Chapter Ins 3

CASUALTY INSURANCE

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Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.07 Rules in chapter Ins 4, fire and allied lines insurance, applicable to casualty insurance. History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76; r. Register, April, 1979, No. 280, eff. 5-1-79.

Ins 3.09 Mortage guaranty insurance. (1) PURPOSE. This rule implements and interprets, including but not limited to, section Ins 6.75 (2) (i) and s. 611.02, 611.24, 618.01, 618.21, 620.02 and 623.04, Stats., for the purpose of establishing minimum requirements for the transaction of mortgage guaranty insurance.

(2) SCOPE. This rule shall apply to the underwriting, investment, marketing, rating, accounting and reserving activities of insurers which write the type of insurance authorized by section Ins 6.75 (2) (i).

(3) DEFINITIONS. (a) Mortgage guaranty insurance is that kind of insurance authorized by section Ins 6.75 (2) (i), and includes the guarantee of the payment of rentals under leases of real estate in which the lease extends for 3 years or longer.

(b) As used in this rule, "person" means any individual, corporation, association, partnership or any other legal entity.

(4) DISCRIMINATION. No mortgage guaranty insurer may discriminate in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed or national origin.

(5) LIMITATION OF TOTAL LIABILITY ASSUMED. A mortgage guaranty insurer shall not at any time have outstanding a total liability under its aggregate insurance policies, computed on the basis of its election to limit coverage and net of reinsurance assumed and of reinsurance ceded to an insurer authorized to transact such reinsurance in this state, exceeding 25 times the sum of its contingency reserve established under subsection (14) and its surplus as regards policyholders.

(6) LIMITATION ON INVESTMENT. A mortgage guaranty insurer shall not invest in notes or other evidences of indebtedness secured by mortgage or other lien upon real property. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

(7) LIMITATION ON ASSUMPTION OF RISKS. A mortgage guaranty insurer shall not insure loans secured by properties in a single or contiguous housing or commercial tract in excess of 10% of the insurer's admitted assets. A mortgage guaranty insurer shall not insure a loan secured by a single risk in excess of 10% of the insurer's admitted assets. In determining the amount of such risk or risks, the insurer's liability shall be computed on the basis of its election to limit coverage and net of reinsurance ceded to an insurer authorized to transact such reinsurance in this state. "Contiguous" for the purpose of this subsection means not separated by more than one-half mile.

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not enter into reinsurance arrangements designed to circumvent the compensation control provisions of subsection (15) or the contingency, reserve requirement of subsection (14). It is the intent of this rule that the unearned premium reserve required by subsection (13) and the contingency reserve required by subsection (14) shall be established and maintained in appropriate proportions in relation to risk retained by the

prohibiting special favors to certain customers. It is not intended to preclude reasonable and customary business entertainment and trade association activities and expense incurred by the title insurer in the course of marketing its products and services. Moderate expenditures for food, meals, beverages and entertainment may be made, if correctly claimed and properly substantiated as a legitimate business expense.

(p) Paying for, or offering to pay for, money, prizes or other things of value for any such person in any kind of a contest or promotional endeavor. This prohibition applies whether or not the offer or payment of a benefit relates to the number of title orders placed or escrows opened with a title insurer or group of such insurers. It does not apply to offers or payments to trade associations, charitable or other functions where the thing of value is in the nature of a contribution or donation rather than a business solicitation.

(q) Paying for, or offering to pay for, any advertising concerning the title insurer which is to appear in a pamphlet, magazine, brochure, or any other advertising material promoted or distributed, with or without cost by any such person. Examples of this kind of advertising material are advertisements appearing in newsletters distributed by real estate brokers, tract brochures issued by land developers or builders, or jointly sponsored promotional magazines. This prohibition does not apply to brochures or other promotional items of the title insurer used in the marketing of its own products, to advertising in trade media or other media not promoted or solicited by such persons, nor to other forms of advertising provided the expected benefit to be derived from customers generally is fairly equivalent to the expense incurred.

(r) Paying for or furnishing, or offering to pay for or furnish any brochures, billboards, or advertisements of such persons, products or services appearing in newspapers, on the radio, or on television, or other advertising or promotional material published or distributed by, or on behalf of, any such person.

(5) PENALTY. Any violation of this rule shall subject the title insurer to the penalties and forfeitures provided by s. 601.64, Stats.

History: Cr. Register, December, 1975, No. 240, eff. 1-1-76; emerg. am. (1), (2) and (3) (a), eff. 6-22-76; am. (1) (2), (3) (a) and (4) (o), Register, September, 1976, No. 249, eff. 10-1-76; am. (2) and (3) (a), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.35 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner of insurance to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or to call upon the insurance industry to prepare plans for his approval.

(b) Health care liability insurance for medical or osteopathic physicians or podiatrists, licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state and for operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employes, and for properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats., is not readily available in

the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding, except as otherwise provided herein, those facilities exempted by s. 50.39 (3), Stats., which operate in this state are not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for those nursing homes as defined in s. 50.01 (3) (a), Stats., which operate in this state and whose functional operations are combined with a hospital as herein defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations, are not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for health care facilities owned or operated by a political subdivision of the state of Wisconsin are not readily available in the voluntary market.

(c) A facility for providing such health care liability insurance should be enacted pursuant to ch. 619, Stats.

(2) PURPOSE. This rule is intended to implement and interpret ch. 619, Stats., for the purpose of establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage on a self-supporting basis for medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; for operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide service in their own facilities with salaried employes; and for properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.; and to provide health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for all hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided herein, which operate in this state. Health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for those nursing homes as defined in s. 50.01 (3) (a), Stats., which operate in this state and whose functional operations are combined with a hospital as herein defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations is also provided. Health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for those health care facilities owned or operated by a political subdivision of the state of Wisconsin is also provided. This rule is also intended to encourage the improvement in reasonable loss prevention measures and to encourage the maximum use of the existing voluntary market.

(3) SCOPE. This rule shall apply to all insurers authorized to transact in this state on a direct basis insurance against liability resulting from personal injuries, except for town mutuals authorized to transact insurance under ch. 612, Stats.

(4) DEFINITIONS. (a) *The Wisconsin health care liability insurance plan,* hereinafter referred to as the Plan, means the statutory, nonprofit, unincorporated association established by this rule to provide for the

issuance of health care liability insurance and liability coverages normally incidental to health care liability insurance at adequate rate levels for risk sharing subject to the right of recoupment and to assist qualified applicants in securing health care liability insurance and liability coverage normally incidental to health care liability insurance.

(b) Insurance against liability resulting from personal injuries means all insurance coverages against loss by the personal injury or death of any person for which loss the insured is liable. It includes the personal injury liability component of multi-peril policies, but it does not include steam boiler insurance authorized under section Ins 6.75 (2) (a), worker's compensation insurance authorized under section Ins 6.75 (2) (k), or medical expense coverage authorized under section Ins 6.75 (2) (d) or (e).

(c) Health care liability insurance means insurance against loss, expense and liability resulting from errors, omissions or neglect in the performance of any professional service by any medical or osteopathic physician or podiatrist licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; by operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employes; by properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.; by all hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided; by those nursing homes as defined in s. 50.01 (3) (a), Stats., whose functional operations are combined with a hospital as herein defined as a single entity, whether or not nursing home operations are physically separate from the hospital operations, which operate in this state; and by health care facilities owned or operated by a political subdivision of the state of Wisconsin.

(d) Liability coverage normally incidental to health care liability insurance shall include owners, landlords and tenants liability insurance; owners and contractors protective liability insurance; completed operations and products liability insurance; contractual liability insurance and personal injury liability insurance.

(e) Premiums written means gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to insurance against liability resulting from personal injuries covering insureds or risks resident or located in this state excluding premiums on risks insured under the Plan.

(f) Servicing company means an insurer which services policies issued on behalf of the Plan.

(g) Confidental claims information means any information relating to the Plan in the possession of the commissioner, the board of governors or an agent thereof which reveals, directly or indirectly, the identity of a health care provider, as defined in s. 655.001 (8), Stats.

(h) Political subdivision means counties, cities, villages and towns.

(5) INSURANCE COVERAGE. (a) All medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employes; by properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.; all hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided herein; those nursing homes as defined in s. 50.01 (3) (a), Stats., whose functional operations are combined with a hospital as defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations; and health care facilities owned or operated by a political subdivision of the state of Wisconsin, which operate in this state and are equitably entitled to but are otherwise unable to obtain suitable health care liability insurance in the voluntary market shall be eligible to apply for insurance under this Plan.

(b) The maximum limits of coverage for the type of health care liability insurance defined in subsection (4) (c) which may be placed under this Plan are $200,000 per claim and $600,000 aggregate for all claims in any one policy year.

(c) The maximum limits of coverage for liability coverages normally incidental to health care liability insurance as defined in subsection (4) (d) which may be placed under this Plan are $1,000,000 per claim and $1,000,000 aggregate for all claims in any one policy year.

(d) Health care liability coverage shall be provided in a standard policy form on an occurrence basis, i.e., coverage for any liability based on a treatment, omission or operation which occurs during the term of the policy and which is brought within the time the applicable statute of limitations continues the liability. The board of governors may authorize the issuance of policies on other bases as an option under the Plan subject to such restrictions and rules as it may deem necessary and appropriate in the circumstances.

(e) Any policyholder holding coverage under the Wisconsin Health Care Liability Insurance Plan shall continue to be subject to the rules governing the Plan which were in force when the coverage was obtained. The renewal of any such coverage shall be subject to the provisions of the rule in effect at the time of the renewal. All obligations and liabilities created under such prior rule shall continue in force under the Plan until they are extinguished.

(f) Coverage for hospitals, nursing homes, or health care facilities owned or operated by a political subdivision of the state of Wisconsin which are eligible for insurance under this plan may include liability coverages normally incidental to health care liability insurance as defined in subsection (4) (d).

(6) MEMBERSHIP. (a) Every insurer, subject to subsection (3) shall be a member of this Plan.

(b) An insurer's membership terminates when the insurer is no longer authorized to write personal injury liability insurance in Wisconsin, but the effective date of termination shall be the last day of the fiscal year of

the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this rule until it completes all of its obligations under the Plan.

(c) Subject to the approval of the commissioner, the board of governors may charge a reasonable membership fee, not to exceed $50.00.

(7) ADMINISTRATION. (a) The Plan shall be administered by a board of governors.

(b) The board of governors shall consist of the commissioner or his designated representative, and 10 other board members. Each shall have one vote.

1. The commissioner shall appoint 5 board members from insurers who are members of the Plan.

a. The following associations shall at the direction of the commissioner nominate board members:

American Insurance Association
Alliance of American Insurers
National Association of Independent Insurers
Wisconsin Insurance Alliance

b. The commissioner shall appoint one board member from other insurers not members of the associations in subdivision a.

2. The state bar association shall appoint one board member who shall be an attorney.

3. The Wisconsin medical society shall appoint one board member who shall be a physician.

4. The Wisconsin Hospital Association shall appoint one board member.

5. The Governor shall appoint 2 public board members for staggered three-year terms who are not attorneys or physicians and who are not professionally affiliated with any hospital or insurance company.

(c) The commissioner or his representative shall be chairman of the board of governors.

(d) Board members other than the commissioner or his representative shall be compensated at the rate of $50 per diem plus actual necessary travel expenses.

(8) DUTIES OF THE BOARD OF GOVERNORS. (a) The board of governors shall meet as often as may be required to perform the general duties of the administration of the Plan or on the call of the commissioner. Six members of the board shall constitute a quorum.

(b) The board of governors shall be empowered to invest, borrow and disburse funds, budget expenses, levy assessments, cede and assume reinsurance, and perform all other duties provided herein as necessary or incidental to the proper administration of the Plan. The board of governors may appoint a manager or one or more agents to perform such duties as may be designated by the board.

(c) The board of governors shall develop rates, rating plans, rating and underwriting rules, rate classifications, rate territories, and policy

forms in accordance with ss. 619.01 (1) (c) 2., 619.04 (5), 625.11, and 625.12, Stats., and subsection (12) of this rule.

(d) The board of governors shall cause all policies written pursuant to this Plan to be separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium level for each classification of risk, and performing loss prevention and other studies of the operation of the Plan.

(e) The board of governors shall determine, subject to the approval of the commissioner, the eligibility of an insurer to act as a servicing company. If no qualified insurer elects to be a servicing company, the board of governors shall assume such duties on behalf of member companies.

(f) The board of governors shall enter into agreements and contracts as may be necessary for the execution of this rule consistent with its provisions.

(g) The board of governors may appoint advisory committees of interested persons, not limited to members of the Plan, to advise the board in the fulfillment of its duties and functions.

(h) The board of governors shall be empowered to develop, at its option, an assessment credit plan subject to the approval of the commissioner, wherein a member of the Plan receives a credit against an assessment levied, based upon Wisconsin voluntarily written health care liability insurance premiums.

(i) The board of governors of the Plan shall be authorized to take such actions as are consistent with law to provide the appropriate examining boards or the department of health and social services with such claims information as may be appropriate.

(j) The board of governors shall assume all duties and obligations formerly vested in the governing committee whenever it becomes necessary to administer any of the provisions governing the Wisconsin Health Care Liability Insurance Plan, which provisions preceded the adoption of the provisions contained in this rule.

(9) ANNUAL REPORTS AND RECORDS. (a) By May 1 of each year the board of governors shall make a report to the members of the Plan and to the standing committees on health insurance in each house of the legislature summarizing the activities of the Plan in the preceding calendar year.

(b) All books, records, documents or audits relating to the Plan or its operation shall be open to public inspection, with the exception of confidential claims information.

(10) APPLICATION FOR INSURANCE. (a) Any medical or osteopathic physician, podiatrist, nurse anesthetist, operating cooperative sickness care plan, teaching facility, hospital, nursing home, or health care facility owned or operated by a political subdivision of the state of Wisconsin eligible for insurance under this plan may submit an application for insurance by the plan directly or through any licensed agent.

(b) The Plan may bind coverage.

(c) The Plan shall, within 8 business days from receipt of an application, notify the applicant of the acceptance, rejection or the holding in

abeyance of the application pending further investigation. Any individuals rejected by the Plan shall have the right to appeal that judgment within 30 days to the board of governors in accordance with subsection (16).

(d) If the risk is accepted by the Plan, a policy shall be delivered to the applicant upon payment of the premium. The Plan shall remit any commission to the licensed agent designated by the applicant; if no licensed agent is so designated, such commission shall be retained by the Plan.

(11) ASSESSMENTS AND PARTICIPATION. (a) In the event that sufficient funds are not available for the sound financial operation of the Plan, and pending recoupment pursuant to s. 619.01 (1) (c) 2., Stats., all members shall, on a temporary basis, contribute to the financial needs of the Plan in the manner prescribed in paragraph (b). When such assessment contribution is recouped, it shall be reimbursed to members as their total share of the assessment contribution bears to the aggregate outstanding contributions.

(b) All members of the Plan shall participate in all premiums, other income, losses, expenses, and costs of the Plan in the proportion that the premiums written of each such member [excluding that portion of premiums attributable to the operation of the Plan and giving effect to any assessment credit plan under subsection (8) (h)] during the preceding calendar year bears to the aggregate premiums written in this state by all members of the Plan. Each member's participation in the Plan shall be determined annually on the basis of such premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner of insurance.

(12) RATES, RATE CLASSIFICATIONS, AND FILINGS. Rates, rate classifications, and filings for coverages issued by the Plan shall be generally subject to ch. 625, Stats., and specifically shall meet the requirements of ss. 619.01 (1) (c) 2., 619.04 (5), 625.11, and 625.12, Stats. Rates and rate classifications shall not discriminate on the basis of the insured's sex, marital status, race, color, creed or national origin. Information supporting the rates and rate classifications filed with the commissioner shall be made a part of such filing. Rates, rate classifications and filings shall be developed in accordance with the following standards or rules:

(a) *Rates.* 1. Rates shall not be excessive, inadequate or unfairly discriminatory.

2. Rates shall be calculated in accordance with generally accepted actuarial principles, using the best available data and shall be reviewed by the board of governors at least once each year.

3. Rates shall be calculated on a basis which will make the Plan self-supporting and shall be presumed excessive if they produce a long run profit or surplus for the Plan over losses and expenses, and loss reserves (including contingency reserves).

4. Any deficit incurred by the Plan in any one year shall be recouped by rate increases applicable prospectively, or any surplus over the loss reserves of the Plan in any one year shall be distributed by rate decreases applicable prospectively.

5. Rates shall reflect past and prospective loss and expense experience in different areas of practice.

6. Wisconsin loss and expense experience shall be used in establishing and reviewing rates to the extent it is statistically credible supplemented by relevant data from outside the state; relevant data shall include, but not be limited to, data provided by other insurance companies, rate service organizations or governmental agencies.

7. Loss and expense experience used in determining initial or revised rates shall be adjusted to indicate as nearly as possible the loss and expense experience which will emerge on policies issued by the Plan during the period for which the rates were being established; for this purpose loss experience shall include paid and unpaid losses, a provision for incurred but not reported losses, and both allocated and unallocated loss adjustment expenses and consideration shall be given to changes in estimated costs of unpaid claims and to indications of trends in claim frequency, claim severity, and level of loss expense.

8. Review of rates for the Plan shall begin with the experience of the Plan, supplemented first by Wisconsin experience of coverage provided by other insurers, and then, to the extent necessary for statistical credibility, by relevant data from outside the state.

9. Information supporting the rate filing shall indicate the existence, extent and nature of any subjective factors in the rates based on judgment of technical personnel, such as consideration of the reasonableness of the rates compared to the cost of comparable coverage where it is available.

10. Expense provisions included in the rate to be used by the Plan shall reflect reasonable prospective operating expense levels of the Plan.

11. All accumulated net income, including investment income under the Plan, shall be used to modify the indicated rates promulgated in accordance with the foregoing criteria.

12. Provision may be made for modification of rates for individual risks in accordance with rating plans or surcharge schedules which establish reasonable standards for measuring probable variation in hazards, expenses, or both.

(b) *Classifications.* 1. Classifications shall reflect past and prospective loss and expense experience in different areas of practice.

2. Classifications shall be established which measure to the extent possible variations in exposure to loss and in expenses based upon the best data available.

3. Classifications shall include recognition of any difference in the exposure to loss of semi-retired or part-time professionals.

4. Classifications shall to the extent possible reflect past and prospective loss and expense experience of risks insured in the Plan and other relevant experience from within and outside this state.

5. Classification schedules may provide for modification of rates for individual risks in accordance with rating plans or surcharge schedules which establish reasonable standards for measuring probable variations in hazards, expenses, or both.

6. Classifications shall be reviewed by the board of governors at least once each year.

(c) *Filings.* 1. All filings of rates, classifications and supporting information of the Plan and all changes and amendments thereof shall be filed with the commissioner within 30 days after they become effective.

2. These filings shall be open to public inspection during the usual business hours of the office of the commissioner of insurance.

(13) VOLUNTARY BUSINESS - CANCELLATION AND NONRENEWAL. Any member cancelling or not renewing voluntarily written health care liability insurance covering any risk eligible under this Plan shall inform the policyholder of the availability of insurance under the Plan. Any such notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage. A copy of such cancellation or nonrenewal notice shall be filed with the office of the commissioner of insurance.

(14) PLAN BUSINESS - CANCELLATION AND NONRENEWAL. (a) The Plan shall not cancel or refuse to renew a policy issued under the Plan except for:

1. Nonpayment of premium; or

2. Revocation of the license of the insured by the appropriate licensing board.

(b) Notice of cancellation or nonrenewal under paragraph (a), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in subsection (16).

(15) COMMISSION. Commission to the licensed agent designated by the applicant shall be $125.00 for each new or renewal policy issued to medical or osteopathic physicians; $15.00 for each new or renewal policy issued to nurse anesthetists; $40 for each new or renewal policy issued to podiatrists; and 5% of the annual premium for each new or renewal policy issued to operating cooperative sickness care plans, or to teaching facilities, or to hospitals, or to health care facilities owned and operated by a political subdivision of the state of Wisconsin, not to exceed $2,500.00 per policy period. The agent need not be licensed with the servicing company.

(16) RIGHT OF APPEAL. Any affected person may appeal to the board of governors within 30 days after notice of any final ruling, action or decision of the Plan. Decisions of the board of governors may be further appealed in accordance with ch. 227, Stats.

(17) REVIEW BY COMMISSIONER. The board of governors shall report to the commissioner the name of any member or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the board of governors or to pay within 30 days any assessment levied.

(18) INDEMNIFICATION. Each person serving on the board of governors or any subcommittee thereof, each member of the Plan, and the manager and each officer and employe of the Plan shall be indemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the board of governors, or

a member or manager or officer or employe of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful or criminal misconduct in the performance of his or its duties as a member of such board of governors, or a member or manager or officer or employe of the Plan. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the Plan. Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employe may be entitled as a matter of law.

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 6-22-76; am. (1) (b), (2), (4) (b) and (c) and (5) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) (b), (2), (4) (c), (5) (a), (5) (f), (10) (a) and (15), cr. (4) (h), Register, May, 1977, No. 257, eff. 6-1-77; am. (1) (b), (2), (4) (c), (5) (a), (10) (a) and (15), Register, September, 1977, No. 261, eff. 10-1-77; am. (1) (b), (2), (4) (b) and (c), (5) (a) and (f), and (15), Register, May, 1978, No. 269, eff. 6-1-78; am. (7) (b) 1.a., Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.36 Statistical reports—health professional liability insurance. (1) PURPOSE. This rule is intended to interpret and implement s. 625.34, Stats., and respond to the mandate of s. 625.35, Stats., for the purpose of obtaining statistical data on health professional liability insurance in Wisconsin.

(2) SCOPE. This rule applies only to insurance issued to health care providers whose principal place of practice or operation is in Wisconsin.

(3) DEFINITIONS. As used in this rule, which interprets the mandate of s. 625.35, Stats.:

(a) Health professional liability insurance means insurance for liability arising out of the acts or omissions of any of the following health care providers whose principal place of practice or operation is in Wisconsin:

1. medical or osteopathic physicians, 2. blood banks, 3. chiropodists, 4. chiropractors, 5. dental hygienists, 6. hearing aid service establishments, 7. medical laboratory technicians, 8. medical or x-ray laboratories, 9. nurses (registered or trained practical nurses), 10. opticians, 11. optometrists, 12. pharmacists, 13. physiotherapists, 14. x-ray laboratories, 15. x-ray technicians, 16. osteopathic hospitals, 17. drugless healing institutions, 18. clinics, dispensaries or infirmaries—out-patient treatment only, 19. convalascent or nursing homes, 20. hospitals, 21. mental-psychopathic institutions, 22. sanitariums or health institutions—not hospitals or mental-psychopathic institutions, 23. dentists, 24. surgeons, 25. radium, laboratory, pathological or x-ray therapy technicians, 26. operational cooperative sickness plans organized under ss. 185.981 to 185.985, Stats., which directly provide services through salaried employes in their own facilities, 27. partnerships comprised of physicians or nurse anesthetists, 28. corporations owned by physicians or nurse anesthetists and operated for the purpose of providing medical services.

(b) Rating class means any of the classifications listed on pages 7 through 14, part III of the Uniform Statistical Plan for Medical Professional Liability Insurance published by the Insurance Services Office effective January 1, 1976, as revised January 19, 1976, plus additional classifications for osteopathic hospitals, nurse anesthetists partnership liability, nurse anesthetists corporate liability, and operational cooperative sickness plans organized under ss. 185.981 to 185.985, Stats., which directly provide services through salaried employes in their own

facilities. The Uniform Statistical Plan for Medical Professional Liability Insurance published by the Insurance Services Office is distributed by Insurance Services Office, 160 Water Street, New York, New York 10038. A copy of this plan is on file at the office of the commissioner of insurance, the secretary of state and the revisor of statutes.

(c) Claim means every occurrence in which a claim for damages is made or a suit is brought against the health care provider defined in paragraph (a) whether or not such claim is false, groundless or fraudulent. Incidents not resulting in a suit or claim for damages shall not constitute a claim. Claims against more than one health care provider joined in a suit shall be treated as separate claims against each health care provider.

(d) Premiums paid means premiums received by the insurer on direct business only, less returned premiums, and shall not include premiums received on account of reinsurance assumed nor shall any deductions be made for premiums ceded on account of reinsurance ceded. Insurers shall also report for each classification the direct earned premiums in Wisconsin for the calendar year of report which shall consist of the direct premiums written less the premiums unearned at the end of the calendar year plus the premiums unearned at the beginning of the calendar year.

(e) Amount of claims means claims paid during the calendar year plus the claims unpaid at the end of the calendar year and less the claims unpaid at the beginning of the calendar year, and shall be further segregated to show:

1. Damages paid to claimants;

2. Reserves for outstanding losses;

3. Incurred but not reported losses;

4. Allocated loss adjustment expenses (i.e., investigative costs, defense costs, court costs, processing costs, etc. attributable to a specific claim);

5. Unallocated loss adjustment expenses (i.e., investigative costs, defense costs, processing costs, etc. not attributable to any specific claim, but rather to all professional liability claims in general).

Note: Insurers who do not compile "incurred but not reported losses" and/or "unallocated loss adjustment expenses" on a state-by-state basis may satisfy this requirement on the basis of estimates which reflect the ratio of Wisconsin losses and expenses to comparable country-wide data.

(f) Health professional liability insurance policy means a policy for which at least 50% of the total premium for the policy is for the insurance of health professional liability.

(g) Principal place of practice or operation means the place where more than 50% of the time of a health professional is spent in practice.

(4) FILING REQUIRED. Each insurer doing business in this state in health professional liability insurance shall report the following information to the commissioner on or before March 1 of each year for the previous calendar year:

(a) The total number of insureds in Wisconsin within each rating class;

(b) The total amount of premium paid by the insureds in each rating class in Wisconsin;

(c) The total number of claims filed against insureds in each rating class in Wisconsin, the year in which the incident giving rise to each claim occurred, and the total number of such claims outstanding as of December 31;

(d) The total number and amount of claims paid by the insurer for insureds in each rating class in Wisconsin and the year in which the incident giving rise to each claim occurred;

(e) The number of lawsuits filed in Wisconsin against the insurer's insureds.

Note: In compiling this information, the instructions and procedures included in the Uniform Statistical Plan for Medical Professional Liability Insurance published by the Insurance Services Office shall be used to the extent applicable.

(5) EXCEPTIONS. Since the statistical information required by subsection (4) may not be readily available for calendar year 1975 in the detail specified: (a) All insurers shall submit on or before March 1, 1976, the basic Wisconsin information required by line 50 of Supplement "A" to Schedule T. Exhibit of Medical Malpractice Premiums Written During Current Year Allocated by States and Territories, a part of the Annual Statement for Fire and Casualty Companies listed in Wisconsin Administrative Code section Ins 7.01 (5) (a).

(b) An insurer who cannot file for calendar year 1975 the information required by subsection (4) based on the rating classes as defined in subsection (3) (b), shall file comparable information, based on the classifications used by that insurer for rating purposes during 1975, with sufficient explanation of the make-up of each rating class so that a proper combination of insurers doing business in Wisconsin may be made.

(c) Where detailed statistical information for calendar year 1975 is not available to an insurer by March 1, 1976, that insurer may, on or before March 1, 1976, file information based on estimated data, provided that detailed information is filed by June 1, 1976.

History: Emerg. cr. eff. 1-20-76; cr. Register, March, 1976, No. 243, eff. 4-1-76.

Ins 3.37 Future medical expense funds. (1) PURPOSE. This rule is intended to implement the provisions of s. 655.015, Stats.

(2) SCOPE. This rule shall apply to all insurers, organizations and persons subject to ch. 655, Stats.

(3) DEFINITIONS. The following definitions shall apply in the administration of this rule:

(a) Fund shall mean the future medical expense fund, Fund No. 35 established by the bureau of financial operations, department of administration under the provisions of ss. 16.40 (5) and 16.41, Stats., to receive payments under s. 655.015, Stats.

(b) Account shall mean that portion of such fund allocated specifically for the benefit of an injured person.

(c) Claimant shall mean the injured person, the individual legally responsible for any medical expenses sustained by the injured person, or the legally designated representative of such injured person.

(d) Medical expense shall mean those charges for medical services, nursing services, medical supplies, drugs or rehabilitation services which are necessary to the comfort and well being of the individual and incidental to the injury sustained.

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the insurer, organization or person responsible for such payment shall forward to the commissioner the amount in excess of $25,000 within 30 days of any such settlement, award or judgment, and shall enclose an appropriately executed copy of the document setting forth the terms under which the payment is to be made.

(b) The commissioner shall cause the monies so received to be paid into the future medical expense fund to be invested by the state of Wisconsin investment board under the authority of s. 25.17 (1) (zm), Stats.

(c) Upon receipt of a request for reimbursement of medical expense of an injured person, the commissioner shall make appropriate investigation and inquiries to determine that the medical supplies or services provided are necessary and incidental to the injury sustained by the person for whom the account was established, and if satisfied that this is the case, shall pay these expenses out of the fund, using standard bookkeeping and accounting records and transactions established by ss. 16.40 (5) and 16.41, Stats.

(d) The commissioner shall not less that once annually inform the claimant of the status of the account including the original amount, payments made, and the balance remaining.

(e) The commissioner shall maintain an individual file record of each account showing the original allocation, payments made, credits and the balance remaining. The commissioner shall further keep an account of the total balance in the fund and the allocations to each account.

(f) The commissioner shall credit each account with a pro rata share of interest earned, if any, based on the remaining value of each account at the time such interest earning is declared by the investment board, and using procedures established by that board.

(g) If the commissioner is satisfied that a third party provider of service has not been reimbursed for services or supplies rendered to the injured person, payments of any medical expense may be made jointly to the claimant and the provider of such medical supplies or services.

(h) Payment shall be made to the claimant for reasonable and necessary medical expense until such time as the allocated amount is exhausted or until the injured person is deceased. Should the injured person become deceased and there is a balance in his account allocation, that amount shall be returned to the insurer, organization or person responsible for establishing the account.

History: Cr. Register, November, 1976, No. 251, eff. 12-1-76.

Ins 3.38 Coverage of newborn infants. (1) PURPOSE. This section is intended to interpret and implement s. 632.91, Stats.

(2) INTERPRETATION AND IMPLEMENTATION. (a) Coverage of each newborn infant is required under a disability insurance policy if 1. the policy provides coverage for another family member, in addition to the insured

person, such as the insured's spouse or a child, and 2. the policy specifically indicates that children of the insured person are eligible for coverage under the policy.

(b) Coverage is required under any type of disability insurance policy as described in paragraph (a), including not only policies providing hospital, surgical or medical expense benefits, but also all other types of policies described in paragraph (a), including accident only and short term policies.

(c) The benefits to be provided are those provided by the policy and payable, under the stated conditions except for waiting periods, for children covered or eligible for coverage under the policy.

(d) Benefits are required from the moment of birth for covered occurrences, losses, services or expenses which result from an injury or sickness condition, including congenital defects and birth abnormalties of the newborn infant to the extent that such covered occurrences, losses, services or expenses would not have been necessary for the routine postnatal care of the newborn child in the absence of such injury or sickness. In addition, under a policy providing coverage for hospital confinement and/or in-hospital doctor's charges, hospital confinement from birth continuing beyond what would otherwise be required for a healthy baby (e.g. 5 days) as certified by the attending physician to be medically necessary will be considered as resulting from a sickness condition.

(e) If a disability insurance policy provides coverage for routine examinations and immunizations, such coverage is required for covered children from the moment of birth.

(f) An insurer may underwrite a newborn, applying the underwriting standards normally used with the disability insurance policy form involved, and charge a substandard premium, if necessary, based upon such underwriting standards and the substandard rating plan applicable to such policy form. The insurer shall not refuse initial coverage for the newborn if the applicable premium, if any, is paid as required by s. 632.91 (3), Stats. Renewal coverage for a newborn shall not be refused except under a policy which permits individual termination of coverage and only as such policy's provisions permit.

(g) An insurer receiving an application, for a policy as described in paragraph (a) providing hospital and/or medical expense benefits, from a pregnant applicant or an applicant whose spouse is pregnant, may not issue such a policy to exclude or limit benefits for the expected child. Such a policy must be issued without such an exclusion or limitation, or the application must be declined or postponed.

(h) Coverage is not required for the child born, after termination of the mother's coverage, to a female insured under family coverage who is provided extended coverage for pregnancy expenses incurred in connection with the birth of such child.

(i) A disability insurance policy described in paragraph (a) shall contain the substance of s. 632.91 (1), (2), (3) and (4), Stats.

(j) Policies issued or renewed on or after November 8, 1975, and before May 5, 1976, shall be administered to comply with s. 204.325, Stats., contained in chapter 98, Laws of 1975. Policies issued or renewed on or after May 5, 1976, and before June 1, 1976, shall be administered to comply with s. 632.91, Stats., contained in chapter 224, Laws of 1975.