WCIRB Aggregate Financial Data Glossary

(Updated 6/1/2016)

Abridged Calendar Year Call. A request from the WCIRB to new member insurers of the WCIRB not currently writing or planning to write significant workers' compensation business in California to submit premium and losses for the calendar year in lieu of the more detailed data calls.

Accident Year (AY). The year in which the accident or injury took place; it includes all accidents that occurred between January 1 and December 31 of the year, regardless of when the policies that covered them were effective or when the accidents were reported.

Accident Year Exhibit. Part II of the Quarterly Call requesting loss, claim count and allocated loss adjustment expense data by accident year as of the end of a calendar quarter.

Advisory Pure Premium Rates. Pure premium rates submitted by the WCIRB to the California Department of Insurance for approval. The approved advisory pure premium rates are used by insurers to establish their own premium rates. Insurer rates are expected to cover the costs of pure premium (losses and loss adjustment expenses) and other administrative expenses and may include a provision for profit and unforeseen contingencies. See also Pure Premium Rates.

Advisory Pure Premium. See Pure Premium at Advisory Pure Premium Rate Level.

Aggregate Indemnity and Medical Costs Call. A request from the WCIRB to its member insurers for calendar year paid indemnity and medical losses segregated by individual benefit type. In addition, earned premium for the calendar year is also requested.

ALAE. See Allocated Loss Adjustment Expense.

Allocated Loss Adjustment Expense. In general, these are expenses incurred by an insurer in investigating and settling claims that can be assigned to a specific claim, such as defense legal fees. (See definition of Allocated Loss Adjustment Expense in the *Workers' Compensation Uniform Statistical Reporting Plan - 1995*.)

Calendar Year (CY). The period between January 1 and December 31 of the same year. Financial activities may be compiled by calendar year accounting periods. For example, calendar year 2015 incurred losses is the sum of 1) losses paid between January 1, 2015 and December 31, 2015, inclusively, and 2) the difference between loss reserves valued as of December 31, 2015 and loss reserves valued as of December 31, 2014.

California Insurance Guarantee Association (CIGA) Assessments. The California Insurance Guarantee Association (CIGA) pays claims of member insurance companies that were licensed to transact business in the state of California that have been found by a court of competent jurisdiction to be insolvent and ordered into liquidation. CIGA assessments are levied from insured employers (through

insurers) to administer and pay for these claims. CIGA assessments should be excluded from the premiums reported on WCIRB data calls.

California Workers' Compensation Fraud Surcharge. The Workers' Compensation Fraud Program was established in 1991 when the California Legislature made workers' compensation fraud a felony, required insurers to report suspected fraud, and established a mechanism for funding enforcement and prosecution activities. Assessments for the program are levied from insured employers (through insurers) and self-insured employers. These assessments should be excluded from the premiums reported on WCIRB data calls.

California Workers' Compensation Revolving Fund Assessment. The Workers' Compensation Administration Revolving Fund was established in 2009 pursuant to the provisions of Labor Code Section 62.5. Assessments for the fund are levied on insured employers (through insurers) and self-insured employers. These assessments should be excluded from the premiums reported on WCIRB data calls.

Capitated Medical Payments Not Otherwise Classified. These are payments made on a capitated or "per covered individual" basis rather than for a specific medical procedure on a specific injury. For reporting on the Aggregate Indemnity and Medical Costs Call, capitated medical payments must include amounts contemplated for payments to physicians, hospitals, drugs and other payments for medical treatment.

Ceded Reinsurance. When an insurance company reinsures its liability with another, the original or primary insurer (i.e., the insurance company that purchases reinsurance) is the "ceding company" that "cedes" business to the reinsurer. "Ceded reinsurance" refers to the portion of the liability that is being reinsured. "Reinsurance assumed" is that portion of a risk that the reinsuring company accepts from the original/primary insurer in return for a stated premium. When reporting on WCIRB data calls, the experience of ceded reinsurance should be included on the ceding company's data calls but excluded on the reinsurer's data calls.

CIGA. See California Insurance Guarantee Association (CIGA) Assessments.

Claim Count Data. Claim count is the count of the number of claims. For WCIRB data call reporting, claims with zero incurred losses shall not be included in claim count data. Claim counts may be segregated into various types. For example, on the Accident Year Exhibit of the Quarterly Call, total indemnity claim counts (cumulative total number of claims that have an incurred indemnity amount greater than zero as of the evaluation date of the data call) and open indemnity claim counts (cumulative total number of open claims that have an incurred indemnity amount greater than zero as of the evaluation date of the data call) are requested in addition to total claim counts. See Claim Count Guidelines for more information about the reporting of claim count data on the Quarterly Call.

Claim Count Development Factor. See Development Factor and Claim Count Development.

Claim Count Development. Statistics showing how claim counts have changed from one historical period to another.

Closed Claim(s). A claim for which final payment has been made.

Commission and Brokerage Expense. Commission and brokerage fees for agents and brokers in underwriting a policy.

Cost of Medical Cost Containment Programs. All expenses related to medical cost containment programs. For reporting on WCIRB data calls, medical cost containment expenses for claims on policies incepting prior to July 1, 2010 are included in medical losses. The costs of medical cost containment programs for claims on policies incepting on or after July 1, 2010 are included in allocated loss adjustment expenses. The costs of Independent Bill Review (IBR) and Independent Medical Review (IMR) reports paid on or before January 1, 2016 are included in the costs of medical cost containment programs. The costs of IBR and IMR reports paid after January 1, 2016 are excluded from the cost of medical cost containment programs but are still included in Allocated Loss Adjustment Expense. See also Allocated Loss Adjustment Expense.

Data Certification Form. A request from the WCIRB to its member insurers to ensure that member insurers are submitting aggregate financial data in accordance with WCIRB requirements. The Data Certification Form is required of all insurers who report Quarterly Call data to the WCIRB. In this certification, a company officer or actuary attests that the data submitted to the WCIRB on data calls evaluated as of December 31 of the preceding calendar year and the Quarterly Call evaluated as of March 31 of the same calendar year in which the certification is due conforms to the instructions and definitions set forth for these data calls by the WCIRB.

DCF. See Data Certification Form.

Death Benefits. Workers' compensation death benefits as required by the California Labor Code. For reporting the "Payment of Death Benefits" on the Aggregate Indemnity and Medical Costs Call, payments for burial allowance must be included. Payments for temporary disability, permanent partial disability and/or permanent total disability benefits made prior to the death of the injured worker must be excluded. Portions of single sum settlements, which can be allocated to this benefit type, must be included.

Death Claim(s). A claim involving the industrial death of a worker.

Deductible Credit. Premium credit amount given by the insurer to the policyholder on a deductible policy to be subtracted from the full coverage premium amount in accordance with the deductible provision of the policy. When reporting premiums on WCIRB data calls, deductible credit amounts should be excluded unless explicitly requested otherwise.

Deductible Policies. Policies with a (deductible) provision where the policyholder is liable for a portion of losses incurred (deductible amount) while the insurer is liable for the remainder. For workers' compensation deductible policies, the employers reimburse the insurers for the deductible amounts. For the Large Deductible Call, the experience of only large deductible policies (ones with deductible amount per claim or accident of at least $100,000) shall be included and reported on a gross (first dollar) basis. For other WCIRB data calls, the experience of all deductible policies (as well as non-deductible policies) shall be included and reported on a gross (first dollar) basis.

Development Factor (DF). The ratio of the value of a data element between two different maturity dates. See also Loss Development and Claim Count Development.

Direct Losses. Losses that are directly from the underlying policy before taking into account any ceding to another insurer or reinsurer. Losses reported on WCIRB data calls should be on a direct loss basis.

Direct Premium. Premium that is directly from the underlying policy before taking into account any ceding to another insurer or reinsurer. Premiums reported on WCIRB data calls should be on a direct premium basis.

Earned but Not Billed or Booked. Premiums that have been earned (based on the insurer's accounting method for earned premium) for a calendar period but which have not been billed to a policyholder or booked into the insurer's system. Earned but not billed or booked premiums should be included in both the Premium at Insurer Level and the Pure Premium at Advisory Pure Premium Rate Level in WCIRB data calls.

Earned Premium. The portion of a premium that has been earned by the insurer for policy coverage already provided.

EBUB. See Earned but Not Billed or Booked.

Employers' Liability Increased Limits. Part of a workers' compensation policy may cover liability arising out of the employees' work-related injuries that do not fall under the workers compensation statute, with the employer's liability limit stated in the policy. An employer may opt to increase that limit by paying for an employers' liability increased limit endorsement through a premium surcharge. The cost of employers' liability increased limits should be included in Premium at Insurer Level and excluded from Pure Premium at Advisory Pure Premium Rate Level on WCIRB data calls.

eSCAD Reporting Group. The group of insurance companies whose data is reported on WCIRB data calls on a combined basis.

eSCAD. A web-based application developed by the WCIRB that allows insurers to electronically submit aggregate financial data to the WCIRB.

Excess Insurance. An insurance policy covering the policyholder for losses in excess of a stated amount (typically a large amount) on the policy. When reporting on WCIRB data calls, the experience of excess insurance should be excluded.

Expense Call. A request from the WCIRB to its member insurers for calendar year premium, loss and expense information (loss adjustment expenses, acquisition expenses, general expenses and other expenses) with detail that is similar to the expense information reported on statutory annual statements. The Expense Call also contains a Reconciliation Report Exhibit that ties the data between the Expense Call and the insurer's annual statements.

Experience Modification. An experience rating adjustment to an employer's premium based on comparing the employer's experience to the experience of its industry. When reporting Pure Premium at the Advisory Pure Premium Rate Level on WCIRB data calls, premiums should be after the application of experience modifications. See also Experience Rating.

Experience Rating. California's workers' compensation experience rating system is a merit rating system intended to provide employers a direct financial incentive to reduce work-related accidents. The experience rating system objectively distributes the cost of workers' compensation insurance more equitably among employers assigned to particular industry classifications by deriving an experience modification for each eligible employer based on the experience rating formula in the *California Workers' Compensation Experience Rating Plan—1995* (Experience Rating Plan). Experience rating is applicable only to and mandatory for employers meeting the eligibility threshold for experience rating specified in each year's Experience Rating Plan. See also Experience Modification.

General Expenses. Insurer general expenses (rent, etc.).

IBNR. See Incurred but Not Reported Reserves.

Incurred but not Reported Reserves. This represents the estimated indemnity and medical dollar amounts reserved for future development on known claims as well as claims that have incurred but have not yet been reported, reopened claims, and any other reserves to meet specific contingencies, as of a particular valuation date.

Incurred Data. Indemnity and medical claim costs as well as other insurance liabilities, such as allocated loss adjustment expense, are often periodically revalued. The incurred cost as of an evaluation date is the sum of cumulative costs paid up to this date and the reserves as of this date. See also Paid Data and Reserves.

Incurred Losses. The sum of cumulative paid losses and the outstanding loss reserves on claims. See also Incurred Data and Losses.

Indemnity Claim(s). A claim with incurred indemnity losses greater than zero, regardless of whether it has any incurred medical losses and/or incurred allocated loss adjustment expenses.

Indemnity Losses. The costs of compensating injured workers, or their dependents in the case of death claims, for financial benefits as a result of a workplace accident. Generally, these costs include compensation for lost wages as well as vocational rehabilitation-type benefits. For WCIRB data calls, indemnity losses shall be reported consistent with the definition of indemnity losses in the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* which specifies:

All indemnity costs including, but not limited to:

a. On a claim closed by a single sum settlement, that portion assignable to indemnity.

b. The following legal expenses for the claimant if they are included in the award to, or incurred on behalf of, a claimant:

   (1) Witness fees.

   EXCEPTION: Expert medical witness fees shall be included in medical loss.

   (2) Attorney fees.

   (3) Other court costs.

(4) Reimbursement for expenses incurred in attending a hearing or deposition, including interpreter fees.

(5) Cost of copies of documents such as birth and death certificates.

c. The cost of all supplemental job displacement benefit vouchers as well as any additional vocational rehabilitation-type benefits (including those provided on a voluntary basis).

d. Allocated Loss Adjustment Expenses incurred for employers' liability claims.

Note: Indemnity losses do not include automatic increases to late indemnity payments made pursuant to California Labor Code Section 4650, penalties for unreasonable delay determined by the Workers' Compensation Appeals Board pursuant to California Labor Code Section 5814, reimbursement of lien filing fee or lien activation fee made pursuant to California Labor Code Section 4903.07 or reimbursement of independent bill review fee made pursuant to California Labor Code Section 4603.6 (c).

Independent Bill Review (IBR). Effective January 1, 2013, the California's workers' compensation system uses a process called independent bill review (IBR) to resolve medical treatment billing and medical-legal billing disputes.

When reporting IBR costs on WCIRB data calls, the costs of IBR reports paid on or before January 1, 2016 shall be included in the costs of medical cost containment programs (MCCP) which is a component of allocated loss adjustment expenses (ALAE). The costs of IBR reports paid after January 1, 2016 shall no longer be included in the costs of MCCP but shall continue to be included in reported ALAE. See also Costs of Medical Cost Containment Programs and Allocated Loss Adjustment Expenses.

Independent Medical Review (IMR). Effective January 1, 2013, the California's workers' compensation system uses a process called independent medical review (IMR) to resolve disputes regarding the medical treatment of injured workers. When a request for medical treatment reviewed through the utilization review process is denied, modified or delayed, the injured worker may request a review of that decision through IMR.

When reporting IMR costs on WCIRB data calls, the costs of IMR reports paid on or before January 1, 2016 shall be included in the costs of medical cost containment programs (MCCP) which is a component of allocated loss adjustment expenses (ALAE). The costs of IMR reports paid after January 1, 2016 shall no longer be included in the costs of MCCP but shall continue to be included in reported ALAE. See also Costs of Medical Cost Containment Programs and Allocated Loss Adjustment Expenses.

Insurer Premium. See Premium at Insurer Level.

Labor Enforcement and Compliance Fund Assessment. The Labor Enforcement and Compliance Fund was established in 2009 (Labor Code Section 62.5 (e)) to support the activities performed by the Division of Labor Standards Enforcement pursuant to various Labor Code sections. Assessments for the fund are levied from insured employers (through insurers) and self-insured employers. These assessments should be excluded from the premiums reported on WCIRB data calls.

Large Deductible Call. A request from the WCIRB to its member insurers for aggregate financial premium, loss, claim count, and allocated loss adjustment expense data as of quarter-end or for a calendar year or calendar-quarter period similar to the Quarterly Call (see Quarterly Call), except the data pertains to Large Deductible policies (policies with deductibles of $100,000 or more) only.

Large Deductible Policies. For the Large Deductible Call, large deductible policies are policies with a deductible amount per claim or accident of at least $100,000.

LCM. See Loss Cost Multiplier.

Loss Cost Multiplier. The "Loss Cost Multiplier" is a factor included in an insurer's workers' compensation rate filing that adjusts the pure premium rates referenced in that rate filing to the insurer's proposed manual rates. Depending on the insurer's preference, the referenced pure premium rates may either be those approved by the California Department of Insurance, proposed by the WCIRB, or another set of rates. For reporting Pure Premium at the Advisory Pure Premium Rate Level on the WCIRB Quarterly Calls, the Loss Cost Multiplier may be used in the calculation to adjust the Premium at Insurer Level to the Pure Premium at the Advisory Pure Premium Rate Level. See Multiplicative Factor. Also see Pure Premium Guidelines and Illustrative Spreadsheet in the Aggregate Financial Data section of the WCIRB website for sample calculations using the Loss Cost Multiplier to obtain the "multiplicative factor".

Loss Deductible. Determines the amount of losses for which the policyholder is liable under the provisions of its deductible policy.

Loss Development (LD). Statistics showing how losses have changed from one historical period to another.

Loss Development Factor (LDF). See Development Factor and Loss Development.

Loss Ratio. The ratio of losses to premium.

Loss Reserves. An estimate of an insurer's liability for future claim payments as of a particular date. Workers' compensation loss reserves are split between indemnity loss reserves and medical loss reserves, just as paid losses are split between indemnity and medical components. On the Accident Year Exhibit of the Quarterly Call, loss reserves are requested by accident year. Case reserves are loss reserves estimated on an individual claim basis. In addition to case reserves, insurers typically have incurred but not reported (IBNR) reserves which are estimated in aggregate to reflect claims for which the insurer has not set up reserves and/or late-reported claims. Insurers may also set up bulk reserves to account for development of losses on known claims over time. See also Losses, Incurred but Not Reported Reserves, and Voluntary Reserves.

Losses. Indemnity and medical claim costs. For WCIRB data call reporting, all loss amounts are on a direct basis (excluding reinsurance assumed and adjustment for reinsurance ceded) and must be reported on a gross basis prior to the application of any deductibles. See also Indemnity Losses and Medical Losses.

MCCP. See Cost of Medical Cost Containment Programs.

Medical Evaluation. An examination of a worker's injury, performed by an independent medical examiner, agreed medical evaluator, treating physician, consulting physician or qualified medical evaluator, for purposes of assessing the worker's eligibility for benefits, ability to return to work, extent of permanent disability and/or need for new and further medical treatment. For reporting on the Aggregate

Indemnity and Medical Costs Call, this does not include independent medical review conducted pursuant to Labor Code Sections 4610.5 and 4610.6 or 4616.4 or independent bill review conducted pursuant to Labor Code Section 4603.6.

Medical Losses. The costs of providing medical care to injured workers. For WCIRB data calls, medical losses shall be reported consistent with the definition of medical losses in the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* which specifies:

All medical costs including, but not limited to:

a. On a claim closed by a single sum settlement, that portion assignable to medical.

b. The cost of all medical evaluations and medical-legal evaluations. This includes all evaluations to determine eligibility for benefits, such as ability to return to work, extent of permanent disability, and/or the need for new and further medical treatment. This also shall include the cost of procuring copies of medical records and interpreter fees related to medical evaluations and medical-legal evaluations. This does not include costs associated with independent medical review conducted pursuant to Labor Code Sections 4610.5, and 4610.6 or 4616.4 or independent bill review conducted pursuant to Labor Code Section 4603.6.

c. Contract medical.

d. Interpreter fees related to medical treatment.

e. All fees or costs related to Medicare Set-aside Arrangements.

Note: Medical losses shall not include increases due to late payments for medical and medical-legal services made pursuant to California Labor Code Sections 4603.2 or 4622.

Medical Payments Made Directly to Injured Workers. For reporting on the Aggregate Indemnity and Medical Costs Call, this is the amount of lump sum settlements apportioned to medical in recognition of future medical expenses paid directly to the injured workers (except for those related to Medicare set-aside accounts). It must exclude any medical payments related to Medicare Set-aside accounts.

Medical Payments Related to Medicare Set-Aside Accounts. For reporting on the Aggregate Indemnity and Medical Costs Call, this is the cost relating to the evaluation of potential future medical care to determine the amount of the Medicare set-aside for submission and approval by the Center for Medicare and Medicaid Services (CMS); the cost of the Medicare set-aside itself (that is paid to a fund to be administered by the injured worker or a third party); and costs involved in the administration of the Medicare set-aside account. This excludes medical reimbursement payments made directly to Medicare related to conditional liens.

Medical-Legal Evaluation / Medical-Legal Report. A medical-legal report is the written report based on the results of the medical evaluation. See also Medical Evaluations.

Medical-only Claim(s). A claim on which medical losses are incurred while no indemnity losses are incurred.

Medicare Set-Aside Accounts. See Medical Payments Related to Medicare Set-Aside Accounts.

Minimum Premium. The least amount of premium to be charged by the insurance company for providing insurance coverage. Premiums from minimum premium policies should be included in the reporting of premiums in WCIRB data calls.

Multiplicative Factor. For reporting on the Quarterly Call, it is a factor that can be used to convert premiums at insurer level to pure premiums at advisory pure premium rate level.

NAIC Code. A unique five-digit identification number assigned by NAIC to each insurance company filing financial data with the NAIC.

NAIC Group. A unique three to five digit number assigned by the NAIC to identify those insurance companies that are part of a larger group of insurance companies.

National Defense Project Insurance. An insurance policy affording coverage relating to national defense projects. When reporting experience (premium, losses, claim count and expenses) on WCIRB data calls, the experience of National Defense Project insurance should be excluded.

Occupational Safety and Health Fund Assessment. The Occupational Safety and Health Fund was created in 2008 to fund the operations of the Division of Occupational Safety and Health. Assessments for the fund are levied from insured employers (through insurers) and self-insured employers. These assessments should be excluded from the premiums reported on WCIRB data calls.

Open Claim(s). A claim that is not closed. See also Closed Claims.

Open Indemnity Claim Counts. Cumulative total number of claims that are open (for which a final loss payment has not yet been made) and have an incurred indemnity amount (sum of indemnity cumulative paid amount and indemnity loss reserves) greater than zero as of the evaluation date. See also Open Claims, Indemnity Claims and Claim Count Data.

Other Acquisition Expenses. Expenses incurred by the insurer in underwriting a policy, excluding commission and brokerage expense. (See also Commission and Brokerage Expense.)

Paid Data. The payment made for losses or expenses. On financial reports, loss and expense payments made within a calendar period may be aggregated. Also, loss and expense payments cumulated from the beginning of an accident year or policy year as of a valuation date may be compiled.

Paid Indemnity Losses on Open Indemnity Claims. Total paid indemnity losses on open indemnity claims for the specified accident year and valuation date. See also Paid Data, Indemnity Losses, Open Claims and Indemnity Claims.

Paid Medical Losses on Open Indemnity Claims. Total paid medical losses on open indemnity claims for the specified accident year and valuation date. See also Paid Data, Medical Losses, Open Claims and Indemnity Claims.

Paid Medical on Medical-Only Claims. Total paid medical losses on medical-only claims for the specified accident year and valuation date. See also Paid Data, Medical Losses and Medical-Only Claims.

Permanent Partial Benefits. Workers' compensation permanent partial disability benefits per the California Labor Code. For reporting the "Payment of Permanent Partial Benefits" on the Aggregate Indemnity and Medical Costs Call, payments for temporary disability, permanent total disability and/or death benefits paid on a claim which had permanent partial benefits paid must be excluded. Permanent partial benefits paid on death and permanent total disability claims must be included. Supplemental vocational rehabilitation maintenance allowances paid to claimants who elect to supplement vocational rehabilitation maintenance benefits by an advance from permanent disability benefits must be included. Portions of single sum settlements, which can be allocated to this benefit type, must also be included.

Permanent Partial Claim(s). A claim with a permanent disability (PD) rating greater than 0% but less than 100%.

Permanent Total Benefits. Workers' compensation permanent total disability benefits per the California Labor Code. For reporting the "Payment of Permanent Total Benefits" on the Aggregate Indemnity and Medical Costs Call, payments for temporary disability, permanent partial disability and/or death benefits paid on a claim which had permanent total benefits paid must be excluded. Supplemental vocational rehabilitation maintenance allowances paid to claimants who elect to supplement vocational rehabilitation maintenance benefits by an advance from permanent disability benefits must be included. Portions of single sum settlements, which can be allocated to this benefit type, must be included.

Permanent Total Claim(s). A claim with a permanent disability (PD) rating of 100%.

Policy Year (PY). The calendar year in which a policy begins. For example, policy year 2015 data consists of data from policies with an inception date between January 1, 2015 and December 31, 2015.

Premium at Insurer Level. The insurer "Final Premium" as defined in the *California Workers' Compensation Uniform Statistical Reporting Plan - 1995*. It is the total premium charged to the policyholder, EXCEPT that it does not include the following:

- Reinsurance assumed,
- Adjustment for reinsurance ceded,
- Retrospective rating adjustments,
- Policyholder dividends,
- Application of deductible credits,
- Terrorism charges,
- The costs incurred by the insurer in unsuccessfully attempting to perform a payroll audit that are reimbursable pursuant to Insurance Code Section 11760.1, and
- Policy assessments.

Premium Exhibit. Part I of the Quarterly Call requesting premium data pertaining to a calendar quarter.

Private Residence Employee Insurance. A workers' compensation insurance policy covering residence employee(s) of the policyholder. When reporting on WCIRB data calls, the experience of private residence employee insurance should be excluded.

Pure Premium at Advisory Pure Premium Rate Level. Premium at the advisory pure premium rate level based on the Insurance Commissioner's approved advisory pure premium rates in effect for the specified year, including the application of experience modifications. Pure premium rates include a provision for losses and loss adjustment expenses but exclude all other types of expenses or adjustments. See also Advisory Pure Premium Rates.

Pure Premium Rates. The loss cost per unit of exposure (typically payroll in hundreds of dollars), including loss adjustment expense, for standard classifications.

Quarterly Call. A request from the WCIRB to its member insurers for aggregate financial premium, loss, claim count, and allocated loss adjustment expense data as of quarter-end or for a calendar year or calendar-quarter period.

Rating Plan / Rating Plan Adjustment. An insurance company may adjust policyholders' premiums based on the policyholder's risk characteristics (e.g., schedule rating) or workers' compensation experience (e.g., merit rating) via a percentage or dollar adjustment. Experience rating and retrospective rating are forms of merit rating. When reporting Premium at Insurer Level on WCIRB data calls, all rating plan adjustments should be included, except for retrospective rating adjustments. When reporting Pure Premium at the Advisory Pure Premium Rate Level, only experience rating adjustment should be included. (See also Experience Rating and Retrospective Rating.)

Reconciliation Report Exhibit. An exhibit in the Expense Call that ties the data between the Expense Call and the insurer's annual statements.

Reimbursements to Medicare. For reporting on the Aggregate Indemnity and Medical Costs Call, this is the direct reimbursement payments made to Medicare related to conditional liens intended to recover payments for past medical services. This would exclude medical payments related to Medicare set-aside accounts.

Reinsurance Assumed. See Ceded Reinsurance. When reporting on WCIRB data calls, the experience of the reinsurance assumed by the reinsurer should be excluded on the reinsurer's data calls. This experience, however, should be included in the ceding company's reported experience.

Reopened Claim. A reopened claim is a claim that was closed at one point in time and later become open again, such as a claim in which the claimant and/or their representatives are seeking additional workers' compensation benefits. For WCIRB data call reporting purposes, a claim that is reopened at a particular point in time is considered an open claim at that time. A reopened claim is not considered a separate claim from the closed claim, and should be treated as a single claim rather than two claims for the purpose of reporting claim count data.

Reserves. See Loss Reserves.

Retrospective Rating Plan / Retrospective Rating Plan Adjustment. An optional rating plan that adjusts the premium of a policy based on the losses incurred during the policy period. Adjustments are made periodically after the policy has expired and may result in additional premium debits or credits. When reporting premiums on WCIRB data calls, retrospective rating adjustments should be excluded.

Salvage and Subrogation. An insurer which compensates an insured due to a loss caused by a third party has a right to recover money from that third party. When reporting losses, allocated loss adjustment expense, and claim count on WCIRB data calls, claims that have been subrogated or will be subrogated should be included.

SCAD Program. The Submission of California Aggregate Data (SCAD) Program is a data quality program that was adopted to encourage insurers to submit timely, accurate and complete aggregate financial data to the WCIRB. The current version of the SCAD Program is available at http://www.wcirb.com/document/503.

Single Sum Settlement Indemnity Payments. Workers' compensation court cases often result in a lump sum award or benefit, such as compromise and release settlements, stipulated awards, findings and awards, and summary ratings. In reporting losses to the WCIRB, insurers must split this lump sum settlement (a.k.a. single sum settlement) into indemnity and medical components. For reporting the "Single Sum Settlement Indemnity Payments" on the Aggregate Indemnity and Medical Costs Call, these single sum payments must include single sum payments which cannot be allocated to a specific indemnity benefit type on the Call.

Subrogation. See Salvage and Subrogation.

Subsequent Injuries Benefits Trust Fund Assessment. The Subsequent Injuries Benefits Trust Fund was created as a special trust fund account in the State Treasury pursuant to Labor Code Section 4751 to pay for a portion of the benefits to workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments. Assessments for the fund are levied from insured employers (through insurers) and self-insured employers. These assessments should be excluded from the premiums reported on WCIRB data calls.

Taxes, Licenses and Fees. Insurer expenses relating to business taxes, business licenses and other fees.

Temporary Disability Benefits. Workers' compensation temporary disability benefits per the California Labor Code. For reporting the "Payment of Temporary Disability Benefits" on the Aggregate Indemnity and Medical Costs Call, payments for temporary disability benefits, including temporary disability benefits paid on claims which had death, permanent total disability and/or permanent partial disability payments per Labor Section Code 4655 must be included. Portions of single sum settlements, which can be allocated to this benefit type, must also be included.

Temporary Disability Claim(s). A claim for which ultimately only temporary disability has been sustained by the injured worker (i.e., no permanent disability has been established or estimated).

Terrorism Surcharge. A policy premium surcharge to cover liability costs resulting from an act of terrorism which are not already contemplated in the insurance company's manual rates. When reporting premiums on WCIRB data calls, terrorism surcharge amounts should be excluded.

Total Claim Counts. Cumulative total number of claims (both open and closed) that have an incurred loss amount (sum of incurred indemnity amount and incurred medical amount) greater than zero as of the valuation date. See also Claim Count Data.

Total Incurred Losses Including IBNR. For reporting "Total Incurred Losses Including IBNR" on the Accident Year Exhibit of the WCIRB Quarterly Call, this is the sum of the incurred indemnity and medical losses and IBNR as of a valuation date. See also Incurred Losses and IBNR.

Total Indemnity Claim Counts. Cumulative total number of claims (both open and closed) that have an incurred indemnity amount greater than zero as of the evaluation date. See also Indemnity Claims and Total Claim Counts.

ULAE. See Unallocated Loss Adjustment Expenses.

Unallocated Loss Adjustment Expenses. In general, these are expenses incurred by an insurer in investigating and settling claims that cannot be assigned to a specific claim, such as claims adjuster salaries. (See definition of Unallocated Loss Adjustment Expense in the *Workers' Compensation Uniform Statistical Reporting Plan - 1995*.)

Uninsured Employers Trust Fund Assessment. The Uninsured Employers Benefits Trust Fund was created pursuant to labor Code Section 3710 as a special trust fund account in the State Treasury to pay for workers' compensation claims for workers injured while employed by uninsured employers. Assessments for the fund are levied from insured employers (through insurers) and self-insured employers. These assessments should be excluded from the premiums reported on WCIRB data calls.

USL&H Insurance. A workers' compensation insurance policy affording coverage under the United States Longshore and Harbor Workers' Compensation Act (USL&H Act). When reporting on WCIRB data calls, the experience of USL&H insurance should be excluded.

USRP. See *Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP).

Vocational Rehabilitation Benefits. Workers' compensation vocational rehabilitation-type benefits per the California Labor Code. For reporting the "Vocational Rehabilitation Benefits" on the Aggregate Indemnity and Medical Costs Call, reported payments for all supplemental job displacement benefits issued in the form of vouchers as well as any additional vocational rehabilitation-type benefits (including those provided on a voluntary basis) must be included. Portions of single sum settlements, which can be allocated to this benefit type, must be included.

Voluntary Reserves. Government agencies, such as the Department of Insurance, often regulate the reserve requirements of insurance companies to ensure their solvency. Voluntary reserves are additionally held liquid assets per the requirement agreed upon between the government agencies and the insurance companies. For WCIRB data calls, voluntary reserves are to be excluded from indemnity and medical loss reserves and IBNR reserves.

WCIRB Insurer Code. A unique three-digit identification number assigned by the WCIRB to each of its member insurance companies.

Workers' Compensation Uniform Statistical Reporting Plan—1995 (USRP). The plan contains instructions for reporting policy data and requirements for reporting detail policy premium, payroll and claims data to the WCIRB. It also contains the Standard Classification System. The USRP is part of the California Insurance Commissioner's regulations. The current version of the USRP is available at http://www.wcirb.com/document/123.

Written Premium. The premium registered on the books of an insurer at the time a policy is issued and paid for.