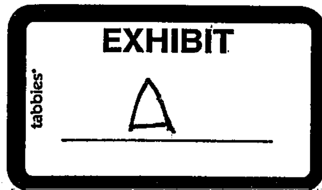


TENNESSEE MARKET CONDUCT EXAMINATION
OF

WAUSAU BUSINESS INSURANCE COMPANY

FOR THE PERIOD

JANUARY 1, 2001 THROUGH DECEMBER 31, 2005

AS OF DECEMBER 31, 2005

Table of Contents

SALUTATION 3
SCOPE OF EXAMINATION 4
HISTORY AND PROFILE 4
METHODOLOGY 5
A. COMPANY OPERATIONS/MANAGEMENT 6
Standard A-09 7
G. CLAIMS PRACTICES 7
Standard G-03 8
Indemnity Claims 8
Payment and Claim Count - Indemnity Feature Electronic Review Table G3-1 9
Claims Sample Indemnity Results (Sample Review) Table G3-2 9
Claims Composite Indemnity Results Table G3-3 9
Medical Claims 10
Claims Results Medical Feature (Electronic Review) Table G3-4 10
Claims Sample Medical Results (Sample Review) Table G3-5 10
Claims Composite Medical Results Table G3-6 11
Standard G-05 11
SUMMARY 12
LIST OF RECOMMENDATIONS 12
CONCLUSION 13
APPENDIX 1 14
Monthly Indemnity Payment Count and Electronic Testing Result 14
APPENDIX 2 17
Monthly Medical Payment Count and Electronic Testing Result 17
AFFIDAVIT 20

SALUTATION

Honorable Paula A. Flowers
Commissioner
Tennessee Department of Commerce and Insurance
500 James Robertson Parkway, 5th Floor
Nashville, Tennessee 37243-1135

Dear Commissioner Flowers:

In compliance with your instructions contained in the Certificate of Examination Authority dated June 22, 2006, and pursuant to statutory provisions including Tenn. Code Ann. § 56-8-104(8)(xi), a limited scope market conduct examination has been conducted of the affairs and practices of:

WAUSAU BUSINESS INSURANCE COMPANY

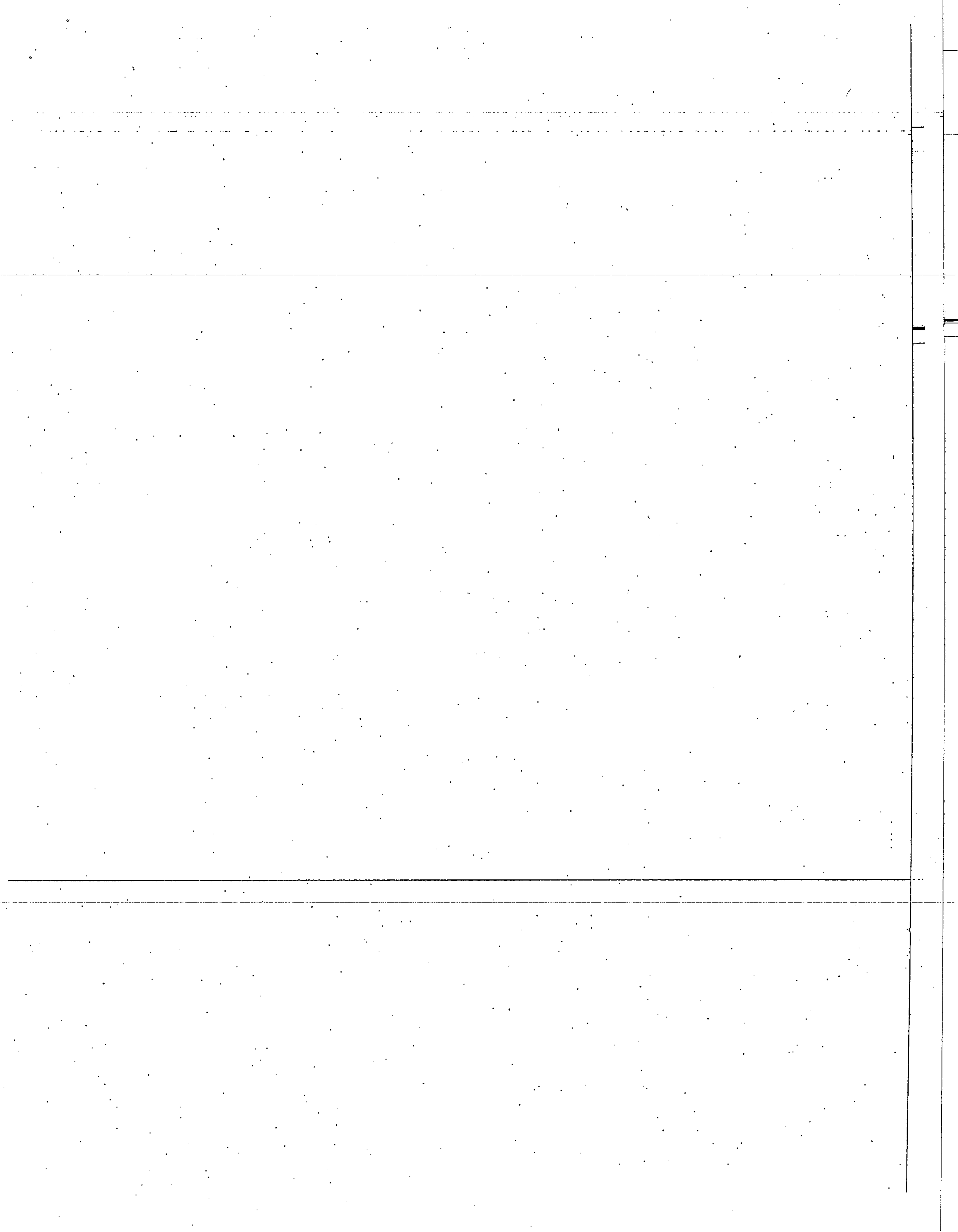
hereinafter referred to as the "Company" or as "WBIC." WBIC is incorporated under the laws of the State of Wisconsin. This examination reviewed only the operations of WBIC as they impact residents, policyholders, and claimants residing in the State of Tennessee. The on-site phase of the examination was conducted at the following location:

925 North Point Parkway, Suite 300, Alpharetta, GA 30005

The examination is as of December 31, 2005.

Examination work was also completed off-site and at the offices of the Tennessee Department of Commerce and Insurance, hereinafter referred to as the "Department" or as "TDCI."

The report of examination thereon is respectfully submitted.



SCOPE OF EXAMINATION

The basic business areas that are subject to a Tennessee Market Conduct Examination of a Property and Casualty insurer are:

A. Company Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

Each business area has standards that an examination can measure. Some standards have specific statutory guidance, others have specific company guidelines, and yet others have contractual guidelines. Please note that some business areas in the *National Association of Insurance Commissioner's ("NAIC") Market Conduct Examiners Handbook* do not have a Tenn. Code Ann. basis and have not been included in this examination. The product line reviewed in this examination is Workers Compensation insurance.

This examination is limited in scope. Only Standards A-09, G-03 and G-05 are tested. These standards are aimed at testing compliance with the provisions of Tenn. Comp. R & Regs. 0800-2-14.04(7) and 0800-2-14.07(1), which pertain to the timeliness of claim payments.

This examination report is a report by test rather than a report by exception. This means that all standards tested are described and the results reported.

HISTORY AND PROFILE

WBIC was incorporated on June 30, 1987, as the "Westwood Insurance Company," under the laws of the state of Illinois to effect a conversion of Canners Exchange Subscribers, an Illinois reciprocal organized in 1907, to a stock company on July 1, 1987. Canners Exchange Subscribers, the predecessor to WBIC, became affiliated with Employers on January 1, 1983, when all of the outstanding shares of its attorney-in-fact corporation, Lansing B. Warner, Inc., were purchased by Wausau Service Corporation. On September 1, 1990, the company re-domiciled to Wisconsin and changed its name to that presently used.

WBIC is a multi-line property and casualty company licensed in all 50 states and the District of Columbia. The corporation is a wholly owned subsidiary of Wausau Service Corporation.

Tennessee Premiums and Losses for the examination period are presented below:

	Premium Written	Premium Incurred	Losses Paid	Losses Incurred	Losses Unpaid
2005	$6,399,586	$7,142,539	$2,693,224	$5,313,898	$8,202,424
2004	$6,127,591	$4,334,835	$1,438,877	$5,198,961	$5,581,749
2003	$879,143	$93,879	$863,322	-$537,514	$1,821,665
2002	$1,262,256	$1,718,036	$1,829,315	$1,333,522	$3,222,501
2001	$2,451,069	$2,807,901	$3,461,757	$1,655,084	$3,718,294

METHODOLOGY

This examination is based on the Standards and Tests for a Market Conduct Examination of a Property and Casualty Insurer found in Chapter VIII of the *NAIC's Market Conduct Examiners Handbook* (2004 edition).

Some standards are measured using a single type of review, while others use a combination or all of the types of review. The types of review used in this examination fall into 3 general categories: "generic," "sample," and "electronic."

A "generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the *NAIC's Market Conduct Examiners Handbook*. For statistical purposes, an error tolerance level of 7% is used for claims reviews. The sampling techniques used are based on 95% confidence level. This means that there is a 95% confidence that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. Note that the statistical error tolerance is not indicative of the TDCI's actual tolerance for deliberate error.

An "electronic" review indicates that a standard was tested through the use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a selected population.

Standards are measured using tests designed to adequately determine how the examinee met the standard. The various tests utilized are set forth in the *NAIC's Market Conduct Examiners Handbook* Chapter for a Property and Casualty Insurer. Each standard applied is described and the result of the testing is provided under the appropriate standard. The standard, its statutory authority under Tennessee statutes, and its source in the *NAIC's Market Conduct Examiners Handbook* are stated and contained within a bold border.

This examination uses the electronic review method to identify payments representing a first indemnity payment for a claim during the examination period without regard to when the claim was first reported. The examiners then use an electronic review to determine how many of these

claims exceeded the 15 day limit authorized in Tenn. Code Ann. §50-6-205(b)(2) and described in Tenn. Comp. R. & Regs. 0800-2-14-.05. Any claim where the payment date is more than 15 days from the date of the First Report of Injury is listed as "questioned." Files subject to sampling were selected from this list of questioned files.

This examination also uses the electronic review method to determine how many Workers' Compensation Medical Payment claims exceed the 45 day limit authorized in Tenn. Code Ann. §50-6-419 and described in Tenn. Comp. R. & Regs. 0800-2-14.07(1). Samples of files were selected from the list of payments where the amount of time between the receipt of the billing or invoice for the service and the date of payment could not be determined.

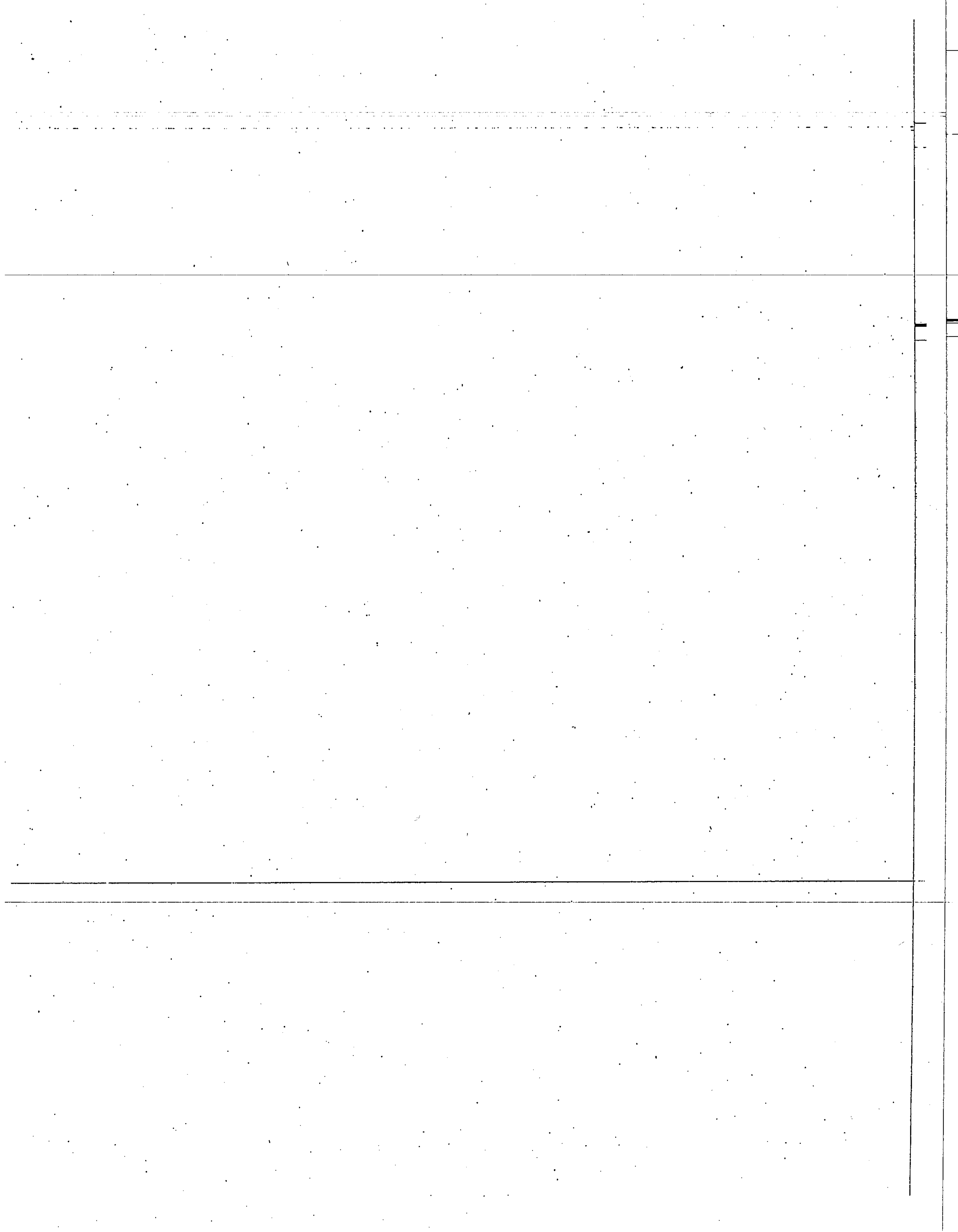
Each Standard contains a brief description of the purpose or reason for the Standard. The "Result" is indicated and the examiners' "Observations" are noted. In some cases a "Recommendation" is made. Results, Observations and Recommendations are reported with the appropriate Standard.

The management of well-run companies generally has some processes that are similar in structure. While these processes vary in effectiveness from company to company, the absence of them or the ineffective application of them is often reflected in the failure of the various Standards tested in a Market Conduct examination. The processes usually include: a planning function where direction, policy, objectives and goals are formulated; an execution or implementation of the planning function elements; a measurement function that considers the results of the planning and execution; and a reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of its operations. This examination reviewed the procedures applicable only to Workers' Compensation claims.

This review includes an analysis of how the Company communicates its instructions and intentions relating to the handling of Workers' Compensation claims to its operating echelons, how it measures and monitors the results of those communications, and how it reacts to and modifies its communications based on the resulting findings of the measurement and monitoring activities. The examiners also determine whether this process is dynamic and results in enhanced compliance activities. This form of analysis has substantial predictive value that aids in identifying those areas where the process used by management does not appear to be achieving appropriate levels of statutory and regulatory compliance.

A. COMPANY OPERATIONS/MANAGEMENT

The evaluation of standards in this business area is based on a review of the Company's responses to information requests, questions, interviews, and presentations made to the examiners. This portion of the examination is designed to provide an overview of the Company and how it operates. It is typically not based on sampling techniques and is more concerned with structure. Since this examination was designed to test compliance with Workers' Compensation prompt pay requirements, only Standard A-09 was tested.



Standard A-09

NAIC Market Conduct Examiners Handbook - Chapter VIII, §A, Standard 9
The Company cooperates on a timely basis with examiners performing the examinations.
Tenn. Code Ann. §56-1-411(b)(1)

The review methodology for this standard is by "generic" review. This standard has a direct insurance statutory requirement. This standard is intended to ensure the Company is cooperating with the state in the completion of an open and cogent review of the Company's operations in Tennessee. Cooperation with the examiners in the conduct of an examination is not only required by statute, it is also conducive to completing the examination in a timely fashion and thereby minimizing costs.

Results: **Pass**

Observations: The Company's responses were complete and accurate. Procedures are in place and adhered to for managing a Market Conduct examination. Company cooperation during the examination was timely.

Recommendations: None

G. CLAIMS PRACTICES

The evaluation of standards in this business area is based on the Company's responses to information items requested by the examiner, discussions with Company staff, electronic testing of claim databases, and file sampling during the examination process. This portion of the examination is designed to provide an overview of how the Company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations.

Since this is a limited scope examination to test compliance with Tenn. Comp. R. & Regs. 0800-2-14-.04(7) and 0800-2-14-.07(1), only Standards G-03 and G-05 are tested.

Observations: The Company has a written claim handling procedure. The claim process is computerized and appears to be thorough. The examiners found the system to be user-friendly with sufficient information available to review the claims selected. Navigation of the system poses no particular challenges.

The examiners reviewed a compliance narrative and workflow chart for the Workers' Compensation Claim Case Management system. This system describes the various phases of claim handling for Workers Compensation including:

- Claim investigation
- Compensability decision
- Litigation
- Disability and Medical Management, and
- Settlement

Each of the phases is associated with one or more compliance risks. The compliance risks are mitigated by Company stated compliance controls.

The compliance risk with which this examination is most concerned is the one dealing with the timely response to statutory or regulatory triggers, specifically, the timely payment of Indemnity or Medical Claims. The sole risk mitigation developed for this compliance risk by the Company is training. However training alone is not a control and is not sufficient to ensure that timely payment is made.

Standard G-03

NAIC Market Conduct Examiners Handbook - Chapter VIII, §G, Standard 3

Claims are resolved in a timely manner.

Tenn. Code Ann. §§50-6-205(b)(2); §50-6-419; §56-8-104(8)(A)(xi); and Tenn. Comp. R. & Regs. 0800-2-14.05(1) & 14.07(1)

The review methodology for this standard is by "generic," "sample," and "electronic" review. For both Indemnity Claims and Medical Claims this standard derives directly from Tenn. Code Ann. §56-8-104(8)(A)(xi) which requires compliance with the provisions of Tenn. Code Ann. §50-6-101 et seq. Indemnity Claims are addressed by Tenn. Code Ann. §50-6-205(b)(2) and Tenn. Comp. R. & Regs. 0800-2-14.05(1) which require first payment of compensation within 15 days of the notice of injury. Medical Claims are addressed by Tenn. Code Ann. §50-6-419 and Tenn. Comp. R. & Regs. 0800-2-14.07(1) which require payment of medical costs within 45 days of the invoice or billing.

Indemnity Claims

Results: **Pass**

Observation: A list of all Indemnity Claim payments for the examination period was reviewed electronically. The database contained 3,784 indemnity claim payments made during the period under review representing one or more payments for 499 claims. Since the conditions and requirement for payment in Tenn. Comp. R. & Regs. 0800-2-14.05(1) essentially apply to initial payment of Temporary Total Disability (TTD) and Temporary Partial Disability (TPD), the examiners filtered the database to remove payments that were not initial payments and that were not TTD or TPD payments. An electronic review of the total Indemnity Claims population by year was conducted for paid claims to determine the quantity of TTD and TPD claims that required more than 15 days to make a first payment. Please refer to Table G3-1. A monthly breakdown of these payments is attached as Appendix 1.

Payment and Claim Count - Indemnity Feature **Electronic Review** **Table G3-1**

Type	Total Payment Count	Total Claims Represented	N/A	Subject to Testing	Pass	Questioned
2001 Indemnity Paid	791	150	78	72	18	**54**
2002 Indemnity Paid	551	63	26	37	14	**23**
2003 Indemnity Paid	361	32	20	12	3	**9**
2004 Indemnity Paid	769	100	10	90	39	**51**
2005 Indemnity Paid	1312	154	20	135	57	**78**
Total	3784	499	154	346	131	**215**

Of the 499 claims representing all indemnity payments for the examination period, 154 were not subject to the 15 day requirement (generally files that did not develop a liability during the 15 day requirement), resulting in 346 files subject to testing. There were 131 files (37.9% of the files subject to testing) where payment was clearly made within 15 days of the Notice of Injury. The remaining 215 files (62.1%) were in question because the time between payment and notice of injury exceeded 15 days. From this population a random sample of 50 files was selected to test and determine how many claims were appropriately or inappropriately delayed. Please refer to Table G3-2. This subpopulation of claims was then tested to determine if the failure to pay within 15 days was in conflict with the provisions of the applicable statute and regulation.

Claims Sample Indemnity Results **(Sample Review)** **Table G3-2**

Type	Sample	Pass	Fail	% Pass	% Fail
2001-2005 Indemnity Paid	50	46	4	92%	8%

The results of the electronic test and the sample results were then combined. Please refer to Table G3-3. Since the sampled files represent 62.1% of the subject claims (215 of 346 claims), the "pass" component of the questioned files, 92%, is 37% of the tested population (92% x 62.1% = 57.1%). 37.9% + 57.1% = 95%. The "fail" component calculation is 8% of 62.1%, which is 5%.

Claims Composite Indemnity Results **Table G3-3**

Type	Claim Count	% Pass	% Fail
2001-2005 Indemnity Paid	346	95%	5%

As noted in the Observations to the Claims Practices introduction, the Company's sole risk mitigation for the compliance risk related to the timely response to statutory or regulatory triggers is training. If the initial report indicates no time loss, the Indemnity feature of the claim is closed even though there may still be an active Medical feature. If in fact the initial report is incorrect as to lost time, the correction may be realized too late to comply with the 15 day requirement. The claim system does not contain a flag or provide a diary warning to alert the claim handler that a critical time requirement is imminent on a closed claim. In such cases it usually takes external notice that may not arrive in time to allow the claim to be paid timely. The process for compliance with the timely payment of the initial compensation tends to be reactive since it does not allow for inadequate, incorrect or missing information. As stated above, the Company's mitigation of the compliance risk is training, however training by itself is not sufficient to ensure that timely payment is made.

Recommendations: It is recommended that the Company develop a computer flag, warning or reminder to ensure that the initial payment on a compensable claim is paid in accordance with the time standards required by statute and/or regulation.

Medical Claims

Results: **Fail**

Observation: An electronic review of the total Medical Claims population by year was conducted for paid claims to determine the quantity of claims that exceeded 45 days to pay. Please refer to Table G3-4. A monthly breakdown of these payments is attached as Appendix 2.

Claims Results Medical Feature **(Electronic Review)** **Table G3-4**

Type	Total Population	Pass	Fail	Question	% Pass	% Fail	% Questioned
2001 Medical Paid	5951	2314	11	3626	38.9%	0.2%	60.9%
2002 Medical Paid	7965	7084	18	863	88.9%	0.3%	10.8%
2003 Medical Paid	3899	3496	3	400	89.7%	0.0%	10.3%
2004 Medical Paid	8160	7485	14	661	91.7%	0.2%	8.1%
2005 Medical Paid	19971	16508	210	3253	82.7%	1.0%	16.3%
Total	45946	36887	256	8803	80.2%	0.6%	19.2%

The electronic review identified a small population of claim payments that did not comply with the 45 day requirement in Tenn. Comp. R. & Regs. 0800-2-14.07(1). A sizeable population labeled by the examiners as "questioned" (refer to Table G3-4 above) was also identified where an electronic test was not possible because either a billing date or invoice date was not captured or the captured billing date provided occurred after the payment for service date. This portion of the file population represented 19.2% of the files in the Total Population and was the source of files selected in the sample to be manually tested.

Of the 45,946 medical claim payments electronically tested, 8,803 questioned files (19.2% of the files subject to testing) were available for review. From this portion of the Medical Claim population, 100 files were randomly selected for review in order to quantify the pass/fail rates of the questioned files. Please refer to Table G3-5. This subpopulation of claims was then tested to determine if the failure to pay within 45 days was in conflict with the provisions of the applicable statute and regulation. If no date of service or billing date was determinable, the payment was considered to have failed the timeliness requirement.

Claims Sample Medical Results (Sample Review) **Table G3-5**

Type	Sample	Pass	Fail	% Pass	% Fail
2001-2005 Medical Paid	100	60	40	60%	40%

The results of the electronic test and the sample results were combined. Please refer to Table G3-6. Since the sampled files represent 19.2% of the subject claims (8803 of 45946 claims), the "pass" component of the questioned files, 60%, is 11.5% of the tested population (60% x 19.2% = 11.5%). 80.2% + 11.5% = 91.7%. The "fail" component calculation is 40% of 19.2% or 7.7%. Therefore 0.6% + 7.7% = 8.3%.

Claims Composite Medical Results Table G3-6

Type	Claim Count	% Pass	% Fail
2001-2005 Medical Paid	45946	91.7%	8.3%

The Company merged its Workers' Compensation claim handling with the Liberty Mutual Group in October 2001. Prior to that time the claim files were primarily handled manually and were not computerized. In October 2001, Company claim files were converted for inclusion into the Liberty Mutual Group computerized claim handling process. During this conversion process data was lost or had met its retention limit and was destroyed. As a result, claims prior to October 2001 were frequently incomplete and data sufficient to complete the testing of files was not available. In addition, converted files were set up as text files and electronic testing is not possible with files structured in this format.

Prior to October 2001, the Company did not capture billing or invoice dates thus preventing any comparison with payment dates to ensure that claims are paid timely. The current system overcomes this shortcoming and provides the necessary audit trail to ensure that all data necessary for review of a claim is captured.

A substantial departure from the usual failure rate for timely payment of Medical Loss was noted for the months of September 2005 and October 2005. These two months represent 73.8% of all errors noted for the examination period. The Company indicated that the quantity of errors noted were the result of the Tennessee Fee Schedule load for Out-Patient Hospitals and Ambulatory Surgical Centers. The Company stated that the fee schedule was effective on July1, 2005, but the pricing was not automated in their system until much later. The Company kept all of these bills on hold until October 2005, when First Health provided them with a pricing calculator that allowed the Company to manually price all of the bills on hold.

Recommendations: None

Standard G-05

NAIC Market Conduct Examiners Handbook - Chapter VIII, §G, Standard 5

Claim files are adequately documented.

Tenn. Code Ann. §§50-6-419; 56-8-104(8)(A)(xi); and Tenn. Comp. R. & Regs. 0800-2-14-.04(5)

The review methodology for this standard is by "generic" review. The sample of files was not specifically tested. This standard derives directly from Tenn. Code Ann. §56-8-104(8)(A)(xi) which requires compliance with the provisions of Tenn. Code Ann. §50-6-101 et seq. Tenn. Comp. R. & Regs. 0800-2-14.04(5) requires "All aspects of contacting and attempts to contact insureds, the claimant and physicians shall be documented within the insurer's file."

Results: **Pass**

Observation: The Company currently uses an electronic system to track and perform its claim activity function as well as to provide management with claim related information. Activities are documented and explained. The examiners were able to navigate the system in a very short time

and the amount of supporting data and case management information available in the system provides a reasonable audit trail and support for the claim function.

The system used prior to October 2001 was primarily paper with the drawbacks associated with access, storage and retention. During 2001 the active files were converted to an electronic format. These files were converted primarily as text files which make the converted files impossible to test electronically. The Indemnity files reviewed generally include a sufficient audit trail for examination purposes. However, the review of the Medical Payment files was difficult since, in most cases, the information sought and supporting documents for these payments prior to the conversion were not available.

Recommendations: None

SUMMARY

Wausau Business Insurance Company is a Property and Casualty insurer domiciled in the State of Wisconsin and licensed to write Workers' Compensation insurance in the State of Tennessee. This limited scope examination focused on the timeliness of claim payments subject to the provisions of Tenn. Comp. R. & Regs. 0800-2-14.05(1) and 0800-2-14.07(1) which address the timely payment of Indemnity Claims and Medical Claims.

The examiners note that the Company's compliance risk mitigation efforts related to the timely payment of indemnity claims for Workers' Compensation are insufficient to ensure timely payment of those claims. The examiners also note that compliance with the time required for payment of Workers' Compensation medical claims failed in 8.3% of the payments subject to review in this examination.

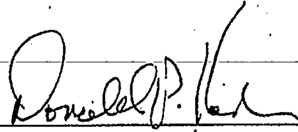
LIST OF RECOMMENDATIONS

G-03 Recommendation

It is recommended that the Company develop a computer flag, warning or reminder to ensure that the initial payment on a compensable claim is paid in accordance with the time standards required by statute and/or regulation.

CONCLUSION

The examination was conducted by Donald P. Koch, CIE, Keith Perry, CIE, and Candace Pickens.



Donald P. Koch, CIE
Examiner-in Charge
State of Tennessee
Department of Insurance

APPENDIX 1

Monthly Indemnity Payment Count and Electronic Testing Result

2001

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-01	80	29	8	3	18
Feb-01	68	13	7	1	5
Mar-01	76	16	10	2	4
Apr-01	70	13	8	1	4
May-01	71	10	5	3	2
Jun-01	87	13	7	1	5
Jul-01	75	10	5	1	4
Aug-01	86	16	10	2	4
Sep-01	64	11	7	2	2
Oct-01	27	5	3	1	1
Nov-01	44	12	7	1	4
Dec-01	43	2	1	0	1
	791	150	78	18	54

2002

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-02	37	5	0	2	3
Feb-02	28	4	1	1	2
Mar-02	53	8	4	1	3
Apr-02	58	6	0	4	2
May-02	57	7	3	1	3
Jun-02	47	5	2	1	2
Jul-02	55	2	0	1	1
Aug-02	60	9	7	1	1
Sep-02	42	4	3	0	1
Oct-02	50	8	3	2	3
Nov-02	29	2	1	0	1
Dec-02	35	3	2	0	1
	551	63	26	14	23

2003

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-03	35	4	3	0	**1**
Feb-03	30	5	5	0	**0**
Mar-03	31	7	4	1	**2**
Apr-03	30	2	1	0	**1**
May-03	27	2	1	0	**1**
Jun-03	29	2	1	0	**1**
Jul-03	34	3	3	0	**0**
Aug-03	38	2	1	0	**1**
Sep-03	31	1	0	0	**1**
Oct-03	24	2	1	0	**1**
Nov-03	21	0	0	0	**0**
Dec-03	31	2	0	2	**0**
	361	**32**	**20**	**3**	**9**

2004

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-04	24	0	0	0	**0**
Feb-04	20	1	1	0	**0**
Mar-04	38	6	2	3	**1**
Apr-04	33	4	0	1	**3**
May-04	63	11	1	4	**6**
Jun-04	59	5	0	4	**1**
Jul-04	69	13	1	4	**8**
Aug-04	91	15	0	2	**13**
Sep-04	101	13	1	4	**8**
Oct-04	99	11	1	8	**2**
Nov-04	101	13	1	7	**5**
Dec-04	71	8	2	2	**4**
	769	**100**	**10**	**39**	**51**

2005

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-05	88	20	3	6	11
Feb-05	68	6	1	5	0
Mar-05	83	15	1	6	8
Apr-05	114	15	2	6	7
May-05	126	19	2	4	13
Jun-05	154	21	3	8	10
Jul-05	126	14	1	4	9
Aug-05	125	13	2	4	7
Sep-05	131	13	0	7	6
Oct-05	131	9	3	1	5
Nov-05	95	4	1	3	1
Dec-05	71	5	1	3	1
	2145	**326**	**45**	**143**	**78**

5-Year Indemnity Totals

	Payment Count	Number of Claims	N/A	Pass	Questionable
	3784	499	154	131	215

APPENDIX 2

Monthly Medical Payment Count and Electronic Testing Result

2001

Month End	Payment Count	Pass	Fail	Questionable
Jan-01	500	61	0	439
Feb-01	535	46	0	489
Mar-01	523	70	0	453
Apr-01	476	88	0	388
May-01	509	111	0	398
Jun-01	491	50	0	441
Jul-01	589	104	0	485
Aug-01	515	101	0	414
Sep-01	0	0	0	0
Oct-01	206	173	0	33
Nov-01	907	849	8	50
Dec-01	700	661	3	36
	5951	**2314**	**11**	**3626**

2002

Month End	Payment Count	Pass	Fail	Questionable
Jan-02	850	767	9	74
Feb-02	725	672	2	51
Mar-02	660	592	1	67
Apr-02	687	625	0	62
May-02	942	799	0	143
Jun-02	647	557	0	90
Jul-02	634	577	0	57
Aug-02	684	567	0	117
Sep-02	611	567	1	43
Oct-02	592	549	3	40
Nov-02	464	395	0	69
Dec-02	469	417	2	50
	7965	**7084**	**18**	**863**

2003

Month End	Payment Count	Pass	Fail	Questionable
Jan-03	464	373	0	91
Feb-03	376	276	0	100
Mar-03	335	290	0	45
Apr-03	302	289	0	13
May-03	478	446	1	31
Jun-03	218	201	2	15
Jul-03	258	245	0	13
Aug-03	313	294	0	19
Sep-03	169	163	0	6
Oct-03	455	419	0	36
Nov-03	228	220	0	8
Dec-03	303	280	0	23
	3899	**3496**	**3**	**400**

2004

Month End	Payment Count	Pass	Fail	Questionable
Jan-04	144	118	0	26
Feb-04	218	215	0	3
Mar-04	287	265	0	22
Apr-04	401	369	5	27
May-04	456	438	0	18
Jun-04	537	488	0	49
Jul-04	769	668	0	101
Aug-04	900	831	0	69
Sep-04	910	830	2	78
Oct-04	990	925	1	64
Nov-04	1249	1177	0	72
Dec-04	1299	1161	6	132
	8160	**7485**	**14**	**661**

2005

Month End	Payment Count	Pass	Fail	Questionable
Jan-05	1277	1186	0	91
Feb-05	1230	1107	2	121
Mar-05	1188	1066	0	122
Apr-05	1429	1257	2	170
May-05	1475	1246	1	228
Jun-05	1965	1674	0	291
Jul-05	1892	1559	4	329
Aug-05	2287	1928	1	358
Sep-05	1782	1379	49	354
Oct-05	2043	1421	140	482
Nov-05	1828	1438	9	381
Dec-05	1575	1247	2	326
	19971	**16508**	**210**	**3253**

5-Year Medical Totals

	Payment Count	Pass	Fail	Questionable
	45946	**36887**	**256**	**8803**

AFFIDAVIT

STATE OF ALASKA }
}
FIRST JUDICIAL DISTRICT }

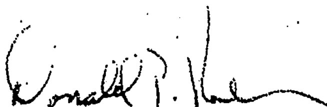
Donald P. Koch, CIE, being duly sworn, upon his oath deposes and states:

That he is an examiner appointed by the Commissioner of the Tennessee Department of Commerce and Insurance;

That a target scope market conduct examination was made of Wausau Business Insurance Company for the period from January 1, 2001 through December 31, 2005;

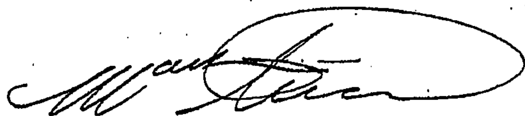
That the foregoing nineteen (19) pages constitute the report to the Commissioner of the Tennessee Department of Commerce and Insurance; and

The statements and data therein contained are true and correct to the best of his knowledge and belief.

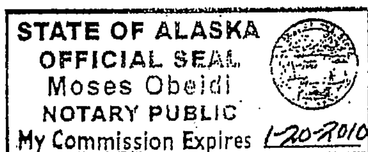


Donald P. Koch, CIE
Examiner-In-Charge
For the State of Tennessee
Department of Commerce and Insurance

Subscribed and sworn to before me on the 28 day of December, 2006.



Notary Public for the State of Alaska
My Commission Expires 1-20-2010


STATE OF ALASKA
OFFICIAL SEAL
Moses Obeidi
NOTARY PUBLIC
My Commission Expires 1-20-2010

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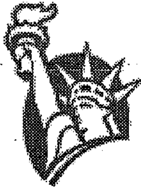

OFFICE OF CORPORATE COMPLIANCE
Liberty Mutual Group
175 Berkeley Street
Boston, MA 02117-0140
Tel: 617-654-3195
Fax: 617-654-4794

September 26, 2007

Mr. Philip Blustein, CFE
Insurance Examinations Director
State of Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

RE: Market Conduct Examination of
Wausau Business Insurance Company
Wausau General Insurance Company
Wausau Underwriters Insurance Company
Employers Insurance Company of Wausau
Made as of December 21, 2005

Dear Mr. Blustein:

Thank you for the opportunity to make a written response to the above Market Conduct Examination Report. We are in agreement with the facts as stated in it. However, we would like to take this opportunity to explain why we only partially passed Standard G-03, the sole Standard we didn't pass in its entirety.

Since your letter of September 11, 2007 that accompanied this Report stated we should "...quote the Comment or Recommendations and page number " in our response, I have done as a separate document for ease of reference.

In closing, I want to acknowledge the examining acumen and professionalism of Don Koch and his examining team.

Sincerely,

Mark Plesha, CPCU, AIS
Regional Director, Market Conduct Services

Att.

Liberty Mutual Group

Wausau Underwriters Insurance Company
Employers Insurance Company of Wausau
Response to Standard G-03 Indemnity Claims result
Pages 9-10

The following appears at the bottom of page 9, concluding at the top of page 10 in the Wausau Underwriters Insurance Company's Draft report and in the middle of page 10 in the Employers Insurance Company of Wausau's Draft Report:

> "As noted in the Observations to the Claims Practices introduction, the Company's sole risk mitigation for compliance risk related to the timely response to statutory or regulatory triggers is training. If the initial report indicates no time loss, the Indemnity feature of the claim is closed even though there may still be an active Medical feature. If in fact the initial report is incorrect as to lost time, the correction may be realized too late to comply with the 15 day requirement. The claim system does not contain a flag or provide a diary warning to alert the claim handler that a critical time requirement is imminent on a closed claim. In such cases it usually takes external notice that may not arrive in time to allow the claim to be paid timely. The process for compliance with the timely payment for the initial compensation tends to be reactive since it does not allow for inadequate, incorrect or missing information. As stated above, the company's mitigation of the compliance risk is training, however training by itself is not sufficient to ensure that timely payment is made."

Though we agree, we want to point out the primary reason we missed the 15-day deadline. In the majority of the claims cited in the Report, our customer initially told us the worker's injury was for Medical only. This could have been in error or, perhaps later in the week, the worker's injury didn't go away or even got worse, forcing him to miss work. Our customer notifies us, (in some cases, not immediately) but by then a portion of the 15 days had elapsed, making it very difficult, if not impossible, to meet that 15-day deadline for paying the Indemnity claim.

The examiner agrees, and states in the Report (statement italicized above) that this was a factor causing us to miss the 15-day deadline. To address his Recommendation, we will be sending a letter (attached) out on every medical only claim file to our employers asking that they contact us if they become aware of lost time. Though we ask this when we first get the notice of injury, the examiner felt that it was the carrier's obligation to ask again about lost time, within the 15 days, to be sure there is no lost time. We believe this second inquiry will do so.

Wausau General Insurance Company
Response to Standard G-03 Medical Claim result
Pages 9-11

Though we agree with the facts as stated in the Draft Report, we believe they present a somewhat inaccurate picture of how well we handle Medical claims. The Composite Medical Results Fail Percentage drops significantly if a more favorable interpretation of the data is considered, as follows:

The following appears in the middle of page 10:

"........If no date of service or billing date was determinable, the payment was considered to have failed the timeliness requirement."

The Claims Sample Medical Results Table G3-5 shows that 17 failed. Of those, 11 "failed" simply because "no date of service or billing date was determinable" as stated in the Draft Report. If we assume those 11 were paid timely, then the Fail Percentage drops from 34% to 12%.

This would impact the Claims Composite Medical Results Fail Percentage. The Draft Report goes onto read on Page 10:

"....The "fail" component calculation is 34% of 37.2% or 12.6%. Therefore 0.5% + 12.6% = 13.1%." *The referenced "0.5%" is the Fail Percentage in the Claims Results Medical Feature Electronic Review (shown at the top of page 10).*

This 13.1% is the Claims Composite Medical Results Fail Percentage. However, if you replace the 34% Fail Percentage with the 12% Fail Percentage, that statement now reads:

"....The "fail" component calculation is 12% of 37.2% or 4.5%. Therefore 0.5% + 4.5% = 5.0%." This 5.0% then would be the Claims Composite Medical Results Fail Percentage.

We understand how the examiner has to err on the side of caution and assume all without dates are wrong, but if a less draconian approach is taken, one which is supported by the 0.5% Fail Ratio in the Claims Results Medical Feature Electronic Review (shown at the top of page 10), one could conclude that the Fail Percentage of 5.0% is more reflective of how we handle Medical claims in Tennessee.

Wausau Business Insurance Company
Response to Standard G-03 Medical Claims result
Page 10 & 11

Though we again agree with the facts as stated in the Draft Report, we believe they present a somewhat inaccurate picture of how well we handle Medical claims. The Composite Medical Results Fail Percentage drops significantly if a more favorable interpretation of the data is considered, as follows:

The following appears towards the bottom of page 10:

"........If no date of service or billing date was determinable, the payment was considered to have failed the timeliness requirement."

The Claims Sample Medical Results Table G3-5 shows that 40 failed. Of those, 16 "failed" simply because "no date of service or billing date was determinable" as stated in the Draft Report. If we assume those 16 were paid timely, then the Fail Percentage drops from 40% to 24%.

This would impact the Claims Composite Medical Results Fail Percentage. The Draft Report goes onto read on Page 10:

"....The "fail" component calculation is 40% of 19.2% or 7.7%. Therefore 0.6% + 7.7% = 8.3%." *The referenced "0.6%" is the Fail Percentage in the Claims Results Medical Feature Electronic Review (shown towards the top of page 10).*

This 8.3% is the Claims Composite Medical Results Fail Percentage. However, if you replace the 40% Fail Percentage with the 24% Fail Percentage, that statement now reads:

"....The "fail" component calculation is 24% of 19.2% or 4.6%. Therefore 0.6% + 4.6% = 5.2%."

This 5.2% then would be the Composite Medical Results Fail Percentage.

Again, we understand how the examiner has to err on the side of caution and assume all without dates are wrong, but if a less draconian approach is taken, one which is supported by the 0.6% Fail Percentage in the Claims Results Medical Feature Electronic Review (shown at the top of page 10) and by the similar example for the Wausau General Insurance Company shown previously, one could conclude that the Fail Percentage of 5.2% is more reflective of how we handle Medical claims in Tennessee.

However, there is a scenario in the Wausau Business Insurance Company Draft Report that is not in the Wausau General Insurance Company's that bears mentioning since it augments our position, as follows:

The following appears in the middle of page 11:

"A substantial departure from the usual failure rate for timely payment of Medical Loss was noted for the months of September 2005 and October 2005. *These two months represent 73.7% of all errors noted for the examination period* (ital mine). The Company indicated that the quantity of errors noted were the result of the Tennessee Fee Schedule load for Out-Patient Hospitals and Ambulatory Surgical Centers. The Company stated that the fee schedule was effective July 1, 2005, but the pricing was not automated in their system until much later. The Company kept all of these bills on hold until October 2005, when First Health provided them with a pricing calculator that allowed the Company to manually price all of the bills on hold. "

Though we agree, we want to point out that had First Health provided us with that pricing calculator timely, (or had accurately implemented the pricing into our system initially) these would have been paid timely. If we assume that all these would have been paid timely, thus removing 73.7% of the errors, our Fail Percentage drops from 8.3% to 2.2%. And that is using the Draft Report's original Composite Medical Results Fail Percentage.

If we use instead the revised Composite Medical Results Fail Percentage of 5.2%, our Fail Percentage drops to 1.4%.

Though revising the Draft Report to show the revised Fail Percentages may not be feasible, the primary point of the above observations for the Wausau General Insurance Company and Wausau Business Insurance Company is to show the Department that we really handle Medical claims in Tennessee better than this Draft Report implies.