R.C. 2066

To the Members of the Board

Re: New York Workers Compensation Statistical Plan Revision
Unit Statistical Reports Through 10th Report

The Rates Committee has adopted, and the New York State Insurance Department has approved, a revision to the New York Workers Compensation Statistical Plan in which unit statistical reports will be required to be submitted to the Rating Board through a 10th report.

For quite some time, the Rating Board, as well as other data collections organizations, has recognized that the present procedure of collecting unit statistical reports (USRs) through only a fifth report was resulting in a portion of the claim data remaining at relatively immature reporting levels, especially for the most serious cases.

In the early 1990’s, the Financial Data Calls were expanded to collect data through a 20th report in recognition that there is a real and measurable development of workers compensation cases for at least a twenty year period. At the same time, unit statistical reporting was retained at a fifth reporting level due in large part to the limitations of computer technology employed at that time by both the carriers and data collection organizations, making it difficult to retain and process reports beyond the traditional 5th report.

Technology has now developed such that the computer systems and the processes for managing large amounts of data records are able to support extended reporting of USRs. Specifically, the Rating Board’s new system is capable of receiving and processing these reports well beyond a 5th reporting level.

The reporting of additional levels of USRs has the potential to improve actuarial methodology and accuracy in the areas of classification ratemaking, excess loss factors, injury type analysis, legislative pricing analyses and actuarial research.

Consequently, the New York Workers Compensation Statistical Plan is being revised to require the reporting of USRs up to a 10th report. This change will commence beginning in September 2005 with policies effective in January of 1999. Those policies with claims open at a 5th report, or reopened after a 5th report, will require a 6th report valued at July 2005 or 78 months from policy inception. The 6th report will be due at the Rating Board in September 2005, or the customary two months after the valuation date. Subsequent reports, i.e., 7th through 10th, will be required in September 2006 through September 2009 as long as a claim remains open or has been reopened. Policies effective subsequent to January 1999 will follow comparable valuations and reporting timeframes.

The additional required reports will be subject to all of the Rating Board’s USR editing criteria, as well as the late reporting fine program for delinquent USRs.
Furthermore, Individual Case Reports (ICRs) are also required to be reported at 6th – 10th report levels, in accordance with customary valuation and reporting dates, as long as a claim requiring an ICR remains open.

Please note that the addition of 6th – 10th report levels will not affect Experience Rating Plan requirements. The 1st, 2nd and 3rd report levels for experience and merit rated risks will continue to be used in the rating process. Revision of losses, as defined in the Experience Rating Plan for the purpose of revising prior experience ratings, will also remain the same.

Statistical Plan pages, which incorporate the expanded reporting requirements, are attached.

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

Very truly yours,
Monte Almer
President

MA/ab
Encl.
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 to tenth reports are valued at successive twelve month intervals 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:
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>
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</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.
Correction reports are required only for prior reports which reflected an amount higher than the net incurred cost.

**Example:** Consider a claim which has been reported as $10,000 (1st report); $40,000 (2nd report); $60,000 (3rd report). A recovery from the Special Disability Fund is in the amount of $25,000. The net incurred cost of the claim is the latest value, minus the recovery ($60,000 - $25,000 = $35,000). The net incurred cost ($35,000) is less than the claim value reported at the 3rd and 2nd reports. A corrected 2nd and 3rd report must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

When the actual allocation of the recovery to indemnity and medical is not known, the net incurred loss must be divided between indemnity and medical losses in the same proportion as the gross incurred indemnity and medical amounts.

Anticipated recovery is defined, for this purpose, as the amount of recovery expected to be recovered from such funds based on the rules governing such funds, or a binding agreement between such funds and the carrier on an amount, or percentage of the incurred cost, to be reimbursed to the carrier on a particular claim.

When such an anticipated recovery becomes known by the carrier, or when a recovery is paid to the carrier, subsequent to the first reporting of the claim, but within one year after the 5th report due date, a correction report must be filed with the Rating Board reducing the incurred cost of the claim by the amount of the paid or anticipated recovery. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report valuation date or subsequent, all adjustments are reported at the next valuation date. Refer to Part VI for additional instructions regarding correction reports.

(3) **Final Awards**

Where a final award has been made by the Workers' Compensation Board, the total incurred compensation must be in agreement with such award, except under the following circumstances:

(a) Where a claimant has appealed for a higher award for a compensable claim, the carrier shall report at least the amount of the award, but may report a higher amount if, in its judgment, the facts in the case indicate an additional reserve is advisable.

(b) In cases where a claim has been officially declared non-compensable, if an appeal has been filed and is undetermined on the valuation date, the carrier shall report the incurred cost that would have been reported had there been no declaration of non-compensability.

(c) In cases where a claim has been officially declared non-compensable, if the period during which an appeal may be filed has not expired by the valuation date, the carrier may report the incurred cost that would have been reported had there been no declaration of non-compensability. In any case where the period for filing an appeal has expired subsequent to the date of valuation, but prior to the date of submission of the statistical report, without an appeal having been filed, the carrier may eliminate from the report the reserve for the non-compensable claim.

The term "declared non-compensable", as used in this rule, refers to an official ruling by the Workers' Compensation Board, specifically holding that a claimant is not entitled to benefits under the provisions of the New York Workers' Compensation Law for part or all of the disability suffered, or alleged to have been suffered, or for death sustained by the injured worker for the reason that such disability or death is not causally related.
(2) For subrogation cases, the net incurred loss is defined as the gross incurred loss (i.e., the gross evaluation of the claim prior to any actual or expected recovery on which the award was based, whether the claim is still open or not) minus the amount recovered less recovery expenses. When the recovery expenses exceed the amount recovered, report the gross incurred loss instead of the net incurred loss. When the allocation of the recovery to indemnity and medical is not known, the net incurred loss must be divided between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amounts.

(3) For cases involving recovery by the injured employee or his dependents, the net incurred loss shall be:

(a) the deficiency, if any, between the outstanding compensation provided by the Workers’ Compensation Law and the net amount of recovery actually collected by the claimant, and

(b) any other incurred indemnity and medical losses not recovered by the carrier’s lien on the proceeds of the claimant’s third party recovery or by a third party action pursued by the insurance carrier.

(4) When recovery by the injured worker or his dependents relieves the carrier of the liability for further compensation benefits as, for example, in the case involving recovery without the consent of the carrier, or where the recovery exceeds all future compensation benefits due, the net incurred loss shall be the sum of all amounts paid and any amounts payable into Special Funds (Sections 15-8 and 25-a), less the net reimbursements, if any, received from the claimant or third party. Where reimbursement is received by the carrier, and the allocation of the reimbursement to indemnity and medical is not known, the net liability incurred shall be apportioned to indemnity and medical in the same proportion as existed in the amounts paid and/or payable by the carrier as defined above.

When the carrier is (1) relieved of liability for death benefits to dependents who have made a compromise settlement with a third party without the consent of the carrier, but (2) is liable for payments to the dependents not involved in such settlement, the sum of the net liabilities for dependency groups (1) and (2), each calculated separately in accordance with the forgoing rules, shall be added to any other indemnity and medical incurred losses to determine the total net liability for the case.

(5) When reimbursement by a third party or a subrogation recovery is received by the carrier subsequent to the first reporting of the claim, but within one year after the 5th report due date, a correction report must be filed with the Rating Board revising the incurred cost on the claim to the net incurred loss as defined above. This must be done for reports which would impact the current and up to six prior modifications. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report valuation date or subsequent, all adjustments are reported at the next valuation date. Refer to Part Two, D.4. of the New York Experience Rating Plan Manual.

Correction reports are required only for prior reports which reflected an amount higher than the net incurred cost.

**Example:** Consider a claim which has been reported as $10,000 (1st report); $40,000 (2nd report); $60,000 (3rd report). A subrogation recovery is in the amount of $25,000 and recovery expense is $3,000. The net incurred cost of the claim is the latest value minus the recovery, plus recovery expenses ($60,000 - $25,000 + $3,000 = $38,000). The net incurred cost ($38,000) is less than the claim value reported at the 3rd and 2nd report. A corrected 2nd and 3rd report must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report. Refer to Part VI for further instructions regarding correction reports.
PART V—INDIVIDUAL CASE REPORTS

1. Definitions

a. Individual Case Report

A supplemental report required to be submitted to the Rating Board on specific claims providing detailed descriptive data on the particulars of the claim.

b. Pension Benefits

Indemnity benefits reserved on the basis of life expectancy or mortality tables and which are payable on a regular basis (weekly, monthly, annually) for the entire lifetime of a particular individual.

c. Transaction Type

A one-digit code required to interface the particular Individual Case Report being submitted with the Rating Board’s Individual Case Report data collection system.

2. General Instructions

a. An Individual Case Report shall be submitted to the Rating Board for:

(1) All permanent total claims established on a life pension basis.

(2) All death claims established on a life pension basis.

Individual Case Reports shall be submitted concurrently with the submission of the corresponding unit statistical report. All information on Individual Case Reports must agree with the information on the corresponding unit statistical report.

b. Individual Case Reports, in connection with up to ten subsequent reportings of experience, are required if:

(1) There are changes in the valuation of the incurred value of the claim, changes to the class code, or changes to the injury type from a previously submitted Individual Case Report.

(2) The claim was subsequently reopened under death or permanent total status.

(3) The claim is a death or permanent total and was previously unreported.

Claims which were not initially reported as death or permanent total on unit statistical reports, but subsequently change to death or permanent total status and are established on a life pension basis, require an Individual Case Report to be submitted concurrently with the unit statistical report as of the next normal valuation date. These Individual Case Reports are to be coded with the Report Number corresponding to that valuation and would be assigned Transaction Type Code 1. Such reports must include all losses incurred prior to the status change.
3. Reporting Instructions

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

a. Classification Code

Report the four-digit numeric code to which the loss was assigned. This code must be identical to the one reported on the unit statistical report for the corresponding claim.

b. Report Number Code

Report the two-digit numeric code corresponding to the policy valuation date. For all Individual Case Reports, this code must be identical to the code reported on the unit statistical reports for the corresponding claim.

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i. 07, 08, 09, 10: Valued 90, 102, 114, 126 months from policy effective month

Transaction Type Code

Report the one-digit numeric code as follows:

1. Initial Report of a Particular Claim on an Individual Case Report—Code 1

This code must be used the first time the Individual Case Report for the claim is submitted regardless of the Report Number Code.

2. Subsequent—Code 2

This code must be used on all Individual Case Reports submitted for a particular claim subsequent to the valuation date for which an initial Individual Case Report (Code 1) was submitted.

3. Revision (Rating Board Initiated)—Code 3

This code must be used when an Individual Case Report is resubmitted due to the rejection by the Rating Board of a previously submitted Individual Case Report for the particular claim. All data on the Correction Report must be identical to the data on the original report except for Transaction Type and the data elements being corrected.

4. Correction (Carrier Initiated)—Code 4

This code is required when the carrier changes an Individual Case Report previously submitted for the particular claim. This corresponds to "C" reports for unit statistical reports filled in compliance with the rules set forth in Part VI, Item 2 of the Plan.
PART VI—SUBSEQUENT REPORTS AND CORRECTIONS

1. Subsequent Reports—When Required

Subsequent reports (2nd - 10th 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.
d. **Number of Claims, Indemnity Incurred, and Medical Incurred for:**

   (1) Death  
   (2) Permanent Total  
   (3) Major Permanent Partial*  
   (4) Minor Permanent Partial*  
   (5) Temporary Total  
   (6) Noncompensable Medical  

   *Refer to the Rating Board for the current value which delineates Major from Minor Permanent Partial claims.*

The totals of the Number of Claims, Indemnity Incurred, and Medical Incurred shall also be shown. A separation of exposure and premium between ex-medical policies and other policies is not required, nor is it necessary to separate and identify incurred losses resulting from employers liability, U.S. Longshore Act, etc.

e. **Expense Constant**

The expense constant premium shall be included in the total earned premium.

f. **Canceled Policy**

A canceled policy shall be counted as one risk and the penalty premium shall be included in the Total Earned Premium.

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i 4. **Second To Tenth Reports**

Second and third reports shall be filed 12 and 24 months, respectively, after filing the original reports. Fourth and subsequent reports on three-year fixed rate policies reported in accordance with this section are not required. However, an error discovered, either by the carrier or by the Rating Board within 12 months after submitting the original report, shall be corrected by submitting a correction. Where the original report was submitted on Form NC-302, the correction shall consist of two NC-302 forms containing the necessary identifying information including the manual classification. One form shall show only the amounts previously reported incorrectly as negative amounts and the second form shall show the corresponding corrected amounts as positive values.

In cases where experience has been assigned to an incorrect manual classification, the correction shall show the original code number with all amounts designated as negative items and the corresponding corrected code number with the same amounts designated as positive values.

5. **Individual Case Reports**

Individual Case Reports are not required.

**Option B—Unit Statistical Report Basis**

1. **Form of Report**

The complete three-year experience incurred under each policy shall be reported on the appropriate Unit Statistical Report form.
NEW YORK WORKERS COMPENSATION STATISTICAL PLAN

1st Reprint  Issued January 1, 2005  PART VII

2. Date of Valuation and Filing

Losses included in the reporting of a given policy shall be valued as of exactly 42 months after the inception date of the policy, and the reports shall be filed not later than 44 months after the effective date of the policy. These reportings shall be specifically identified as three-year fixed rate policy experience by placing a "Y" in the Three-Year Fixed Rate Indicator of the “Policy Conditions” field and shall be segregated and reported independently of the reportings of one-year policies.

3. Data to be Reported

The data required shall be the data specified by the New York Workers Compensation Statistical Plan. Cancellation penalty premium shall be assigned to statistical Code 0931.

4. Second To Tenth Reports

Second and third reports shall be filed 12 and 24 months, respectively, after filing the original reports. Fourth and subsequent reports are not required on these three-year fixed rate policies.

5. Individual Case Reports

Individual Case Reports are not required.

Option C—Magnetic Tape Reporting

Data for three-year fixed rate policies may be submitted on magnetic tape. For further information regarding magnetic tape reporting, refer to the Workers Compensation Magnetic Tape Specifications Manual.