PROASSURANCE CORP
Form 10-K
February 24, 2015
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United States
Securities and Exchange Commission
Washington, D.C. 20549
FORM 10-K
(Mark One)
ý Annual report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934 [Fee Required]
for the fiscal year ended December 31, 2014,
or
¨ Transition report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934 [No Fee Required]
for the transition period from to .
Commission file number: 001-16533
ProAssurance Corporation
(Exact name of registrant as specified in its charter)

Delaware	63-1261433
(State of incorporation or organization)	(I.R.S. Employer Identification No.)
100 Brookwood Place, Birmingham, AL	35209
(Address of principal executive offices)	(Zip Code)

(205) 877-4400
(Registrant's Telephone Number, Including Area Code)
Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange On Which Registered
Common Stock, par value $0.01 per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None.
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ý No ¨
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No ý
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ý No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	ý	Accelerated filer	¨
Non-accelerated filer	¨ (Do not check if a smaller reporting company)	Smaller reporting company	¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ¨ No ý

The aggregate market value of voting stock held by non-affiliates of the registrant at June 30, 2014 was $2,557,238,513.

As of February 20, 2015, the registrant had outstanding approximately 55,814,475 shares of its common stock.

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Documents incorporated by reference in this Form 10-K

(i) The definitive proxy statement for the 2015 Annual Meeting of the Stockholders of ProAssurance Corporation (File No. 001-16533) is incorporated by reference into Part III of this report.

General Information

Throughout this report, references to ProAssurance, “we”, “us”, “our” or "the Company" refer to ProAssurance Corporation and its consolidated subsidiaries. Also, as ProAssurance is an insurance holding company and certain terms and phrases common to the insurance industry are used in this report that carry special and specific meanings, we encourage you to read the Glossary of Selected Insurance and Related Financial Terms posted on the Supplemental Information page of our website (www.ProAssurance.com/InvestorRelations/supplemental.aspx).

Caution Regarding Forward-Looking Statements

Any statements in this Form 10-K that are not historical facts are specifically identified as forward-looking statements. These statements are based upon our estimates and anticipation of future events and are subject to certain risks and uncertainties that could cause actual results to vary materially from the expected results described in the forward-looking statements. Forward-looking statements are identified by words such as, but not limited to, "anticipate," "believe," "estimate," "expect," "hope," "hopeful," "intend," "likely," "may," "optimistic," "possible," "potential," "preliminary," "project," "should," "will" and other analogous expressions. There are numerous factors that could cause our actual results to differ materially from those in the forward-looking statements. Thus, sentences and phrases that we use to convey our view of future events and trends are expressly designated as forward-looking statements as are sections of this Form 10-K that are identified as giving our outlook on future business.

Forward-looking statements relating to our business include among other things: statements concerning future liquidity and capital requirements, investment valuation and performance, return on equity, financial ratios, net income, premiums, losses and loss reserve, premium rates and retention of current business, competition and market conditions, the expansion of product lines, the development or acquisition of business in new geographical areas, the availability of acceptable reinsurance, actions by regulators and rating agencies, court actions, legislative actions, payment or performance of obligations under indebtedness, payment of dividends, and other matters.

These forward-looking statements are subject to significant risks, assumptions and uncertainties, including, among other things, the following factors that could affect the actual outcome of future events:

- changes in general economic conditions, including the impact of inflation or deflation and unemployment;
- our ability to maintain our dividend payments;
- regulatory, legislative and judicial actions or decisions that could affect our business plans or operations;
- the enactment or repeal of tort reforms;
- formation or dissolution of state-sponsored insurance entities providing coverages now offered by ProAssurance which could remove or add sizable numbers of insureds from or to the private insurance market;
- changes in the interest rate environment;
- changes in U.S. laws or government regulations regarding financial markets or market activity that may affect the U.S. economy and our business;
- changes in the ability of the U.S. government to meet its obligations that may affect the U.S. economy and our business;
- performance of financial markets affecting the fair value of our investments or making it difficult to determine the value of our investments;
- changes in requirements or accounting policies and practices that may be adopted by our regulatory agencies, the Financial Accounting Standards Board, the Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board, or the New York Stock Exchange (NYSE) and that may affect our business;
- changes in laws or government regulations affecting the financial services industry, the property and casualty insurance industry or particular insurance lines underwritten by our subsidiaries;

the effect on our insureds, particularly the insurance needs of our insureds, and our loss costs, of changes in the healthcare delivery system, including changes attributable to the Patient Protection and Affordable Care Act (the Affordable Care Act);

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- consolidation of our insureds into or under larger entities which may not have a risk profile that meets our underwriting criteria or which may not use external providers for insuring or otherwise managing substantial portions of their liability risk;
- uncertainties inherent in the estimate of our loss and loss adjustment expense reserve and reinsurance recoverable;
- changes in the availability, cost, quality, or collectability of insurance/reinsurance;
- the results of litigation, including pre- or post-trial motions, trials and/or appeals we undertake;
- allegations of bad faith which may arise from our handling of any particular claim, including failure to settle;
- loss or consolidation of independent agents, agencies, brokers, or brokerage firms;
- changes in our organization, compensation and benefit plans;
- changes in the business or competitive environment may limit the effectiveness of our business strategy and impact our revenues;
- our ability to retain and recruit senior management;
- the availability, integrity and security of our technology infrastructure;
- the impact of a catastrophic event, as it relates to both our operations and our insured risks;
- the impact of acts of terrorism and acts of war;
- the effects of terrorism related insurance legislation and laws;
- assessments from guaranty funds;
- our ability to achieve continued growth through expansion into other states or through acquisitions or business combinations;
- changes to the ratings assigned by rating agencies to our insurance subsidiaries, individually or as a group;
- provisions in our charter documents, Delaware law and state insurance laws may impede attempts to replace or remove management or may impede a takeover;
- state insurance restrictions may prohibit assets held by our insurance subsidiaries, including cash and investment securities, from being used for general corporate purposes;
- taxing authorities can take exception to our tax positions and cause us to incur significant amounts of legal and accounting costs and, if our defense is not successful, additional tax costs, including interest and penalties; and
- expected benefits from completed and proposed acquisitions may not be achieved or may be delayed longer than expected due to business disruption; loss of customers, employees and key agents; increased operating costs or inability to achieve cost savings; and assumption of greater than expected liabilities, among other reasons.

Additional risks that could arise from our membership in the Lloyd's of London market (Lloyd's) and our participation in Lloyd's Syndicate 1729 (Syndicate 1729) include, but are not limited to, the following:

- members of Lloyd's are subject to levies by the Council of Lloyd's based on a percentage of the member's underwriting capacity, currently a maximum of 3%, but can be increased by Lloyd's;
- Syndicate operating results can be affected by decisions made by the Council of Lloyd's over which the management of Syndicate 1729 has little ability to control, such as a decision to not approve the business plan of the Syndicate, or a decision to increase the capital required to continue operations, and by our obligation to pay levies to Lloyd's;
- Lloyd's insurance and reinsurance relationships and distribution channels could be disrupted or Lloyd's trading licenses could be revoked making it more difficult for Syndicate 1729 to distribute and market its products; and
- rating agencies could downgrade their ratings of Lloyd's as a whole.

Our results may differ materially from those we expect and discuss in any forward-looking statements. The principal risk factors that may cause these differences are described in “Item 1A, Risk Factors” in this report.

We caution readers not to place undue reliance on any such forward-looking statements, which are based upon conditions existing only as of the date made, and advise readers that these factors could affect our financial performance and could cause actual results for future periods to differ materially from any opinions or statements

expressed with respect to future periods in any current statements. Except as required by law or regulations, we do not undertake and specifically decline any obligation to publicly release the result of any revisions that may be made to any forward-looking statements to reflect events or circumstances after the date of such statements or to reflect the occurrence of anticipated or unanticipated events.

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PART I

ITEM 1. BUSINESS

Overview

ProAssurance Corporation is a holding company for property and casualty insurance companies. For the year ended December 31, 2014, our net premiums written totaled $701.8 million, and at December 31, 2014 we had total assets of $5.2 billion and $2.2 billion of shareholders' equity. We seek to be a strong and trusted partner, helping our customers to confront uncertainty through innovative loss transfer and loss mitigation solutions for liability risks. Our emphasis is on healthcare, but we also serve other types of insureds. Our wholly owned insurance subsidiaries provide professional liability insurance for healthcare professionals and facilities, professional liability insurance for attorneys, liability insurance for medical technology and life sciences risks, workers' compensation insurance, and we are the majority capital provider for Lloyd's of London Syndicate 1729, which writes a range of property and casualty insurance and reinsurance lines.

Our executive offices are located at 100 Brookwood Place, Birmingham, Alabama 35209 and our telephone number is (205) 877-4400. Our stock trades on the NYSE under the symbol “PRA.” Our website is www.ProAssurance.com and we maintain a dedicated Investor Relations section on that website (www.ProAssurance.com/InvestorRelations) to provide specialized resources for investors and others seeking to learn more about us.

As part of our disclosure through the Investor Relations section of our website, we publish our annual report on Form 10-K, our quarterly reports on Form 10-Q, and our current reports on Form 8-K and all other public SEC filings as soon as reasonably practical after filing with the SEC on its EDGAR system. These SEC filings can be found on our website at www.ProAssurance.com/InvestorRelations/reports_filings.aspx. This section also includes information regarding stock trading by corporate insiders by providing access to SEC Forms 3, 4 and 5 when they are filed with the SEC. In addition to federal filings on our website, we make available other documents that provide important additional information about our financial condition and operations. Documents available on our website include the financial statements we file with state regulators (compiled under Statutory Accounting Principles as required by regulation), news releases that we issue, a listing of our investment holdings, and certain investor presentations. The Governance section of our website provides copies of the charters for our governing committees and many of our governing policies. Printed copies of these documents may be obtained from Frank O’Neil, Senior Vice President, ProAssurance Corporation, either by mail at P.O. Box 590009, Birmingham, Alabama 35259-0009, or by telephone at (205) 877-4400 or (800) 282-6242.

Our History

We were incorporated in Delaware in 2001 as the successor to Medical Assurance, Inc. in conjunction with its merger with Professionals Group, Inc. ProAssurance has a history of growth through acquisitions. Acquisitions completed in the most recent five years include:

- American Physicians Service Group, Inc. and subsidiaries, (APS), acquired November 30, 2010,
- Independent Nevada Doctors Insurance Exchange, (IND), acquired November 30, 2012,
- Medmarc Mutual Insurance Company and subsidiaries, (Medmarc), acquired January 1, 2013, and
- Eastern Insurance Holdings, Inc., (Eastern), acquired January 1, 2014.

We provided the majority of the capital for Syndicate 1729 in November 2013, and Syndicate 1729 began active operations effective January 1, 2014.

Our Strategy

Our business objectives are to generate attractive returns on equity and book value per share growth for our shareholders. The basic components of our strategy for achieving these objectives are as follows:

- Serve a broad spectrum of the healthcare market, providing specialized expertise to meet evolving demands. In addition to providing traditional products to healthcare providers in a number of professions, we are also leveraging our reach, expertise and financial strength to provide innovative and customized products to meet the risk management needs of larger organizations or groups.
- Effectively manage capital. We carefully monitor use of our capital, and consider various options for capital deployment, such as business expansion by our existing subsidiaries, opportunities that arise for mergers or

acquisitions, share repurchases and payment of dividends.

- Pursue profitable underwriting opportunities. We emphasize profitability, not market share. Key elements of our approach are prudent risk selection using established underwriting guidelines, appropriate pricing and adjusting our business mix as appropriate to effectively utilize capital and achieve market synergies.

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- Emphasize risk management. We seek to reduce risk at the corporate level by actively managing our enterprise risk and by maintaining strong internal controls. We also emphasize the importance of risk management to our insureds and offer training in the use of risk reduction tools and techniques.
- Manage claims effectively. Our experienced claims teams have industry and insurance expertise that, with our extensive local knowledge, allows us to resolve claims in an effective manner, considering the circumstances of each claim. When practical, we utilize formalized claims management processes and protocols as a means of reducing claim costs.
- Provide superior customer service. Our mission statement, We Exist to Protect Others, goes hand-in-hand with our corporate motto, "Treated Fairly." Our employees demonstrate our core values of integrity, respect, involvement of our insureds, collaboration, communication and enthusiasm every day and are focused on meeting the needs of our customers.
- Maintain a conservative investment strategy. We believe that we follow a conservative investment strategy designed to emphasize the preservation of our capital and provide adequate liquidity for the prompt payment of claims. Our investment portfolio consists primarily of investment-grade, fixed-maturity securities of short-to medium-term duration.
- Maintain financial stability. We are committed to maintaining claims paying ratings of "A" or better.

Organization and Segment Information

We operate through multiple insurance organizations and report our operating results in four segments, as follows:

- Specialty Property and Casualty Segment - This segment includes our professional liability business and our medical technology and life sciences business.
- Workers' Compensation Segment - This segment includes our workers' compensation business which we provide for employers, groups and associations.
- Lloyd's Syndicate Segment - This segment includes operating results from our participation in Lloyd's Syndicate 1729.
- Corporate Segment - This segment includes our investing operations managed at the corporate level, non-premium revenues generated outside of our insurance entities, and corporate expenses, including interest and U. S. income taxes.

Gross Premiums Written

Gross premiums written for the years ended December 31, 2014, 2013 and 2012 were comprised as follows:

	Year Ended December 31								
($ in thousands)	2014			2013			2012		
Professional liability:									
Healthcare related (1) (2)	$449,115	58	%	$483,494	85	%	$488,261	91	%
Legal professionals	27,776	4	%	27,060	5	%	17,146	3	%
Medical technology and life sciences products liability	35,265	5	%	34,190	6	%	—	—	%
Workers' compensation	225,363	29	%	—	—	%	—	—	%
Syndicate 1729: (3)									
Casualty	21,703	3	%	—	—	%	—	—	%
Property	6,110	1	%	—	—	%	—	—	%
Catastrophe	5,918	1	%	—	—	%	—	—	%
All other, primarily tail	20,452	3	%	22,803	4	%	31,024	6	%
Inter-segment revenues (2)	(12,093)	(2	%)	—	—	%	—	—	%
Total	$779,609	100	%	$567,547	100	%	$536,431	100	%

(1) Primarily comprised of one-year term policies, but includes premium related to policies with a two-year term of $19.9 million in 2014, $25.6 million in 2013 and $13.1 million in 2012.

(2) In 2014, Lloyd's Syndicate 1729 casualty premiums included $12.1 million of healthcare related premiums assumed from our Specialty P&C segment. The assumption was eliminated on a consolidated basis.

(3)

Attributable to our 58% share of premiums written by Syndicate 1729.

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Prior to the acquisition of Medmarc on January 1, 2013 we did not have any medical technology and life sciences products liability premium. Prior to the acquisition of Eastern and the commencement of Syndicate 1729 operations on January 1, 2014 we did not write any significant amounts of workers' compensation premium. Additional detailed information regarding premium by individual product type within each of our insurance segments is provided in Item 7, Management's Discussion and Analysis, Results of Operations, under the heading "Premiums Written".

Prior to 2014, substantially all of our insurance exposures were within the United States. As a result of our participation in Syndicate 1729, approximately $1.9 million of our 2014 premium written is related to insurance exposures that were outside of the United States, see segment discussion below.

Specialty Property and Casualty Segment

Professional Liability Insurance

Our professional liability business is primarily focused on providing professional liability insurance to healthcare providers. We target the full spectrum of the healthcare professional liability market, covering multiple categories of healthcare professionals and healthcare entities, including hospitals and other healthcare facilities. While most of our business is written in the standard market, we also offer professional liability insurance on an excess and surplus lines basis, and we offer alternative risk and self-insurance products on a custom basis. We also provide professional liability coverage to attorneys, but this is a less significant portion of our business, accounting for approximately 4% of our 2014 gross premiums written. We are licensed to do business in every state.

We utilize independent agencies and brokers as well as an internal sales force to write our healthcare professional liability (HCPL) business. For the year ended December 31, 2014 approximately 63% of our healthcare professional liability gross premiums written were produced through independent insurance agencies or brokers. The agencies and brokers we use typically sell through professional liability insurance specialists who are able to convey the factors that differentiate our professional liability insurance products. In 2014, our ten largest agencies, brokers or brokerage agencies produced approximately 24% of our healthcare related professional liability premium; individually, no one agency produced more than 10% of our healthcare related professional liability premium.

In marketing our professional liability products we emphasize our financial strength, product flexibility, excellent claims and underwriting services, and risk resource services. We market our insurance products through our direct sales force and through our agents, as well as direct mailings, and advertising in industry-related publications. We also are involved in professional societies and related organizations and support legislation that will have a positive effect on healthcare and legal liability issues. We maintain regional underwriting centers which permit us to consistently provide a high level of customer service to both small and large accounts.

We maintain claim processing centers where our internal claims personnel investigate and monitor the processing of our professional liability claims. We engage experienced, independent litigation attorneys in each venue to assist with the claims process as we believe this practice aids us in providing a defense that is aggressive, effective and cost-efficient. We evaluate the merit of each claim and determine the appropriate strategy for resolution of the claim, either seeking a reasonable good faith settlement appropriate for the circumstance of the claim or aggressively defending the claim. As part of the evaluation and preparation process for healthcare professional liability claims, we meet regularly with medical advisory committees in our key markets to examine claims, attempt to identify potentially troubling practice patterns and make recommendations to our staff.

Medical Technology and Life Sciences Insurance

Our Medical Technology and Life Sciences business, acquired January 1, 2013 through the acquisition of Medmarc, offers products liability insurance for medical technology and life sciences companies that manufacture or distribute products that are almost all regulated by the United States Food and Drug Administration. Products insured include imaging and non-invasive diagnostic medical devices, orthopedic implants, pharmaceuticals, clinical lab instruments, medical instruments, dental products, and animal pharmaceuticals and medical devices. We also provide coverage for clinical trials and contract manufacturers.

Underwriting decisions for our products liability coverages consider the type of risk, the amount of coverage being sought, the expertise and experience of the applicant, and the expected volume of product sales. Close to 100% of our products liability business is written through independent brokers. In 2014, our top ten brokers generated approximately 44% of our medical technology and life sciences gross written premium, with no one agent

representing more than 12%. We do not appoint agents for our products liability business.

Our products liability claims are centrally processed in Chantilly, Virginia. We strongly defend these claims, with a negotiated settlement being the most frequent means of resolution.

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Workers' Compensation Segment

Effective January 1, 2014 ProAssurance acquired Eastern, which offers workers' compensation products in the Mid-Atlantic (primarily in Pennsylvania), Southeast, and Midwest regions of the continental United States. Our workers' compensation business consists of two major business activities:

- Traditional workers' compensation insurance coverages provided to employers, generally those with 1,000 employees or less. Types of policies offered include guaranteed cost policies, policyholder dividend policies, retrospectively-rated policies, and deductible policies.
- Alternative market workers' compensation solutions provided to individual companies, groups and associations whereby the policy written is 100% reinsured though a reinsurance entity owned by or related to the policyholder. Most often this reinsurance entity is a segregated portfolio cell (SPC) operated through Eastern Re Ltd., SPC (Eastern Re), our subsidiary domiciled in the Cayman Islands. Each SPC is owned, fully or in part, by the policyholder or affiliates of the policyholder, hereafter referred to as cell participants. The SPC is operated solely for the benefit of cell participants of that particular cell, and the pool of assets of one segregated portfolio cell are statutorily protected from the creditors of any other SPC. The underwriting results and investment income of the segregated portfolio cells are shared with the cell participants in accordance with the terms of the cell agreements. We are a partial owner in selected SPCs and receive a share of the earnings of these SPCs. We generally hold a 50% participation, but our interest ranges from 25% to 82.5%. Our share of SPC profits for the year ended December 31, 2014 was approximately 27%.

Both groups of workers' compensation products are distributed through a group of appointed independent agents.

We utilize an individual account underwriting strategy for our workers' compensation business that is focused on selecting quality accounts. The goal of our workers' compensation underwriters is to select a diverse book of business with respect to risk classification, hazard level and geographic location. We target accounts with strong return to work and safety programs in low to middle hazard levels such as clerical office, light manufacturing, healthcare, auto dealers and service industries and maintain a strong risk management unit in order to better serve our customers' needs.

We actively seek to reduce our workers' compensation loss costs by placing a concentrated focus on returning injured workers to work as quickly as possible. We emphasize early intervention and aggressive disability management, utilizing in-house and third-party specialists for case management, including medical cost management. Strategic vendor relationships have been established to reduce medical claim costs and include preferred provider, physical therapy, prescription drug, and catastrophic medical services.

Lloyd's Syndicate Segment

We are the majority (58%) capital provider to Lloyd's of London Syndicate 1729, which began writing business as of January 1, 2014. The remaining capital for Syndicate 1729 is provided by unrelated third parties, including private names and other corporate members. We have committed capital of £50.2 million (approximately $78.2 million at December 31, 2014) for the Syndicate's 2015 underwriting year and have a total capital commitment through 2019 of up to $200 million. Syndicate 1729 covers a range of property and casualty insurance and reinsurance lines, and has a maximum underwriting capacity of £75.0 million (approximately $116.8 million at December 31, 2014) for the 2015 underwriting year, of which £43.2 million (approximately $67.2 million at December 31, 2014) is our allocated underwriting capacity as a corporate member.

Corporate Segment

We manage our investments at the corporate level and we apply a consistent management strategy to the entire portfolio. Accordingly, we report our investment results and net realized investment gains and losses within our corporate segment. Our corporate segment also includes non-premium revenues generated outside of our insurance entities, and corporate expenses, including interest expense and U. S. income taxes. Our overall investment strategy is to maximize current income from our investment portfolio while maintaining safety, liquidity, duration targets and portfolio diversification. The portfolio is generally managed by professional third party asset managers whose results we monitor and evaluate. The asset managers typically have the authority to make investment decisions within the asset classes they are responsible for managing, subject to our investment policy and oversight, including a requirement that securities in a loss position cannot be sold without specific authorization from us. See Note 4 of the

Notes to Consolidated Financial Statements for more information on our investments.

Competition

The marketplace for all our lines of business includes many insurers and is very competitive. Within the U. S. our competitors are primarily domestic and range from large national insurers whose financial strength and resources may be greater than ours to smaller insurance entities that concentrate on a single state and as a result have an extensive knowledge of the local markets. Additionally, there are many providers, domestic and international, of alternative risk management solutions. Syndicate 1729, which is based in the U.K., faces significant competition from other Lloyd's syndicates as well as other

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international and domestic insurance firms operating in the country of the insured. Competitive distinctions include pricing, size, name recognition, service quality, market commitment, market conditions, breadth and flexibility of coverage, method of sale, financial stability, ratings assigned by rating agencies and regulatory conditions.

The healthcare market is the largest industry segment that we serve and the changing healthcare environment within the U. S. presents us with both competitive challenges and opportunities. Many physicians now practice as employees of larger healthcare entities. Further, healthcare services are increasingly being provided by professionals other than physicians and outside of a traditional hospital or clinic setting. Such trends are widely expected to continue. Larger healthcare entities have differing customer service and risk management needs than the traditional solo or small physician group. Larger entities are more likely to combine risks such as workers' compensation and professional liability when purchasing insurance and are also more likely to manage all or a part of their risk through alternative insurance mechanisms. We have addressed these issues by refining our existing hospital/physician insurance programs, expanding our coverage of healthcare providers other than physician or hospitals, expanding our coverages to include workers' compensation and product liability, and by enhancing our customer service capabilities, particularly with regard to the needs of larger accounts. We have also increased our focus on offering unique, joint or cooperative insurance programs that are attractive to larger healthcare entities.

We recognize the importance of providing our products at competitive rates, but we do not underwrite at rates that will not permit us to meet our profit targets. We base our rates on current loss projections, maintaining a long-term focus even when this approach reduces our top line growth. We believe that our size, reputation for effective claims management, unique customer service focus, multi-state presence, and broad spectrum of coverages offered provides us with competitive advantages, even as the needs of our insureds change.

Rating Agencies

Our claims paying ability is regularly evaluated and rated by three major rating agencies: A.M. Best, Fitch and Moody’s. In developing their claims paying ratings, these agencies make an independent evaluation of an insurer’s ability to meet its obligations to policyholders. See "Risk Factors" for a table presenting the claims paying ratings of our principal insurance operations.

Four rating agencies evaluate and rate our ability to service current debt and potential debt. These financial strength ratings reflect each agency’s independent evaluation of our ability to meet our obligation to holders of our debt, if any. While financial strength ratings may be of greater interest to investors than our claims paying ratings, these ratings are not evaluations of our equity securities nor a recommendation to buy, hold or sell our equity securities.

Insurance Regulatory Matters

We are subject to regulation under the insurance and insurance holding company statutes of various jurisdictions, including the domiciliary states of our insurance subsidiaries and other states in which our insurance subsidiaries do business. Our insurance subsidiaries are primarily domiciled in the United States. Our states of domicile include Alabama, Illinois, Michigan, Pennsylvania, and Vermont. We have reinsurance operations based in the Cayman Islands, a territory of the United Kingdom (U.K.), as well as U.K. based insurance and reinsurance operations.

United States

Our insurance subsidiaries are required to file detailed annual statements in their states of domicile and with the state insurance regulators in each of the states in which they do business. The laws of the various states establish agencies with broad authority to regulate, among other things, licenses to transact business, premium rates for certain types of coverage, trade practices, agent licensing, policy forms, underwriting and claims practices, reserve adequacy, transactions with affiliates, and insurer solvency. Such regulations may hamper our ability to meet operating or profitability goals, including preventing us from establishing premium rates for some classes of insureds that adequately reflects the level of risk assumed for those classes. Many states also regulate investment activities on the basis of quality, distribution and other quantitative criteria. States have also enacted legislation, including the Risk Management and Own Risk and Solvency Assessment Model Act (ORSA), which regulates insurance holding company systems, including acquisitions, the payment of dividends, the terms of affiliate transactions, enterprise risk and solvency management, and other related matters.

Applicable state insurance laws, rather than federal bankruptcy laws, apply to the liquidation or reorganization of insurance companies.

Insurance companies are also subject to state and federal legislative and regulatory measures and judicial decisions. These could include new or updated definitions of risk exposure and limitations on business practices.

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Insurance Regulation Concerning Change or Acquisition of Control

The insurance regulatory codes in each of the domiciliary states of our operating subsidiaries contain provisions (subject to certain variations) to the effect that the acquisition of "control" of a domestic insurer or of any person that directly or indirectly controls a domestic insurer cannot be consummated without the prior approval of the domiciliary insurance regulator. In general, a presumption of "control" arises from the direct or indirect ownership, control or possession with the power to vote or possession of proxies with respect to 10% (5% in Alabama) or more of the voting securities of a domestic insurer or of a person that controls a domestic insurer. Because of these regulatory requirements, any party seeking to acquire control of ProAssurance or any other domestic insurance company, whether directly or indirectly, would usually be required to obtain such approvals.

In addition, certain state insurance laws contain provisions that require pre-acquisition notification to state agencies of a change in control of a non-domestic insurance company admitted in that state. While such pre-acquisition notification statutes do not authorize the state agency to disapprove the change of control, such statutes do authorize certain remedies, including the issuance of a cease and desist order with respect to the non-domestic admitted insurers doing business in the state if certain conditions exist, such as undue market concentration.

Statutory Accounting and Reporting

Insurance companies are required to file detailed quarterly and annual reports with state insurance regulators in their state of domicile and each of the states in which they do business; and their business and accounts are subject to examination by such regulators at any time. The financial information in these reports is prepared in accordance with Statutory Accounting Principles (SAP). Insurance regulators periodically examine each insurer's adherence to SAP, financial condition, and compliance with insurance department rules and regulations.

Regulation of Dividends and Other Payments from Our Operating Subsidiaries

Our operating subsidiaries are subject to various state statutory and regulatory restrictions that limit the amount of dividends or distributions an insurance company may pay to its shareholders, including our insurance holding company, without prior regulatory approval. Generally, dividends may be paid only out of unassigned earned surplus. In every case, surplus subsequent to the payment of any dividends must be reasonable in relation to an insurance company's outstanding liabilities and must be adequate to meet its financial needs.

State insurance holding company regulations generally require domestic insurers to obtain prior approval of extraordinary dividends. Insurance holding company regulations that govern our principal operating subsidiaries deem a dividend as extraordinary if the combined dividends and distributions to the parent holding company in any twelve-month period exceed prescribed thresholds. Such thresholds are statutorily prescribed by the state of domicile and currently are based on either net income for the prior fiscal year (reduced by realized capital gains in certain domiciliary states) or a percentage of unassigned surplus at the end of the prior fiscal year, depending upon the wording of the statute.

If insurance regulators determine that payment of a dividend or any other payments within a holding company group, (such as payments under a tax-sharing agreement or payments for employee or other services) would, because of the financial condition of the paying insurance company or otherwise, be a detriment to such insurance company's policyholders, the regulators may prohibit such payments that would otherwise be permitted.

Risk-Based Capital and Risk Assessment

In order to enhance the regulation of insurer solvency, the NAIC specifies risk-based capital requirements for property and casualty insurance companies. At December 31, 2014, all of ProAssurance's insurance subsidiaries substantially exceeded the minimum required risk-based capital levels.

In late 2010, the National Association of Insurance Commissioners (the NAIC) adopted the Model Insurance and Holding Company System Regulatory Act and Regulation ("Model Law"). The Model Law, as compared to previous NAIC guidance, increases regulatory oversight of and reporting by insurance holding companies, including reporting related to non-insurance entities, and requires reporting of risks affecting the holding company group. Additionally, in 2012 the NAIC adopted ORSA, which requires insurers to maintain a framework for identifying, assessing, monitoring, managing and reporting on the "material and relevant risks" associated with the insurer's (or insurance group's) current and future business plans. ORSA will also require insurers to file an internal assessment of solvency with insurance regulators annually beginning in 2015. Although no specific capital adequacy standard is currently

articulated in ORSA, it is possible that such standard will be developed over time. The Model Law and ORSA will be binding only if adopted by state legislatures and/or state insurance regulatory authorities and actual regulations adopted by any state may differ from the Model Law.

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The NAIC revised the Model Law to include provisions which allow regulatory supervision of the holding company group through supervisory colleges and which require reporting of risk and solvency assessments for the group. The NAIC expects states to adopt these revisions no later than January 1, 2016. Certain states in which the Company operates adopted these revisions early and the Company began filing its risk and solvency assessment in 2014.

Investment Regulation

Our operating subsidiaries are subject to state laws and regulations that require diversification of investment portfolios and that limit the amount of investments in certain investment categories. Failure to comply with these laws and regulations may cause non-conforming investments to be treated as non-admitted assets for purposes of measuring statutory surplus and, in some instances, would require divestiture of investments. We monitor the practices used by our operating subsidiaries for compliance with applicable state investment regulations and take corrective measures when deficiencies are identified.

Guaranty Funds

Admitted insurance companies are required to be members of guaranty associations which administer state guaranty funds. To fund the payment of claims (up to prescribed limits) against insurance companies that become insolvent, these associations levy assessments on all member insurers in a particular state on the basis of the proportionate share of the premiums written by member insurers in the covered lines of business in that state. Maximum assessments permitted by law in any one year generally vary between 1% and 2% of annual premiums written by a member in that state, although state regulations may permit larger assessments if insolvency losses reach specified levels. Some states permit member insurers to recover assessments paid through surcharges on policyholders or through full or partial premium tax offsets, while other states permit recovery of assessments through the rate filing process. In recent years, participation in guaranty funds has not had a material effect on our results of operations.

Shared Markets

State insurance regulations may force us to participate in mandatory property and casualty shared market mechanisms or pooling arrangements that provide certain insurance coverage to individuals or other entities that are otherwise unable to purchase such coverage in the commercial insurance marketplace. Our operating subsidiaries' participation in such shared markets or pooling mechanisms is not material to our business at this time.

Changes in Legislation and Regulation

Tort reforms generally restrict the ability of a plaintiff to recover damages by, among other limitations, eliminating certain claims that may be heard in a court, limiting the amount or types of damages, changing statutes of limitation or the period of time to make a claim, and limiting venue or court selection. A number of states in which we do business have previously enacted tort reform legislation in an effort to reduce escalating loss trends. These reforms are generally thought to have contributed to the improvement in the overall loss trends in those states, although loss trends have also been favorable in states that did not pass any type of tort reform. In states where these reforms are perceived to have improved the legal climate for liability defendants, we have experienced an increase in competition.

Challenges to tort reform have been undertaken in most states where tort reforms have been enacted, and in some states the reforms have been fully or partially overturned. Additional state reforms may also be overturned, although we cannot predict with any certainty how appellate courts will rule. We monitor developments on a state-by-state basis and make business decisions accordingly.

Tort reform proposals are considered from time to time at the Federal level. As in the states, passage of a Federal tort reform package would likely be subject to judicial challenge and we cannot be certain that it would be upheld by the courts.

The Affordable Care Act (ACA) was passed and signed into law in March 2010. All of the provisions of ACA have not yet become fully effective, and effects from enacted provisions may gradually increase. We do not expect that the provisions thus far enacted will have a significant direct effect on our business, but specific regulations to implement the law are still being written.

ACA is expected to have a significant impact on the practice of medicine in future years and could have unanticipated or indirect effects on our business or alter the risk and cost environments in which we and our insureds operate. These risks include: reduced operating margins that may cause physicians and hospitals to join in larger groupings which are more likely to utilize alternative risk mechanisms to manage their professional liability risks; use of electronic medical

records may lead to additional medical malpractice litigation or increase the cost of litigation; patient dissatisfaction may increase due to greater strain on the patient-physician relationship; there may be an overall increase in healthcare costs which would increase loss costs for claims involving bodily injury; and additional health conditions may be identified as being work-related which could increase the number of workers' compensation claims. Conversely, it is anticipated that there will be growth in the number of

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ancillary healthcare providers that will become customers for professional liability products. We are unable to predict with any certainty the effect that ACA or future related legislation will have on our insureds or our business.

The Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) was passed in July 2010. The Act establishes new regulatory oversight of financial institutions and regulations are still in the process of development for various portions of the Act. Although provisions of the Act do not appear to affect our business materially, as new regulations are implemented, there could be changes in the regulatory environment that affect the way we conduct our operations or the cost of compliance, or both.

One of the federal government bodies created by the Dodd-Frank Act was the Federal Insurance Office (FIO) which, in December 2013, released a proposal on insurance modernization and improvement of the system of insurance regulation in the United States. Although the FIO is prohibited from directly regulating the business of insurance, it has authority to represent the United States in international insurance matters and has limited power to preempt certain types of state insurance laws. The recent proposal advocates significantly greater federal involvement in insurance regulation and identifies necessary reforms by the states to preclude further consideration of direct federal regulation. While the proposal does not necessarily imply that the federal government will displace state regulation completely, it does recommend more of a hybrid approach to insurance regulation. In response to the FIO proposal, the NAIC and a number of state legislatures have considered or adopted legislative proposals that alter and, in many cases, increase the authority of state agencies to regulate insurance companies and insurance holding company systems. We cannot predict whether the proposals will be adopted or what impact, if any, subsequently enacted laws might have on our business, financial condition or results of operations.

Terrorism Risk Insurance Act

The Federal Terrorism Risk Insurance Act (TRIA), initially enacted in 2002 and reauthorized in 2007 and 2015, ensures the availability of insurance coverage for certain acts of terrorism, as defined in the legislation. The 2015 reauthorization extended the program through 2020. TRIA currently provides that during 2015 a loss event must exceed $100 million to trigger coverage and that Federal government will reimburse 85% of an insurer’s losses in excess of the insurer’s deductible, up to the maximum annual Federal liability of $100 billion. The event trigger will gradually increase to $200 million in 2020 and the reimbursement percentage will gradually decline to 80% in 2020. TRIA requires that we offer terrorism coverage to our commercial policyholders in our workers' compensation line of business, for which we may, when warranted, charge an additional premium. The policyholders may or may not accept such coverage.

International

Cayman Islands

Our segregated portfolio cell business operates through our subsidiary, Eastern Re, which is organized and licensed as a Cayman Islands unrestricted Class B insurance company. Eastern Re is subject to regulation by the Cayman Islands Monetary Authority (CIMA). Applicable laws and regulations govern the types of policies that Eastern Re can insure or reinsure, the amount of capital that it must maintain and the way it can be invested, and the payment of dividends without approval by the CIMA. Eastern Re is required to maintain minimum capital of approximately $120,000 and must receive approval from the CIMA before it can pay any dividends.

Lloyd's Syndicate 1729

Syndicate 1729 is regulated in the U.K. by the Prudential Regulation Authority and the Financial Conduct Authority. All Lloyd's syndicates must also comply with the bylaws and regulations established by the Council of Lloyd's including submission and approval of an annual business plan and maintenance of stipulated capital levels. Also, the Council of Lloyd's may call or assess a percentage of a member's underwriting capacity (currently a maximum of 3%) as a contribution to Lloyd's Central Fund, which, similar to state guaranty funds in the United States, meets policyholder obligations if a Lloyd's member is otherwise unable to do so.

The European Union's executive body, the European Commission, is implementing new capital adequacy and risk management regulations called Solvency II that would apply to businesses within the European Union. Solvency II is currently required to be implemented on January 1, 2016, and certain interim transition measures are required for 2014 and 2015. We comply currently with the guidelines set out by the Council of Lloyd's relative to compliance with Solvency II.

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Enterprise Risk Management

As a large property and casualty insurance provider, we are exposed to many risks. These risks, whether taken intentionally or unintentionally, are a function of the environment within which we operate. Since certain risks can be correlated with other risks, an event or a series of events can impact multiple areas of the Company simultaneously and have a material effect on the Company's results of operations, financial position and/or liquidity. In response to these exposures we have implemented an Enterprise Risk Management (ERM) program. Our ERM program consists of numerous processes and controls that have been designed by our senior management, with oversight by our Board of Directors, and have been implemented across our organization. We utilize ERM to identify potential risks from all aspects of our operations and to evaluate these risks in a manner that is both prudent and balanced. Our primary objective is to develop a risk appetite that creates and preserves value for all of our stakeholders.

Employees

At December 31, 2014, we had 967 employees, none of whom were represented by a labor union. We consider our employee relations to be good.

ITEM 1A. RISK FACTORS.

There are a number of factors, many beyond our control, which may cause results to differ significantly from our expectations. Some of these factors are described below. Any factor described in this report could by itself, or together with one or more other factors, have a negative effect on our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations.

Insurance market conditions may alter the effectiveness of our current business strategy and impact our revenues.

The property and casualty insurance business is highly competitive. We compete in a fragmented market comprised of many insurers, ranging from smaller single state mono-line insurers who have an extensive knowledge of local markets to large national insurers who offer multiple product lines and whose financial strength and resources may be greater than ours. In many instances, coverage we offer is also available through mutual entities whose return on equity objectives may be lower than ours. Also, there are many opportunities for self-insurance and for participation in an alternative risk transfer mechanism, such as captive insurers or risk retention groups.

Competition in the property and casualty insurance business is based on many factors, including premiums charged and other terms and conditions of coverage, services provided, financial ratings assigned by independent rating agencies, claims services, reputation, geographic scope, local presence, agent and client relationships, financial strength and the experience of the insurance company in the line of insurance to be written. Actions of competitors could adversely affect our ability to attract and retain business at current premium levels, impact our market share and reduce the profits that would otherwise arise from operations.

Because we are a property and casualty insurer, our business may suffer as a result of unforeseen catastrophe losses.

As a property and casualty insurer we are exposed to claims arising out of catastrophes, primarily through our workers' compensation and Syndicate 1729 operations. Catastrophes can be caused by various events, including hurricanes, tsunamis, tornadoes, windstorms, earthquakes, hailstorms, explosions, flooding, severe winter weather and fires and may include man-made events, such as terrorist attacks or a wide-spread financial crisis. The incidence, frequency and severity of catastrophes are inherently unpredictable. While we use historical data and modeling tools to assess our potential exposure to catastrophic losses under various conditions and probability scenarios, such assessments do not necessarily accurately predict future losses or accurately measure our potential exposure. The extent of losses from a catastrophe is a function of both the total amount of insured exposure in the area affected by the event and the severity of the event.

Our loss exposure for a terrorist act meeting the TRIA definition is mitigated by our coverage provided by this program as described in Part I under the caption Insurance Regulatory Matters. Congress has the ability to alter or repeal the provisions of TRIA at its discretion, and if altered or repealed our exposure could further increase and result in premium increases for those types of coverages. Workers' compensation coverages cannot exclude damages related to an act of terrorism and if TRIA were repealed or the benefits were substantially reduced, this might affect our ability to offer these coverages at a reasonable rate.

Insurance companies are not permitted to reserve for a catastrophe until it has occurred. Although we purchase reinsurance protection for risks we believe bear a significant level of catastrophe exposure, actual losses resulting

from a catastrophic event or events may exceed our reinsurance protection. It is therefore possible that a catastrophic event or multiple catastrophic events could have a material adverse effect on our financial position, results of operations and liquidity.

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Our results of operations and financial condition may be affected if actual insured losses differ from our loss reserves or if actual amounts recoverable under reinsurance agreements differ from our estimated recoverables.

We establish reserves as balance sheet liabilities representing our estimates of amounts needed to resolve reported and unreported losses and pay related loss adjustment expenses. Our largest liability is our reserve for loss and loss adjustment expenses. Due to the size of our reserve for loss and loss adjustment expenses, even a small percentage adjustment to our reserve can have a material effect on our results of operations for the period in which the change is made.

The process of estimating loss reserves is complex. Significant periods of time may elapse between the occurrence of an insured loss, the reporting of the loss by the insured and payment of that loss. Ultimate loss costs, even for claims with similar characteristics, can vary significantly depending upon many factors, including but not limited to, the nature of the claim, including whether or not the claim is an individual or a mass tort claim, and the personal situation of the claimant or the claimant's family, the outcome of jury trials, the legislative and judicial climate where the insured event occurred, general economic conditions and, for claims involving bodily injury, the trend of healthcare costs. Consequently, the loss cost estimation process requires actuarial skill and the application of judgment, and such estimates require periodic revision. As part of the reserving process, we review the known facts surrounding reported claims as well as historical claims data and consider the impact of various factors such as:

- for reported claims, the nature of the claim and the jurisdiction in which the claim occurred;
- trends in paid and incurred loss development;
- trends in claim frequency and severity;
- emerging economic and social trends;
- trend of healthcare costs for claims involving bodily injury;
- inflation and levels of employment; and
- changes in the regulatory, legal and political environment.

This process assumes that past experience, adjusted for the effects of current developments and anticipated trends, is an appropriate, but not necessarily accurate, basis for predicting future events. There is no precise method for evaluating the impact of any specific factor on the adequacy of reserves, and actual results are likely to differ from original estimates. We evaluate our reserves each period and increase or decrease reserves as necessary based on our estimate of future claims payments. An increase to reserves has a negative effect on our results of operations in the period of increase; a reduction to reserves has a positive effect on our results of operations in the period of reduction.

Our loss reserves also may be affected by court decisions that expand liability of our policies after they have been issued and priced. In addition, a significant jury award or series of awards against one or more of our insureds could require us to pay large sums of money in excess of our reserved amounts. Due to uncertainties inherent in the jury system, any case that is litigated to a jury verdict has the potential to incur a loss that has a material adverse effect on our results of operations.

We purchase reinsurance to mitigate the effect of large losses. Our receivable from reinsurers on unpaid losses and loss adjustment expenses represents our estimate of the amount of our reserve for losses that will be recoverable under our reinsurance programs. We base our estimate of funds recoverable upon our expectation of ultimate losses and the portion of those losses that we estimate to be allocable to reinsurers based upon the terms and conditions of our reinsurance agreements. Given the uncertainty of the ultimate amounts of our losses, our estimates of losses and related amounts recoverable may vary significantly from the eventual outcome. Also, we estimate premiums ceded under reinsurance agreements wherein the premium due to the reinsurer, subject to certain maximums and minimums, is based in part on losses reimbursed or to be reimbursed under the agreement. Due to the size of our reinsurance balances, changes to our estimate of the amount of reinsurance that is due to us could have a material effect on our results of operations in the period for which the change is made.

We are exposed to and may face adverse developments involving mass tort claims arising from coverages provided to our insureds.

Establishing claim and claim adjustment expense reserves for mass tort claims is subject to uncertainties due to many factors, including expanded theories of liability, geographical location and jurisdiction of the lawsuits. Moreover, it is difficult to estimate our ultimate liability for such claims due to evolving judicial interpretations of various tort

theories of liability and defense theories, such as federal preemption and joint and several liability, as well as the application of insurance coverage to these claims.

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If market conditions cause reinsurance to be more costly or unavailable, we may be required to bear increased risk or reduce the level of our underwriting commitments.

As part of our overall risk and capacity management strategy, we purchase reinsurance for significant amounts of risk underwritten by our insurance company subsidiaries. Market conditions beyond our control determine the availability and cost of the reinsurance. We may be unable to maintain current reinsurance coverage or to obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or to obtain new reinsurance coverage, either our net exposure to risk would increase or, if we are unwilling to bear an increase in net risk exposures, we would need to reduce the amount of our underwritten risk.

We cannot guarantee that our reinsurers will pay in a timely fashion or at all, and, as a result, we could experience losses.

We transfer part of our risks to reinsurance companies in exchange for part of the premium we receive in connection with the risk. Although our reinsurance agreements make the reinsurer liable to us to the extent the risk is transferred, our liability to our policyholders remains our responsibility. Reinsurers may periodically dispute our demand for reimbursement from them based upon their interpretation of the terms of our agreements or may fail to pay us for financial or other reasons. If reinsurers refuse or fail to pay us or fail to pay on a timely basis, our financial results and/or cash flows would be adversely affected and could have a material effect on our results of operations in the period in which uncollectible amounts are identified.

At December 31, 2014 our Receivable from reinsurers on unpaid losses is $238.0 million and our Receivable from reinsurers on paid losses is $6.5 million. As of December 31, 2014 the estimated net amount due from three of our reinsurers exceeded $20 million, on an individual basis, with the largest estimated amount due from an individual reinsurer being $23.1 million. A table listing significant reinsurers is provided in Item 7. Management's Discussion and Analysis, as a part of the Liquidity section, under the caption "Reinsurance".

Our claims handling could result in a bad faith claim against us.

We have been, from time to time, sued for allegedly acting in bad faith during our handling of a claim. The damages claimed in actions for bad faith may include amounts owed by the insured in excess of the policy limits as well as consequential and punitive damages. Awards above policy limits are possible whenever a case is taken to trial. These actions have the potential to have a material adverse effect on our financial condition and results of operations.

Changes in healthcare policy could have a material effect on our operations.

ACA was passed and signed into law in March 2010. While the primary provisions of ACA do not appear to directly affect our business, specific regulations to implement the law are still being written.

ACA is expected to have a significant impact on the practice of medicine in future years and could have unanticipated or indirect effects on our business or alter the risk and cost environments in which we and our insureds operate. These risks include: reduced operating margins that may cause physicians and hospitals to join in larger groupings which are more likely to utilize self-insured solutions for HCPL insurance products; use of electronic medical records may lead to additional medical malpractice litigation or increase the cost of litigation; patient dissatisfaction may increase due to greater strain on the patient-physician relationship; there may be an overall increase in healthcare costs which would increase loss costs for claims involving bodily injury; and additional health conditions may be identified as work-related which could increase the number of workers' compensation claims. Conversely, it is anticipated that there will be growth in the number of ancillary healthcare providers that will become customers for HCPL products. We are unable to predict with any certainty the effect that ACA or future related legislation will have on our insureds or our business.

Changes due to financial reform legislation could have a material effect on our operations.

The Dodd-Frank Act (the Act) was passed and signed into law in July 2010. The Act establishes new regulatory oversight of financial institutions, and regulations are still in development for various portions of the Act. As detailed regulations are developed to implement the provisions of the Act, there may be changes in the regulatory environment that affect the way we conduct our operations or the cost of regulatory compliance, or both. We are unable to predict with any certainty the effect that the Dodd-Frank Act will have on our business.

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One of the federal government bodies created by the Dodd-Frank Act was the Federal Insurance Office (FIO) which, in December 2013, released a proposal on insurance modernization and improvement of the system of insurance regulation in the United States. Although the FIO is prohibited from directly regulating the business of insurance, it has authority to represent the United States in international insurance matters and has limited powered to preempt certain types of state insurance laws. The recent proposal advocates significantly greater federal involvement in insurance regulation and identifies necessary reforms by the states to preclude further consideration of direct federal regulation. While the proposal does not necessarily imply that the federal government will displace state regulation completely, it does recommend more of a hybrid approach to insurance regulation. We cannot predict whether the proposals will be adopted or what impact, if any, enacted laws may have on our business, financial condition or results of operations.

The passage of tort reform or other legislation, and the subsequent review of such laws by the courts could have a material impact on our operations.

Tort reforms generally restrict the ability of a plaintiff to recover damages by, among other limitations, eliminating certain claims that may be heard in a court, limiting the amount or types of damages, changing statutes of limitation or the period of time to make a claim, and limiting venue or court selection. A number of states in which we do business previously enacted tort reform legislation in an effort to reduce escalating loss trends.

Challenges to tort reform have been undertaken in most states where tort reforms have been enacted, and in some states the reforms have been fully or partially overturned. Additional challenges to tort reform may be undertaken. We cannot predict with any certainty how state appellate courts will rule on these laws. While the effects of tort reform have been generally beneficial to our business in states where these laws have been enacted, there can be no assurance that such reforms will be ultimately upheld by the courts. Further, if tort reforms are effective, the business of providing professional liability insurance may become more attractive, thereby causing an increase in competition. In addition, the enactment of tort reforms could be accompanied by legislation or regulatory actions that may be detrimental to our business because of expected benefits which may or may not be realized. These expectations could result in regulatory or legislative action limiting the ability of professional liability insurers to maintain rates at adequate levels.

Coverage mandates or other expanded insurance requirements could also be imposed. States may also consider state-sponsored insurance entities that could remove our potential insureds from the private insurance market.

We continue to monitor developments on a state-by-state basis, and make business decisions accordingly.

Our performance is dependent on the business, economic, regulatory and legislative conditions of states where we have a significant amount of business.

Our top five states, Pennsylvania, Alabama, Texas, Indiana and Michigan, represented 42% of our direct premiums written for the year ended December 31, 2014. Moreover, on a combined basis, Pennsylvania, Alabama and Texas accounted for 31%, 23%, and 23% of our direct premiums written for the years ended December 31, 2014, 2013 and 2012, respectively. As Eastern has only been a part of our consolidated numbers since January 1, 2014, direct premiums written for our workers' compensation business are only included in the 2014 by state information. Unfavorable business, economic or regulatory conditions in any of these states could have a disproportionately greater effect on us than they would if we were less geographically concentrated.

We may be unable to identify future strategic acquisitions or expected benefits from completed and proposed acquisitions may not be achieved or may be delayed longer than expected.

Our corporate strategy anticipates growth through the acquisition of other companies or books of business. However, such expansion is opportunistic and sporadic, and there is no guarantee that we will be able to identify strategic acquisition targets in the future. Additionally, if we are able to identify a strategic target for acquisition, state insurance regulation concerning change or acquisition of control could delay or prevent us from growing through acquisitions. State insurance regulatory codes provide that the acquisition of “control” of a domestic insurer or of any person that directly or indirectly controls a domestic insurer cannot be consummated without the prior approval of the domiciliary insurance regulator. There is no assurance that we will receive such approval from the respective insurance regulator or that such approvals will not be conditioned in a manner that materially and adversely affects the aggregate economic value and business benefits expected to be obtained and cause us to not complete the acquisition.

The Company performs thorough due diligence before agreeing to a merger or acquisition, however there is no guarantee that the procedures we perform will adequately identify all potential weaknesses or liabilities of the target company or potential risks to the consolidated entity.

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There is also no guarantee that businesses acquired in the future will be successfully integrated. Ineffective integration of our businesses and processes may result in substantial costs or delays and adversely affect our ability to compete. The process of integrating an acquired company or business can be complex and costly, and may create unforeseen operating difficulties and expenditures. Potential problems that may arise include, but are not limited to, business disruption, loss of customers and employees, the ineffective integration of underwriting, claims handling and actuarial practices, the increase in the inherent uncertainty of reserve estimates for a period of time until stable trends reestablish themselves within the combined organization, diversion of management time and resources to acquisition integration challenges, the cultural challenges associated with integrating employees, increased operating costs, assumption of greater than expected liabilities, or inability to achieve cost savings. Furthermore, claims may be asserted by either the policyholders or shareholders of any acquired entity related to payments or other issues associated with the acquisition and merger into the consolidated entity. Such claims may prove costly or difficult to resolve or may have unanticipated consequences.

If we are unable to maintain favorable financial strength ratings, it may be more difficult for us to write new business or renew our existing business.

Independent rating agencies assess and rate the claims-paying ability and the financial strength of insurers based upon criteria established by the agencies. Periodically the rating agencies evaluate us to confirm that we continue to meet the criteria of previously assigned ratings. The financial strength ratings assigned by rating agencies to insurance companies represent independent opinions of financial strength and ability to meet policyholder and debt obligations and are not directed toward the protection of equity investors.

Our principal operating subsidiaries hold favorable claims paying ratings with A.M. Best, Fitch and Moody’s. Claims paying ratings are used by agents and customers as an important means of assessing the financial strength and quality of insurers. If our financial position deteriorates or the rating agencies significantly change the rating criteria that are used to determine ratings, we may not maintain our favorable financial strength ratings from the rating agencies. A downgrade or involuntary withdrawal of any such rating could limit or prevent us from writing desirable business.

The following table presents the claims paying ratings of our core insurance subsidiaries as of February 20, 2015.

	Rating Agency (1)		
	A.M. Best (www.ambest.com)	Fitch (www.fitchratings.com)	Moody’s (www.moodys.com)
ProAssurance Indemnity Company, Inc.	A+ (Superior)	A (Strong)	A2
ProAssurance Casualty Company	A+ (Superior)	A (Strong)	A2
ProAssurance Specialty Insurance Company, Inc.	A+ (Superior)	A (Strong)	NR
Podiatry Insurance Company of America	A (Excellent)	A (Strong)	A2
PACO Assurance Company, Inc.	A- (Excellent)	A (Strong)	NR
Noetic Specialty Insurance Company	A (Excellent)	A (Strong)	NR
Medmarc Casualty Insurance Company	A (Excellent)	A (Strong)	NR
Lloyd's Syndicate 1729 (2)	A (Excellent)	AA- (Strong)	NR
Eastern Alliance Insurance Company	A (Excellent)	A (Strong)	NR
Allied Eastern Indemnity Company	A (Excellent)	A (Strong)	NR
Eastern Advantage Assurance Company	A (Excellent)	A (Strong)	NR
Eastern Re Ltd., SPC	A (Excellent)	NR	NR

(1) NR indicates that the subsidiary has not been rated by the listed rating agency.

(2) Rating provided is the rating applicable to all Lloyd's syndicates.

Four rating agencies evaluate and rate our ability to service current debt and potential debt. These financial strength ratings reflect each agency’s independent evaluation of our ability to meet our obligation to holders of our debt, if any. While these ratings may be of greater interest to investors than our claims paying ratings, these are not ratings of our equity securities nor a recommendation to buy, hold or sell our equity securities.

Our business could be adversely affected by the loss or consolidation of independent agents, agencies, or brokers or brokerage firms.

We heavily depend on the services of independent agents and brokers in the marketing of our insurance products. We face competition from other insurance companies for their services and allegiance. These agents and brokers may choose to direct business to competing insurance companies.

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Our success is dependent upon our ability to effectively design and execute our business strategy and to adequately and appropriately serve our customers.

The Company depends upon the skill and work product of our officers and employees in executing our business strategy. While management and the Board of Directors ("the Board" or "our Board") monitor the strategic direction of the Company, strategic changes could be made that are not supportable by our capital base. In addition, our business could potentially be impacted if we are unable to align our strategy with the expectations of our stakeholders. The operations of the Company are also heavily dependent upon the delivery of superior customer service across a broad customer base, by which negative feedback from agents, insureds or internal staff could result in a loss of revenue for the Company.

Our business could be affected by the loss of one or more of our senior executives.

We are heavily dependent upon our senior management, and the loss of services of our senior executives could adversely affect our business. Our success has been, and will continue to be, dependent on our ability to retain the services of existing key employees and to attract and retain additional qualified personnel in the future. The loss of the services of key employees or senior managers, or the inability to identify, hire and retain other highly qualified personnel in the future, could adversely affect the quality and profitability of our business operations.

Our Board regularly reviews succession planning relating to our Chief Executive Officer as well as other senior officers. Mr. Starnes, our Chief Executive Officer and President, has indicated to the Board that he has no immediate plans for retirement.

Provisions in our charter documents, Delaware law and state insurance law may impede attempts to replace or remove management or may impede a takeover, which could adversely affect the value of our common stock.

Our certificate of incorporation, bylaws and Delaware law contain provisions that may have the effect of inhibiting a non-negotiated merger or other business combination. We currently have no preferred stock outstanding, and no present intention to issue any shares of preferred stock. In addition, our Corporate Governance Principles provide that the Board, subject to its fiduciary duties, will not issue any series of preferred stock for any defense or anti-takeover purpose, for the purpose of implementing any stockholders rights plan, or with features intended to make any acquisition more difficult or costly without obtaining stockholder approval. However, because the rights and preferences of any series of preferred stock may be set by the Board in its sole discretion, the rights and preferences of any such preferred stock may be superior to those of our common stock and thus may adversely affect the rights of the holders of common stock.

The voting structure of common stock and other provisions of our certificate of incorporation are intended to encourage a person interested in acquiring us to negotiate with, and to obtain the approval of, the Board in connection with a transaction. However, certain of these provisions may discourage our future acquisition, including an acquisition in which stockholders might otherwise receive a premium for their shares. As a result, stockholders who might desire to participate in such a transaction may not have the opportunity to do so.

In addition, state insurance laws provide that no person or entity may directly or indirectly acquire control of an insurance company unless that person or entity has received approval from the insurance regulator. An acquisition of control of ProAssurance would be presumed if any person or entity acquires 10% (5% in Alabama) or more of our outstanding common stock, unless the applicable insurance regulator determines otherwise. These provisions apply even if the offer may be considered beneficial by stockholders.

We are a holding company and are dependent on dividends and other payments from our operating subsidiaries, which are subject to dividend restrictions.

We are a holding company whose principal source of funds is cash dividends and other permitted payments from operating subsidiaries. If our subsidiaries are unable to make payments to us, or are able to pay only limited amounts, we may be unable to make payments on our indebtedness, meet other holding company financial obligations, or pay dividends to shareholders. The payment of dividends by these operating subsidiaries is subject to restrictions set forth in the insurance laws and regulations of their respective states of domicile, as discussed under the caption "Insurance Regulatory Matters".

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Regulatory requirements or changes to regulatory requirements could have a material effect on our operations.

Our insurance businesses are subject to extensive regulation by state insurance authorities in each state in which they operate. Regulation is intended for the benefit of policyholders rather than shareholders. In addition to the amount of dividends and other payments that can be made to a holding company by insurance subsidiaries, these regulatory authorities have broad administrative and supervisory power relating to:

- licensing requirements;
- trade practices;
- capital and surplus requirements;
- investment practices; and
- rates charged to insurance customers.

These regulations may impede or impose burdensome conditions on rate changes or other actions that we may desire to take in order to enhance our results of operations. In addition, we may incur significant costs in the course of complying with regulatory requirements. Most states also regulate insurance holding companies like us in a variety of matters such as acquisitions, solvency and risk assessment, changes of control and the terms of affiliated transactions. Also, certain states sponsor insurance entities which affect the amount and type of liability coverages purchased in the sponsoring state. Changes to the number of state sponsored entities of this type could result in a large number of insureds changing the amount and type of coverage purchased from private insurance entities such as ProAssurance.

As a result of our acquisition of Eastern, we own a subsidiary domiciled in the Cayman Islands and subject to the laws of the Cayman Islands and regulations promulgated by the CIMA. Failure to comply with these laws, regulations and requirements could result in consequences ranging from a regulatory examination to a regulatory takeover of our Cayman subsidiary, which could potentially impact profitability of alternative market solutions offered through this subsidiary.

Syndicate 1729 is regulated in the U.K. by the Prudential Regulation Authority and the Financial Conduct Authority. All Lloyd's syndicates must also comply with the bylaws and regulations established by the Council of Lloyd's. Failure to comply with bylaws and regulations could affect our ability to underwrite as a Lloyd's Syndicate in the future and therefore affect our profitability. Changes in bylaws and regulations could also affect the profitability of the operations.

The European Union's executive body, the European Commission, is implementing new capital adequacy and risk management regulations called Solvency II that would apply to businesses within the European Union. Solvency II is currently required to be implemented on January 1, 2016, and certain interim transition measures were required for 2014 and 2015. We are unable to predict with any certainty the effect that such regulations will have on the profitability of Lloyd's or Syndicate 1729.

As a member of the Lloyd's market and a capital provider to Lloyd's Syndicate 1729 we are subject to certain risks which could materially and adversely affect us.

As a member of the Lloyd's market we are obligated to contribute to the Lloyd's Central Fund and to pay levies to Lloyd's and also have our ongoing exposure to levies and charges in order to underwrite at Lloyd's. Whenever a member of Lloyd's is unable to pay its policyholder obligations, such obligations may be payable by the Lloyd's Central Fund. If Lloyd's determines that the Central Fund needs to be increased, it has the power to assess premium levies on current Lloyd's members up to 3% of a member's underwriting capacity in any one year. We do not believe that any assessment is likely in the foreseeable future and have not provided an allowance for such an assessment. However, based on our 2015 estimated underwriting capacity at Lloyd's of £43.2 million ($67.2 million), the December 31, 2014 exchange rate of 1.5577 dollars per GBP and assuming the maximum 3% assessment, we could be assessed up to $2.0 million for the 2015 underwriting year.

As a participant in Lloyd's of London, Syndicate 1729 is subject to certain risks and uncertainties, including the following:

- its reliance on insurance and reinsurance brokers and distribution channels to distribute and market its products;
- its obligation to pay levies to Lloyds;
-

its obligations to maintain funds to support its underwriting activities in that its risk-based capital requirements are assessed periodically by Lloyd's and subject to variation;

- its reliance on ongoing approvals from Lloyd's and various regulators to conduct its business, including a requirement that its Annual Business Plan be approved by Lloyd's before the start of underwriting for each account year;
- its financial strength rating is derived from the rating assigned to Lloyd's, although it has limited ability to directly affect the overall Lloyd's rating; and
- its reliance on Lloyd's trading licenses in order to underwrite business outside the U.K.

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The guaranty fund assessments that we are required to pay to state guaranty associations may increase or our participation in mandatory risk retention pools could be expanded and our results of operations and financial condition could suffer as a result.

Each state in which we operate has separate insurance guaranty fund laws requiring admitted property and casualty insurance companies doing business within their respective jurisdictions to be members of their guaranty associations. These associations are organized to pay covered claims (as defined and limited by the various guaranty association statutes) under insurance policies issued by insurance companies that have become insolvent. Most guaranty association laws enable the associations to make assessments against member insurers to obtain funds to pay covered claims after a member insurer becomes insolvent. These associations levy assessments (up to prescribed limits) on all member insurers in a particular state on the basis of the proportionate share of the premiums written by member insurers in the covered lines of business in that state. Maximum assessments generally vary between 1% and 2% of annual premiums written by a member in that state. Some states permit member insurers to recover assessments paid through surcharges on policyholders or through full or partial premium tax offsets, while other states permit recovery of assessments through the rate filing process. We had net guaranty fund recoupments of $0.2 million in 2014 and net guaranty fund assessments of less than $0.1 million in 2013. Our practice is to accrue for insurance insolvencies when notified of assessments. We are not able to reasonably estimate assessments or develop a meaningful range of possible assessments prior to notice because the guaranty funds do not provide sufficient information for development of such estimates or ranges.

Certain states have established risk pooling mechanisms that offer insurance coverage to individuals or entities who are otherwise unable to purchase coverage from private insurers. Authorized property and casualty insurers in these states are generally required to share in the underwriting results of these pooled risks, which are typically adverse. Should our mandatory participation in such pools be increased or if the assessments from such pools increased, our results of operations and financial condition would be negatively affected, although that was not the case in 2014, 2013 or 2012.

Our investment results will fluctuate as interest rates change.

Our investment portfolio is primarily comprised of interest-earning assets, marked to market each period. Thus, prevailing economic conditions, particularly changes in market interest rates, may significantly affect our results of operations. Significant movements in interest rates potentially expose us to lower yields or lower asset values. Changes in market interest rate levels generally affect our net income to the extent that reinvestment yields are different than the yields on maturing securities. Changes in interest rates also can affect the value of our interest-earning assets, which are principally comprised of fixed and adjustable-rate investment securities. Generally, the values of fixed-rate investment securities fluctuate inversely with changes in interest rates. Interest rate fluctuations could adversely affect our stockholders' equity, income and/or cash flows.

Our investments are subject to credit, prepayment and other risks.

A significant portion of our total assets ($4.0 billion or 78%) at December 31, 2014 are financial instruments whose value can be significantly affected by economic and market factors beyond our control including, among others, the unemployment rate, the strength of the domestic housing market, the price of oil, changes in interest rates and spreads, consumer confidence, investor confidence regarding the economic prospects of the entities in which we invest, corrective or remedial actions taken by the entities in which we invest, including mergers, spin-offs and bankruptcy filings, the actions of the U.S. government, and global perceptions regarding the stability of the U.S. economy. Adverse economic and market conditions could cause investment losses or other-than-temporary impairments of our securities, which could affect our financial condition, results of operations, or cash flows.

At December 31, 2014 approximately 11% of our investment portfolio is invested in mortgage and asset-backed securities. We utilize ratings determined by Nationally Recognized Statistical Rating Organizations (NRSROs) (Moody's, Standard & Poor's, and Fitch) as an element of our evaluation of the credit worthiness of our securities. The ratings are subject to error by the agencies; therefore, we may be subject to additional credit exposure should the rating be misstated.

Our asset-backed securities are also subject to prepayment risk. A prepayment is the unscheduled return of principal. When rates decline, the propensity for refinancing may increase and the period of time we hold our asset-backed

securities may shorten due to prepayments. Prepayments may cause us to reinvest cash proceeds at lower yields than the retired security. Conversely, as rates increase, and motivations for prepayments lessen, the period of time over which our asset-backed securities are repaid may lengthen, causing us to not reinvest cash flows at the higher available yields.

At December 31, 2014 the fair value of our state/municipal portfolio was $1.1 billion (amortized cost basis of $1.0 billion). While our state/municipal portfolio had a high credit rating (AA on average), which indicates a strong ability to pay, there is no assurance that there will not be a credit related event which would cause fair values to decline. An economic downturn could lessen tax receipts and other revenues in many states and their municipalities and the frequency of credit downgrades of these entities has increased.

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Our tax credit partnership interests are subject to risks related to the potential forfeiture of the tax credits and all or a portion of the previously claimed tax credits. Loss of the tax credits might occur if the property owner fails to meet the specified requirements of planning, constructing and operating the property or if the property fails to generate the projected tax credits. At December 31, 2014 the carrying value of our tax credit partnership interests was approximately $133.1 million.

U.S. Government debt rating.

U.S Government securities are no longer rated with the highest possible rating by one of the major rating agencies, and there is potential for a further downgrade or for additional rating agencies to also downgrade U. S. Government securities. The rating agencies have also indicated that debt instruments of issuers dependent upon federal support and distributions, including state and local municipalities, may also be downgraded, but this has not yet occurred to any widespread extent except with respect to U.S. Agency debt or U.S. Agency guaranteed debt. If ratings downgrades occur, the average credit rating of our investment portfolio will be reduced. Due to the unpredictable nature of this situation, we are unable to provide a reliable estimate regarding the extent to which our portfolio might be affected. As of December 31, 2014 debt securities represented 78% of our total investments and included U.S. Government debt, U.S. Agency debt, and U.S. Agency guaranteed debt having a combined fair value of $491 million and state and municipal securities having a combined fair value of $1.1 billion.

In a period of market illiquidity and instability, the fair values of our investments are more difficult to assess and our assessments may prove to be greater or less than amounts received in actual transactions.

In accordance with applicable GAAP, we value 94% of our investments at fair value and the remaining 6% at cost, equity, or cash surrender value. See Notes 1, 3 and 4 of the Notes to Consolidated Financial Statements for additional information.

We determine the fair value of our investments using quoted exchange or over-the-counter (OTC) prices, when available. At December 31, 2014, we valued approximately 10% of our investments in this manner. When exchange or OTC quotes are not available, we estimate fair values based on broker dealer quotes and various other valuation methodologies, which may require us to choose among various input assumptions and which requires us to utilize judgment. At December 31, 2014 approximately 84% of our investments were valued in this manner. When markets exhibit significant volatility, there is more risk that we may utilize a quoted market price, broker dealer quote, valuation technique or input assumption that results in a fair value estimate that is either over or understated as compared to actual amounts that would be received upon disposition or maturity of the security.

Our Board may decide that our financial condition does not allow the continued payment of a quarterly cash dividend, or requires that we reduce the amount of our quarterly cash dividend.

Our Board approved a cash dividend policy in September 2011, and most recently paid a $0.31 per share dividend for the three months ended December 31, 2014. However, any decision to pay future cash dividends is subject to the Board’s final determination after a comprehensive review of the Company’s financial performance, future expectations and other factors deemed relevant by the Board.

Our ability to issue additional debt or letters of credit or other types of indebtedness on terms consistent with current debt is subject to market conditions, economic conditions at the time of proposed issuance, and the results of ratings reviews. Also, our current credit agreement requires that our debt to capital ratio be 0.35 to 1.0 or less, and the issuance of debt by one of our insurance subsidiaries requires regulatory approval, both of which may limit or prohibit the issuance of additional debt.

During 2013 we issued $250 million of unsecured Senior Notes Payable due in 2023 at a 5.3% interest rate. There is no guarantee that additional debt could be issued on similar terms in the future as rates available to us may change due to changes in the economic climate or shifts in the yield curve may occur or an increase in our level of debt may result in rating agencies lowering our debt rating. Also, our insurance subsidiaries must obtain regulatory approval before incurring additional debt. A further restriction is that our credit facility agreement requires that our consolidated debt to capital ratio (0.12 to 1.0 at December 31, 2014) be 0.35 to 1.0 or less.

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Resolution of uncertain tax matters and changes in tax laws or taxing authority interpretations of tax laws could result in actual tax benefits or deductions that are different than we have estimated, both with regard to amounts recognized and the timing of recognition. Such differences could affect our results of operations or cash flows.

Our provision for income taxes, our recorded tax liabilities and net deferred tax assets, including any valuation allowances, are recorded based on estimates. These estimates require us to make significant judgments regarding a number of factors, including, among others, the applicability of various federal and state laws, the interpretations given to those tax laws by taxing authorities, courts and the Company, the timing of future income and deductions, and our expected levels and sources of future taxable income. We believe our tax positions are supportable under tax laws and that our estimates are prepared in accordance with GAAP. Additionally, from time to time there are changes to tax laws and interpretations of tax laws which could change our estimates of the amount of tax benefits or deductions expected to be available to us in future periods. In either case, changes to our prior estimates would be reflected in the period changed and could have a material effect on our effective tax rate, financial position, results of operations and cash flow. The reinsurance portion of our workers' compensation business is domiciled in the Cayman Islands. Changes in Cayman Island tax laws could result in the loss of profitability of that business.

We are subject to U.S. federal and various state income taxes. We are periodically under routine examination by various federal, state and local authorities regarding income tax matters and our tax positions could be successfully challenged; the costs of defending our tax positions could be considerable. Our estimate of our potential liability for known uncertain tax positions is reflected in our financial statements. As of December 31, 2014 we had a federal income tax receivable of approximately $1 million. We also had a liability for unrecognized current tax benefits of $0.6 million, and we had a net deferred tax liability of approximately $18.8 million. Unrecognized tax benefits at December 31, 2014, if recognized, would not affect the effective tax rate but would accelerate the payment of tax.

New or changes in existing accounting standards, practices and/or policies, as well as subjective assumptions, estimates and judgments by management related to complex accounting matters could significantly affect our financial results or our ability to maintain investor confidence and shareholder value.

U.S. generally accepted accounting principles (GAAP) and related accounting pronouncements, implementation guidelines and interpretations with regard to a wide range of matters that are relevant to our business, such as revenue recognition, estimation of losses, determination of fair value, asset impairment (particularly investment securities and goodwill) and tax matters, are highly complex and involve many subjective assumptions, estimates and judgments. Changes in these rules or their interpretation or changes in underlying assumptions, estimates, or judgments could significantly change our reported or expected financial performance or financial condition. See Note 1 of the Notes to Consolidated Financial Statements for a description of our significant accounting policies.

ProAssurance is primarily a holding company of insurance subsidiaries which are required to comply with statutory accounting principles (SAP). SAP and its components are subject to review by the NAIC and state insurance departments. The NAIC Accounting Practices and Procedures Manual provides that a state insurance department may allow insurance companies that are domiciled in that state to depart from SAP by granting them permitted non-SAP accounting practices. This permission may permit a competitor or competitors to use a more favorable accounting policy.

It is uncertain whether or how SAP might be revised or whether any revisions will have a positive or negative effect. It is also uncertain whether any changes to SAP or its components or any permitted non-SAP accounting practices granted to our competitors will negatively affect our financial results or operations. See the Insurance Regulatory Matters section in Item 1 for the full discussion on regulatory matters.

Our interpretation, integration and/or compliance with new or changes to existing pronouncements by GAAP or SAP could materially impact us as a publicly traded company as it relates to investor confidence and shareholder value.

We are subject to numerous NYSE and SEC regulations including insider trading regulations, Regulation FD, and regulations requiring timely and accurate reporting of our operating results as well as certain events and transactions. Non-compliance with these regulations could subject us to enforcement actions by the NYSE or the SEC, and could affect the value of our shares and our ability to raise additional capital.

The Company carefully adheres to NYSE and SEC requirements as the loss of trading privileges on the NYSE or an SEC enforcement action could have a significant financial impact on the Company. Failure to comply with various

SEC reporting and record keeping requirements could result in a decline in the value of our stock or a decline in investor confidence which could directly impact our ability to efficiently raise capital. Failure to adhere to NYSE requirements could result in fines, trading restriction or delisting.

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The operations of the Company are heavily reliant upon the Company's reputation as an ethical business organization providing needed services to its customers.

The Company's positive reputation is critical to its role as an insurance provider and as a publicly traded company. The Board adopted a Code of Ethics and Conduct and management is heavily focused on the integrity of our employees and third party suppliers, agents or brokers. Illegal, unethical or fraudulent activities perpetrated by an employee or one of our third party agencies or brokers for personal gain could expose the Company to a potential financial loss.

A natural disaster or pandemic event, or closely related series of events, could cause loss of lives or a substantial loss of property or operational ability at one or more of the Company's facilities.

The Company's disaster preparedness encompasses our Business Continuity Plan, Disaster Recovery Plan, Operations Plan, and Pandemic Response Plan. Our disaster preparedness is focused on maintaining the continuity of the Company's data processing and telephone capabilities as well as the use of alternate and temporary facilities in the event of a natural disaster or medical event. The Company's plans are reviewed during the insurance department examinations of the statutory insurance companies. While the Company has plans in place to respond to both short- and long-term disaster scenarios, the loss of certain key operating facilities or data processing capabilities could have a significant impact on Company operations.

The operations of the Company are dependent upon the availability, integrity and security of our internal technology infrastructure and that of certain third parties. Any significant disruption of these infrastructures could result in unauthorized access to Company data or reduce our ability to conduct business effectively, or both.

The Company is dependent upon its technology infrastructure and that of certain third parties to operate and report financial and other Company information accurately and timely. The Company has focused resources on securing and preserving the integrity of our data processing systems and related data. Additionally, the Company evaluates the integrity and security of the technology infrastructure of third parties that process or store data that the Company considers to be significant. However, there is no guarantee that measures taken to date will completely prevent possible disruption, damage or destruction by intentional or unintentional acts or events such as cyber-attacks, viruses, sabotage, human error, system failure or the occurrence of numerous other human or natural events. Disruption, damage or destruction of any of our systems or data could cause our normal operations to be disrupted or unauthorized internal or external knowledge or misuse of confidential Company data could occur, all of which could be harmful to the Company from both a financial and reputational perspective.

ITEM 1B. UNRESOLVED STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

We own five office properties, all of which are unencumbered:

Property Location	Square Footage of Properties		
	Occupied by ProAssurance	Leased or Available for Lease	Total
Birmingham, AL*	104,000	61,000	165,000
Franklin, TN	52,000	51,000	103,000
Okemos, MI	53,000	—	53,000
Madison, WI	38,000	—	38,000
Las Vegas, NV	4,640	—	4,640

* Corporate Headquarters

ITEM 3. LEGAL PROCEEDINGS.

Our insurance subsidiaries are involved in various legal actions, a substantial number of which arise from claims made under insurance policies. While the outcome of all legal actions is not presently determinable, management and its legal counsel are of the opinion that these actions will not have a material adverse effect on our financial position or results of operations. See Note 9 of the Notes to Consolidated Financial Statements included herein.

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EXECUTIVE OFFICERS OF PROASSURANCE CORPORATION

The executive officers of ProAssurance Corporation (ProAssurance) serve at the pleasure of the Board. We have a knowledgeable and experienced management team with established track records in building and managing successful insurance operations. Following is a brief description of each executive officer of ProAssurance, including their principal occupation, and relevant background with ProAssurance and former employers.

W. Stancil Starnes	Mr. Starnes was appointed as Chief Executive Officer in 2007 and has served as the Chairman of the Board since 2008. In 2012 he was appointed President of ProAssurance. Mr. Starnes previously served as President, Corporate Planning and Administration of Brasfield & Gorrie, Inc., a large national commercial contractor. Prior to 2006, Mr. Starnes served as the Senior and Managing Partner of the law firm of Starnes & Atchison, LLP, where he was extensively involved with ProAssurance and its predecessors in the defense of healthcare professional liability claims for over 25 years. Mr. Starnes currently serves as a director of Infinity Property and Casualty Corporation, a public insurance holding company, where he serves on the audit, compensation and executive committees. He is also on the Board of Directors of The National Bank of Commerce, located in Birmingham, Alabama, where he serves as Chairman of the Nominating and Corporate Governance Committee and is a member of the compensation committee. (Age 66)
Howard H. Friedman	Mr. Friedman was appointed as President of our Healthcare Professional Liability Group in 2014, and is also our Chief Underwriting Officer and Chief Actuary. Mr. Friedman has previously served as a Co-President of our Professional Liability Group, Chief Financial Officer, Corporate Secretary, and as the Senior Vice President of Corporate Development. Mr. Friedman joined our predecessor in 1996. Mr. Friedman is an Associate of the Casualty Actuarial Society and a member of the American Academy of Actuaries. (Age 56)
Jeffrey P. Lisenby	Mr. Lisenby was appointed as an Executive Vice President in 2014 and is also our General Counsel, Corporate Secretary and head of the corporate Legal Department. Mr. Lisenby has previously served as Senior Vice President. Prior to joining ProAssurance, Mr. Lisenby practiced law privately in Birmingham, Alabama. Mr. Lisenby is a member of the Alabama State Bar and the United States Supreme Court Bar and is a Chartered Property Casualty Underwriter. (Age 46)
Edward L. Rand, Jr.	Mr. Rand was appointed as an Executive Vice President in 2014 and is also our Chief Financial Officer. Mr. Rand previously served as our Senior Vice President of Finance upon joining ProAssurance in 2004. Prior to joining ProAssurance, Mr. Rand was the Chief Accounting Officer and Head of Corporate Finance for PartnerRe Ltd. Prior to that time Mr. Rand served as the Chief Financial Officer of Atlantic American Corporation. (Age 48)
Frank B. O'Neil	Mr. O'Neil was appointed as our Senior Vice President and Chief Communications Officer in 2001. Mr. O'Neil has previously served as our Senior Vice President of Corporate Communications, having joined our predecessor in 1987. (Age 61)
Michael L. Boguski	Mr. Boguski is President of our Eastern subsidiary. Prior to the acquisition of Eastern, Mr. Boguski served as President and Chief Executive Officer of Eastern, and first joined Eastern in 1997. (Age 52)

Mary Todd Peterson	Ms. Peterson is President of our Medmarc subsidiary. Prior to the acquisition of Medmarc, Ms. Peterson served as Medmarc's President and CEO. She previously served as Medmarc's Senior Vice President and Chief Operating Officer as well as its Senior Vice President, Chief Financial Officer and Treasurer. Ms. Peterson serves on the Board of Governors for the Property Casualty Insurance Association of America where she chairs the Investment Committee and serves on the Executive and Finance Committees. Ms. Peterson also serves on the Board of Directors of The Community Financial Corporation where she chairs the Audit Committee. (Age 60)
Ross E. Taubman	Dr. Taubman is President and Chief Medical Officer of our PICA subsidiary. Prior to joining PICA, Dr. Taubman practiced podiatry for 26 years. During that time, Dr. Taubman served as Treasurer, Vice-President and President of the Maryland Podiatric Medical Association. Dr. Taubman is a diplomate in the American Board of Podiatric Surgery. (Age 57)
Kelly B. Brewer	Ms. Brewer was appointed as our Chief Accounting Officer in 2014 and has served as our Vice President of Finance since joining ProAssurance in 2008. Prior to joining ProAssurance, Ms. Brewer was a Senior Manager for PricewaterhouseCoopers for four years. Prior to that time Ms. Brewer served financial services clients in audit and forensic accounting engagements for five years. Ms. Brewer is a Certified Public Accountant. (Age 39)

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We have adopted a Code of Ethics and Conduct that applies to our directors and executive officers, including but not limited to our principal executive officers, principal financial officer, and principal accounting officer. We also have share ownership guidelines in place to ensure that management maintains a significant portion of their personal investments in the stock of ProAssurance. Both our Code of Ethics and Conduct and our Share Ownership Guidelines are available on the Governance section of our website. Printed copies of these documents may be obtained from Frank O'Neil, Senior Vice President, ProAssurance Corporation, either by mail at P.O. Box 590009, Birmingham, Alabama 35259-0009, or by telephone at (205) 877-4400 or (800) 282-6242.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

At February 20, 2015, ProAssurance Corporation (PRA) had 2,861 stockholders of record and 55,814,475 shares of common stock outstanding. ProAssurance's common stock currently trades on the NYSE under the symbol "PRA".

	2014		2013	
Quarter	High	Low	High	Low
First	$48.11	$42.90	$47.92	$43.06
Second	45.79	43.71	52.73	47.11
Third	46.58	43.63	55.28	45.06
Fourth	48.08	43.78	49.38	42.70

	Dividends Declared		Dividends Paid	
Quarter	2014	2013	2014	2013
First	$0.30	$0.25	$0.30	$—
Second	0.30	0.25	0.30	0.25
Third	0.30	0.25	0.30	0.25
Fourth*	2.96	0.30	0.30	0.25

* Includes a special dividend of $2.65 per common share in 2014.

The Board declared a quarterly dividend in each quarter of 2014 and 2013. The dividends were paid in the month after the quarter ended. The Board also declared a special dividend of $2.65 per common share in the fourth quarter of 2014 that was paid in January 2015. Any decision to pay regular or special cash dividends in the future is subject to the Board's final determination after a comprehensive review of financial performance, future expectations and other factors deemed relevant by the Board.

ProAssurance's insurance subsidiaries are subject to restrictions on the payment of dividends to the parent. Information regarding restrictions on the ability of the insurance subsidiaries to pay dividends is incorporated herein by reference from the paragraphs under the caption "Insurance Regulatory Matters–Regulation of Dividends and Other Payments from Our Operating Subsidiaries" in Item 1 of this 10-K.

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Securities Authorized for Issuance Under Equity Compensation Plans

The following table provides information regarding ProAssurance's equity compensation plans as of December 31, 2014.

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(a)	(b)	(c)
Equity compensation plans approved by security holders	796,934	$24.64 *	2,680,075
Equity compensation plans not approved by security holders	—	—	—

*Applicable only to approximately 4,000 outstanding options. Other outstanding share units have no exercise price.

Issuer Purchases of Equity Securities

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs * (in thousands)
October 1 - 31, 2014	496,623	$44.77	496,623	$111,869
November 1 - 30, 2014	363,388	$45.48	363,388	$97,880
December 1 - 31, 2014	348,474	$46.86	348,474	$181,542
Total	1,208,485	$45.59	1,208,485	

* Under its current plan begun in November 2010, the ProAssurance Board of Directors has authorized $500 million for the repurchase of common shares or the retirement of outstanding debt, including $200 million authorized in 2014. This is ProAssurance's only plan for the repurchase of common shares, and the plan has no expiration date.

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ITEM 6. SELECTED FINANCIAL DATA.

	Year Ended December 31				
	2014	2013	2012	2011	2010
	(In thousands except per share data)				
Selected Financial Data (1)					
Gross premiums written	$779,609	$567,547	$536,431	$565,895	$533,205
Net premiums earned	699,731	527,919	550,664	565,415	519,107
Net investment income	125,557	129,265	136,094	140,956	146,380
Equity in earnings (loss) of unconsolidated subsidiaries	3,986	7,539	(6,873)	(9,147)	1,245
Net realized investment gains (losses)	14,654	67,904	28,863	5,994	17,342
Other revenues	8,398	7,551	7,106	13,566	7,991
Total revenues	852,326	740,178	715,854	716,784	692,065
Net losses and loss adjustment expenses	363,084	224,761	179,913	162,287	221,115
Net income (2)	$196,565	$297,523	$275,470	$287,096	$231,598
Net income per share (3):					
Basic	$3.32	$4.82	$4.49	$4.70	$3.64
Diluted	$3.30	$4.80	$4.46	$4.65	$3.60
Weighted average shares outstanding (3):					
Basic	59,285	61,761	61,342	61,140	63,576
Diluted	59,525	62,020	61,833	61,684	64,351
Balance Sheet Data, as of December 31					
Total investments	$4,009,707	$3,941,045	$3,926,902	$4,090,541	$3,990,431
Total assets	5,169,160	5,150,099	4,876,578	4,998,878	4,875,056
Reserve for losses and loss adjustment expenses	2,058,266	2,072,822	2,054,994	2,247,772	2,414,100
Long-term debt	250,000	250,000	125,000	49,687	51,104
Total liabilities	3,011,216	2,755,685	2,605,998	2,834,425	3,019,193
Total capital	$2,157,944	$2,394,414	$2,270,580	$2,164,453	$1,855,863
Total capital per share of common stock outstanding (3)	$38.17	$39.13	$36.85	$35.42	$30.17
Common stock outstanding, period end (3)	56,534	61,197	61,624	61,107	61,506

(1) Includes acquired entities since date of acquisition only.

(2) Includes a loss on extinguishment of debt of $2.2 million for the year ended December 31, 2012.

(3) For all periods presented, share and per share amounts reflect the effect of the two-for-one stock split effected in the form of a stock dividend that was effective December 27, 2012.

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ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

The following discussion should be read in conjunction with the Consolidated Financial Statements and Notes to those statements which accompany this report. A glossary of insurance terms and phrases is available on the investor section of our website. Throughout the discussion, references to "ProAssurance", "PRA", "Company", "we", "us" and "our" refer to ProAssurance Corporation and its consolidated subsidiaries. The discussion contains certain forward-looking information that involves risks and uncertainties. As discussed under the heading "Forward-Looking Statements", our actual financial condition and operating results could differ significantly from these forward-looking statements.

ProAssurance Overview

We are an insurance holding company and our operating results are primarily derived from the operations of our insurance subsidiaries, which provide professional liability insurance for healthcare professionals and facilities, professional liability insurance for attorneys, liability insurance for medical technology and life sciences risks, and, effective January 1, 2014, workers' compensation insurance. We are also a 58% capital provider to Syndicate 1729, which began underwriting and reinsuring a range of property and casualty insurance lines effective January 1, 2014.

We report our results in four distinct segments, based on the operational focus of the segment. Our Specialty Property and Casualty (Specialty P&C) segment includes our professional liability business and our medical technology and life sciences business. Our Workers' Compensation segment includes the business acquired through our January 1, 2014 purchase of Eastern and includes workers' compensation insurance for employers, groups and associations. Our Lloyd's Syndicate segment includes operating results from our participation in Lloyd's Syndicate 1729, which began operations January 1, 2014. Information regarding Lloyd's operations derived from U.K. based entities is reported on a quarter delay, although investment results associated with our Funds at Lloyd's (FAL) investments are reported concurrently as those results are available on an earlier time frame. Our Corporate segment includes our U.S. investment operations which are managed at the corporate level, non-premium revenues generated outside of our insurance entities, corporate expenses, interest and U.S. income taxes. Additional information regarding our segments is included in Note 15 of the Notes to Consolidated Financial Statements and in Part I.

Growth Opportunities and Outlook

We expect our long-term growth to come through controlled expansion of our existing operations and through the acquisition of other specialty insurance companies or books of business. Growth through acquisition is often opportunistic and cannot be predicted.

We operate in very competitive markets and face strong competition from other insurance companies for all of our insurance products. Healthcare professional liability insurance represents a significant portion of our gross premiums written (58% in 2014, excluding tail) and the healthcare market has been trending toward the formation of larger medical practice groups, and the employment of physicians by hospitals. Large medical groups and facilities frequently manage their healthcare professional liability exposure outside of the traditional insurance marketplace using self-insured mechanisms and other risk sharing arrangements. In response to these trends, we offer products designed to provide greater risk sharing options to hospitals and large physician groups.

We have expanded our lines of business in new directions by acquiring Eastern, a provider of workers' compensation insurance, on January 1, 2014 and Medmarc, an underwriter of products liability insurance for medical technology and life sciences companies, on January 1, 2013. We have also been a consistent acquirer of other physician insurers, most recently IND in 2012, APS in 2010 and PICA in 2009. Other 2009 acquisitions included an agency largely focused on the professional liability needs of allied healthcare providers and an insurer focused on the legal professional liability market. We continue to see new opportunities from each of the acquisitions and believe each will provide organic growth through expansion in their existing markets and relationships.

Late in 2013, we completed the process of becoming a corporate member of Lloyd's of London, an internationally recognized specialist insurance market. We are the majority (58%) capital provider to Syndicate 1729, which began underwriting and reinsuring business as of January 1, 2014. Syndicate 1729 will cover a range of property and casualty insurance and reinsurance lines, and has a maximum underwriting capacity of £75 million for the 2015 underwriting year, of which £43.2 million ($67.2 million at December 31, 2014) is our allocated underwriting capacity as a corporate member.

We believe our emphasis on fair treatment of our insureds and other important stakeholders through our commitment to “Treated Fairly” has enhanced our market position and differentiated us from other insurers. We will continue to practice the values of “Treated Fairly” in all of our activities, and we believe that as we reach more customers with this message we will continue to improve retention and add new insureds.

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Key Performance Measures

We have sustained our financial stability during difficult market conditions through responsible underwriting, pricing and loss reserving practices and through conservative investment practices. We are committed to maintaining prudent operating and financial leverage and to conservatively investing our assets. We recognize the importance that our customers and producers place on the financial strength of our principal insurance subsidiaries and we manage our business to protect our financial security.

We consider a number of performance measures, including the following:

- The net loss ratio is calculated as net losses incurred divided by net premiums earned and is a component of underwriting profitability.
- The underwriting expense ratio is calculated as underwriting, policy acquisition and operating expenses incurred divided by net premiums earned and is a component of underwriting profitability.
- The combined ratio is the sum of the underwriting expense ratio and the net loss ratio and measures underwriting profitability.
- The investment income ratio is calculated as net investment income divided by net premiums earned and measures the contribution investment earnings provides to our overall profitability.
- The operating ratio is the combined ratio, less the investment income ratio. This ratio provides the combined effect of investment income and underwriting profitability.
- The tax ratio is calculated as total income tax expense divided by income (loss) before income taxes and measures our effective tax rate.
- Return on equity (ROE) is calculated as net income for the period divided by the average of beginning and ending shareholders' equity. This ratio measures our overall after-tax profitability and shows how efficiently invested capital is being used.
- Growth in book value. Book value per share is calculated as total shareholders' equity at the balance sheet date divided by the total number of common shares outstanding. This ratio measures the net worth of the company to shareholders on a per-share basis. The declaration of dividends decreases book value per share. Growth in book value per share adjusted for dividends declared is an indicator of overall profitability.

We particularly focus on our combined ratio and investment returns, both of which directly affect our ROE and growth in our book value. Historically we have targeted a long-term average ROE of 12% to 14%. Given the persistent low interest rate environment which prevails in the United States and the soft pricing environment for our products, the realization of this long-term ROE target in the next few years will likely prove difficult.

Our emphasis on rate adequacy, selective underwriting, effective claims management and prudent investments is a key factor in our achievement of our ROE target. We closely monitor premium revenues, losses and loss adjustment costs, and underwriting and policy acquisition expenses. Our overall investment strategy is to focus on maximizing current income from our investment portfolio while maintaining safety, liquidity, duration and portfolio diversification. While we engage in activities that generate other income, such activities, principally insurance agency services, do not constitute a significant use of our resources or a significant source of revenues or profits.

Critical Accounting Estimates

Our Consolidated Financial Statements are prepared in conformity with U.S. generally accepted accounting principles (GAAP). Preparation of these financial statements requires us to make estimates and assumptions that affect the amounts we report on those statements. We evaluate these estimates and assumptions on an ongoing basis based on current and historical developments, market conditions, industry trends and other information that we believe to be reasonable under the circumstances. There can be no assurance that actual results will conform to our estimates and assumptions; reported results of operations may be materially affected by changes in these estimates and assumptions. Management considers the following accounting estimates to be critical because they involve significant judgment by management and the effect of those judgments could result in a material effect on our financial statements.

Reserve for Losses and Loss Adjustment Expenses

The largest component of our liabilities is our reserve for losses and loss adjustment expenses ("reserve for losses" or "reserve"), and the largest component of expense for our operations is incurred losses and loss adjustment expenses (also referred to as "losses and loss adjustment expenses", "incurred losses", "losses incurred", and "losses"). Incurred losses

reported in any period reflect our estimate of losses incurred related to the premiums earned in that period as well as any changes to our previous estimate of the reserve required for prior periods.

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As of December 31, 2014 our reserve is almost entirely comprised of long-tail exposures. The estimation of long-tailed losses is inherently difficult and is subject to significant judgment on the part of management. Due to the nature of our claims, our loss costs, even for claims with similar characteristics, can vary significantly depending upon many factors, including but not limited to: the specific characteristics of the claim and the manner in which the claim is resolved. Long-tailed insurance is characterized by the extended period of time typically required to assess the viability of a claim, potential damages, if any, and to then reach a resolution of the claim. The claims resolution process may extend to more than five years. The combination of continually changing conditions and the extended time required for claim resolution results in a loss cost estimation process that requires actuarial skill and the application of significant judgment, and such estimates require periodic modification.

Our reserve is established by management after taking into consideration a variety of factors including premium rates, claims frequency, historical paid and incurred loss development trends, the expected effect of inflation, general economic trends, the legal and political environment, and the conclusions reached by our internal and consulting actuaries. We update and review the data underlying the estimation of our reserve for losses each reporting period and make adjustments to loss estimation assumptions that we believe best reflect emerging data. Both our internal and consulting actuaries perform an in-depth review of our reserve for losses on at least a semi-annual basis using the loss and exposure data of our insurance subsidiaries.

We partition our reserves by accident year, which is the year in which the claim becomes our liability. As claims are incurred (reported) and claim payments are made, they are aggregated by accident year for analysis purposes. We also partition our reserves by reserve type: case reserves and IBNR reserves. Case reserves are established by our claims department based upon the particular circumstances of each reported claim and represent our estimate of the future loss costs (often referred to as expected losses) that will be paid on reported claims. Case reserves are decremented as claim payments are made and are periodically adjusted upward or downward as estimates regarding the amount of future losses are revised; reported loss is the case reserve at any point in time plus the claim payments that have been made to date. IBNR reserves represent our estimate of future development on losses that have been reported to us and our estimate of losses that have been incurred but not reported to us.

Our reserving process can be broadly grouped into three areas: the establishment of the initial reserve for risks assumed in business combinations (the acquired reserve), the establishment of the reserve for the current accident year (the initial reserve) and the re-estimation of the reserve for prior accident years (development of prior accident years). A summary of the activity in our net reserve for losses during 2014, 2013 and 2012 is provided in the Liquidity and Capital Resources and Financial Condition section that follows under the heading "Losses."

Acquired Reserve

The acquisition of Eastern, which specializes in workers' compensation insurance and reinsurance, on January 1, 2014 increased our loss reserve by $153.2 million which represented the fair value of Eastern's loss reserve at the time of the acquisition. The fair value of the reserve for losses and loss adjustment expenses and related reinsurance recoverables was based on an actuarial estimate of the expected future net cash flows, a reduction of those cash flows for the time value of money determined utilizing the U.S. Treasury Yield Curve, and a risk adjustment to reflect the net present value of profit that an investor would demand in return for the assumption of the associated risks. Expected net cash flows were derived from the expected loss payment patterns included in an actuarial analysis of Eastern's reserve performed as of December 31, 2013. The fair value of the reserve, including the risk margin discussed above, exceeded the undiscounted loss reserve previously established by Eastern by $9.3 million; this fair value adjustment is being amortized over the average expected life of the reserve of 6 years.

Current Accident Year - Initial Reserve

Considerable judgment is required in establishing our initial reserve for any current accident year period, as there is limited data available upon which to base our case reserves. Our process for setting an initial reserve considers the unique characteristics of each line of business, but in general we rely heavily on the loss assumptions that were used to price business, as our pricing reflects our analysis of loss costs that we expect to incur relative to the business being priced.

Specialty P&C Segment. Professional and product liability loss costs are impacted by many factors, including but not limited to, the nature of the claim, including whether or not the claim is an individual or a mass tort claim, the

personal situation of the claimant or the claimant's family, the outcome of jury trials, the legislative and judicial climate where any potential litigation may occur, general economic conditions and, for claims involving bodily injury, the trend of healthcare costs. Within our Specialty P&C segment, for our healthcare professional liability (HCPL) business (62% of consolidated gross premiums earned for the year ended December 31, 2014), we set an initial reserve using the average loss ratio used in our pricing, plus an additional provision in consideration of the historical loss volatility we and others in the industry have experienced. For our HCPL business our target loss ratio during recent accident years has approximated 75% and the provision for loss volatility has ranged from 8 to 10 percentage points, producing an overall average initial loss ratio for our HCPL

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business of approximately 85%. We believe use of a provision for volatility considers inherent risks associated with our rate development process and the historic volatility of professional liability losses (the industry has experienced accident year loss ratios as high as 163% and as low as 53% over the past 30 years) and produces a reasonable best estimate of the reserve required to cover actual ultimate unpaid losses. A similar practice is followed for our legal professional liability business (4% of consolidated gross premiums earned for the year ended December 31, 2014). The risks insured in our medical technology and life sciences products liability business (5% of consolidated gross premiums earned for the year ended December 31, 2014) are more varied, and policies are individually priced based on the risk characteristics of the policy. Therefore, for this business we establish an initial reserve using our most recently developed actuarial estimates of losses expected to be incurred based on factors which include: results from prior analysis of similar business, industry indications, observed trends and judgment. The products liability line of business exhibits similar volatility to HCPL, and the actuarial pricing estimate includes a provision for this volatility.

Workers' Compensation Segment. Many factors affect the ultimate losses incurred for our workers' compensation coverages (28% of consolidated gross premiums earned for the year ended December 31, 2014), including, but not limited to, the type and severity of the injury, age and occupation of the injured worker, the estimated length of disability, medical treatment and related costs, and the jurisdiction of the injury occurrence. We use various actuarial methodologies in developing our workers' compensation reserve combined with a review of the exposure base generally based upon payroll. For the current accident year, given the lack of seasoned information, the different actuarial methodologies produce results with significant variability; therefore, more emphasis is placed on supplementing the actuarial methodologies used with trends in exposure base, medical expense inflation, general inflation, severity, and claim counts, among other things, to select an expected loss ratio.

Development of Prior Accident Years

In addition to setting the initial reserve for the current accident year, each period we reassess the amount of reserve required for prior accident years.

The foundation of our reserve re-estimation process is an actuarial analysis that is performed by both our internal and consulting actuaries. This very detailed analysis projects ultimate losses on a line of business, geographic, coverage layer and accident year basis. The procedure uses of the most representative data for each partition, capturing its unique patterns of development and trends. In all there are over 140 different partitions of our business for purposes of this analysis. We believe that the use of consulting actuaries provides an independent view of our loss data as well as a broader perspective on industry loss trends.

For both the Specialty P&C and Workers' Compensation segments the analysis performed by the consulting actuaries analyzes each partition of our business in a variety of ways and uses multiple actuarial methodologies in performing these analyses, including:

- Bornhuetter-Ferguson (Paid and Reported) Method
- Paid Development Method
- Reported Development Method
- Average Paid Value Method
- Average Reported Value Method
- Backward Recursive Development Method
- The Adjusted Reported and the Adjusted Paid Methods

A brief description of each method follows.

Bornhuetter-Ferguson Method. We use both the Paid and the Reported Bornhuetter-Ferguson methods. The Paid method assigns partial weight to initial expected losses for each accident year (initial expected losses being the first established case and IBNR reserves for a specific accident year) and partial weight to paid to-date losses. The Reported method assigns partial weight to the initial expected losses and partial weight to current expected losses. The weights assigned to the initial expected losses decrease as the accident year matures.

Paid Development and Reported Development Method. These methods use historical, cumulative losses (paid losses for the Paid Development Method, reported losses for the Reported Development Method) by accident year and develop those actual losses to estimated ultimate losses based upon the assumption that each accident year will develop to estimated ultimate cost in a manner that is analogous to prior years, adjusted as deemed appropriate for the

expected effects of known changes in the claim payment environment (and case reserving environment for the Reported Development Method), and, to the extent necessary, supplemented by analyses of the development of broader industry data.

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Average Paid Value and Average Reported Value Methods. In these methods, average claim cost data (paid claim cost for the Average Paid Value Method and reported claim cost for the Reported Value Method) is developed to an ultimate average cost level by report year based on historical data. Claim counts are similarly developed to an ultimate count level. The average claim cost (after rounding and adjustment, if necessary, to accommodate report year data that is not considered to be predictive) is then multiplied by the ultimate claim counts by report year to derive ultimate loss and ALAE.

Backward Recursive Development Method. This method is an extrapolation of the movements in case reserve adequacy in order to estimate unpaid loss costs. Historical data showing incremental changes to case reserves over progressive time periods is used to derive factors that represent the ratio of case reserve values at successive maturities. Historical claims payment data showing the additional payments in progressive time periods is used to derive factors that represent the portion of a case reserve paid in the following period. Starting from the most mature period, after which all of the case reserve is paid and the case reserve is exhausted, the next prior ultimate development factor for the prior case reserve can be calculated as the case factor times the established ultimate development factor plus the paid factor. For each successive prior maturity, the ultimate development factor is calculated similarly. The result of multiplying the ultimate development factor times the case reserve is the total indicated unpaid amount.

The Adjusted Reported and the Adjusted Paid Methods. These methods are based on the premise that the relative change in a given accident year's adjusted reported loss estimates (Adjusted Reported Method) or adjusted paid losses (Adjusted Paid Method) from one evaluation point to the next is similar to changes observed for earlier accident years at the same evaluation points. In the Adjusted Reported Method reported loss estimates are adjusted to reflect a common case reserve adequacy basis. In the Adjusted Paid Method, the historical paid loss experience is adjusted to reflect a common claim settlement rate basis. We principally use these methods to evaluate reserves for our legal liability coverages.

Generally, methods such as the Bornhuetter-Ferguson method are used on more recent accident years where we have less data on which to base our analysis. As time progresses and we have an increased amount of data for a given accident year, we begin to give more confidence to the development and average methods, as these methods typically rely more heavily on our own historical data. These methods emphasize different aspects of loss reserve estimation and provide a variety of perspectives for our decisions.

Certain of the methodologies utilized to estimate the ultimate losses for each partition of our reserves consider the actual amounts paid. Paid data is particularly influential when a large portion of known claims have been closed, as is the case for older accident years. In selecting a point estimate for each partition, management considers the extent to which trends are emerging consistently for all partitions and known industry trends. Thus, actual, rather than estimated severity trends are given more consideration. If actual severity trends are lower than those estimated at the time that reserves were previously established, the recognition of favorable development is indicated. This is particularly true for older accident years where our actuarial methodologies give more weight to actual loss costs (severity).

The various actuarial methods discussed above are applied in a consistent manner from period to period. In addition, we perform statistical reviews of claims data such as claim counts, average settlement costs and severity trends when establishing our reserves.

We utilize the selected point estimates of ultimate losses to develop estimates of ultimate losses recoverable from reinsurers, based on the terms and conditions of our reinsurance agreements. An overall estimate of the amount receivable from reinsurers is determined by combining the individual estimates. Our net reserve estimate is the gross reserve point estimate less the estimated reinsurance recovery.

For our workers’ compensation segment we utilize the various actuarial methodologies discussed above, with particular reliance on incurred development, paid loss development and Bornhuetter-Ferguson, to develop our reserve for each accident year. The actuarial review includes the stratification of claims data (lost item claims, medical only claims) using different variations that allow us to identify trends that may not be readily identifiable if the data was evaluated only in the aggregate. Incurred and paid loss development factors are key assumptions in the reserve estimation process and are based on our historical incurred and paid loss development patterns. As accident years mature, the various actuarial methodologies produce more consistent loss estimates.

Use of Judgment

Even though the actuarial process is highly technical, it is also highly judgmental, both as to the selection of the data used in the various actuarial methodologies (e.g., initial expected loss ratios and loss development factors) and in the interpretation of the output of the various methods used. Each actuarial method generally returns a different value and for the more recent accident years the variations among the various methodologies can be significant. For each partition of our reserves, the results of the various methods, along with the supplementary statistical data regarding such factors as closed with and without indemnity ratios, claim severity trends, the expected duration of such trends, changes in the legal and legislative environment and the current economic environment, are used to develop a point estimate based upon management's judgment and past

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experience. The process of selecting the point estimate is based upon the judgment of management taking into consideration the actuarial methods and other environmental factors discussed previously. The series of selected point estimates is then combined to produce an overall point estimate for ultimate losses.

Given the potential for unanticipated volatility for long-tailed lines of business, we are cautious in giving full credibility to emerging trends that, when more fully mature, may lead to the recognition of either favorable or adverse development of our losses. There may be trends, both positive and negative, reflected in the numerical data both within our own information and in the broader marketplace that mitigate or reverse as time progresses and additional data becomes available. This is particularly true for our HCPL business which has historically exhibited significant volatility as previously discussed.

HCPL. Over the past several years the most influential factor affecting the analysis of our HCPL reserves and the related development recognized has been the change, or lack thereof, in the severity of claims. The severity trend is an explicit component of our pricing models, whereas in our reserving process the severity trend's impact is implicit. Our estimate of this trend and our expectations about changes in this trend impact a variety of factors, from the selection of expected loss ratios to the ultimate point estimates established by management.

Because of the implicit and wide-ranging nature of severity trend assumptions on the loss reserving process it is not practical to specifically isolate the impact of changing severity trends. However, because severity is an explicit component of our HCPL pricing process we can better isolate the impact that changing severity can have on our loss costs and loss ratios as regards our pricing models for this business component. Our current HCPL pricing models assume a severity trend of 2% to 3% in most states and lines of business. If the severity trend were to be higher by 1 percentage point, the impact would be an increase in our expected loss ratio for this business of 3.2 percentage points, based on current claim disposition patterns. An increase in the severity trend of 3 percentage points would result in a 10.1 percentage point increase in our expected loss ratio. Due to the long tailed nature of our claims and the previously discussed historical volatility of loss costs, selection of a severity trend assumption is a subjective process that is inherently likely to prove inaccurate over time. Given the long-tail and volatility, we are generally cautious in making changes to the severity assumptions within our pricing models. Also of note is that all open claims and accident years are generally impacted by a change in the severity trend, which compounds the effect of such a change.

For the 2004 to 2009 accident years, both our internal and consulting actuaries observed an unprecedented reduction in the frequency of HCPL claims (or number of claims per exposure unit) that cannot be attributed to any single factor. We believe that much of the reduction in claim frequency is the result of a decline in the filing of non-meritorious lawsuits that have historically been dismissed or otherwise resulted in no payment of indemnity on behalf of our insureds. With fewer non-meritorious claims being filed we expect that the claims that are filed have the potential for greater average losses, or greater severity. As a result, we cannot be certain as to the impact this decline will ultimately have on the average cost of claims, and this has complicated the selection or an appropriate severity trend for our pricing model for these lines. It has also made it more challenging to factor severity into the various actuarial methodologies we use to evaluate our reserve. Based on weighted average of payments, typically 85% of our HCPL claims are resolved after eight years for a given accident year. Due to this long tail, we continue to be uncertain of the full impact of the observed decline in frequency and whether the expected increase in severity will materialize.

Although we remain uncertain regarding the ultimate severity trend to project into the future due to the long-tailed nature of our business, we have given consideration to observed loss costs in setting our rates. For our HCPL business this practice has resulted in rate reductions in recent years. For example, on average, excluding our podiatry business acquired in 2009, we have gradually reduced the premium rates we charge on our standard physician renewal business (our largest HCPL line) by approximately 17% from the beginning of 2006 to December 31, 2014. Loss ratios for the current accident years have thus remained fairly constant because expected loss reductions have been reflected in our rates.

Workers' Compensation. Severity has not historically been an influential factor affecting our workers' compensation analysis of reserves, as claims are typically resolved more quickly. As previously mentioned, the determination and calculation of loss development factors requires considerable judgment. In particular the selection of tail factors requires considerable judgment as they are determined in the absence of direct loss development history and thus require reliance upon industry data which may not be representative of the Company’s data and experience.

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Loss Development

We recognized net favorable reserve development of $182 million for the year ended December 31, 2014, of which $181 million related to our Specialty P&C segment and $1 million related to our Workers' Compensation segment. The development recognized within the Specialty P&C segment was primarily attributable to the favorable resolution of HCPL claims during the period and an evaluation of established case reserves and paid claims data that indicated that the actual severity trend associated with the remaining HCPL claims is less than we had previously estimated. The Specialty P&C segment also reflects, to a lesser degree, favorable development attributable to the products liability line. Favorable reserve development recognized within the traditional business of our Workers' Compensation segment includes the amortization of the purchase accounting fair value adjustment of $1.6 million for 2014, and was partially offset by unfavorable reserve development of $0.3 million for the annual period recognized by our segregated portfolio cells (SPCs), which are evaluated at the cell level. Because a relatively small number of claims are open per cell, the closing of claims can affect the actuarial projections for the remaining open claims in the cell to an extent that indicates development should be recognized for the cell.

Specialty P&C Segment

Professional Liability

Our professional liability line of business includes both our HCPL and legal professional lines, with our HCPL line representing the largest component of our reserve. In support of our concern that the decline in frequency will result in a higher severity trend for our HCPL claims, we saw our closed-with-indemnity-payment ratio (i.e., the number of claims closed with an indemnity or loss payment as compared to the total number of closed claims) for our claims increase from 10% in 2005 to 15% in 2014. While this trend has been in keeping with our expectations, the anticipated increase in severity incorporated into our loss assumptions has not occurred. Rather, we have experienced lower than expected severity which has been the primary driver of the favorable development recognized in recent years.

The following table presents additional information about the loss development for our professional liability line of business:

(In thousands)		2014		2013		2012	
Accident Years	Estimated Ultimate Losses, Net of Reinsurance at December 31, 2014	Reserve Development (favorable) unfavorable	% of Known Claims Closed	Reserve Development (favorable) unfavorable	% of Known Claims Closed	Reserve Development (favorable) unfavorable	% of Known Claims Closed
2014	$395,067	N/A	19.8%	N/A	N/A	N/A	N/A
2013	435,516	$14	53.4%	N/A	18.7%	N/A	N/A
2012	465,722	(7,528)	73.2%	$5,905	46.6%	N/A	13.5%
2011	450,124	(37,246)	84.5%	(11,022)	69.5%	$(4,889)	45.0%
2010	434,458	(34,399)	91.8%	(26,032)	82.4%	(13,612)	68.8%
2009	395,560	(24,995)	94.9%	(44,086)	89.0%	(24,378)	80.6%
2008	370,919	(14,598)	97.5%	(38,233)	94.6%	(55,659)	90.3%
2007	355,276	(11,476)	98.7%	(34,199)	97.2%	(51,047)	93.9%
2006	337,357	(4,673)	99.2%	(19,680)	98.5%	(38,708)	97.1%
2005	360,029	(5,092)	99.4%	(14,232)	99.0%	(24,961)	98.4%
Prior to 2005	$5,891,013	(28,862)		(27,420)		(58,785)	

An extended period of time is required to get a clear estimate of the loss cost for a given accident year. As an example, looking at the 2009 accident year for our professional liability reserves, we had resolved 80.6% of the known claims by the end of 2012, 89% of the known claims by the end of 2013, and 94.9% of the known claims by the end of 2014. These statistics are based on the number of reported claims; since many non-meritorious claims are resolved early, percentages of ultimate loss payments known at the same points in time are considerably lower. A similar pattern can be seen in each open accident year as demonstrated in the above table.

Historically we have resolved more than 85% of our physician and hospital professional liability claims with no indemnity payment and generally these claims are the first to be resolved. As an accident year matures, the number of claims resolved with indemnity payments progressively increases. In a similar fashion, we typically expend more in loss adjustment expenses (legal fees) as claims mature.

Based upon the additional claims closed during 2014, 2013 and 2012, as shown above, and better than expected severity trends, management reduced its expected ultimate losses in each of these years resulting in the recognition of corresponding amounts of favorable development in the income statements of those periods. At December 31, 2014, 2013 and 2012

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management reserve estimates for the three most recent prior accident years (which have closed claim percentages below 85%) were influenced by the initial reserve estimate set for these years, moderated to reflect consideration of better than anticipated claims experience observed during the periods. Estimates for older accident years with higher percentages of closed claims were more heavily influenced by the more moderate severity trend, particularly with regard to claims closed during the periods.

This can be seen in looking at both the absolute amount of favorable reserve development recognized for the less developed accident years as well as the size of such development when compared to established ultimates for those same accident years at the end of the preceding calendar year. The following table provides this information for years ended December 31, 2014, 2013 and 2012 with respect to the three then most recent prior accident years:

($ in millions)	2014	2013	2012
Prior accident years	2011-2013	2010-2012	2009-2011
Net favorable development recognized for the specified years	$44.8	$31.1	$42.9
Development as a % of established ultimates, prior calendar year end	3.2%	2.1%	2.9%

Medical Technology and Life Sciences Products Liability

The following table presents additional information about the loss development for our medical technology and life sciences products liability line of business:

(In thousands)		2014		2013	
Accident Years	Estimated Ultimate Losses, Net of Reinsurance at December 31, 2014	Reserve Development (favorable) unfavorable	% of Known Claims Closed	Reserve Development (favorable) unfavorable	% of Known Claims Closed
2014	$13,920	N/A	48.6%	N/A	N/A
2013	12,032	$(2)	74.1%	N/A	36.1%
2012	13,456	1,891	84.8%	$(1,521)	66.7%
2011	18,695	(3,635)	75.8%	(1,330)	63.6%
2010	27,169	(4,997)	94.9%	(371)	65.1%
2009	25,740	(4,693)	95.4%	(3,264)	92.4%
2008	46,645	2,997	99.7%	(3,645)	98.3%
Prior to 2008	498,970	(3,492)		(3,619)	

Approximately $10.3 million of the total net favorable development recognized in 2014 of $11.9 million related to the 2008 to 2011 accident years. The development for the 2008 to 2011 accident years represents an 8.0% reduction to the ultimates established for those reserves at December 31, 2013. Approximately $10.1 million of the total net favorable development recognized in 2013 of $13.8 million related to the 2008 to 2012 accident years. The development for the 2008 to 2012 accident years represents a 6.8% reduction to the ultimates established for those reserves at January 1, 2013, the date the reserves were acquired. In both 2014 and 2013 the development was largely attributable to favorable results from claims closed during the year. As time has elapsed we have recognized that actual loss experience has on average been better than what we estimated. We have been cautious in recognizing the improvement, but as claims have matured and outcomes are known (claims are closed) or have become more certain for the remaining open claims, we have revised reserve estimates. We believe the need for a cautious approach is required as outcomes are uncertain and results can be significantly affected by outcomes for a small number of cases, as evidenced by the unfavorable experience shown for specific accident years in the table above.

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Workers' Compensation Segment

The following table presents additional information about the loss development for our workers' compensation line of business:

(In thousands)		2014	
Accident Years	Estimated Ultimate Losses, Net of Reinsurance at December 31, 2014	Reserve Development (favorable) unfavorable	% of Known Claims Closed
2014	$126,854	N/A	41.4%
2013	117,314	$1,519	82.9%
2012	101,986	(463)	93.6%
2011	95,398	854	97.4%
2010	76,011	(288)	98.8%
2009	66,061	(412)	99.1%
Prior to 2009	351,705	(955)	

We recognized $0.3 million of net unfavorable development at our SPC's related to the reserve acquired from Eastern, primarily reflecting medical severity-related claims activity in the 2013 accident year. More than offsetting this unfavorable development was $1.6 million in favorable reserve development in our traditional workers' compensation business related to the amortization of the purchase accounting fair value adjustment for 2014.

Variability of Loss Reserves

As previously noted, the number of data points and variables considered and the subjective process followed in establishing our loss reserve makes it impractical to isolate individual variables and demonstrate their impact on our estimate of loss reserves. However, to provide a better understanding of the potential variability in our reserves, we have modeled implied reserve ranges around our single point net reserve estimates for our various lines of business assuming different confidence levels. The ranges have been developed by aggregating the expected volatility of losses across partitions of our business to obtain a consolidated distribution of potential reserve outcomes. The aggregation of this data takes into consideration correlations among our geographic and specialty mix of business. The result of the correlation approach to aggregation is that the ranges are narrower than the sum of the ranges determined for each partition.

We have used this modeled statistical distribution to calculate an 80% and 60% confidence interval for the potential outcome of our consolidated net reserve for losses. The high and low end points of the distributions are as follows:

	Low End Point	Carried Net Reserve	High End Point
80% Confidence Level	$1.402 billion	$1.820 billion	$2.294 billion
60% Confidence Level	$1.516 billion	$1.820 billion	$2.102 billion

Any change in our estimate of net ultimate losses for prior years is reflected in net income in the period in which such changes are made. Over the past several years such changes reduced our estimate of net ultimate losses, resulting in a reduction of reported losses for the period and a corresponding increase in consolidated pre-tax income.

Due to the size of our consolidated reserve for losses and the large number of claims outstanding at any point in time, even a small percentage adjustment to our total reserve estimate could have a material effect on our results of operations for the period in which the adjustment is made.

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Reinsurance

We use insurance and reinsurance (collectively, "reinsurance") to provide capacity to write larger limits of liability, to provide protection against losses in excess of policy limits, to stabilize underwriting results in years in which higher losses occur, and to provide a mechanism for sharing risk with insureds or their affiliates. The purchase of reinsurance does not relieve us from the ultimate risk on our policies, but it does provide reimbursement for certain losses we pay. We make a determination of the amount of insurance risk we choose to retain based upon numerous factors, including our risk tolerance and the capital we have to support it, the price and availability of reinsurance, volume of business, level of experience with a particular set of claims and our analysis of the potential underwriting results. We purchase reinsurance from a number of companies to mitigate concentrations of credit risk. We utilize a reinsurance broker to assist us in the placement of our reinsurance programs and in the analysis of the credit quality of our reinsurers. The determination of which reinsurers we choose to do business with is based upon an evaluation of their then-current financial strength, rating and stability.

We evaluate each of our ceded reinsurance contracts at inception to confirm that there is sufficient risk transfer to allow the contract to be accounted for as reinsurance under current accounting guidance. At December 31, 2014, all ceded contracts were accounted for as risk transferring contracts.

Our receivable from reinsurers on unpaid losses and loss adjustment expenses represents our estimate of the amount of our reserve for losses that will be recoverable under our reinsurance programs. We base our estimate of funds recoverable upon our expectation of ultimate losses and the portion of those losses that we estimate to be allocable to reinsurers based upon the terms and conditions of our reinsurance agreements. Our assessment of the collectability of the recorded amounts receivable from reinsurers considers the payment history of the reinsurer, publicly available financial and rating agency data, our interpretation of the underlying contracts and policies, and responses by reinsurers.

Given the uncertainty inherent in our estimates of losses and related amounts recoverable from reinsurers, these estimates may vary significantly from the ultimate outcome.

Under the terms of certain of our reinsurance agreements, the amount of premium that we cede to our reinsurers is based in part on the losses we recover under the agreements. Therefore we make an estimate of premiums ceded under these reinsurance agreements subject to certain maximums and minimums. Any adjustments to our estimates of losses recoverable under our reinsurance agreements or the premiums owed under our agreements are reflected in then-current operations. Due to the size of our reinsurance balances, an adjustment to these estimates could have a material effect on our results of operations for the period in which the adjustment is made.

The financial strength of our reinsurers and their ability to pay us may change in the future due to forces or events we cannot control or anticipate. We have not experienced significant collection difficulties due to the financial condition of any reinsurer as of December 31, 2014; however, reinsurers may periodically dispute our demand for reimbursement from them based upon their interpretation of the terms of our agreements. We have established appropriate reserves for any balances that we believe may not be ultimately collected. Should future events lead us to believe that any reinsurer will not meet its obligations to us, adjustments to the amounts recoverable would be reflected in the results of current operations. Such an adjustment has the potential to be material to the results of operations in the period in which it is recorded; however, we would not expect such an adjustment to have a material effect on our capital position or our liquidity.

Investment Valuations

We record the majority of our investments at fair value as shown in the table below. The distribution of our investments based on GAAP fair value hierarchies (levels) was as follows:

	Distribution by GAAP Fair Value Hierarchy			December 31, 2014
	Level 1	Level 2	Level 3	Total Investments
Investments recorded at:				
Fair value	10%	80%	4%	94%
Other valuations				6%
Total Investments				100%

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. All of our fixed maturity and equity security investments are carried at fair value. Our short-term securities are carried at amortized cost, which approximates fair value.

Because of the number of securities we own and the complexity and cost of developing accurate fair values, we utilize multiple independent pricing services to assist us in establishing the fair value of individual securities. The pricing services provide fair values based on exchange traded prices, if available. If an exchange traded price is not available, the pricing

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services, if possible, provide a fair value that is based on multiple broker/dealer quotes or that has been developed using pricing models. Pricing models vary by asset class and utilize currently available market data for securities comparable to ours to estimate the fair value for our security. The pricing services scrutinize market data for consistency with other relevant market information before including the data in the pricing models. The pricing services disclose the types of pricing models used and the inputs used for each asset class. Determining fair values using these pricing models requires the use of judgment to identify appropriate comparable securities and to choose a valuation methodology that is appropriate for the asset class and available data.

The pricing services provide a single value per instrument quoted. We review the values provided for reasonableness each quarter by comparing market yields generated by the supplied value versus market yields observed in the market place. We also compare yields indicated by the provided values to appropriate benchmark yields and review for values that are unchanged or that reflect an unanticipated variation as compared to prior period values. In addition, we compare provided information for consistency with our other pricing services, known market data and information from our own trades, considering both values and valuation trends. We also review weekly trades versus the prices supplied by the services. If a supplied value appears unreasonable, we discuss the valuation in question with the pricing service and make adjustments if deemed necessary. To date, our review has not resulted in any changes to the values supplied by the pricing services.

The pricing services do not provide a fair value unless an exchange traded price or multiple observable inputs are available. As a result, the pricing services may provide a fair value for a security in some periods but not others, depending upon the level of recent market activity for the security or comparable securities.

Level 1 Investments

Fair values for our equity securities and a portion of our convertible securities and short-term securities are determined using exchange traded prices. There is little judgment involved when fair value is determined using an exchange traded price. In accordance with GAAP, for disclosure purposes we classify securities valued using an exchange traded price as Level 1 securities.

Level 2 Investments

Most fixed income securities do not trade daily, and thus exchange traded prices are generally not available for these securities. However, market information (often referred to as observable inputs or market data, including but not limited to, last reported trade, non-binding broker quotes, bids, benchmark yield curves, issuer spreads, two sided markets, benchmark securities, offers and recent data regarding assumed prepayment speeds, cash flow and loan performance data) is available for most of our fixed income securities. We determine fair value for a large portion of our fixed income securities using available market information. In accordance with GAAP, for disclosure purposes we classify securities valued based on multiple market observable inputs as Level 2 securities.

Level 3 Investments

When a pricing service does not provide a value for one of our fixed maturity securities, management estimates fair value using either a single non-binding broker quote or pricing models that utilize market based assumptions which have limited observable inputs. The process involves significant judgment in selecting the appropriate data and modeling techniques to use in the valuation process. For disclosure purposes we classify fixed maturity securities valued using limited observable inputs as Level 3 securities.

We also classify as Level 3 our investment interests that are carried at equity, valued using a fund-provided net asset value (NAV) for our interest, which approximates fair value. All investments valued in this manner are LP or LLC interests that hold debt and equity securities. At December 31, 2014 interests valued using a fund-provided NAV totaled $133.3 million, or 3% of total investments, and were classified as part of our Investment in Unconsolidated Subsidiaries.

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Investments - Other Valuation Methodologies

Certain of our investments, in accordance with GAAP for the type of investment, are measured using methodologies other than fair value. At December 31, 2014 these investments represented approximately 6% of total investments, and are detailed in the following table. Additional information about these investments is provided in Notes 3 and 4 of the Notes to Consolidated Financial Statements.

(In millions)	Carrying Value	GAAP Measurement Method
Other investments:		
Investments in LPs, at cost	$53.3	Cost
Other, principally Federal Home Loan Bank capital stock	3.8	Cost
Total other investments	57.1	
Investment in unconsolidated subsidiaries:		
Investments in tax credit partnerships	133.1	Equity
Equity method LPs/LLCs	10.1	Equity
Total investment in unconsolidated	143.2	
Business owned life insurance	56.4	Cash surrender value
Total investments - Other valuation methodologies	$256.7	

Investment Impairments

We evaluate our investments on at least a quarterly basis for declines in fair value that represent other than temporary impairment (OTTI). We consider an impairment to be an OTTI if we intend to sell the security or if we believe we will be required to sell the security before we fully recover the amortized cost basis of the security. Otherwise, we consider various factors in our evaluation, as discussed below.

For debt securities, we consider whether we expect to fully recover the amortized cost basis of the security, based upon consideration of some or all of the following:

- third party research and credit rating reports;
- the current credit standing of the issuer, including credit rating downgrades;
- the extent to which the decline in fair value is attributable to credit risk specifically associated with the security or its issuer;
- our internal assessments and those of our external portfolio managers regarding specific circumstances surrounding a security, which can cause us to believe the security is more or less likely to recover its value than other securities with a similar structure;
- for asset-backed securities, the origination date of the underlying loans, the remaining average life, the probability that credit performance of the underlying loans will deteriorate in the future, and our assessment of the quality of the collateral underlying the loan;
- failure of the issuer of the security to make scheduled interest or principal payments;
- any changes to the rating of the security by a rating agency;
- recoveries or additional declines in fair value subsequent to the balance sheet date; and
- our intent to sell and whether it is more likely than not we will be required to sell the security before the recovery of its amortized cost basis.

In assessing whether we expect to recover the cost basis of debt securities, particularly asset-backed securities, we must make a number of assumptions regarding the cash flows that we expect to receive from the security in future periods. These judgments are subjective in nature and may subsequently be proved to be inaccurate.

We evaluate our cost method interests in LPs/LLCs for OTTI by considering whether there has been a decline in fair value below the recorded value, which involves assumptions and estimates. We receive a report from each of the LPs/LLCs at least quarterly which provides us a NAV for our interest. The NAV is based on the fair values of securities held by the LP/LLC as determined by the LP/LLC manager. We consider the most recent NAV provided, the performance of the LP/LLC relative to the market, the stated objectives of the LP/LLC, the cash flows expected from the LP/LLC and audited financial statements of the entity, if available, in considering whether an OTTI exists.

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Our investments in tax credit partnerships are evaluated for OTTI by considering both qualitative and quantitative factors which include: whether cash flows currently expected from the investment, primarily tax benefits, equal or exceed the carrying value of the investment, whether currently expected cash flows are less than those expected at the time the investment was acquired, and our ability and intent to hold the investment until the recovery of its carrying value.

We also evaluate our holdings of Federal Home Loan Bank (FHLB) capital stock for impairment. We consider the current capital status of the FHLB, whether the FHLB is in compliance with regulatory minimum capital requirements, and the FHLB's most recently reported operating results.

Deferred Policy Acquisition Costs

Policy acquisition costs (primarily commissions, premium taxes and underwriting salaries) which are directly related to the successful acquisition of new and renewal premiums are capitalized as deferred policy acquisition costs and charged to expense, net of ceding commissions earned, as the related premium revenue is recognized. We evaluate the recoverability of our deferred policy acquisition costs each reporting period, and any amounts estimated to be unrecoverable are charged to expense in the current period. As of December 31, 2014 we have not determined that any amounts are unrecoverable.

ProAssurance's fair value estimate of the value of business acquired (VOBA), calculated as the present value of future earnings expected from the insurance contracts acquired, approximated the carrying value of Eastern's asset for deferred policy acquisition costs as of the acquisition date. Consequently, Eastern's asset for deferred policy acquisition costs was recognized in the purchase price allocation in lieu of recognizing an intangible asset for VOBA.

Deferred Taxes

Deferred federal income taxes arise from the recognition of temporary differences between the bases of assets and liabilities determined for financial reporting purposes and the bases determined for income tax purposes. Our temporary differences principally relate to our loss reserve, unearned premiums, deferred policy acquisition costs, unrealized investment gains (losses), and basis differences on investment assets. Deferred tax assets and liabilities are measured using the enacted tax rates expected to be in effect when such benefits are realized. We review our deferred tax assets quarterly for impairment. If we determine that it is more likely than not that some or all of a deferred tax asset will not be realized, a valuation allowance is recorded to reduce the carrying value of the asset. In assessing the need for a valuation allowance, management is required to make certain judgments and assumptions about our future operations based on historical experience and information as of the measurement period regarding reversal of existing temporary differences, carryback capacity, future taxable income (including its capital and operating characteristics) and tax planning strategies. We did not have any significant valuation allowances as of December 31, 2014.

Unrecognized Tax Benefits

We evaluate tax positions taken on tax returns and recognize positions in our financial statements when it is more likely than not that we will sustain the position upon resolution with a taxing authority. If recognized, the benefit is measured as the largest amount of benefit that has a greater than fifty percent probability of being realized. We review uncertain tax positions each period, considering changes in facts and circumstances, such as changes in tax law, interactions with taxing authorities and developments in case law, and make adjustments as we consider necessary. Adjustments to our unrecognized tax benefits may affect our income tax expense, and settlement of uncertain tax positions may require the use of cash. At December 31, 2014, our liability for unrecognized tax benefits approximated $0.6 million.

Goodwill

Goodwill is recognized in conjunction with acquisitions as the excess of the purchase consideration for the acquisition over the fair value of identifiable assets acquired and liabilities assumed. The fair value of identifiable assets and liabilities, and thus goodwill, is subject to redetermination within a measurement period of up to one year following completion of an acquisition.

Management evaluates the carrying value of goodwill at the segment (or reporting unit) level annually as of October 1st. If, at any time during the year, events occur or circumstances change that would more likely than not reduce the fair value below the carrying value, we also evaluate goodwill at that time.

The goodwill impairment assessment requires evaluating qualitative factors or performing a quantitative assessment to determine if a reporting unit's carrying value is likely to exceed its fair value. For our reporting units, we elected to assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. When using the qualitative approach, we considered macroeconomic factors such as industry and market conditions. We also considered reporting unit-specific events, actual financial performance versus expectations and management's future

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business expectations. As part of our qualitative evaluation of recently acquired reporting units with material goodwill, we considered the fact that the business had been recently acquired in an orderly transaction between market participants, and our purchase price represented fair value at acquisition. A significant amount of judgment is required in performing goodwill impairment analysis. We concluded as of our last evaluation date, October 1, 2014, that the fair value of our reporting units exceeded the carrying value and deemed it unnecessary to perform further testing.

Intangibles

Intangible assets with definite lives are amortized over the estimated useful life of the asset. Amortizable intangible assets primarily consist of agency and policyholder relationships, renewal rights and trade names. Intangible assets with an indefinite life, primarily state licenses, are not amortized. Increases in both amortizable and non-amortizable intangible assets during 2014 were attributable to intangible assets recognized related to the 2014 acquisition of Eastern. Intangible assets are evaluated for impairment on an annual basis. Additional information regarding intangible assets is included in Note 1 of the Notes to Consolidated Financial Statements.

Audit Premium

Workers' compensation premiums are determined based upon the payroll of the insured, the applicable premium rates and, where applicable, an experience based modification factor. An audit of the policyholders' records is conducted after policy expiration to make a final determination of applicable premiums. Audit premium due from or due to a policyholder as a result of an audit is reflected in net premiums earned when billed. We track, by policy, the amount of additional premium billed in final audit invoices as a percentage of payroll exposure and use this information to estimate the probable additional amount of earned, but unbilled, (EBUB) premium as of the balance sheet date. We include changes to the EBUB premium estimate in net premiums earned in the period recognized.

Accounting Changes

We did not adopt any accounting changes during 2014 that had a material effect on our results of operations nor are we aware of any accounting changes not yet adopted as of December 31, 2014 that would have a material effect on our results of operations or financial position. Note 1 of the Notes to Consolidated Financial Statements provides additional detail regarding accounting changes.

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Liquidity and Capital Resources and Financial Condition

Overview

ProAssurance Corporation is a holding company and is a legal entity separate and distinct from its subsidiaries. Dividends from its operating subsidiaries represent a significant source of funds for holding company obligations, including debt service and shareholder dividends. At December 31, 2014, we held cash and liquid investments of approximately $402.5 million outside our insurance subsidiaries that were available for use by the holding company without regulatory or other restriction. The holding company paid shareholder dividends totaling $167.3 million in January 2015.

During 2014, our insurance subsidiaries paid dividends of $285 million, including extraordinary dividends of $56 million. Our insurance subsidiaries, in aggregate, are permitted to pay dividends of approximately $230 million over the course of 2015 without the prior approval of state insurance regulators. The payment of any dividend requires prior notice to the insurance regulator in the state of domicile, and the regulator may prevent the dividend if, in its judgment, payment of the dividend would have an adverse effect on the surplus of the insurance subsidiary.

Operating Activities and Related Cash Flows

The principal components of our operating cash flows are the excess of premiums collected and net investment income over losses paid and operating costs, including income taxes. Timing delays exist between the collection of premiums and the payment of losses associated with the premiums. Premiums are generally collected within the twelve-month period after the policy is written, while our claim payments are generally paid over a more extended period of time. Likewise, timing delays exist between the payment of claims and the collection of any associated reinsurance recoveries.

Operating cash flows for the years ended December 31, 2014, 2013 and 2012 compare as follows:

	Operating Cash Flow		
	Year Ended December 31,		
(In millions)	2014	2013	2012
Cash provided by operating activities	$96	$39	$91

Reconciliation of Operating Cash Flows	2014 vs 2013	2013 vs 2012	2012 vs 2011
Cash provided by operating activities, prior year	$39	$91	$159
Increase (decrease) in operating cash flows attributable to:			
Premium receipts	(30)	(33)	(12)
Payments to reinsurers	(14)	3	(8)
Losses paid, net of reinsurance recoveries	(3)	(3)	(35)
Deposit contracts	—	(4)	3
Cash received from investments	(10)	(9)	(8)
Cash paid for other expenses and operating liabilities	(5)	6	13
Cash paid for interest on long-term debt	(13)	2	1
Federal and state income tax payments	95	(3)	(18)
Operations acquired or begun during the period	34	(11)	—
Other amounts not individually significant, net	3	—	(4)
Cash provided by operating activities, current year	$96	$39	$91

The comparative effect resulting from operations acquired or begun in the current year is shown separately in the reconciliation and is therefore excluded from the other amounts in the reconciliation and the related explanations below.

Premium receipts. The reductions in premium receipts for 2014, 2013 and 2012 are each primarily attributable to lower premium volume in the current year as compared to the prior year. The decline for 2013 was also affected by timing changes on several large policies. Comparatively, both 2013 and 2012 were affected by a single $8 million tail policy written and fully collected in 2012; there was no similar tail policy in either 2013 or in 2011.

Payments to reinsurers. Reinsurance contracts are generally for premiums written in a specific annual period, but, absent a commutation agreement, remain in effect until all claims under the contract have been resolved. Some contracts require annual settlements while others require settlement only after a number of years have elapsed, thus the amounts paid can vary widely from period to period. The increase in payments to reinsurers in 2014 was primarily attributable to expansion of our

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shared risk arrangements and to payments made pursuant to our quota share reinsurance agreement with Syndicate 1729. Our 58% share of Syndicate 1729 net cash flows, identified below, reflects receipt of these payments.

Losses paid, net of reinsurance recoveries. The timing of our net loss payments varies from period to period because the process for resolving claims is complex and occurs at an uneven pace depending upon the circumstances of the individual claim. The increase in loss payments in 2012 primarily related to the number of large settlements paid and the timing of reinsurance collections on those settlements as compared to claim settlement activity in the 2011.

Deposit contracts. We are party to certain contracts that involve claims handling but do not transfer insurance risk. These contracts do not constitute a significant business activity for us, but did affect comparative cash flows in 2013 and 2012.

Cash received from investments. Receipts from fixed income securities have declined due to both lower yields and a smaller fixed income portfolio. Also, the timing of dividend receipts and income distributions from our investment LPs/LLCs is uneven.

Cash paid for other expenses and operating liabilities. Variations were attributable to the following:

(In millions)	2014 vs 2013	2013 vs 2012	2012 vs 2011
Effect of Syndicate 1729 reporting lag (1)	$(8.0)	$—	$—
Other (2)	3.5	6.4	13.0
	$(4.5)	$6.4	$13.0

(1) We report Syndicate 1729 activity on a one quarter lag, and, for consistency, have reported the reinsurance payment made to Syndicate 1729 during the fourth quarter of 2014 as an operating liability payment.

(2) The increase for 2012 primarily reflects the effect of acquisition payments made during 2011 related to the integration costs of an entity acquired in 2010.

Federal and state income tax payments. Variations in tax payments were attributable to the following:

(In millions)	2014 vs 2013	2013 vs 2012	2012 vs 2011
Refunds and payments related to Internal Revenue Service (IRS) examination settled in 2014 (1)	$51.1	$(20.6)	$—
Final tax payments made in the current year for the prior fiscal year	29.6	8.3	(7.4)
Estimated tax payments for the current fiscal year	17.0	3.4	4.8
Change in excess tax benefits associated with share-based compensation (2)	0.4	4.9	(5.3)
Refunds and payments related to prior years (3)	(3.3)		(11.4)
State and other tax payments	0.5	1.0	1.8
	$95.3	$(3.0)	$(17.5)

(1) The effect of funds returned in 2014 and a protective tax payment made in 2013 related to an IRS examination of our 2009 and 2010 tax returns. See discussion that follows under the heading "Taxes."

(2) GAAP requires that excess tax benefits recognized when shares are issued under stock compensation plans be reflected as a reduction to operating cash flows and as an increase to financing cash flows in the period the shares are issued.

(3) Both 2014 and 2013 were affected by a refund received in 2013 of $3.3 million related to pre-acquisition tax periods of acquired entities. Comparatively, our 2012 cash flows were lower than in 2011 due to refunds received in 2011 of $17.3 million related to pre-acquisition tax periods of acquired entities and capital loss carry backs, and a payment made in 2011 of $5.9 million which related to previously recorded tax liabilities for the 2008 and 2007 tax years.

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Operations acquired or begun during the period. Expansion of our business operations has affected our operating cash flows as follows:

(In millions)	2014 vs 2013	2013 vs 2012	2012 vs 2011
Cash flows contributed in the year operations commenced or were acquired, including the effect of transaction-related costs paid in the fiscal year in which the transaction is closed:			
Eastern acquisition	$31.2	$—	$—
Lloyd's Syndicate operations	(0.9)	—	—
Medmarc and IND acquisitions (1)	—	(7.7)	—
Transaction costs (2)	3.2	(3.2)	—
	$33.5	$(10.9)	$—

(1) Primarily attributable to transaction costs, loss payments related to accident years prior to the acquisition, and normal expense payments for which the timing of the payment differs from the recognition of the expense.

(2) In 2013 we paid approximately $3.2 million related to the formation of Syndicate 1729, which, comparatively, increased 2014 cash flows.

Losses

The following table, known as the Analysis of Reserve Development, presents information over the preceding ten years regarding the payment of our losses as well as changes to (the development of) our estimates of losses during that time period. As noted in the table, ProAssurance has completed various acquisitions over the ten year period which have affected original and re-estimated gross and net reserve balances as well as loss payments.

The table includes losses on both a direct and an assumed basis and is net of anticipated reinsurance recoverables. The gross liability for losses before reinsurance, as shown on the balance sheet, and the reconciliation of that gross liability to amounts net of reinsurance are reflected below the table. We do not discount our reserve for losses to present value.

Information presented in the table is cumulative and, accordingly, each amount includes the effects of all changes in amounts for prior years. The table presents the development of our balance sheet reserve for losses; it does not present accident year or policy year development data. Conditions and trends that have affected the development of liabilities in the past may not necessarily occur in the future. Accordingly, it is not appropriate to extrapolate future redundancies or deficiencies based on this table.

The following may be helpful in understanding the Analysis of Reserve Development:

- The line entitled “Reserve for losses, undiscounted and net of reinsurance recoverables” reflects our reserve for losses and loss adjustment expense, less the receivables from reinsurers, each as reported in our consolidated financial statements at the end of each year (the Balance Sheet Reserves).
- The section entitled “Cumulative net paid, as of” reflects the cumulative amounts paid as of the end of each succeeding year with respect to the previously recorded Balance Sheet Reserves.
- The section entitled “Re-estimated net liability as of” reflects the re-estimated amount of the liability previously recorded as Balance Sheet Reserves that includes the cumulative amounts paid and an estimate of the remaining net liability based upon claims experience as of the end of each succeeding year (the Net Re-estimated Liability).
- The line entitled “Net cumulative redundancy (deficiency)” reflects the difference between the previously recorded Balance Sheet Reserve for each applicable year and the Net Re-estimated Liability relating thereto as of the end of the most recent fiscal year.

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Analysis of Reserve Development
(in thousands)
December 31,

	2004	2005	2006	2007	2008	2009	2010	2011	2012
Reserve for losses, undiscounted and net of reinsurance recoverables	$1,544,981	$1,896,743	$2,236,385	$2,232,596	$2,111,112	$2,159,571	$2,136,664	$2,000,114	$1,860,076
Cumulative net paid, as of:									
One Year Later	199,617	242,608	331,295	312,348	278,655	291,654	264,597	300,703	311,835
Two Years Later	384,050	503,271	600,500	550,042	468,277	476,682	491,657	526,903	563,805
Three Years Later	578,455	697,349	787,347	694,113	584,410	614,369	639,220	682,576	
Four Years Later	728,582	825,139	897,814	777,114	666,105	706,091	737,253		
Five Years Later	805,270	901,644	955,728	833,471	724,377	761,659			
Six Years Later	861,512	937,984	995,921	874,479	758,863				
Seven Years Later	888,065	959,870	1,022,273	898,646					