Chapter Ins 3

CASUALTY INSURANCE

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

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

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may

not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

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

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

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

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

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

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

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

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

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

(8) REINSURANCE. A mortgage guaranty insurer may, by contract, reinsure any insurance it transacts in any assuming insurer authorized to transact mortgage guaranty insurance in this state, except it shall not

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

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

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

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

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

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

Note: Ins 3.35 was renumbered to be Ins 17.25.

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

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

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

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

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

(b) Rating class means any of the classifications listed on pages 7 through 14, part III of the Uniform Statistical Plan for Medical Professional Liability Insurance published by the Insurance Services Office effective January 1, 1976, as revised January 19, 1976, plus additional classifications for osteopathic hospitals, nurse anesthetists partnership liability, nurse anesthetists corporate liability, and operational cooperative sickness plans organized under ss. 185.981 to 185.985, Stats., which directly provide services through salaried employes in their own facilities. The Uniform Statistical Plan for Medical Professional Liability Insurance published by the Insurance Services Office is distributed by Insurance Services Office, 160 Water Street, New York, New York 10038. A copy of this plan is on file at the office of the commissioner of insurance, the secretary of state and the revisor of statutes.

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

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

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

1. Damages paid to claimants;

2. Reserves for outstanding losses;

3. Incurred but not reported losses;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: Ins 3.37 was renumbered to be Ins 17.26.

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

(2) INTERPRETATION AND IMPLEMENTATION. (a) Coverage of each newborn infant is required under a disability insurance policy if 1. the policy provides coverage for another family member, in addition to the insured person, such as the insured's spouse or a child, and 2. the policy specifically indicates that children of the insured person are eligible for coverage under the policy.

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

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

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

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

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

(g) An insurer receiving an application, for a policy as described in paragraph (a) providing hospital and/or medical expense benefits, from a pregnant applicant or an applicant whose spouse is pregnant, may not issue such a policy to exclude or limit benefits for the expected child.

Such a policy must be issued without such an exclusion or limitation, or the application must be declined or postponed.

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

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

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

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