimated unfunded liability was $1.056 billion as of December 31, 2020.

Act 13 provided for the phase-out to begin in 2006, subject to a review and report by the Insurance Commissioner. Thus far, based on statutorily prescribed capacity studies, the commissioner has maintained the aforementioned coverage levels. Most recently on June 30, 2021, the Insurance Commissioner provided notice that current coverage limits will remain in place for calendar years 2022 and 2023.

Once the Insurance Commissioner finds that additional basic insurance capacity is available, the phase-out of Mcare will begin and the amount of required primary coverage for providers will be increased. A similar exercise will take place three years after the initial phase-out of Mcare. Unless the Insurance Commissioner finds that additional basic insurance coverage capacity is not available, the amount of required primary coverage for providers will again be increased. Corresponding decreases in Mcare coverage will also take place as the required primary coverage is increased during this two-part phase-out. The chart below is for illustration purposes only and the effective date is dependent on a determination by the Insurance Commissioner.

Medical Professional Liability Coverage - Sample Scenario (Occurrence / Aggregate Limits)			
Policy Year	Mandatory Primary Coverage		Mcare Fund Excess Coverage
	Health Care Providers (Excluding Hospitals)	Hospitals	
1	$750,000 / $2,250,000	$750,000 / $3,750,000	$250,000 / $750,000
2	$1,000,000 / $3,000,000	$1,000,000 / $4,500,000	$0 / $0

Assessment

The Mcare Fund receives no General Fund revenue. Mcare is funded by a yearly assessment on the health care providers it serves. Providers covered under Act 13 conducting 50 percent or more of their health care business within the Commonwealth are required to participate in Mcare. The Mcare assessment is a percentage of the Pennsylvania Liability Joint Underwriting Association (JUA) rates as approved by the Pennsylvania Insurance Department. The assessment rate for 2023 is 19 percent. The chart below displays the yearly assessment rate for the past twelve years.

Assessment Rate by Year			
Assessment Year	Assessment Rate	Assessment Year	Assessment Rate
2012	22%	2018	19%
2013	25%	2019	19%
2014	19%	2020	19%
2015	12%	2021	19%
2016	17%	2022	12%
2017	19%	2023	19%

Private market insurers calculate, bill, collect, and remit the assessment to Mcare for each provider it insures. Self-insured providers perform the same function on their own behalf. The governor's executive budget estimates that $190 million will be collected in 2022/23.

Act 13 stated that the assessment shall, in the aggregate, produce an amount 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 from the Catastrophic Loss Benefits Continuation Fund.
- (iv) Provide a reserve that shall be 10 percent of the sum of subparagraphs (i), (ii) and (iii).

For 2022/23, the governor's executive budget estimated a beginning cash balance of $83.8 million for the Mcare Fund. Adding in the estimated assessments of $190 million, a small amount of interest and subtracting estimated disbursements of $190 million, produces a projected ending balance of $83.8 million for 2022/23, sufficient funds to cover the 10 percent reserve requirement.