1969 Senate Bill 525

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CHAPTER 144, LAWS OF 1969

AN ACT to repeal 25.17 (1) (m) and (w), 102.65, 200.13 (1) (f), 201.60, 203.23, 203.32, 204.341, 204.342, 204.37 to 204.54 and 205.15; to amend 15.731, 15.761, 200.13 (1) (e), (2) (e) and (3) (d), 201.53 (2), 203.06 (6) and 209.04 (2) (b); to repeal and recreate 20.145 (7), 25.17 (1) (j) and 645.63 (5); and to create 200.15 (2) (f) and chapters 619, 625, 631 and 646 of the statutes, relating to protection of insurance consumers.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 15.731 of the statutes, as affected by chapter , laws of 1969 (Senate Bill 355), is amended to read:

15.731 The office of the commissioner of insurance shall have the program responsibilities specified for the office under chs. 199 to 212 ~~and~~ , *619, 625, 631,* 645 *and 646* and ss. 23.14 (16), 66.412, 72.15 (4), 72.76 (3) and (4), 102.31, ~~102.65,~~ 148.03, 151.17, 152.53, 182.032, 185.983, 185.984, 185.992, 185.994, 189.13 (7) and (8), 314.06 and 954.44.

SECTION 2. 15.761 of the statutes, as affected by chapter , laws of 1969 (Senate Bill 355), is amended to read:

15.761 The investment board shall have the program responsibilities specified for the board under ss. 14.58 (16), 16.40, 23.14 (6), 25.14 to 25.19, 38.24, 42.243, 42.65, 42.66, 66.904 (1) (a), 66.9065 (7) (b), 66.912 (1) (q), 66.914 (1), 67.04 (9), 70.115, 71.20 (4), 102.49 (8), 102.59 (4), ~~102.65 (10),~~ 210.05 (2), 220.08 (15) , ~~and~~ 231.45 *and 646.05.*

SECTION 3. 20.145 (7) of the statutes is repealed and recreated to read:

20.145 (7) INSURANCE SECURITY FUND. (u) *Fund receipts.* All moneys paid into the insurance security fund under ch. 646, including the temporary workmen's compensation insurance security fund under s. 646.23, to carry out the purposes of that fund as provided in ch. 646.

SECTION 4. 25.17 (1) (j) of the statutes is repealed and recreated to read:

25.17 (1) (j) Insurance security fund (s. 646.05);

SECTION 5. 25.17 (1) (m) of the statutes is repealed.

SECTION 6. 25.17 (1) (w) of the statutes is repealed.

SECTION 7. 102.65 of the statutes is repealed.

SECTION 8. 200.13 (1) (e) of the statutes is amended to read:

200.13 (1) (e) ~~Rating bureaus~~ *Rate service organizations*, $100;

SECTION 9. 200.13 (1) (f) of the statutes is repealed.

SECTION 10. 200.13 (2) (e) of the statutes is amended to read:

200.13 (2) (e) ~~Rating~~ *Rate service* organizations~~:~~ ~~fire, casualty and workmen's compensation~~, $100;

SECTION 11. 200.13 (3) (d) of the statutes is amended to read:

200.13 (3) (d) ~~Rating~~ *Rate service* organizations~~:~~ ~~fire, casualty and workmen's compensation~~, $100;

SECTION 12. 200.15 (2) (f) of the statutes is created to read:

200.15 (2) (f) A statement of receipts and expenses and of the assets of the insurance security fund.

SECTION 13. 201.53 (2) of the statutes is amended to read:

201.53 (2) No insurance company, nor any officer, agent or employe thereof, shall pay, allow or give or offer to pay, allow or give, nor shall any person receive, any rebate of premium, or any special favor or advantage whatever in the dividends or other benefits to accrue, or any valuable consideration or inducement whatever not specified in the policy. ~~Any violation of this subsection that is a violation of section 204.52 shall be subject to the fine provided in section 204.53 in lieu of the penalty imposed by section 201.53 (9).~~

SECTION 14. 201.60 of the statutes is repealed.

SECTION 15. 203.06 (6) of the statutes is amended to read:

203.06 (6) The standard policy shall not be mandatory for motor vehicle insurance or for marine, or for inland marine insurance~~, as the same is defined in s. 203.32 (2),~~ or for insurance on growing crops, or for livestock insurance or for nuclear facilities.

SECTION 16. 203.23 of the statutes is repealed.

SECTION 17. 203.32 of the statutes is repealed.

SECTION 18. 204.341 and 204.342 of the statutes are repealed.

SECTION 19. 204.37 to 204.54 of the statutes are repealed.

SECTION 20. 205.15 of the statutes is repealed.

SECTION 21. 209.04 (2) (b) of the statutes is amended to read:

209.04 (2) (b) Each applicant for a certificate of registration or agent's license (if no such certificate is required) shall pay an examination fee as required by s. 200.13 (17) and submit to a personal written examination to determine his competence with respect to the kind of insurance contracts he intends to solicit, negotiate or effect and his familiarity with the pertinent laws of this state and passes the same to the satisfaction of the commissioner; except that no such examination or fee therefor shall be required of any person who makes application to solicit exclusively ~~the kinds of~~ insurance ~~described in s. 203.32 (2) (b) 6~~ for domestic windstorm, cyclone and tornado insurance companies operating on an assessment plan or by any person who makes application to solicit, exclusively, the kind of insurance for which he held a license as a resident agent within the 5 years immediately preceding the date of filing his application unless during that period, renewal of his license was denied for cause. The commissioner may, upon showing just cause, require any applicant having previously held a certificate of registration to submit to a written examination and pass the same for any certificate before effecting the renewal of such certificate. The commissioner shall require further examination of a certificate holder whenever such person indicates intent to solicit, negotiate or effect kinds of insurance for which he has not been licensed for any insurer within the last 5 years. The commissioner shall establish rules with respect to the scope, frequency, grading of papers, announcements of the results of such written examinations and the times and places within the state where they shall be held. The commissioner shall cause ex-

aminations to be conducted throughout the state at places reasonably accessible to applicants at no less frequency than once each month. In advance of such examinations the commissioner shall cause notice to be given to all applicants. The commissioner is authorized to appoint representatives deemed competent who shall conduct the examination and to pay a fee to each person conducting the examinations as his deputy.

SECTION 22. Chapter 619 of the statutes is created to read:

CHAPTER 619.

RISK SHARING PLANS.

619.01 Mandatory risk sharing plans.

619.02 State contribution for federally reinsured losses.

619.03 Voluntary risk sharing plans.

PRELIMINARY COMMENT: Recent investigations have demonstrated that critical residual markets do exist. Not all Wisconsin residents can obtain the insurance protection they need to use automobiles, operate businesses or even to protect their residences.

Residual Property Insurance Market

The problem is nationwide. It has been here for a long time but became the center of public concern as a result of the widespread destruction of the long hot summers in riot-torn Watts, Detroit, Newark and other cities.

In Wisconsin the major problems center around Milwaukee, although the rural areas of northwestern Wisconsin also present some difficulties. Although the problem is the same, the causes differ radically: Isolated communities make fire protection more difficult and hence more expensive; the areas are somewhat depressed economically, hence companies find it unprofitable to work the areas. The Wisconsin commissioner of insurance began investigating complaints about the shortage of adequate protection in Milwaukee in 1963. Three years later the "Milwaukee Plan" was formulated. It was a voluntary plan administered by the Fire Insurance Rating Bureau.

Until the Milwaukee riots of June, 1967, the bureau received only 36 complaints, and was able to help 22 of the complainants. The number of complaints increased markedly after the riots, however. Because of the continued urgency of the problem, the commissioner encouraged creation of a voluntary plan designed to provide basic property insurance to responsible applicants throughout the state of Wisconsin who have been unable to secure such coverage in the normal insurance market. Designated the WISCONSIN INSURANCE PLAN, it was drafted to conform with requirements of the Urban Property Protection and Reinsurance Act enacted by Congress in 1968. That arrangement has worked adequately as a temporary measure. However, not all companies are participating in the plan. It is unfair that those who do participate must bear disproportionately heavy burdens because some other insurers do not take part. More important, the public interest demands a constant and assured source of protection that can come only through a comprehensive mandatory pool.

Residual Automobile Insurance Market

The growing difficulty of obtaining adequate automobile insurance is a problem not only for those who live in core areas but for those who are very old or very young or who have other characteristics underwriters do not like. The factors that lead companies to cancel or to fail to renew create an important residual market.

The residual automobile insurance market is probably a permanent problem, and assigned risk plans exist in all states to deal with it. Under this chapter, that plan can be continued or can be improved without further legislation. A rule promulgated by the commissioner could provide

for an extension of the assigned risk plan or other facility, for additional coverages and for higher limits to meet the real needs of the population, but would also make it possible for the ingenuity of the insurance industry to be harnessed for the development of even more imaginative devices to meet the need more efficiently and equitably.

Workmen's Compensation Residual Market

Workmen's compensation insurance is mandatory for nearly all employers. A residual market facility is imperative and has long existed. This chapter merely makes it possible to adapt it to an evolving situation.

619.01 MANDATORY RISK SHARING PLANS. (1) MANDATORY PLANS. (a) *Establishment of plans.* If the commissioner finds after a hearing that in any part of this state automobile insurance, property insurance or workmen's compensation insurance is not readily available in the voluntary market, and that the public interest requires such availability, he may by rule either promulgate plans to provide such insurance coverages for any risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or may call upon the industry to prepare plans for his approval.

(b) *Purposes and contents of risk sharing plans.* The plan promulgated or prepared under par. (a) shall:

1. Give consideration to the need for adequate and readily accessible coverage, to alternative methods of improving the market affected, to the preferences of the insurers and agents, to the inherent limitations of the insurance mechanism, to the need for reasonable underwriting standards, and to the requirement of reasonable loss prevention measures;

2. Establish procedures that will create minimum interference with the voluntary market;

3. Spread the burden imposed by the facility equitably and efficiently within the industry; and

4. Establish procedures for applicants and participants to have grievances reviewed by an impartial body.

(c) *Persons required to participate.* Each plan shall require participation by all insurers doing any business in this state of the types covered by the specific plan and all agents licensed to represent such insurers in this state for the specified types of business, except that the commissioner may exclude classes of persons for administrative convenience or because it is not equitable or practicable to require them to participate in the plan.

(d) *Voluntary participation.* The plan may provide for optional participation by insurers not required to participate under par. (c).

(e) *Classifications and rates.* Each plan shall provide for the method of classifying risks and making and filing rates applicable thereto.

(2) BASIS OF PARTICIPATION. The plan shall specify the basis of participation of insurers and agents and the conditions under which risks must be accepted.

(3) DUTY TO PROVIDE SERVICE. Every participating insurer and agent shall provide to any person seeking coverages of kinds available in the plans the services prescribed in the plans, including full information on the requirements and procedures for obtaining coverage under the plans whenever the business is not placed in the voluntary market.

(4) COMMISSIONS. The plan shall specify what commission rates shall be paid for business placed in the plans.

(5) PROVISION OF MARKETING FACILITIES. If the commissioner finds that the lack of cooperating insurers or agents in an area makes the functioning of the plan difficult, he may order that the plan set up branch service offices or take other appropriate steps to ensure that service is available.

(6) TRANSITION. The existing assigned risk plan set up under former s. 204.51 (2) and the existing rejected risk plan set up under former s. 205.15 shall continue unless changed in accordance with this chapter.

COMMENT: This general power for the commissioner to find there is a need for a plan in one of the three specified but broad areas of the insurance market, and then to supervise the creation of one, gives maximum flexibility in handling residual markets as they develop.

Sub. (1) (a) provides for creation of a facility in the traditional way, through industry-commissioner cooperation, or in case of need by the commissioner's direct promulgation of a rule.

Subs. (3) and (4) are intended to motivate both insurers and agents to handling insurance needs through the voluntary market.

Sub. (5) tries to meet a basic cause of residual markets, the simple absence of appropriate marketing outlets for the private industry.

619.02 STATE CONTRIBUTION FOR FEDERALLY REINSURED LOSSES. (1) ASSESSMENT OF INSURERS. The commissioner is authorized to assess each insurance company authorized to do business in this state an aggregate amount sufficient to provide a fund to reimburse the U.S. secretary of housing and urban development in the manner set forth in sec. 1223 (a) (1) of the national housing act as amended by sec. 1103 of the urban property protection and reinsurance act of 1968, P.L. 90-448, 82 Stat. 476. The assessment shall be on those lines reinsured during the current year in this state by the U.S. secretary of housing and urban development pursuant to such act. The assessment shall be in the proportion that the premiums earned during the preceding calendar year by each such company in this state bear to the aggregate premiums earned on those lines in this state by all insurers. The fund may be provided in whole or in part from appropriations by the legislature.

(2) RECOUPMENT. Rates used by an insurer shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments made under this section.

COMMENT: This section provides a method of making the state's contribution to cover riot losses that is required if Wisconsin insurers are to be eligible for federal riot reinsurance. The "Urban Property Protection and Reinsurance Act of 1968" provides that federal riot reinsurance shall not be offered in any state that does not provide for reimbursement of the secretary of housing and urban development "in an amount up to 5 per centum of the aggregate property insurance premiums earned in that state during the preceding calendar year on those lines of insurance reinsured by the Secretary in the state during the current year, such that the Secretary may be reimbursed for amounts paid by him in respect to reinsured losses that occurred in that state during a calendar year in excess of (A) reinsurance premiums received in that state during the same calendar year plus (B) the excess of (i) the total premiums received by the Secretary for reinsurance in that state during a preceding period measured from the end of the most recent calendar year with respect to which the Secretary was reimbursed for losses under this subchapter over (ii) any amounts paid by the Secretary for reinsured losses that occurred during this same period." Sec. 1223 (1). In other words, this state may be called upon to reimburse the secretary for federally reinsured losses which in any calendar year exceed the total reinsurance premiums received since the end of the most recent year in which the state had reimbursed the secretary for such losses.

The federal law gives this state one year from August 1, 1968, to provide for this financing.

Sub. (1) provides the needed financing through an assessment on all companies writing lines of insurance which are being reinsured under the federal legislation. In order to obtain the broadest distribution of the so-

cial costs of riots, all companies—even those not reinsuring under the federal program—would be subject to the assessment. Sub. (1) also permits appropriations from general revenues to substitute, in whole or in part, for the assessment. It is conceivable that repeated riot losses over a period of years could make assessment financing unduly burdensome, and induce the legislature to make an appropriation. The section merely creates the framework for such a course of action.

Sub. (2) permits the companies to recover the premiums, through the premium structure, by an earmarked charge on all policies. It makes the riot burden clearer to all policyholders.

619.03 VOLUNTARY RISK SHARING PLANS. Insurers doing business within this state are authorized to prepare voluntary plans providing any specified kind, line or class of insurance coverage or subdivision or combination thereof for all or any part of this state in which such insurance is not readily available in the voluntary market and in which the public interest requires the availability of such coverage. Such plans shall be submitted to the commissioner and if approved by him may be put into operation.

SECTION 23. Chapter 625 of the statutes is created to read:

CHAPTER 625.
RATE REGULATION.

PRELIMINARY COMMENT: The basic concepts of this chapter are the result of a long and careful study of rate regulation which has led to the following conclusions:

(1) The existing system of rate regulation has been rendered unnecessary through the development of a strikingly greater degree of meaningful price competition in many of the most important lines of insurance.

(2) The rate-making process in insurance (other than life) is so imprecise that the difficulty and cost of the regulatory effort are too great in relation to the beneficial results achieved by it.

(3) Rate regulation in the traditional manner produces unfortunate side effects: It distracts attention from real problems in the marketplace to formalistic tests of imagined "reasonableness". It generates a feeling that the system is responsible for most problems that plague insurance today, ranging from constriction of the market and lack of profitability to the tendency to disinvest in the insurance business.

(4) Much discussion has been misdirected toward the question whether one or another system will produce lower rates. But no system should always seek lower rates. A rate regulatory system should prevent

unconscionably high rates or dangerously low rates but should not seek to determine the "proper" rate, for that is not possible.

These conclusions call for a system of rate control which eliminates the requirement that rates be reviewed by the commissioner before use. However, it does not seem advisable to completely abandon all rate regulation. Rates must be filed after they have begun to be used, and the commissioner's power to intervene decisively is clearly preserved.

There are many reasons for not simply abandoning rate regulation. First, while there is now meaningful price competition, this was not always so, and it may not always remain so. Price competition is dependent on attitudes among managers, sometimes influenced by irrational factors; it is not predictable. Bad performance of the fire insurance business prior to 1910 bred an anti-competitive mood which dominated the entire industry until about 1940. Now, after 30 years of increasing competition, there are more and more complaints about inadequate rates and decreasing profits. While at the moment these problems are charged to the deficiencies of prior approval rate regulation, if conditions do not improve significantly in the future, the industry may again develop hostility to price competition and seek to suppress it.

The law must be prepared to deal speedily and effectively with such changes. Whenever in a part of the insurance business price competition is replaced by price fixing in concert there is no assurance that the resulting prices reflect the reasonable cost of the coverage. Then the regulatory system must step in to protect policyholders.

Moreover, rate-making in concert is not the only danger to healthy price competition. Insurers may voluntarily and individually conclude that it is more probitable for them to compete in other ways than by lowering premiums. Historically, a persistent perversion of insurance competition has been the focusing of competitive efforts on obtaining agents through higher commissions. Though rate regulation may not be the final answer to such problems, it is an important part of it.

Third, insurance tends rather to be "sold" than "bought". It is sold by agents who never have a full display of products available for easy comparison. Comparison of competing coverages is made extremely difficult even for sophisticated buyers by the abstract nature and inherent legal complexity of an insurance policy, and by the variations in policy forms and rating plans. While an increasing number of insurance buyers do "shop around", they may not know how to choose. Others do not even look around because they lack knowledge of the market. This limits the effectiveness of competition. The law cannot allow partially informed buyers to be exploited by unscrupulous operators. The commissioner must have the power to eradicate such practices and have appropriate procedures for doing so selectively.

Fourth, competition may become unreasonable or excessive. "Rate wars", of the 19th century variety, are not likely again. Modern managements are better informed than those in the pioneer days of the insurance business. But there is still constant danger of excessive optimism. The cost of insurance is not exactly known in advance but must be estimated. Management tends to be too optimistic, especially in industrial or commercial insurance where buyers are sophisticated, where bargaining is tough and where premiums of a single contract are substantial. The result may be a decline of premium levels for a segment of the industry, insufficient reserves for catastrophic losses and the resulting danger of insolvencies. The commissioner must be able to intervene in time to prevent harm to policyholders. Usually the control of reserves and the remedies of ch. 645 will be sufficient, but in exceptional cases direct action on rates may be needed.

It is not the purpose of this chapter to guarantee the continued existence and success of every insurer now operating in Wisconsin. Com-

petition as a regulator assumes rewards for efficiency and punishments for its absence. The regulatory system cannot allow policyholders to pay the full ultimate price for failure of the insurer to adjust to the harsh demands of the marketplace; bankruptcies that cause loss to policyholders must be avoided. But the losers in the competitive struggle should be forced to retire from the market while they can do so without financial loss to policyholders, and the commissioner has both general duties and powers, and special powers under ch. 645, to see that they do.

The new law tries to provide procedures to handle these residual problems without falling back into the defects of a comprehensive prior approval system.

As a rule, insurers can use the rates they choose. No approval is required, and a filing is required only for information and after the fact. If the commissioner wants to inform himself about rate levels and practices in a segment of the market, he may get such information under his general powers. [Proposed s. 601.42]. Rates may be made individually or collectively by bureaus, but agreements to adhere to bureau rates are prohibited. Bureaus may not refuse their services to anyone ready to pay the fair and usual price.

Section 625.11 continues the traditional rate standards, "not excessive", "not inadequate" and "not unfairly discriminatory" but deals with them in such a way as to leave no doubt that the regulator is to be concerned only with serious departures from a "reasonable" rate level. Experience with the prior approval system has shown that it is impossible to decide on the "right" or "proper" premium. Unreliable facts and assumptions make any figure within a broad range likely to be the "right" premium. So long as the rate falls within the permissible range, the commissioner should not interfere. Only serious disparity between the cost of the coverage and the premium, leading to an unreasonable profit, or inadequate premiums that threaten the solidity of the insurer should lead the commissioner to demand an adjustment.

Administrative action is provided for various sets of facts, with the commissioner's powers and procedures geared to the occasion. Precautions are taken to limit the action to the portion of the market where the problem exists, and the requirements of due process are always observed.

If in a portion of the market price competition ceases to operate, or loses its effectiveness as a rate regulator, the commissioner may make a rule requiring the advance filing of rates and a waiting period similar to that under present law, during which the commissioner can review the rates. He may add a requirement that supporting information be submitted. He may disapprove rates, however, only if they are outside the range described earlier, not because they do not meet his personal view of an "ideal" rate. Section 625.21 restricts the effective period of any rule made under this authority to one year, to prevent its petrification. If the adverse market conditions should persist, a new finding to that effect and a new rule would have to be made.

Finally, s. 625.22 authorizes the commissioner to disapprove rates that exceed the broad limits of the statutory standards, whether or not they have been filed. No special fact-gathering procedure is needed. The commissioner is equipped to seek out violations, learning of the possibility either through complaints or through ordinary examination.

625.01 CONSTRUCTION AND PURPOSES. (1) CONSTRUCTION. This chapter shall be liberally construed to achieve the purposes stated in sub. (2), which shall constitute an aid and guide to interpretation but not an independent source of power.

(2) PURPOSES. The purposes of this chapter are:

(a) To protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

(b) To encourage, as the most effective way to produce rates that conform to the standards of par. (a), independent action by and reasonable price competition among insurers;

(c) to provide formal regulatory controls for use if independent action and price competition fail;

(d) To authorize cooperative action among insurers in the rate-making process, and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition;

(e) To encourage the most efficient and economic marketing practices; and

(f) To regulate the business of insurance in a manner that will preclude application of federal antitrust laws.

COMMENT: This formulation of the purposes of rate regulation reflects the close interrelationship between rate regulation and competition. The wise commissioner (and the wise legislature) will make competition do as much of the regulatory job as possible. On the whole, the insurance market is fairly competitive, and attention directed to making it more so will be more rewarding than effort directed to the regulation of particular rates.

In an ideal market, competition would produce the same rates that an ideal regulator would approve; in fact, regulation should be seeking the level of rates that a hypothetical perfect free market would set. But because competition is not perfect, it cannot be relied on completely.

625.02 DEFINITIONS. In this chapter, unless contrary to context:

(1) "Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule and any other information prescribed by rule of the commissioner.

(2) "Rate service organization" means any person, other than an employe of an insurer, who assists insurers in rate making or filing by:

(a) Collecting, compiling and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or by

(c) Advising about rate questions, except as an attorney giving legal advice.

(3) "Market segment" means any line or kind of insurance or, if it is described in general terms, any subdivision thereof or any class of risks or combination of classes.

625.03 SCOPE OF APPLICATION. This chapter applies to all kinds and lines of direct insurance written on risks or operations in this state by any insurer authorized to do business in this state, except:

(1) Ocean marine insurance;

(2) Workmen's compensation insurance;

(3) Contracts issued by fraternal benefit socieites;

(4) Life insurance other than credit life insurance; and

(5) Variable and fixed annuities.

(6) Group and blanket accident and sickness insurance other than credit accident and sickness insurance.

625.04 EXEMPTIONS. The commissioner may by rule exempt any person or class of persons or any market segment from any or all of the provisions of this chapter, if and to the extent that he finds their application unnecessary to achieve the purposes of this chapter.

625.11 RATE STANDARDS. (1) GENERAL. Rates shall not be excessive, inadequate or unfairly discriminatory, nor shall an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly.

(2) EXCESSIVENESS. (a) *Competitive market.* Rates are presumed not to be excessive if a reasonable degree of price competition exists at the consumer level with respect to the class of business to which they apply. In determining whether a reasonable degree of price competition exists, the commissioner shall consider all relevant tests including:

1. The number of insurers actively engaged in the class of business;
2. The existence of rate differentials in that class of business;
3. Whether long-run profitability for insurers generally of the class of business is unreasonably high in relation to its riskiness.

(b) *Noncompetitive market.* If such competition does not exist, rates are excessive if they are likely to produce a long run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

(3) INADEQUACY. Rates are inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

(4) UNFAIR DISCRIMINATION. One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise or blanket policy.

COMMENT: Sub. (1) continues the established standards of ss. 203.32 (1), 204.39 (1) (d) and of statutes in other states. The last part of this subsection is new and supplements the basic rate standards. Such rates might be defined as "inadequate" but that would distort the proper meaning of inadequate. The setting of rates that will destroy competition may not result in inadequate rates but should not be permitted, anyway. This portion of the subsection should eventually be transferred to the chapter on Unfair Trade Practices, when it is rewritten.

Subs. (2), (3) and (4) try to give more concreteness and specificity to the very general standards of sub. (1). The language is new. It reflects an attempt to define concepts that are difficult to define for statutory purposes.

Sub. (2) ties the notion of excessiveness to unreasonable profits. Obviously there is much uncertainty left in the definition but the problem is lessened, since the standard to be conformed to is no longer the "right" rate, but one that is not clearly too high by reason of producing an unreasonable profit. Par. (a) assumes that very rarely could an "excessive" rate develop in a competitive market.

Sub. (3) makes a rate adequate if an insurer can afford to offer it, whatever its competitive effect. Of course there can be unfair competitive practices carried out with "adequate" rates, with the intention of later exploiting a monopolistic or oligopolistic position. Sub. (1) deals with that special problem. The investment income attributable to particular rates would include that derived from unearned premium reserves and loss reserves, but not that derived from other funds of the insurer. Under this liberal type of rate law, no greater specificity than that provided here would be useful.

There is no reason that the law should prevent an insurer, particularly a mutual, that does not have the usual "growth" psychology and chooses to "top out" in size and thereafter operate without generating any additional surplus, or even an insurer which wishes to contract and gradually reduce its surplus (and the size of its clientele), from doing so. There is a built-in

discipline against such a course of action having an untoward effect on the market by the eventual exhaustion of the surplus. In other words, it seems silly to *compel* an insurer to make a profit, as was done in *Hartford Mutual Ins. Co. v. Virginia*, (1960), 201 Va. 491, 112 S.E. 2d 142. Of course, particular attention should be paid to solvency in such cases.

The second sentence of sub. (4) is inserted to make it clear that group marketing of all branches of insurance is hereby expressly authorized. Nothing else can be found in our economic mythology quite so absurd as the notion that it is "unfairly discriminatory" to give insurance buyers the advantages of mass marketing. Existing prohibitions against or limitations upon group insurance are anti-competitive and suggestions for continuing them come ungraciously out of the mouths of an industry that not only claims to *be* competitive but seeks to produce an even more competitive market.

625.12 RATING METHODS. In determining whether rates comply with the standards under s. 625.11, the following criteria shall be applied:

(1) BASIC FACTORS IN RATES. Due consideration shall be given to past and prospective loss and expense experience within and outside of this state, to catastrophe hazards and contingencies, to trends within and outside of this state, to loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers, and to all other relevant factors, including the judgment of technical personnel.

(2) CLASSIFICATION. Risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that classifications may not be based on race, color, creed or national origin. Rates thus produced may be modified for individual risks in accordance with rating plans or schedules which establish reasonable standards for measuring probable variations in hazards, expenses, or both.

(3) EXPENSES. The expense provisions included in the rates to be used by an insurer may reflect the operating methods of the insurer and, so far as it is credible, its own expense experience.

(4) PROFITS. The rates may contain an allowance permitting a profit that is not unreasonable in relation to the riskiness of the class of business.

COMMENT: Sub. (1) follows fairly closely ss. 203.32 (3) (a) 3 and 204.39 (1) (a) but has been slightly rearranged, perhaps in a more logical order.

Sub. (2) follows generally the form and substance of s. 204.39 (1) (c), but with the addition of the "civil rights" language, which is of course not new public policy in this state.

Sub. (3) is patterned after s. 204.39 (1) (b), and is permissive, not mandatory.

Sub. (4) deliberately speaks only of "profit", not "underwriting profit". The industry insistence on the latter has been one of the classic cases of falling into a trap of one's own making. Underwriting profit is totally irrelevant. What is important is investor's profit. It should be reasonable, and that means reasonably adequate as well as not excessive. Probably it has been inadequate for many lines in recent years. But the solution is *not* to argue against the consideration of investment income, an industry position that is theoretically indefensible and is now proving to be politically inept. Rather, it is to urge recognition that insurers deserve to make an "adequate" but "reasonable" profit. So far as this chapter is concerned, the regulation is only structured to prevent an unconscionable profit.

625.13 FILING OF RATES. Every authorized insurer and every rate service organization licensed under s. 625.31 which has been designated by any insurer for the filing of rates under s. 625.15 (2) shall file with the commissioner all rates and supplementary rate information and all

changes and amendments thereof made by it for use in this state within 30 days after they become effective.

COMMENT: This provision gives the commissioner the minimum information he needs in order to keep a full overview of the market situation. With this general information he will be able to concentrate his attention on those areas where competition is lacking or is not operating properly. The commissioner could require regular rate filings under his general powers, [proposed s. 601.42 (1)], but it seems useful and desirable to establish a special statutory obligation here. Useless filings in areas where regulatory concern is unnecessary can be avoided by exercising the authority under s. 625.04.

There is no change in procedure. Bureau members or subscribers using bureau rates need not file these rates but may refer to the bureau filings. See s. 625.15 (2).

625.14 FILINGS OPEN TO INSPECTION. Each filing and any supporting information filed under this chapter shall, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

COMMENT: This section represents an advance in the 1967 legislature, by ch. 272, which opened filings to public inspection as soon as they are made, rather than only after they are in effect. It is covered also by proposed s. 601.46 (4), but the specific reference seems desirable here, because of the importance of the case.

625.15 DELEGATION OF RATE MAKING AND RATE FILING OBLIGATION. (1) RATE MAKING. An insurer may itself establish rates and supplementary rate information for any market segment based on the factors in s. 625.12, or it may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

(2) RATE FILING. An insurer may discharge its obligation under s. 625.13 by giving notice to the commissioner that it uses rates and supplementary rate infomation prepared by a designated rate service organization, with such information about modifications thereof as are necessary fully to inform the commissioner. The insurer's rates and supplementary rate information shall be those filed from time to time by the rate service organization, including any amendments thereto as filed, subject, however, to the modifications filed by the insurer.

COMMENT: Sub. (1) reflects a basic departure from previous rate regulaory philosophy. In effect it encourages an insurer using bureau rates to modify the rates to reflect its own expense experience. In doing this, the law seeks to achieve the more efficient marketing and the elimination of wasteful practices mentioned in s. 625.01 (2) (e).

Of course, a competitively oriented rating law such as this one will not provide for active regulatory intervention to ensure what this section directs, but it sets the standard and relies mainly on competition to achieve the goal.

625.21 DELAYED EFFECT OF RATES. (1) RULE INSTITUTING DELAYED EFFECT. If the commissioner finds that competition is not an effective regulator of the rates charged or that a substantial number of companies are competing irresponsibly through the rates charged, or that there are widespread violations of this chapter, in any kind or line of insurance or subdivision thereof or in any rating class or rating territory, he may promulgate a rule requiring that in the kind or line of insurance or subdivision thereof or rating class or rating territory comprehended by the

finding any subsequent changes in the rates or supplementary rate information be filed with him at least 15 days before they become effective. He may extend the waiting period for not to exceed 15 additional days by written notice to the filer before the first 15-day period expires.

(2) SUPPORTING DATA. By rule, the commissioner may require the filing of supporting data as to any or all kinds or lines of insurance or subdivisions thereof or classes of risks or combinations thereof as he deems necessary for the proper functioning of the rate monitoring and regulating process. The supporting data shall include:

(a) The experience and judgment of the filer, and, to the extent it wishes or the commissioner requires, of other insurers or rate service organizations;

(b) Its interpretation of any statistical data relied upon;

(c) Descriptions of the actuarial and statistical methods employed in setting the rates; and

(d) Any other relevant matters required by the commissioner.

(3) EXPIRATION OF RULE. A rule promulgated under sub. (1) shall expire no more than one year after issue. The commissioner may renew it after a hearing and appropriate findings under sub. (1).

(4) SUPPORTING INFORMATION. Whenever a filing is not accompanied by such information as the commissioner has required under sub. (2), he may so inform the insurer and the filing shall be deemed to be made when the information is furnished.

COMMENT: This section offers a method which, in practical effect, can restore the prior approval mechanism for a limited time only (one year). The thrust of this law is more liberal than the existing prior approval system, however. The rule does not necessarily require supporting data, but leaves it explicitly to the commissioner to decide when he needs and wants it. If it is required, however, the supporting data ordinarily should be essentially what has been required, as in s. 203.32 (4) (b). The presumption is against permanence of the restoration—a new rule will be required each year to keep prior approval in effect. Moreover, it is contemplated that the deemer clause will be regularly used, partly because the commissioner and the insurers will become habituated to a lesser degree of intervention in the rate making process. Finally, the commissioner's rule under this section only changes from a use-and-file to a file-and-wait practice—there is no compulsion on him to go further to prior approval though under s. 625.22 he may disapprove and thus, in practice, force a prior approval.

Thus, this section represents a liberalization of the present law, even for cases within the rule.

625.22 DISAPPROVAL OF RATES. (1) ORDER IN EVENT OF VIOLATION. If the commissioner finds after a hearing that a rate is not in compliance with s. 625.11, he shall order that its use be discontinued for any policy issued or renewed after a date specified in the order.

(2) TIMING OF ORDER. The order under sub. (1) shall be issued within 30 days after the close of the hearing or within such reasonable time extension as the commissioner may fix.

(3) APPROVAL OF SUBSTITUED RATE. Within one year after the effective date of an order under sub. (1), no rate promulgated to replace a disapproved one may be used until it has been filed with the commissioner and not disapproved within 30 days thereafter.

(4) INTERIM RATES. Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account

approved by him. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are *de minimis* shall not be required.

COMMENT: This section provides for the process of disapproval of rates, whether before, after or without filing. The procedural details are dealt with adequately in proposed ch. 601, the Administration of the Insurance Law. Where the formal act of rate approval has disappeared and the formal order of disapproval of rates is a normal but merely occasional action of the commissioner, the order procedure of ch. 601 is perfectly adequate. Rate regulation is not a place for formal, quasi-litigious proceedings. The process is a very technical one better suited to less formal processes. However, hearing and judicial review are preserved as essential elements of "due process", despite their cumbersomeness in application to rate regulation.

No one other than the insurer and the commissioner should have a formal place in rate procedures—i.e. should have "standing". It is the commissioner's job to protect the public and any remedies against him should not be built into the rate review procedure but should be more general and applicable to any malfeasance or nonfeasance in office. To achieve this objective, it is not necessary actually to deny third parties "standing"—they had it before only when it was specified in the statute that "aggrieved persons" had standing.

Sub. (1) of course does not contemplate any miscalled "renewal" cases where a policy is "renewed" at agreed rates by virtue of a contractual provision requiring it. Interference with established contract rights would have to be authorized in much more explicit terms.

Sub. (3) will prevent an insurer from evading the effects of disapproval of filings when engaged in controversy with the commissioner. If a rate is disapproved, a more stringent procedure is triggered for one year. Then the more expeditious procedure is automatically restored.

625.23 SPECIAL RESTRICTIONS ON INDIVIDUAL INSURERS. The commissioner may by order require that a particular insurer file any or all of its rates and supplementary rate information 15 days prior to their effective date, if and to the extent that he finds, after a hearing, that the protection of the interests of its insureds and the public in this state requires closer supervision of its rates because of the insurer's financial condition or rating practices. He may extend the waiting period for any filing for not to exceed 15 additional days by written notice to the insurer before the first 15-day period expires. A filing not disapproved before the expiration of the waiting period shall be deemed to meet the requirements of this chapter, subject to the possibility of subsequent disapproval under s. 625.22.

COMMENT: One purpose of this section is to prevent "flash filings" to circumvent the "use-and-file" provisions of s. 625.13. The other and probably more important reason is that a particular insurer may need closer surveillance either because of its financial weakness or because of its rating practices.

It would be possible to move, under this section, to a *de facto* prior approval requirement on the particular insurer, but only in severe cases would full prior approval be required. In most instances the more limited sanction of a delayed "file-and-use" would suffice. But the commissioner need not let the deemer period run without action. This section is in a sense a counterpart to the proposed restricted insurer provisions of s. 620.02 (investments) and s. 611.02 (domestic insurance corporations).

625.31 OPERATION AND CONTROL OF RATE SERVICE ORGANIZATIONS. (1) LICENSE REQUIRED. No rate service organization shall provide any service relating to the rates of any insurance subject to this

chapter, and no insurer shall utilize the services of such organization for such purposes unless the organization has obtained a license under s. 625.32.

(2) AVAILABILITY OF SERVICES. No rate service organization shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

COMMENT: Sub. (1) continues the prohibition against financial aid to certain organizations by insurers, implementing it by a licensing requirement that is somewhat expanded from present law but not burdensome. Most of the requirements are already found in ss. 201.60, 203.32 (6), 204.42, etc., but are made more broadly applicable to all relevant organizations.

625.32 LICENSING. (1) APPLICATION. A rate service organization applying for a license as required by s. 625.31 shall include with its application:

(a) A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of one or more residents of this state upon whom notices, process affecting it or orders of the commissioner may be served;

(d) A statement showing its technical qualifications for acting in the capacity for which it seeks a license; and

(e) Any other relevant information and documents that the commissioner may require.

(2) CHANGE OF CIRCUMSTANCES. Every organization which has applied for a license under sub. (1) shall thereafter promptly notify the commissioner of every material change in the facts or in the documents on which its application was based.

(3) GRANTING OF LICENSE. If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed, and that all requirements of law are met, he shall issue a license specifying the authorized activity of the applicant. He shall not issue a license if the proposed activity would tend to create a monopoly or to lessen or destroy price competition.

(4) DURATION. Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the state or until the license is suspended or revoked.

(5) AMENDMENTS TO CONSTITUTION AND BYLAWS. Any amendment to a document filed under sub. (1) (a) shall be filed at least 30 days before it becomes effective. Failure to comply with this subsection shall be a ground for revocation of the license granted under sub. (3).

COMMENT: Sub. (1) continues the thrust of ss. 201.60 (1), 203.32 (6) (a), and 204.42 (2), but implements it through a licensing requirement.

Sub. (4) makes licenses continuing.

625.33 BINDING AGREEMENTS BY INSURERS. No insurer shall assume any obligation to any person other than a policyholder or other companies under common control to use or adhere to certain rates or rules, and no other person shall impose any penalty or other adverse consequence for failure of an insurer to adhere to certain rates or rules.

COMMENT: This section is consistent with traditional law. See e.g. ss. 203.32 (6) (e) and 203.32 (13) (c). It is an important provision for preserving the conditions of open competition in accordance with antitrust principles.

625.34 RECORDING AND REPORTING OF EXPERIENCE. The commissioner shall promulgate or approve reasonable rules, including rules providing statistical plans, for use thereafter by all insurers in the recording and reporting of loss and expense experience, in order that the experience of such insurers may be made available to him. No insurer shall be required to record or report its experience on a classification basis inconsistent with its own rating system. The commissioner may designate one or more rate service organizations to assist him in gathering such experience and making compilations thereof, which shall be made available to the public.

COMMENT: This section follows generally s. 203.32 (13) (a).

625.35 EXAMINATION OF RATE SERVICE ORGANIZATIONS. (1) POWER TO EXAMINE. (a) *Rate service organizations.* Whenever he deems it necessary in order to inform himself about any matter related to the enforcement of the insurance laws, the commissioner may examine the affairs and condition of any rate service organization under s. 625.31 (1).

(b) *Collateral examinations.* So far as reasonably necessary for an examination under par. (a), the commissioner may examine the accounts, records, documents or evidences of transactions, so far as they relate to the examinee, of any officer, manager, general agent, employe, person who has executive authority over or is in charge of any segment of the examinee's affairs, person controlling or having a contract under which he has the right to control the examinee whether exclusively or with others, person who is under the control of the examinee, or any person who is under the control of a person who controls or has a right to control the examinee whether exclusively or with others.

(c) *Availability of records.* On demand every examinee under par. (a) shall make available to the commissioner for examination any of its own accounts, records, documents or evidences of transactions and any of those of the persons listed in par. (b).

(2) *Duty to examine.* The commissioner shall examine every licensed rate service organization at intervals to be established by rule.

(3) AUDITS OR ACTUARIAL EVALUATIONS. In lieu of all or part of an examination under subs. (1) and (2), or in addition to it, the commissioner may order an independent audit by certified public accountants or actuarial evaluation by actuaries approved by him of any person subject to the examination requirement. Any accountant or actuary selected shall be subject to rules respecting conflicts of interest promulgated by the commissioner. Any audit or evaluation under this subsection shall be subject to subs. (6) to (15), so far as appropriate.

(4) ALTERNATIVES TO EXAMINATION. In lieu of all or part of an examination under this section, the commissioner may accept the report of an audit already made by certified public accountants or actuarial evaluation by actuaries approved by him, or the report of an examination made by the insurance department of another state.

(5) PURPOSE AND SCOPE OF EXAMINATION. An examination may but need not cover comprehensively all aspects of the examinee's affairs and condition. The commissioner shall determine the exact nature and scope of each examination, and in doing so shall take into account all relevant factors, including but not limited to the length of time the examinee has been operating, the length of time he has been licensed in this state, the nature of the services provided, the nature of the accounting records available and the nature of examinations performed elsewhere.

(6) ORDER OF EXAMINATION. For each examination under this section, the commissioner shall issue an order stating the scope of the examination and designating the examiner in charge. Upon demand a copy of the order shall be exhibited to the examinee.

(7) ACCESS TO EXAMINEE. Any examiner authorized by the commissioner shall, so far as necessary to the purposes of the examination, have access at all reasonable hours to the premises and to any books, records, files, securities, documents or property of the examinee and to those of persons under sub. (1) (b) so far as they relate to the affairs of the examinee.

(8) COOPERATION. The officers, employes and agents of the examinee and of persons under sub. (1) (b) shall comply with every reasonable request of the examiners for assistance in any matter relating to the examination. No person shall obstruct or interfere with the examination in any way other than by legal process.

(9) CORRECTION OF BOOKS. If the commissioner finds the accounts or records to be inadequate for proper examination of the condition and affairs of the examinee or improperly kept or posted, he may employ experts to rewrite, post or balance them at the expense of the examinee.

(10) REPORT ON EXAMINATION. The examiner in charge of an examination shall make a proposed report of the examination which shall include such information and analysis as is ordered in sub. (6), together with the examiner's recommendations. Preparation of the proposed report may include conferences with the examinee or his representatives at the option of the examiner in charge. The proposed report shall remain confidential until filed under sub. (11).

(11) ADOPTION AND FILING OF EXAMINATION REPORT. The commissioner shall serve a copy of the proposed report upon the examinee. Within 20 days after service, the examinee may serve upon the commissioner a written demand for a hearing on the contents of the report. If a hearing is demanded, the commissioner shall give notice and hold a hearing under ch. 227, except that on demand by the examinee the hearing shall be private. Within 60 days after the hearing or if no hearing is demanded then within 60 days after the last day on which the examinee might have demanded a hearing, the commissioner shall adopt the report with any necessary modifications and file it for public inspection, or he shall order a new examination.

(12) COPY FOR EXAMINEE. The commissioner shall forward a copy of the examination report to the examinee immediately upon adoption, except that if the proposed report is adopted without change, the commissioner need only so notify the examinee.

(13) COPIES FOR BOARD. The examinee shall forthwith furnish copies of the adopted report to each member of its board of directors or other governing board.

(14) COPIES FOR OTHER PERSONS. The commissioner may furnish, without cost or at a price to be determined by him, a copy of the adopted report to the insurance commissioner of each state in the United States and of each foreign jurisdiction in which the examinee is licensed and to any other interested person in this state or elsewhere.

(15) REPORT AS EVIDENCE. In any proceeding by or against the examinee or any officer or agent thereof the examination report as adopted by the commissioner shall be admissible as evidence of the facts stated therein. In any proceeding by or against the examinee, the facts asserted in any report properly admitted in evidence shall be presumed to be true in the absence of contrary evidence.

(16) COSTS TO BE PAID BY EXAMINEE. The reasonable costs of an examination under this section shall be paid by the examinee except as provided in sub. (19). The costs shall include the salary and expenses of each examiner and any other expenses which may be directly apportioned to the examination.

(17) DUTY TO PAY. The amount payable under sub. (16) shall become due 10 days after the examinee has been served a detailed account of the costs.

(18) DEPOSIT. The commissioner may require any examinee, before or from time to time during an examination to deposit with the state treasurer such deposits as the commissioner deems necessary to pay the costs of the examination. Any deposit and any payment made under subs. (16) and (17) shall be credited to the appropriation under s. 20.145 (1) (g).

(19) EXEMPTIONS. On the examinee's request or on his own motion, the commissioner may pay all or part of the costs of an examination from the appropriation under s. 20.145 (1) (g) whenever he finds that because of the frequency of examinations or other factors, imposition of the costs would place an unreasonable burden on the examinee. The commissioner shall include in his annual report information about any instance in which he applied this subsection.

(20) RETALIATION. Deposits and payments under subs. (16) to (19) shall not be deemed to be a tax or license fee within the meaning of any statute. If any other state charges a per diem fee for examination of examinees domiciled in this state, any examinee domiciled in that other state shall be required to pay the same fee when examined by the insurance office of this state.

COMMENT: This section parallels proposed ss. 601.43, 601.44, and 601.45, suitably adapted to cover only rate service organizations. As soon as ch. 601 is enacted, this section can be dropped, since ss. 601.43, 601.44 and 601.45 are framed in general terms to apply to all licensees.

SECTION 24. Chapter 631 of the statutes is created to read:

CHAPTER 631.

INSURANCE CONTRACTS GENERALLY.

631.36 Termination of insurance contracts.

PRELIMINARY COMMENT: Chapter 631 will deal with insurance contracts generally. This particular section, however, is designated to deal more broadly with some of the problems that have arisen from cancellation and nonrenewal of policies. Whether the problems are serious or not is less clear than that they are a matter of great annoyance. The most pressing of them are dealt with by s. 204.341, introduced by Laws of 1967, ch. 337, and applicable only to automobile insurance. The principles of that enactment, however, deserve quite general application.

This legislation should give better assurance that a policyholder will get a product on which he can rely despite the wish of an insurer to cancel the policy during its term. It prohibits cancellation by the insurer in all lines that are subject to approval of policy forms. The permissible grounds for cancellation are nonpayment of premium and such other grounds as may be specified in the policy, subject to disapproval by the commissioner. Midterm cancellations should be restricted to unforseeable changes in the hazard of such a serious degree that the insurer cannot be expected to wait until expiration of the policy in order to be relieved of the risk. Cancellation would also be permitted with a requirement of justification during the first 60 days of the policy term. The insurer must also give the policyholder 30 days notice of nonrenewal. For the average individual who purchases property or liability insurance, much of the value of his insurance lies in the fact that he may rely on the security of his property to insulate his savings from disasters beyond his control and give him some peace of mind. If an insurer may cancel a policy at midterm without justification, or may decline to renew without sufficient notice, these values are undermined.

The privilege of cancellation is an aspect of freedom of contract, but that notion has doubtful relevance in today's insurance market. All too often, cancellation has been exercised with no better reason than timidity in the underwriter who has acted on the basis of guess, hunch, and inadequate information. As a result, the public has recently demanded and secured protection against certain kinds of cancellation.

Early cancellation clauses have been carried into present day insurance policies in substantially the same form. But whereas at an early date, the contract was one between equals, at the present time the parties are not equal. The individual buyer lacks the economic power, bargaining position, and sophistication to deal on an equal basis with the insurer. Because of these changes in conditions, the entire theory underlying cancellation clauses should be reexamined.

The cancellation privilege has already been significantly curtailed in some situations, while remaining completely a matter of free contract in others.

Thus life insurance policies are required by statute to be incontestable, i.e. noncancellable, after they have been in force for a specified period.

Recognizing that arbitrary cancellation of automobile liability insurance was a serious problem, the insurance industry in 1960 attempted to meet it on a voluntary basis. Most writers of automobile insurance adopted a new policy endorsement restricting the company's right to cancel, reduce or refuse to renew automobile liability coverages. This voluntary response by the industry did not, however, solve the problem completely.

There is little disagreement about the objectives of this section, which seeks only to ensure for *all* policyholders the fair treatment in contract relationships that wise insurers give as a matter of course. There is much more disagreement about how the objective can be best and most fairly worked out. The problems of preparing an adequate statute dealing with termination of insurance contracts are many: they include the truly chaotic underlying common law on the subject of contract termination and renewal, the great variety of procedures now used or historically applied by the insurance business, which vary not only from line to line of insurance but even, within lines, from company to company, the ambiguity of terminology and especially the many senses in which the word "renewal" is used, and the fact that a great variety of discrete problems exist. More and more keep surfacing as work proceeds on the subject.

Of necessity, this section has dealt with only the most obvious problems, and will need to be supplemented later. It seems desirable, despite complexity and variety of practice, to deal with the subject as broadly as possible rather than attempt to build a crazy-quilt of laws to accommodate a crazy-quilt of practices.

631.36 TERMINATION OF INSURANCE CONTRACTS. (1) SCOPE OF APPLICATION. (a) *General.* This section shall apply to all contracts of insurance the general terms of which are required to be approved or are subject to disapproval by the commissioner, except as otherwise provided by statute or by rule under par. (c).

(b) *Contracts more favorable to policyholder.* The contract may provide terms more favorable to policyholders than are required by this section.

(c) *Exemption by rule.* The commissioner may by rule exempt from this section classes of insurance contracts where the policyholders do not need protection against arbitrary termination.

(d) *Other rights.* The rights provided by this section shall be in addition to and shall not prejudice any other rights the policyholder may have at common law or under other statutes.

(e) *Construction.* Nothing in this section shall be construed to prevent the rescission or reformation of any life or disability insurance con-

tract not otherwise denied by the terms of the contract or by any other statute.

(2) MIDTERM CANCELLATION. (a) *Permissible grounds.* No insurance policy that has been in effect for at least 70 days or that has been renewed may be canceled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is less, except on any one of the following grounds:

1. Failure to pay a premium when due; and

2. Such grounds as are specified in the policy. The commissioner shall not disapprove grounds for cancellation specified in the policy which are reasonably necessary to protect the insurer against material misrepresentations and against substantial changes in the risk it has assumed, except to the extent that it should reasonably foresee such changes.

(b) *Notice.* No cancellation under par. (a) shall be effective until in the case of par. (a) 1 at least 10 days and in the case of par. (a) 2 at least 30 days after the first class mailing or delivery of a written notice to the policyholder.

(3) ANNIVERSARY CANCELLATION. A policy issued for a term longer than one year may be canceled by the insurer by giving notice 30 days prior to any anniversary date, as provided in sub. (4) (a) for nonrenewals.

(4) NONRENEWAL. (a) *Notice required.* Subject to sub. (2), a policyholder has a right to have his policy renewed, on the terms then being applied by the insurer to persons similarly situated, for an additional period of time equivalent to the expiring term if the agreed term is a year or less, or for one year if the agreed term is longer than one year, unless at least 30 days prior to the date of expiration provided in the policy the insurer mails first class or delivers to him a notice of intention not to renew the policy beyond the agreed expiration date.

(b) *Exceptions.* This subsection shall not apply if the policyholder has accepted replacement coverage or has requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable by a clause approved or deemed to be approved by the commissioner.

(5) RENEWAL WITH ALTERED TERMS. If the insurer offers or purports to renew the policy but on different terms, including different rates, the policyholder shall, for 30 days after he receives notice calling his attention to the changes in the policy, have the option of canceling it. If he elects to cancel, the insurer shall refund to him the excess of the premium paid by him above the pro rata premium for the expired portion of the new term.

(6) INFORMATION ABOUT GROUNDS. If a notice of cancellation or nonrenewal under this section does not state with reasonable precision the facts on which the insurer's decision is based, the insurer must supply that information within 5 days after receipt of a written request by the policyholder. No notice shall be effective unless it contains adequate information about the policyholder's right to make such request.

(7) INFORMATION ABOUT PLANS. No notice under this section shall be effective unless it contains adequate instructions enabling the policyholder to apply for insurance through any voluntary or mandatory risk-sharing plan under ch. 619 existing at the time of the notice, for which the policyholder may be eligible.

(8) IMMUNITY. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer, its authorized representative, its agents, its employes, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal, for any statement made by them in complying with this section, or for the providing of information pertaining thereto.

(9) PROHIBITED CANCELLATION AND NONRENEWAL. No insurer shall cancel or refuse to renew an automobile liability insurance policy solely because of the age, residence, race, color, creed, national origin, ancestry or occupation of anyone who is an insured.

SECTION 25. 645.63 (5) of the statutes is repealed and recreated to read:

645.63 (5) CLAIMS UNDER SECURITY FUND. The state treasurer as custodian of the insurance security fund may file a claim with the liquidator for all claims to which the fund has been subrogated under s. 646.14 (1).

SECTION 26. Chapter 646 of the statutes is created to read:

CHAPTER 646.

INSURANCE SECURITY FUND.

646.01 Scope, purpose and construction.
646.02 Organization and administration of fund.
646.03 Board of the fund.
646.04 Custody of assets.
646.05 Investments.
646.11 Eligible claims.
646.12 Procedure for payment.
646.13 Appeal and review.
646.14 Subrogation and cooperation.
646.21 Assessments.
646.22 Disposal of unused assets.
646.23 Transition provisions for workmen's compensation security funds.
646.31 Unfair trade practices.

PRELIMINARY COMMENT: The principal goal of insurance regulation has always been to prevent insurer insolvencies. It is pursued in various ways. The law prescribes minimum capital and surplus requirements. Department examiners regularly examine licensed companies to ensure that they measure up to appropriate standards of financial and management strength; the department may and does conduct a special examination of any company whenever it wishes and the annual financial reports of licensed companies are audited to verify compliance with the law.

The justification for this emphasis on solidity is not to protect a private business from the vicissitudes of competition nor the consequences of inefficiency. It is to assure that insurers can pay what they owe, for in the case of insurers, unlike other corporations, the insolvency of the seller destroys, often completely, the value to the buyer of what has already been sold and paid for.

Insurer insolvencies are infrequent, but when an insurer does become insolvent, its policyholders suddenly find that the risks they thought they had transferred were not transferred at all. The public should not have to acquiesce in the serious financial consequences of even the unlikely insolvency of an insurer, when the very existence of the insurance industry is largely the result of a legitimate desire and need to get rid of risk.

Wisconsin has been fortunate in having a small number of insolvencies, but they do occur even here. Moreover, the nationwide history of insolvencies should serve as a warning that even worse experience is possible.

Most insolvencies come from 3 categories of causes:

1. Catastrophic events, such as hurricanes or floods, and economic depressions;

2. Poor management, involving inadequate underwriting standards, marketing errors which reduce premium volume, under-reserving and inept investment techniques; and

3. Dishonest management, which converts company funds for personal use, falsifies assets, or enters into such "milking" schemes as fictitious reinsurance.

Some of these causes of insolvency can be detected enough in advance for a determined and qualified regulatory agency to prevent the insolvency or at least to start liquidation while funds are still available to pay all obligations to policyholders. On some occasions, the frequent and thorough surveillance of problem companies by the expert professional staff of the better insurance departments has revealed deteriorating financial conditions early enough for the company to be saved by prompt and forceful remedial measures. The techniques of regulating for solvency are crucial and their constant improvement is a matter of highest priority.

Nevertheless, it is also evident that some causes of insolvency cannot be detected in time for remedial measures. Then the fact that relatively few insolvencies occur in Wisconsin is small comfort to those policyholders and third party claimants whose losses cannot be paid in full or who face long delays in payment because of the insolvency. In the usual insolvency, not enough money is left to pay all legitimate claimants in full, and even though under ch. 645, the more important claims have a preference, some socially important claims must still be denied. Characteristically, in the past the dividends in liquidations have probably averaged less than 50 cents on the dollar.

Even when full payment is ultimately made, as it sometimes is, liquidation cannot be carried on hastily and serious hardship may result from the delay. Sound business judgment dictates that the liquidator first conserve and then search, sometimes at length, for the best market for the saleable assets of the insolvent company. The New York liquidation of Preferred Accident Insurance Company, which finally paid 100 cents on the dollar, lasted seven years. The average length of time for liquidating companies is even longer, even without full payment.

Insolvencies affect policyholders in all lines of insurance, not only in those now covered by security funds. In fact, workmen's compensation is no longer a special problem, and in 1969 it is no longer the most important line from a social point of view. Automobile insurance, especially in high risk companies, has been a fruitful source of difficulty, but not for any reason inherent in automobile insurance. With adequate regulation and appropriate capitalization, automobile insurance is no more a threat to company solvency than are other lines. Insolvency is more frequent in property—liability than in life, but it has occurred even in the latter. Equal hardship would result from a comparable insolvency in any line. As a matter of equity, policyholders and claimants in all lines are equally deserving of protection.

The cost of additional protection against insolvency is small if it is spread across the entire industry, whereas the cost to the individual who relies upon a worthless policy can be catastrophic.

It is possible to provide policyholders security against insolvency either by providing a security fund, like the Federal Deposit Insurance Corporation or the Wisconsin Workmen's Compensation Security Funds (s. 102.65), or by a *post hoc* assessment plan. No funding that is reasonable in amount could ever be adequate for a catastrophic rash of insolvencies touched off by a major and unprecedented depression or other serious change of direction of our society. All that any security device can do is to take care of the risk to policyholders that is inherent in the insurance mechanism itself, viz., the risk that bad management or speculation in a given firm will result in bankruptcy and loss to policyholders. Because the dimensions of insolvencies thus caused are inherently small in an industry with a large number of business units, it seems much preferable to use a *post hoc* assessment plan. Since there is an established fund for

workmen's compensation, this chapter contemplates that that fund will continue as a temporary fund but will be used up by crediting it against assessments insurers would otherwise have to pay on workmen's compensation premiums.

In view of the lack of advance funding, a maximum spread of the slight risk that exists is highly desirable. Consequently, all lines of insurance are lumped into 3 large accounts, for life insurance, for disability insurance and for the rest of nonlife insurance.

The cost of protection thus devised is minimal. Since the insolvencies which do occur in the insurance business affect in each case only a small portion of the total number of policyholders, and since losses are usually only partial, the cost can be so widely spread that it is hardly felt.

The principal argument against a system of insolvency protection, therefore, has not been and cannot be that the cost would be prohibitive or would constitute a hardship to insurers. Rather, and at first glance more plausibly, it has been argued that the existence of such protection would reward incompetent management or at least remove some of the economic incentive for management to keep an insurer solvent, and in addition, that it would lead the regulatory authorities to be less careful in performing their duties.

These arguments are fanciful. Indeed it is only good regulation that makes the system practicable. Under the proposed system, an insolvency will be no less embarrassing than now for the management of the insurer or for the commissioner. The fact that policyholders are protected against hardship does not prevent management and stockholders from suffering in full the consequences of insolvency. The security fund is not set up in the interest of the failing insurer. Its purpose is the protection of policyholders, and the fund will be fully subrogated against the insurer. It will receive the dividends to which the policyholders would otherwise be entitled in the liquidation.

It is naive to believe that management would work less hard to avoid insolvency because policyholders would not suffer by the insolvency, or that the knowledge that policyholders are thus secured would reduce management's zeal in preserving the company's solidity. Managements are guided by other considerations altogether.

The protection provided by the program would apply to Wisconsin policyholders of both domestic and foreign companies. It is the policyholders and not the company the proposal is seeking to protect; this state should be equally concerned with the reliability of all policies sold here, whatever the domicile of the insurer.

As noted above, the two causes of hardship in insolvencies are insufficiency of funds and delay in payment. The plan would meet both. Essentially full payment would be made promptly by the Fund. The Fund, and not the policyholder, would then await the results of the liquidation proceeding as subrogee.

646.01 SCOPE, PURPOSE AND CONSTRUCTION. (1) SCOPE. This chapter shall apply to all kinds and lines of direct insurance, except variable annuities and variable value life insurance contracts, and to all insurers authorized to do business in this state except fraternal benefit societies, assessable mutual corporations including town mutual insurance corporations, nonprofit service plans, the state insurance fund, and the Wisconsin indemnity fund.

(2) PURPOSE. The purpose of this chapter is to maintain public confidence in the promises of insurers by providing a mechanism for protecting insureds in this state from excessive delay and loss in the event of liquidation of insurers and by assessing the cost of such protection among insurers.

(3) CONSTRUCTION. This chapter shall be liberally construed to effect the purpose stated in sub. (2) which shall constitute an aid and guide to interpretation but not an independent source of power.

COMMENT: The goals and methods of operation of the security fund are fairly simple and should be self-evident upon the most superficial reading of the provisions of this chapter. The exception for reinsurance recognizes that insurers are peculiarly able to protect themselves. A draft for a corresponding law following a different approach in New York proposes to limit insolvency protection to "personal and small commercial" insurance. That would exclude from protection the large industrial, manufacturing and commercial risks. However, the effects of an insurer's insolvency can be as disastrous and damaging in these cases as in the case of a small homeowner. For instance, if after an explosion or a fire a production plant cannot be reconstructed because the insurer has collapsed, this can mean the loss of hundreds of jobs and financial distress for a large area. For the same reasons, no upper limit for payments (like the $15,000 maximum provided for the Federal Deposit Insurance Corporation) has been fixed.

Sub. (2) makes clear that the protection afforded by this chapter is not limited to direct monetary losses caused by insufficient funds but is designed to include the delay usually involved in liquidation proceedings, for whatever reason they might have been instituted, even if all claims should eventually be paid in full.

646.02 ORGANIZATION AND ADMINISTRATION OF FUND. (1) ORGANIZATION. There is created a fund to be known as the "Insurance Security Fund", hereinafter referred to as the "fund". The fund shall consist of all payments made by insurers under s. 646.21, of the earnings resulting from investments under s. 646.05 and of the amounts recovered under s. 646.14.

(2) ACCOUNTS. The fund shall be divided into 3 separate accounts, one for life insurance and annuities, one for disability insurance and one for all other covered insurance. There shall also be a temporary workmen's compensation insurance security fund, under s. 646.23. When its assets have been distributed under s. 646.23 (2) that temporary fund shall be terminated. Until then, all provisions relating to the fund shall apply to the workmen's compensation insurance security fund, unless either obviously inappropriate or expressly inapplicable.

(3) ADMINISTRATION. The commissioner shall be administrator of the fund. He shall receive no additional compensation for administering it.

(4) EXPENSES OF FUND. The fund's necessary expenses of administration in connection with an actual liquidation shall be charged to the fund. All other expenses shall be charged to the budget of the office of the commissioner of insurance.

(5) LIABILITY. No one shall be personally liable for any obligations of the fund, and the rights of creditors shall be solely against the assets of the fund.

COMMENT: This section formally establishes the insurance security fund. As a consequence of the basic idea, more fully explained in the comment on s. 646.21, that the purposes of this chapter can be better achieved by *post hoc* assessments than by accumulation of a huge fund that lies idle most of the time, no assets will be accumulated, except that the already existing workmen's compensation security funds would be carried over until used as provided by s. 646.23.

Sub. (2) reflects the idea that life insurance and disability insurance are sufficiently different from other business to justify separate guaranty groupings.

Sub. (3) puts the administration of the fund into the hands of the commissioner who is best equipped for that task. He operates under the supervision of a board (s. 646.03) which makes the major policy decisions. Specific functions are assigned to other officials: the treasurer serves as the custodian of the fund (s. 646.04) and the investment of assets is in the jurisdiction of the state investment board (s. 646.05).

The fund is to become active only in the event of an actual liquidation, and it should be completely dormant except for the establishment of procedures, until there is a liquidation. To provide for advance contributions to build a fund, or even to provide a special source of income for current administration costs would only bring "Parkinson's law" into operation. Consequently, sub. (4) attributes the trivial expenses necessary during any dormant period to the commissioner's budget. When a liquidation is in progress, of course, expenses are involved in processing the claims, and these should then be borne by the fund.

646.03 BOARD OF THE FUND. (1) COMPOSITION. The fund shall have a board of not less than 5 nor more than 11 members. The attorney general, the treasurer and the commissioner of insurance shall be ex officio members with full right to vote. The commissiioner shall be chairman of the board. The other members shall represent domestic and foreign or alien insurers subject to this chapter. They shall be selected through a procedure to be specified in a rule promulgated by the commissioner. The rule may provide that instead of individual persons, particular insurers or associations of insurers can be selected as members of the board, to act through any duly authorized representative.

(2) POWERS. The board shall:

(a) Adopt rules for the administration of this chapter, including its own procedure;

(b) Create committees for each of the accounts of the fund, and delegate to them any of the powers under pars. (c) to (f);

(c) Reduce awards under s. 646.12 (2);

(d) Determine the rate of assessments under 646.21;

(e) Decide on appeals under ss. 646.13 and 646.21 (8); and

(f) Approve the plan of distribution under s. 646.22 (1).

(3) COMPENSATION. The members of the board shall receive no compensation for their services as members but shall be entitled to reimbursement for all reasonable and necessary expenses incurred in connection with the performance of their duties as members.

COMMENT: This section defines the composition and the powers of the board. In view of the nature and functions of the board it seems desirable to have both public officials and representatives of the insurance industry on the governing body. The commissioner has discretion, within the confines of the rulemaking process, to set standards for the selection of such members as are best suited for the purposes of this chapter.

646.04 CUSTODY OF ASSETS. The treasurer shall be custodian of the fund. He shall not receive additional compensation for his services as custodian, but his reasonable and necessary expenses in performing his duties as custodian shall be charged to the fund.

COMMENT: The last sentence of this section is based on the assumption that there will be expenses for custody only when there are actually assets in the fund which must be accounted for, kept and disbursed. These expenses should properly be at the charge of the fund. Any expenses of the treasurer as a board member are in the absence of a liquidation chargeable to the insurance office budget, under s. 646.02 (4).

646.05 INVESTMENTS. The fund shall be invested by the investment board under s. 25.17. All income from the investments shall be credited to the fund.

646.11 ELIGIBLE CLAIMS. (1) CONDITIONS OF ELIGIBILITY FOR PAYMENT. Payment shall be made under this chapter for a claim that:

(a) *Issued by authorized insurer.* Arises out of an insurance policy or annuity issued by an insurer which was authorized to do an insurance business in this state either at the time the policy or annuity was issued or when the insured event occurred; and

(b) *Assessability of insurer.* Arises out of a class of business with respect to which the insurer is not exempt from assessment under s. 646.21 (2); and

(c) *Approved in liquidation.* Has been approved in the liquidation of the insurer issuing the policy or annuity, carried out under ch. 645 or under the similar laws of another state or foreign country; and

(d) *Contact with state.* Is a member of one of the classes of claims under sub. (2).

(2) CLASSES OF CLAIMS TO BE PAID. A claim shall not be paid unless it is:

(a) *Residents.* The claim of a policyholder or an insured of, or a beneficiary under, a policy or annuity, who at the time of the insured event or of the liquidation order was a resident of this state; or

(b) *Owners of property interests.* The claim of a person having an insurable interest in or related to property which was situated in this state at the time of the insured event; or

(c) *Third party claimants.* A claim under a liability or workmen's compensation insurance policy, if:

1. Either the insured or the 3rd party claimant was a resident of this state at the time of the insured event; or

2. The claim is for bodily or personal injuries suffered in this state or by a person who when he suffered the injuries was a resident of this state; or

3. The claim is for damage to property situated in this state at the time of damage.

(d) *Assignees.* The claim of a direct or indirect assignee of a person who except for the assignment might have claimed under par. (a) or (b).

(3) LIMITATION OF AMOUNT. Payment under this chapter shall be limited to the amount by which the allowance on any claim exceeds $200 and, if the insurer is not liquidated under ch. 645, to the amount in excess of $200 for which the claim would be allowable in a liquidation under ch. 645, as determined under s. 646.12 (2).

COMMENT: This section defines the claims for which Wisconsin public policy requires protection in the event of liquidation of an insurer. The first two subsections try to define the claims that are properly regarded as "Wisconsin claims" for purposes of this chapter. The scope is marginally broader than, for example, the basis of premium taxation or of assessment under s. 646.21, but the difference is only marginal and protects people this state should be interested in protecting. It does not protect a buyer in the nonadmitted market, but only those who buy from insurers over which the commissioner has some control.

The deductible prescribed in sub. (3) corresponds to s. 645.68 (3). The second half of the sentence preserves to the administrator the power to make his own evaluation of judgment claims, as in a Wisconsin liquidation under ss. 645.62 (3) and 645.68 (6). This power is important since in a time of financial stress an insurer tends to neglect the proper defense of lawsuits.

646.12 PROCEDURE FOR PAYMENT. (1) LIQUIDATION. The claims found by the administrator to be eligible under s. 646.11 shall be paid out of the fund as soon as they have been approved or settled under ss. 645.71 (2) and 645.87 (2) or the corresponding laws of another jurisdiction, sub-

ject to the board's power under sub. (2) to reduce the amount of the award.

(2) CERTIFICATE OF APPROVAL. For each claim found by the administrator to be eligible under s. 646.11 and approved or settled as specified in sub. (1), the administrator shall execute a certificate, upon receipt of which the treasurer shall pay the indicated amount to the claimant. If in the judgment of the administrator, an improper award is made or an excessive amount is awarded in a liquidation under the laws of another jurisdiction, he may recommend to the board that the award shall be paid only in part out of the fund, and the board shall thereupon determine the amount to be paid.

(3) INELIGIBLE CLAIMS. If the administrator finds that a claim for which the claimant has requested payment out of the fund is not eligible under s. 646.11 or the board reduces the amount of the award under sub. (2), the administrator shall notify the claimant in writing and advise him of his rights under s. 646.13.

COMMENT: This section seeks to ensure that payments on claims are made with as little delay as possible. Some delay, of course, is unavoidable; in order to avoid payment of unjustified claims, sub. (1) relies on the ordinary procedure of settling and approving creditors' claims in liquidation proceedings (s. 645.71).

After approval as a justified claim, a second decision has to be made to determine whether the claimant is entitled to payments under this chapter. This decision is made by the administrator. He will be able to make the necessary findings and the decision more expeditiously than a court can in the traditionally slow moving liquidation procedure. The fact that funds for immediate payment of approved claims are available might help to speed up the approval procedure under s. 645.71.

In case the commissioner's decision on eligibility is unfavorable, sub. (3) provides for proper notice to the claimant, and s. 646.13 gives the claimant the right to appeal to the full board and, eventually, to challenge the decision in court.

The second sentence of sub. (2) protects the fund against unjustified claims originating elsewhere. Full faith and credit should present no problem. Full effect is not being denied to the other state's judgment so far as the claim is against the defendant's own assets. A limitation on the amount that strangers should be assessed to pay claims is an altogether different matter. This statute both creates and defines the right, which does not exist without the statute.

646.13 APPEAL AND REVIEW. (1) APPEAL. A claimant whose claim has been declared to be ineligible or reduced by the administrator under s. 646.12 (3) may appeal to the board within 30 days after the claimant has been notified of the administrator's decision and of his rights under this section.

(2) REVIEW. Decisions of the board under sub. (1) and s. 646.12 (2) shall be subject to judicial review.

COMMENT: The procedure of the board in considering and deciding the appeal should follow established practices, including notice and hearing, as specified in ch. 227. Details are subject to rules as authorized in s. 646.03 (2) (a).

646.14 SUBROGATION AND COOPERATION. (1) SUBROGATION. Upon payment to any claimant under s. 646.12 the fund shall be subrogated to the claimant's full right of recovery against the insurer, its conservator or liquidator. The fund shall retain the amount it has paid to the claimant and expended to enforce the recovery, and pay over any balance to the claimant.

(2) COOPERATION. The claimant shall cooperate with the fund in pursuing its rights under sub. (1) and if cooperation is unreasonably withheld, the fund shall have a right to recover from the claimant any payment made to him.

COMMENT: This section ensures that the protection afforded to policyholders and insureds does not benefit the defunct insurer or its other creditors. The dividends that in the absence of this chapter would have been paid to eligible claimants will thus eventually go into the fund and lessen the burden on the contributing insurers. If only a portion of the claim is paid, under this chapter, the claimant remains entitled to dividends for the residue, after the fund has been fully repaid.

646.21 ASSESSMENTS. (1) INSURERS SUBJECT TO ASSESSMENTS. All insurers to which this chapter applies shall be subject to assessments as provided in this section.

(2) EXEMPTIONS FROM ASSESSMENTS. If the commissioner finds that a foreign or alien insurer is subject to another guaranty fund plan providing substantially the same protection to claimants under s. 646.11 as would be provided by this chapter, he shall exempt the insurer from assessments on the classes of business to which the other plan applies.

(3) CONDITIONS AND PROCEDURE. As soon as practicable after a liquidation order as specified in s. 646.12 (1) has been issued, the administrator shall make an estimate of the amount that will be necessary to make the payments provided by this chapter, separately for each of the accounts of s. 646.02 (2) and shall submit the estimate to the board, together with his recommendations for the assessment to be levied.

(4) CALCULATION. The board shall fix assessments separately for each account as a percentage of the gross premiums and other consideration received for direct insurance and annuities written in this state in the classes protected by the account, less return premiums and dividends paid in cash to policyholders or applied in part payment of premiums, as reported in the most recent annual statements. Assessments may be made payable in one sum or in instalments.

(5) LIMITS. The maximum assessment upon an insurer in any year shall be 2% of the assessable premiums as defined in sub. (4).

(6) USE OF ASSETS. No assessment shall be levied as long as the assets held by the appropriate account of the fund are sufficient to cover all estimated payments for liquidations in process.

(7) COLLECTION. After the rate of assessment has been fixed by the board, the administrator shall send to each insurer a statement of the exact amount to be paid by it. The assessments or instalments shall be paid and collected in the same manner as premium taxes or license fees under ch. 76.

(8) APPEAL AND REVIEW. Any insurer may, within 10 days after receipt of the statement under sub. (7), appeal to the board with respect to the amount of the assessment demanded by the administrator. The decision of the board on this appeal is subject to judicial review. However, there shall be no delay in payment by reason of the pendency of an appeal or of review.

(9) RECOUPMENT. Rates used by an insurer shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments made under this chapter.

COMMENT: The principal thrust of this section is to provide for the financing of the entire insolvency protection program exclusively through assessments, to be levied only upon the actual occurrence of a liquidation, and then to be limited to the estimated payments to be made in connection with it. One reason for choosing this system is that liquidations and the losses caused by them cannot be predicted with accuracy. It

would not be feasible to build up a fund slowly to reach the right amount at the right time. To give protection against any likely contingency, a fund would have to be set up quickly at a fairly high amount. If accumulation continued thereafter, the fund might then grow beyond all reasonable need. For instance, the motor vehicle liability security fund established in New York in 1947 now holds assets in the amount of $125 million. There seems no sound reason for tying up such huge sums of money if possible needs in the event of insolvency can be met adequately by special assessments.

In Wisconsin, insolvencies of insurers have heretofore been comparatively few, and aggregate losses to Wisconsin insureds have not been alarming. Under an improved delinquency law which gives the commissioner power to deal quickly and efficiently with insurers whose solvency is threatened it can be expected that the frequency and severity of failures will be still smaller in the future. While this does not eliminate the necessity for an insolvency protection program, it can and must be considered in estimating the financial needs of such a program.

A large amount of money can be raised by means of relatively modest assessments without causing excessive hardship for the assessed insurers. On the basis of the 1967 premium volume, a 2 per cent assessment would produce roughly $8,000,000 in the life insurance account, $4,000,000 in the disability account and $8,000,000 in the nonlife account. It should further be noted that the payments need not be made to fall due all at once upon the institution of liquidation proceedings, but could be spread in instalments over several years depending on a predicted schedule of need for cash. With financing sources of such dimensions, very sizeable failures could be handled without serious problems or burdens. It should be remembered also, that this proposal only contemplates guaranteeing the Wisconsin business of any failing company, not its total business. If insurers felt it desirable and if it would have tax or other advantages, it would be easy to add a section to this chapter either permitting or requiring the building of a special reserve large enough to pay any such assessment if it should be made.

Sub. (3) prescribes the procedure for determining the necessary amount of money. Since the first assessment should be levied as soon as possible after insolvency to provide the funds for expenses and early claim payments, there will usually only be a very rough estimate of the financial needs. On the other hand, it can be safely assumed that the commissioner has had the insurer under special observation for some time before applying for a liquidation order. Thus he can be expected to make a reasonably educated guess. If the payment is ordered in instalments, the assessment can be adjusted downward as the liquidation proceeds, if the need was overestimated at first.

The inevitable delay between the issuance of the liquidation order and the availability of funds is not likely to cause any problems. The commissioner's estimate and recommendation under sub. (3) and the board's resolution under sub. (4) could be made very quickly. The collection of the first instalment of an assessment under sub. (7) could be completed quickly. It will take much longer for the court and the liquidator to proceed so far that many claims can be settled or approved under s. 645.71.

646.22 DISPOSAL OF UNUSED ASSETS. After the termination of all liquidations initiated in any year in either account of the fund, all surplus assets left in that account and attributable to those liquidations shall be redistributed among those who paid assessments, in proportion to the amounts they paid. After all claims against the fund arising from such liquidations have been paid, partial distributions may be made as dividends are received from the liquidations.

COMMENT: This section tries to solve the problem resulting from the fact that at the end of a liquidation there will be assets left in the fund, resulting both from caution in estimating the fund's needs and fixing the assessments, and from dividends recovered under s. 646.14 which cannot be considered in calculating the assessments since they are determined only at a very late stage in the proceedings. Under the general philosophy governing this chapter, it seems preferable to return this money to the insurers rather than to keep it for indefinite future use.

646.23 TRANSITION PROVISIONS FOR WORKMEN'S COMPENSATION SECURITY FUNDS. (1) CONSOLIDATION AND TRANSFORMATION. The stock workmen's compensation security fund established under s. 102.65 (2), the mutual workmen's compensation security fund established under s. 102.65 (4) and the reciprocal workmen's compensation security fund established under s. 102.65 (6) are hereby consolidated and transformed into the temporary workmen's compensation insurance security fund.

(2) PAYMENTS FROM TEMPORARY WORKMEN'S COMPENSATION INSURANCE FUND. After the effective date of this chapter (1969), whenever an assessment is levied against insurers under s. 646.21 that portion of any assessment attributable under s. 646.21 (4) to workmen's compensation insurance shall be transferred from the temporary fund under sub. (1) to the account for all other covered insurance under s. 646.02 (2). When the temporary fund under sub. (1) is exhausted it shall cease to exist.

COMMENT: This section provides for the transformation of the present workmen's compensation funds into a single security fund. While it seems justified to keep the already accumulated fund and to reserve it for the purposes for which it was built up by the workmen's compensation carriers, it does not seem justified to continue separate funds for stock, mutual and reciprocal insurers, as now provided in s. 102.65.

Sub. (2) provides for crediting the funds now available against future assessments until they are exhausted and then terminating the fund.

646.31 UNFAIR TRADE PRACTICES. It is an unfair trade practice for any insurer or agent to make use in any manner of the protection given policyholders by this chapter as a reason for buying insurance from him.

COMMENT: For the benefit of the public, strong and well-managed insurers are subjected to the risk of a slight loss to help preserve the integrity of the insurance institution. The cost to them is very slight and unobjectionable in every respect. However, the fund should not be used as a competitive weapon by any insurer or agent, since it protects all policyholders of all insurers equally. The commissioner may implement this provision by rules that forbid specific practices.

SECTION 27. In the statutory sections listed in column "A" below, the cross references in column "B" are changed to the references shown in column "C".

A Statutory sections	B Old cross references	C New cross references
201.22	203.32	ch. 625
205.05 (5)	203.32 or ss. 204.37 to 204.54	ch. 625
218.01 (6) (e)	204.37 to 204.54	ch. 625
645.47 (1) (b)	102.65	ch. 646

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