February 4, 2000

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R.C. 1932

To the Members of the Board

Re: New York Workers Compensation
Statistical Plan Revision
Claim Grouping Option

The Rates Committee has adopted, and the New York State Insurance Department has approved, a revision to the New York Workers Compensation Statistical Plan which provides clarifying language regarding the claim grouping option.

With the introduction of the revised New York Statistical Plan in 1996, the claim grouping option was amended to permit only the grouping of medical-only claims under $2,000 in lieu of the previous criteria which combined both indemnity and medical claims under $2,000. At that time, other language within the claim grouping option rule was left unchanged which, upon subsequent review, does not completely describe the conditions under which grouped unit statistical data may be reported to the Rating Board.

The attached manual page sets forth the clarifying verbiage relating to the claim grouping option. This language is a more precise description of the conditions under which claims may be grouped in New York and is consistent with the wording used in other jurisdictions.

An effective data of January 1, 2000 has been established for this change.

Manual pages will be included in the 2000 edition of the New York manual to be distributed early this year.

Very truly yours,

Monte Almer

President

MA/ab
Encl.
PART IV—REPORTING INSTRUCTIONS—LOSSES

Note: Those fields appearing on the Unit Statistical Report for which no reporting instructions are provided may be left blank.

1. Update Type

Leave this field blank on an original First Report submission. For details regarding correction and subsequent reports, refer to Part VI, Item 3.B. of the Plan.

2. Claim Number

a. Individual Claim Reporting

Report the alphanumeric code that uniquely identifies the specific claim excluding blanks, punctuation marks and special characters. EACH CLAIM THAT CONTAINS AN INDEMNITY OR EMPLOYERS LIABILITY LOSS AMOUNT MUST BE REPORTED INDIVIDUALLY WITH AN APPROPRIATE CLAIM NUMBER.) Each claim that contains a “Medical Only” loss amount greater than $2,000 must likewise be reported individually with an appropriate claim number. If a claim has been previously reported as an individual claim, subsequent reportings of that claim must also be submitted on an individual claim basis. Claim number is not reported if a carrier elects the claim grouping option explained below.

b. Claim Grouping Option

At the option of the carrier, Medical Only claims of $2,000 or less may be listed individually or grouped by class. Medical Only claims which are grouped must contain the same loss conditions, fraudulent status, lump-sum settlement status or managed care organization status. Under the grouping option, the number of claims must be reported in the "Accident Date/Number of Claims" column. Refer to Item 4 below for instructions in determining the number of claims. If any claim within the group is open, the entire group shall be considered as open, and subsequent reports must be submitted in accordance with Part VI of the Plan.

If the incurred medical for any claim in the group exceeds $2,000 or if a grouped Medical Only claim subsequently develops into an indemnity case, the claim must be removed from the group at the next valuation and reported individually with full statistical detail according to the instructions in this section of the Plan.

3. Accident Date

Report, in the format MM/DD/YY, the month, day and year on which the injury occurred. Accident date is not to be reported if the carrier has elected the claim grouping option.

4. Number Of Claims

Report the number of claims contained in each group when the Claim Grouping Option has been selected.

a. Cases to be counted as claims must be only those in connection with which a loss payment has been made or a loss reserve established.

No case shall be counted as a claim if it involves only allocated loss adjustment expense except for coverage B claims.

b. A case closed without a loss payment shall not be counted as a claim.

c. A claim on which more than one payment is made shall be counted only once.

d. An accident resulting in two or more reported claims shall have each claim counted separately.