NORTH CAROLINA RATE BUREAU
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August 23, 2004

CIRCULAR LETTER TO ALL MEMBER COMPANIES

Re: Workers Compensation Insurance

Item U-1390 – Unit Statistical Reporting Instruction Enhancements

The Bureau has adopted and the North Carolina Commissioner of Insurance has approved an enhancement of the reporting requirements by adding 6th – 10th unit statistical report levels.

The attached Filing Memorandum (Item U-1390) describes the changes which have been approved to become effective at 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.

Updates to reflect these future changes will be made to the North Carolina Statistical Plan Manual which can be accessed on the North Carolina Rate Bureau website at http://www.ncrb.org/ncrb/workers comp services/forms/NCRB Stat Plan Manual.pdf.

Sincerely,

Sue Taylor

Director of Workers Compensation

ST:dg

C-04-9

Attachment

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.~~

EXHIBIT 5

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 4—LOSS INFORMATION

1. **REPORTING OF LOSSES**

c. **Claim Grouping Option (for policies effective July 1, 1999 and subsequent)**

- Medical-only claims that do not contain the same loss conditions (act, type of loss, type of recovery, type of coverage, type of settlement), ~~fraudulent status~~ fraudulent claim code, lump-sum settlement status or managed care organization status.

16. **FRAUD AMOUNT**

~~When reporting a claim where all of the claim cost is deemed fraudulent, report all loss components (e.g., medical costs, indemnity costs, etc.) apportioned as existed in the gross loss unless a more accurate split can be determined. The Type of Recovery code must be reported. When reporting the Type of Recovery on a partially or fully fraudulent claim, use the Type of Recovery code for Subrogation only (Third Party). When the Subrogation only (Third Party) code is used for indicating fraud recovery, the Fraudulent Claim Code field must be populated with the applicable Partially Fraudulent or Fully Fraudulent code appropriate to the determination under the applicable state law. Please refer to Item 30 of this part and Part 7 Coding Specifications for the relevant Type of Recovery and Fraud codes.~~ A fraudulent claim is a claim that meets either of the following conditions:

- The claim has been ruled (or officially declared) fully fraudulent by a court decision
- The claim, or a portion of the claim, has been deemed to be partially fraudulent by a court decision

Refer to Item 30 of this part and Part 7, Item 17, Fraudulent Claim (Code).

Reporting Fully Fraudulent Claims

When a claim has been ruled or declared to be fully fraudulent, the entire cost of the claim must be netted down to zero for unit statistical reporting.

- If the claim has been ruled or declared fully fraudulent prior to the 1st unit statistical report, the claim is considered noncompensable and is not to be reported.
- If the claim is ruled or declared to be fully fraudulent 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. Reduce the incurred cost on the claim to zero. This must be done for reports impacting the current and up to two prior modifications.
- If the claim is ruled or declared to be fully fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the incurred cost on the claim to zero at the next valuation date.

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

EXHIBIT 5 (cont'd)

Reporting Partially Fraudulent Claims
When a claim, or a portion of the claim, has been ruled or declared to be partially fraudulent, the cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount.

- If the claim, or a portion of the claim, has been ruled or declared partially fraudulent prior to the 1st unit statistical report, the net incurred cost of the claim on the 1st report must reflect the reduction of the claim by the partially fraudulent amount.
- If the claim, or a portion of the claim, is ruled or declared to be partially fraudulent 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. The cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount. This must be done for reports impacting the current and up to two prior modifications.
- If the claim, or a portion of the claim, is ruled or declared to be partially fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the net incurred loss by the declared fraudulent amount at the next valuation date.

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

The "net incurred cost" is defined as the gross incurred loss (i.e., the gross evaluation of the claim whether the claim is still open or not) minus the amount declared to be partially fraudulent.

For example, consider a claim that has been reported as $10,000 (1st report), $40,000 (2nd report), and $60,000 (3rd report). Subsequent to the 3rd report, the claim was ruled partially fraudulent with the partially fraudulent amount set at $25,000. The net incurred cost of the claim is the latest value minus the partially fraudulent amount: $60,000 – $25,000 = $35,000. The net incurred cost ($35,000) is less than the claim value reported at the 2nd and 3rd reports. Correction reports must be submitted for the 2nd and 3rd reports. 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 partially fraudulent amount has not been allocated into indemnity and medical components by the adjudicator, the net incurred loss must be divided between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amount.

20. **LOSS CONDITION CODE**
    c. **Type of Recovery** (also refer to Items 11 and 15 in this section regarding recoveries from state Second Injury Funds and other third parties)

(03) Subrogation Only (Third Party)
A recovery due to subrogation that occurs when the carrier has received reimbursements from an entity other than the employer, with legal liability due to circumstances for the injury. ~~When a recovery is received from a finding of fraud in accordance with the applicable state law, this code is used in combination with the Fraudulent Claim Code coded for a partially or fully fraudulent claim. See Fraud, Item 16 of this part and Part 7—Coding Specifications, Fraudulent Claim Code.~~

EXHIBIT 5 (cont'd)

30. **FRAUDULENT CLAIM (CODE)***

The Fraudulent Claim Code identifies if the claim is Not Fraudulent, Partially Fraudulent or Fully Fraudulent. Refer to Item 16, Fraud Amount of this part for the definition of a fraudulent claim, and also to Part 7, Item 17, Fraudulent Claim (Code) for code values and definitions.

~~Report the code that identifies the involvement of fraud in a claim. Specific fraudulent claim coding instructions are located in Item 16 of this part and also in Part 7—Coding Specifications, Fraudulent Claim (Code) of this Plan.~~

~~(00) Not Fraudulent—The claim does not involve fraud.~~
~~(01) Partially Fraudulent—A portion of the claim cost is deemed invalid, unnecessary or excessivein accordance with the law of the jurisdiction state, if applicable.~~
~~(02) Fully Fraudulent—A claim where all claim costs were found to have arisen from a falsely reported injury in accordance with the law of the jurisdiction state, if applicable.~~

Exceptions: *Oklahoma: This field is required for policies effective January 10, 2002 and subsequent.*

* Reporting of this field is required for policies effective January 1, 2002 and after. For policies effective prior to January 1, 2002, this field is optional.

EXHIBIT 6

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 5—SUBSEQUENT REPORTS AND CORRECTIONS

2. **CORRECTION REPORTS**

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

- ~~A carrier recovers paid indemnity or medical on a partially fraudulent or fully fraudulent claim under the applicable state law. For further information, please refer to Part 4, Item 16. Fraud Amount and Part 7 for specific fraud reporting codes.~~

- A claim is ruled or declared to be fully fraudulent subsequent to the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears. Reduce the incurred cost of the claim to zero. This must be done for reports impacting the current and up to two prior modifications. If the claim is ruled or declared to be fully fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the incurred cost on the claim to zero at the next valuation date. For further information, refer to Part 4, Item 16, Fraud Amount and Item 30, Fraudulent Claim (Code); and Part 7, Item 17, Fraudulent Claim (Code).

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

- A claim, or a portion of the claim, is ruled or declared to be partially fraudulent subsequent to the 1st reporting, but within one year after the 5th report due date of the report on which the claim appears. The cost of the claim must be netted down to reduce the net incurred loss by the declared fraudulent amount. This must be done for reports impacting the current and up to two prior modifications. If the claim, or a portion of the claim, is ruled or declared to be partially fraudulent as of the 6th report due date or subsequent, a correction report is not required. If the claim remains open, reduce the net incurred loss by the declared fraudulent amount at the next valuation date. For further information, refer to Part 4, Item 16, Fraud Amount and Item 30, Fraudulent Claim (Code); and Part 7, Item 17, Fraudulent Claim (Code).

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

EXHIBIT 7

URE WORKERS COMPENSATION STATISTICAL PLAN

PART 7—CODING SPECIFICATION

17. **FRAUDULENT CLAIM (CODE)**
This code identifies the involvement of fraud in a claim.

Code	Description
00	Not Fraudulent—The claim does not involve fraud.
01	Partially Fraudulent—The claim, or a portion of the claim, has been deemed partially fraudulent by a court decision.
02	Fully Fraudulent—The claim has been ruled (or officially declared) fully fraudulent by a court decision.