July 3, 2001

Contact: Alex Vajda
Actuarial Manager
Ext: 164

R.C. 1977

To the Members of the Board

Re: New York Workers Compensation Statistical Plan
Amendments to Modernize and Clarify Language

The Rates Committee has adopted, and the New York State Insurance Department has approved, revisions to the New York Workers Compensation Statistical Plan which modernize language and clarify certain instructions for the reporting of unit statistical report data.

Most of the changes are consistent with those being implemented by the NCCI in states under its jurisdiction and were considered to be appropriate for use in New York as well. The approved changes are as follows:

• **Part I, Paragraph 14: Date of Valuation and Filing** — a modernization of the language and a more direct manner of providing reporting instructions; also, a change in wording from “shall” to “must” to emphasize the mandatory nature of reporting advance special reports on retrospectively rated policies.

• **Part II, Paragraph 4: Carrier Code** — an explicit statement that the five-digit code is numeric and must remain the same for all reporting throughout the life of a policy.

• **Part II, Paragraph 21: Deductible Codes** — the addition of two codes not previously contained in the New York Plan, as well as a corrected definition of the Per Policy and Accident (aggregate) deductible code.

• **Part IV, Paragraph 2b: Claim Grouping Option** — a clarification that claims which are reported using the claim grouping option must contain the same loss conditions, fraudulent status, lump-sum settlement status and managed care organization status code.
Part IV, Paragraph 12; MCO Type — to be consistent with the ASWG Specifications Manual, the New York Plan will now refer to two-digit MCO Type codes in lieu of the present reference to one-digit codes.

Part V, Paragraph 30; MCO Type — same change as the MCO change in Part IV, but applicable to Individual Case Reports.

The appropriate New York Statistical Plan pages containing these revisions are attached.

Since all of the changes are clarifications to existing Statistical Plan rules and are not changes in procedures or rules, an issue date, in lieu of an effective date, of July 1, 2001 is applicable.

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

Very truly yours,

Monte Almer

President
Example: Three-year personal liability policy effective 7/01/99; workers compensation and employers liability endorsed effective 4/01/01
4/01/01 - 7/01/01 report due 3/01/02
7/01/01 - 7/01/02 report due 3/01/03

d. Afforded Under Homeowners and Other Personal Liability Policies (As provided in Chapter 540, Laws of 1984)

Experience for workers compensation and employers liability coverage included in these policies shall not be reported under this Plan. Experience for these risks shall be reported in a special annual call conducted by the Rating Board.

11. Self-Insurer's Release Policies

The experience for this type of policy shall be submitted as follows:

a. As soon as a policy is written, an experience report should be filed showing the premium collected. It should not show any serial number and no letter of transmittal need be submitted.

b. Whenever a loss is incurred, an individual report must be submitted showing the original estimate and all the applicable details.

c. Subsequent valuations of each claim should be submitted at 12-month intervals until a report is submitted reflecting the final disposition of the case.

12. Excess Coverage for Medical Payments (Per Claim or Per Accident Basis)—Ex-Medical Policies

a. The experience under this coverage shall be reported separately from the experience for the basic coverage provided by the policy. The instructions contained in this Plan are applicable to the reporting of such excess coverage, but the experience should be assigned an entirely separate series of card serial numbers and should be submitted with a separate letter of transmittal.

b. Losses. Each loss incurred under such coverage shall be listed individually under the same claim number and type of injury as assigned to the experience for the basic coverage.

13. Fractions of Dollars

Report all monetary amounts in whole dollars only. Round fifty-cents and greater up to the next dollar. Reject the cents if less than fifty.

14. Date of Valuation and Filing

Losses included in the first reporting of a given policy shall be valued as of 18 months after the month in which the policy became effective, and the report shall be filed not later than 20 months after the effective date of the policy. Second, third, fourth and fifth reports are valued 12, 24, 36 and 48 months, respectively, after the valuation of the first report. Each report level must be filed no later than two months after the respective valuation date.

The table shown below displays, on a monthly basis, the correct valuation and filing dates for all first reportings:
## VALUATION AND FILING DATES FOR FIRST REPORTS

<table>
<thead>
<tr>
<th>Effective Month (Year X)</th>
<th>Valuation Month (Year X + 1)</th>
<th>Reporting Month (20 months after policy effective date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>July</td>
<td>September</td>
</tr>
<tr>
<td>February</td>
<td>August</td>
<td>October</td>
</tr>
<tr>
<td>March</td>
<td>September</td>
<td>November</td>
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<tr>
<td>April</td>
<td>October</td>
<td>December</td>
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<tr>
<td>May</td>
<td>November</td>
<td>January</td>
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<td>June</td>
<td>December</td>
<td>February</td>
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<td>July</td>
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<td>March</td>
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<td>August</td>
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<td>September</td>
<td>March</td>
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<td>October</td>
<td>April</td>
<td>June</td>
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<tr>
<td>November</td>
<td>May</td>
<td>July</td>
</tr>
<tr>
<td>December</td>
<td>June</td>
<td>August</td>
</tr>
</tbody>
</table>

Advance special reports are required by the New York Retrospective Rating Plan due to short-term policies, cancellations, bankruptcy, liquidation, reorganization, or similar situations, but only in cases where a specific request for verification of retrospective premium has been made. If a specific request for verification of retrospective premium has been made, the advance report must be automatically filed directly with the Retrospective Rating Division of the Rating Board. The losses must be valued as of the date exactly six months after the termination date except that, in cases of bankruptcy, liquidation, reorganization, or similar situations, an earlier valuation date is permissible.

Such advance special reportings shall require no letters of transmittal. They shall be marked "RRO" in the "card serial number" block. These advance reportings are entirely independent of, and in addition to, the normal reportings that include losses valued as of a later date.

Refer to Item 17 below for instructions on filing reports for multiple year policies other than three-year fixed rate policies.

### 15. Dates

Dates must be reported in the numeric format specified for the applicable data fields in subsequent parts of the Plan.

### 16. Classification Code

Report the codes corresponding to the classifications assigned to the insured according to the rules of the New York Workers Compensation and Employers Liability Manual or the statistical code defined by the Rating Board.

No claim may be assigned to any classification unless exposure has also been reported for that classification. For losses, report the classification code under which the injured worker's premium is assigned, even if, at the time of the injury, the worker may have been involved in an activity that would be classified differently.
PART II—REPORTING INSTRUCTIONS—POLICY INFORMATION

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

1. Report Number

Report the 2-digit numeric code that corresponds to the policy valuation date.

<table>
<thead>
<tr>
<th>Code</th>
<th>Report Level</th>
<th>Valuation Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>First Report</td>
<td>Valued 18 months from policy effective month</td>
</tr>
<tr>
<td>02</td>
<td>Second Report</td>
<td>Valued 30 months from policy effective month</td>
</tr>
<tr>
<td>03</td>
<td>Third Report</td>
<td>Valued 42 months from policy effective month</td>
</tr>
<tr>
<td>04</td>
<td>Fourth Report</td>
<td>Valued 54 months from policy effective month</td>
</tr>
<tr>
<td>05</td>
<td>Fifth Report</td>
<td>Valued 66 months from policy effective month</td>
</tr>
</tbody>
</table>

2. Correction Sequence Number

Report the 2-digit sequential number that corresponds to the number of correction reports submitted within a particular report level. Report "00" for original report level submissions.

Example: 3rd correction to a first report = Report Number "01", Correction Sequence Number "03".

3. Correction Type

Report the 1-position alphabetic code that indicates the type of correction report being submitted. This field must be left blank for original report level submissions (i.e., Correction Sequence Number = 00).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Header Record Correction</td>
</tr>
<tr>
<td>E</td>
<td>Exposure Record Correction (First Reports Only) (includes associated total corrections)</td>
</tr>
<tr>
<td>L</td>
<td>Loss Record Correction (includes associated total corrections)</td>
</tr>
<tr>
<td>T</td>
<td>Total Record Correction Only</td>
</tr>
<tr>
<td>M</td>
<td>Corrections to Multiple Record Types</td>
</tr>
</tbody>
</table>

4. Carrier Code

Report the 5-digit numeric code assigned to the reporting company by the NCCI. This numeric code must remain the same throughout the life of the policy, unless a correction has been submitted revising the carrier code previously reported.

5. Policy Number

Report the alphanumeric code (up to 18 characters) that uniquely identifies the policy under which the experience occurred excluding blanks, punctuation marks, and special characters. This number must be identical to the number set forth on the Policy Information Page or as endorsed.

The complete policy number including prefixes or suffixes, if used, must remain the same throughout the life of the policy, and the reporting of experience under that policy.
21. Deductible Type

Report the 4-position code that identifies the type of deductible being reported. Leading zeros may be suppressed on hard copy submissions. For policies without deductibles, leave blank.

<table>
<thead>
<tr>
<th>FIRST TWO POSITIONS</th>
<th>LAST TWO POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>01</td>
<td>Medical Losses only</td>
</tr>
<tr>
<td>02</td>
<td>Indemnity Losses only</td>
</tr>
<tr>
<td>03</td>
<td>Medical and Indemnity Losses</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Benefits Coinsurance</td>
</tr>
<tr>
<td>08</td>
<td>Per Accident Coinsurance</td>
</tr>
<tr>
<td>09</td>
<td>Per Policy and Accident (aggregate) i.e., the deductible amount applies to each accident up to an aggregate limit.</td>
</tr>
<tr>
<td>10</td>
<td>Per Claim and Policy (aggregate) i.e., the deductible amount applies to each claim up to an aggregate limit.</td>
</tr>
<tr>
<td>11</td>
<td>Coinurance with Per Claim and Policy Aggregate i.e., the insured is responsible for a percent of the claim, both a per claim and a policy aggregated deductible amount applicable to each claim and policy.</td>
</tr>
</tbody>
</table>

22. Deductible Percent

Report the whole percent of the deductible to be paid by the insured, if applicable, as defined by the deductible program. Applicable only with deductible types 0104, 0105, 0204, 0205, 0304, and 0305.

23. Deductible Amount Per Claim/Accident

Report the loss amount for each claim/accident to be paid by the insured, if applicable, as defined by the deductible program.

24. Deductible Amount Aggregate

Report the maximum loss amount for all claims to be paid by the insured, if applicable, as defined by the deductible program.

25. Reserved for Carrier Use

Companies may use this space for internal purposes.

26. Reserved for Bureau Use

Leave this field blank.
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 and 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 $2000 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.

Note: 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.
e. **Type of Settlement**

   Report the applicable Type of Settlement associated with each claim.

   - Code 00 - Claim not Subject to Settlement
   - Code 05 - Non-Compensable
   - Code 09 - All Other Settlements

10. **Jurisdiction State**

    Report the two-digit state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process when that state is not New York.

11. **Catastrophe Number**

    Report the two-digit sequential number for 2 or more claims resulting from the same occurrence. For each policy, the claims from the first such occurrence shall be assigned a Catastrophe Number of 01, claims from the second occurrence shall be 02, etc. When an occurrence results in only one claim being reported, leave this field blank.

12. **Managed Care Organization Type**

    * Report the two-digit code that corresponds to the type of organization which administers the applicable medical loss on the claim

    * Code 00 - Not Administered by an approved Managed Care Organization
    * Code 01 - Administered by an approved Managed Care Organization
    * Code 03 - Administered by an approved Preferred Provider Organization

13. **Injury Description Code**

    Report the 3 two-digit codes that represent the Part of Body, Nature of Injury and Cause of Injury for each claim. Refer to Part VIII for the applicable codes.

14. **Fraudulent Claim Indicator**

    Report the one-digit code that identifies the involvement of fraud in the claim.

    - Code 1 - Partially Fraudulent
    - Code 2 - Fully Fraudulent

    If there is no fraud identified with a particular claim, leave this field blank.

15. **Totals**

    Report the arithmetic totals of the amounts reported for Number of Claims, Incurred Indemnity and Incurred Medical.

    In the case of corrections and subsequent reports, the totals shown must be the revised totals.

    For multi-page reports, report the totals on the last card only.
n. Jurisdiction State

Report the two-digit state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process when that state is different from New York. This code must be identical to that reported on the corresponding unit statistical report.

o. Managed Care Organization Type

* Report the two-digit code that corresponds to the type of organization which administers the applicable medical loss on the claim.

* Code 00 - Not Administered by an approved Managed Care Organization
* Code 01 - Administered by an approved Managed Care Organization
* Code 03 - Administered by an approved Preferred Provider Organization

p. Insured Name

Enter the full name of the insured as shown on the Policy Information Page.

q. Accident Date

Report, in the format (MM/DD/YY), the month, day and year on which the injury occurred. For time-related injuries (i.e., occupational disease, cumulative injury), report the month, day and year corresponding to the last day the injured person worked or the last day of coverage, whichever is earlier.

r. Date of Death

Report, in the format (MM/DD/YY), the month, day and year on which the injured worker died.

Leave this field blank for claims not involving death.

s. Date Reported

Report, in the format (MM/DD/YY), the month, day and year in which the claim was first established in carrier statistical/accounting systems.

t. Date of Birth

Report, in the format (MM/DD/YY), the month, day and year on which the injured worker was born.

u. Worker’s Last Name

Enter the last name of the injured or deceased worker.

v. Average Weekly Wage

Report the injured worker’s full weekly wage, not the wage sufficient to qualify for the maximum weekly benefit. This amount must be reported in whole dollars only.