R.C. 1989

To the Members of the Board

Re: New York Workers Compensation
    Statistical Reporting – September 11, 2001 Terrorist Attacks

In R.C. Bulletin 1985, dated September 21, 2001, the Rating Board provided its members with preliminary information regarding the recording and reporting of claim data as a result of the September 11, 2001 terrorist acts. At this time, more specific instructions are being provided to ensure accurate and consistent reporting of this data.

New York Workers Compensation Statistical Plan

The Rates Committee has authorized, and the New York State Insurance Department has approved, revisions to the New York Workers Compensation Statistical Plan which define Catastrophe Number 48 claims and amend relevant reporting rules in the Plan.

Consequently, for data reporting purposes, the definition of Catastrophe Number 48 claims is as follows:

“All claims directly arising from the commercial airline hijackings of September 11, 2001 and the resulting subsequent events with accident dates of September 11, 2001 through September 14, 2001”.

This definition encompasses the deaths and injuries directly attributable to the September 11, 2001 attacks. A three-day window for claim occurrence is included within this definition which is the accident date extension being used by all rating organizations. It is anticipated that stress claims and potential respiratory cases, as long as their accident dates are considered to be within the specified time period, will also be reported under Catastrophe Number 48. Claims emanating from recovery and clean-up efforts are not to be included under this code if injuries occur after September 14, 2001. In addition, the recent anthrax biochemical incidents are not to be included within the definition of Catastrophe Number 48.

Based on the definition of Catastrophe Number 48, as set forth above, the following Statistical Plan changes, effective on or after September 11, 2001, have been approved:
Part IV, Item 2.b. – Specifies that, for the Claim Grouping Option, all medical-only claims that are designated as code 48 cases must be grouped together for reporting purposes.

Part IV, Item 11 – The use of code 48 is outside of the customary treatment of catastrophe coding for workers compensation so that the definition of Catastrophe Number 48 is stated as an exception to the current rule.

Part VI, Item 2.g. – This additional paragraph has been included to explicitly provide that claims which meet the definition of code 48 and were not previously reported as such, should be treated as correction reports for immediate submission and not as subsequent reports in accordance with a policy’s normal valuation schedule.

Part V, Individual Case Reports – There will not be any additional requirements for the filing of individual case reports beyond those set forth in Part V of the Plan.

A copy of each of the amended sections of the Plan are enclosed for your reference.

Manual pages will be distributed as soon as they are available.

New York Financial Data Calls

Beginning with the 2002 Financial Data Calls, a separate reporting of the losses emanating from claims assigned under Catastrophe Number 48, as defined in the Statistical Plan, will be required. The New York Calls affected by this requirement are: Policy Year Call (NY101); Accident Year Call (NY125); Policy Year Large Deductible Call (NY101D); and, Accident Year Large Deductible Call (NY125D).

A copy of the applicable pages for NY101 and NY125 are attached for your reference. The NY101D and NY125D pages, not shown, will be similar to their counterparts which are included in the attachment. At this time, it has still not been determined whether or not the New York Financial Call Information System will be able to accommodate the additional pages for the 2002 reporting. Information regarding this aspect of the Financial Calls will be provided with the annual Call instructions at a later date.

Anthrax Biochemical Cases

For the reporting of loss information resulting from anthrax or other biochemical terrorism acts, the Part, Nature, Cause codes that should be reported at this time are: 91 (Body Systems and Multiple Body Systems), 42 (Poisoning General) and 89 (Person in Act of a Crime), respectively. Catastrophe Number 48 does not apply to these cases.

Please distribute this bulletin to the appropriate statistical reporting personnel in your organization.

Very truly yours,

Monte Almer

President

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 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.

* If claims otherwise eligible for the claim grouping option contain Catastrophe Number 48, these claims must be grouped separately with “48” reported in the Catastrophe Number field. Refer to Part IV, Item 11 for definition of losses included under Catastrophe Number 48.

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.
PART IV

Effective September 11, 2001

Original Printing

**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.

*EXCEPTION:* Report Catastrophe Number 48 for all claims directly arising from the commercial airline hijackings of September 11, 2001 and the resulting subsequent events with accident dates of September 11, 2001 through September 14, 2001.

*Note:* Catastrophe Number 48 will apply to both single and multiple claims.

**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.
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).

*g. it is determined that one or more claims should be reported with Catastrophe Number 48. Refer to Part IV, Item 11 for definition of losses included under Catastrophe Number 48.

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.
AGGREGATE LOSS INFORMATION FROM CATASTROPHE CODE 48 CLAIMS.

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