Chapter Ins 16

REGULATORY STRUCTURES

Ins 16.01 Annual billings for the examination of domestic insurers. (1) PURPOSE. The purpose of this rule is to develop a framework for the regular annual billing of domestic insurers, (except for town mutuals), to fund the costs of administering examinations as prescribed by s. 601.44, Stats., and to interpret s. 601.45 (1), Stats.

(2) SCOPE. The billing structure established by subsection (5) shall apply to all domestic insurers as defined by s. 600.03 (27) (c), Stats., with the exception of town mutuals.

(3) CLASSIFICATION OF DOMESTIC INSURERS. For the purposes of this rule, domestic insurers other than town mutuals shall be classified into the following categories:

(a) Insurers authorized to issue property and casualty insurance as defined in section Ins 6.75 (2), including the state property insurance fund;

(b) Insurers authorized to issue life and disability insurance as defined in section Ins 6.75 (1), including the state life insurance fund;

(c) Service insurance corporations and other insurers authorized under ch. 613, s. 185.981 or s. 185.991, Stats.; and,

(d) Fraternal benefit societies authorized under ch. 614, Stats.

(4) BILLING FOR EXAMINATION CHARGES. (a) On February 1, 1978, and annually thereafter, each domestic insurer subject to the provisions of this rule shall be billed an amount equivalent to such insurer's share of the estimated cost of conducting the insurer examinations program during that year.

(b) All other insurers, including town mutual insurers, shall be billed on a charge-back basis for the full cost of their examinations, including actual salaries and expenses of examinations and other apportionable expenses.

(5) BILLING STRUCTURE. (a) The commissioner shall annually, prior to the first day of each calendar year, estimate the cost of administering the insurer examinations program for the next calendar year. This amount shall be based on the biennial budget as approved by the legislature. Included in the estimated cost of administering the insurer examinations program shall be:

1. Salaries, fringe benefits and expenses of insurer examinations staff, including office overhead;

2. Supplies, office space, training costs, related data processing charges; and,

3. A contingency fund for hiring outside consulting or technical services.

(b) Excluded from this amount shall be the estimated share of the costs of the examination function which shall be provided through funding by insurers who will be charged for their examinations on a charge-back basis.

(c) In the event that the sum of a year's billing under this rule exceeds the actual cost of administering the insurer examinations program, the amount of the excess shall be applied as an offset to the estimated cost for the next year's examinations program.

(6) ACCOUNTING SUMMARY. On or before January 31 of each year, an accounting summary of the previous calendar year's examination costs shall be prepared. This summary will be furnished upon request to those insurers subject to this rule.

(7) DETERMINATION OF INDIVIDUAL BILLINGS. In determining the proportionate amount to be billed each domestic insurer subject to this rule, the commissioner shall:

(a) Take into account the following types of factors, based upon the insurers' status as of December 31, of the second preceding calendar year:

1. Size of insurer;

2. Type of business;

3. Category of insurer under subsection (3);

4. Premium volume;

5. Historical examination experience; and

6. Such other factors as may be deemed appropriate.

(b) Review the pattern of examination costs over previous years, and calculate the proportion of regular examination charges applicable to each of the 4 categories of insurers listed in subsection (3).

(c) Within each of the 4 categories of insurers listed in subsection (3), analyze the relationship between the costs of past regular examination billings, the amount of assets and the amount of premiums of domestic insurers, to mathematically determine a line of best fit formula for that category of insurers, which shall .then be applied uniformly to all insurers in that category.

(8) LIMITATIONS ON AMOUNT OF BILLINGS. The annual bill for each insurer subject to this rule shall be determined utilizing the formula developed for the category of insurance to which it belongs, for its proportionate share of cost of the examination function, under the procedure outlined in subsection (7), except that:

(a) The maximum annual billing for any insurer shall be 1% of Net Premiums Earned or Premiums & Annuity Considerations reported under Nationwide Operations in the Wisconsin Insurance Commissioner's Report for business of the second preceding calendar year, subject to a requirement that the minimum bill for any insurer be $300.

(b) For the first year of this rule the bill for any insurer, not subject to the limits established in paragraph (a), shall not exceed 150% of the previously paid examination fee on an annualized basis, adjusted for inflation, and adjusted to reflect all costs referred to in subsection (5). Thereafter, the annual bill for any insurer shall not exceed the previous year's bill for that insurer, adjusted to reflect the proportionate annual increase in the cost of examinations for all insurers, by more than 25%.

(9) ANNUAL HEARING. The commissioner shall annually schedule a hearing under s. 601.41 (5), Stats., to review problems in the area of examinations, and the formulas established for the 4 categories of insurers under subsection (7) (c).

(10) DUE DATE. Amounts billed to domestic insurers under subsection (4) shall be due and payable to the commissioner no later than March 1 of each year.

Note: The approach taken in this rule for the development of an annual billing structure for examination costs of domestic insurers attempts to balance the historical examination experience of individual insurers with a statistically-determined approximation of what insurers of a certain premium (or asset) size would have paid.

Any approach to this task must, of necessity, contain elements of arbitrariness and human judgment. The parameters established in the rule are attempts to guard against drastic departures from past experience.

The idea to develop formulas, based upon premiums (and/or assets), to statistically explain the "line of best fit" of examination costs, grew out of the work of the McKinsey study for the National Association of Insurance Commissioners ("Strengthening the Surveillance System," 1974), and the simple observation that there should be some relationship between examination costs and the premium volume or assets of an insurer. The problem then becomes one of determining that relationship.

The technique of multiple regression analysis was used to evaluate the variables and their respective weights. Data (net admitted assets, net earned premiums, or logarithmic transformations of assets and premiums) for the examinations of calendar years 1971 through 1976 was considered.

After generating formulas which minimized the sum of the squared differences from a fitted line (i.e. "explained" the line best), a number of factors were analyzed to decide which of the formulas would make the most sense to use, including:

1. the r^2 factor, which measures the percentage of the total variation in examination costs which is due to their relationship with the variables in question.

2. the F-factor, which generally is the ratio of explained variability to unexplained variability.

3. the residuals, which are the difference between predicted and observed values.

The formulas selected for the first year's billings under subsection (7) (c), subject to subsection (8), are as follows:

1. Property and casualty insurers [subsection (3) (a)]:
   1978 Billing = $(0.675271) \times 10^{[0.7055378 + 0.4593663 (\log_{10} P)]}$

2. Life insurers [subsection (3) (b)]:
   1978 Billing = $-22{,}005 + (1{,}661.13) (\log_e A) + (2.6674284 \times 10^{-5}) \times P$;

3. Service insurers and others [subsection (3) (c)]:
   1978 Billing = $1{,}297 + (6.4377 \times 10^{-5}) \times P$;

4. Fraternal benefit societies [subsection (3) (d)]:
   1978 Billing = $3640.0 + (1.03231098 \times 10^{-4}) \times P$

where P = Net Premiums Earned or Premiums & Annuity Considerations reported under Nationwide Operations in the 1977 Wisconsin Insurance Commissioners Report (Business of 1976)

A = Admitted Assets reported in the 1977 Wisconsin Insurance Commissioners Report (Business of 1976)

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The estimated percentages of total regular examination costs under subsection (7) (b) based on the triennialized last examination cost for each company, and excluding town mutuals were as follows:

1. property and casualty, 52.0%;

2. life, 32.8%;

3. service insurers and others, 6.7%; and

4. fraternals, 8.5%.

A "full cost of examinations conversion factor" for the initial billing utilized in subsection (8), was set at 1.5873 based on analysis of historic examination and budgetary experience, and the factor to adjust for inflation was set at 1.11 for years immediately prior to 1977 and at 1.09 for the calendar year 1977.

History: Cr. Register, December, 1977, No. 264, eff. 1-1-78.

Ins 16.02 Annual audited financial reports and examinations. (1) PURPOSE. This rule is promulgated to implement, interpret and set forth procedural requirements necessary to carry out the purpose and provisions of ss. 601.42 and 601.43, Stats.

This rule shall not prohibit, preclude, or in any way limit the commissioner, or his designee, from ordering or conducting or performing examinations of insurers under his jurisdiction as to practices, procedures, financial condition, market conduct and other aspects of the operations of such insurers.

(2) SCOPE. This rule shall apply to all insurers licensed under chs. 611, 612, 613, 614 and 618, Stats., and the state life fund.

(3) EXEMPTIONS. (a) Upon written application of any insurer, the commissioner may grant an exemption from compliance with this rule if the commissioner finds, upon review of the application, that compliance with this rule would constitute a financial or organizational hardship upon the insurer.

(b) An exemption may be granted at any time and from time to time for a specified period or periods.

(c) Within 10 days from a denial of an insurer's request for an exemption from this rule, such insurer may request a hearing on its application for an exemption as provided by s. 227.075, Stats.

(d) Insurers having premiums written in Wisconsin of less than $100,000 in any year and having less than 1,000 Wisconsin policyholders at the end of any year are exempt from this rule for such year.

(4) DEFINITIONS. Unless the context otherwise requires:

(a) "Accountant" means those persons who meet the requirements of sub. (13) of this rule.

(b) "Audited financial report" means and includes those items specified in sub. (6) of this rule.

(c) "Executive officer" means any individual charged with active management and control in an executive capacity of a person, whether incorporated or unincorporated. These individuals include but are not

limited to a chairman of the board, president, vice president, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers.

(d) "Insurer" has the meaning set forth in s. 600.03 (27) (a), Stats.

(e) "Workpapers" are the records kept by the accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the examination of the financial statements of an insurer. Workpapers, accordingly, shall include work programs, analyses, memoranda, letters of confirmation and representation, management letters, abstracts of company documents and schedules or commentaries prepared or obtained by the accountant in the course of the examination of the financial statements of an insurer and which support the opinion thereon.

(5) SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT. (a) Financial statements furnished pursuant to sub. (6) shall be audited by an independent certified public accountant.

(b) The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards and such other procedures as promulgated by the national association of insurance commissioners, as the accountant deems necessary.

(c) The commissioner may from time to time require that additional auditing procedures be observed by the accountant in the audit of the financial statements of insurers pursuant to this rule. Any separate reports given to the commissioner on the additional procedures and findings shall be considered to be the commissioner's workpapers.

(6) CONTENTS OF ANNUAL AUDITED FINANCIAL REPORT. (a) The annual audited financial report shall report the admitted assets, liabilities and surplus; the results of its operations; the changes in financial position and the changes in capital and surplus for the year then ended in conformity with accounting practices prescribed or otherwise permitted in annual statements filed with the commissioner, as described in Ins 7.01 (5). In the alternative, such reports may be prepared in accordance with generally accepted accounting principles provided that the notes to the financial statements include a reconciliation of surplus (or stockholder's equity) and results of operations on the basis of generally accepted accounting principles to the statutory basis of accounting.

(b) The annual audited financial report shall include the following:

1. Report of independent certified public accountant.

2. Statement of admitted assets, liabilities, capital and surplus.

3. Statement of gain or loss from operations.

4. Statement of changes in financial position.

5. Statement of changes in capital and surplus.

6. Notes to financial statements. These notes shall be those needed for fair presentation and disclosure and shall include a reconciliation of differences, if any, between the audited financial statements described in par. (b) and the annual statement filed with the commissioner and described in Ins 7.01 (5) with a written description of the nature of these differences.

7. Supplementary data and information which the commissioner may from time to time require to be disclosed.

(7) CONSOLIDATED OR COMBINED ANNUAL AUDITED FINANCIAL REPORTS. (a) An insurer may file an annual audited financial report which contains audited consolidated or combined financial statements in lieu of separate annual audited financial statements provided that the following are included:

1. An organization chart of the companies included in the report.

2. A worksheet setting forth the amounts shown on the consolidated or combined annual audited financial report with a reconciliation to individual amounts shown on the annual statements of the insurers which are filed with the commissioner. The reconciliation shall be in columnar form and must include explanations of consolidating and eliminating entries. Amounts for each insurer subject to this rule must be stated separately.

(b) The commissioner may require an insurer to file a separate annual audited financial report.

(8) NOTIFICATION OF ADVERSE FINANCIAL CONDITION. (a) The insurer required to furnish an annual audited financial report shall require the accountant to immediately notify in writing an executive officer of the insurer of any determination by that accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the December 31 immediately preceding, or of any determination that the insurer does not meet the minimum capital and surplus requirements of the commissioner.

(b) Any executive officer or director of an insurer required to file an annual audited financial report who received any notification from the accountant, shall within 3 business days report the existence of the materially misstated financial condition or the failure to meet the minimum capital and surplus requirements of the commissioner, through a written report to the commissioner

(9) EVALUATION OF ACCOUNTING PROCEDURES AND SYSTEM OF INTERNAL CONTROL. (a) In addition to the annual audited financial report, each insurer shall furnish the commissioner with a report of evaluation performed by the accountant, in connection with his audit, of the accounting procedures of the insurer and its system of internal control.

(b) The report described in par. (a), including a summary of any remedial action taken or proposed, shall be filed annually by the insurer with the commissioner within 60 days after the due date for filing the annual audited financial report.

(c) This report on internal control shall be in a form prescribed by generally accepted auditing standards.

(10) FILING OF ANNUAL AUDITED FINANCIAL REPORTS. Every insurer must file an annual audited financial report on or before June 30, for the year ended December 31 immediately preceding.

(11) EXTENSIONS FOR FILING OF ANNUAL AUDITED FINANCIAL REPORTS. (a) Extensions of the June 30 filing date may be granted by the commissioner for 30 day periods upon the insurer and its accountant showing the reasons for requesting such extension.

(b) Requests for extensions must be submitted in writing not less than 10 days prior to the due date and in sufficient detail to permit the commissioner to make an informed decision with respect to a requested extension.

(12) DESIGNATION OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT. (a) Each insurer currently engaging an independent accountant to examine its financial statements must within 60 days of the effective date of this rule, furnish the commissioner the name and address of the accountant retained to conduct the annual audit.

(b) Insurers which do not have an accountant for the year ending December 31, 1978 and which are not exempted pursuant to sub. (3) shall furnish the name and address of their retained accountant by September 1, 1979.

(c) The insurer shall obtain a letter from such accountant, and file a copy with the commissioner, stating that the accountant is aware of the provisions of the Wisconsin insurance code and the rules of the commissioner that relate to accounting and financial matters and affirming that the opinion will be expressed in terms of conformity to accounting practics prescribed or otherwise permitted by the commissioner, specifying such exceptions as are appropriate.

(d) If an accountant who was not the accountant for the immediately preceding filed audited financial report is engaged to audit the insurer's financial statements, the insurer shall within 30 days of the date the accountant is engaged notify the commissioner of this event.

1. The insurer shall also furnish the commissioner with a separate letter stating whether in the 24 months preceding such engagement there were any disagreements with the former accountant on any matter of accounting principles (either statutory or generally accepted accounting principles) or practices, financial disclosure, or auditing scope or procedure, which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him to make reference to the subject matter of the disagreement in connection with his opinion.

2. The insurer shall also in writing request such former accountant to furnish it a letter stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for disagreement. The insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

(13) QUALIFICATIONS OF ACCOUNTANT. (a) The commissioner shall not recognize any person as an independent certified public accountant who is not duly registered to practice and in good standing under the laws of the state of Wisconsin or in any state with similar licensing requirements. It shall also mean, for British or Canadian companies, a Canadian or British chartered accountant.

(b) Except as otherwise provided herein, a certified public accountant shall be recognized as independent as long as he or she conforms to the standards of the profession.

(c) The commissioner may hold a hearing pursuant to the authority granted by ch. 227, Stats., to determine whether a certified public accountant is independent and, considering the evidence presented, may rule that the accountant is not independent for purposes of expressing

an opinion on the financial statements in the annual audited financial report.

(d) As a result of the hearing held pursuant to (c) above, the commissioner may order the insurer to replace the accountant with another whose relationship with the insurer is independent within the meaning of this rule.

(14) AVAILABILITY AND MAINTENANCE OF CPA WORKPAPERS. (a) Every insurer required to file an audited financial report pursuant to this rule, shall require the accountant to make available for review, the workpapers prepared in the conduct of his audit. The insurer shall require that the accountant retain the audit workpapers for a period of not less than 5 years after the period reported.

(b) In the conduct of a periodic review by the commissioner, it shall be agreed that copies of pertinent audit workpapers may be made and retained by the commissioner. Such copies shall be considered part of the commissioner's workpapers.

(15) EXAMINATIONS. (a) The commissioner shall determine the nature, scope and frequency of examinations conducted pursuant to s. 601.43, Stats.

(b) Such examinations may, but need not, cover all aspects of the insurer's assets, condition, affairs and operations and may include and be supplemented by audit procedures performed by accountants as herein provided.

(c) Scheduling of examinations will take into account such matters as analysis of financial test results, changes in management, results of market conduct examinations, and audited financial reports.

(d) The type of examinations under the provisions of this rule performed by the commissioner after the effective date of this rule shall be as follows:

1. Compliance examinations will consist of a review of the accountant's workpapers defined under sub. (4) of this rule and a general review of the insurer's corporate affairs and insurance operations to determine compliance with the Wisconsin insurance code and the rules and regulations of the commissioner. The examiners may perform alternative or additional examinations procedures to supplement those performed by the accountant when the examiners determine that such procedures are necessary to verify the financial condition of the insurer.

2. Targeted examinations may cover such areas as life reserve valuations, claims analyses, organizational and capital changes, loss reserves, market conduct and such other areas as the commissioner may deem appropriate.

3. Comprehensive examinations will be performed when the report of the accountant as provided for in sub. (6) or the notification required by sub. (8) or the results of compliance or targeted examinations or other circumstances indicate in the judgment of the commissioner that a complete examination of the condition and affairs of the insurer is necessary.

(16) SEPARABILITY. If any provision of this rule shall be held invalid the remainder of the rule shall not be affected thereby.

(17) PENALTY. Violations of this rule shall subject the person violating the same to s. 601.64, Stats.

(18) EFFECTIVE DATE. (a) Insurers not retaining an independent certified public accountant on the effective date of this rule shall comply with this rule for the year ending December 31, 1979 unless the commissioner permits otherwise. The annual audit report for the year ending December 31, 1979 need not include the statements required in (6) (b) 3., (6) (b) 4. and (6) (b) 5.

(b) Insurers retaining an independent certified public accountant on the effective date of this rule shall comply with this rule for the year ending December 31, 1978, unless the commissioner permits otherwise. If the insurer's stock is held by another insurer or by a holding company as defined under Ins 12.01 (3) and this owner-insurer or holding company had retained an independent certified public accountant prior to December 31, 1978, the insurer shall be deemed to be audited for purposes of this rule.

(c) For insurers licensed under ch. 612, the effective date of this rule shall be January 1, 1981.

History: Cr. Register, January, 1979, No. 278, eff. 2-1-79.