

CHAPTER 601

INSURANCE — ADMINISTRATION

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Cross-reference: See definitions in ss. 600.03 and 628.02.

SUBCHAPTER I

GENERAL PROVISIONS

601.01 Purposes. The purposes of chs. 600 to 655 are:

- (1) To ensure the solidity of all insurers doing business in this state;
- (2) To ensure that policyholders, claimants and insurers are treated fairly and equitably;
- (3) To ensure that the state has an adequate and healthy insurance market, characterized by competitive conditions and the exercise of initiative;
- (4) To provide for an office that is expert in the field of insurance, and able to enforce chs. 600 to 655;
- (5) To encourage full cooperation of the office with other regulatory bodies, both of this and other states and of the federal government;
- (6) To improve and thereby preserve state regulation of insurance;
- (7) To maintain freedom of contract and freedom of enterprise so far as consistent with the other purposes of the law;
- (8) To encourage self-regulation of the insurance enterprise;
- (9) To encourage loss prevention as an aspect of the operation of the insurance enterprise;
- (10) To keep the public informed on insurance matters; and
- (11) To achieve the other purposes stated in chs. 600 to 655.

History: 1971 c. 260; 1977 c. 339 ss. 27, 28, 43; 1979 c. 89, 102, 177; 1989 a. 187 s. 29.

Cross-reference: See also *Ins*, Wis. adm. code.

Why process consumer complaints? A case study of the office of the commissioner of insurance of Wisconsin. Whitford, Kimball, 1974 WLR 639.

601.02 Definitions. In this chapter, unless the context indicates otherwise:

(1) “Adjuster” means any person who represents an insurer or an insured in negotiations for the settlement of a claim against the insurer arising out of the coverage provided by an insurance policy.

(3) “Agent” means an intermediary as defined in s. 628.02 (4).
History: 1971 c. 260; 1975 c. 371.

601.04 Certificate of authority; fee. (1) **SCOPE.** This section applies to all insurers incorporated or organized under any law of this state except chs. 611, 612, 613 and 614.

(2) **REQUIREMENT OF LICENSE.** No insurer or plan subject to this section may transact insurance business in this state without having in effect a certificate of authority.

(3) **LICENSING.** The commissioner shall issue to any insurer or plan subject to this section a certificate of authority authorizing it to transact the business of insurance in this state if the commissioner is satisfied that it has met all requirements of law and that its methods and practices and the character and value of its assets will adequately safeguard the interests of its insureds and the public in this state. Each certificate shall be issued for a period of no longer than one year and shall expire on May 1. It may be renewed from year to year.

(4) **FEEs.** Every insurer or plan obtaining or renewing its certificate shall pay the fee required by s. 601.31 (1) (b) or (c).

History: 1971 c. 260; 1973 c. 22; 1975 c. 223, 373; 1977 c. 339 s. 6m; Stats. 1977 s. 601.04; 1979 c. 102 ss. 236 (6), 237; 1981 c. 41.

Cross-reference: See also s. *Ins* 15.01, Wis. adm. code.

SUBCHAPTER II

OFFICE OF THE COMMISSIONER OF INSURANCE

601.11 Personnel. (1) DEPUTY COMMISSIONER. (a) *Appointment.* The deputy commissioner shall be appointed subject to ss. 15.04 (2) and (3) and 15.73.

(b) *Acting commissioner.* When the office of commissioner is vacant, or when the commissioner is unable to perform his or her duties because of mental or physical disability, the deputy commissioner shall be acting commissioner. The deputy commissioner shall have such other duties and powers as the commissioner delegates and assigns.

(2) OTHER PERSONNEL. Except for those employed under s. 601.14 (2) or otherwise specifically exempted, all personnel including staff attorneys shall be appointed under the classified service.

History: 1977 c. 418.

601.12 Legal services. (1) LEGAL SERVICES. The attorney general shall allocate personnel as the legal needs of the office demand.

(2) ENFORCEMENT. Upon request of the commissioner, the attorney general shall proceed in any federal or state court or agency to recover any tax or fee related to insurance payable under the laws of this state and not paid when due, and any penalty or forfeiture authorized by chs. 600 to 655. Upon request of the commissioner, the attorney general or, in a proper case, the district attorney of any county, shall aid in any investigation, hearing or other procedure under chs. 600 to 655 and shall institute, prosecute and defend proceedings relating to the enforcement or interpretation of chs. 600 to 655, including any proceeding to which the state, or the insurance commissioner or any employee of the office, in the employee's official capacity, shall be a party or in which the commissioner or the employee is interested.

History: 1975 c. 189; 1977 c. 339 s. 43; 1979 c. 89, 102, 177; 1983 a. 358 s. 14; 1989 a. 187 s. 29.

601.13 Financial services; deposits. (1) RECEIPT OF DEPOSITS. Subject to the approval of the commissioner, the secretary of administration shall accept deposits or control of acceptable book-entry accounts from insurers and other licensees of the office as follows:

- (a) Deposits required or permitted by the laws of this state;
- (b) Deposits of domestic insurers or of alien insurers domiciled in this state if required by the laws of other states as prerequisite to authority to do an insurance business in other states; and
- (c) Deposits resulting from application of any retaliatory provisions.

(2) TERMS OF DEPOSIT. Unless otherwise provided by the law requiring or permitting the deposit, each deposit shall be held in trust: first, for the claimants under s. 645.68 (3); 2nd, for the claimants under s. 645.68 (3c); 3rd, for the claimants under s. 645.68 (3m); 4th, for the claimants under s. 645.68 (4); and thereafter, for all other creditors in the order of priority established by s. 645.68. No claim may be made against the deposit of an alien insurer unless the claim arises out of a transaction in the United States.

(3) SECURITIES ELIGIBLE. All deposits may consist of any of the securities authorized in this subsection. Each security must be approved by the commissioner, must be subject to disposition by the secretary of administration, and must not be available to any other person except as expressly provided by law. The authorized securities are:

- (a) Lawfully authorized bonds or other evidences of indebtedness which are the direct obligation of the United States or Canada or any state or province thereof.
- (b) Lawfully authorized bonds or other evidences of indebtedness which are the direct obligation of any county, city, village, town, school district or other governmental or civil division within the United States or Canada.

(c) Lawfully authorized bonds or other evidences of indebtedness payable from and adequately secured by revenues specifically pledged therefor of the United States or Canada, or of any state or province, or of a commission, board or other instrumentality of one or more of them.

(d) Interest-bearing notes of any savings bank or savings and loan association organized under the laws of this state.

(e) Bonds or other securities of any savings and loan finance corporation organized under the laws of this state.

(f) Investment shares of any savings bank or savings and loan association to the extent that they are or may be insured or guaranteed by the federal government, by the federal deposit insurance corporation or by any other agency of the United States.

(g) Shares of corporations chartered or incorporated under section 5 of the homeowners' loan act of 1933.

(h) Certificates of deposit of any bank organized under the laws of this state or of any national bank located in this state.

(4) VALUATION. Securities held on deposit shall be valued under s. 623.03 for valuation of such investments of life insurers, or at market, whichever is lower.

(5) RECEIPT, INSPECTION, AND RECORD. The secretary of administration shall deliver to the depositor a receipt for all securities deposited or held under the control of the secretary of administration and shall permit the depositor to inspect its physically held securities at any reasonable time. On application of the depositor the secretary of administration shall certify when required by any law of the United States or of any other state or foreign country or by the order of any court of competent jurisdiction that the deposit was made. The secretary of administration and the commissioner shall each keep a permanent record of securities deposited or held under the control of the secretary of administration and of any substitutions or withdrawals and shall compare records at least annually.

(6) TRANSFER OF SECURITIES. No transfer of a deposited security, whether voluntary or by operation of law, is valid unless approved in writing by the commissioner and countersigned by the secretary of administration.

(7) NOT SUBJECT TO LEVY. No judgment creditor or other person shall levy upon any deposit held under this section.

(8) INTEREST AND SUBSTITUTIONS. Subject to s. 16.401 (11), a depositor shall, while solvent and complying with the laws of this state, be entitled:

- (a) To receive interest and cash dividends accruing on the securities held on deposit for its account; and
- (b) To substitute for deposited securities other eligible securities, as expressly approved by the commissioner.

(9) VOLUNTARY EXCESS DEPOSIT. A depositor may deposit eligible securities in excess of requirements to absorb fluctuations in value and to facilitate substitution of securities.

(10) RELEASE OF DEPOSIT. Upon approval of the commissioner, any deposit or part thereof shall be released upon the depositor's request to the extent permitted by law.

(11) ADVANCE DEPOSIT OF FEES. With the approval of the commissioner, any person required to pay fees or assessments to the state through the commissioner may make a deposit with the secretary of administration from which the fees or assessments shall be paid on order of the commissioner not less than twice each year. Upon request by the depositor, any balance remaining shall be returned on the certificate of the commissioner that all fees and assessments have been paid to date.

History: 1971 c. 40 s. 93; 1971 c. 260 s. 92 (6); 1977 c. 203 ss. 102, 103; 1977 c. 339 s. 43; 1979 c. 89, 102, 177; 1991 a. 221; 1999 a. 30; 2003 a. 33.

601.14 Supporting services. (1) OFFICES. The department of administration shall provide suitable premises for the offices of the commissioner of insurance:

- (a) In the city of Madison; and
- (b) Elsewhere, if approved by the governor as necessary for the efficient operation of the office.

3 Updated 15–16 Wis. Stats.

(2) MATERIALS, SUPPLIES, EQUIPMENT AND CONTRACTUAL SERVICES. The department of administration shall provide the office with all materials, supplies, equipment and contractual services necessary for its efficient operation, including reasonable library facilities and books. Part-time or temporary services of professionals and experts shall be provided by the department of administration upon the recommendation of the commissioner, and may be provided without regard to the restrictions of subch. II of ch. 230.

History: 1971 c. 307; 1977 c. 196 s. 131.

601.15 Oath. The deputy commissioner shall take and file the official oath.

601.16 Official seal and signature. (1) SEAL. The commissioner need not have nor use an official seal. Any statutory or common law requirement that an official seal be affixed is satisfied by the signature of the commissioner.

(2) SIGNATURES. Any signature of the commissioner may be in facsimile unless specifically required to be handwritten.

History: 1977 c. 203 s. 103.

601.18 Delegation. Any power, duty or function vested in the commissioner by law may be exercised, discharged or performed by any employee of the office acting in the commissioner's name and by the commissioner's delegated authority. Any person whose own course of action in good faith depends upon proof of the validity of an asserted delegation is not obligated to act until the person is shown a written delegation with a handwritten signature of the commissioner or deputy commissioner.

History: 1979 c. 102.

601.19 Organization of the office. The commissioner shall publish periodically in the Wisconsin administrative code an up-to-date chart and explanation of the organization of the commissioner's office, making clear the allocation of responsibility and authority among the staff.

History: 1979 c. 102 s. 236 (14).

601.20 Advisory councils and committees. (1) AUTHORIZATION TO FORM COUNCILS AND COMMITTEES. The commissioner may create advisory councils and committees under s. 15.04 (1) (c) to assist in dealing with regulatory problems. The commissioner may appoint members and may provide by rule for the creation, governance, duties and termination of any council or committee the commissioner establishes.

History: 1975 c. 372, 375, 421; 1977 c. 196 s. 131; 1979 c. 102, 221.

Cross-reference: See also s. Ins 6.79, Wis. adm. code.

SUBCHAPTER III

FINANCING THE INSURANCE OFFICE

601.31 Fees. (1) Except as provided in sub. (2m), the following fees, unless revised by the commissioner as provided in s. 601.32, shall be paid to the commissioner:

(a) For filing documents for examination preliminary to initial licensing or for any other initial filing of documents required by law as a prerequisite for operating or otherwise providing services in this state, including the filing of articles of incorporation, the first declaration or statement, a certified copy of charter, and others:

1. Domestic and nondomestic insurers, \$400.
2. Rate service organizations, \$400.
3. Motor clubs, \$400.
5. Providers of services under ch. 647, \$100.

(b) For issuing a permit or certificate of authority:

1. Domestic and nondomestic insurers, \$400.
2. Rate service organizations, \$400.
3. Motor clubs, \$400.

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5. Providers of services under ch. 647, \$100.

(c) Annually for continuation of a permit or certificate of authority:

1. Domestic and nondomestic insurers, \$100.
2. Rate service organizations, \$100.
3. Motor clubs, \$100.
5. Providers of services under ch. 647, \$25.

(d) For filing articles of amendment, domestic companies, \$25.

(e) For filing a copy of amendments to the articles of a nondomestic insurer, \$25.

(f) For filing articles of merger, \$100.

(g) For filing a copy of articles of merger of a nondomestic insurer, other than with a domestic corporation, \$25.

(h) For filing an application by a nondomestic insurer for amended certificate of authority to transact business in this state, \$25.

(i) For filing an application to reserve a corporate name, \$25.

(j) For filing a notice of transfer of a reserved corporate name, \$25.

(k) For filing an annual statement:

1. Domestic and nondomestic insurers, \$100.
2. Rate service organizations, \$100.
3. Motor clubs, \$100.
5. Providers of services under ch. 647, \$25.

6. Domestic mutual insurance holding companies, \$100.

(km) For processing and maintaining registration records under s. 100.203 (2), a fee to be set by the commissioner by rule but not to exceed \$250 annually.

(kr) For processing and maintaining license records under s. 616.54 (4), \$400 upon initial licensure and \$100 annually thereafter, unless the commission specifies a different amount by rule.

(L) For issuing or enlarging the scope of a license, amounts to be set by the commissioner by rule but not to exceed:

2. Corporation, limited liability company or partnership intermediary, \$100; and
3. Licensees authorized to place business under s. 618.41, \$100.

(Lg) For filing an original electronic resident intermediary license application following successful completion of any required prelicensing education or examination under s. 628.04, \$10.

(Lp) For certifying as an independent review organization under s. 632.835, \$400.

(Lr) For each biennial recertification as an independent review organization under s. 632.835, \$100.

(m) For regulating resident intermediaries and nonresident intermediaries, annually after the year in which the initial license is issued, amounts to be set by the commissioner by rule and paid at times and under procedures set by the commissioner.

(mc) For regulating a holder of a license to place business under s. 618.41, annually after the year in which the initial license is issued, an amount to be set by the commissioner by rule and paid at times and under procedures set by the commissioner, but not to exceed \$100.

(mm) For initial issuance of a license as a provider under s. 632.69 (2) (b), \$750.

(mp) For each annual renewal of a license as a provider under s. 632.69 (2) (j), \$250.

(mr) For initial issuance of a license as a broker under s. 632.69 (2) (b), \$750.

(ms) For each annual renewal of a license as a broker under s. 632.69 (2) (j), \$250.

(n) For appointing, or renewing an appointment of, an agent under s. 628.11, \$16 annually for resident agents or \$30 annually for nonresident agents, unless the commissioner sets a higher fee

by rule, to be paid at times and under procedures set by the commissioner.

NOTE: Par. (n) is shown as amended eff. 1–1–19 by 2017 Wis. Act 59. Prior to 1–1–19 it reads:

(n) For appointing, or renewing an appointment of, an agent under s. 628.11, \$16 annually for resident agents or \$40 annually for nonresident agents, unless the commissioner sets a higher fee by rule, to be paid at times and under procedures set by the commissioner.

(nm) For issuing a license as an individual navigator under s. 628.92 (1), unless the commissioner specifies a different amount by rule:

1. Initial issuance, \$75.
2. Annual renewal, \$35.

(np) For registering as a navigator entity under s. 628.92 (2), unless the commissioner specifies a different amount by rule:

1. Initial registration, \$100.
2. Annual renewal, \$100.

(o) For examination of an applicant for a license as an insurance intermediary, an amount to be set by the commissioner by rule.

(p) For substituted service of process on the commissioner under s. 601.72, \$10.

(q) For a copy of a paper filed in the commissioner's office, actual cost.

(r) For preparation and furnishing of lists of insurers or intermediaries, actual cost.

(t) For filing documents for examination preliminary to initial listing by the commissioner for surplus lines insurance under s. 618.41 (6) (d), \$100.

(tc) For each annual listing by the commissioner for surplus lines insurance under s. 618.41 (6) (d), \$500.

(w) For initial issuance and for each annual renewal of a license as an administrator under ch. 633, \$100.

(x) 1. For issuing approval to an organization to offer prelicensing or continuing education courses or programs for intermediaries under s. 628.04 (3), a fee to be set by the commissioner by rule, but not to exceed \$500.

2. By organizations approved under subd. 1., for renewing the approval of such organizations, annually after the year in which the approval under subd. 1. is issued, an amount to be set and paid at times and under procedure set by the commissioner by rule, but not to exceed \$100.

3. By organizations approved under subd. 1., for submitting, for initial approval or approval of any subsequent modification, each course for prelicensing or continuing education, a fee to be set by the commissioner by rule, but not to exceed \$25 per credit hour.

(y) 1. For certifying a copy of an annual statement, an examination report, a certificate of authority or articles and bylaws, or amendments to any of those documents, \$10.

2. For a duplicate certification that is requested at the same time as the certification under subd. 1., \$5.

(2) Town mutuals and insurers operating under subch. I of ch. 616 are exempt from all provisions of this section except sub. (1) (b), (c) and (q).

(2m) An individual who is eligible for the veterans fee waiver program under s. 45.44 is not required to pay a fee under sub. (1) for the issuance to the individual of any license, certificate, or permit specified in sub. (1).

(3) The commissioner may not increase fees under sub. (1) (m) above the amounts in effect on March 25, 1988, except for the purpose of funding projected expenses for the office's supervision of the insurance industry.

History: 1971 c. 40 s. 93; 1971 c. 125, 260, 307; 1975 c. 223, 371, 373, 374, 421; 1979 c. 102 ss. 63 to 65, 237; 1979 c. 261, 355; 1981 c. 20 ss. 1739 to 1748, 2202 (26) (a); 1981 c. 38, 314; 1983 a. 358; 1985 a. 29; 1987 a. 27, 166; 1989 a. 31; 1991 a. 39; 1993 a. 112; 1995 a. 27, 371, 396; 1999 a. 9, 155; 2003 a. 261, 302; 2007 a. 169; 2009 a. 28, 342, 344; 2011 a. 209, 226; 2013 a. 20, 271; 2017 a. 59.

Legislative Council Note on sub. (2), 1979: In addition to some editorial corrections, this provision has been amended to apply s. 601.31 (2) [(1) (b)] and (3) [(1) (c)]

to former ch. 185 insurers, now operating under subch. I of ch. 616. It also applies s. 601.31 (2) [(1) (b)] and (3) [(1) (c)] to town mutuals. The exemption of fraternal in sub. (25) from certain fees is not justified and is deleted. [Bill 21–S]

601.32 Supervision of industry, supplementary fee.

(1) If the moneys credited to s. 20.145 (1) (g) 1. under other sections of the statutes prove inadequate for the office's supervision of insurance industry program, the commissioner may increase any or all of the fees imposed by s. 601.31, or may in any year levy a special assessment on all domestic insurers, or both, for the general operation of that program.

(2) Any special assessment shall be in addition to all other taxes, fees, dues and charges and shall not exceed for any such company a maximum of 25 cents per \$1,000 of gross premiums received by it during the preceding calendar year on direct insurance in this state, less returned premiums and cancellations.

(3) Any assessment made by the commissioner which is less than the maximum shall be prorated among said companies in the same proportion as if it were a maximum assessment. Any such assessment shall be paid to the commissioner on or before July 31 of each year.

(4) The commissioner may omit the levy of any assessment which would be smaller than the cost of processing and collecting it.

History: 1975 c. 372 s. 41; 1977 c. 339; 1979 c. 102 ss. 66, 236 (4); 1983 a. 215; 2007 a. 20.

601.33 Exemption from taxation. Municipal insurance mutuals organized under s. 611.11 (4) are not subject to any taxes or fees except those imposed by ss. 601.31 and 601.32.

History: 1977 c. 346.

SUBCHAPTER IV

POWERS AND DUTIES OF COMMISSIONER

601.41 General duties and powers. (1) **DUTIES.** The commissioner shall administer and enforce chs. 600 to 655 and ss. 59.52 (11) (c), 66.0137 (4) and (4m), 100.203, and 120.13 (2) (b) to (g) and shall act as promptly as possible under the circumstances on all matters placed before the commissioner.

(2) **POWERS.** The commissioner shall have all powers specifically granted to the commissioner, or reasonably implied in order to enable the commissioner to perform the duties imposed by sub. (1).

(3) **RULES.** (a) The commissioner shall have rule-making authority under s. 227.11 (2).

(b) The commissioner may, without the consent of the attorney general as required under s. 227.21 (2), adopt standards of the National Association of Insurance Commissioners by incorporating by reference in rules promulgated by the commissioner any materials published, adopted, or approved by the National Association of Insurance Commissioners, without reproducing the standards in full. The standards referred to in this paragraph do not include any model act or model regulation proposed or adopted by the National Association of Insurance Commissioners. Any materials of the National Association of Insurance Commissioners that are incorporated by reference in rules promulgated by the commissioner shall be obtainable from, and are only required to be kept on file at, the office, which shall be stated in any rule containing such an incorporation by reference. Nothing in this paragraph prohibits the commissioner from adopting standards of the National Association of Insurance Commissioners through incorporation by reference in rules in the manner provided under s. 227.21 (2).

(4) **ENFORCEMENT PROCEEDINGS.** (a) The commissioner shall issue such prohibitory, mandatory, and other orders as are necessary to secure compliance with the law. An order requiring remedial measures or restitution may include any of the following:

1. Remedial measures or restitution under s. 628.347 (5).

5 Updated 15–16 Wis. Stats.

2. Remedial measures or restitution to enforce s. 611.72 or ch. 617, including seizure or sequestering of voting securities of an insurer owned directly or indirectly by a person who has acquired or who is proposing to acquire voting securities in violation of s. 611.72 or ch. 617.

(b) On request of any person who would be affected by an order under par. (a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

(5) **INFORMAL HEARINGS AND PUBLIC MEETINGS.** The commissioner may at any time hold informal hearings and public meetings, whether or not called hearings, for the purposes of investigation, the ascertainment of public sentiment, or informing the public. No effective rule or order may result from the hearing unless the requirements of ch. 227 are satisfied.

(6) **REGULATION OF RISK RETENTION GROUPS AND RISK PURCHASING GROUPS.** (a) The commissioner may by rule regulate the condition and conduct of risk retention groups and risk purchasing groups doing business in this state. The commissioner may by order prohibit a risk retention group or risk purchasing group from doing business in this state.

(b) The regulation of risk retention groups and risk purchasing groups under ss. 601.72, 618.41, 618.415, 618.43, 628.02, 628.03 and 628.48 is in addition to any other provisions of chs. 600 to 655 which apply to risk retention groups or risk purchasing groups and does not authorize a risk retention group or risk purchasing group to do an insurance business except as permitted under chs. 600 to 655.

(7) **INFORMATION AND TECHNICAL ASSISTANCE TO EMPLOYEES AND FORMER EMPLOYEES WHO LOSE HEALTH CARE COVERAGE.** The commissioner shall provide to employees and former employees who lose health care coverage under a group health insurance plan or self-insured health plan information and technical assistance regarding all of the following:

(a) Any rights that the individuals may have under state or federal laws affecting health benefit plans, including laws that relate to portability or continuation coverage or conversion coverage under s. 632.897.

(b) The availability of individual health benefit plans in the area in which the individual resides.

(8) **UNIFORM EMPLOYEE APPLICATION FORM.** (a) In this subsection:

1. "Group health benefit plan" has the meaning given in s. 632.745 (9).

2. "Small employer" has the meaning given in s. 635.02 (7).

3. "Small employer insurer" has the meaning given in s. 635.02 (8).

(b) In consultation with the appropriate advisory council or committee designated by the commissioner, the commissioner shall by rule develop a uniform employee application form that a small employer insurer must use when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer. The commissioner shall revise the form at least every 2 years.

(9) **UNIFORM CLAIM PROCESSING FORM.** (a) In this subsection, "health care provider" has the meaning given in s. 146.81 (1) (a) to (p).

(b) If the federal government has not developed by July 1, 2003, a uniform claim processing form that must be used by all health care providers for submitting claims to insurers and by all insurers for processing claims submitted by health care providers, the commissioner shall develop, by December 31, 2003, a uniform claim processing form for that purpose.

(10) **UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.** (a) The commissioner shall by rule prescribe uniform questions and the format for applications, which may not exceed 10 pages in length, for individual major medical health insurance policies.

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(b) After the effective date of the rules promulgated under par. (a), an insurer may use only the prescribed questions and format for individual major medical health insurance policy applications. The commissioner shall publish a notice in the Wisconsin Administrative Register that states the effective date of the rules promulgated under par. (a).

(c) For purposes of this subsection, an individual major medical health insurance policy includes health coverage provided on an individual basis through an association.

(11) **PRELICENSING TRAINING.** (a) In this subsection:

1. "Instruction" means education, training, instruction, or other experience related to an occupation or profession.

2. "License" means a license, certificate, or permit issued by the commissioner under chs. 601 to 655 for an occupation or profession.

(b) In connection with the issuance of a license, the commissioner shall count any relevant instruction that an applicant for a license has obtained in connection with military service, as defined in s. 111.32 (12g), toward satisfying any requirements for instruction for that license, if the applicant demonstrates to the satisfaction of the commissioner that the instruction obtained by the applicant is substantially equivalent to the instruction required for the license.

History: 1977 c. 339 s. 43; 1979 c. 89, 102, 177; 1983 a. 358 s. 14; 1985 a. 29; 1985 a. 182 s. 57; 1987 a. 247; 1989 a. 187 s. 29; 1989 a. 201, 336; 1991 a. 39; 1993 a. 16; 1995 a. 201; 1997 a. 27, 51, 252; 1999 a. 150 s. 672; 2001 a. 16, 65, 109; 2003 a. 261, 302; 2005 a. 74, 249; 2007 a. 170; 2009 a. 28; 2011 a. 120; 2013 a. 20.

Cross-reference: See also *Ins.*, Wis. adm. code.

Sub. (4) gives the commissioner the authority to issue not only prohibitory and mandatory orders, but also other orders as are necessary to secure compliance with the law. There is no limitation on the nature of the other orders except that they be necessary to secure compliance with the law. Sub. (4) permitted the order of refunds when the commissioner determined that a company violated the law by selling its contracts without a certificate of authority. *Homeward Bound Services, Inc. v. Office of the Insurance Commissioner*, 2006 WI App 208, 296 Wis. 2d 481, 724 N.W. 2d 380, 05–1781.

Why process consumer complaints? A case study of the office of the commissioner of insurance of Wisconsin. Whitford, Kimball, 1974 WLR 639.

601.415 Miscellaneous duties. The duties listed in this section are in addition to other duties imposed under chs. 600 to 655. Failure to list a specified power, duty or function of the commissioner in this section does not affect the validity of the power, duty or function.

(1) **JOINT SURVEY COMMITTEE ON RETIREMENT SYSTEMS.** The commissioner or an experienced actuary in the office designated by the commissioner shall serve as a member of the joint survey committee on retirement systems under s. 13.50.

(2) **GROUP INSURANCE BOARD.** The commissioner shall serve as a member of the group insurance board under s. 15.165 (2).

(3) **WISCONSIN RETIREMENT BOARD.** The commissioner or an experienced actuary in the office designated by the commissioner shall serve as a member of the Wisconsin retirement board under s. 15.165 (3) (b).

(5) **COOPERATION WITH DEPARTMENT OF ADMINISTRATION.** The commissioner shall cooperate with the department of administration in placing insurance under s. 16.865 (4).

(7) **DETERMINATION OF VARIABLE INTEREST RATE ADJUSTMENTS.** The commissioner shall approve indexes for variable interest rate adjustments under s. 138.055 (4) (c).

(8) **LONG-TERM CARE PARTNERSHIP PROGRAM.** The commissioner shall provide the certifications required under s. 49.45 (31) (b) 5. and shall cooperate with the department of health services in approving the training program under s. 49.45 (31) (c) for agents who sell long-term care insurance policies.

(9) **CONSUMER CREDIT LAW.** The commissioner shall cooperate with the division of banking in the administration of ch. 424, shall determine the method for computation of refunds under s. 424.205, shall approve forms, schedules of premium rates and charges under s. 424.209 and shall issue rules or orders of compliance to insurers under s. 424.602.

(10) PETROLEUM PRODUCT STORAGE REMEDIAL ACTION PROGRAM RULES. The commissioner shall promulgate the rules required under s. 292.63 (1m).

(11) AMENDMENTS TO OWN RISK AND SOLVENCY ASSESSMENT GUIDANCE MANUAL. The commissioner shall, in his or her discretion, adopt amendments made after April 18, 2014, by the National Association of Insurance Commissioners to the guidance manual, as defined in s. 622.03 (1). Any such amendments made by the National Association of Insurance Commissioners become effective in this state if adopted by the commissioner by order after giving 30 days' notice to insurers of the changes proposed by the National Association of Insurance Commissioners. If one or more insurers request a hearing on the proposed changes during the 30-day period, the commissioner shall hold a hearing to determine whether the commissioner will, in his or her discretion, adopt one or more of the changes made by the National Association of Insurance Commissioners.

(12) HEALTH INSURANCE RISK-SHARING PLAN. The commissioner shall perform the duties specified to be performed by the commissioner in s. 149.13, 2011 stats., and under 2013 Wisconsin Act 20, section 9122 (1L) (b) 8.

(13) MEMBERSHIP IN THE NATIONAL CONFERENCE OF INSURANCE LEGISLATORS. Annually, from the appropriation account under s. 20.145 (1) (g), the commissioner shall credit to the appropriation account under s. 20.765 (3) (g) an amount sufficient for the payment of annual dues by the legislature for membership in the National Conference of Insurance Legislators.

History: 1979 c. 102; 1981 c. 96, 314; 1983 a. 358 s. 14; 1985 a. 256; 1987 a. 27, 47, 247; 1989 a. 31; 1989 a. 187 s. 29; 1991 a. 243; 1995 a. 27, 462; 1997 a. 27; 2005 a. 74, 316; 2007 a. 20 ss. 3652m, 9121 (6) (a); 2009 a. 342; 2013 a. 20, 279; 2017 a. 59.

601.42 Reports and replies. (1g) REPORTS. The commissioner may require any of the following from any person subject to regulation under chs. 600 to 655:

(a) Statements, reports, answers to questionnaires and other information, and evidence thereof, in whatever reasonable form the commissioner designates, and at such reasonable intervals as the commissioner chooses, or from time to time.

(b) Full explanation of the programming of any data storage or communication system in use.

(c) That information from any books, records, electronic data processing systems, computers or any other information storage system be made available to the commissioner at any reasonable time and in any reasonable manner.

(d) Statements, reports, answers to questionnaires or other information, or reports, audits or certification from a certified public accountant or an actuary approved by the commissioner, relating to the extent liabilities of a health maintenance organization insurer are or will be liabilities for health care costs for which an enrollee or policyholder of the health maintenance organization is not liable to any person under s. 609.91.

(1r) REPORTS BY INDIVIDUAL PRACTICE ASSOCIATIONS. The commissioner may by rule require that an individual practice association submit to the commissioner information reasonably necessary to determine the financial condition of the individual practice association. The information required under this subsection may include, but is not limited to, financial statements of the individual practice association, except the commissioner may not require members of the individual practice association or other health care providers who contract with the individual practice association to submit individual financial statements.

(2) FORMS. The commissioner may prescribe forms for the reports under subs. (1g) and (1r) and specify who shall execute or certify such reports. The forms for the reports required under sub. (1g) shall be consistent, so far as practicable, with those prescribed by other jurisdictions.

(3) ACCOUNTING METHODS. The commissioner may prescribe reasonable minimum standards and techniques of accounting and

data handling to ensure that timely and reliable information will exist and will be available to the commissioner.

(4) REPLIES. Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), any independent review organization certified or recertified under s. 632.835 (4) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

(5) VERIFICATION. The commissioner may require that any communication made to the commissioner under this section be verified.

(6) IMMUNITY. (a) In the absence of actual malice, no communication to the commissioner required by law or by the commissioner shall subject the person making it to an action for damages for defamation. This paragraph applies to communications received by the commissioner before May 11, 1990, or on or after June 1, 1994.

(b) In the absence of actual malice, no communication to the commissioner or office required by law or by the commissioner shall subject the person making it to an action for damages for the communication. This paragraph applies to communications received by the commissioner or office on or after May 11, 1990, and before June 1, 1994.

(7) EXPERTS. The commissioner may employ experts to assist the commissioner in an examination or in the review of any transaction subject to approval under chs. 600 to 646. The person that is the subject of the examination, or that is a party to a transaction under review, including the person acquiring, controlling or attempting to acquire the insurer, shall pay the reasonable costs incurred by the commissioner for the expert and related expenses.

History: 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 69, 236 (8), (21); 1979 c. 177; 1983 a. 358 ss. 9, 14; 1987 a. 247; 1989 a. 23; 1989 a. 187 ss. 1m, 29; 1989 a. 332; 1991 a. 316; 1997 a. 237; 1999 a. 30, 155.

Cross-reference: See also s. 623.02 as to standards for accounting rules.

Cross-reference: See also ss. Ins 6.61, 6.62, and 6.63, Wis. adm. code.

601.423 Social and financial impact reports. (1) DEFINITION. In this section, "health insurance mandate" means a statute of this state that does any of the following:

(am) Requires an insurance policy, plan, or contract to do any of the following:

1. Permit a person insured under the policy, plan or contract to obtain treatment or services from a particular type of health care provider, including, but not limited to, requiring a health maintenance organization, preferred provider plan, limited service health organization or other plan to select a particular type of health care provider for participation in the plan.

2. Provide coverage for the treatment of a particular disease, condition or other health care need.

3. Provide coverage of a particular type of health care treatment or service, or of equipment, supplies or drugs used in connection with a health care treatment or service.

4. Provide coverage for particular persons because of their relation to the insured or legal status with respect to the insured, or for any other reason.

(bm) Requires a particular benefit design or imposes conditions on cost sharing under an insurance policy, plan, or contract for the treatment of a particular disease, condition, or other health care need, for a particular type of health care treatment or service, or for the provision of equipment, supplies, or drugs used in connection with a health care treatment or service.

(cm) Imposes limits or conditions on a contract between an insurer and a health care provider, as defined in s. 146.81 (1).

(2) PREPARATION OF REPORT. (a) Subject to par. (b), the office shall submit a report on the social and financial impact of any health insurance mandate contained in any bill or amendment affecting an insurance policy, plan, or contract, or, if the office decides not to submit a report, a written statement explaining the reason for not preparing the report, to the chief clerk of the house of the legislature in which the bill or amendment is introduced or offered.

(b) 1. The office shall submit the report or written statement for a bill within 10 working days after receiving the copy of the bill from the legislative reference bureau under s. 13.0966 (2) (b).

2. The office shall submit the report or written statement within 10 working days after receiving a copy of the amendment from the legislative reference bureau under s. 13.0966 (2) (b). The office is not required to prepare or submit a report or written statement for an amendment if, by the end of the next business day after receiving a copy of the amendment from the legislative reference bureau, the amendment has failed adoption or failed to be reported out of committee.

(3) CONTENTS OF REPORT. (a) *Social impact factors.* Any report prepared under sub. (2) shall assess to the extent possible all of the following social impact factors that are relevant to the type of health insurance mandate created, expanded, or continued by the bill or amendment:

1. The portion of this state's residents who use the treatments or services covered by the health insurance mandate.

2. The extent to which individuals under subd. 1. use these treatments or services.

3. The availability of insurance coverage for these treatments or services.

4. The number of persons who would be eligible for coverage under the health insurance mandate, and the availability of insurance coverage for these persons without the health insurance mandate.

(b) *Financial impact factors.* Any report prepared under sub. (2) shall assess to the extent possible all of the following financial impact factors that are relevant to the type of health insurance mandate created, expanded, or continued by the bill or amendment:

1. Whether the health insurance mandate may increase or decrease the costs of the treatments or services covered by the health insurance mandate.

2. Whether the health insurance mandate would increase the use of the treatments or services covered by the health insurance mandate.

3. Whether any increased use under subd. 2. would substitute for more expensive treatments or services.

4. The impact of the health insurance mandate on total costs of health care in this state.

5. Whether the health insurance mandate may increase the administrative costs to insurance companies and the premium costs to policyholders.

History: 1987 a. 177; 2015 a. 288; 2017 a. 239.

601.43 Examinations and alternatives. (1) POWER TO EXAMINE. (a) *Insurers, other licensees and other persons subject to regulation.* Whenever the commissioner deems it necessary in order to inform himself or herself about any matter related to the enforcement of chs. 600 to 647, the commissioner may examine the affairs and condition of any licensee or permittee under chs. 600 to 647 or applicant for a license or permit, of any person or organization of persons doing or in process of organizing to do an insurance business in this state, and of any advisory organization serving any of the foregoing in this state.

(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 of the following:

1. An officer, manager, general agent, employee, or person who has executive authority over or is in charge of any segment of the examinee's affairs.

2. A person controlling or having a contract under which the person has the right to control the examinee whether exclusively or with others.

3. A person who is under the control of the examinee, or a person who is under the control of a person who controls or has a right to control the examinee whether exclusively or with others.

4. An individual practice association which contracts with the examinee to provide health care services.

(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). Failure to do so shall be deemed to be concealment of records under s. 645.41 (8), except that if the examinee is unable to obtain accounts, records, documents or evidences of transactions, failure shall not be deemed concealment if the examinee terminates immediately the relationship with the other person.

(d) *Delivery of records to the office.* On order of the commissioner any licensee or permittee under chs. 600 to 647 shall bring to the office for examination such records as the order reasonably requires.

(2) DUTY TO EXAMINE. (a) *Insurers and rate service organizations.* The commissioner shall examine every domestic insurer and every licensed rate service organization.

(b) *On request.* Whenever the commissioner is requested by verified petition signed by 25 persons interested as shareholders, policyholders or creditors of an insurer alleging that there are grounds for formal delinquency proceedings, the commissioner shall forthwith examine the insurer as to any matter alleged in the petition. Whenever the commissioner is requested to do so by the board of directors of a domestic insurer, the commissioner shall examine the insurer as soon as reasonably possible.

(c) *Specific requirements.* The commissioner shall examine insurers as otherwise required by law.

(3) AUDITS OR ACTUARIAL OR OTHER 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 an actuarial or other evaluation by actuaries or other experts approved by the commissioner of any person subject to the examination requirement. Any accountant, actuary or other expert selected is subject to rules respecting conflicts of interest promulgated by the commissioner. Any audit or evaluation under this section is subject to s. 601.44, 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 of an actuarial or other evaluation already made by actuaries or other experts approved by the commissioner, or the report of an examination made by the insurance department of another state or of the examination by another government agency in this state, the federal government or 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 doing business, the length of time the examinee has been licensed in this state, the nature of the business being examined, the nature of the account-

ing records available and the nature of examinations performed elsewhere. The examination of an alien insurer shall be limited to insurance transactions and assets in the United States unless the commissioner orders otherwise after finding that extraordinary circumstances necessitate a broader examination.

History: 1977 c. 203; 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 70, 71, 236 (6), (9); 1979 c. 177; 1981 c. 20; 1983 a. 358; 1985 a. 29; 1987 a. 247; 1989 a. 23; 1999 a. 30.

601.44 Conducting examinations. (1) ORDER OF EXAMINATION. For each examination under s. 601.43, 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.

(2) 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 s. 601.43 (1) (b) so far as they relate to the affairs of the examinee.

(3) COOPERATION. The officers, employees and agents of the examinee and of persons under s. 601.43 (1) (b) shall comply with every reasonable request of the examiners for assistance in any matter relating to the examination. No person may obstruct or interfere with the examination in any way other than by legal process.

(4) 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, the commissioner may employ experts to rewrite, post or balance them at the expense of the examinee.

(5) 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. (1), together with the examiner's recommendations. Preparation of the proposed report may include conferences with the examinee or the examinee's representatives at the option of the examiner in charge. The proposed report shall remain confidential until filed under sub. (6).

(6) 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 the commissioner shall order a new examination.

(7) 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.

(8) COPIES FOR BOARD. The examinee shall forthwith furnish copies of the adopted report to each member of its board.

(9) COPIES FOR OTHER PERSONS. The commissioner may furnish, without cost or at a price to be determined by the commissioner, 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 authorized to do business, and to any other interested person in this state or elsewhere.

(10) 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 commenced under ch. 645, the examination report whether adopted by the commissioner or not 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.

History: 1977 c. 203 s. 102; 1979 c. 102 ss. 72, 236 (6), (17); 1991 a. 316.

Cross-reference: See also ch. Ins 5, Wis. adm. code.

601.45 Examination costs. (1) COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations and audits under ss. 601.43, 601.44, and 601.83 (5) (f) shall be paid by examinees except as provided in sub. (4), either on the basis of a system of billing for actual salaries and expenses of examiners and other apportionable expenses, including office overhead, or by a system of regular annual billings to cover the costs relating to a group of companies, or a combination of such systems, as the commissioner may by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The commissioner shall schedule annual hearings under s. 601.41 (5) to review current problems in the area of examinations.

(2) DUTY TO PAY. The amount payable under sub. (1) shall become due 10 days after the examinee has been served a detailed account of the costs.

(3) DEPOSIT. The commissioner may require any examinee, before or from time to time during an examination, to deposit with the secretary of administration such deposits as the commissioner deems necessary to pay the costs of the examination. Any deposit and any payment made under subs. (1) and (2) shall be credited to the appropriation account under s. 20.145 (1) (g) 1.

(4) EXEMPTIONS. On the examinee's request or on the commissioner's own motion, the commissioner may pay all or part of the costs of an examination from the appropriation under s. 20.145 (1) (g) 1., whenever the commissioner 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 or her annual report information about any instance in which the commissioner applied this subsection.

(5) RETALIATION. Deposits and payments under this section 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.

History: 1977 c. 29; 1979 c. 102; 1981 c. 20; 2003 a. 33; 2007 a. 20; 2011 a. 32; 2017 a. 138.

Cross-reference: See also s. Ins 16.01, Wis. adm. code.

601.46 Commissioner's records and reports.

(1) RECORD MAINTENANCE. The commissioner shall maintain the records required by law and those necessary to provide for the continued effective operation of the office, to constitute an adequate and proper recording of its activities and to protect the rights of the people of this state. The records shall be preserved in the office except as provided in s. 16.61.

(2) RECORD OF PROCEEDINGS AND ACTIVITIES. The commissioner shall maintain a permanent record of proceedings and important activities, including a concise statement of the condition of each insurer visited or examined, and including a record of all certificates of authority and licenses issued.

(3) ANNUAL REPORTS. Prior to September 1 of each year, the commissioner shall submit a report to the governor and to the chief clerk of each house of the legislature, for distribution to the legislature under s. 13.172 (2), which shall include, for the preceding calendar year:

(a) The chart and explanation prepared under s. 601.19;

(b) A general review of the insurance business in this state, including a report on emerging regulatory problems, developments and trends;

(c) A summary of the complaints made to or processed by the office about insurers, agents and others connected with insurance, and information about their disposition;

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(d) A summary of rules promulgated and circular letters distributed;

(e) A list of all insurers authorized to do business in this state during the year, with appropriate and useful information concerning them; including a list of insurers organized, admitted, merged or withdrawn;

(f) A list of all revocations of licenses or certificates of authority and the reasons therefor;

(g) The changes made in chs. 600 to 655;

(h) A summary of receipts and expenses, including the information required to be included by s. 601.45 (4);

(i) The kind and amount of insurance carried in all state insurance funds under chs. 604 to 607 together with the amount of premiums collected, the source and nature of any other income, and the disbursements made. The report shall state separately the premiums, losses, the kind and amount of insurance carried on state property, and on other than state property; and

(j) Such other information on the general conduct and condition of insurers doing business in this state as the commissioner or the governor deems necessary or as is prescribed by law.

(4) PUBLIC INSPECTION. All records and reports shall be open to public inspection unless specifically otherwise provided by statute or by rule.

(5) COPIES OF RECORDS. The commissioner shall provide to any person on request certified or uncertified copies of any record in the department that is open to public inspection.

(6) AUDITS. The commissioner shall reimburse the legislative audit bureau for the cost of audits required to be performed under s. 13.94 (1) (de).

History: 1971 c. 40 ss. 82, 93; 1973 c. 117; 1975 c. 41 s. 52; 1977 c. 339 s. 43; 1979 c. 89, 102, 221; 1981 c. 20 s. 2202 (26) (c); 1983 a. 358 s. 14; 1987 a. 186; 1989 a. 187 s. 29; 1993 a. 16.

601.465 Nondisclosure of information. (1m) TYPES OF INFORMATION. The office may refuse to disclose and may prevent any other person from disclosing any of the following:

(a) Testimony, reports, records and information that are obtained, produced or created in the course of an inquiry under s. 601.42.

(b) Except as provided in s. 601.44 (6) to (10), testimony, reports, records and information that are obtained, produced or created in the course of an examination under s. 601.43.

(c) Testimony, reports, records, communications, and information that are obtained by the office from, or provided by the office to, any of the following, under a pledge of confidentiality or for the purpose of assisting or participating in monitoring activities or in the conduct of an inquiry, investigation, or examination:

1. The National Association of Insurance Commissioners.
2. An agent or employee of the National Association of Insurance Commissioners.
3. The insurance commissioner of another state.
4. An agent or employee of the insurance commissioner of another state.
5. An international, federal, state or local regulatory or law enforcement agency.
6. An agent or employee of an agency described in subd. 5.
7. Members of a supervisory college described in s. 617.215.
8. The International Association of Insurance Supervisors.
9. An agent or employee of the International Association of Insurance Supervisors.

(d) Biographical data reported under s. 611.54 (1) relating to directors or principal officers of a corporation.

(1n) PRESUMPTION OF CONFIDENTIALITY. (a) Notwithstanding sub. (1m) and subch. II of ch. 19, it is presumed that nonpublic documents and information provided by an insurer to the office under s. 601.42 or 601.43 are proprietary and confidential and that the potential for harm and competitive disadvantage to the insurer

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if the documents and information are made public by the office outweighs the public interest in the disclosure of the documents and information.

(b) With notice to the insurer, the presumption under par. (a) may be rebutted by the requesting party presenting clear and convincing evidence to a court of competent jurisdiction that the public interest in the disclosure of the documents and information substantially outweighs the potential for harm or competitive disadvantage to the insurer if the documents and information are disclosed and that the public interest concerns cannot be addressed without the disclosure of the documents and information. If the presumption under par. (a) is successfully rebutted, disclosure of the documents and information shall be made only to the extent necessary to protect the public interest.

(c) Paragraph (a) does not apply to the commissioner's discretion to disclose documents and information provided by an insurer to the office under s. 601.42 or 601.43 as a part of an enforcement proceeding the commissioner brings under s. 601.64.

(2m) WAIVER AND APPLICABILITY OF THE PRIVILEGE. All of the following apply to the privilege under this section:

(a) The privilege may be waived only by the affirmative written and specific consent of the commissioner.

(b) The privilege may not be constructively waived.

(c) The privilege applies to testimony, reports, records, communications, and information obtained, created, or provided by any official, employee, or agent of the office for the purpose of assisting or participating in monitoring activities or in the conduct of an inquiry, investigation, or examination by, or coordinated through, the National Association of Insurance Commissioners.

(d) The privilege applies to testimony, reports, records, communications, and information in existence on or after April 9, 2008.

(e) Privileged information is not subject to inspection or copying under s. 19.35 (1).

(f) Privileged information is not subject to subpoena or discovery and is not admissible as evidence in any private civil action.

(g) The commissioner may not be compelled to testify concerning privileged information in any private civil action.

(h) No person, while acting under the authority of the commissioner, may testify concerning privileged information in any private civil action.

(i) The privilege is not waived as a result of the commissioner sharing information as authorized under sub. (1m).

(3) EXCEPTIONS. This section does not apply to any of the following:

(a) Own risk and solvency assessment reports and related information provided by an insurer under ch. 622, which are subject only to the confidentiality provisions in ch. 622.

(b) Enterprise risk filing and any related information provided by an insurer under rules promulgated under s. 617.12, which are not subject to subch. II of ch. 19 and are subject only to any confidentiality provisions of rules promulgated under s. 617.12.

(c) Reports of internal control over financial reporting and any related information provided by an insurer under s. Ins 50.17, Wis. Adm. Code, which are not subject to subch. II of ch. 19 and are subject only to the confidentiality provisions of s. Ins 50.17 (6) (b), Wis. Adm. Code.

(d) Any information defined as confidential information under s. 623.06 (12) (am), which is subject only to the confidentiality provisions in s. 623.06 (12).

(e) All information protected under s. 610.80 (4), including the corporate governance annual disclosures and related information,

which is subject only to the confidentiality provisions in s. 610.80 (4).

History: 1991 a. 269; 1999 a. 30; 2003 a. 261; 2007 a. 170; 2013 a. 279; 2015 a. 90; 2017 a. 313; s. 35.17 correction in (3) (e).

Cross-reference: See also s. [Ins 6.13](#), Wis. adm. code.

601.47 Publications. (1) **GENERAL.** The commissioner may prepare books, pamphlets, and other publications relating to insurance and sell them in the manner and at the prices the commissioner determines. The cost of publication and distribution may be paid from the appropriation under s. 20.145 (1) (g) 1.

(2) **ANNUAL REPORT.** The commissioner shall determine the form for the report required in s. 601.46 (3) and shall have the report published in sufficient quantity to meet all requests for copies. The commissioner shall distribute copies upon request to any person who pays the price determined for the report under sub. (1).

(3) **FREE DISTRIBUTION.** The commissioner may furnish free copies of the publications prepared under subs. (1) and (2) to public officers and libraries in this state and elsewhere. The cost of free distribution shall be charged to the appropriation under s. 20.145 (1) (g) 1.

History: 1971 c. 125; 1979 c. 102 ss. 75, 236 (6); 2001 a. 16; 2007 a. 20.

601.48 Participation in organizations. (1) **NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.** The commissioner and the office of the commissioner shall maintain close relations with the commissioners of other states and shall participate in the activities and affairs of the National Association of Insurance Commissioners and other organizations so far as it will, in the judgment of the commissioner, enhance the purposes of chs. 600 to 655. The actual and necessary expenses incurred thereby shall be reimbursed out of the appropriation under s. 20.145 (1) (g) 1.

(2) **CONSULTATION IN REGULATION.** The commissioner may exchange information and data and consult with other persons in order to improve and carry out insurance regulation.

History: 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 s. 236 (14); 1979 c. 177; 1983 a. 358 s. 14; 1989 a. 187 s. 29; 2007 a. 20.

601.49 Access to records. The commissioner shall have access to the records of any agency of the state government or of any political subdivision thereof which the commissioner may wish to consult in discharging his or her duties.

History: 1979 c. 102.

601.51 Provision of certified copies and notices.

(1) **CERTIFIED COPIES.** On request of any insurer authorized to do a surety business and its payment of the fee under s. 601.31 (1), the commissioner shall mail a certified copy of its certificate of authority to any designated public officer in this state who requires such a certificate before accepting a bond. That public officer shall file it. Whenever a certified copy has been furnished to a public officer it is unnecessary, while the certificate remains effective, to attach a copy of it to any instrument of suretyship filed.

(2) **NOTICE OF REVOCATION OF CERTIFICATE.** Whenever the commissioner revokes the certificate of authority of any insurer authorized to do a surety business, the commissioner shall immediately give notice thereof to each officer who was sent a certified copy under sub. (1).

History: 1975 c. 375, 421; 1979 c. 102 s. 237; 1981 c. 20 s. 2202 (26) (a).

Legislative Council Note, 1975: This continues the substance of s. 204.04 (1) and (2). [Bill 642–S]

601.53 Insolvency notices. (1) **INSURERS DOING A SURETY BUSINESS.** Whenever any authorized insurer doing a surety business is placed in liquidation under ch. 645 or a similar law of another state or jurisdiction, the commissioner shall immediately notify the director of state courts. Upon receipt of the notice, the director of state courts shall notify each register in probate, probate registrar and clerk of circuit court, who shall notify and require every fiduciary that has filed a bond on which the company is surety to file a new bond with a different surety.

(2) **OTHER.** The commissioner as liquidator of an insurer shall send notices as provided in s. 645.47.

History: 1975 c. 375, 421; 1977 c. 449 s. 497; 1989 a. 141; 1991 a. 144.

Legislative Council Note, 1975: Sub. (1) continues the substance of s. 204.04 (3). Sub. (2) is new and is a useful cross reference. [Bill 642–S]

601.55 Nondomestic insurers; additional requirements. If another state or a foreign country requires domestic insurers doing business in that state or foreign country to deposit security, to pay a fee or tax not included in the computation under s. 76.66, to pay a fine or penalty or to comply with an obligation, prohibition or restriction that is in addition to or greater than requirements imposed by this state on nondomestic insurers doing a similar business in this state, this state may, as a condition for issuing a license to an insurer domiciled in that state or foreign country, impose a similar security requirement, fee, tax, fine, penalty, obligation, prohibition or restriction.

History: 1989 a. 31.

601.56 Study and rules on standards for health insurers. (1) **STUDY.** (a) The commissioner shall study whether, in their transactions with health care providers, compliance by health insurers with certain standards, such as standard codes, forms and formats, is likely to reduce the cost of health care administration. The study shall investigate compliance with standards in at least all of the following types of transactions between insurers and health care providers:

1. Confirmation of eligibility.
2. Pretreatment authorization.
3. Referral to specialty providers.
4. Coordination of benefits.

(b) On or before February 1, 1994, the commissioner shall submit the results of the study to the legislature under s. 13.172 (2) and to the governor.

(2) **RULES.** If, as a result of the study under sub. (1), the commissioner determines that in transactions with health care providers compliance by health insurers with certain standards will likely reduce the cost of health care administration, the commissioner shall promulgate rules to establish and implement appropriate standards.

History: 1993 a. 16.

601.57 Study and rules on health insurance identification cards. (1) **STUDY.** (a) The commissioner, in consultation with the department of health services, shall study the feasibility and cost-effectiveness of requiring every health insurer to issue to its insureds uniform machine-readable health insurance identification cards and to establish a computerized support system for the cards that will accept and respond to electronically conveyed requests from health care providers for information related to an insured, such as eligibility, coverages and authorizations. The study shall consider the feasibility and cost-effectiveness of including the medical assistance program under subch. IV of ch. 49 in the system of identification cards and the computerized support system and the feasibility of using those systems to coordinate the payment of benefits by health insurers and the medical assistance program.

(b) On or before February 1, 1994, the commissioner shall submit the results of the study to the legislature under s. 13.172 (2) and to the governor.

(2) **RULES.** If, as a result of the study under sub. (1), the commissioner determines that a health insurance identification card system and its computerized support system are feasible and would be cost-effective, the commissioner shall promulgate rules to establish and implement the systems.

History: 1993 a. 16; 1995 a. 27 ss. 7007, 9126 (19); 2007 a. 20 s. 9121 (6) (a).

601.58 Interstate insurance product regulation compact. The interstate insurance product regulation compact is hereby enacted into law and entered into by this state with all other

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jurisdictions legally joining therein, in substantially the following form:

(1) ARTICLE I — PURPOSES. Through means of joint and cooperative action among the compacting states, the purposes of this compact include all of the following:

(a) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products.

(b) To develop uniform standards for insurance products covered under the compact.

(c) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states.

(d) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard.

(e) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact.

(f) To create the interstate insurance product regulation commission.

(g) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

(2) ARTICLE II — DEFINITIONS. In this compact:

(a) “Advertisement” means any material designed to create public interest in a product or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the commission.

(b) “Bylaws” mean those bylaws established by the commission for its governance, or for directing or controlling the commission’s actions or conduct.

(c) “Commission” means the interstate insurance product regulation commission established by this compact.

(d) “Commissioner” means the chief insurance regulatory official of a state, including, but not limited to, commissioner, superintendent, director, or administrator.

(e) “Compacting state” means any state that has enacted this compact legislation and that has not withdrawn under sub. (14) (a) or been terminated under sub. (14) (g).

(f) “Domiciliary state” means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(g) “Insurer” means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this section.

(h) “Member” means the person chosen by a compacting state as its representative to the commission, or his or her designee.

(i) “Noncompacting state” means any state that is not at the time a compacting state.

(j) “Operating procedures” mean procedures promulgated by the commission implementing a rule, a uniform standard, or a provision of this compact.

(k) “Product” means the form of a policy or contract, including any application, endorsement, or related form that is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue.

(L) “Rule” means a statement of general or particular applicability and future effect promulgated by the commission, including a uniform standard developed under sub. (7), designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the commission,

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which shall have the force and effect of law in the compacting states.

(m) “State” means any state, district, or territory of the United States of America.

(n) “Third-party filer” means an entity that submits a product filing to the commission on behalf of an insurer.

(o) “Uniform standard” means a standard adopted by the commission for a product line, pursuant to sub. (7), and shall include all of the product requirements in the aggregate; provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the commission.

(3) ARTICLE III — ESTABLISHMENT OF THE COMMISSION AND VENUE. The compacting states hereby create the interstate insurance product regulation commission. Pursuant to sub. (4), the commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided, that it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance, and any such filing shall be subject to the laws of the state where filed. The commission is a body corporate and politic, and an instrumentality of the compacting states. The commission is solely responsible for its liabilities except as otherwise specifically provided in this compact. Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located.

(4) ARTICLE IV — POWERS OF THE COMMISSION. The commission shall have all of the following powers:

(a) To promulgate rules, pursuant to sub. (7), which shall be binding in the compacting states to the extent and in the manner provided in this compact.

(b) To exercise its rule-making authority and establish reasonable uniform standards for products covered under the compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the commission; provided, that a compacting state shall have the right to opt out of such uniform standard pursuant to sub. (7), to the extent and in the manner provided in this compact; and provided further, that any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners’ Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the National Association of Insurance Commissioners’ Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners require amending of the uniform standards established by the commission for long-term care insurance products.

(c) To receive and review in an expeditious manner products filed with the commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the compact.

(d) To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission, and give

approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this subsection shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the compact.

(e) To exercise its rule-making authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission.

(f) To promulgate operating procedures, pursuant to sub. (7), that shall be binding in the compacting states to the extent and in the manner provided in this compact.

(g) To bring and prosecute legal proceedings or actions in its name as the commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected.

(h) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence.

(i) To establish and maintain offices.

(j) To purchase and maintain insurance and bonds.

(k) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a compacting state.

(L) To hire employees, professionals, or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the compact, and determine their qualifications; and to establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel.

(m) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided, that at all times the commission shall strive to avoid any appearance of impropriety.

(n) To lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use, any property, real, personal, or mixed; provided, that at all times the commission shall strive to avoid any appearance of impropriety.

(o) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(p) To remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures.

(q) To enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws.

(r) To provide for dispute resolution among compacting states.

(s) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact.

(t) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments.

(u) To establish a budget and make expenditures.

(v) To borrow money.

(w) To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws.

(x) To provide and receive information from, and to cooperate with, law enforcement agencies.

(y) To adopt and use a corporate seal.

(z) To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.

(5) ARTICLE V — ORGANIZATION OF THE COMMISSION. (a) Each compacting state shall have one member. Each member shall be qualified to serve in such capacity under the applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

(b) Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the commission with respect to the promulgation of a uniform standard shall be effective unless two-thirds of the members vote in favor thereof.

(c) The commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the compact, including, but not limited to:

1. Establishing the fiscal year of the commission.

2. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee.

3. Providing reasonable standards and procedures for all of the following:

a. The establishment and meetings of other committees.

b. Governing any general or specific delegation of any authority or function of the commission.

4. Providing reasonable procedures for calling and conducting meetings of the commission that consist of a majority of commission members, ensuring reasonable advance notice of each such meeting, and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the commission must make public all of the following:

a. A copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed.

b. Votes taken during such meeting.

5. Establishing the titles, duties, and authority, and reasonable procedures for the election, of the officers of the commission.

6. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission.

7. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees.

8. Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment or reserving of all of its debts and obligations.

(d) The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compacting states.

(e) A management committee comprising no more than 14 members shall be established as follows:

1. One member from each of the 6 compacting states with the largest premium volume for individual and group annuities, life insurance, disability income, and long-term care insurance prod-

ucts, determined from the records of the National Association of Insurance Commissioners for the prior year.

2. Four members from those compacting states with at least 2 percent of the market based on the premium volume described in subd. 1., other than the 6 compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws.

3. Four members from those compacting states with less than 2 percent of the market, based on the premium volume described in subd. 1., with one selected from each of the 4 zone regions of the National Association of Insurance Commissioners as provided in the bylaws.

(f) The management committee shall have such authority and duties as may be set forth in the bylaws, including, but not limited to, all of the following:

1. Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission.

2. Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard; provided, that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the management committee.

3. Overseeing the offices of the commission.

4. Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the commission.

(g) The commission shall elect annually officers from the management committee, with each having such authority and duties as may be specified in the bylaws.

(h) The management committee may, subject to the approval of the commission, appoint or retain an executive director for such period, upon such terms and conditions, and for such compensation as the commission determines appropriate. The executive director shall serve as secretary to the commission, but may not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission.

(i) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the commission, including the management committee; provided, that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget, or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

(j) The commission shall establish 2 advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(k) The commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

(L) The commission shall maintain its corporate books and records in accordance with the bylaws.

(m) The members, officers, executive director, employees, and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of or relating to any actual

or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

(n) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

(o) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

(p) Section 893.80 does not apply to claims against the commission.

(6) ARTICLE VI — MEETINGS AND ACTS OF THE COMMISSION.

(a) The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

(b) Each member of the commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

(7) ARTICLE VII — RULES AND OPERATING PROCEDURES; RULE-MAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS. (a) The commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, in the event the commission exercises its rule-making authority in a manner that is beyond the scope of the purposes of this section, or the powers granted hereunder, then such an action by the commission shall be invalid and have no force and effect.

(b) Rules and operating procedures shall be made pursuant to a rule-making process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to all relevant state legislative committees in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(c) A uniform standard shall become effective 90 days after its promulgation by the commission or such later date as the commission may determine; provided, that a compacting state may opt out of a uniform standard as provided in this subsection. "Opt out" shall be defined as any action by a compacting state to decline to

adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure, or amendment.

(d) 1. A compacting state may opt out of a uniform standard either by legislation or regulation duly promulgated by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, it must give written notice to the commission no later than 10 business days after the uniform standard is promulgated, or at the time the state becomes a compacting state, and find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance all of the following factors and find that the conditions in the state and needs of the citizens of the state outweigh all of the following factors:

a. The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this section.

b. The presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

2. Notwithstanding subd. 1., a compacting state may, at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such an opt out may not be treated as a material variance in the offer or acceptance of any state to participate in this compact. Such an opt out shall be effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

(e) If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time as the opt out legislation is enacted into law or the regulation opting out becomes effective. Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force or effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under sub. (14) for withdrawals.

(f) If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the commission, at least 15 days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended by the commission; provided, that a stay may not be permitted to remain in effect for more than one year unless the compacting state can show extraordinary circumstances that warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge that prevents the compacting state from opting out. A stay may be terminated by the commission upon notice that the rule-making process has been terminated.

(g) Not later than 30 days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such

a petition may not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

(8) ARTICLE VIII — COMMISSION RECORDS AND ENFORCEMENT.

(a) The commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure may not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the commission; provided, that disclosure to the commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and provided further, that, except as otherwise expressly provided in this section, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the commission shall remain confidential after such information is provided to any commissioner.

(c) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of its noncompliance with commission bylaws, rules, or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default under sub. (14).

(d) The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions:

1. With respect to the commissioner's market regulation of a product or advertisement that is approved by or certified to the commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards, or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

2. Before a commissioner may bring an action for violation of any provision, standard, or requirement of the compact relating to the content of an advertisement not approved by or certified to the commission, the commission, or an authorized commission officer or employee, must authorize the action. However, authorization pursuant to this subdivision does not require notice to the insurer, opportunity for hearing, or disclosure of requests for authorization or records of the commission's action on such requests.

(9) ARTICLE IX — DISPUTE RESOLUTION. The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and that may arise between 2 or more compacting states, or between compacting states and noncompacting states, and the commission shall promulgate an operating procedure providing for resolution of such disputes.

(10) ARTICLE X — PRODUCT FILING AND APPROVAL. (a) Insurers and 3rd-party filers seeking to have a product approved by the commission shall file the product with, and pay applicable filing fees to, the commission. Nothing in this section shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

(b) The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the commission shall promulgate rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(c) Any product approved by the commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

(11) ARTICLE XI — REVIEW OF COMMISSION DECISIONS REGARDING FILINGS. (a) Not later than 30 days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or 3rd-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with sub. (3).

(b) The commission shall have authority to monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in par. (a).

(12) ARTICLE XII — FINANCE. (a) The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of its duties shall not be compromised.

(b) The commission shall collect a filing fee from each insurer and 3rd-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

(c) The commission's budget for a fiscal year may not be approved until it has been subject to notice and comment as set forth in sub. (7).

(d) The commission shall be exempt from all taxation in and by the compacting states.

(e) The commission may not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the commission shall be audited annually by an independent

certified public accountant. Upon the determination of the commission, but no less frequently than every 3 years, the review of the independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of each of the compacting states, which shall include a report of the independent audit. The commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request; provided, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(g) No compacting state shall have any claim to or ownership of any property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact.

(13) ARTICLE XIII — COMPACTING STATES, EFFECTIVE DATE, AND AMENDMENT. (a) Any state is eligible to become a compacting state.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by 2 compacting states; provided, that the commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the commission that satisfy applicable uniform standards only after 26 states are compacting states or, alternatively, only after states representing greater than 40 percent of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the National Association of Insurance Commissioners for the prior year, are compacting states. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(c) Amendments to the compact may be proposed by the commission for enactment by the compacting states. No amendment shall become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.

(14) ARTICLE XIV — WITHDRAWAL, DEFAULT, AND TERMINATION. (a) Once effective, the compact shall continue in force and remain binding upon each and every compacting state; provided, that a compacting state may withdraw from the compact ("withdrawing state") by enacting a statute specifically repealing the statute that enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. The withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state, unless the approval is rescinded by the withdrawing state as provided in par. (e).

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of such legislation within 10 days after its receipt of notice thereof.

(e) The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the

prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the compact.

(g) If the commission determines that any compacting state has at any time defaulted (“defaulting state”) in the performance of any of its obligations or responsibilities under this compact, the bylaws, or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state’s suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact and all rights, privileges, and benefits conferred by this compact shall be terminated from the effective date of termination.

(h) Product approvals by the commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily under par. (a).

(i) Reinstatement following termination of any compacting state requires a reenactment of the compact.

(j) The compact dissolves effective upon the date of the withdrawal or default of the compacting state that reduces membership in the compact to one compacting state.

(k) Upon the dissolution of this compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

(15) ARTICLE XV — SEVERABILITY AND CONSTRUCTION. (a) The provisions of this compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of this compact shall be liberally construed to effectuate its purposes.

(16) ARTICLE XVI — BINDING EFFECT OF COMPACT AND OTHER LAWS. (a) Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in par. (b).

(b) For any product approved by or certified to the commission, the rules, uniform standards, and any other requirements of the commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such products. For advertisement that is subject to the commission’s authority, any rule, uniform standard, or other requirement of the commission that governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the commission shall abrogate or restrict any of the following:

1. The access of any person to state courts.
2. Remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product.
3. State law relating to the construction of insurance contracts.
4. The authority of the secretary of agriculture, trade and consumer protection or the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual states shall be subject to the laws of those states.

(d) All lawful actions of the commission, including all rules and operating procedures promulgated by the commission, are binding upon the compacting states. All agreements between the commission and the compacting states are binding in accordance with their terms. Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(e) In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the commission shall be ineffective as to that compacting state, and such obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which such obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this compact becomes effective.

History: 2007 a. 168.

SUBCHAPTER V

PROCEDURES AND ENFORCEMENT

601.61 Auxiliary procedural powers. The commissioner may administer oaths, take testimony, issue subpoenas and take depositions in connection with any hearing, meeting, examination, investigation or other proceeding that the commissioner may conduct.

History: 1979 c. 102 s. 236 (6).

601.62 Hearings. (1) HEARING REQUIRED. Whenever chs. 600 to 655 expressly so provide, the commissioner shall hold a hearing before issuing an order.

(2) SPECIAL INSURANCE HEARINGS. Chapter 227 shall apply to all hearings under chs. 600 to 655, except those for which special procedures are prescribed.

(3) ADJUDICATORY HEARINGS. In addition to the requirements of ch. 227, the following provisions apply:

(a) *Subsequent hearings.* Whenever an order is issued without a hearing, any person aggrieved by the order may demand a hearing within 30 days after the date on which the notice of the order was mailed. Failure to demand a hearing within the period prescribed therefor is waiver of a hearing. The demand shall be in writing and shall be served on the commissioner by delivering a copy to the commissioner or by leaving it at the commissioner’s office. The commissioner shall thereupon hold a hearing not less than 10 nor more than 60 days after service of the demand.

(c) *Reduction and extension of periods.* Upon request of the person demanding the hearing or of any other aggrieved person, the commissioner may reduce or extend the period prescribed by par. (a) for holding a hearing.

(4) FEES IN INVESTIGATIONS AND HEARINGS. The fees for stenographic services in investigations, examinations, and hearings may not exceed the sum provided for like services in the circuit court. The fees of officers, witnesses, interpreters, and stenographers on behalf of the commissioner or the state shall be paid by the secretary of administration, authorized by the certificate of the commissioner, and shall be charged to the appropriation under s. 20.145 (1) (g) 1.

(5) IMMUNITY FROM PROSECUTION. (a) No natural person is excused from attending and testifying or from producing any document or record before the commissioner, or from obedience to the subpoena of the commissioner, or from appearing in any proceeding instituted by the commissioner, on the ground that the testimony or evidence required from the person may tend to incriminate the person or subject the person to a penalty or forfeiture; but

no such person may be criminally prosecuted for or on account of his or her testimony or evidence, after claiming privilege against self-incrimination, except that the person testifying is not exempt from prosecution and punishment for perjury, false swearing or contempt committed in testifying.

(b) The immunity provided under par. (a) is subject to the restrictions under s. 972.085.

History: 1975 c. 371; 1975 c. 414 ss. 27, 28; 1975 c. 421; 1977 c. 203 ss. 81, 82, 102; 1977 c. 339 ss. 30, 43; 1979 c. 89; 1983 a. 358 s. 14; 1989 a. 122; 1989 a. 187 s. 29; 1995 a. 396; 2003 a. 33; 2007 a. 20.

Cross-reference: See also ch. Ins 5, Wis. adm. code.

Legislative Council Note on sub. (5), 1975: This replaces ss. 207.13 and 201.53 (11) and (12) [repealed by this act]. Section 207.13 was in the unfair insurance business methods chapter but applied in terms “to any hearing”. This new provision is even broader in proceedings covered. It is modeled after the securities act provision (s. 551.56 (3) of the statutes) with one phrase deleted because s. 601.18 makes it unnecessary, and other changes, some editorial and one limiting the scope of the immunity to criminal prosecution. Other similar provisions are to be found in s. 93.17 (department of agriculture), s. 97.20 (10) (same; food regulation), s. 111.07 (employment relations commission), s. 196.48 (public service commission), and s. 972.08 (criminal proceedings). Section 201.53 (11) and (12) only applied in terms to s. 201.53, which contained a miscellaneous group of provisions, mostly concerning unfair marketing practices, but it applied very broadly to all proceedings and, apparently, even informal requests for information. [Bill 16–S]

601.63 Notice and effective date of orders. (1) NOTICE TO PERSON ADDRESSED BY ORDER. Notice of any order by the commissioner shall be served under s. 227.48.

(2) NOTIFICATION TO AGENTS OF REVOCATION OF CERTIFICATE OF AUTHORITY OF INSURER. Upon issuance of any order limiting, suspending or revoking an insurer’s authority to do business in this state, the commissioner shall notify by mail all agents of the insurer of whom the commissioner has record. The commissioner shall also publish a class 1 notice of the order under ch. 985.

(3) DELAY OF EFFECTIVE DATE. Except as provided in sub. (4) or as expressly provided otherwise by statute, all orders of the commissioner shall take effect 10 days after notice under sub. (1) or at a later date specified in the order.

(3m) HEARING REQUEST. If the order was issued without a hearing, any person aggrieved by the order may demand a hearing under s. 601.62 (3) (a). If no demand for a hearing is made within the prescribed time, the order is final.

(4) SUSPENSION OF ORDER. Whenever a hearing is demanded under s. 601.62 (3) (a) or a rehearing is requested under s. 227.49, the commissioner may suspend the order or any part thereof until after the hearing or rehearing. If the commissioner refuses to suspend the order, any person aggrieved thereby may seek a court order under ch. 813 to restrain enforcement of the order until after the hearing or rehearing.

(5) ACTIONS SUBJECT TO APPROVAL OR DISAPPROVAL. (a) *Required approval.* Whenever the law requires the commissioner’s approval for a certain action, the action is not effective until expressly approved. The approval is deemed refused if the commissioner does not act within 60 days after receiving the application for approval.

(b) *Reserved disapproval.* Whenever the law provides that a certain action does not become effective if disapproved by the commissioner within a certain period, the action may be made effective prior to the expiration of the period by being affirmatively approved by the commissioner.

(c) *Specific provisions.* Paragraphs (a) and (b) do not apply to the extent that the law specifically provides otherwise.

History: 1971 c. 40 s. 93; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 218; 1975 c. 414 s. 28; 1977 c. 26; 1977 c. 203 ss. 83, 84, 104; 1979 c. 102; 1985 a. 182 s. 57; 1995 a. 396.

601.64 Enforcement procedure. (1) INJUNCTIONS AND RESTRAINING ORDERS. The commissioner may commence an action in circuit court in the name of the state to restrain by temporary or permanent injunction or by temporary restraining order any violation of chs. 600 to 655 or s. 149.13, 2011 stats., any rule promulgated under chs. 600 to 655, or any order issued under s. 601.41 (4). The commissioner need not show irreparable harm or

lack of an adequate remedy at law in an action commenced under this subsection.

(2) COMPULSIVE FORFEITURES. If a person does not comply with an order issued under s. 601.41 (4) within 2 weeks after the commissioner has given the person notice of the commissioner’s intention to proceed under this subsection, the commissioner may commence an action for a forfeiture in such sum as the court considers just, but not exceeding \$5,000 for each day that the violation continues after the commencement of the action until judgment is rendered. No forfeiture may be imposed under this subsection if at the time the action was commenced the person was in compliance with the order, nor for any violation of an order occurring while any proceeding for judicial review of the order was pending, unless the court in which the proceeding was pending certifies that the claim of invalidity or nonapplicability of the order was frivolous or a sham. If after judgment is rendered the person does not comply with the order, the commissioner may commence a new action for a forfeiture and may continue commencing actions until the person complies. The proceeds of all actions under this subsection, after deduction of the expenses of collection, shall be paid into the common school fund of the state.

(3) FORFEITURES AND CIVIL PENALTIES. (a) *Restitutory forfeiture.* Whoever violates an effective order issued under s. 601.41 (4), any insurance statute or rule, or s. 149.13, 2011 stats., shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

(b) *Forfeiture for violation of order.* Whoever violates an order issued under s. 601.41 (4) which is effective under s. 601.63 shall forfeit to the state not more than \$1,000 for each violation. Each day that the violation continues is a separate offense.

(c) *Forfeiture for violation of statute or rule.* Whoever violates an insurance statute or rule or s. 149.13, 2011 stats., intentionally aids a person in violating an insurance statute or rule or s. 149.13, 2011 stats., or knowingly permits a person over whom he or she has authority to violate an insurance statute or rule or s. 149.13, 2011 stats., shall forfeit to the state not more than \$1,000 for each violation. If the statute or rule imposes a duty to make a report to the commissioner, each week of delay in complying with the duty is a new violation.

(d) *Procedure.* The commissioner may order any person to pay a forfeiture imposed under this subsection or s. 601.65, which shall be paid into the common school fund. If the order is issued without a hearing, the affected person may demand a hearing under s. 601.62 (3) (a). If the person fails to request a hearing, the order is conclusive as to the person’s liability. The scope of review for forfeitures ordered is that specified under s. 227.57. The commissioner may cause action to be commenced to recover the forfeiture. Before an action is commenced, the commissioner may compromise the forfeiture.

(4) CRIMINAL PENALTY. Whoever intentionally violates or intentionally permits any person over whom he or she has authority to violate or intentionally aids any person in violating any insurance statute or rule of this state, s. 149.13, 2011 stats., or any effective order issued under s. 601.41 (4) is guilty of a Class I felony, unless a specific penalty is provided elsewhere in the statutes. Intent has the meaning expressed under s. 939.23.

(5) REVOCATION, SUSPENSION AND LIMITATION OF LICENSES. Whenever a licensee of the office other than an insurer, a motor club, an adjuster or an insurance intermediary persistently or substantially violates chs. 600 to 646 or an order of the commissioner under s. 601.41 (4), or if the licensee’s methods and practices in the conduct of business endanger, or financial resources are inadequate to safeguard, the legitimate interests of customers and the public, the commissioner may, after a hearing, in whole or in part revoke, suspend or limit the license.

History: 1971 c. 260; Sup. Ct. Order, 67 Wis. 2d 585, 776 (1975); 1975 c. 218, 371, 421; 1977 c. 203; 1977 c. 339 s. 43; 1979 c. 89; 1979 c. 102 ss. 78, 236 (5); 1979

c. 177; 1985 a. 29; 1987 a. 167, 247; 1989 a. 332; 1995 a. 396; 1997 a. 27, 283; 2001 a. 109; 2003 a. 261; 2005 a. 74; 2013 a. 20.

Legislative Council Note on sub. (5), 1975: This amendment removes insurance intermediaries from the purview of the subsection. Under this act, revocation of an intermediary's license will be governed by s. 628.10 (2). [Bill 16–S]

601.65 Marketing firm forfeitures. (1) In this section “firm” means a person that markets insurance but does not include an insurer.

(2) A firm is liable for a forfeiture of not more than \$1,000 for each violation by an insurance agent of a provision of, a rule promulgated under or an order issued under chs. 600 to 655 if the violation is in connection with an insurance policy or group certificate obtained or to be obtained through or from the firm and if any of the following applies:

(a) The firm regularly utilizes the insurance agent to market insurance policies or group certificates.

(b) The primary insurance marketing activities of the insurance agent are in connection with insurance policies or group certificates obtained or to be obtained through or from the firm.

(c) The insurance agent is employed by or is under contract with the firm to market insurance policies or group certificates.

(3) If a provision of, a rule promulgated under or an order issued under chs. 600 to 655 imposes a duty to submit a periodic or recurring report to the commissioner, each week of delay in submitting the report constitutes a separate violation. Each day of continued violation of an order issued under s. 601.41 (4) constitutes a separate violation.

History: 1985 a. 29.

601.71 Enforcement of policyholder rights. When the commissioner is satisfied that any nondomestic insurer which no longer has a certificate of authority in this state does or omits to do any act whereby the rights of policyholders who are residents of this state, or who hold contracts issued or delivered in this state, are adversely affected, or whereby its ability to carry out its contracts with those policyholders is impaired, the commissioner may, with the agreement of the attorney general, bring an action in the name of the state on behalf of all policyholders so situated for the purpose of enforcing their rights. The attorney general shall act as attorney for the state in the action and the expenses shall be borne as in other civil actions in behalf of the state. Upon service of the complaint the insurer shall file with the commissioner the names and addresses of all policyholders so situated. A notice of the action shall be mailed to every such policyholder either by the commissioner or by the insurer, as the commissioner determines. Any policyholder affected by the action may intervene.

History: 1979 c. 102.

601.715 Registered agent for service of process.

(1) Every authorized insurer shall continuously maintain in this state a registered agent for service of process, notice or demand on the insurer. The authorized insurer shall file the name and address of the registered agent with the commissioner. The registered agent may be any of the following:

(a) A natural person who resides in this state.

(b) A domestic corporation, nonstock corporation or limited liability company incorporated or organized in this state with a business office in this state.

(c) A foreign corporation or limited liability company authorized to transact business in this state with a business office in this state.

(2) (a) An authorized insurer may change its registered agent by delivering to the commissioner for filing a statement of registered agent change that is signed by an officer of the insurer and that includes all of the following information:

1. The name and home office address of the authorized insurer.

2. The name of the registered agent, as changed.

3. The complete address of the registered agent, as changed.

4. Any other information that the commissioner may require.

(b) An authorized insurer may change its registered agent no more than one time per year.

(3) A registered agent of an authorized insurer may change its registered agent address by doing all of the following:

(a) Notifying in writing the authorized insurer for which the registered agent is acting.

(b) Delivering to the commissioner for filing a statement that includes all of the following:

1. The name and home office address of the authorized insurer for which the registered agent is acting.

2. The complete new registered agent address.

3. An attached copy of the notice under par. (a).

(4) (a) A registered agent of an authorized insurer may resign by signing and delivering to the commissioner for filing a statement of resignation that includes all of the following information:

1. The name and home office address of the authorized insurer for which the registered agent is acting.

2. The name of the registered agent.

3. A statement that the registered agent resigns.

(b) After filing the statement, the commissioner shall mail a copy to the authorized insurer under par. (a) 1.

(c) The resignation is effective on the earlier of the following:

1. Sixty days after the commissioner receives the statement of resignation for filing.

2. The date on which the appointment of a successor registered agent is effective.

(4m) Service on an insurer under this section shall be made by personally serving the process, notice or demand on the registered agent of the insurer. In lieu of delivery to the registered agent, the process, notice or demand may be left at the office of the registered agent with the person who is apparently in charge of the office.

(5) If an authorized insurer has no registered agent for service of process in this state or if the registered agent cannot with reasonable diligence be served, substituted service may be made on the commissioner under ss. 601.72 and 601.73. If substituted service is made on the commissioner, an affidavit attesting that the authorized insurer has no registered agent or that the registered agent could not with reasonable diligence be served shall be attached to the process, notice or demand that is served.

(6) Except as provided in sub. (5), this section does not limit or affect the right to serve summons, notice, orders, pleadings, demands or other process upon an authorized insurer in any other manner provided by law.

History: 1995 a. 396; 1999 a. 30.

601.72 Service of process through state officer.

(1) **GENERAL.** Under procedures specified in s. 601.73, the commissioner is by law constituted attorney, except in cases in which the proceeding is to be brought by the state against an insurer or intermediary other than a risk retention group or risk purchasing group, in which event the department of financial institutions is by law constituted attorney, to receive service of summons, notices, orders, pleadings and all other legal process relating to any court or administrative agency in this state for all of the following:

(a) *Authorized insurers.* All insurers authorized to do business in this state, while authorized to do business in this state, and thereafter in any proceeding arising from or related to any transaction having any connection with this state, provided the requirements under s. 601.715 (5) are satisfied.

(b) *Surplus lines insurers.* All insurers as to any proceeding arising out of any contract that is permitted by s. 618.41, or out of any certificate, cover note or other confirmation of such insurance.

(c) *Unauthorized insurers.* All insurers or other persons doing an unauthorized insurance business in this state, including but not limited to risk purchasing groups, as to any proceeding arising out of the unauthorized transaction.

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(d) *Risk purchasing groups and nonresident intermediaries.* All risk purchasing groups or nonresident intermediaries as to any proceeding arising out of insurance activities within this state or out of insurance activities related to policies on risks within this state.

(2) APPOINTMENT OF ATTORNEY. Except as provided in sub. (2m), every licensed insurer by applying for and receiving a certificate of authority, every surplus lines insurer by entering into a contract subject to the surplus lines law, and every unauthorized insurer by doing an insurance business in this state, is deemed to have irrevocably appointed the commissioner and department of financial institutions as the insurer's attorneys in accordance with sub. (1).

(2m) RISK RETENTION GROUPS AND RISK PURCHASING GROUPS. A risk retention group or risk purchasing group may not do an insurance business or engage in any insurance activity in this state until it registers with the commissioner and designates the commissioner as its agent for the purposes described in sub. (1). The commissioner may prescribe the form of registration under this subsection. If a risk retention group or risk purchasing group fails to designate the commissioner as required by this subsection, the commissioner is appointed agent for the risk retention group or risk purchasing group as provided in sub. (2).

(3) OTHERS AFFECTED. The commissioner and department of financial institutions shall also be attorneys for the personal representatives, receivers, trustees, or other successors in interest of the persons specified in sub. (1).

(4) FEES. Litigants serving process on the commissioner under this section shall pay the fees specified in s. 601.31 (1) (p).

(5) ORDINARY MEANS OF SERVICE. The right to substituted service under this section does not limit the right to serve summons, notice, orders, pleadings, demands or other process upon any person in any manner provided by law.

History: 1995 a. 27, 396; 2001 a. 102.

Legislative Council Note on sub. (1) (d), 1975: Under s. 628.04 (created by this act), Wisconsin takes an important step in liberalizing prevailing licensing laws by not requiring residence for unrestricted Wisconsin intermediaries' licenses. As a correlative measure, however, the reach of the Wisconsin courts and administrative agencies is extended to all such nonresidents. [Bill 16–S]

The commissioner has the duty to accept service for all insurers, but does not have a duty to determine whether an insurer is a party to the action in which service is sought. *Davies v. Heiman*, 186 Wis. 2d 370, 520 N.W.2d 917 (Ct. App. 1994).

601.73 Procedure for service of process through state officer. (1) REQUIREMENTS FOR EFFECTIVE SERVICE. Service upon the commissioner or department of financial institutions under s. 601.72 is service on the principal, if:

(a) Two copies of the process are left in the hands or office of the commissioner or department of financial institutions respectively; and

(b) The commissioner or department of financial institutions mails a copy of the process to the person served according to sub. (2) (b).

(2) COMMISSIONER'S ACTION. (a) *Records.* The commissioner and department of financial institutions shall give receipts for and keep records of all process served through them.

(b) *Process mailed.* The commissioner or department of financial institutions shall send immediately by certified mail to the person served, at the person's last-known principal place of business, residence or post-office address or at an address designated in writing by the person, one copy of any process received and shall retain the other copy.

(c) *Default judgment.* No plaintiff or complainant is entitled to a judgment by default in any proceeding in which process is served under this section and s. 601.72 until the expiration of 45 days after the date of mailing of the process under par. (b). If the proceeding is to foreclose or otherwise enforce a lien or security interest, the plaintiff or complainant is not entitled to a judgment by default under this paragraph until the expiration of 20 days after the date of mailing of the process under par. (b).

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(3) PROOF OF SERVICE. A certificate by the commissioner or the department of financial institutions, showing service made upon the commissioner or department of financial institutions, and attached to a copy of the process presented for that purpose is sufficient evidence of the service.

History: 1971 c. 189; 1977 c. 203 ss. 87, 103; 1979 c. 102; 1989 a. 164; 1995 a. 27, 396; 1999 a. 76; 2001 a. 16.

Legislative Council Note, 1979: [Repeal of (1) (c)] In its original form, the procedures of ss. 601.72 and 601.73 for substituted service of process through the commissioner or secretary of state required, in s. 601.73 (1) (b), the serving party to also mail a copy of the process to the person served, as additional assurance that this substituted service would provide actual notice. Sub. (1) (c) then required filing of an affidavit of compliance with (1) (a) and (b) to make the service effective. It may have been cumbersome, but it was logical. Some time later, the requirement of mailing by the serving party was eliminated by an amendment (ch. 189, laws of 1971) that did not go through the Insurance Laws Revision Committee, and did not make the necessary collateral changes. It makes little sense for the serving party to have to provide an affidavit as to what the public official does under (1) (b). Moreover, under (1) (b) the service is not complete anyway unless the public official does perform the statutory duty. Thus, the affidavit seems unnecessary and, because service is not complete without mailing by the public official, no further requirement seems needed. The reasonable solution, therefore, is to repeal (1) (c). [Bill 146–S]

Section 801.15 (5) does not extend the time for answering a complaint served by substitute service under this section. *Leonard v. Cattahach*, 214 Wis. 2d 236, 571 N.W.2d 444 (Ct. App. 1997), 96–3167.

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

601.80 Definitions; healthcare stability plan. In this subchapter:

(1) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111–148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111–152, and any amendments to or regulations or guidance issued under those acts.

(2) "Attachment point" means the amount set under s. 601.83 (2) for the healthcare stability plan that is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs are eligible for reinsurance payments.

(3) "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

(4) "Coinsurance rate" means the rate set under s. 601.83 (2) for the healthcare stability plan that is the rate at which the commissioner will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(5) "Eligible health carrier" means an insurer, as defined in s. 632.745 (15), that offers an individual health plan and incurs claims costs for an enrolled individual's covered benefits in the applicable benefit year.

(6) "Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act.

(7) "Health benefit plan" has the meaning given in s. 632.745 (11).

(8) "Healthcare stability plan" means the state-based reinsurance program known as the Wisconsin Healthcare Stability Plan administered under s. 601.83 (1).

(9) "Individual health plan" means a health benefit plan that is not a group health plan, as defined in s. 632.745 (10), or a grandfathered plan.

(10) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the healthcare stability plan.

(12) "Reinsurance cap" means the threshold amount set under s. 601.83 (2) for the healthcare stability plan for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments.

(13) “Reinsurance payment” means an amount paid by the commissioner to an eligible health carrier under the healthcare stability plan.

History: 2017 a. 138.

601.83 Healthcare stability plan; administration.

(1) PLAN ESTABLISHED; GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer a state-based reinsurance program known as the healthcare stability plan.

(b) 1. The commissioner may submit a request to the federal department of health and human services for one or more waivers under 42 USC 18052 to implement the healthcare stability plan for benefit years beginning January 1, 2019. The commissioner may adjust the payment parameters under sub. (2) to the extent necessary to secure federal approval of the waiver request under this paragraph.

2. If the federal department of health and human services does not approve the healthcare stability plan in the waiver request submitted under subd. 1. or a substantially similar healthcare stability plan, the commissioner may not implement the healthcare stability plan.

(c) If the federal government enacts into law Senate Bill 1835 of the 115th Congress or a similar bill providing support to states to establish reinsurance programs, the commissioner shall seek, if necessary, and receive federal moneys for the purpose of reinsurance programs that result from that enacted law to expend for the purposes of this subchapter.

(d) In accordance with sub. (5) (c), the commissioner shall collect the data from an eligible health carrier as necessary to determine reinsurance payments.

(e) Beginning on a date determined by the commissioner, the commissioner shall require each eligible health carrier to calculate the rates the eligible health carrier would have charged for a benefit year if the healthcare stability plan had not been established and submit the calculated rates as part of its rate filing submitted to the commissioner. The commissioner shall consider the calculated rate information provided under this paragraph as part of the rate filing review.

(f) 1. For each applicable benefit year, the commissioner shall notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the calendar year following the applicable benefit year.

2. Quarterly during the applicable benefit year, the commissioner shall provide each eligible health carrier with the calculation of total amounts of reinsurance payment requests.

3. By August 15 of the calendar year following the applicable benefit year, the commissioner shall disburse all applicable reinsurance payments to an eligible health carrier.

(g) The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section, except that any rules promulgated under this paragraph shall seek to maximize federal funding for the healthcare stability plan. The commissioner may promulgate rules necessary to implement this section as emergency rules under s. 227.24. Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this paragraph.

(h) In 2019 and in each subsequent year, the commissioner may expend no more than \$200,000,000 from all revenue sources for the healthcare stability plan under this section, unless the joint committee on finance under s. 13.10 has increased this amount upon request by the commissioner.

(2) PAYMENT PARAMETERS. The commissioner, after consulting with an actuarial firm, shall design and adjust payment parameters with the goal to do all of the following:

(a) Stabilize or reduce premium rates in the individual market.

(b) Increase participation by health carriers in the individual market.

(c) Improve access to health care providers and services for individuals purchasing coverage in the individual market.

(d) Mitigate the impact high-risk individuals have on premium rates in the individual market.

(e) Take into account any federal funding available for the plan.

(f) Take into account the total amount available to fund the plan.

(3) OPERATION. (a) The commissioner shall set the payment parameters as described under sub. (2) by no later than March 30 of the calendar year before the applicable benefit year or, if the commissioner specifies a different date by rule, the date specified by the commissioner by rule.

(b) If the amount available for expenditure for the healthcare stability plan is not anticipated to be adequate to fully fund the payment parameters set under par. (a) as of July 1 of the calendar year before the applicable benefit year, the commissioner shall adjust the payment parameters in accordance within the moneys available to expend for the healthcare stability plan. The commissioner shall allow an eligible health carrier to revise its rate filing based on the final payment parameters for the applicable benefit year.

(c) If funding is not available to make all reinsurance payments to eligible health carriers in a benefit year, the commissioner shall make reinsurance payments in proportion to the eligible health carrier’s share of aggregate individual health plan claims costs eligible for reinsurance payments during the given benefit year, as determined by the commissioner. The commissioner shall notify eligible health carriers if there are insufficient funds available to make reinsurance payments in full and the estimated amount of payment as soon as practicable after the commissioner becomes aware of the insufficiency.

(4) REINSURANCE PAYMENT CALCULATION. (a) The commissioner shall calculate a reinsurance payment with respect to each eligible health carrier’s incurred claims costs for an enrolled individual’s covered benefits in the applicable benefit year. If the claims costs for an enrolled individual do not exceed the attachment point set under sub. (2), the commissioner may not make a reinsurance payment with respect to that enrollee. If the claims costs for an enrolled individual exceed the attachment point, subject to par. (b), the commissioner shall make a reinsurance payment that is calculated as the product of the coinsurance rate and whichever of the following is less:

1. The claims costs minus the attachment point.
2. The reinsurance cap minus the attachment point.

(b) The commissioner shall ensure that any reinsurance payment made to an eligible health carrier does not exceed the total amount paid by the eligible health carrier for any claim. For purposes of this paragraph, the total amount paid of a claim is the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or copayment paid by another person as of the time the data are submitted or made accessible under sub. (5) (c).

(5) REINSURANCE PAYMENT REQUESTS. (a) An eligible health carrier may request reinsurance payments from the commissioner when the eligible health carrier meets the requirements of this subsection and sub. (4).

(b) An eligible health carrier shall make any requests for a reinsurance payment in accordance with any requirements established by the commissioner.

(c) Each eligible health carrier shall provide the commissioner with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 USC 18063. Each eligible health carrier shall submit to the commissioner attesting to compliance with the dedicated data environments, data requirements, estab-

21 Updated 15–16 Wis. Stats.

ishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) Each eligible health carrier shall provide the access under par. (c) for each applicable benefit year by April 30 of the calendar year following the end of the applicable benefit year.

(e) Each eligible health carrier shall maintain for at least 6 years documents and records, by paper, electronic, or other media, sufficient to substantiate a request for a reinsurance payment made under this section. An eligible health carrier shall make the documents and records available to the commissioner, upon request, for purposes of verification, investigation, audit, or other review of a reinsurance payment request.

(f) The commissioner may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier shall ensure that its contractors, subcontractors, or agents cooperate with any audit under this paragraph. Within 30 days of receiving notice that an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding. Within 60 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall do all of the following:

1. Provide a written corrective action plan to the commissioner for approval.
2. Implement the corrective action plan under subd. 1. as approved by the commissioner.
3. Provide the commissioner with written documentation of the corrective action after implementation.

(g) The commissioner may recover from an eligible health carrier any overpayment of reinsurance payments as determined under the audit under par. (f).

(h) A health carrier is not eligible to receive a reinsurance payment unless the health carrier agrees not to bring a lawsuit against the commissioner or a state agency or employee over any delay in reinsurance payments or any reduction in reinsurance payments in accordance with sub. (3) (c).

(6) ACCESS TO INFORMATION. Information submitted by an eligible health carrier or obtained by the commissioner for purposes of the healthcare stability plan shall be used only for purposes of this subchapter and is proprietary and confidential under s. 601.465.

History: 2017 a. 138.

601.85 Accounting, reports, and audits. (1) ACCOUNTING. The commissioner shall keep an accounting for each benefit year of all of the following:

- (a) Funds appropriated for reinsurance payments and administrative and operational expenses.
- (b) Requests for reinsurance payments received from eligible health carriers.
- (c) Reinsurance payments made to eligible health carriers.
- (d) Administrative and operational expenses incurred for the healthcare stability plan.

(2) REPORTS. By November 1 of the calendar year following the applicable benefit year or by 60 days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the commissioner shall make available to the public a report summarizing the healthcare stability plan's operations for each benefit year by posting the summary on the office's Internet site.

(3) LEGISLATIVE AUDITOR. The healthcare stability plan is subject to audit by the legislative audit bureau. The commissioner shall ensure that its contractors, subcontractors, or agents cooperate with any audit of the healthcare stability plan performed by the legislative audit bureau.

INSURANCE — ADMINISTRATION 601.935

(4) REQUIRED RECOMMENDATION REPORT. By December 31, 2018, the commissioner shall submit to the governor recommendations on implementing a waiver under s. 601.83 (1) (b), any possible additional waivers to be requested, and any other options to stabilize the individual health care market in this state. In developing the recommendations, the commissioner shall consider and include in the report the impacts of creating a high-risk pool or an invisible high-risk pool; funding of consumer health savings accounts; expanding consumer plan choices, including catastrophic plans or coverage and new low-cost plan options; and implementing any other approach that will lower consumer costs, stabilize the insurance market, or expand the availability of private insurance coverage.

History: 2017 a. 138.

SUBCHAPTER VIII**FIRE DEPARTMENT DUES**

601.93 Payment of dues. (1g) In this section, "fire insurance" includes insurance against loss of or damage to:

(a) Notes, acceptances or any other valuable papers or documents, resulting from any cause, except while in the mail or in the custody or possession of and being transported by any carrier for hire; and

(b) Personal property of individuals when written under an all-risk type of policy commonly known as the "personal property floater", whenever these risks are written in conjunction with insurance against burglary or theft.

(1m) Any insurer doing a fire insurance business in this state shall pay fire department dues equal to 2 percent of the amount of all premiums which, during the preceding calendar year, have been received by, or have been agreed to be paid to, the company for insurance against loss by fire, including insurance on property exempt from taxation.

(2) Every insurer doing a fire insurance business in this state shall, before March 1 in each year, file with the commissioner a statement, showing the amount of premiums upon fire insurance due for the preceding calendar year. Return premiums may be deducted in determining the premium on which the fire department dues are computed. Payments of quarterly installments of the total estimated payment for the then current calendar year under this subsection are due on or before April 15, June 15, September 15 and December 15. On March 1 the insurer shall pay any additional amounts due for the preceding calendar year. Overpayments will be credited on the amount due April 15. The commissioner shall, prior to May 1 each year, report to the department of safety and professional services the amount of dues paid under this subsection and to be paid under s. 101.573 (1).

History: 1971 c. 154; 1975 c. 372 ss. 5, 38; 1975 c. 421; Stats. 1975 s. 601.93; 1977 c. 29; 1979 c. 34, 102, 177, 221; 1981 c. 20; 1987 a. 166; 1995 a. 27 ss. 7019, 9130 (4); 2001 a. 103; 2011 a. 32.

601.935 Penalties. (1) LATE PAYMENT. An insurer that fails to make quarterly payments under s. 601.93 (2) of at least 25 percent of either the total fire dues paid for the previous calendar year or 80 percent of the actual fire dues for the current calendar year is liable, in addition to the amount due, for interest of 1.5 percent of the amount due and unpaid for each month or part of a month that the amount due, together with any interest, remains unpaid.

(2) NEGLIGENCE. An insurer that fails to pay an amount due, or file a statement required, under s. 601.93 (2), unless the insurer shows that the failure is due to reasonable cause and not due to willful neglect, is liable for the greater of the following amounts:

- (a) Five hundred dollars.
- (b) Five percent of the amount due for each month or fraction of a month during which the failure continues, but not more than 25 percent of the amount due.

History: 1987 a. 166.