June 19, 2000

Contact: Alex Vajda
Actuarial Manager
Ext: 164

R.C. 1941

To the Members of the Board

Re: New York Workers Compensation
Statistical Plan Revisions
a. Claim Status
b. Subsequent Reports

The Rates Committee has adopted, and the New York State Insurance Department has approved, revisions to the New York Workers Compensation Statistical Plan which enhance and clarify reporting rules relating to claim status and the submission of subsequent reports.

The revision is effective for all losses incurred on or after July 1, 2000, applicable to policies effective January 1, 1996 and subsequent which coincides with the effective date of the revised New York Workers Compensation Statistical Plan.

a. Part IV - Claim Status

The current New York rule sets forth the codes to be used for open claims (code 0) and closed claims (code 1), but does not specify the nationally used code for reopened claims (code 2). Furthermore, the New York rule does not presently provide explanations or definitions of the various claim status codes.

The amended New York rule includes both the code for reopened claims and the definitions of the three claim status codes. The manual pages, showing the revised rule, are attached as Exhibit I.
b. Part VI - Subsequent Reports

Although the current New York rule is correct and complete in its present form, the new wording provides a clearer description of when subsequent reports are required. Furthermore, with the addition of the code for reopened claims in Part IV, as explained above, the reference to reopened claims is necessary in this rule for completeness and consistency.

The revised rule for subsequent reports is attached as Exhibit II.

Printed manual pages will be distributed as soon as they become available.

Very truly yours,

Monte Almer

President

MA/ab
Encl.
f. **Contract Medical—Code 07**

In conjunction with the Managed Care Pilot Program in New York, medical costs incurred under a contract for medical services that cannot be allocated to individual claims shall be reported in the aggregate as incurred medical and shall be assigned to the governing classification. Contract medical costs, or medical costs incurred outside of the contractual arrangement that are allocated to individual claims shall be reported in connection with these claims and shall not be included in the amount otherwise reported as contract medical.

g. **Aggregate Trust Fund**

All death cases and some permanent total and permanent partial disability cases are payable to the Aggregate Trust Fund. In determining the present value of the losses incurred on these claims, the tables published by the Workers' Compensation Board (Bulletin 222B) must be used.

When an award directing such payment has been made, include in the indemnity losses the assessment charged by the Aggregate Trust Fund for the handling of such cases. This assessment should not, however, be included in the calculation of the present value of any case in which the award has not yet been made.

For all permanent total and permanent partial disability cases for which a life award is being made, but for which payments have not been designated for placement into the Aggregate Trust Fund, the table shown below shall be used in determining the present value for reporting under this Plan.

### TABLE I

**Life Awards—Permanent Total and Permanent Partial Disabilities**

<table>
<thead>
<tr>
<th>Age</th>
<th>Present Value</th>
<th>Age</th>
<th>Present Value</th>
<th>Age</th>
<th>Present Value</th>
<th>Age</th>
<th>Present Value</th>
<th>Age</th>
<th>Present Value</th>
<th>Age</th>
<th>Present Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>25.401</td>
<td>26</td>
<td>23.283</td>
<td>41</td>
<td>20.061</td>
<td>56</td>
<td>15.439</td>
<td>71</td>
<td>10.074</td>
<td>86</td>
<td>5.051</td>
</tr>
<tr>
<td>15</td>
<td>24.890</td>
<td>30</td>
<td>22.552</td>
<td>45</td>
<td>18.952</td>
<td>60</td>
<td>14.045</td>
<td>75</td>
<td>8.650</td>
<td>90</td>
<td>3.997</td>
</tr>
<tr>
<td>25</td>
<td>23.452</td>
<td>40</td>
<td>20.320</td>
<td>55</td>
<td>15.780</td>
<td>70</td>
<td>10.438</td>
<td>85</td>
<td>5.343</td>
<td>100</td>
<td>2.295</td>
</tr>
</tbody>
</table>

1989-1991 U.S. Decennial Life Tables for Total Population
3.5% Annual Rate of Interest

### 8. Claim Status

Report the one-digit numeric code that indicates the status of the claim. Report "0" if the claim is open, "1" if the claim is closed or "2" if the claim is reopened as of the valuation date.
Open means that the carrier still expects to make further indemnity or medical payments on that claim (the exact nature of these payments is not known), or may not have determined as of yet whether payments will be made in the future.

Reopened means that subsequent indemnity and/or medical payments have been made on a claim previously closed by the carrier or, due to a recent event, further indemnity and/or medical payments are expected and a reserve has been established for a claim previously closed by the carrier.

Closed means that the carrier does not expect to make any further indemnity or medical payment on that resolved claim.

Report claims covered entirely by contract medical with a closed claim status unless more payments are expected in addition to the contract amount.

9. Loss Conditions

Report the two-digit codes for each Loss Condition element described below. On hard copy, it is acceptable to suppress leading zeros of each element of the Loss Conditions.

a. Act

For coverage under the State Act, report "01 ". For coverage under the Federal (USL&H) Act for "F" classes or "Non-F" classes, report "02".

b. Type of Loss

Report the type of loss corresponding to the definitions below:

(1) Trauma—Code 01

Trauma is an injury resulting in disability or death that is traceable to a definite compensable accident occurring during the worker's present or past employment and cannot be classified as either a Cumulative Injury or an Occupational Disease.

(2) Occupational Disease—Code 02

Occupational Disease is any abnormal condition resulting in disability or death which is not traceable to a definite compensable accident occurring during the worker's present or past employment. The injury is understood to have been caused by exposure to a disease producing agent or agents present in the worker's occupational environment.

Example: A granite worker presents a claim for the occupational disease of silicosis due to exposure to the disease agent silica.

It is intended that, in order for a claim to be coded as an occupational disease case, it must have resulted from repetitive exposure extending over a period of time. It is not intended that claims which arise from single identifiable incidents be coded as occupational disease claims even though they may have been caused by inhalation, absorption, ingestion or other environmental factors.
PART VI—SUBSEQUENT REPORTS AND CORRECTIONS

1. Subsequent Reports—When Required

Subsequent reports shall be filed with the Rating Board in accordance with the valuation schedule set forth in Part II, Item 1 of this Plan for each policy when:

* a. there are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data.

* b. there are claims indicated as closed on a previous report that are reopened.

* c. there are previously unreported claims.

* d. there are previously reported claims and the current valuation differs in any manner from the previously submitted data.

Where a claim was previously identified with a claim number, all subsequent reports of this claim must be submitted on an individual claim basis, even if the claim becomes a medical only claim.

2. Correction Reports—When Required

A correction report must be filed whenever an error of any kind is discovered on a previously filed report including Individual Case Reports.

A correction of a loss report must also be filed when any of the following occur between valuation dates:

a. loss values are found to have been included or excluded through a mistake other than error of judgment.

b. one or more claims, or any part thereof, are declared non-compensable (as defined in Part IV, Item 5.a.3.c. of the Plan).

c. the carrier or the claimant has obtained a subrogation recovery in an action against a third party or has received, or anticipates to receive, reimbursement from the Special Disability Fund or Reopened Case Fund.

**Note:** Correction reports are required only for prior reports which reflected an amount higher than the net incurred cost. Refer to Part IV, Items 5.a.2 and 5.f. of the Plan.

d. the exposure of the claimant has been reassigned to another classification through the revision of an audit.

e. a clerical error in either the classification assignment or the injury code assignment of a given claim, or group of claims, has been discovered.

f. one or more claims, or any part thereof, are officially determined to be fraudulent (as defined in Part IV, Item 5.i. of the Plan).

Correction reports shall **not** be filed to revise values because of developments in the claim amounts and/or injury type between two valuation dates. Such developments shall be reported as described in Item 1 above.