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PCRB
PENNSYLVANIA
Compensation Rating Bureau

PENNSYLVANIA AND DELAWARE
CALL FOR EXPERIENCE #9A

GROSS (1ST DOLLAR) LARGE DEDUCTIBLE CLENDAR – ACCIDENT YEAR CALL FOR COMPENSATION EXPERIENCE BY STATE VALUED AS OF DECEMBER 31, 2023 - DUE MARCH 15, 2024 IN DELAWARE AND APRIL 15, 2024 IN PENNSYLVANIA

In accordance with the approved statistical program, you are requested to file with the Bureaus on or before March 15, 2024 in Delaware and April 15, 2024 in Pennsylvania, your compensation experience for large deductible policies on a **gross** basis valued as of December 31, 2023. **Data reported in this Call is not subject to the Financial Data Incentive Program (FDIP) until calls valued as of December 31, 2024 and must be submitted using the Financial Data Manager (FDM).**

To qualify as a Large Deductible program, the deductible amount per claim or accident cannot be less than $100,000. All programs with a deductible of less than $100,000 should be reported on the standard Calendar-Accident Year Call on a gross basis.

Data collected in the **Gross (1st Dollar)** Large Deductible Accident Year Call includes earned premiums and incurred losses generated by the application of large deductible coverage on a **gross** basis (**prior to** the large deductible credit). Large deductible experience is also collected on a **net** basis (**after** large deductible credits) in Call **#8.**

This Call will collect loss experience for 31 full accident years (1993-2023) and experience for all accident years prior to 1993 should be accumulated and shown on the "Prior to 1993" line of the Call. The premium experience is only required for the last 5 years of calendar year premium reported in columns 1-3, lines X, Y and Z are not required.

For Pennsylvania carriers only, please note that the data used to complete this Call, as well as Calls for Experience #1 and #8, must be consistent and comparable to the data used to complete the Pennsylvania Schedule W.

All questions should be directed to Financial Data Reporting at (215) 568-2371.

A. GENERAL INSTRUCTIONS:

1. Group Report

This Call reports this information by individual member or by group as was established on the Designation of Contact Person form.

2. Calendar – Accident Year Call

Report paid losses, claim counts from the date of accident through December 31 of the current reporting year. Report loss reserves and IBNR as of December 31 of the current reporting year.

The Financial Calls on a calendar – accident year basis provide data from the latest year which is not available on a policy year basis. This makes the Calendar-Accident Year Calls valuable when analyzing loss development patterns and future severity and frequency trends.

3. Premium Reported in Calendar-Accident Year Calls

Report premium by transaction date for the latest five calendar years only (do not report data for any shaded rows). The premium reported must match the calendar year premium derived from Policy Year Call #9 (line Z), from Calls values as of December 31,2019 through December 31, 2023, respectively.

Refer to Policy Year Call #9 instructions for a guide to premium components included in Standard @ Bureau Level (column 1), Standard @ Company Level (column 2) and Net Premium (column 3).

4. 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 DE/PA 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.

You are required to report accumulated total incurred losses (i.e., from date of inception through December 31, 2023) on a **gross** basis (**prior** the deductible reimbursement). The Call further requires that accumulated total incurred losses be split into the following components: accumulated indemnity losses (separately for Paid, Outstanding Excluding IBNR - Case and Bulk, and IBNR) and accumulated medical losses (separately for Paid, Outstanding Excluding IBNR - Case and Bulk, and IBNR). The reporting of these components of incurred losses is mandatory for all carriers. Please note that for line Z only, under Outstanding Excluding IBNR and IBNR, the calendar year change should be reported rather than the accumulated total.

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.

5. 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.

Paid losses represent the amount actually paid by the insurance company and are essential to the Bureau's ratemaking process.

Subrogation—In some instances, a carrier is able to recover some or all of the paid losses from a third party. Such recoveries are called "subrogation." 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.

The Outstanding Excluding IBNR category is designed to capture case reserves and bulk reserves. For the purposes of this Call, the following working definitions may be used by carriers:

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. Case reserves can also be offset by what the future payments on the claim will be. Case reserves can also be offset by anticipated subrogation. 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, the Bureau needs to have the case reserves clearly separated from bulk reserves.

The goal of this reporting is to clearly isolate 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 Bureaus' development of IBNR data.

For this reason, carriers who have reported bulk reserves in IBNR should continue to do so. Located in the Questions icon of the Reporting Form, these carriers should respond "Yes" and then indicate "In IBNR" to the interrogatory regarding bulk reserves.

Those carriers who report bulk reserves in the Outstanding Excluding IBNR category should respond "Yes" and then indicate "In Outstanding reserves" to the interrogatory regarding bulk reserves located in the Questions icon of the Reporting Form. These carriers should have data reported in both the case reserves and 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.

6. **Claim Count Information**

Claim count information reported on Financial Calls is necessary for the Bureaus 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 claim 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.

a. Incurred Indemnity Claim Count

The incurred indemnity claim count (i.e., the accumulated number of claims for which an indemnity payment has been made and/or and outstanding reserve exists) must be reported on a mandatory basis for accident Years 1990 and subsequent.

The incurred indemnity claim should exclude claims that start out with an indemnity reserve but were resolved as medical only claims or closed without payment. If a claim, which was originally thought to include indemnity losses, turns out to be a medical only claim, the incurred indemnity claim count should be reduced at the time of discovery.

The incurred indemnity claim count should include claims that start out as medical only but were resolved as indemnity at future valuations. If a medical

only claim develops indemnity, then the indemnity claim count should be increased at the time the indemnity developed.

If indemnity claims are reopened, they should not be added to the incurred indemnity claim count.

Counts for claims with incurred amounts below the deductible amount should be included.

b. Closed (Paid) Indemnity Claim Count

This count includes those claims which are paid in full with no existing indemnity reserves. Claims that are reopened for which a case reserve exists at the valuation date should be removed from this category.

Report the accumulated number of paid and closed indemnity claims. Claims included in this count should contain indemnity or a combination of indemnity and medical.

1. Include claims that start out as medical only claims but were resolved as indemnity at future valuations.

2. Exclude indemnity claims that are resolved as medical only claims and claims closed without payment.

c. Open (Outstanding) Indemnity Claim Count

This includes those indemnity claims for which outstanding indemnity case reserves exist regardless of whether or not any payments have been made on those claims.

Report the total number of open indemnity claims which have outstanding reserves at year end. Claims with both indemnity payments and outstanding indemnity are also counted in this column.

If a claim previously closed with indemnity payment is reopened in the year and remains open at the valuation date, then the open indemnity claim count should be increased.

For PENNSYLVANIA CARRIERS ONLY, separate reporting of open and closed claims is required for Accident Years 1990 and subsequent since this data is consistent with and available in Schedule "W".

For DELAWARE CARRIERS ONLY, separate reporting of open and closed claims is required for Accident Years 1993 and subsequent. (Those carriers who are in a position to do so are requested to report the open and/or closed indemnity claim counts for as many accident years prior to 1993 as possible.)

Please note that if a carrier is able to capture open indemnity claims, then you may be able to report closed indemnity claims from the total indemnity claims. This can be done by subtracting the open indemnity claims from the total indemnity claims.

d. Paid Losses on Closed Claims

Report the accumulated losses paid on claims included in the Closed (Paid) Claim Count. Once again, note if a carrier is able to capture incurred (paid plus outstanding) losses on open indemnity claims then they may be able to report indemnity losses on closed claims. This can be done by subtracting the incurred (paid plus outstanding) losses on open indemnity claims from the total indemnity losses.

If a claim previously closed with payment is reopened in the year and remains open at the valuation date, then the losses paid on the claim should be excluded from the Paid Losses on Closed Claims.

In addition, losses paid on closed medical only claims should be included.

All of the information reported relating to indemnity claim counts should be reported consistently with incurred losses; i.e., on a direct basis excluding "F" classifications, underground coal mines, excess policies, National Defense Projects as well as coverages included in Call #1.

7. **Allocated Loss Adjustment Expense**

FOR PENNSYLVANIA CARRIERS ONLY, the reporting of Allocated Loss Adjustment Expense in this call is not required. Columns (23) through (26) should be left blank for Pennsylvania reporting.

For DELAWARE CARRIERS ONLY, starting in 1995 (data valued as of December 31, 1994), the reporting of Allocated Loss Adjustment Expenses, is mandatory for Policy Years 1994 and subsequent. Starting with Policy Year 1994, the reporting of Paid, Case and Bulk + IBNR (columns (23) through (26)) is mandatory.

Note that the Allocated Loss Adjustment Expenses reported should be consistent with the incurred losses; i.e., reported on a direct basis excluding "F" classifications, coal mines, excess policies, National Defense Projects as well as coverages included in Call #1.

Allocated Loss Adjustment Expense Definition

Effective January 1, 1998, the NAIC developed a new definition for Allocated Loss Adjustment Expense. For the reporting of policy years 1998 and subsequent, the new NAIC definition should be used.

For Policy Years 1994 through 1997, allocated loss adjustment expense should be reported according to the definition approved in filing No. 94-01. DCRB Circular #678 announced the approval of Delaware reference filing No. 94-01 which included Attachment (14) [Filing Item U-1292], establishing a definition of allocated loss adjustment expense.

For Policy Years 1993 and prior, allocated loss adjustment expense should be reported according to the old definition of allocated loss adjustment expense.

8. **No Experience**

State reports should not be submitted for any state in which the carrier(s) has (have) never had experience. In this case, Acknowledgment Forms should be completed and submitted through the FDRA on or before the required due date so the Bureaus can positively confirm the status of those carriers who will not be submitting data for this Call. In instances where the carrier(s) failed to have experience in one or more, but not all, of the Prior to 1993 – 2023 Accident Years in a given state, enter zeroes across the appropriate Accident Year line(s) for that state.

9. **Complete Submission**

A complete Call submission per state consists of entering data in Section #1, and providing a response as required to the edits located in the Errors icon of the call and submitting the Call through FDM.

10. **Rounding Procedure and Reporting of Credits**

Please report amounts of premiums and losses in WHOLE DOLLARS ONLY. FDM will not allow cents to be entered onto the form. If the values are not entered as whole dollars, the application will return an error message and will not allow the importing of the template. Negative amounts must have a negative sign in front of the number being entered.

B. **SPECIFIC INSTRUCTIONS:**

1. **"F" Classifications**

Experience of the "F" Classifications for policies effective January 1, 1974, and thereafter MUST BE EXCLUDED.

2. **Coal Mine Experience**

Coal Mine experience MUST BE EXCLUDED. Note that in Pennsylvania, this exclusion applies to ALL Coal Mine Experience, not just underground coal mines.

3. **Excess Policies**

Experience on excess policies MUST BE EXCLUDED.

4. **National Defense Projects**

Experience on National Defense Projects written under either the old Comprehensive Rating Plan or the new National Defense Projects Rating Plan

MUST BE EXCLUDED. Experience incurred on a Defense Base should be included unless written under the National Defense Projects Rating Plan.

5. **Terrorism**

All premiums collected in connection with Terrorism (Statistical Classification 9740) MUST BE EXCLUDED. Qualifying losses should be included.

6. **Catastrophe (Other than Certified Acts of Terrorism)**

Catastrophe (Other than Certified Acts of Terrorism) (Statistical Classification 9741) MUST BE EXCLUDED. Qualifying losses should be included.

7. **Reinsurance**

No deductions shall be made from premiums and losses for or on account of reinsurance ceded. Premiums and losses arising from reinsurance received by the reporting company shall be excluded from the experience. Experience should be DIRECT BUSINESS ONLY.

8. **Assigned Risk**

Experience for assigned risk policies must be INCLUDED. Assigned risk policies must be reported at the level of approved assigned risk rates.

9. **Experience Incurred Under Occupational Disease Act**

Experience incurred under any Occupational Disease Act, which is separate and distinct from the Compensation Act for the state, shall be combined with the traumatic experience under the State Compensation Act, and the total of such combined experience shall be reported.

10. **IBNR**

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

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 Bureaus' development of IBNR data.

11. **Reopened Cases**

Include an appropriate loss reserve for reopened cases in the IBNR reserve.

12. **Reserves for Specific Contingencies**

Include medical and other loss reserves to meet specific contingencies in the IBNR reserve.

13. **Other Voluntary Reserves**

Exclude voluntary reserves other than those mentioned above.

14. **Expenses**

Exclude all expenses, allocated or unallocated, except allocated Employers Liability loss adjustment expense from losses. Allocated loss adjustment expense is to be separately reported (Delaware only).

15. **Assessments and Special Compensation Funds**

The inclusion of assessments and other compensation special funds as incurred losses in this Accident Year Call follow the same instructions that apply in reporting of experience under the Bureaus' Workers Compensation Unit Statistical Plan Manual. Specifically, where the compensation law states that, in connection with a certain type 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 states 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 Bureaus. In other words, special funds or assessments are reported as incurred losses only when the assessment is levied on certain types of injuries.

Please note that the due date for reporting this data is on or before March 15, 2024 in Delaware and April 15, 2024 in Pennsylvania.

It is urged that every effort be made to comply with these reporting dates, as a delay in receiving this data will seriously hamper the Bureaus in the preparation of filings.