EXHIBIT
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TENNESSEE MARKET CONDUCT EXAMINATION
OF

EMPLOYERS INSURANCE COMPANY OF WAUSAU

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 6
A. COMPANY OPERATIONS/MANAGEMENT 7
Standard A-09 7
G. CLAIMS PRACTICES 8
Standard G-03 9
Indemnity Claims 9
Payment and Claim Count - Indemnity Feature (Electronic Review) Table G3-1 9
Claims Sample Indemnity Results (Sample Review) Table G3-2 10
Claims Composite Indemnity Results Table G3-3 10
Medical Claims 10
Claims Results Medical Feature (Electronic Review) Table G3-4 11
Claims Sample Medical Results (Sample Review) Table G3-5 11
Claims Composite Medical Results Table G3-6 11
Standard G-05 12
SUMMARY 13
LIST OF RECOMMENDATIONS 13
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

EMPLOYERS INSURANCE COMPANY OF WAUSAU

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

Employers Insurance Company of Wausau, a stock Property and Casualty company, was originally incorporated as a mutual company in the state of Wisconsin on August 21, 1911, under the name "Employers Mutual Liability Insurance Company of Wisconsin." Employers Mutual Liability Insurance Company of Wisconsin merged with Employers Mutual Indemnity Corporation and Employers Mutual Fire Insurance Company on June 30, 1937, and December 22, 1975, respectively, with the original company being the surviving entity in both mergers. The name of the company was changed on September 1, 1979, to EMPLOYERS INSURANCE OF WAUSAU A Mutual Company (hereinafter "Employers").

On November 23, 1985, Employers consummated an affiliation agreement with Nationwide Mutual Insurance Company (hereinafter "NMIC") dated November 6, 1985. Within the context of this agreement, and certain subsequent agreements, NMIC exercised control of Employers and its subsidiaries and control of a Nationwide reinsurance pool to which all direct premiums written by Employers were ceded and from which all net premiums written were then assumed. The directors of Employers continued to be elected by the policyholders of Employers but election and reelection of nominees associated with NMIC on the Employers Board preserved the affiliation.

In 1998, NMIC decided to end its affiliation with Employers.

On October 5, 1998, Employers entered into an Affiliation and Contribution Note Purchase Agreement with Liberty Mutual Insurance Company (hereinafter "LMIC") and a De-Affiliation Master Agreement with NMIC. The affiliation with Liberty Mutual Insurance Company was approved by the Wisconsin Office of the Commissioner of Insurance (hereinafter "OCI") following a public hearing on December 16, 1998, and under the terms of the agreement, became effective January 1, 1999. The disaffiliation with NMIC was approved in writing on December 16, 1998, and under the terms of that agreement, became effective December 31, 1998.

Effective on November 21, 2001, EMPLOYERS INSURANCE OF WAUSAU A Mutual Company was restructured into a mutual holding company pursuant to the provisions of ch. 644, Wis. Stat. This restructuring was approved by OCI on November 19, 2001, following a public hearing, and was approved by vote of the policyholder members of Employers on November 20, 2001. Pursuant to the mutual holding company restructuring, Employers became a stock company, and the company was also renamed "Employers Insurance Company of Wausau," (hereinafter "EICOW") effective November 21, 2001. Thereafter, 100% of the stock of Employers was owned by the newly formed Employers Insurance of Wausau Mutual Holding Company. Effective on March 19, 2002, Employers Insurance of Wausau Mutual Holding Company was merged into Liberty Mutual Holding Company Inc. Since that time, policyholders of EICOW have been members of Liberty Mutual Holding Company Inc. This merger was approved by OCI on February 20, 2002. Through these transactions, EICOW became an affiliate of LMIC, and its current ultimate parent, Liberty Mutual Holding Company, Inc.

EICOW is licensed in all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Canada and in various other foreign countries. The company wrote business in every jurisdiction in which it is licensed in the United States.

Business is obtained and written through two producer channels. One is a "captive" direct sales force separately incorporated from EICOW and named the "Wausau Signature Agency." Wausau Signature Agency's account representatives are employees of LMIC and appointed to sell products for the company. In addition, independent agents produce business for EICOW and are compensated on a usual commission basis.

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

	Premium Written	Premium Incurred	Losses Paid	Losses Incurred	Losses Unpaid
2005	$12,549,927	$12,638,180	$6,673,767	$7,203,875	$31,369,286
2004	$12,603,393	$13,321,448	$8,749,885	$6,148,944	$30,839,178
2003	$21,674,828	$20,245,045	$6,987,869	$10,457,294	$33,440,119
2002	$17,700,561	$14,839,535	$4,553,767	$6,890,143	$29,970,694
2001	$8,990,689	$9,838,638	$5,289,288	$5,857,382	$27,634,318

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 a 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 law, 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. Comments, 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 posed 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: **Fail**

Observation: A list of all Indemnity Claim payments for the examination period was reviewed electronically. The database contained 12,600 indemnity claim payments made during the period under review representing one or more payments for 1,418 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	2781	383	162	225	51	**174**
2002 Indemnity Paid	2235	287	80	207	61	**146**
2003 Indemnity Paid	2876	328	77	251	107	**144**
2004 Indemnity Paid	2806	245	76	169	69	**100**
2005 Indemnity Paid	1902	175	65	110	50	**60**
Total	12600	1418	460	962	338	**624**

Of the 1418 claims representing all indemnity payments for the examination period, 460 were not subject to the 15 day requirement (generally files that did not develop a liability during the fifteen day requirement), resulting in 962 files subject to testing. There were 338 files (35.1% of the files subject to testing) where payment was clearly made within 15 days of the Notice of Injury. The remaining 624 files (64.9%) 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 applicable statute and regulation.

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

Type	Sample	Pass	Fail	% Pass	% Fail
2001-2005 Indemnity Paid	50	34	16	68%	32%

The results of the electronic test and the sample results were then combined. Please refer to Table G3-3. Since the sampled files represent 64.9% of the subject claims (624 of 862 claims), the "pass" component of the questioned files, 68%, is 44.1% of the tested population (68% x 64.9% = 54.1%). 35.1% + 44.1% = 79.2%. The "fail" component calculation is 32% of 64.9%, which is 20.8%.

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

Type	Claim Count	% Pass	% Fail
2001-2005 Indemnity Paid	962	79.2%	20.8%

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	11985	4328	51	7606	36.1%	0.4%	63.5%
2002 Medical Paid	29577	25382	98	4097	85.8%	0.3%	13.9%
2003 Medical Paid	41350	35330	110	5910	85.4%	0.3%	14.3%
2004 Medical Paid	35443	30082	83	5278	84.9%	0.2%	14.9%
2005 Medical Paid	26744	21450	200	5094	80.2%	0.8%	19.0%
Total	145099	116572	542	27985	80.3%	0.4%	19.3%

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" (See 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 19.3% of the files in the Total Population and was the source of files selected in the sample to be manually tested.

Of the 145,099 Medical Claim payments electronically tested, 27,985 questioned files (19.3% 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	93	7	93%	7%

The results of the electronic test and the sample results were combined. Please refer to Table G3-6. Since the sampled files represent 19.3% of the subject claims (27,985 of 145,099 claims), the "pass" component of the questioned files, 93%, is 17.9% of the tested population (93% x 19.3% = 17.9%). 80.3% + 17.9% = 98.2%. The "fail" component calculation is 7% of 19.3% or 1.4%. Therefore 0.4% + 1.4% = 1.8%.

Claims Composite Medical Results Table G3-6

Type	Claim Count	% Pass	% Fail
2001-2005 Medical Paid	145099	98.2%	1.8%

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 23% 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 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.

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 was not available.

Recommendations: None

SUMMARY

Employers Insurance Company of Wausau 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..

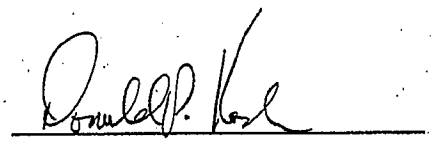
The examiners note that the Company's compliance risk mitigation efforts pertaining to the timely payment of Indemnity Claims for Workers' Compensation are insufficient to ensure timely payment of those claims. The examiners' observed a failure rate of 20.8% for claims subject to payment within 15 days of the Notice of Injury. The examiners also note that compliance with the time required for payment of Workers' Compensation Medical Claims was generally in compliance with the applicable regulation.

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	259	90	38	3	51
Feb-01	220	31	20	5	6
Mar-01	244	36	15	3	18
Apr-01	239	30	11	3	16
May-01	245	25	9	4	12
Jun-01	257	27	8	6	13
Jul-01	238	20	10	2	8
Aug-01	281	31	14	5	12
Sep-01	233	21	6	4	11
Oct-01	149	21	8	5	9
Nov-01	200	26	14	5	7
Dec-01	216	25	9	6	12
	2781	383	162	51	174

2002

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-02	220	27	10	6	11
Feb-02	174	18	5	4	9
Mar-02	190	22	9	3	10
Apr-02	152	15	3	6	6
May-02	179	26	8	4	14
Jun-02	127	13	6	2	5
Jul-02	160	27	9	4	14
Aug-02	190	29	5	8	16
Sep-02	177	26	7	6	13
Oct-02	228	37	8	8	21
Nov-02	213	22	3	5	14
Dec-02	225	25	7	5	13
	2235	287	80	61	246

2003

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-03	205	18	2	5	11
Feb-03	190	22	4	8	10
Mar-03	204	33	9	11	13
Apr-03	212	20	7	7	6
May-03	244	44	8	18	18
Jun-03	243	24	4	10	10
Jul-03	258	20	5	5	10
Aug-03	274	37	9	13	15
Sep-03	262	26	4	8	14
Oct-03	287	31	9	10	12
Nov-03	226	31	7	8	16
Dec-03	271	22	9	4	9
	2876	**328**	**77**	**107**	**144**

2004

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-04	225	14	4	6	4
Feb-04	190	19	8	4	7
Mar-04	227	24	9	4	11
Apr-04	264	32	4	9	19
May-04	224	24	5	7	12
Jun-04	251	17	8	3	6
Jul-04	265	26	6	8	12
Aug-04	262	33	8	12	13
Sep-04	240	14	2	6	6
Oct-04	212	11	3	4	4
Nov-04	228	16	9	2	5
Dec-04	218	15	10	4	1
	2806	**245**	**76**	**69**	**100**

2005

Month End	Payment Count	Number of Claims	N/A	Pass	Questionable
Jan-05	181	19	11	1	7
Feb-05	133	12	8	1	3
Mar-05	165	18	9	2	7
Apr-05	152	12	6	3	3
May-05	142	12	4	2	6
Jun-05	155	12	3	4	5
Jul-05	150	12	5	3	4
Aug-05	165	16	2	7	7
Sep-05	179	15	5	4	6
Oct-05	157	18	5	10	3
Nov-05	152	8	0	5	3
Dec-05	171	21	7	8	6
	1902	175	65	50	60

5-Year Indemnity Totals

	Payment Count	Number of Claims	N/A	Pass	Questionable
	12600	1418	460	338	624

APPENDIX 2

Monthly Medical Payment Count and Electronic Testing Result

2001

Month End	Payment Count	Pass	Fail	Questionable
Jan-01	654	0	0	654
Feb-01	728	0	0	728
Mar-01	781	0	0	781
Apr-01	850	0	0	850
May-01	833	0	0	833
Jun-01	955	0	0	955
Jul-01	1,219	0	0	1,219
Aug-01	1,105	0	0	1,105
Sep-01	89	0	0	89
Oct-01	686	680	6	0
Nov-01	2,121	1,896	14	211
Dec-01	1,964	1,752	31	181
	11,985	**4,328**	**51**	**7,606**

2002

Month End	Payment Count	Pass	Fail	Questionable
Jan-02	1,868	1,600	20	248
Feb-02	2,122	1,733	7	382
Mar-02	2,291	1,996	2	293
Apr-02	2,218	1,991	4	223
May-02	2,605	2,418	0	187
Jun-02	2,078	1,819	9	250
Jul-02	2,227	1,929	6	292
Aug-02	2,801	2,247	9	545
Sep-02	2,531	1,956	17	558
Oct-02	2,941	2,462	14	465
Nov-02	2,915	2,573	9	333
Dec-02	2,980	2,658	1	321
	29,577	25,382	98	4,097

2003

Month End	Payment Count	Pass	Fail	Questionable
Jan-03	3042	2,662	16	364
Feb-03	2,620	2,205	10	405
Mar-03	3,063	2,594	4	465
Apr-03	3,524	2,992	13	519
May-03	3,505	3,013	12	480
Jun-03	3,397	2,913	0	484
Jul-03	3,577	3,105	1	471
Aug-03	3,374	2,815	5	554
Sep-03	3,404	2,804	0	600
Oct-03	4,143	3,571	7	565
Nov-03	3,879	3,386	6	487
Dec-03	3,822	3,270	36	516
	41,350	**35,330**	**110**	**5,910**

2004

Month End	Payment Count	Pass	Fail	Questionable
Jan-04	2,637	2,220	0	417
Feb-04	3,054	2,682	0	372
Mar-04	3,338	2,768	13	557
Apr-04	3,186	2,717	28	441
May-04	3,049	2,643	5	401
Jun-04	3,281	2,815	5	461
Jul-04	3,234	2,646	0	588
Aug-04	3,531	2,952	20	559
Sep-04	2,889	2,456	0	433
Oct-04	2,880	2,462	0	418
Nov-04	2,524	2,212	0	312
Dec-04	1,840	1,509	12	319
	35,443	**30,082**	**83**	**5,278**

2005

Month End	Payment Count	Pass	Fail	Questionable
Jan-05	2,597	2,241	2	354
Feb-05	2,070	1,640	4	426
Mar-05	2,434	1,932	7	495
Apr-05	2,304	1,935	0	369
May-05	2,126	1,736	30	360
Jun-05	2,341	1,887	0	454
Jul-05	1,957	1,621	5	331
Aug-05	2,172	1,722	0	450
Sep-05	1,962	1,559	21	382
Oct-05	2,308	1,684	124	500
Nov-05	2,293	1,810	7	476
Dec-05	2,180	1,683	0	497
	26,744	21,450	200	5,094

5-Year Medical Totals

	Payment Count	Pass	Fail	Questionable
	145,099	116,572	542	27,985

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 Employers Insurance Company of Wausau 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

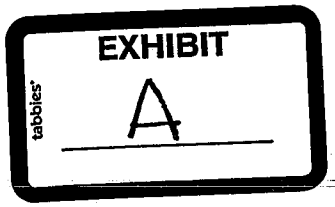
The statements and data therein contained are true and correct to the best of his knowledge and belief.

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.

WAUSAU

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