Minnesota Workers' Compensation
Insurers Association, Inc.
7701 France Avenue South ▪ Suite 450
Minneapolis, MN 55435-3200

December 17, 2004

To: ALL ASSOCIATION MEMBERS

Circular Letter No. 04-1440

RE: Enhancement of Class Loss Development Beyond 5th Reports [NCCI Item U-1390 — Unit Statistical Reporting Instruction Enhancements]

The Minnesota Department of Commerce has approved the above filing for use in the State of Minnesota effective 12:01 a.m. July 1, 2005 for all unit statistical data with policy effective dates of 1-1-1999 (6th report) and subsequent.

MWCIA staff recently reviewed NCCI Item U-1390 — Unit Statistical Reporting Instruction Enhancements for adaptation into the ***Minnesota Statistical Plan Manual***. NCCI Item U-1390 is a two-part filing. The first part expands the Stat Plan's requirements to include 6th-10th report levels for unit statistical reporting purposes. NCCI Item U-1390's second rule change enhances language in NCCI's current URE Workers' Compensation Statistical Plan Manual regarding fraudulent claim reporting. Inasmuch as Minnesota does not collect fraudulent claim data, however, it is important that each member carrier alert their reporting personnel that this portion of NCCI Item U-1390 is not approved for use in Minnesota.

The Minnesota exhibits included as part of MWCIA Circular Letter No. 04-1440 illustrate the language changes to the ***Minnesota Statistical Plan Manual*** necessary to implement the enhancement of class loss development to the 10th reporting level in Minnesota.

As you review Exhibits I-IV, please note the following:

- The approved changes should have no impact on current premium
- Conditions for filing subsequent reports are unchanged
- 6th-10th report levels do not impact the ***Experience Rating Plan Manual*** rules
- Column 1 illustrates ***MN Statistical Plan Manual***'s current language
- Column 2 illustrates ***MN Statistical Plan Manual***'s new language
- Strikethroughs in Column 1 represent deleted language
- Underlining in Column 2 represents new or amended language
- NCCI Item U-1390 Exhibits 5 – 7 are not approved for use in Minnesota

The National Council's original filing memorandum is included to provide members with additional background information on this particular filing. Please remember to disregard all sections pertaining to fraudulent claim reporting when reviewing NCCI's memorandum.

Specific questions regarding this filing may be directed to our Unit Statistical Department at 952.897.1737, option 4; or by sending an email to info@mwcia.org.

A NOTICE TO MEMBERSHIP:

The Minnesota Department of Commerce requests that MWCIA remind its members that the above filing only applies automatically to insurance companies who have filed a Limited Power of Attorney agreement with our Commerce Department. A properly executed Limited Power of Attorney authorizes MWCIA to make filings on behalf of individual insurance companies. Any insurance company who has not filed a Limited Power of Attorney must independently submit the changes represented in each filing item to the Minnesota Department of Commerce for their approval.

EXHIBIT I

MINNESOTA STATISTICAL PLAN MANUAL
SECTION ONE — REPORTING OF INDIVIDUAL EMPLOYER EXPERIENCE

CURRENT PHRASEOLOGY:	PROPOSED PHRASEOLOGY:
PART I — GENERAL INSTRUCTIONS	**PART I — GENERAL INSTRUCTIONS**
3. DATE OF VALUATION AND FILING	**3. DATE OF VALUATION AND FILING**
Losses included in the first reporting of a given policy shall be valued during the eighteenth month after the effective month of the policy, and the report shall be filed ~~no~~t later than twenty months after the effective month of the policy. ~~Second, third, fourth, and fifth~~ report~~s~~ ~~are~~ valued 12~~,~~ ~~24, 36 and 48~~ months~~,~~ ~~respectively,~~ after the valuation date of the ~~first~~ report. The table shown below displays, on a monthly basis, the correct valuation and filing dates for all first reportings. Refer to Part I, Item 12 for instructions on filing reports on policies covering more than one year. Refer to Part VI for reporting of experience incurred under three year fixed rate policies.	Losses included in the first reporting of a given policy shall be valued during the eighteenth month after the effective month of the policy, and the report shall be filed no later than twenty months after the effective month of the policy. Subsequent reporting of loss data (2^{nd} – 10^{th})* must be valued 12 months after the valuation date of the preceding report and filed no later than 2 months from that date. The table shown below displays, on a monthly basis, the correct valuation and filing dates for all first reportings. Refer to Part I, Item 12 for instructions on filing reports on policies covering more than one year. Refer to Part VI for reporting of experience incurred under three year fixed rate policies. Refer to the chart under Part II, Item 1 for a listing of correct valuation dates for filing subsequent loss reportings.

VALUATION AND FILING DATES TABLE			VALUATION AND FILING DATES TABLE		
Effective Month	**Valuation Month (18 months after policy effective month)**	**Reporting Month (20 months after policy effective month)**	**Effective Month**	**Valuation Month (18 months after policy effective month)**	**Reporting Month (20 months after policy effective month)**
January	July	September	SAME		
February	August	October			
March	September	November			
April	October	December			
May	November	January			
June	December	February			
July	January	March			
August	February	April			
September	March	May			
October	April	June			
November	May	July			
December	June	August			

NONE	* Unit statistical data for policies effective 12/31/1998 and prior that meet the requirements for subsequent reporting require only 2^{nd} – 5^{th} subsequent reports. Refer to Part V.5. for instructions on filing revised reports for these years.
NONE	[Note: Minnesota does not incorporate rules for self-insureds into the *Minnesota Statistical Plan Manual*. Refer to the *Minnesota Self-Insured Statistical Data Manual* for information on self-insured reporting.]

EXHIBIT I

MINNESOTA STATISTICAL PLAN MANUAL
SECTION ONE — REPORTING OF INDIVIDUAL EMPLOYER EXPERIENCE

CURRENT PHRASEOLOGY:	PROPOSED PHRASEOLOGY:
PART II – REPORTING INSTRUCTIONS— POLICY IDENTIFICATION DATA	
1. Report Number	
Report the 2-digit numeric code that corresponds to the loss valuation date.	

Code	**Report Level**	**Valuation Schedule**	**Code**	**Report Level**	**Valuation Schedule**
01	First Report	Valued 18 months from policy effective month	SAME		
02	Second Report	Valued 30 months from policy effective month			
03	Third Report	Valued 42 months from policy effective month			
04	Fourth Report	Valued 54 months from policy effective month			
05	Fifth Report	Valued 66 months from policy effective month			
NONE			06	Sixth Report	Valued 78 months from policy effective month
			07	Seventh Report	Valued 90 months from policy effective month
			08	Eighth Report	Valued 102 months from policy effective month
			09	Ninth Report	Valued 114 months from policy effective month
			10	Tenth Report	Valued 126 months from policy effective month

EXHIBIT I

MINNESOTA STATISTICAL PLAN MANUAL
SECTION ONE — REPORTING OF INDIVIDUAL EMPLOYER EXPERIENCE

CURRENT PHRASEOLOGY: **PROPOSED PHRASEOLOGY:**

[NOTE: PROPOSED PHRASEOLOGY CHANGES ARE INDICATED IN THE HIGHLIGHTED AREA]

APPENDIX A

ASWG UNIT REPORT DATA ELEMENTS
CODING SPECIFICATIONS

DATA ELEMENT	BYTES EL	BYTES HC	CLASS EL	CLASS HC	SPECIFICATIONS
HEADER RECORD					
Report Number	1	2	AN	N	Report the 2-digit numeric code that corresponds to the loss valuation date. Code — Report Level — Loss Valuation Schedule 1 — First Report — Valued 18 months after policy effective month 2 — Second Report — Valued 30 months after policy effective month 3 — Third Report — Valued 42 months after policy effective month 4 — Fourth Report — Valued 54 months after policy effective month 5 — Fifth Report — Valued 66 months after policy effective month 6 — Sixth Report — Valued 78 months after policy effective month 7 — Seventh Report — Valued 90 months after policy effective month 8 — Eighth Report — Valued 102 months after policy effective month 9 — Ninth Report — Valued 114 months after policy effective month 10 — Tenth Report — Valued 126 months after policy effective month **Action-Reject**

EXHIBIT II

MINNESOTA STATISTICAL PLAN MANUAL
SECTION ONE — REPORTING OF INDIVIDUAL EMPLOYER EXPERIENCE

CURRENT PHRASEOLOGY:	PROPOSED PHRASEOLOGY:
PART IV — REPORTING INSTRUCTIONS— LOSSES	**PART IV — REPORTING INSTRUCTIONS— LOSSES**
5. Incurred Losses	**5. Incurred Losses**
F. Subrogation and Third Party Cases	*F. Subrogation and Third Party Cases*
5. When reimbursement by a third party or a subrogation recovery is received by the carrier subsequent to the first reporting of the claim, a correction report must be filed with MWCIA revising the incurred cost on the claim to the net incurred loss as defined above. This should be done for reports which would impact any experience modifications in which the claim has been used. If fourth ~~and/or fifth~~ unit reports have been previously filed, correction reports ~~to the fourth and/or fifth reports~~ must also be submitted. Refer to Part V for further instructions regarding correction reports.	5. When reimbursement by a third party or a subrogation recovery is received by the carrier subsequent to the first reporting of the claim, a correction report must be filed with MWCIA revising the incurred cost on the claim to the net incurred loss as defined above. This should be done for reports which would impact any experience modifications in which the claim has been used. If fourth unit reports or any subsequent reports have been previously filed, corrections of those reports must also be submitted. Refer to Part V for further instructions regarding correction reports.

EXHIBIT III

MINNESOTA STATISTICAL PLAN MANUAL
SECTION ONE — REPORTING OF INDIVIDUAL EMPLOYER EXPERIENCE

CURRENT PHRASEOLOGY:	PROPOSED PHRASEOLOGY:
PART V – SUBSEQUENT REPORTS AND CORRECTIONS	**PART V – SUBSEQUENT REPORTS AND CORRECTIONS**
1. Subsequent Reports – When Required	**1. Subsequent Reports – When Required**
Subsequent reports shall be filed with the MWCIA in accordance with the valuation schedule set forth in Part VII, Item I of this Manual for each policy where one or more claims have been:	SAME
A. Reported as open on the previous report. B. Previously reported as closed but are now open. C. Previously unreported. D. Previously reported and the current valuation differs in any manner from the previously submitted data.	SAME
Where a claim was previously identified with a claim number, all subsequent reports of this claim must be submitted on an individual claim basis, even if the claim becomes a medical only claim. Subsequent reports are ~~only~~ required through ~~a fifth~~ report.	Where a claim was previously identified with a claim number, all subsequent reports of this claim must be submitted on an individual claim basis, even if the claim becomes a medical only claim. Subsequent reports are required through the tenth report. Refer to Part I for additional instructions on valuation and filing.
NONE	[Note: Unit statistical data for policies effective 12/31/1998 and prior that meet the requirements for subsequent reporting are only required to file the 2nd – 5th subsequent reports.
2. CORRECTION REPORTS – When Required	**2. CORRECTION REPORTS – When Required**
B. *Loss Corrections.*	B. *Loss Corrections.*
NONE	[Note: Unit statistical data for policies effective 12/31/1998 and prior that meet the requirements for subsequent reporting are only required to file revisions of the 2nd – 5th unit reports. Refer to Part V.5. for instructions on filing revised reports for these years.
PART VI -- THREE-YEAR FIXED RATE POLICIES	**PART VI -- THREE-YEAR FIXED RATE POLICIES**
Option B. Unit Reporting Basis	**Option B. Unit Reporting Basis**
3. Second~~, Third, Fourth~~ and ~~Fifth~~ Reports	3. *Second and Subsequent Reports*
Second reports shall be filed only on policies where losses or change of exposure have occurred during the last year of the three-year fixed rate policy period under the following circumstances:	SAME
A. Open Claims B. Reopened Cases C. Previously Unreported Claims D. Changes in Valuation or Exposure	SAME
Such second reports shall be filed twelve months after filing of the original reports. Third~~, fourth and fifth~~ reports are **NOT** required on three-year fixed rate policies.	Such second reports shall be filed twelve months after filing of the original reports. Third and subsequent reports are **NOT** required on three-year fixed rate policies.

EXHIBIT IV

MINNESOTA STATISTICAL PLAN MANUAL
SECTION ONE — REPORTING OF INDIVIDUAL EMPLOYER EXPERIENCE

[NOTE: NCCI LANGUAGE IS BEING PROVIDED BELOW FOR INFORMATIONAL PURPOSES ONLY AS LANGUAGE IS BEING DELETED IN NCCI PART 8 THAT DOES NOT EXIST UNDER THE COMPARABLE RULE IN THE *MINNESOTA STATISTICAL PLAN MANUAL*.]

NCCI CURRENT PHRASEOLOGY WITH PROPOSED CHANGES:	CURRENT MN PHRASEOLOGY:	PROPOSED MN PHRASEOLOGY:
URE WCOMP STATISTICAL PLAN MANUAL	**MN STATISTICAL PLAN MANUAL**	**MN STATISTICAL PLAN MANUAL**
PART 8 – PENSION TABLES (limited to Note language only)	**PART VII — ANNUITY TABLES**	**PART VII — ANNUITY TABLES**
	TABLE A – TABLE D	**TABLE A – TABLE D**
~~NOTE: Unit plan reporting ceases at 5th report; however, this example is included to assist companies in computing reserves beyond 5th report for internal purposes.~~	NONE	NONE

CURRENT PHRASEOLOGY:	PROPOSED PHRASEOLOGY:
PART XII — MAGNETIC TAPE SPECIFICATIONS	**PART XII — MAGNETIC TAPE SPECIFICATIONS**
1. Introduction	**1. Introduction**
The purpose of the document is to provide information to assist carriers in the preparation and submission of unit statistical reports on magnetic tape for Minnesota. We follow the standards as published by the National Council on Compensation Insurance. This document must be used in conjunction with the Magnetic Tape Manual. We accept reports 1-~~5~~ and corrections with the appropriate testing procedures.	The purpose of the document is to provide information to assist carriers in the preparation and submission of unit statistical reports on magnetic tape for Minnesota. We follow the standards as published by the National Council on Compensation Insurance. This document must be used in conjunction with the Magnetic Tape Manual. We accept reports 1-10 and corrections with the appropriate testing procedures.
4. Link Data	**4. Link Data**
E. Report Number must be numeric, 1 through ~~5~~. ~~Reports after number 5 are **NOT** accepted.~~ Reports must be received by MWCIA in contiguous, ascending order, i.e. 1st reports must be received before 2nd reports, etc.	E. Report Number must be numeric, 1 through 10. Reports must be received by MWCIA in contiguous, ascending order, i.e. 1st reports must be received before 2nd reports, etc.

National
Council on
Compensation
Insurance, Inc.

Terri Robinson
State Relations Executive
Regulatory Services Division

June 22, 2004

Mr. Bruce Tollefson, President
Minnesota Workers Compensation Insurers Association
7701 France Avenue South, Suite 450
Minneapolis, Minnesota 55435

Re: **Item U-1390—Unit Statistical Reporting Instruction Enhancements**

Dear Mr. Tollefson:

We will soon file the above captioned item in a number of jurisdictions. The attached filing memorandum describes the changes proposed. This filing memorandum ("Memorandum") is proprietary and copyrighted by NCCI

Should you elect to adopt NCCI's proposed Filing Memorandum, permission is hereby granted to your organization by NCCI to copy the Filing Memorandum verbatim for integration into your published materials and for no other purpose.

NCCI's Memorandum shall not be reprinted for distribution or sale except as provided for above. The NCCI copyright notice must be indicated on each page that includes the NCCI Memorandum, along with the correct year and the following statement:

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Please notify NCCI at your earliest convenience whether your organization intends to adopt the Memorandum so that NCCI may complete its Filing Status Circular.

Sincerely,

Terri Robinson
State Relations Executive

TR:ah

11430 Gravois Road • Suite 310 • St. Louis, Missouri 63126-0530
Telephone: 314-843-4001 • Fax: 314-842-3188 • E-mail: Terri_Robinson@NCCI.com

FILING MEMORANDUM

ITEM U-1390—UNIT STATISTICAL REPORTING INSTRUCTION ENHANCEMENTS

Addition of 6th–10th reports to be effective 12:01 a.m. on July 1, 2005 (6th report valuation date) for unit statistical data with policy effective dates of January 1, 1999 and subsequent.

Fraudulent claim reporting instructions to be effective upon approval.

PURPOSE

The purpose of this filing is to enhance reporting requirements to the ***URE Workers Compensation Statistical Plan*** by:

- Adding 6th–10th unit statistical report levels (claims)
- Improving the clarity of the definition and reporting instructions for fraudulent claims

BACKGROUND

Class Loss Development Beyond 5th Reports

NCCI has identified the need to collect additional report levels of unit statistical data through the 10th unit report level. Our actuarial analysis has determined that access to more fully developed unit statistical data through the 10th report level will enable us to provide benefits and improvements to the following:

- Rates and loss costs—More comprehensive data used to enhance the ratemaking process, including improved class equity, industry group differential methodology, better tail factor estimates, and enhanced large loss analyses and procedures
- Retrospective rating—Improved analysis of this voluntary rating system, permitting adjustment on the basis of the insured's own loss experience, including better estimates of excess loss factors, better grouping classes, and better employers liability limits factors
- Legislative analysis—More comprehensive pricing of reforms, including improved ability to identify cost drivers and enhanced understanding of emergence of occupational disease claims
- Research initiatives—Improved analysis, including long-term medical research, impact of workers compensation litigation on claim costs, and emerging causes of losses

Fraudulent Claim Reporting

The ***URE Workers Compensation Statistical Plan*** currently contains instruction on fraudulent claims, including the Fraudulent Claim Codes used to identify these claims. NCCI analysis and feedback indicates that fraudulent claim reporting must be further enhanced and clarified to include the following:

- Clarify that a court decision determines if a claim is partially or fully fraudulent. This action prompts the subsequent unit statistical reporting and reduction of the loss, not the actual recovery (which may or may not occur).
- Add reporting instructions for claims declared to be partially and fully fraudulent (prior to and subsequent to the 1st report), including how the claim cost is reduced.
- Add instructions for filing correction reports when claims are declared to be partially or fully fraudulent.
- Revise the definition of the Fraudulent Claim (Code) field.

ITEM U-1390—UNIT STATISTICAL REPORTING INSTRUCTION ENHANCEMENTS

PROPOSAL

This filing proposes that:

- Unit reporting requirements are to be increased to include 6th–10th report levels for unit statistical reports with policy effective dates of January 1, 1999 and after. The initial reporting of 6th reports for policies effective January 1, 1999 would be valued as of July 2005, and due to be reported to NCCI by September 2005.
- Enhanced language that clarifies and provides further direction for the reporting of fraudulent claims to be effective upon approval.

IMPACT

There will be no impact on premium as a result of these changes.

Class Loss Development Beyond 5th Reports

The requirements for the additional report levels will be consistent with current requirements for subsequent reporting (2nd–5th unit reports). Although subsequent reports will be extended through the 10th report level, the conditions for which subsequent reports are required will remain the same.

The addition of the 6th–10th report levels will not impact Experience Rating Plan requirements. Only 1st–3rd unit reports for rated risks will continue to be used in the experience rating process. Revision of losses as defined by the Experience Rating Plan where the time frame for the three (current and two preceding) modifications is limited to the risk's fifth most recent rating effective date will remain the same.

Fraudulent Claim Reporting

The enhanced definition of fraudulent claims and loss reporting instructions will require that carriers review their unit statistical reporting processes to ensure that they are in compliance with these instructions. Proper reporting by the industry will provide benefits to unit statistical data quality, correctness of experience ratings, and the accuracy of Fraudulent Claim (Code) reporting.

EXHIBITS

Proposed additions or changes to the attached ***URE Workers Compensation Statistical Plan*** exhibit pages are shaded. Proposed deletions are indicated with a strike through where the deletion will occur.

Class Loss Development Beyond 5th Reports

The ***URE Workers Compensation Statistical Plan*** changes outlined in the attached exhibits provide the following:

- Direction for reporting and correcting unit statistical data for 6th through 10th reports
- Clarifying language and instructions for reporting recoveries beyond 5th reports

Exhibits 1–4 provide the changes to the ***URE Workers Compensation Statistical Plan*** for the addition of 6th–10th report levels.

Exhibit	*URE Workers Compensation Statistical Plan*
1	General Rules
2	Loss Information
3	Subsequent Reports and Corrections
4	Pension Tables (limited to Note language only)

ITEM U-1390—UNIT STATISTICAL REPORTING INSTRUCTION ENHANCEMENTS

Fraudulent Claim Reporting
The ***URE Workers Compensation Statistical Plan*** changes outlined in the attached exhibits provide the following:

- The specific definition of when a claim is to be considered partially or fully fraudulent
- Separate reporting instructions for partially and fully fraudulent claims including a reporting example
- Usage of correction reports when fraudulent claim recovery is received subsequent to the 1st report
- Revised definition of Fraudulent Claim (Code) values to align with the industry standard definitions

Exhibits 5–7 provide the changes to the ***URE Workers Compensation Statistical Plan*** for the reporting of fraudulent claims.

Exhibit	*URE Workers Compensation Statistical Plan*
5	Loss Information
6	Subsequent Reports and Corrections
7	Coding Specifications

IMPLEMENTATION

Class Loss Development Beyond 5th Reports
The transition to extended reporting will begin in September 2005 with policies effective January 1, 1999. These policies with claims open at 5th report or reopened after 5th report require a 6th report valued July 2005, or 78 months from the policy effective month. The 6th report is due to NCCI in September 2005 (within two months of valuation).

These same policies, with claims open or reopened, will become subject to:

- 7th reports in 2006
- 8th reports in 2007
- 9th reports in 2008
- 10th reports in 2009

Policies effective after January 1, 1999 will also require 6th–10th reports to be reported to NCCI.

The attached exhibits for the ***URE Workers Compensation Statistical Plan*** include the proposed changes necessary to implement this item.

Fraudulent Claim Reporting
The attached exhibits for the ***URE Workers Compensation Statistical Plan*** include the proposed changes necessary to implement this item.

EXHIBIT 1

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 1—GENERAL RULES

16. DATE OF VALUATION AND FILING

Losses included in the 1st reporting of a given policy must be valued as of 18 months after the month in which the policy became effective. Subsequent reporting of loss data (2nd–10th)* must be valued 12~~, 24, 36 and 48~~ months~~, respectively,~~ after the valuation date of the ~~1st~~ preceeding report. Each report level must be filed no later than two months after the respective valuation date. Please refer to the following chart for specifics.

Report Level	Valuation Date	Filing Due Date
1st	18th month	20th month
2nd	30th month	32nd month
3rd	42nd month	44th month
4th	54th month	56th month
5th	66th month	68th month
6th	78th month	80th month
7th	90th month	92nd month
8th	102nd month	104th month
9th	114th month	116th month
10th	126th month	128th month

*** Unit statistical data with policies effective 12/31/1998 and prior that meets the requirements for subsequent reporting requires only 2nd–5th subsequent reports.**

EXCEPTION FOR AFFILIATE SELF-INSURERS: *6th through 10th subsequent reports are to be reported in accordance with the scope of this plan. Refer to SCOPE AND EFFECTIVE DATE OF THE PLAN for the minimum reporting requirement.*

EXHIBIT 2

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 4—LOSS INFORMATION

11. **REPORTING OF ASSESSMENTS AND SPECIAL FUNDS**
In connection with certain types of injury, the law specifies that an amount must be paid into special funds, such as a Second Injury Fund. These amounts, in addition to the compensation payable to the injured worker or their dependents, must 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.

Any special payments to the states, which are assessed on total premium writings or total losses paid or incurred, are for tracking purposes only and must not be reported under this Plan. For example, Second Injury Fund assessments paid to the state instead of on a per claim basis.

Refer also to Item 11.a. Procedures for All States Except Louisiana and New Hampshire, and 11.b. Procedures for Louisiana and New Hampshire.

a. **Procedures for All States Except Louisiana and New Hampshire**
In all cases where a claim is eligible for reimbursement to the carrier from a special fund such as a Second Injury Fund or the Handicapped Workers' Reserve Fund, the gross incurred cost of the claim and the paid cost of the claim must be reduced by the amount of any paid or anticipated recovery from the fund, and the net incurred and net paid costs of the claim must be reported. The gross incurred cost of the claim is the gross evaluation of the claim on which the reimbursement is based prior to the reimbursement, whether or not the claim is still open. The net incurred cost of the claim is defined as the gross incurred cost less net recovery. The type of recovery as defined under Item 20.c, must be submitted on reports that would impact the current and up to two prior modifications. Correction reports are required only for prior reports that reflected an amount higher than the net incurred cost.

For example, consider a claim that has been reported as $10,000 (1st report), $40,000 (2nd report), and $60,000 (3rd report). A recovery from a Second Injury Fund is in the amount of $25,000. The net incurred cost of the claim is the latest value minus the recovery: $60,000 – $25,000 = $35,000. The net incurred cost ($35,000) is less than the claim value reported at the 3rd and 2nd report. A corrected 2nd and 3rd report must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

When the actual allocation of the recovery to indemnity and medical is unknown, the net incurred loss must be divided between indemnity and medical losses in the same proportion as the gross incurred indemnity and medical amounts.

If the total recovery amount is less than 10 percent of the gross incurred cost of the claim, do not file a correction report.

EXHIBIT 2 (cont'd)

"Anticipated recovery" is defined, for this purpose, as the amount expected to be recovered from such funds based on one of the following:

- The rules governing these funds
- A written agreement between these funds and the carrier on an amount
- Percentage of the incurred cost, reimbursed to the carrier on a particular claim

When an anticipated recovery becomes known by the carrier, or when a recovery is paid to the carrier subsequent to the 1st reporting of the claim but within one year after the 5th report due date, correction reports must be filed with NCCI. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim remains open. Reduce the paid and incurred costs on the claim by the amount of the paid or anticipated recovery as outlined above. Refer to Part 5 for additional instructions on correction reports. For reporting examples, refer to the ***URQ User's Guide,*** URE Correction Reports—Section 7. Refer to the ***Experience Rating Plan Manual*** for time frames of modification revisions.

Exceptions: *Maine: The gross incurred losses and the paid losses are required to be reported according to Maine Law, when the carrier is eligible for reimbursement from the Supplemental Benefits Fund for benefit duration extensions.*

b. **Procedures for Louisiana and New Hampshire**

In all cases where a claim is eligible for reimbursement to the carrier from a special fund, such as a Second Injury Fund or Handicapped Workers' Reserve Fund, the gross incurred cost and paid cost of the claim prior to any reimbursement must be reduced by the amount of any paid or anticipated recovery from a fund. The net incurred cost of the claim must be reported and the type of recovery should be indicated. (Refer to the Loss Condition Code instructions in this part.)

"Anticipated recovery" is defined, for this purpose, as the amount expected to be recovered from such funds based on one of the following:

- The rules governing the funds
- A written agreement between the funds and the carrier on an amount
- A percentage of the incurred cost, reimbursed to the carrier on a particular claim

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

For example, consider a claim that has been reported as $10,000 (1st report), $40,000 (2nd report), and $60,000 (3rd report). A recovery from a Second Injury Fund is in the amount of $25,000. The net incurred cost of the claim is the latest value minus the recovery: $60,000 – $25,000 = $35,000. The net incurred cost ($35,000) is less than the claim value reported at the 3rd and 2nd report. A corrected 2nd and 3rd report must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

If the total recovery amount is less than 10 percent of the gross incurred cost of the claim, do not file a correction report. Refer to Part 5 for additional instructions on correction reports. For reporting examples, refer to the ***URQ User's Guide***, URE Correction Reports—Section 7.

EXHIBIT 2 (cont'd)

15. **SUBROGATION AMOUNT**

When there has been recovery of loss due to subrogation, the amount of loss reported must be the net incurred loss. The "net incurred loss" is defined as the gross incurred loss (i.e., the gross evaluation of the claim on which the recovery was based, whether the claim is still open or not) minus the amount recovered less recovery expenses. When the recovery expenses exceed the amount recovered, report the gross incurred loss instead of the net incurred loss. When the allocation of recovery to indemnity and medical is unknown, the net incurred loss must be divided between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amounts. The Type of Recovery must also be reported.

When a subrogation recovery is received by the carrier subsequent to the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears, a correction report must be filed. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim remains open.

Refer to the ***Experience Rating Plan Manual*** for time frames of modification revisions.

*(**Louisiana and New Hampshire Exceptions:** When a subrogation recovery is received by the carrier subsequent to the 1st reporting of the claim, correction reports must be filed, reducing the incurred and paid cost on the claim by the amount of the subrogation recovery received.)*

Reduce the incurred cost on the claim to the net incurred loss as defined above. In addition, reduce the paid cost of the claim to the net paid loss. This must be done for reports impacting the current and up to two prior modifications. Correction reports are required only for prior reports that reflected an amount higher than the net incurred cost.

For example, consider a claim that has been reported as $10,000 (1st report), $40,000 (2nd report), and $60,000 (3rd report). A subrogation recovery is in the amount of $25,000. The net incurred cost of the claim is the latest value minus the recovery: $60,000 – $25,000 = $35,000, plus a total of $3,000 recovery expenses. The net incurred cost ($38,000) is less than the claim value reported at the 3rd and 2nd report. A corrected 2nd and 3rd report must be submitted. As the net incurred cost is higher than the $10,000 reported in the 1st report, no correction report is needed for the 1st report.

If the total recovery amount is less than 10 percent of the gross incurred cost of the claim, do not file a correction report.

EXHIBIT 3

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 5—SUBSEQUENT REPORTS AND CORRECTIONS

1. **SUBSEQUENT REPORTS**

   a. **Reporting Conditions**

   Subsequent reports (~~The~~ 2nd~~, 3rd, 4th and 5th~~ –10th reports)* (~~subsequent reports~~) must be filed when:

   - There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data.
   - There are claims indicated as closed on a previous report that are reopened.
   - There are claims that were previously not reported, or the claim did not exist at the time of the previous reporting.
   - There are changes in losses valued from the prior to the current valuation period, yet claims were closed in both valuation periods.

   Losses are valued 12 ~~, 24, 36 or 48~~ months after the valuation date of the ~~1st~~ preceding report level. Refer to Part 1 for additional instructions on valuation and filing.

   * Unit statistical data with policies effective 12/31/1998 and prior that meets the requirements for subsequent reporting requires only 2nd–5th subsequent reports.

   b. **Revaluation of Losses**

   If a claim is closed and there is no change in the loss in that valuation period, it should not be reported in the next valuation period. If a change occurs, report the revised values for each open, reopened or closed claim on the 2nd~~, 3rd, 4th and 5th~~ –10th* report. The cumulative total may be reported for the following fields:

   - Number of claims
   - Paid indemnity
   - Incurred indemnity
   - Paid medical
   - Incurred medical
   - ALAE paid
   - ALAE incurred (Optional)

* Unit statistical data with policies effective 12/31/1998 and prior that meets the requirements for subsequent reporting requires only 2nd–5th subsequent reports.

2. **CORRECTION REPORTS**

   Correction reports must be filed without delay when any of the following conditions occur:

   - The carrier or claimant has received, or anticipates to receive, reimbursement from a Second Injury or similar type fund. When such a recovery is received by the carrier subsequent to the reporting of the claim (between valuation dates), but within one year after the 5th report due date, correction reports must be filed revising the paid and incurred loss on the claim as described in Part 4, Item 11. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim remains open. Correction reports are required only for prior reports that

EXHIBIT 3 (cont'd)

reflected an amount higher than the net incurred cost. If the total recovery amount is less than 10 percent of the gross incurred cost of the claim, do not file a correction report. Refer to the ***Experience Rating Plan Manual*** for time frames of modification revisions.

Exceptions: *Maine: The gross incurred losses and the paid losses are required to be reported according to Maine Law, when the carrier is eligible for reimbursement from the Supplemental Benefits Fund for benefit duration extensions.*

For reporting examples, refer to the ***URQ User's Guide,*** URE Correction Reports—Section 7.

- The carrier or claimant has obtained a subrogation recovery in an action against a third party. When such a recovery is received by the carrier subsequent to the reporting of the claim (between valuation dates), but within one year after the 5th report due date, correction reports must be filed revising the paid and incurred loss on the claim as described in Part 4, Item 15. If an anticipated recovery becomes known by the carrier, or a recovery is paid to the carrier as of the 6th report due date or subsequent, a correction report is not required; all adjustments are reported at the next valuation date if the claim remains open. Correction reports are required only for prior reports that reflected an amount higher than the net incurred cost. Refer to the ***Experience Rating Plan Manual*** for time frames of modification revisions.

  If the total recovery amount is less than 10 percent of the gross incurred cost of the claim, do not file a correction.

  Exceptions: *For Louisiana and New Hampshire, replace the two preceding bullets with the following: The carrier or claimant has obtained a subrogation recovery in an action against a third party or has received, or anticipates to receive, reimbursement from a Second Injury or similar type fund. When such a recovery is received by the carrier subsequent to the reporting of the claim (between valuation dates), correction reports must be filed revising the paid and incurred loss on the claim by the amount of subrogation received. Refer to Part 4, Items 11 and 15 for further instructions. If the total recovery amount is less than 10 percent of the gross incurred cost of the claim, do not file a correction report. For reporting examples, refer to NCCI's* ***URQ User's Guide,*** *URE Correction Reports—Section 7.*

  Exceptions: *For Kansas only, when reimbursement of the benefits deductible is received after the valuation date of a claim, a correction report must be immediately filed. For reporting procedures, refer to Item 4 within this Part. For reporting examples, refer to NCCI's* ***URQ User's Guide,*** *URE Correction Reports—Section 7.*

  Exceptions: *For Idaho compensation reimbursement claims only: If a claim exceeds the incurred loss limit of $1,000 after the initial reporting of the claim, submit a correction report to remove the compensation reimbursement for all report levels. Claims that exceed the $1,000 loss limit become the insurer's responsibility and a compensation reimbursement from the insured is not allowed.*

Correction reports submitted in connection with 1st~~, 2nd, 3rd, 4th and 5th~~ through 10th* reports must be identified with a correction type and sequence number. Please refer to Part 7 for specific correction type codes. Refer to NCCI's ***URQ User's Guide,*** URE Correction Reports, Section 7 for specific correction type reporting instructions.

Correction reports must be filed as soon as the changes are known.

* Unit statistical data with policies effective 12/31/1998 and prior that meets the requirements for subsequent reporting requires only 2nd-5th subsequent reports.

EXHIBIT 4

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 8—PENSION TABLES (limited to Note language only)

~~NOTE: Unit plan reporting ceases at 5th report; however, this example is included to assist companies in computing reserves beyond 5th report for internal purposes.~~