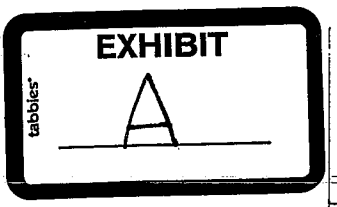

TENNESSEE MARKET CONDUCT EXAMINATION
OF

WAUSAU UNDERWRITERS INSURANCE COMPANY

FOR THE PERIOD

JANUARY 1, 2001 THROUGH DECEMBER 31, 2005

AS OF DECEMBER 31, 2005

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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 UNDERWRITERS INSURANCE COMPANY

hereinafter referred to as the "Company" or as "WUIC." WUIC is incorporated under the laws of the State of Wisconsin. This examination reviewed only the operations of WUIC 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

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 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

Wausau Underwriters Insurance Company was incorporated on September 27, 1979, as the "Wausau Insurance Company," under the laws of the state of Wisconsin to effect a change in the corporate domicile of Volkswagen Insurance Company from Arkansas to Wisconsin. The name of the corporation was changed to that presently used when the change of domicile was consummated on January 1, 1980.

The Company had its origins in the Select Risk Insurance Company, an Arkansas-domiciled insurer formed in 1959 to become successor to the Select Risk Mutual Insurance Company, which had itself been organized in August 1954. The corporate name of the Company underwent many changes over the years. The corporate title was changed on October 1, 1959, to Southern Grange Insurance Company; on February 11, 1963 to VICO Insurance Company; on November 17, 1964 to Volkswagen Insurance Company; and in mid-1978 to Wausau Underwriters Insurance Company. Administrative offices were moved from St. Louis, Missouri, to Wausau, Wisconsin, in late 1980. WUIC became affiliated with Employers Insurance Company of Wausau when it was purchased from VICO Corporation of Englewood Cliffs, New Jersey, on December 30, 1977.

WUIC is a multi-line property and casualty company licensed in all 50 U.S. states, Puerto Rico, the U.S. Virgin Islands and the District of Columbia.

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

	Premium Written	Premium Incurred	Losses Paid	Losses Incurred	Losses Unpaid
2005	$19,580,530	$19,231,794	$4,589,566	$10,373,903	$16,842,619
2004	$19,908,201	$16,603,146	$4,418,420	$10,150,306	$11,058,282
2003	$7,114,267	$4,988,766	$3,035,397	$2,367,625	$5,326,396
2002	$4,541,198	$4,908,788	$2,724,162	$2,319,574	$5,994,167
2001	$3,779,871	$4,177,344	$4,107,269	$3,550,450	$6,398,756

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 three 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 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 description of the purpose or reason for the Standard. The "Result" is indicated and examiner "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 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 was 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: **Fail**

Observation: A list of all Indemnity Claim payments for the examination period was reviewed electronically. The database contained 6,377 Indemnity Claim payments made during the period under review representing one or more payments for 949 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	1128	181	59	122	23	99
2002 Indemnity Paid	816	108	33	75	19	56
2003 Indemnity Paid	807	121	36	85	40	45
2004 Indemnity Paid	1481	213	29	184	82	102
2005 Indemnity Paid	2145	326	45	281	143	138
Total	6377	949	202	747	307	440

Of the 949 claims representing all indemnity payments for the examination period, 202 were not subject to the 15 day requirement (generally files that did not develop a liability during the fifteen day requirement), resulting in 747 files subject to testing. There were 307 files (41% of the file subject to testing) where payment was clearly made within 15 days of the Notice of Injury. The remaining 440 files (59%) 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	Sampled	Pass	Fail	% Pass	% Fail
2001-2005 Indemnity Paid	50	31	19	62%	38%

The results of the electronic test and the sample results were then combined. Please refer to Table G3-3. Since the sampled files represent 59% of the subject claims (440 of 947 claims), the "pass" component of the questioned files, 62%, is 37% of the tested population (62% x 59% = 37%). 37% + 41% = 78%. The "fail" component calculation is 38% of 59%, which is 22%.

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

Type	Claim Count	% Pass	% Fail
2001-2005 Indemnity Paid	747	78%	22%

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: **Pass**

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	7536	3064	48	4424	40.7%	0.6%	58.7%
2002 Medical Paid	14753	13332	69	1352	90.4%	0.5%	9.1%
2003 Medical Paid	16895	14951	91	1855	88.5%	0.5%	11.0%
2004 Medical Paid	29295	26452	81	2762	90.3%	0.3%	9.4%
2005 Medical Paid	48236	41658	655	5923	86.4%	1.4%	12.2%
Total	116715	99457	944	16316	85.2%	0.8%	14.0%

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 either 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 14% of the files in the Total Population and was the source of files selected in the sample to be manually tested.

Of the 116715 Medical Claim payments electronically tested, 16316 questioned files (14% 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	Sampled	Pass	Fail	% Pass	% Fail
2001-2005 Medical Paid	100	67	33	67%	33%

The results of the electronic test and the sample results were then combined. Please refer to Table G3-6. Since the sampled files represent 14% of the subject claims (16316 of 116715 claims), the "pass" component of the questioned files, 67%, is 9.4% of the tested population (67% x 14% = 9.4%). 85.2% + 9.4% = 94.6%. The "fail" component calculation is 33% of 14% or 4.6%. Therefore 0.8% + 4.6% = 5.4%.

Claims Composite Medical Results **Table G3-6**

Type	Claim Count	% Pass	% Fail
2001-2005 Medical Paid	116,715	94.6%	5.4%

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 October 2005. This months represents 68% of all errors noted for the examination period. Examiners requested an explanation. 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 exceeds expectations.

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 Underwriters 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 Payment Claims.

The examiners noted 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 noted that compliance with the time required for the payment of Workers' Compensation Medical Claims was generally in compliance with the regulation but there is a need for improvement of the late payment situation.

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 Reese.

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

APPENDIX 1

Monthly Indemnity Payment Count and Electronic Testing Result

2001

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-01	114	43	10	6	27
Feb-01	101	17	2	1	14
Mar-01	102	11	4	1	6
Apr-01	93	14	7	1	6
May-01	102	19	9	2	8
Jun-01	104	14	4	1	9
Jul-01	100	12	3	3	6
Aug-01	117	17	5	3	9
Sep-01	104	11	4	2	5
Oct-01	66	13	5	1	7
Nov-01	63	3	1	1	1
Dec-01	62	7	5	1	1
	1128	**181**	**59**	**23**	**99**

2002

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-02	70	11	1	3	7
Feb-02	63	5	3	0	2
Mar-02	54	6	4	0	2
Apr-02	78	15	5	2	8
May-02	68	7	4	1	2
Jun-02	72	9	2	0	7
Jul-02	61	5	1	3	1
Aug-02	61	11	4	4	3
Sep-02	55	5	1	1	3
Oct-02	85	15	4	2	9
Nov-02	70	15	4	2	9
Dec-02	79	4	0	1	3
	816	**108**	**33**	**19**	**56**

2003

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-03	46	5	3	0	2
Feb-03	63	8	2	4	2
Mar-03	63	4	1	1	2
Apr-03	62	9	4	1	4
May-03	68	14	6	6	2
Jun-03	60	10	3	3	4
Jul-03	82	18	6	6	6
Aug-03	57	9	2	3	4
Sep-03	80	20	2	9	9
Oct-03	92	4	1	2	1
Nov-03	67	13	3	5	5
Dec-03	67	7	3	0	4
	807	**121**	**36**	**40**	**45**

2004

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-04	68	11	3	8	0
Feb-04	60	12	3	4	5
Mar-04	86	19	2	2	15
Apr-04	80	14	3	4	7
May-04	119	14	1	5	8
Jun-04	116	19	1	9	9
Jul-04	145	17	2	8	7
Aug-04	162	23	2	10	11
Sep-04	174	25	2	14	9
Oct-04	159	17	2	6	9
Nov-04	166	19	3	5	11
Dec-04	146	23	5	7	11
	1481	**213**	**29**	**82**	**102**

2005

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-05	143	25	5	10	10
Feb-05	107	12	1	8	3
Mar-05	127	30	9	7	14
Apr-05	145	26	5	11	10
May-05	119	24	2	12	10
Jun-05	164	26	2	7	17
Jul-05	149	28	3	15	10
Aug-05	233	31	4	16	11
Sep-05	210	33	4	15	14
Oct-05	243	28	1	11	16
Nov-05	252	34	5	17	12
Dec-05	253	29	4	14	11
	2145	326	45	143	138

5 Year Indemnity Totals

	Payment Count	Number of Claims	N/A	Pass	Questionable
	6377	949	202	307	440

APPENDIX 2

Monthly Medical Payment Count and Electronic Testing Result

2001

Month End	Payment Count	Pass	Fail	Questionable
Jan-01	520	45	0	475
Feb-01	549	68	0	481
Mar-01	648	80	0	568
Apr-01	683	51	0	632
May-01	495	41	0	454
Jun-01	529	62	0	467
Jul-01	624	87	0	537
Aug-01	724	133	0	591
Sep-01	133	128	0	5
Oct-01	331	297	6	28
Nov-01	1189	1095	8	86
Dec-01	1111	977	34	100
	7536	**3064**	**48**	**4424**

2002

Month End	Payment Count	Pass	Fail	Questionable
Jan-02	984	857	35	92
Feb-02	1250	1161	3	86
Mar-02	1401	1283	2	116
Apr-02	1090	969	0	121
May-02	1277	1144	8	125
Jun-02	1210	1131	6	73
Jul-02	1237	1146	6	85
Aug-02	1321	1244	2	75
Sep-02	1184	1055	2	127
Oct-02	1433	1253	2	178
Nov-02	1207	1085	3	119
Dec-02	1159	1004	0	155
	14753	**13332**	**69**	**1352**

2003

Month End	Payment Count	Pass	Fail	Questionable
Jan-03	1501	1295	20	186
Feb-03	948	883	0	65
Mar-03	1143	1006	6	131
Apr-03	1322	1147	2	173
May-03	1590	1413	0	177
Jun-03	1208	1002	0	206
Jul-03	1332	1125	8	199
Aug-03	1375	1251	6	118
Sep-03	1345	1197	0	148
Oct-03	1641	1413	14	216
Nov-03	1731	1617	8	106
Dec-03	1759	1602	27	130
	16895	**14951**	**91**	**1855**

2004

Month End	Payment Count	Pass	Fail	Questionable
Jan-04	1229	1111	5	113
Feb-04	1351	1232	3	116
Mar-04	2094	1850	2	242
Apr-04	2179	2017	1	161
May-04	2237	1970	12	255
Jun-04	2751	2534	17	200
Jul-04	2592	2356	2	234
Aug-04	2828	2528	10	290
Sep-04	2809	2594	8	207
Oct-04	3356	3065	0	291
Nov-04	3013	2636	6	371
Dec-04	2856	2559	15	282
	29295	**26452**	**81**	**2762**

2005

Month End	Payment Count	Pass	Fail	Questionable
Jan-05	3485	3144	46	295
Feb-05	3077	2690	5	382
Mar-05	3179	2851	4	324
Apr-05	3558	3235	22	301
May-05	3006	2664	19	323
Jun-05	3509	3083	5	421
Jul-05	3716	3202	17	497
Aug-05	4141	3557	19	565
Sep-05	4704	4017	43	644
Oct-05	5640	4335	447	858
Nov-05	4952	4318	23	611
Dec-05	5269	4562	5	702
	48236	**41658**	**655**	**5923**

5 Year Medical Totals

	Payment Count	Pass	Fail	Questionable
	116715	**99457**	**944**	**16316**

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 Underwriters 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

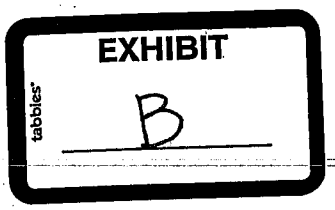
The statements and data therein contained are true and correct to the best of his knowledge and belief.

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



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.

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.

Date

PO Box 105067
Atlanta GA 30348-5067

Telephone (800) 943-1113
Fax (603) 334-0299

RE: Employee:
Employer
Contract #:
Claim #:
Injury:
Date of Injury:
Date of Report

Dear

This will acknowledge receipt of the Workers' Compensation claim for the above referenced employee. In accordance with the Workers' Compensation Laws of Tennessee there is a 7 day waiting period before any lost wage benefits are payable. The employee is not owed compensation due to lost time because the waiting period was not met as a result of this injury.

Please contact me immediately if this employee has additional lost time as a result of this claim.

Please feel free to contact me if you have any questions.

Sincerely