



MINNESOTA AGGREGATE FINANCIAL DATA REPORTING GUIDEBOOK

Annual Calls for Experience
Valued as of December 31, 2025

MINNESOTA WORKERS' COMPENSATION INSURERS ASSOCIATION, INC.

AGGREGATE FINANCIAL DATA REPORTING GUIDEBOOK

ANNUAL CALLS FOR EXPERIENCE

As the licensed Data Service Organization in Minnesota, MWCIA collects aggregate financial data annually. The aggregate Financial Calls provide the timely information needed for overall cost analysis to develop Minnesota's Ratemaking Report. The Ratemaking Report provides any needed changes to existing pure premium base rates to achieve our goal of providing adequate rate levels to maintain a healthy workers' compensation system.

In accordance with the approved statistical program, carriers are required to file on or before April 1 of each year their compensation experience valued as of December 31 of the prior year. Seven Calls for Experience are required. These Calls are due at MWCIA on April 1 of each year. Since the Minnesota Ratemaking Report depends on these figures, it is essential that the Calls be submitted on or before the required due date.

All questions and requests for additional information on these Calls should be directed to the Actuarial Services Department of MWCIA.

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PART 1—FILING REQUIREMENTS

There are seven financial aggregate Calls that are submitted to MWCIA. These Calls are used directly for ratemaking in determining the overall rate level. The Policy Year and Calendar-Accident Year Calls are the major ratemaking Calls. They provide historical information on earned premium and aggregate claim data enabling MWCIA to analyze loss ratios and emerging claim patterns. By collecting historical data on Calls valued as of year-end, MWCIA is able to compare the current Call with Calls from past years to calculate loss development factors and trend factors necessary in determining an overall pure premium rate level change.

Since rates for federal classes are calculated separately, this experience is NOT included in the Calls.

Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.

The following are intended as carrier aids to successfully complete and control the Annual Calls for Experience.

1. Acknowledgment Form

The Acknowledgment Form lists all seven Calls, with the following two columns to check off for each Call: 1) you have experience to report, or 2) you have no experience to report for the Call. Carriers should complete the online Acknowledgment Form immediately. This form determines which Calls the MWCIA can expect from each carrier.

NOTICE: MWCIA will be continuing the Financial Call Incentive Program (FCIP) similar to the NCCI's ADQIP program. This program applies to the following aggregate Calls for experience:

- Policy Year Call
- Policy Year Large Deductible Call
- Calendar-Accident Year Call
- Calendar-Accident Year Large Deductible Call

The intent of MWCIA's program is to provide incentives for carriers to submit financial data in a timely and accurate manner. FCIP ensures that costs of late and/or inaccurate submissions are allocated back to offending carriers, and also rewards carriers for early, accurate submissions.

Details on the program are provided in Part 10.

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PART 2—FINANCIAL CALL REPORTING SCHEDULE

Schedule

This reporting schedule identifies all of the Financial Calls, their due date, and Financial Call Incentive Plan (FCIP) applicability. This schedule can also be used for carriers' internal control purposes in monitoring the timely submission of their Financial Calls.

Annual Calls for Experience – 2026 Reporting Schedule

Call	Call Name	Due Date	FCIP Applicability
P1	Policy Year Call for Compensation Experience	4/1/2026	Yes
C1	Calendar-Accident Year Call for Compensation Experience	4/1/2026	Yes
SR	Supplemental Call for Schedule Rating Premium Adjustments	4/1/2026	No
P2	Large Deductible Policy Year Call for Compensation Experience	4/1/2026	Yes
C2	Large Deductible Calendar-Accident Year Call for Compensation Experience	4/1/2026	Yes
RR	Reconciliation Report	4/1/2026	No
LL	Large Loss and Catastrophe Call	4/1/2026	No

Self-Audit Form

The Self-Audit Form contains components to be reviewed, related to the reporting of your Financial Call data, to ensure that they are reported in accordance with the rules and instructions contained within the Aggregate Financial Data Reporting Guidebook. The form consists of six tabs within ACCEDE. The first five (General Experience, Premium, Losses, Indemnity Claim Counts, and DCCE) contain a listing of items that must be reviewed to ensure that they are being accounted for correctly when reporting Financial Calls to MWCIA. The items on the form contain specific references to supporting instructions contained within this Guidebook. For each item within the checklist, you will select one of three options: Confirm, Not Applicable, or Exception. If Exception is the applicable option, a comment must also be provided to support and explain the limitations to the verification of your Financial Call data. The last tab (Additional Details) contains three questions that require a response.

The Self-Audit Form appears in ACCEDE once calls have been selected for submission. Each question must be answered before you are allowed to complete the submission of your Financial Call data. Upon completion, the Self-Audit Form will automatically accompany your Financial Call submission to MWCIA. Completed Self-Audit Forms can be accessed and printed through the Submit Calls screen in ACCEDE.

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PART 3—REPORTING REQUIREMENTS

OVERVIEW

MWCIA collects aggregate financial data to fulfill our role as the Data Service Organization in Minnesota. The aggregate Financial Calls provide the timely information needed for overall cost analysis to develop the pure premium base rates. The base rates provide any needed changes to existing loss costs to achieve our goal of providing adequate rate levels to maintain a healthy workers' compensation system.

This **Reporting Requirements** section provides you with general information on the following:

- A. Financial Call Types
- B. Expected Financial Call Reporting
- C. Call preparation Checklist

A. FINANCIAL CALL TYPES

There are seven aggregate Financial Calls that support either primary ratemaking or supplemental ratemaking. These Calls are separated into the two functions:

- **Primary Ratemaking Calls**—Calls P1, C1, P2, C2, and RR
- **Supplemental Ratemaking Calls**—Call SR, LL

The following is a summary of the Calls:

1. Primary Ratemaking Calls

This Call type is used either to determine the overall rate level or to confirm the accuracy of the ratemaking data. The two major types of Calls are Policy Year and Calendar-Accident Year.

- **Policy Year Calls**—Calls P1 and P2—A policy year is composed of premiums and losses for all policies with effective dates in that year. For example, for policies with effective dates from January 1 to December 31, 2023, all claims that develop for these policies must be reported under Policy Year 2023, regardless of the year the injury occurred or the year it was reported to the carrier. The Financial Calls on a policy year basis provide a stable match of premium and losses and, therefore, are widely used for testing rate adequacy and for ratemaking. Policy Year Calls include a half year (or partial year) of data for the latest policy year, individual full years of data for each of the previous years, and one line of cumulative data for all prior years. The half year of data is due to the fact that not all policies in the latest policy year have expired by year-end (valuation date).
- **Calendar-Accident Year Calls**—Calls C1 and C2—The title Calendar-Accident Year reflects the way the financial data is organized. The term “calendar” pertains to the premium, which is organized by transaction date. The term “accident” pertains to the losses (and associated claim counts), which are organized by the date the injury occurred. For example, Calendar-Accident Year 2024 includes premium transactions occurring in 2024, along with claims with accident dates occurring in 2024. Unlike Financial Calls on a policy year basis, the latest year for a Call on a calendar-accident year basis contains a full year of data. This makes the Calendar-Accident Year Calls particularly valuable when examining loss development patterns and future rate level trends, as well as for reconciliation purposes in conjunction with Call RR.

The fact that both Policy Year and Calendar-Accident Year Call types provide 30 full years of data, with each one being re-evaluated as of year-end, provides MWCIA with a continuous history of the individual policy year or accident year. By comparing a given policy or accident year from valuation to valuation, MWCIA is able to analyze development patterns. Using these results, MWCIA can then calculate development factors and trend factors needed to determine an overall premium rate level change.

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The Reconciliation Report (Call RR) is used to reconcile calendar year premium, losses and paid Defense and Cost Containment Expense (DCCE) from the Calendar-Accident Year Call to the Exhibit of Premiums and Losses (Statutory Page 14 Data) of your company's National Association of Insurance Commissioners (NAIC) Annual Statement. This Call ensures that the methodology for determining the premium, losses and DCCE reported on the Policy Year and Calendar-Accident year Calls is consistent with the methodology used for reporting the experience on Exhibit of Premiums and Losses (Statutory Page 14 Data) of your company's NAIC Annual Statement.

2. Supplemental Ratemaking Calls

Supplemental ratemaking Financial Call data supports ratemaking, market analysis, research, and responses to regulatory requirements.

B. EXPECTED FINANCIAL CALL REPORTING

The table that follows provides the conditions under which you would be expected to report a given Financial Call. As a general rule, null (zero filled) reports are not to be submitted for Financial Calls.

Call	Required Reporting
P1—Policy Year Call for Compensation Experience	You are required to report Call P1 if you have ever written a workers' compensation policy in Minnesota. You are not required to report Call P1 if you have written only Large Deductible, F-classification, Excess Coverage, or National Defense Base policies—with coverage under National Defense Projects Rating Plan.
C1—Calendar-Accident Year Call for Compensation Experience	You are required to report Call C1 if you have ever written a workers' compensation policy in Minnesota. You are not required to report Call C1 if you have written only Large Deductible, F-classification, Excess Coverage, or National Defense Base policies—with coverage under National Defense Projects Rating Plan.
SR—Supplemental Call for Schedule Rating Premium Adjustments	You are required to report Call SR if you had schedule rating premium adjustments (credits or debits) in the past five years, and you reported the Policy Year and Calendar-Accident Year Calls (P1 and C1).
P2—Large Deductible Policy Year Call for Compensation Experience	You are required to report Call P2 if you have ever written a large deductible workers' compensation policy in Minnesota. Large Deductible is defined as a deductible amount of \$100,000 or more per claim, per accident or per aggregate.
C2—Large Deductible Calendar-Accident Year Call for Compensation Experience	You are required to report Call C2 if you have ever written a large deductible workers' compensation policy in Minnesota. Large Deductible is defined as a deductible amount of \$100,000 or more per claim, per accident or per aggregate.
RR—Reconciliation Report for Calendar Year Data	You are required to report Call RR if you reported the Policy Year and Calendar-Accident Year Calls (P1 and C1) or you reported the Large Deductible Calls (P2 and C2).

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LL—Large Loss and Catastrophe Call	<p>You are required to report Call LL if you have ever written a workers' compensation policy in Minnesota and reported the Policy Year and Calendar-Accident Year Calls (P1 and C1) or the Large Deductible Calls (P2 and C2), and:</p> <ul style="list-style-type: none">• You have at least one claim with combined (indemnity + medical) total paid plus case outstanding loss of \$500,000 or more; or• You have a claim that meets the criteria for an Extraordinary Event Loss. <p>Note: (1) Report all Extraordinary Event Loss claims, regardless of the size of total incurred loss. (2) Report both Traditional AND Large Deductible claims.</p>
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C. CALL PREPARATION CHECKLIST

The following general instructions are for Financial Call reporting purposes:

- **Group Report**—Submit all Calls on the same basis, i.e., group report or individual company report. This facilitates carrier data reconciliation.
- **Rounding Procedure**—Report amounts of premiums, losses, and Defense and Cost Containment Expense (DCCE) in whole dollars only. Fifty cents or more is rounded up to the nearest dollar; less than fifty cents is rounded down to the nearest dollar.
- **No Experience to Report**—Do not submit Calls in which you have never had experience. As a general rule, null (zero filled) reports are not to be submitted for Financial Calls.
- **Complete Submission**—You must complete all pages in which you report experience. For instructions about the required Acknowledgment Form, see **Filing Requirements** (Part I).
- **Data Submission Information**—There are two methods for submitting Financial Calls—electronic and hard copy.
 - **Electronic**—We encourage you to report electronically using the preferred data reporting method of **Automated Carrier Call Entry and Data Edit (ACCEDE)** via mwcia.org. All Financial Calls can be submitted using this online data reporting tool.
 - **Hard Copy**—We encourage you to submit your Financial Calls electronically whenever possible. However, Call reporting forms are available for hard copy reporting in cases where you are not able to use **ACCEDE**. Hard copy processing charges may apply.

Due Dates—For the Financial Call due dates, refer to the **Financial Call Reporting Schedule** section (Part 2).

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PART 4—FINANCIAL CALL COMPONENTS

This section contains a discussion of the various Financial Call components, and is intended to provide you with further details for the reporting of your Financial Call data. Specifically, this is your detailed source of information on:

- A. Premium Reported in Financial Calls
- B. Losses Reported in Financial Calls
- C. Claim Count Information
- D. Defense and Cost Containment Expense (DCCE)

A. PREMIUM REPORTED IN FINANCIAL CALLS

Premium can be Policy Year or Calendar Year, Standard Earned Premium at MWCIA Designated Statistical Reporting Level (DSR Level), Standard Earned Premium at Company Level, or Net Earned Premium.

The three earned premium types (levels) reported in Financial Calls and their components are defined as follows:

1. **Standard Earned at MWCIA Designated Statistical Reporting (DSR) Level**—Premium used by MWCIA for ratemaking. It is the premium that would be developed if the carriers' business were written at the MWCIA filed and Commerce approved level instead of at the company's own selected rate level.
2. **Standard Earned at Company Level**—Premium calculated at full company rates, including any individual risk experience modification, but prior to the application of any other risk specific adjustments such as premium discounts, Schedule Rating, and retrospective rating adjustments. For comparative purposes, it is Net Earned Premium with adjustments added back in. This company premium includes the impact of the loss cost multiplier or any other approved deviation that the carrier has applied.
3. **Net Earned**—Premium collected by the carrier after all adjustments, credits, and discounts have been applied. This is the actual earned premium on a carrier's books, and should reconcile to the premium reported by the carrier in its Annual Statement (Annual State Statutory Page 14, Exhibit of Premiums and Losses). The only items not included in Net Earned Premium, which otherwise represents the company's bottom line premium, are Special Compensation Fund assessments, terrorism and catastrophe provision premiums, Workers' Compensation Reinsurance Association Policyholder Deficiency Assessments, and dividends.

Minnesota is a Loss Cost state (also known as a competitive pricing state). The MWCIA publishes loss costs (also known as pure premiums) to cover indemnity losses, medical losses, and loss adjustment expenses. To cover items not included in the loss costs, carriers must file a loss cost multiplier (LCM), which is a factor applied to the published loss cost to create the full rate. Carriers select their own LCM, subject to approval by the Minnesota Department of Commerce, and can even include a loss cost deviation in the multiplier if their experience can justify it. The MWCIA DSR Level is the state-approved and published loss cost level, and the carrier LCM, along with the expense constant premium, must be removed from the Standard Premium at Company Level in the calculation of DSR premium.

4. **Premium Components Summary**—the most frequently utilized components of each premium type are illustrated in the following table, and further defined in the bullets below.

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Component	Net	Company Standard	DSR
Published loss costs	X	X	X
Employers liability increased limits	X	X	X
MWCIA and NCCI experience rating modifications	X	X	X
Expense constants	X	X	
Minimum premium	X	X	
Company loss cost multiplier	X	X	
Minnesota contractors premium adjustment program (MCPAP)	X	X	
Schedule rating adjustments	X		
Managed care credits	X		
Drug-free workplace credits	X		
Workplace safety program credits	X		
Return to work credit	X		
Collective bargaining program premium credits	X		
Premium credits for deductible coverage	X		
Deviations from MWCIA published experience rating modification factor	X		
Retrospective rating plan adjustments	X		
Premium discounts	X		
Short rate penalty premium	X		
Merit rating plan adjustments	X		
Waiver of Subrogation	X		
Audit Noncompliance Credit premium	X		
Payment to paid furloughed employees	Do Not Report		
Payment of policyholder dividends	Do Not Report		
Special Compensation Fund assessment	Do Not Report		
Terrorism and Catastrophe exposure	Do Not Report		
Workers' Compensation Reinsurance Association (WCRA) Policyholder Deficiency Assessments	Do Not Report		

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1. **Published Loss Costs**—Minnesota loss costs are updated every January 1. They are also referred to as pure premium base rates.
 2. **Employers Liability Increased Limits**—As part of the normal workers' compensation policy, employers get coverage for employers liability with standard loss limits on an accident, employee, and policy basis. If the employer wants higher limits, an additional percentage is applied to the manual premium to pay for this additional coverage. Any additional premium for increased loss limits on employers liability coverage, whether on an accident, employee, or policy basis, should be included in DSR, Company Standard and Net premium.
 3. **MWCIA and NCCI Experience Rating Modifications**—Loss experience for each employer above a given premium size is compared with that of other employers in the same line of work in Minnesota. The employer is then issued an experience rating modification by either MWCIA or NCCI, which may be higher than 1.00 if the employer's experience is worse than average (debit mod) and lower than 1.00 if the experience is better than average (credit mod). This mod is applied to the employer's manual premium, raising or lowering it to recognize the individual risk's experience. Overall, the average modification issued by MWCIA for a given classification is approximately 1.00, with the premium credit received by some employers being offset by the extra premium being paid by other employers.
 4. **Expense Constant**—Some costs associated with issuing and servicing a policy are fixed, i.e., they do not vary depending on the size of the policy. MWCIA does not publish an expense constant. Instead, each carrier is entitled to select its own loss expense constant based on experience and market conditions. Expense constants should be excluded from DSR, but included in Company Standard and Net premium.
 5. **Minimum Premium**—Minimum premium is the lowest premium that is required to provide insurance under the standard policy. Any additional premium required to balance to the minimum premium, as reported in Statistical Codes 0990—Minimum Premium (Balance to), 9848—Minimum Premium for Employers Liability (Balance to), and 9849—Increased Limits for Admiralty and/or FELA Coverage—Balance to Minimum, should be excluded from DSR, but included in Company Standard and Net premium.
 6. **Company Loss Cost Multiplier**—In Minnesota, carriers must file a loss cost multiplier (LCM) to cover items not included in the loss costs. The approved LCMs are included in the Net and Company Standard premium but must be removed when calculating DSR premium.
 7. **Minnesota Contractors Premium Adjustment Program**—To maintain a premium level consistent with risk, Minnesota has created a Contractors Premium Adjustment Program (MCPAP) that provides graduated premium credits on contracting classes for employers that pay a relatively high hourly wage. This credit is excluded from DSR, but included in Company Standard and Net premium.
 8. **Schedule Rating Adjustments**—To reflect the impact on losses of such things as employer procedures, training, or equipment that may not have been in place during the historical experience period, carriers are permitted to issue Schedule Rating Adjustments (either debits or credits) to specific policyholders. These adjustments are included in Net premium but should not be included in either Company Standard or DSR premium.
 9. **Managed Care Credits**—Managed care credits provide credits to employers who subscribe to the services of a designated medical provider. This credit is excluded from DSR and Company Standard, but included in Net premium.
 10. **Drug-Free Workplace Credits**—Drug-free workplace credits are provided to employers who maintain a drug-free workplace environment through such efforts as employee education, company rules, and periodic drug testing. This credit is excluded from DSR and Company Standard, but included in Net premium.
 11. **Workplace Safety Program Credits**—Workplace safety program credits are provided to employers who maintain a safety program that may include such things as employee safety training, safety rules, first aid services, accident record keeping, and management supervision. This credit is excluded from DSR and Company Standard, but included in Net premium.
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12. **Return to Work Credits**—Carriers may offer credits to employers who offer return to work programs designed to return an injured employee to work with a few simple modifications to their work environment, duties or schedule. Return to Work credits are excluded from DSR and Company Standard, but included in Net premium.
13. **Collective Bargaining Program Premium Credit**—Carriers may offer credits to employers who are party to an approved collective bargaining agreement. These credits are included in Net premium but should not be included in either Company Standard or DSR premium.
14. **Premium Credits for Deductible Coverage**—Premium credits for small deductible policies (deductibles under \$100,000) and large deductibles (deductibles of \$100,000 or more), whether the deductible is per claim, per accident, or on an aggregate basis, are included in Net premium but should not be included in either Company Standard or DSR premium. Large deductible experience is reported on the Policy Year Call for Large Deductible Experience and the Calendar-Accident Year Call for Large Deductible Experience.
15. **Deviations from MWCIA Published Experience Rating Modification Factors**—Minnesota statutes allow carriers to file their own experience rating plan parameters used in the calculation of experience modification factors. The resulting experience modification factors are insurer-specific. Any deviations from official MWCIA modifications are included in Net premium but should not be included in either Company Standard or DSR premium.
16. **Retrospective Rating Plan Adjustments**—Premium for retrospective policies is based ultimately on the employers' loss experience during the applicable policy years. These policies undergo an annual loss review and premium adjustment for a preset number of years after the policy expires. These adjustments are policyholder specific. They are included in Net premium for the applicable policy year but should not be included in either Company Standard or DSR premium.
17. **Premium Discounts**—The cost of issuing and administering policies as a percentage of premiums, decreases with the size of the policy. To recognize this decrease, large employers are given a premium discount that varies with the size of premium. These discounts are included in Net premium but should not be included in either Company Standard or DSR premium.
18. **Short-Rate Penalty Premium**—Premium applied when a policy is cancelled mid-term by the insured, except when retiring from business. This premium is included in Net premium but should not be included in either Company Standard or DSR premium.
19. **Merit Rating Plan Adjustments**—To compensate for the lack of an experience rating program for small assigned risk employers, the Minnesota Assigned Risk Merit Rating Plan provides credits or debits to small employers that have had either unusually good or unusually poor claim experience in the most recent one or two years. These credits or debits are excluded from DSR and Company Standard, but included in Net premium.
20. **Waiver of Subrogation**—It is permissible to issue a Standard Policy with the provision that allows the carrier to waive its right of recovery against specified third parties liable for an injury covered by the policy. The premium charge for a waiver of subrogation is developed in conjunction with the work for which the waiver of subrogation is provided. This premium is included in Net premium but should not be included in either Company Standard or DSR premium.
21. **Audit Noncompliance Charge Premium**—Premium charges where the insurance carrier applies additional premium, after standard premium, when an insured is noncompliant with the final audit, in which the premium is reported as Audit Noncompliance Charge is included in Net premium but should not be included in either Company Standard or DSR premium.
22. **Payments to Paid Furloughed Employees**—Any experience and premium effects associated with payments allocated to paid furloughed employees must be excluded from all Calls and valuations.

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23. **Payment of Policyholder Dividends**—Policyholder dividends should not be included in Net, Company Standard, or DSR premium. Dividends are not a reconciliation item when reconciling data reported to MWCIA to data reported to the NAIC.
24. **Special Compensation Fund Assessments**—The Special Compensation Fund (SCF) assessment pays the operating expenses of the workers' compensation divisions of the Department of Labor and Industry, the Office of Administrative Hearings and the Workers' Compensation Court of Appeals, and also funds special statutory workers' compensation programs. The assessment base for individual insurance companies is the DSR premium. The SCF assessment is not considered premium but rather a "pass through" and should not be included in Net, Company Standard or DSR premium.
25. **Terrorism and Catastrophe Exposure**—Any premium surcharge for terrorism and catastrophe should not be included in Net, Company Standard or DSR premium.
26. **Workers' Compensation Reinsurance Association Policyholder Deficiency Assessments**—Any premium surcharge for WCRA assessments to policyholders should not be included in Net, Company Standard or DSR premium.

B. LOSSES REPORTED IN FINANCIAL CALLS

Financial Call losses (and premium) for a given policy should be reported only if the corresponding policy premium was assigned to Minnesota as well. Do not report losses by state of injury or state of benefit. Do not report losses for claims with accident dates outside of the policy period that are required to be paid due to an official ruling, and where there is no corresponding exposure. Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.

Report losses on an accumulated basis, from the issue date of the policy (policy year) or the date of accident (accident year) through December 31 of the most recent year. For line Z only, report the calendar year change in losses rather than the accumulated total. Report Vocational Rehabilitation costs, including evaluation and testing, incurred due to the purchase of vocational rehabilitation services from outside vendors as part of indemnity losses. For noncompensable and fraudulent claims, report loss amounts that are reflective of the losses in the insurers' system.

Additionally, incurred losses are split into indemnity and medical losses. When a claim involves a lump sum, the actual lump sum amount is subdivided according to indemnity and medical.

1. Indemnity and Medical Losses

Workers' Compensation losses can be either for the replacement of lost wages (indemnity losses) or for the medical care (medical losses). Lost wage (indemnity) benefits can either be for the period during which the worker is recovering from the injury (temporary benefits) or for the loss of earning capacity once maximum recovery has been achieved (permanent benefits).

An **indemnity claim** is one that has either paid or expected indemnity losses. An indemnity claim may also have (and usually does have) medical losses as well as indemnity losses.

A **medical-only claim** is one that, by definition, has medical losses only. The injured worker was not eligible for wage replacement, either because the worker returned directly to work after the injury or was not out of work for more than a three-day waiting period. A medical-only claim never has indemnity losses.

Incurred Losses—The following sections provide you with general definitions of the various loss categories used in Financial Calls. Incurred Losses include Paid Losses, Case Reserves, Bulk Reserves, and Incurred But Not Reported (IBNR) Reserves.

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- **Paid Losses** represent the amount actually paid by the insurance company, and are essential to MWCIA's ratemaking process. There are two situations, however, that require special clarification—deductible policies and subrogations:
 - **Deductible Policies**—For deductible policies (large and small), all losses, including paid losses, should be reported by the insurance company gross of (i.e., “before the recovery of”) losses ultimately paid by the insured.
 - **Subrogations**—In some instances, a carrier is able to recover some or all of the paid losses from a third party. Such recoveries are called “subrogations.” Paid losses should be reduced by any losses recovered (actual, not anticipated) through subrogation, but under no circumstances should the reduction be more than the original paid loss. Subrogation and other recoveries should not be applied to Defense and Cost Containment Expense (DCCE).
 - **Case Reserves** are amounts set aside for future expected payments on a specific claim (or case). Case reserves represent the carrier claim adjuster's best estimate of what the future payments on the claim will be. As such, the case reserves are frequently used as the basis for MWCIA ratemaking. Case reserves can also be offset by anticipated subrogations. The amount of the offset should never be more than the case incurred loss.
 - **Bulk Reserves** are also amounts set aside for future expected payments on known claims. In contrast to case reserves, however, the amount is not associated with any specific claim. Even though case reserves are adjusted on an annual basis, some carriers prefer to set aside this bulk reserve for the possible overall variation in actual future loss payments from the amount set aside in the expected case reserves. Most, but not all, companies include bulk reserves with their estimate of IBNR (see below). In any case, MWCIA needs to have the case reserves clearly separated from bulk reserves.
 - **Incurred But Not Reported (IBNR) Reserves** are amounts set aside for future expected payments on claims that have yet to be reported to the carrier. Carriers know from experience that some claims will not be reported until sometime after a policy has expired. Some injured workers—because they are initially unaware that they have been injured, or perhaps because they are seeking legal advice—delay the submission of an injury claim. Based on past experience, carrier actuaries calculate reserves estimates to cover these future anticipated losses.

2. General Reporting Instructions for Accumulated Incurred Losses

The following sections are to assist you in reporting Paid Losses and Loss Reserves for Financial Calls—on a column-by-column basis.

a. Paid Losses

- Actual paid losses
- Net of any subrogation
- Gross of deductibles

b. Outstanding Excluding IBNR

For most carriers, this will be case reserves only (assuming bulk reserves are estimated as part of IBNR).

- If your company does not include bulk reserves with IBNR, then bulk reserves must be added to case reserves in calculating the outstanding reserve. In this case, the necessary separation of case and bulk reserves is made elsewhere in the report (i.e., page 3 for applicable Calls).
- Loss reserves may include or exclude statutorily allowable discounting, as long as the approach is consistent from year to year. If there is a change, MWCIA must be notified and two prior Call valuations must be provided on a consistent basis.

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c. IBNR

- For most carriers, this will be the sum of IBNR reserves and bulk reserves (assuming bulk reserves are estimated as part of IBNR).
- If your company does not include bulk reserves with IBNR, then bulk reserves must be added to case reserves in calculating the Outstanding reserve. In this case, the necessary separation of case and bulk reserves is made elsewhere in the report (i.e., page 3 for applicable Calls).
- Loss reserves may include or exclude statutory allowable discounting, as long as the approach is consistent from year to year. If there is a change, MWCIA must be notified and two prior Call valuations must be provided on a consistent basis.

d. Case Reserves

- If bulk reserves are estimated as part of IBNR, then this field should be left blank.
- If your company does not include bulk reserves with IBNR, but instead combines bulk reserves with case reserves in the calculation of Outstanding reserves, then case reserves must be shown separately.

e. Bulk Reserves

- If bulk reserves are estimated as part of IBNR, then this field should be left blank.
- If your company does not include bulk reserves with IBNR, but instead combines bulk reserves with case reserves in the calculation of Outstanding reserves, then bulk reserves must be shown separately in the Bulk Reserves fields.

f. Paid Losses on Closed Claims

- Closed claims are those that are paid in full with no existing loss reserves or Defense and Cost Containment reserves.
- Indemnity paid losses on closed claims should be consistent with the "indemnity closed with payment" claim count.
- Medical paid losses on closed claims should include paid losses on closed medical-only claims as well as the paid medical component of indemnity claims. Therefore, the medical losses will not be consistent with "indemnity closed with payment" claim count.
- The medical loss column should include contract medical dollars.
- Both indemnity and medical paid losses should be on a direct basis.
- If a claim was closed with payment in the previously reported Call valuation, but was then reopened and remains open at the time of this year's valuation, the losses paid on the claim should be excluded from "paid losses on closed claims" for this year's valuation of the Call.
- The reporting of paid losses on closed claims is currently optional for all years on the Call.

C. CLAIM COUNT INFORMATION

Claim count information reported on Financial Calls is necessary for MWCIA to determine the frequency, severity, and claim count development, which may be used in trend factor analyses. These analyses uncover changing patterns that are not apparent in loss ratio trends. Timely information on emerging trends is critical for developing accurate loss costs, as well as for providing key information for reform legislation.

Financial data claim counts include only indemnity claims, i.e., claims that require payment for lost wages due to injury. Unlike the Financial Call incurred losses, which include indemnity and medical, Financial Call claims counts do not include medical-only claims (claims that have medical benefits only).

Reporting of claim counts (other than as noted above) should be consistent with the reporting of incurred losses, e.g., both should be on a direct basis.

In conformity with MWCIA requirements listed in the *Minnesota Statistical Plan Manual* for accidents involving multiple claims, report claim count as the total number of claims, rather than as a single incident.

An accident for one claimant with reportable losses under both workers' compensation and employers liability is counted as one claim, based on combined loss experience.

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1. **Incurred Indemnity Claim Count**

Incurred indemnity claim count is the accumulated number of claims for which an indemnity payment has been made and/or an outstanding indemnity loss reserve exists.

The incurred indemnity claim count excludes those claims that started out with an indemnity reserve but were subsequently resolved as medical-only claims, Defense and Cost Containment Expense-only claims, or claims closed without payment. If in a previous Call valuation, claims were originally thought to include indemnity losses, but at a subsequent Call valuation do not include indemnity benefits, the indemnity claim count should be reduced for these claims only in the subsequent Call valuation.

The incurred indemnity claim count includes claims that started out as medical-only but were later resolved as indemnity claims at subsequent valuations. If a medical-only claim develops indemnity, the incurred indemnity claim count should be increased in the Call valuation year where the indemnity losses were first determined to exist.

If indemnity claims that were closed with payment are reopened, they should not be added again to the incurred indemnity claim count.

If claims closed without payment are reopened as indemnity claims, they should be added to the incurred indemnity claim count.

The status of a claim can be either "Open" or "Closed." Specifically, claim counts are reported for closed claims and open claims, as well as incurred (open and closed) claims.

Separate reporting of open and closed claims is required for Policy Years 1993 and subsequent. (If you are in a position to do so, please report the open and/or closed indemnity claim counts for as many policy years prior to 1993 as possible.)

- **Closed (Paid) Indemnity Claim Count**

- This count includes those indemnity claims that are paid in full with no existing outstanding loss and/or Defense and Cost Containment Expense (DCCE) claim reserves.
- Indemnity claims that were closed at the previous valuation, but later were reopened and remain open as of this valuation date, should be removed from this column.
- Claims that started out as medical-only claims but were resolved as indemnity claims at a subsequent valuation should be added to this column.
- Claims that started out as indemnity claims but were resolved as medical-only claims or closed without payment should be removed from this column.

- **Open (Outstanding) Indemnity Claim Count**

- This count includes those indemnity claims for which outstanding case and/or Defense and Cost Containment Expense (DCCE) reserves exist at year-end, regardless of whether or not any payments have been made on those claims.
- Indemnity claims that were closed at the previous valuation but were reopened and remain open as of this valuation date should be added to this column.

2. **Paid Losses on Closed Claims**

In addition to claim counts, the Financial Calls also include fields for the indemnity and medical losses paid on closed claims.

The reporting of paid losses on closed claims is currently optional for all years on the Call.

For indemnity losses paid on closed claims, the set of underlying closed claims is the same as the set of claims shown in the Closed (Paid) Indemnity Claim Count field.

It should be noted that for the medical losses paid on closed claims, the set of underlying closed claims include medical-only claims and, therefore, does not match the set of claims shown in the Closed (Paid) Indemnity

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Claim Count field. The reporting of medical losses on closed claims is consistent, however, with the reporting of medical losses in the other parts of the Financial Call, such as Paid Medical Losses.

D. DEFENSE AND COST CONTAINMENT EXPENSE (DCCE)

Defense and Cost Containment Expense (DCCE) is defined as expenses for defense by the insurer in contentious situations (whether a first-party or third-party claim) for litigation involving a claim and for cost containment expense.

Report DCCE on an accumulated basis, from the issue date of the policy (policy year) or the date of accident (accident year) through December 31 of the most recent year.

1. **DCCE Included Expenses**—The following expenses are included but are not limited to:
 - Surveillance expenses.
 - Fixed amounts for cost containment expenses.
 - Case Management expenses for the purpose of managing the overall cost of a claim.
 - Litigation management expenses.
 - Fees or salaries for appraisers, private investigators, hearing representatives, inspectors, and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such costs are not included in the loss.
 - Attorney fees incurred owing to a duty to defend, even when other coverage does not exist.
 - Cost of engaging experts.
 - Cost of an Independent Medical Examination (IME) unless the IME is required by an Industrial Board or Commission. If the IME is required by an Industrial Board or Commission, it is reported as a medical loss.
2. **DCCE Excluded Expenses**—The following expenses are excluded:
 - Any expense incurred in the determination of coverage; this expense is part of Adjusting and Other Expenses.
 - Case Management expenses incurred for the purpose of achieving maximum medical recovery of the injured worker; in this scenario, this expense should be included with the losses, and not reported as a loss adjustment expense.
 - DCCE associated with Employers Liability (Part II) coverage; in this scenario, DCCE should be included with the indemnity losses, and not reported as a loss adjustment expense.

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PART 5—ADDITIONAL REQUIREMENTS FOR EXPERIENCE

OVERVIEW

This section pertains to the inclusion and exclusion of certain types of experience (items) and to certain Call preparation instructions when reporting your Financial Calls. Some specific categories of experience that data providers have frequently asked about are provided under “Experience Included” and “Experience Excluded.”

- **Experience Included in Call Submission**—Unless otherwise specified, all of your workers’ compensation policy year and calendar-accident experience is reported under the applicable Call. Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.
- **Experience Excluded from Call Submission**—If any of the following workers’ compensation experience is excluded from your Call submission, this is provided under “Experience Excluded.”

When excluding experience from a Call submission, all experience must be excluded (premiums, losses, claim counts, and expenses), as well as any premium adjustments related to the excluded experience (schedule rating, deductible credits, workplace safety credits, etc.). Any effects of premium adjustments that are excluded must also be removed.

Refer to MWCIA’s *Statistical Plan Manual* for the applicable statistical codes related to these experience types.

The items in this section are listed alphabetically.

A. EXPERIENCE TYPES

1. Aircraft Seat Surcharge

Include Aircraft Seat Surcharge premium in all calls.

2. Assessments and Special Compensation Funds

a. Experience Included

The reporting of assessments and other compensation special funds follow the same instructions that apply in the reporting of experience under Section One of the *Minnesota Statistical Plan Manual*. Include the combined loss and assessment total as incurred indemnity losses when the compensation law states both the following:

- In connection with a certain type of injury, a specified amount should be paid into special funds (e.g., a Second Injury Fund).
- When these amounts are in addition to the compensation payable to the injured worker or his/her dependents.

b. Experience Excluded

Exclude any special payments, which are assessed on total premium writings, on total losses paid or incurred, or on total indemnity losses paid or incurred (e.g., Special Compensation Fund assessments paid to the state instead of on a per-claim basis).

3. Assigned Risk

Experience for Assigned Risk policies effective March 1, 1982 and subsequent MUST BE EXCLUDED.

4. Balance to Minimum Premium Adjustment

Include the Balance to Minimum premium adjustment association with classification codes, Admiralty and/or FELA (only for years prior to January 1, 2003, where maritime and other FELA experience is included in the Financial Calls), and Employers Liability Increased Limits coverage when reporting premium experience in the Net and Company Standard Premium columns.

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5. COVID-19 (Coronavirus)

Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.

6. Domestic Workers Experience

a. Experience Included

Include domestic worker experience (premiums, losses and expenses) written under workers' compensation and employers liability policies in all Calls.

b. Experience Excluded

Exclude domestic worker experience from all Calls in conjunction with the following:

- Experience for residence and farm employees written under other liability insurance
- Experience for workers compensation policies written for domestic employees as part of homeowners insurance.

7. Earned But Unbilled Premium

a. Experience Included

Include any provision for Earned But Unbilled Premium (EBUB) if it can be properly allocated by policy year.

b. Experience Excluded

If it cannot be properly allocated by policy year, then it should be omitted from Policy and Calendar Accident Year Calls and entered under Reason for Differences in Call RR.

8. Excess Policies

a. Experience Included

Experience for Excess policies is included as a reconciliation item in Call RR.

b. Experience Excluded

Experience for Excess policies MUST BE EXCLUDED from Calls P1, C1, SR, P2, C2, and LL.

9. Expenses

a. Experience Included

Experience for Defense and Cost Containment Expense (DCCE) paid and case outstanding are included on Calls P1, C1, P2, C2, LL and RR.

b. Experience Excluded

Exclude Adjusting and Other Expenses.

10. F Classifications

a. Experience Included

Experience for federal (F) classifications is included as a reconciliation item in Call RR.

b. Experience Excluded

Experience of the F Classifications for policies effective January 1, 1974 and thereafter MUST BE EXCLUDED from Calls P1, C1, SR, P2, C2, and LL.

11. IBNR

Losses reported should include an appropriate reserve for incurred but not reported cases. The IBNR reserve must be reported separately for indemnity and medical.

Commencing with the Policy Year Call valued as of December 31, 1986, the Outstanding Excluding IBNR category has been further refined to capture case reserves and bulk reserves.

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This reporting clearly isolates case reserves without impacting the carrier methodology of reporting IBNR. Carriers should not alter the mix of data which has historically been allocated to IBNR, since doing so would adversely impact the MWCIA development of IBNR data.

For this reason, carriers who have reported bulk reserves in IBNR should continue to do so. On the Outstanding Excluding IBNR Page 3 Reporting Form, these carriers should respond "Yes" to the question in Note A.

12. Large Deductibles

Large deductibles are deductibles of \$100,000 or more, whether the deductible is per claim, per accident, or on an aggregate basis.

a. Experience Included

Large deductibles are reported in Calls P2, C2, and LL, and as a reconciliation item in Call RR.

b. Experience Excluded

Large deductible experience is excluded from Calls P1, C1, and SR.

13. Maritime and Other Federal Employer Liability Act (FELA) Classifications

a. Experience Included

Experience for Maritime and other Federal Employer Liability Act (FELA) classifications is included as a reconciliation item in Call RR.

b. Experience Excluded

Experience for Maritime and other Federal Employer Liability Act (FELA) classifications **MUST BE EXCLUDED** from Calls P1, C1, SR, P2, C2, and LL.

14. Multiyear Policies

Multiyear policies may be reported either as one policy with a single policy effective date, or as separate policies with individual effective dates for each of the annual components. However, except for the case of Three-Year Fixed Rate policies, separation into annual policies is encouraged to maintain consistency with **Minnesota Statistical Plan Manual** reporting requirements.

15. National Defense Projects

a. Experience Included

Experience incurring on a Defense Base should be included unless written under the National Defense Projects Rating Plan which is included as a reconciliation item in Call RR.

b. Experience Excluded

Experience on National Defense Projects written under either the old Comprehensive Rating Plan or the new National Defense Projects Rating Plan **MUST BE EXCLUDED** from Calls P1, C1, SR, P2, C2, and LL.

16. Reinsurance

No deductions shall be made from premiums, losses and expenses for or as a result of reinsurance ceded. Premiums, losses and expenses arising from reinsurance by the reporting carrier shall be excluded from the experience. This includes all reinsurance transactions with the Minnesota Workers' Compensation Reinsurance Association (WCRA). Experience reported should be **DIRECT BUSINESS ONLY**.

17. Reopened Cases

Include an appropriate loss amount paid and/or reserve or Defense and Cost Containment Expense (DCCE) paid and/or reserve for reopened cases.

18. Reserves for Specific Contingencies

Include medical and other loss reserves to meet specific contingencies.

19. Return to Work

Include premium for Return to Work programs when reporting premium experience in the Net Earned premium column.

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20. Terrorism and Catastrophic Industrial Accidents

Premium for TRIA, TRIEA and TRIPRA programs and premium for catastrophic industrial accidents should be EXCLUDED from Calls P1, C1, SR, P2, and C2, but INCLUDED as a reconciliation item in Call RR.

21. Wrap-Up Policies

A wrap-up policy may be referred to as an Owner Controlled Insurance Program (OCIP) or a Contractor Controlled Insurance Program (CCIP). A Master Wrap-Up Policy that covers multiple years must be reported as separate policies with individual effective dates for each of the annual components. Include experience (premiums, losses and expenses) of all associated owner/contractor and subcontractors in all calls.

22. Workers' Compensation Reinsurance Association Policyholder Deficiency Assessments

Premium surcharge for WCRA assessments to policyholders should be EXCLUDED from all premium types.

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PART 6—DESIGNATED STATISTICAL REPORTING (DSR) LEVELS

OVERVIEW

The Designated Statistical Reporting (DSR) Level is the standard earned premium that would develop if carrier business were written at the MWCIA pure premium base rate level instead of at the rates filed by the carrier. In Minnesota the carriers must adjust reported premium to the MWCIA DSR level.

Standard Earned Premium at Company Level is adjusted to Standard Earned Premium at DSR Level by referencing the pure premium base rates published annually in the *Minnesota Ratemaking Report* for the particular policy period.

The following pages contain a detailed summary of procedures for reporting statistical premium and a historical summary of DSR levels for Minnesota. The summary of procedures includes requirements and procedures that must be followed in statistical reporting.

PROCEDURES

This section provides detailed procedures for the reporting of premium in the Aggregate Calls for Experience. See the **Financial Call Components** section (Part 4) for a full discussion of the various types of pricing structures and their applicability to Financial Calls.

1. Aggregate Calls for Experience—Premium

Aggregate Calls for Experience require three types of earned premium:

- Net Earned Premium
- Standard Earned Premium at Company Level
- Standard Earned Premium at Designated Statistical Reporting (DSR) Level

NOTE: See the **Financial Call Components (Part 4)** section for a full description of the three types of earned premium and the specific premium components that are included in each.

2. Standard Earned Premium at Designated Statistical Reporting Level (DSR) Premium

DSR Premium is Standard Earned Premium at Company Level adjusted to remove effects of carrier deviations from MWCIA pure premium base rates (e.g., loss cost multipliers). The method used to calculate DSR premium depends on whether the company applies the same deviation across all classes (flat deviation) or applies separate deviations by class (class deviation). The following are detailed procedures for each of these two types of deviations—first for flat deviations, and then for class deviations.

a. Procedure for Flat Deviations

To calculate the DSR premium for a flat deviation, the following information is required:

- Standard Premium at Company Level
- MWCIA DSR level
- Company loss cost level
- Company loss cost multiplier

MWCIA DSR levels are updated each January 1 in the *Minnesota Ratemaking Report*. It is important to note that:

- MWCIA DSR levels vary by policy period
- The aggregate Standard Premium by Company Level must be separated by policy effective date and matched with the proper MWCIA DSR level policy period prior to performing the adjustment to Standard Premium at DSR Level
- To ensure the accurate calculation of DSR premium, carriers should always include any outstanding pure premium base rate change filed by MWCIA, whether or not they were actually adopted by the company.

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The following example represents typical situations encountered by carriers when analyzing the impact of outstanding changes in pure premium base rates and calculating DSR premium.

Example:

Company Policy Period—7/1/2023 – 6/30/2024

Company Loss Cost Multiplier—1.350

Standard Premium at Company Level = \$1,350,000

MWCIA Policy Year 2023 DSR levels:

From 7/1/2023 to 12/31/2023 = 1/1/2023 loss cost level

From 1/1/2024 to 6/30/2024 = 1/1/2024 loss cost level

DSR Rate Level History

For informational purposes, shown below are summaries of individual and cumulative pure premium level changes since 1983.

Pure Premium Level	Individual Change	Cumulative Change Since 1983	Pure Premium Level	Individual Change	Cumulative Change Since 1983
1/1/2026***	–4.6%	–46.8%	1/1/2004	–0.3%	–8.8%
1/1/2025***	–0.5%	–44.2%	1/1/2003	+5.9%	–8.5%
1/1/2024***	–10.3%	–44.0%	1/1/2002	+1.4%	–13.6%
1/1/2023***	+5.7%	–37.5%	1/1/2001	–5.0%	–14.8%
1/1/2022**	–6.5%	–40.9%	1/1/2000	–3.8%	–10.3%
1/1/2021**	–1.2%	–36.8%	1/1/1999	–2.8%	–6.8%
1/1/2020**	–0.4%	–36.0%	1/1/1998	–14.3%	–4.1%
1/1/2019**	+1.2%	–35.8%	1/1/1997	–14.8%	+11.9%
1/1/2018**	–6.7%	–36.5%	1/1/1996*	–15.6%	+31.3%
1/1/2017**	–12.1%	–32.0%	1/1/1995	–5.6%	+55.6%
1/1/2016**	+2.0%	–22.6%	1/1/1994	+1.3%	+64.8%
1/1/2015	–2.5%	–24.1%	1/1/1993	+1.6%	+62.7%
1/1/2014	–2.0%	–22.2%	1/1/1992	+6.5%	+60.1%
1/1/2013	–0.8%	–20.6%	1/1/1991	–2.8%	+50.4%
1/1/2012	–2.7%	–19.9%	1/1/1990	+2.7%	+54.7%
1/1/2011	–1.7%	–17.7%	1/1/1989	+2.6%	+50.6%
1/1/2010	–2.4%	–16.3%	1/1/1988	+10.7%	+46.8%
1/1/2009	+1.7%	–14.2%	1/1/1987	–2.1%	+32.6%
1/1/2008	–2.6%	–15.7%	1/1/1986	+2.4%	+35.5%
1/1/2007	–3.6%	–13.4%	1/1/1985	+7.2%	+32.3%
1/1/2006	–0.3%	–10.2%	1/1/1984	+23.4%	+23.4%
1/1/2005	–1.2%	–9.9%			

* 1/1/1996 pure premiums were reduced another 10% to reflect the inclusion of vacation/holiday/sick pay in the payroll base.

** 1/1/2016 losses developed to a 10th report, 1/1/2017 losses developed to a 14th report, 1/1/2018 losses developed to an 18th report, 1/1/2019 losses developed to a 24th report and 1/1/2020 through 1/1/2022 losses developed to a 27th report. Years prior to 2016 were developed to an eighth report.

*** 1/1/2023 and subsequent pure premiums include trend, development to ultimate, and loss adjustment expenses.

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PART 7—TAXES AND ASSESSMENTS

The inclusion of assessments and other compensation special funds as incurred losses in the Call data follow the same instructions that apply in reporting of experience under the *Minnesota Statistical Plan Manual*. Specifically, where the compensation law states that in connection with certain types of injury a specified amount shall be paid into special funds (e.g., a Second Injury Fund), and that such amounts are in addition to the compensation payable to the injured worker or his dependents, then the combined total amount shall be reported as incurred indemnity losses. Examples are (1) payments in no-dependent death claims, and (2) a specified percentage of the permanent partial award. However, any special payments to the state which are assessed on total premium writings, total losses paid or incurred, or total indemnity losses paid or incurred instead of on a per claim basis shall **NOT** be reported as losses to the MWCIA. In other words, special fund or assessments are reported as incurred losses only when the assessment is levied on certain types of injuries.

A list of specific assessments and other compensation special funds and the proper treatment for including these assessments in the Calls is as follows:

Tax/Assessment	How Collected	Include as Losses in Submission
Minnesota Insurance Guaranty Association	Tax on premium	No
Special Compensation Fund	\$25,000 in no-dependency death cases	Yes
	Difference between \$25,000 and actual award payments made in dependency death cases where benefits are less than \$25,000; subject to \$5,000 minimum payment per case	Yes
	Assessment as a percent of DSR premium	No
Assigned Risk Plan Review	Assessments on assigned risk premium (servicing carriers only)	No
Assigned Risk Plan Assessment	Assessment on premium (all carriers except servicing carriers)	No

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PART 8—FINANCIAL CALL INSTRUCTIONS

OVERVIEW

Part 8 provides the instructions for completing each aggregate Financial Call. These detailed Call instructions provide you with general and row/column instructions. A sample reporting form for each Financial Call follows the instructions for that Call.

MWCIA collects seven aggregate Financial Calls for the 2025 reporting season, all of which are available for electronic reporting for ***Automated Carrier Call Entry and Data Edit (ACCEDE)***. For further details on electronic reporting, refer to Part 11.

The instructions included in this section are for all of the aggregate Financial Calls as follows:

- Call P1—Policy Year Call
- Call C1—Calendar-Accident Year Call
- Call SR—Schedule Rating Premium Adjustments Call
- Call P2—Large Deductible Policy Year Call
- Call C2—Large Deductible Calendar-Accident Year Call
- Call RR—Reconciliation Report
- Call LL—Large Loss and Catastrophe Call

The Call instructions are intended to be used in conjunction with other supporting sections contained in these instructions. Some key supporting sections are:

- **Financial Call Components** (Part 4)—provides further details on premium, losses, claim counts, and Defense and Cost Containment Expense (DCCE).
- **Additional Requirements for Experience** (Part 5)—further describes the experience to include or exclude when completing your Calls.

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CALL FOR EXPERIENCE P1—POLICY YEAR CALL

Due Date – April 1

Background

This Policy Year Call contains statewide data, including voluntary premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE), grouped by policy effective year. For example, for policies with effective dates from January 1 to December 31, 2024, all premiums associated with those policies and all claims that develop for those policies must be reported under the effective year (2024), regardless of the year the premium was earned or the claim occurred.

General Instructions

- The data reported in this Call should **include** all of your workers' compensation policy year experience on a direct basis, unless otherwise specified as an excluded item.
- For further information on experience to include or exclude, refer to the **Additional Requirements for Experience** section (Part 5).
- Premium reported on this Call should include Earned But Unbilled (EBUB) premium only if the adjustment can be allocated to the proper policy year. If the adjustment cannot be allocated, then the EBUB premium should be excluded and the exclusion noted under "Reason for Difference" in the Reconciliation Report (Call RR).
- The data reported in the Call should **exclude** the following experience:
 - Large Deductible policies
 - Excess Policies
 - Federal (F) Classifications (however, any USL&HW experience associated with industrial classifications should be included)
 - Maritime and other FELA Classifications
 - Assigned Risk experience effective March 1, 1982 and subsequent
 - Reinsurance assumed
 - Terrorism and Catastrophe provisions
 - Adjusting and Other Expenses
 - Special Compensation Fund Assessment
 - Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment
 - Payments to Paid Furloughed Employees
 - Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.
- Experience for deductible policies other than large deductibles should be reported on a gross basis inclusive of the employer paid loss amount.
- Detailed definitions and procedures for calculating premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) can be found in the **Financial Call Components** section (Part 4). For further details on defining and calculating Designated Statistical Reporting (DSR) Level premium, refer to the **Designated Statistical Reporting (DSR) Levels** section (Part 6)
- For the method(s) for reporting this Financial Call, refer to Data Submission Information in the **Reporting Requirements** section (Part 3).
- This Call is included in the Financial Call Incentive Program (FCIP) and is subject to assessments for late and/or inaccurate reporting. Refer to the **FCIP** section (Part 10)

Row Instructions

- For each row, the **Prior to** line and each individual policy year, report the cumulative premiums, paid losses, claim counts and paid DCCE from the date of policy inception to December 31 of the current reporting year. Report loss reserves and DCCE reserves as of December 31 of the current reporting year.
- For Line X, report the sum of all policy years including the **Prior to** line.
- For Line Y, report the total on Line X from the previous valuation.

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- For Line Z, show the difference of Line X minus Line Y. This is the calendar year total for the current year.
 - The Net Earned Premium, the total of paid losses, the total of incurred losses and the total of DCCE paid should reconcile with the amount reported on your company's National Association of Insurance Commissioners (NAIC) Annual Statement, Statutory Page 14.
 - The amounts in the loss columns should equal the amounts shown on Line Z in the Calendar-Accident Year Call, Call C1.

Column Instructions

Policy Year Accumulated Earned Premium—Standard at MWCIA DSR Level

- Report the Standard Premium at MWCIA Designated Statistical Reporting (DSR) Level for each of the indicated policy years. This is the standard premium that would be earned using the appropriate MWCIA published loss costs without the application of company loss cost multipliers or rate deviations.
- For every policy with Standard Premium at Company Level, Premium at DSR Level must also be reported.
- For a guide to applicable premium components included in DSR Level Premium, refer to the Premium Component Chart in the **Financial Call Components** section (Part 4). For further details on defining and calculating DSR premium, refer to **Designated Statistical Reporting (DSR) Levels** (Part 6).

Policy Year Accumulated Earned Premium—Standard at Company Level

- Report the Standard Premium at Company Level. This is the full premium that would be earned using the company's selected loss costs, loss cost multipliers, and rate deviations.
- Standard Premium at Company Level differs from the Standard at MWCIA DSR level in that it includes the following:
 - Company selected expense constants
 - Balance to Minimum Premium adjustments
 - Loss cost multiplier and rate deviations
 - Minnesota contractors premium adjustment program (MCPAP)
- Standard Premium at Company Level differs from the Net Premium in that it excludes the following:
 - Premium discounts
 - Schedule rating and other prospective premium adjustments
 - Retrospective rating adjustments
 - Deductible credits
 - Certain other adjustments (e.g., Independent Carrier Filing credit/debit adjustments)
- For further details on adjustments and on defining and calculating Standard Premium at Company Level, refer to the **Financial Call Components** section (Part 4).

Policy Year Accumulated Earned Premium—Net

- Report the Net premium. This is the actual net earned premium (net of deductible credits) on all risks prior to the payments of policyholder dividends, Special Compensation Fund assessments, Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment and terrorism and catastrophic industrial accidents.
- Retrospective premium adjustments are included, but should be assigned to the original year in which the policy was written, not to the year in which the adjustment was made.
- For further details on defining and calculating Net premium, refer to the **Financial Call Components** section (Part 4).

Policy Year—Incurred Indemnity Claim Count

- Include only claims that have either paid indemnity losses, outstanding indemnity loss reserves, or both.
- Do not include medical-only claims, Defense and Cost Containment Expense (DCCE)-only claims or claims closed without payment.
- Incurred Indemnity Claim Count should equal the sum of Incurred Indemnity Claim Count—Accumulated Closed (Paid) plus Incurred indemnity Claim Count—Open (Outstanding).
- For further details on defining and calculating the indemnity claim count, refer to the **Financial Call Components** section (Part 4).

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Policy Year—Accumulated Paid Indemnity Losses

- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Policy Year—Accumulated Paid Medical Losses

- Include paid medical losses for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Indemnity Excluding IBNR

- Report indemnity case loss reserves, plus bulk indemnity loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Medical Excluding IBNR

- Report medical case loss reserves, plus bulk medical loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- Include medical reserves for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—IBNR Indemnity

- Report Incurred But Not Reported (IBNR) indemnity reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—IBNR Medical

- Report Incurred But Not Reported (IBNR) medical reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year Defense and Cost Containment Expense—Accumulated Paid

- The reporting of expenses should be consistent with reporting of paid losses and loss reserves.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

Policy Year Defense and Cost Containment Expense—Case Outstanding

- The reporting of expenses should be consistent with the reporting of paid losses and loss reserves.
- Do not include Incurred But Not Reported (IBNR) or bulk Defense and Cost Containment Expense (DCCE) reserves in this column.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

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Policy Year—Outstanding Indemnity Case Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Indemnity Bulk Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Medical Case Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the medical case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Medical Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Medical Bulk Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the medical bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Medical Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year Incurred Indemnity Claim Count—Accumulated Closed (Paid)

- Closed indemnity claims are indemnity claims that are paid in full with no existing outstanding loss reserves or Defense and Cost Containment Expense (DCCE) reserves.
- Include claims that started out as medical-only claims but were resolved as indemnity at subsequent valuations.
- Exclude indemnity claims that are resolved as medical-only claims.
- Exclude claims that were closed without payment.
- Indemnity claims that were closed at the previous valuation, but later reopened and remain open as of this valuation date, should be removed from this column for this year's valuation of the Call.
- Reporting is mandatory for Policy Years 1993 and subsequent.
- Reporting for policy years prior to 1993 is not mandatory, but encouraged.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

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Policy Year Incurred Indemnity Claim Count—Open (Outstanding)

- Open indemnity claims are indemnity claims for which outstanding loss reserves or Defense and Cost Containment Expense (DCCE) reserves exist, regardless of whether any payments have been made on the claim.
- Indemnity claims that were closed at the previous valuation, but later reopened and remain open as of this valuation date should be added to this column for this year's valuation of the Call.
- Reporting is mandatory for Policy Years 1993 and subsequent.
- Reporting for policy years prior to 1993 is not mandatory, but encouraged.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

Accumulated Policy Year Losses—Paid Indemnity Losses on Closed Claims

- Indemnity losses on closed claims are indemnity losses on claims that are paid in full with no existing outstanding loss reserves or Defense and Cost Containment Expense (DCCE) reserves. The reporting of paid indemnity losses on closed claims is currently optional for all years on this call.
- Indemnity losses paid on indemnity claims that were closed at the previous valuation, but were later reopened and remain open as of this valuation date should be removed from this column for this year's valuation of the Call.
- All information reported relating to indemnity paid losses on closed claims should be consistent with Incurred Indemnity Claim Count—Accumulated Closed (Paid) data.
- The reporting of paid indemnity losses on closed claims is currently optional for all years on this Call.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

Accumulated Policy Year Losses—Paid Medical Losses on Closed Claims

- Include paid losses on medical-only claims as well as on indemnity claims (even though medical-only claims are not included in Incurred Indemnity Claim Count—Accumulated Closed (Paid) data).
- Include contract medical dollars.
- Medical losses paid on either indemnity or medical-only claims that were closed at the previous valuation, but were later reopened and remain open as of this valuation date should be removed from this column for this year's valuation of the Call.
- The reporting of paid medical losses on closed claims is currently optional for all years on this Call.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

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CALL FOR EXPERIENCE C1—CALENDAR-ACCIDENT YEAR CALL

Due Date – April 1

Background

This Calendar-Accident Year Call contains statewide data, including voluntary premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) grouped by calendar-accident year.

Calendar-accident year refers to how the financial data is organized which is as follows:

- The term “calendar” pertains to premiums organized by transaction date
- The term “accident” pertains to losses organized by the date the claim occurred

For example, the premium associated with premium transactions occurring in Calendar Year 2024, and losses associated with claims with accident dates occurring in 2024, must be reported under year 2024, regardless of the effective date of the underlying policy.

General Instructions

- The data reported in this Call should **include** all of your workers' compensation calendar-accident year experience on a direct basis, unless otherwise specified as an excluded item.
- The data on Statutory Page 14 of your company's National Association of Insurance Commissioners (NAIC) Annual Statement is used to reconcile the data in this Call.
- For further information on experience to include or exclude, refer to the **Additional Requirements for Experience** section (Part 5).
- Premium reported on this Call should include Earned But Unbilled (EBUB) premium if the adjustment was included on the corresponding Policy Year Call (Call P1). If the adjustment was not included in the corresponding Policy Year Call (e.g., because the adjustment could not be properly allocated by policy year), then the EBUB premium should be excluded from the Calendar-Accident Year Call as well; and the exclusion noted under “Reason for Difference” in the Reconciliation Report (Call RR).
- The data reported in the Call should **exclude** the following experience:
 - Large Deductible policies
 - Excess Policies
 - Federal (F) Classifications (however, any USL&HW experience associated with industrial classifications should be included)
 - Maritime and other FELA Classifications
 - Assigned Risk experience effective March 1, 1982 and subsequent
 - Reinsurance assumed
 - Terrorism and Catastrophe provisions
 - Adjusting and Other Expenses
 - Special Compensation Fund Assessment
 - Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment
 - Payments to Paid Furloughed Employees
 - Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.
- Experience for deductible policies other than large deductibles should be reported on a gross basis inclusive of the employer paid loss amount.
- Detailed definitions and procedures for calculating premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) can be found in the **Financial Call Components** section (Part 4).
- For the method(s) for reporting this Financial Call, refer to Data Submission Information in the **Reporting Requirements** section (Part 3).
- This Call is included in the Financial Call Incentive Program (FCIP) and is subject to assessments for late and/or inaccurate reporting. Refer to the **FCIP** section (Part 10)

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Row Instructions

- For each row, the **Prior to** line and each individual year, report the cumulative premiums, paid losses, claim counts and paid DCCE from the date of accident through December 31 of the current reporting year. Report loss reserves and DCCE reserves as of December 31 of the current reporting year. Report premium by transaction date for the most recent five calendar years only (do not report in any cells where there is shading).
- For Line X, in the loss columns, report the sum of all years including the **Prior to** line. For the premium columns leave Line X blank (do not report in any cells where there is shading).
- For Line Y, in the loss columns, report the total on Line X from the previous valuation. For the premium columns, leave Line Y blank (do not report in any cells where there is shading).
- For Line Z, in the loss columns, show the difference of Line X minus Line Y. This is the calendar year total for the current year.
 - For the premium columns, leave Line Z blank (do not report in any cells where there is shading).
 - The Net Earned Premium, the total of paid losses, the total of incurred losses and the total of the DCCE paid should reconcile with the amount reported on your company's National Association of Insurance Commissioners (NAIC) Annual Statement, Statutory Page 14.
 - The amounts in the loss and DCCE columns should equal the amounts shown on Line Z in the Policy Year Call, Call P1.

Column Instructions

Calendar Year Accumulated Earned Premium—Standard at MWCIA DSR Level

- Report the Standard Premium at MWCIA Designated Statistical Reporting (DSR) Level for each of the indicated calendar years. This is the standard premium that would be earned using the appropriate MWCIA published loss costs without the application of company loss cost multipliers or rate deviations.
- For every year with Standard Premium at Company Level, Premium at DSR Level must also be reported.
- For a guide to applicable premium components included in DSR Level Premium, refer to the Premium Component Chart in the **Financial Call Components** section (Part 4). For further details on defining and calculating DSR premium, refer to **Designated Statistical Reporting (DSR) Levels** (Part 6).
- This Call requires only the most recent five years of calendar year premium reported in this column, because the earlier calendar year premiums are not critical to the ratemaking process. Only report data in the rows for the most recent five years (do not report any cells where there is shading).
- Premium for the most recent calendar year row should match the Line Z premium in the Standard at MWCIA DSR Level column of the corresponding Policy Year Call (Call P1).
- Premium for the prior four calendar year rows should match the Standard at MWCIA DSR Level column premium for the same calendar year on last year's Calendar-Accident Year Call.

Calendar Year Accumulated Earned Premium—Standard at Company Level

- Report the Standard Premium at Company Level. This is the full premium that would be earned using the company's selected loss costs, loss cost multipliers, and rate deviations.
- This Call requires only the most recent five years of calendar year premium reported in this column, because the earlier calendar year premiums are not critical to the ratemaking process. Only report data in the rows for the most recent five years (do not report any cells where there is shading).
- Premium for the most recent calendar year row should match the Line Z premium in the Standard at Company Level column of the corresponding Policy Year Call (Call P1).
- Premium for the prior four calendar year rows should match the premium for the same calendar year on last year's Calendar-Accident Year Call.
- Standard Premium at Company Level differs from the Standard at MWCIA DSR level premium in that it includes the following:
 - Company selected expense constants
 - Balance to Minimum Premium adjustments
 - Loss cost multiplier and rate deviations
 - Minnesota contractors premium adjustment program (MCPAP)
- Standard Premium at Company Level differs from the Net Premium in that it excludes the following:
 - Premium discounts

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- Schedule rating and other prospective premium adjustments
 - Retrospective rating adjustments
 - Deductible credits
 - Certain other adjustments (e.g., Independent Carrier Filing credit/debit adjustments)
- For further details on adjustments and on defining and calculating Standard Premium at Company Level, refer to the **Financial Call Components** section (Part 4).

Calendar Year Accumulated Earned Premium—Net

- Report the Net premium. This is the actual net earned premium (net of deductible credits) on all risks prior to the payments of policyholder dividends, Special Compensation Fund assessments, Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment and terrorism and catastrophic industrial accidents.
- This Call requires only the most recent five years of calendar year premium reported in this column, because the earlier calendar year premiums are not critical to the ratemaking process. Only report data in the rows for the most recent five years (do not report any cells where there is shading).
- Premium for the most recent calendar year row should match the Line Z premium of the corresponding Policy Year Call (Call P1).
- Premium for the prior four calendar year rows should match the premium for the same calendar year on last year's Calendar-Accident Year Call.
- Retrospective premium adjustments are included, but should be assigned to the calendar year in which the adjustment was made.
- For further details on defining and calculating Net premium, refer to the **Financial Call Components** section (Part 4).

Accident Year—Incurred Indemnity Claim Count

- Include only claims that have either paid indemnity losses, outstanding indemnity loss reserves, or both.
- Do not include medical-only claims, Defense and Cost Containment Expense (DCCE)-only claims or claims closed without payment.
- Incurred Indemnity Claim Count should equal the sum of Incurred Indemnity Claim Count—Accumulated Closed (Paid) plus Incurred Indemnity Claim Count—Open (Outstanding).
- For further details on defining and calculating the indemnity claim count, refer to the **Financial Call Components** section (Part 4).

Accident Year—Accumulated Paid Indemnity Losses

- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Accident Year—Accumulated Paid Medical Losses

- Include paid medical losses for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Indemnity Excluding IBNR

- Report indemnity case loss reserves, plus bulk indemnity loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

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Accident Year—Outstanding Medical Excluding IBNR

- Report medical case loss reserves, plus bulk medical loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- Include medical reserves for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—IBNR Indemnity

- Report Incurred But Not Reported (IBNR) indemnity reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—IBNR Medical

- Report Incurred But Not Reported (IBNR) medical reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year Defense and Cost Containment Expense—Accumulated Paid

- The reporting of expenses should be consistent with reporting of paid losses and loss reserves.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

Accident Year Defense and Cost Containment Expense—Case Outstanding

- The reporting of expenses should be consistent with the reporting of paid losses and loss reserves.
- Do not include Incurred But Not Reported (IBNR) or bulk Defense and Cost Containment Expense (DCCE) reserves in this column.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Indemnity Case Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Indemnity Bulk Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Medical Case Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.

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- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the "Bulk in IBNR" tab in ACCEDE and fill in the medical case reserves only.
 - If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the "Bulk in IBNR" tab in ACCEDE and leave Outstanding Medical Case Excluding IBNR blank.
 - For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Medical Bulk Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the "Bulk in IBNR" tab in ACCEDE and fill in the medical bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the "Bulk in IBNR" tab in ACCEDE and leave Outstanding Medical Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year Incurred Indemnity Claim Count—Accumulated Closed (Paid)

- Closed indemnity claims are indemnity claims that are paid in full with no existing outstanding loss reserves or Defense and Cost Containment Expense (DCCE) reserves.
- Include claims that started out as medical-only claims but were resolved as indemnity at subsequent valuations.
- Exclude indemnity claims that are resolved as medical-only claims.
- Exclude claims that were closed without payment.
- Indemnity claims that were closed at the previous valuation, but later reopened and remain open as of this valuation date should be removed from this column for this year's valuation of the Call.
- Reporting is mandatory for accident years 1993 and subsequent.
- Reporting for accident years prior to 1993 is not mandatory, but encouraged.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

Accident Year Incurred Indemnity Claim Count—Open (Outstanding)

- Open indemnity claims are indemnity claims for which outstanding loss reserves or Defense and Cost Containment Expense (DCCE) reserves exist, regardless of whether any payments have been made on the claim.
- Indemnity claims that were closed at the previous valuation, but later reopened and remain open as of this valuation date should be added to this column for this year's valuation of the Call.
- Reporting is mandatory for accident years 1993 and subsequent.
- Reporting for accident years prior to 1993 is not mandatory, but encouraged.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

Accumulated Accident Year Losses—Paid Indemnity Losses on Closed Claims

- Indemnity losses on closed claims are indemnity losses on claims that are paid in full with no existing outstanding loss reserves or Defense and Cost Containment Expense (DCCE) reserves. The reporting of paid indemnity losses on closed claims is currently optional for all years on this call.
- Indemnity losses paid on indemnity claims that were closed at the previous valuation, but were later reopened and remain open as of this valuation date should be removed from this column for this year's valuation of the Call.
- All information reported relating to indemnity paid losses on closed claims should be consistent with Incurred Indemnity Claim Count—Accumulated Closed (Paid) data.
- The reporting of paid indemnity losses on closed claims is currently optional for all years on this Call.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

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Accumulated Accident Year Losses—Paid Medical Losses on Closed Claims

- Include paid losses on medical-only claims as well as on indemnity claims (even though medical-only claims are not Incurred Indemnity Claim Count—Accumulated Closed (Paid) data.
- Include contract medical dollars.
- Medical losses paid on either indemnity or medical-only claims that were closed at the previous valuation, but were later reopened and remain open as of this valuation date should be removed from this column for this year's valuation of the Call.
- The reporting of paid medical losses on closed claims is currently optional for all years on this Call.
- For further details on defining closed and open claims, refer to the **Financial Call Components** section (Part 4).

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CALL FOR EXPERIENCE SR—SUPPLEMENTAL CALL FOR SCHEDULE RATING PREMIUM ADJUSTMENTS

Due Date – April 1

Background

MWCIA uses this Call to verify that carriers have properly accounted for scheduled rating premium adjustments in their Call submissions that are used in the ratemaking process. Specifically, these programs would be reported under the Schedule Rating credit code 9887 and debit code 9889.

Compilations of this data are also used in market analysis to measure the impact of this form on competitive pricing.

The adjustments from these programs, reflected in the statistical codes above, are issued to specific policyholders. These adjustments reflect the impact on losses of such things as employer procedures, training, or equipment that may not have been in place during the historical experience period.

General Instructions

- For the method(s) for reporting this Financial Call, refer to Data Submission Information in the **Reporting Requirements** section (Part 3).
- Null reports, zero-filled, are not expected for this Call when there are no schedule rating premium adjustments to report.

Specific Instructions

- Report the policy year accumulated earned premium at company reporting level including schedule rating premium adjustments for the most current five policy years on Lines A-E, respectively. This is basically the same figure as reported in the Policy Year Call except that schedule rating premium adjustments are **included**.
- Report the calendar year accumulated earned premium at company reporting level including schedule rating premium adjustments for the most current calendar year on Line F. This is basically the same figure as reported in the Calendar-Accident Year Call except that schedule rating premium adjustments are **included**.
- Report the calendar year accumulated earned premium at company reporting level for the most current calendar year on Line G. This is the same figure as reported in the Calendar-Accident Year Call.
- Report the difference of Line F – Line G on Line H. This is your overall calendar year schedule rating premium adjustment.
- Experience included and excluded for this Call should be on a basis consistent with the Policy Year Call (Call P1).
- **Exclude** schedule rating adjustments associated with the following experience:
 - Excess Policies
 - Federal (F) Classifications (however, any USL&HW experience associated with industrial classifications should be included)
 - Maritime and other FELA Classifications
 - Assigned Risk experience effective March 1, 1982 and subsequent
 - Reinsurance assumed
 - Terrorism and Catastrophe provisions
 - Adjusting and Other Expenses
 - Experience under large deductible policies – for purposes of this Call, large deductible policies are policies with deductibles of \$100,000 or more per claim, per accident, or in aggregate
 - Special Compensation Fund Assessment
 - Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment
 - Payments to Paid Furloughed Employees

See the **Additional Requirements for Experience** (Part 5) for further details on exclusions.

MINNESOTA WORKERS' COMPENSATION INSURERS ASSOCIATION, INC.

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CALL FOR EXPERIENCE P2—LARGE DEDUCTIBLE POLICY YEAR CALL

Due Date – April 1

Background

This Call contains statewide data, including premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) for large deductible policies, grouped by policy effective year.

For example, for policies with effective dates from January 1 to December 31, 2024, all premiums associated with those policies and all claims that develop for those policies must be reported under the effective year (2024), regardless of the year the premium was earned or the claim occurred.

General Instructions

- This Call includes policies with deductibles of \$100,000 or more, whether the deductible applies per claim, per accident, or in aggregate, and whether pertaining to a Large Deductible policy or a Retrospective Rated policy that contains a large deductible.
 - Other deductible policies that do not qualify as large deductibles should be reported on the traditional Policy Year Call and Calendar-Accident Year call, which are reported on a gross basis.
- Premium reported on this call should include Earned But Unbilled (EBUB) premium if the adjustment can be allocated to the proper policy year. If the adjustment cannot be allocated, then the EBUB premium should be excluded, and the exclusion noted under “Reason for Difference” in the Reconciliation Report (Call RR).
- The data reported in this Call should **include** all your workers compensation large deductible policy year experience unless otherwise specified as an excluded item.
- For further information on experience to include or exclude, refer to the **Additional Requirements for Experience** section (Part 5).
- The data reported in the Call should **exclude** the following experience:
 - Excess Policies
 - Federal (F) Classifications (however, any USL&HW experience associated with industrial classifications should be included)
 - Maritime and other FELA Classifications
 - Assigned Risk experience effective March 1, 1982 and subsequent
 - Reinsurance assumed
 - Terrorism and Catastrophe provisions
 - Adjusting and Other Expenses
 - Special Compensation Fund Assessment
 - Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment
 - Payments to Paid Furloughed Employees
 - Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.
- Detailed definitions and procedures for calculating premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) can be found in the **Financial Call Components** section (Part 4).
- For the methods for reporting this Financial Call, refer to the **Reporting Requirements** section (Part 3).
- This Call is included in the Financial Call Incentive Program (FCIP) and is subject to assessments for late and/or inaccurate reporting. Refer to the **FCIP** section (Part 10).

Row Instructions

- For each row, the **Prior to** line and each individual policy year, report the cumulative premiums, paid losses, claim counts and paid Defense and Cost Containment Expense (DCCE) from the date of policy inception to December 31 of the current reporting year. Report loss reserves and Defense and Cost Containment Expense (DCCE) reserves as of December 31 of the current reporting year.
- For Line X, report the sum of all policy years including the **Prior to** line.

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- For Line Y, report the total on Line X from the previous valuation.
 - For Line Z, show the difference of Line X minus Line Y. This is the calendar year total for the current year.
 - The amount in the loss columns should equal the amount shown on Line Z in the Large Deductible Calendar-Accident Year Call, Call C2.

Column Instructions

Policy Year Accumulated Earned Premium—Standard at MWCIA DSR Level

- Report the Standard Premium at MWCIA Designated Statistical Reporting (DSR) Level generated by the application of large deductible coverage on a gross basis (prior to premium credits) for each of the indicated policy years. This is the standard premium that would be earned using the appropriate MWCIA published loss costs without the application of company loss cost multipliers or rate deviations.
- For every policy with Standard Premium at Company Level, Premium at DSR Level must also be reported.
- For a guide to applicable premium components included in DSR Level Premium, refer to the Premium Component Chart in the **Financial Call Components** section (Part 4). For further details on defining and calculating DSR premium, refer to **Designated Statistical Reporting (DSR) Levels** (Part 6).

Policy Year Accumulated Earned Premium—Standard at Company Level

- Report the Standard Premium at Company Level generated by the application of large deductible coverage on a gross basis (prior to the large deductible credit). This is the full premium that would be earned using the company's selected loss costs, loss cost multipliers, and rate deviations.
- Standard Premium at Company Level differs from the Standard at MWCIA DSR level in that it includes the following:
 - Company selected expense constants
 - Balance to Minimum Premium adjustments
 - Loss cost multiplier and rate deviations
 - Minnesota contractors premium adjustment program (MCPAP)
- Standard Premium at Company Level differs from the Net Premium in that it excludes the following:
 - Premium discounts
 - Schedule rating and other prospective premium adjustments
 - Retrospective rating adjustments
 - Large Deductible credits
 - Certain other adjustments (e.g., Independent Carrier Filing credit/debit adjustments)
- For further details on adjustments and on defining and calculating Standard Premium at Company Level, refer to the **Financial Call Components** section (Part 4).

Policy Year Accumulated Earned Premium—Net

- Report the Net premium. This is the actual net earned premium (net of all deductible credits) on all risks prior to the payments of policyholder dividends, Special Compensation Fund assessments, Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment and terrorism and catastrophic industrial accidents.
- Retrospective premium adjustments are included, but should be assigned to the original year in which the policy was written, not to the year in which the adjustment was made.
- For further details on defining and calculating Net premium, refer to the **Financial Call Components** section (Part 4).

Policy Year—Incurred Indemnity Claim Count

- Include only claims that have either paid indemnity losses, outstanding indemnity loss reserves, or both.
- Do not include medical-only claims, Defense and Cost Containment Expense (DCCE)-only claims or claims closed without payment.
- For further details on defining and calculating the indemnity claim count, refer to the **Financial Call Components** section (Part 4).

Policy Year—Accumulated Paid Indemnity Losses

- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).

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- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Policy Year—Accumulated Paid Medical Losses

- Include paid medical losses for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Indemnity Excluding IBNR

- Report indemnity case loss reserves, plus bulk indemnity loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Medical Excluding IBNR

- Report medical case loss reserves, plus bulk medical loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- Include medical reserves for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—IBNR Indemnity

- Report Incurred But Not Reported (IBNR) indemnity reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—IBNR Medical

- Report Incurred But Not Reported (IBNR) medical reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year Defense and Cost Containment Expense—Accumulated Paid

- The reporting of expenses should be consistent with reporting of paid losses and loss reserves.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

Policy Year Defense and Cost Containment Expense—Case Outstanding

- The reporting of expenses should be consistent with the reporting of paid losses and loss reserves.
- Do not include Incurred But Not Reported (IBNR) or bulk Defense and Cost Containment Expense (DCCE) reserves in this column.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

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Policy Year—Outstanding Indemnity Case Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Indemnity Bulk Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Medical Case Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the medical case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Medical Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Policy Year—Outstanding Medical Bulk Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the medical bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Medical Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

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CALL FOR EXPERIENCE C2—LARGE DEDUCTIBLE CALENDAR-ACCIDENT YEAR CALL

Due Date – April 1

Background

This Call contains statewide data, including voluntary premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) for large deductible policies, grouped by calendar-accident year.

Calendar-accident year refers to how the financial data is organized which is as follows:

- The term “calendar” pertains to premiums organized by transaction date
- The term “accident” pertains to losses organized by the date the claim occurred

For example, the premium associated with premium transactions occurring in Calendar Year 2024, and losses associated with claims with accident dates occurring in 2024, must be reported under year 2024, regardless of the effective date of the underlying policy.

General Instructions

- This Call includes policies with deductible of \$100,000 or more, whether the deductible applies per claim, per accident, or in aggregate, and whether pertaining to a Large Deductible policy or a Retrospective Rated policy that contains a large deductible.
 - Other deductible policies that do not qualify as large deductibles should be reported on the traditional Policy Year Call and Calendar-Accident Year Call, which are reported on a gross basis.
- The data reported in this Call should **include** all of your workers' compensation large deductible calendar-accident year experience on a direct basis, unless otherwise specified as an excluded item.
- The data on Statutory Page 14 of your company's National Association of Insurance Commissioners (NAIC) Annual Statement is used to reconcile the data in this Call.
- For further information on experience to include or exclude, refer to the **Additional Requirements for Experience** section (Part 5).
- Premium reported in this Call should include Earned But Unbilled (EBUB) premium if the adjustment was included on the corresponding Policy Year Call (Call P2). If the adjustment was not included in the corresponding Policy Year Call (e.g., because the adjustment could not be properly allocated by policy year), then the EBUB premium should be excluded from the Calendar-Accident Year Call as well; and the exclusion noted under “Reason for Difference” in the Reconciliation Report (Call RR).
- The data reported in the Call should **exclude** the following experience:
 - Excess Policies
 - Federal (F) Classifications (however, any USL&HW experience associated with industrial classifications should be included)
 - Maritime and other FELA Classifications
 - Assigned Risk experience effective March 1, 1982 and subsequent
 - Reinsurance assumed
 - Terrorism and Catastrophe provisions
 - Adjusting and Other Expenses
 - Special Compensation Fund Assessment
 - Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment
 - Payments to Paid Furloughed Employees
 - Claim experience associated with Extraordinary Loss Event (ELE) Catastrophe Code 12 must be included in all Calls. Catastrophe Code 12 is designated for claims attributable to the COVID-19 (coronavirus) pandemic that occurred during the accident date range of December 1, 2019 through June 30, 2023.
- Detailed definitions and procedures for calculating premiums, losses, claim counts and Defense and Cost Containment Expense (DCCE) can be found in the **Financial Call Components** section (Part 4).
- For the method(s) for reporting this Financial Call, refer to Data Submission Information in the **Reporting Requirements** section (Part 3).

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- This Call is included in the Financial Call Incentive Program (FCIP) and is subject to assessments for late and/or inaccurate reporting. Refer to the **FCIP** section (Part 10)

Row Instructions

- For each row, the **Prior to** line and each individual year, report the cumulative premiums, paid losses, claim counts and paid DCCE from the date of accident through December 31 of the current reporting year. Report loss reserves and DCCE reserves as of December 31 of the current reporting year. Report premium by transaction date for the most recent five calendar years only (do not report in any cells where there is shading).
- For Line X, in the loss columns, report the sum of all years including the **Prior to** line. For the premium columns leave Line X blank (do not report in any cells where there is shading).
- For Line Y, in the loss columns, report the total on Line X from the previous valuation. For the premium columns, leave Line Y blank (do not report in any cells where there is shading).
- For Line Z, in the loss columns, show the difference of Line X minus Line Y. This is the calendar year total for the current year.
 - For the premium columns, leave Line Z blank (do not report in any cells where there is shading).
 - The Net Earned Premium, the total of paid losses, the total of incurred losses and the total of DCCE paid should reconcile with the amount reported on your company's National Association of Insurance Commissioners (NAIC) Annual Statement, Statutory Page 14.
 - The amounts in the loss columns should equal the amounts shown on Line Z in the Policy Year Call, Call P2.

Column Instructions

Calendar Year Accumulated Earned Premium—Standard at MWCIA DSR Level

- Report the Standard Premium at MWCIA Designated Statistical Reporting (DSR) Level generated by the application of large deductible coverage on a gross basis (prior to premium credits) for each of the indicated calendar years. This is the standard premium that would be earned using the appropriate MWCIA published loss costs without the application of company loss cost multipliers or rate deviations.
- For every year with Standard Premium at Company Level, Premium at DSR Level must also be reported.
- For a guide to applicable premium components included in DSR Level Premium, refer to the Premium Component Chart in the **Financial Call Components** section (Part 4). For further details on defining and calculating DSR premium, refer to **Designated Statistical Reporting (DSR) Levels** (Part 6).
- This Call requires only the most recent five years of calendar year premium reported in this column, because the earlier calendar year premiums are not critical to the ratemaking process. Only report data in the rows for the most recent five years (do not report any cells where there is shading).
- Premium for the most recent calendar year row should match the Line Z premium of the corresponding Large Deductible Policy Year Call (Call P2).
- Premium for the prior four calendar year rows should match the premium for the same calendar year on last year's Large Deductible Calendar-Accident Year Call.

Calendar Year Accumulated Earned Premium—Standard at Company Level

- Report the Standard Premium at Company Level generated by the application of large deductible coverage on a gross basis (prior to the large deductible credit). This is the full premium that would be earned using the company's selected loss costs, loss cost multipliers, and rate deviations.
- This Call requires only the most recent five years of calendar year premium reported in this column, because the earlier calendar year premiums are not critical to the ratemaking process. Only report data in the rows for the most recent five years (do not report any cells where there is shading).
- Premium for the most recent calendar year row should match the Line Z premium of the corresponding Large Deductible Policy Year Call (Call P2).
- Premium for the prior four calendar year rows should match the premium for the same calendar year on last year's Large Deductible Calendar-Accident Year Call.
- Standard Premium at Company Level differs from the Standard at MWCIA DSR level in that it includes the following:
 - Company selected expense constants
 - Balance to Minimum Premium adjustments

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- Loss cost multiplier and rate deviations
 - Minnesota contractors premium adjustment program (MCPAP)
- Standard Premium at Company Level differs from the Net Premium in that it excludes the following:
 - Premium discounts
 - Schedule rating and other prospective premium adjustments
 - Retrospective rating adjustments
 - Large Deductible credits
 - Certain other adjustments (e.g., Independent Carrier Filing credit/debit adjustments)
- For further details on adjustments and on defining and calculating Standard Premium at Company Level, refer to the **Financial Call Components** section (Part 4).

Calendar Year Accumulated Earned Premium—Net

- Report the Net premium. This is the actual net earned premium (net of all deductible credits) on all risks prior to the payments of policyholder dividends, Special Compensation Fund assessments, Workers' Compensation Reinsurance Association Policyholder Deficiency Assessment and terrorism and catastrophic industrial accidents.
- This Call requires only the most recent five years of calendar year premium reported in this column, because the earlier calendar year premiums are not critical to the ratemaking process. Only report data in the rows for the most recent five years (do not report any cells where there is shading).
- Premium for the most recent calendar year row should match the Line Z premium of the corresponding Large Deductible Policy Year Call (Call P2).
- Premium for the prior four calendar year rows should match the premium for the same calendar year on last year's Large Deductible Calendar-Accident Year Call.
- Retrospective premium adjustments are included, but should be assigned to the calendar year in which the adjustment was made.
- For further details on defining and calculating Net premium, refer to the **Financial Call Components** section (Part 4).

Accident Year—Incurred Indemnity Claim Count

- Include only claims that have either paid indemnity losses, outstanding indemnity loss reserves, or both.
- Do not include medical-only claims, Defense and Cost Containment Expense (DCCE)-only claims or claims closed without payment.
- For further details on defining and calculating the indemnity claim count, refer to the **Financial Call Components** section (Part 4).

Accident Year—Accumulated Paid Indemnity Losses

- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Accident Year—Accumulated Paid Medical Losses

- Include paid medical losses for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.
- When a claim involves a lump sum, report the actual lump sum amount subdivided into indemnity and medical, accordingly.
- For further details on defining paid losses, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Indemnity Excluding IBNR

- Report indemnity case loss reserves, plus bulk indemnity loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.

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- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Medical Excluding IBNR

- Report medical case loss reserves, plus bulk medical loss reserves if your company does not include bulk reserves with Incurred But Not Reported (IBNR) reserves.
- Include medical reserves for medical-only claims as well as medical losses for claims with indemnity losses.
- Include contract medical dollars.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—IBNR Indemnity

- Report Incurred But Not Reported (IBNR) indemnity reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—IBNR Medical

- Report Incurred But Not Reported (IBNR) medical reserves for all claims. IBNR may include bulk reserves depending on the carrier method of reporting bulk.
- For further details on defining bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year Defense and Cost Containment Expense—Accumulated Paid

- The reporting of expenses should be consistent with reporting of paid losses and loss reserves.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

Accident Year Defense and Cost Containment Expense—Case Outstanding

- The reporting of expenses should be consistent with the reporting of paid losses and loss reserves.
- Do not include Incurred But Not Reported (IBNR) or bulk Defense and Cost Containment Expense (DCCE) reserves in this column.
- For further details on defining Defense and Cost Containment Expense, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Indemnity Case Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Indemnity Bulk Excluding IBNR

- This column should be completed only if your company included bulk reserves in the Outstanding Indemnity Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Indemnity Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the indemnity bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Indemnity Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

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Accident Year—Outstanding Medical Case Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the medical case reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Medical Case Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

Accident Year—Outstanding Medical Bulk Excluding IBNR

- This column should be completed only if your company reported bulk reserves in the Outstanding Medical Excluding IBNR column.
- If your company includes bulk reserves in the Outstanding Medical Excluding IBNR column then respond **No** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and fill in the medical bulk reserves only.
- If your company includes bulk reserves with IBNR, then respond **Yes** to the question in Note A on the “Bulk in IBNR” tab in ACCEDE and leave Outstanding Medical Bulk Excluding IBNR blank.
- For further details on defining case reserves, bulk reserves, and IBNR reserves, refer to the **Financial Call Components** section (Part 4).

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CALL FOR EXPERIENCE RR—RECONCILIATION REPORT FOR CALENDAR YEAR DATA

Due Date – April 1

Background

The Reconciliation Report reconciles data that MWCIA uses for ratemaking with data reported on your company's National Association of Insurance Commissioners (NAIC) Annual Statement Statutory Page 14.

General Instructions

- **Reconciliation Requirement**—The Call must reconcile data reported on the Exhibit of Premiums and Losses (Statutory Page 14) of your company's NAIC Annual Statement with calendar year data reported to MWCIA on the Calendar-Accident Year Call—most recent reporting (Net Premium) and Line Z (losses and expenses).
- **Reconciliation Items**—Certain items, reported in the Statutory Page 14 data of your company's NAIC Annual Statement, must be separately reported as reconciliation items since they are not included in the Calendar-Accident Year Call reported to MWCIA.
- **Reason for Difference**—If the calendar year data from the Calendar-Accident Year Call (Call C1) plus the Large Deductible Calendar-Accident Year Call (Call C2) adjusted for the reconciliation items does not equal the amount reported on the Exhibit of Premiums and Losses (Statutory Page 14) of your company's NAIC Annual Statement, you must provide a detailed explanation for the difference.
- For the methods of reporting this Financial Call, refer to the **Reporting Requirements** section (Part 3).

Column Instructions

Direct Earned Premium

- Report premiums earned on a direct basis with respect to reinsurance.
- Report amounts in whole dollars only.

Direct Losses—Paid

- Report paid losses on a direct basis with respect to reinsurance.
- Report amounts in whole dollars only.

Direct Losses—Incurred

- Report incurred losses on a direct basis with respect to reinsurance.
- Report amounts in whole dollars only.

Direct Defense and Cost Containment Expenses—Paid

- Report paid Defense and Cost Containment Expense on a direct basis with respect to reinsurance.
- Report amounts in whole dollars only.

Row Instructions

Row 1—Industrial Classifications—Excluding Large Deductible Policies

- For Net Earned premium, enter Calendar-Accident Year Call (C1), Net Earned Premium amount from most recent reporting year.
- For Paid Losses, enter the sum of Accumulated Paid Indemnity Losses plus Accumulated Paid Medical Losses from the Calendar-Accident Year Call (C1), Line Z.
- For Incurred Losses, enter the total incurred losses from Calendar-Accident Year Call (C1), Line Z.
For Direct Defense and Cost Containment Expense (DCCE) Paid, enter the total paid DCCE from the Calendar-Accident Year Call (C1), Line Z amount.

Row 2—Industrial Classifications—Large Deductible Policies

- For Net Earned premium, enter Large Deductible Calendar-Accident Year Call (C2), Net Earned Premium, amount from most recent reporting year.

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- For Paid Losses, enter the sum of Accumulated Paid Indemnity Losses plus Accumulated Paid Medical Losses from the Large Deductible Calendar-Accident Year Call (C2), Line Z.
 - For Incurred Losses, enter the total incurred losses from Large Deductible Calendar-Accident Year Call (C2), Line Z.
 - For Direct Defense and Cost Containment Expense (DCCE) Paid, enter the total paid DCCE from the Calendar-Accident Year Call (C2), Line Z amount.

Row 3—Total (1) + (2)

Row 4—F-Classifications—including Large Deductible Policies on a Net Basis

- Include experience (premium, losses and expenses) for F-classifications. This does not include United States Longshore and Harbor Workers' Act (USL&HW) experience associated with industrial classification because additional experience should be included in Rows 1 and 2. For the list of F-classification codes, refer to the **Minnesota Ratemaking Report**.

Row 5—Maritime and Other FELA Classifications—including Large Deductible Policies on a Net Basis

- Include premium, losses and expenses for Maritime and other FELA classification. For the list of Maritime and other FELA classification codes, refer to the **Minnesota Ratemaking Report**.

Row 6—National Defense Projects Experience—including Large Deductible Policies on a Net Basis

- Include premiums, losses and expenses for policies written under the National Defense Projects Rating Plan.

Row 7—Large Deductible Policies—Difference

- Report the difference between gross amounts reported to MWCIA and net amounts reported on your company's NAIC Annual Statement.
- Report for losses and expenses only, not for premium.
- The direct incurred losses for large deductibles included on Line 2 should be reported on a gross basis.
- Since the losses reported on your company's NAIC Annual Statement are on a net basis, report the difference between gross losses reported to MWCIA and net losses reported on your company's NAIC Annual Statement as a reconciliation item on Line 7.
- For this Call, large deductible policies are defined as policies with deductibles of \$100,000 or more per claim, per accident, or in aggregate.

Row 8—Small Deductible Policies—Difference

- Report the difference between gross amounts reported to MWCIA and net amounts reported on your company's NAIC Annual Statement.
- Report for losses and expenses only, not for premium.
- The direct incurred losses for small deductibles included on Line 1 should be reported on a gross basis.
- Since the losses reported on your company's NAIC Annual Statement are on a net basis, report the difference between gross losses reported to MWCIA and net losses reported on your company's NAIC Annual Statement as a reconciliation item on Line 8.
- For this Call, small deductibles are defined as deductibles of less than \$100,000, whether on a per claim, per accident, or aggregate basis.

Row 9—Excess Policies

- Report premium, losses and expenses for excess policies.

Row 10—Terrorism and Catastrophe Provision Premium

- Include premiums for catastrophe provisions.
- Note: Catastrophe Provisions include the following:
 - Terrorism Risk Insurance Act, Terrorism Risk Insurance Extension Act and Terrorism Risk Insurance Program Reauthorization Act premium reported in Statistical Code 9740.
 - Other catastrophe premium

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Row 11—Total (3) + (4) + (5) + (6) – (7) – (8) + (9) + (10)

Row 12—Exhibit of Premiums and Losses (Statutory Page 14 data)

- Report workers compensation earned premiums, paid losses, incurred losses and Defense and Cost Containment Expense paid from Statutory Page 14 of your company's NAIC Annual Statement.

Row 13—Difference (12) – (11)

- Calculate the difference by subtracting Row 11 from Row 12.
- Any necessary explanations should be addressed in the applicable rows, Rows 14 through 17.

Row 14—Reason for Difference—Premium Earned

- Provide an explanation for the difference in Premium Earned.

Row 15—Reason for Difference—Losses Paid

- Provide an explanation for the difference in Losses Paid.

Row 16—Reason for Difference—Losses Incurred

- Provide an explanation for the difference in Losses Incurred.

Row 17—Reason for Difference—Defense and Cost Containment Expense Paid

- Provide an explanation for the difference in Defense and Cost Containment Expense Paid.

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CALL FOR EXPERIENCE LL—LARGE LOSS AND CATASTROPHE CALL

Due Date – April 1

Background

The Large Loss and Catastrophe Call includes:

- Large loss claims where total case incurred losses (the sum of indemnity paid and indemnity case reserves plus medical paid and medical case reserves) are \$500,000 or greater.
- Extraordinary Loss Event claims that are assigned unique catastrophe numbers. All catastrophe-related claims with loss dollars greater than or equal to \$1 are to be reported in this call. Please refer to the NCCI for a list of all Extraordinary Loss Event codes and descriptions. **Claims reported with new ELE Catastrophe Number 12, which are attributable to COVID-19 (coronavirus), must be included.**

For further information on the reporting of a specific catastrophe, refer to the Circular for that catastrophe number on mwcia.org.

General Instructions

- Report all large loss claims where total case incurred losses (i.e., sum of indemnity paid, indemnity case, medical paid, and medical case) are greater than or equal to \$500,000 at the time of valuation; this includes medical-only claims.

Example:

A claim occurred in 1990 and then closed in 1992. The incurred indemnity was \$400,000 and the incurred medical was \$200,000. This claim should be reported for data valued as of December 31 of the most recent reporting year.

- Do not report Large Loss claims with total case incurred losses (i.e., sum of indemnity paid, indemnity case, medical paid, and medical case) for the current valuation and subsequent valuations in which the claim(s) drop below \$500,000. These claims would continue to be captured in the prior valuations where they were equal to or greater than this \$500,000 threshold.
- Report all Extraordinary Loss Event claims (as of December 31 of the most recent reporting year), regardless of the size of the claim.
- The losses and Defense and Cost Containment Expense (DCCE) reported on this Call must be consistent with the statewide experience included on the standard Policy Year Call (Call P1), Calendar-Accident Year Call (Call C1), Policy Year Large Deductible Call (Call P2), and Calendar-Accident Year Large Deductible Call (Call C2).
- Report claims individually; claims cannot be grouped.
- Include closed, open, and reopened claims.
- Include medical-only claims.
- Include a claim number for each claim reported.
- Report loss amounts net of second injury fund and other recoveries such as subrogation.
- Report loss amounts gross of deductible reimbursements, consistent with the Policy and Calendar-Accident Year Calls.
- Case Outstanding may include or exclude statutorily allowable discounting, as long as the approach is consistent with the Policy and Calendar-Accident Year Calls.
- Carriers that have merged companies should report amounts consistent with their other Financial Call reporting.
- The data reported in this Call should **include** large deductible claims.
- The data reported in this Call should **exclude** the following experience:
 - Excess Policies
 - Federal (F) Classifications (however, any USL&HW experience associated with industrial classifications should be included)
 - Maritime and other FELA Classifications
 - Assigned Risk experience effective March 1, 1982 and subsequent

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- Reinsurance assumed
 - Adjusting and Other Expenses
- For further details on specific included or excluded experience, refer to the **Additional Requirements For Experience** section (Part 5).
- For the methods for reporting this Financial Call, refer to Data Submission Information in the **Reporting Requirements** section (Part 3).

Column Instructions

Claim Number

- Report the claim number assigned to the claim.
- Claim numbers must be reported consistently from one valuation to the next.

Note: Claims cannot be grouped.

Policy Number

- Report the policy number associated with the claim.
- Policy numbers must be reported consistently from one valuation to the next.

Catastrophe Number

- Report the Catastrophe Number for all Extraordinary Loss Events, regardless of the size of the claim.
- Claims not associated with an Extraordinary Loss Event should be populated with zero (0).

Policy Effective Date

- Report the date of inception for the policy associated with the claim. In the case of multiyear policies, the date of inception should be consistent with company reporting for the standard Policy Year Call (Call P1) or Large Deductible Policy Year Call (Call P2).

Note: For Calls P1 and P2, multiyear policies may be reported either as one policy with a single effective date or as separate policies with individual effective dates for each of the annual components. However, except for the case of Three-Year Fixed Rate policies, separation into annual policies is encouraged to maintain consistency with *Minnesota Statistical Plan Manual* reporting requirements.

Accident Date

- Report the date the large loss or catastrophe claim occurred.

Claim Status Code

- Indicate status of the claim as:
 - 0—Open
 - 1—Closed
 - 2—Reopened

Accumulated Paid Losses—Indemnity

- Report the accumulated indemnity paid loss associated with the claim valued as of December 31 of the most recent year. This applies to all open and closed claims.
- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.

Accumulated Paid Losses—Medical

- Report the accumulated medical paid loss associated with the claim valued as of December 31 of the most recent year. This applies to all open and closed claims.
- Paid losses should be reported net of subrogation (e.g., recoveries from second injury funds).
- Paid losses should be reported gross of deductible reimbursements.

Case Outstanding—Indemnity

- Report the indemnity case reserve associated with the claim as of December 31 of the most recent year.

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Case Outstanding—Medical

- Report the medical case reserve associated with the claim as of December 31 of the most recent year.

Accumulated Paid—Defense and Cost Containment Expense

- Report the accumulated paid Defense and Cost Containment Expense associated with the claim as of December 31 of the most recent year.

Case Outstanding—Defense and Cost Containment Expense

- Report the case reserve for Defense and Cost Containment Expense associated with the claim as of December 31 of the most recent year.

Note: If you do not set case reserves for Defense and Cost Containment Expense, report zero (0).

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PART 9—FINANCIAL CALL EDITING

MWCIA's editing process is performed to ensure that the data submitted is consistent with reporting requirements and that it meets quality standards. The editing process is also referred to as the validation process, which is a key component in the workflow when preparing to submit your Financial Calls.

An edit is the system quality check performed to verify the validity of the data. Each edit informs the data provider of one or more potential errors. Financial Call edits are performed on all the columns of data of each Financial Call.

It is necessary to respond to all edit validation inquiries to ensure the availability of usable data. Addressing errors is also necessary to avoid potential penalties administered through MWCIA's Financial Call Incentive Plan (FCIP). Monetary assessments may be levied on data providers for specific errors.

A. Edit Types

Financial Call edits are divided into two categories: Basic and Actuarial.

Basic Edits are designed to identify conditions that can only occur as the result of an error or omission and can be determined based upon a comparison of data elements on one or more Financial Calls.

Actuarial Edits are the subjective edits involving unusual loss ratios, DSR to standard ratios, etc. Values outside the expected parameters for these edits do not necessarily indicate that the data is incorrect, and upon investigation an adequate explanation may be provided.

B. Edit Descriptions

The following are Basic and Actuarial Edit descriptions for general reference. These lists are provided to assist the carriers in identifying common types of edit failures. It should be noted that Actuarial Edit standards are not rigid criteria, but rather identify situations requiring an explanation of further investigation to verify accuracy. Edit failures will not result in an assessment if the data is correct, but an explanation of why the data falls outside the norms will greatly assist us in accepting the submission without necessary delay. **Also, the edit descriptions are not all-inclusive; there may be other types of data problems which could result in the carrier failing an Actuarial Edit and incurring assessments.**

BASIC EDITS

Policy Year (Traditional & Large Deductible) Call

1. N/A
2. N/A
3. N/A
4. N/A
5. N/A
6. If the response to NOTE A on the "Bulk in IBNR" tab of ACCEDE is "No" then:
 - a. The sum of Outstanding Excluding IBNR Indemnity Case and Outstanding Excluding IBNR Indemnity Bulk must equal Outstanding Excluding IBNR Indemnity, and
 - b. The sum of Outstanding Excluding IBNR Medical Case and Outstanding Excluding IBNR Medical Bulk must equal Outstanding Excluding IBNR Medical.
7. The sum of Incurred Indemnity Claim Count—Accumulated Closed (Paid) plus Incurred Indemnity Claim Count—Open (Outstanding) must equal the Incurred Indemnity Claim Count (mandatory reporting for Policy Years 1993 and subsequent).
8. Line (Y) from the current Call must equal line (X) from the preceding Policy Year Call.
9. N/A
10. For all columns, all data items must be non-negative.
11. For any policy year where losses or Defense and Cost Containment Expense (DCCE) are reported, there must be corresponding earned premium reported the premium columns.
12. Incurred Indemnity Claim Count amount reported must be greater than zero, if either Accumulated Paid Indemnity Losses or Outstanding Indemnity Excluding IBNR Losses are reported.

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13. If there are no indemnity losses reported in both Accumulated Paid Indemnity Losses or Outstanding Indemnity Excluding IBNR Losses, then the Incurred Indemnity Claim Count should be zero.
 14. For policy years where the reporting of open and closed incurred indemnity claims counts is mandatory, the following conditions must hold:
 - a. If the amount reported in Incurred Indemnity Claim Count—Accumulated Closed (Paid) is greater than zero, then Accumulated Paid Indemnity Losses must be greater than zero. (If there are closed claims, there should be associated paid indemnity amounts.)
 - b. If Accumulated Paid Indemnity Losses equals zero, then the Incurred Indemnity Claim Count—Accumulated Closed (Paid) must equal zero. (If there is no paid indemnity, there should be no closed claims.)
 - c. If Incurred Indemnity Claim Count—Open (Outstanding) is greater than zero, then Outstanding Indemnity Excluding IBNR, Outstanding Medical Excluding IBNR or Defense and Cost Containment Expense (DCCE) Case Outstanding should be greater than zero. (If there are open claims, there must be case reserves.)
 - d. If Incurred Indemnity Claim Count—Open (Outstanding) is equal to zero, then Outstanding Indemnity Excluding IBNR should equal zero unless only bulk reserves are being reported. (If there are no open claims, then there should be no indemnity case reserves.)
 - e. Incurred Indemnity Claim Count—Accumulated Closed (Paid) and Incurred Indemnity Claim Count—Open (Outstanding) must each be greater than or equal to zero.
 15. N/A
 16. N/A
 17. The most current calendar year premium reported on the Calendar-Accident Year calls must equal the calendar year premium reported on Line Z of the Policy Year Calls.

Calendar-Accident Year (Traditional & Large Deductible) Calls

1. N/A
2. N/A
3. N/A
4. N/A
5. N/A
6. If the response to NOTE A on the "Bulk in IBNR" tab of ACCEDE is "No" then:
 - a. The sum of Outstanding Excluding IBNR Indemnity Case and Outstanding Excluding IBNR Indemnity Bulk must equal Outstanding Excluding IBNR Indemnity, and
 - b. The sum of Outstanding Excluding IBNR Medical Case and Outstanding Excluding IBNR Medical Bulk must equal Outstanding Excluding IBNR Medical.
7. The sum of Incurred Indemnity Claim Count—Accumulated Closed (Paid) plus Incurred Indemnity Claim Count—Open (Outstanding) must equal the Incurred Indemnity Claim Count (mandatory reporting for Accident Year 1993 and subsequent).
8. Line (Y) from current Call must equal line (X) from the preceding Calendar-Accident Year Call.
9. N/A
10. For each calendar-accident year, the premium reported must equal the corresponding premium from last year's Call for the same calendar-accident year.
11. For all loss and claim count columns, all data items must be non-negative.
12. For the latest five calendar-accident years, where incurred losses or Defense and Cost Containment Expense (DCCE) are reported there must be corresponding earned premium reported in the premium columns.
13. Incurred Indemnity Claim Count amount reported must be greater than zero, if either Accumulated Paid Indemnity Losses or Outstanding Indemnity Excluding IBNR Losses are reported.
14. If there are no indemnity losses reported in both Accumulated Paid Indemnity Losses or Outstanding Indemnity Excluding IBNR Losses, then the Incurred Indemnity Claim Count should be zero.
15. For policy years where the reporting of open and closed incurred indemnity claims counts is mandatory, the following conditions must hold:
 - a. If the amount reported in Incurred Indemnity Claim Count—Accumulated Closed (Paid) is greater than zero, then Accumulated Paid Indemnity Losses must be greater than zero. (If there are closed claims, there should be associated paid indemnity amounts.)
 - b. If Accumulated Paid Indemnity Losses equals zero, then the Incurred Indemnity Claim Count—Accumulated Closed (Paid) must equal zero. (If there is no paid indemnity, there should be no closed claims.)

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- c. If Incurred Indemnity Claim Count—Open (Outstanding) is greater than zero, then Outstanding Indemnity Excluding IBNR, Outstanding Medical Excluding IBNR or Defense and Cost Containment Expense (DCCE) Case Outstanding should be greater than zero. (If there are open claims, there must be case reserves.)
 - d. If Incurred Indemnity Claim Count—Open (Outstanding) is equal to zero, then Outstanding Indemnity Excluding IBNR should equal zero unless only bulk reserves are being reported. (If there are no open claims, then there should be no indemnity case reserves.)
 - e. Incurred Indemnity Claim Count—Accumulated Closed (Paid) and Incurred Indemnity Claim Count—Open (Outstanding) must each be greater than or equal to zero.
16. N/A

ACTUARIAL EDITS

Policy Year Calls

1. For DSR premium, the ratio of the premium on the current **traditional** Call for a specific policy year to the premium on the preceding **traditional** Call for the same policy year should fall within tolerance.
2. For DSR premium, the ratio of the premium on the current **large deductible** Call for a specific policy year to the premium on the preceding **large deductible** Call for the same policy year should fall within tolerance.
3. For Net Earned premium, the ratio of the premium on the current **traditional** Call for a specific policy year to the premium on the preceding **traditional** Call for the same policy year should fall within tolerance.
4. For Net Earned premium, the ratio of the premium on the current **large deductible** Call for a specific policy year to the premium on the preceding **large deductible** Call for the same policy year should fall within tolerance.
5. For Indemnity Claim Count, the ratio of counts on the current **traditional** Call for a specific policy year to the counts on the preceding **traditional** Call for the same policy year should fall within tolerance.
6. For Indemnity Claim Count, the ratio of counts on the current **large deductible** Call for a specific policy year to the counts on the preceding **large deductible** Call for the same policy year should fall within tolerance.
7. For Paid Indemnity Losses, the ratio of losses on the current **traditional** Call for a specific policy year to the losses on the preceding **traditional** Call for the same policy year should fall within tolerance.
8. For Paid Indemnity Losses, the ratio of losses on the current **large deductible** Call for a specific policy year to the losses on the preceding **large deductible** Call for the same policy year should fall within tolerance.
9. For Paid Medical Losses, the ratio of losses on the current **traditional** Call for a specific policy year to the losses on the preceding **traditional** Call for the same policy year should fall within tolerance.
10. For Paid Medical Losses, the ratio of losses on the current **large deductible** Call for a specific policy year to the losses on the preceding **large deductible** Call for the same policy year should fall within tolerance.
11. For Paid + Case Indemnity Losses, the ratio of losses on the current **traditional** Call for a specific policy year to the losses on the preceding **traditional** Call for the same policy year should fall within tolerance.
12. For Paid + Case Indemnity Losses, the ratio of losses on the current **large deductible** Call for a specific policy year to the losses on the preceding **large deductible** Call for the same policy year should fall within tolerance.
13. For Paid + Case Medical Losses, the ratio of losses on the current **traditional** Call for a specific policy year to the losses on the preceding **traditional** Call for the same policy year should fall within tolerance.
14. For Paid + Case Medical Losses, the ratio of losses on the current **large deductible** Call for a specific policy year to the losses on the preceding **large deductible** Call for the same policy year should fall within tolerance.
15. The ratio of Standard Earned Premium at Company Level to the DSR premium for both the traditional and large deductible Policy Year Calls should fall within tolerance around the Loss Cost Multiplier (LCM) reported on the LCM screen.
16. For all loss columns, the calendar year experience on both the traditional and large deductible Policy Year Calls should equal the calendar year experience on the traditional and large deductible Calendar-Accident Year Calls for the corresponding column. [Line (Z) on the Policy Year Calls should equal lines (Z) on the Calendar-Accident Year Calls.]
17. For Paid Indemnity Losses, all lines will be checked when the losses on the current **traditional** Policy Year Calls for a specific policy year are less than the losses on the preceding **traditional** Policy Year Calls for the same policy year.
18. For Paid Indemnity Losses, all lines will be checked when the losses on the **current large deductible** Policy Year Calls for a specific policy year are less than the losses on the preceding **large deductible** Policy Year Calls for the same policy year.

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19. For Paid Medical Losses, all lines will be checked when the losses on the current **traditional** Policy Year Calls for a specific policy year are less than the losses on the preceding **traditional** Policy Year Calls for the same policy year.
 20. For Paid Medical Losses, all lines will be checked when the losses on the current **large deductible** Policy Year Calls for a specific policy year are less than the losses on the preceding **large deductible** Policy Year Calls for the same policy year.
 21. The **traditional** Policy Year Calls Paid + Case Indemnity Loss severity is checked when the severity is outside the expected range.
 22. The **large deductible** Policy Year Calls Paid + Case Indemnity Loss severity is checked when the severity is outside the expected range.
 23. The **traditional** Policy Year Calls Paid + Case Medical Loss severity is checked when the severity is outside the expected range.
 24. The **large deductible** Policy Year Calls Paid + Case Medical Loss severity is checked when the severity is outside the expected range.
 25. The **traditional** Policy Year Calls Indemnity frequency per \$1 million of standard company level premium is checked when the frequency is outside the expected range.
 26. The **large deductible** Policy Year Calls Indemnity frequency per \$1 million of standard company level premium is checked when the frequency is outside the expected range.
 27. When the sum of Paid + Case Indemnity and Medical losses is greater than zero, the Paid + Case Defense and Cost Containment Expense (DCCE) is also expected to be greater than zero on both the traditional and large deductible Policy Year Calls
 28. The ratio of Paid Defense and Cost Containment Expense (DCCE) to Paid Indemnity and Medical Losses is checked when the ratio is outside of the expected range on both the traditional and large deductible Policy Year Calls.
 29. The ratio of Paid + Case Defense and Cost Containment Expense (DCCE) to Paid + Case Indemnity and Medical Losses is checked when the ratio is outside of the expected range on both the traditional and large deductible Policy Year Calls.

Calendar-Accident Year Calls

1. For Indemnity Claim Count, the ratio of counts on the current **traditional** Call for a specific accident year to the counts on the preceding **traditional** Call for the same accident year should fall within tolerance.
2. For Indemnity Claim Count, the ratio of counts on the current **large deductible** Call for a specific accident year to the counts on the preceding **large deductible** Call for the same accident year should fall within tolerance.
3. For Paid Indemnity Losses, the ratio of losses on the current **traditional** Call for a specific accident year to the losses on the preceding **traditional** Call for the same accident year should fall within tolerance.
4. For Paid Indemnity losses, the ratio of losses on the current **large deductible** Call for a specific accident year to the losses on the preceding **large deductible** Call for the same accident year should fall within tolerance.
5. For Paid Medical Losses, the ratio of losses on the current **traditional** Call for a specific accident year to the losses on the preceding **traditional** Call for the same accident year should fall within tolerance.
6. For Paid Medical Losses, the ratio of losses on the current **large deductible** Call for a specific accident year to the losses on the preceding **large deductible** Call for the same accident year should fall within tolerance.
7. For Paid + Case Indemnity Losses, the ratio of losses on the current **traditional** Call for a specific accident year to the losses on the preceding **traditional** Call for the same accident year should fall within tolerance.
8. For Paid + Case Indemnity Losses, the ratio of losses on the current **large deductible** Call for a specific accident year to the losses on the preceding **large deductible** Call for the same accident year should fall within tolerance.
9. For Paid + Case Medical Losses, the ratio of losses on the current **traditional** Call for a specific accident year to the losses on the preceding **traditional** Call for the same accident year should fall within tolerance.
10. For Paid + Case Medical Losses, the ratio of losses on the current **large deductible** Call for a specific accident year to the losses on the preceding **large deductible** Call for the same accident year should fall within tolerance.
11. N/A
12. For Paid Indemnity Losses, all lines will be checked when the losses on the current **traditional** Calendar-Accident Year Call for a specific accident year are less than the losses on the preceding **traditional** Calendar-Accident Year Call for the same accident year.

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13. For Paid Indemnity Losses, all lines will be checked when the losses on the current **large deductible** Calendar-Accident Year Calls for a specific accident year are less than the losses on the preceding **large deductible** Calendar-Accident Year Calls for the same accident year.
 14. For Paid Medical Losses, all lines will be checked when the losses on the current **traditional** Calendar-Accident Year Calls for a specific accident year are less than the losses on the preceding **traditional** Calendar-Accident Year Calls for the same accident year.
 15. For Paid Medical Losses, all lines will be checked when the losses on the current **large deductible** Calendar-Accident Year Calls for a specific accident year are less than the losses on the preceding **large deductible** Calendar-Accident Year Calls for the same accident year.
 16. The **traditional** Calendar-Accident Year Calls Paid + Case Indemnity Loss severity is checked when the severity is outside the expected range.
 17. The **large deductible** Calendar-Accident Year Calls Paid + Case Indemnity Loss severity is checked when the severity is outside the expected range.
 18. The **traditional** Calendar-Accident Year Calls Paid + Case Medical Loss severity is checked when the severity is outside the expected range.
 19. The **large deductible** Calendar-Accident Year Calls Paid + Case Medical Loss severity is checked when the severity is outside the expected range.
 20. The **traditional** Calendar-Accident Year Calls Indemnity frequency per \$1 million of standard company level premium is checked when the frequency is outside the expected range.
 21. The **large deductible** Calendar-Accident Year Calls Indemnity frequency per \$1 million of standard company level premium is checked when the frequency is outside the expected range.
 22. When the sum of Paid + Case Indemnity and Medical losses is greater than zero, the Paid + Case Defense and Cost Containment Expense (DCCE) is also expected to be greater than zero on both the traditional and large deductible Policy Year Calls
 23. The ratio of Paid Defense and Cost Containment Expense (DCCE) to Paid Indemnity and Medical Losses is checked when the ratio is outside of the expected range on the traditional and large deductible Policy Year Calls.
 24. The ratio of Paid + Case Defense and Cost Containment Expense (DCCE) to Paid + Case Indemnity and Medical Losses is checked when the ratio is outside of the expected range on the traditional and large deductible Policy Year Calls.

Supplemental Call for Schedule Rating Adjustments

1. Line G must equal the calendar year Standard Earned Premium at Company Level reported on the Policy Year Call P1, Line Z.
2. When the Standard Earned Premium at Company Level is greater than zero for a policy year on the Policy Year Call P1, the premium reported for the same policy year on the Schedule Rating Call SR should also be greater than zero.
3. When the Standard Earned Premium at Company Level is zero for a policy year on the Policy Year Call P1, the premium reported for the same policy year on the Schedule Rating Call SR is also expected to be zero.
4. N/A
5. Line F is expected to be greater than zero when the sum of Lines D and E is greater than zero.

Reconciliation Report

1. Net Earned Premium in row 1 must equal Calendar-Accident Year Call (C1) Net Earned Premium from the most recent reporting year.
2. Direct Losses Paid in row 1 must equal the sum of Accumulated Paid Indemnity Losses plus Accumulated Paid Medical Losses from Calendar-Accident Year Call (C1), Line Z.
3. Direct losses Incurred in row 1 must equal the total incurred losses from Calendar-Accident Year Call (C1), Line Z.
4. Paid Defense and Cost Containment Expense (DCCE) in row 1 must equal the total DCCE Paid losses from Calendar-Accident Year Call (C1), Line Z.
5. Net Earned Premium in row 2 must equal Large Deductible Calendar-Accident Year Call (C2), Net Earned Premium from the most recent reporting year.
6. Direct Losses Paid in row 2 must equal the sum of Accumulated Paid Indemnity Losses plus Accumulated Paid Medical Losses from Large Deductible Calendar-Accident Year Call (C2), Line Z.

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7. Direct losses Incurred in row 2 must equal the total incurred losses from Large Deductible Calendar-Accident Year Call (C2), Line Z.
 8. Paid Defense and Cost Containment Expense (DCCE) in row 2 must equal the total DCCE Paid losses from Large Deductible Calendar-Accident Year Call (C2), Line Z.
 9. If the difference shown in row 13 is not equal to zero, an explanation must be provided in the respective row 14, 15, 16 and/or 17.
 10. Row 2 must be blank if there is no experience to report on the Large Deductible Calendar-Accident Year Call (C2).
 11. Row 7 must be blank if there is no experience to report on the Large Deductible Calendar-Accident Year Call (C2).

Large Loss and Catastrophic Call

1. The Accident Date must be greater than Policy Effective Date, but less than the Policy Effective Date + 36 months.
2. When the sum of Paid Indemnity Losses plus Case Outstanding Indemnity is greater than \$500,000, the sum of Paid Medical Losses plus Case Outstanding Medical is expected to be greater than zero.
3. When the sum of Paid Medical Losses plus Case Outstanding Medical is greater than \$500,000, the sum of Paid Indemnity Losses plus Case Outstanding Indemnity is expected to be greater than zero.
4. When the Claim Status is closed, then the total losses and DCCE Case Outstanding should be zero.
5. When the Claim Status is open or re-opened, the total losses and DCCE Case Outstanding should not be zero.
6. The Claim Number must be unique within each Policy Number.
7. Claims with less than \$500,000 in total case incurred losses are not expected to be reported.
8. Claims reported on the preceding Call should be reported on the current Call.
9. When the sum of Indemnity and Medical Paid plus Case losses is greater than \$500,000, the sum of Paid Plus Case DCCE is expected to be greater than zero.
10. Paid amounts should be non-negative.

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PART 10—FINANCIAL CALL INCENTIVE PROGRAM (FCIP)

The intent of the Financial Call Incentive Program (FCIP) is to provide an incentive for carriers to submit aggregate data in a timely and accurate manner by offering credits for early reporting. The program reallocates the costs of late and/or inaccurate experience back to the carriers who are not reporting financial data in a timely and accurate manner. Assessments are also levied on carriers for errors detected on submissions of Financial Calls.

1. Introduction

Beginning with calls received in 1988, MWCIA implemented a Monetary and Financial Incentive Program. This program was revised in 1994, 2004, 2011, and in 2016 to the current Financial Call Incentive Program (FCIP). The credits offered in the program better reflect the value to MWCIA of getting accurate and timely data. The assessments better recognize the importance of receiving quality financial data for ratemaking as well as a more exact allocation of cost to MWCIA for correcting inaccurate data.

2. Application

The FCIP administered will apply to the following four Financial Calls due April 1.

Financial Call
Policy Year Call
Policy Year Large Deductible Call
Calendar-Accident Year Call
Calendar-Accident Year Large Deductible Call

3. Procedures

A. Timeliness

- 1. Overview—**The timely collection of accurate data is essential to MWCIA's operations. The data collected in the Calls for Experience is used for ratemaking purposes. Late reports can lead to delays in the preparation of the Minnesota Ratemaking Report. These delays could result in the postponement of a needed rate relief. Processing the enormous amount of data collected is very time consuming. To produce the Ratemaking Report in a timely fashion, it is necessary to receive data on time or preferably prior to the due date, if possible.
- 2. Early Reporting Credit—**As an incentive for carriers to report data as soon as possible, carriers will receive credits if the ratemaking Calls are submitted prior to March 16. Early reporting credits apply only to Calls that are received by MWCIA via the ACCEDE tool prior to March 16, and are edit-free or have edit explanations on the original submission found acceptable by MWCIA.

Calls received at MWCIA prior to March 16 will be eligible for 17 days of early reporting credits. Any Calls received after March 15 will not be eligible for these credits. Calls received prior to March 15 do not start to earn credit until March 15.

If MWCIA has to generate a Validation Correspondence notification about an edit situation, early reporting credit is forfeited for every call questioned by MWCIA, regardless of whether the carrier responds by submitting a correction or a valid explanation. Submitting a resubmission also negates any early reporting credits.

Each data Call will be considered a submission for the purposes of calculating credits. Credits for Calls received prior to March 16 will consist of a per day amount based on the particular carrier's market share. The credit for early submissions will be calculated as follows:

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<u>Market Share</u>	<u>Credit</u> <u>(per calendar day, per call)</u>
< 2.0%	\$5
2.0% to < 5.0%	\$15
5.0% to < 10.0%	\$25
10% and +	\$50

Example: If a carrier has 1.5% of the market in 2025 and the Policy Year Call for 2025 Experience was received on March 15, the credit for early reporting would be:

$$17 \text{ days} \times \$5/\text{day} = \$85$$

3. **Assessments**—Assessments for late submissions will be governed by the April 1 due date. **The submitted date of the latest revision of a carrier's Call is used to determine lateness.** If the carrier's submission is not received at MWCIA prior to midnight Central Time on April 1, that particular submission is considered late and assessments will accrue until the Call is received or up to a maximum number of days calculated through August 31. If the required due date falls on a Saturday, Sunday, or national holiday, the next business day will be considered the due date for purposes of the FCIP.

Each individual Call will be considered a submission for purposes of levying assessments. The assessment for timeliness will be calculated as follows:

<u>Market Share</u>	<u>Assessments</u> <u>(per calendar day, per call)</u>
< 2.0%	\$30
2.0% to < 5.0%	\$60
5.0% to < 10.0%	\$120
10% and +	\$240

Example: If a carrier has 1.5% of the market in 2025 and was 15 days late with the Policy Year Call for 2025 Experience, the assessment would be:

$$15 \text{ days} \times \$30/\text{day} = \$450$$

B. Quality

1. **Assessments-Edits**—Assessments for the quality of data submitted are based on the occurrence of an edit. Call are validated within the ACCEDE tool prior to submission to identify edit conditions in need of correction or explanation. There are two categories of edits:
- a. **Basic Edits**—Basic Edits follow a structured format and are performed on data as it is processed through ACCEDE's internal data processing programs. **Each submission that contains one or more uncorrected Basic Edit will be subject to a flat assessment of \$100 per error occurrence.** Basic Edits are primarily validation checks that identify conditions that can only occur as the result of an error or omission. A major source of Basic Edit error is incorrect arithmetic or careless data entry.
 - b. **Actuarial Edits**—Actuarial Edits are those checks performed on a carrier's data designed to verify the accuracy and reasonableness of the data submitted by the carrier. **Each submission with Edit Explanations that are vague or incomplete that require MWCIA to generate a Validation Correspondence notification will be subject to a flat assessment of \$100 per error occurrence.** No assessment will apply if the data is correct and accurate, as long as a satisfactory explanation is included when the Call is submitted.
2. **Assessments-Response Timeliness**—As part of the processing of Call data, MWCIA reviews all carrier explanations to data edits entered into ACCEDE's Validation Correspondence. If an explanation

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is not complete or it fails to properly address the edit situation, MWCIA will generate a Validation Correspondence notification requesting further explanation or a correction. Carriers are given up to 10 business days to respond to the notification. Edit responses not received within the time frame specified are subject to response timeliness assessments of \$25 per calendar day per Call until a sufficient response is received. A response is defined as revised Call data or a detailed explanation of why the data does not fall within the expected range.

C. Maximum Assessment or Credit

The maximum assessment for any carrier or group will be limited to 0.5% (.005) of the individual carrier/group's prior calendar year net earned workers compensation premium, or \$500, whichever is greater.

The maximum credit for any carrier or group will be limited to 0.25% (.0025) of the individual carrier/group's prior calendar year net earned workers compensation premium, or \$250, whichever is greater.

D. Final Credit Reapportionment

The capped credit is reapportioned to ensure that MWCIA shows no net balance due to the operation of FCIP. This is done using the following formula:

$$A = C \times (T1 / T2)$$

where:

A = Final Credit Amount

C = Capped Credit

T1 = Total Assessments Against All Carriers

T2 = Total Capped Credits For All Carriers

Example: If the total of the assessments against all carriers for the 202 Calls for experience was \$50,000 and the total of the capped credits for the year was \$100,000, the final credit for a carrier receiving a credit of \$2,750 would be:

$$A = \$2,750 \times (\$50,000 / \$100,000)$$

$$A = \$2,750 \times 0.5 = \$1,375$$

4. Release of Carrier FCIP Performance Reports

MWCIA will release the FCIP Performance Reports for the previous year's Calls by December 15 of each year.

5. Disbursement/Collection of Funds

Any monies due a carrier/group or the MWCIA as a result of FCIP will be disbursed/collected at the time of the reapportionment of Association expenses for the reporting year.

6. Appeal Procedures

A. Appeal—Carriers will have 30 days after the release of Performance Evaluation Reports to appeal the propriety of any assessments.

Appeals of lateness charge should be supported by documentation showing the date on which data was submitted via ACCEDE as evidence of timely submission of the Call.

Appeals of quality edit charges should be supported by an explanation of why the submission was correct. Please note that the nature of Actuarial Edits is verification of the reasonableness of data. It is not intended that assessment be levied while dialogue is taking place between MWCIA and the carrier to determine if the data is accurate.

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Assessments will be considered valid if the submission fails the standards outlined in **Financial Call Editing** (Part 9) or any list of specific Basic and Actuarial standards provided to carriers. **Other quality edit assessments may apply when the failure serves to impact MWCIA operations negatively.**

- B. Acknowledgment**—MWCIA will acknowledge the appeal of an assessment within ten (10) working days of receipt. All appeals of assessments should be in writing and emailed to actuarial@mwcia.org.
- C. Response**—Within thirty (30) working days of acknowledgment, MWCIA will either provide additional information supporting the assessment charged or accept the carrier's explanation and withdraw the assessment. If an assessment is subject to further review, then the due date will be extended until the matter is resolved.

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PART 11—AUTOMATED CARRIER CALL ENTRY AND DATA EDIT (ACCEDE)

ACCEDE© (Automated Carrier Call Entry and Data Edit) is the web application for reporting financial data to MWCIA. ACCEDE© enables carriers to upload, enter, validate, and address anomalies prior to submitting financial data. All applicable Financial Calls required by Minnesota are to be submitted in ACCEDE©.

All seven of the Calls required by Minnesota may be submitted through ACCEDE©. They include:

Policy Year Call	Due April 1
Accident Year Call	Due April 1
Large Deductible Policy Year Call	Due April 1
Large Deductible Accident Year Call	Due April 1
Supplemental Call for Schedule Rating Adjustments Call	Due April 1
Reconciliation Report – Calendar Year Data	Due April 1
Large Loss and Catastrophe Call	Due April 1

At no time will MWCIA be liable for any damages arising out of the use or inability to use the material recommended or presented in programs or in documentation. MWCIA is not responsible for any costs including, but not limited to, those incurred as a result of lost profits or revenue, or loss of use of computer software or hardware. Furthermore, MWCIA cannot assume liability for submissions of financial data that are late because of hardware or software failure associated with running ACCEDE . Use of ACCEDE is also subject to all terms and conditions contained in the user agreement incorporated in that software product.

If you have any questions regarding ACCEDE , please contact our Actuarial Services Department at 952-897-1737, option 3.