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 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) DEFINITIONS. (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

(i) "Policyholders' surplus" means an insurer's net worth, the difference between its assets and liabilities, as reported in its annual statement.

(4) MINIMUM CAPITAL OR PERMANENT SURPLUS. The minimum capital or permanent surplus of a municipal bond insurer shall be $2 million for an insurer first authorized to do business in Wisconsin on or before Janu-

1. A pre-existence defense;

2. A waiting period, such as for pregnancy, surgery or other stated condition or procedure;

3. A benefit maximum; or

4. Other policy limitation.

(5) EFFECTIVE DATE. This rule shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after December 1, 1974, except that sub. (3) (a) 4. a. and b. shall apply to coverage issued after said date and sub. (3) (a) 3. d., e. and g. shall apply to such activities after February 1, 1975.

History: Cr. Register, November, 1974, No. 227, eff. 12-1-74; emerg. am. (1), (2), (3) (intro.) and (c) and (4), eff. 6-22-76; am. (1), (2), (3) (intro.) and (c) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), (2), (3) (intro.), (3) (a) 3. d., f. and 4. b., (3) (c) and (4), r. and recr. (3) (a) 3. c., (3) (b) 1. and 3., (4) (b) 1. and 3., Register, April, 1982, No. 316, eff. 5-1-82.

Ins 3.32 Title insurance; prohibited practices. (1) PURPOSE. This rule implements and interprets s. 601.01 (3) and ch. 628, Stats., for the purpose of prohibiting unfair practices in the transaction of the business of title insurance.

(2) SCOPE. This rule shall apply to all operations of title insurers which write the type of insurance authorized by s. Ins 6.75 (2) (h).

(3) DEFINITIONS. (a) *Title insurer* as used in this rule means all insurance companies authorized to write title insurance as defined by section Ins 6.75 (2) (h), and includes all officers and employes of such insurance companies, all agents or representatives of such insurance companies, and all affiliated entities including the officers and employes of such affiliated entities.

(b) *Affiliated entity* as used in this rule means any person or business entity who, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with, a title insurance company.

(c) *Such person* as used in this rule means any of the following, other than a title insurer or affiliated entity as defined herein, who order or influence, directly or indirectly, the ordering of title insurance and related services:

1. Any owner or prospective owner of real or personal property or any interest therein;

2. Any lender or prospective lender in a transaction involving an obligation secured or to be secured either in whole or in part by real or personal property or any interest therein; and

3. Any agent, representative, attorney or employe of any owner or prospective owner or of any lender or prospective lender.

(d) *Title insurance rates* as used in this rule means all charges made by a title insurer in connection with the issuance of a title insurance policy or a commitment to issue a title insurance policy and specifically includes search and examination charges and all other charges.

(e) *Supplementary rate information* as used in this rule has the meaning as defined in s. 625.02 (1), Stats.

(4) PROHIBITED PRACTICES. No title insurer shall engage in any of the following practices:

(a) Charging an amount for a title insurance policy or commitment for a title insurance policy other than the amount developed by application of the apropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner for use by the title insurer.

(b) Waiving, or offering to waive, all or any part of the applicable title insurance rate or premium developed by proper application of the appropriate title insurance rate developed from the rates and supplementary rate information on file with the commissioner.

(c) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when the property involved is ineligible for such reduced rate.

(d) Charging a reduced title insurance rate under a so-called "take-off" or subdivision policy when such rate is not applicable in the particular transaction because the volume required to qualify for such reduced rate includes ineligible property.

(e) Paying, or offering to pay, the cancellation fee, the fee for a preliminary title report or other fee on behalf of any such person after inducing such person to cancel an order with another title insurer.

(f) Making or guaranteeing, or offering to make or guarantee, either directly or indirectly, any loan to any such person, regardless of the terms of the note or guarantee. This prohibition is not applicable to customary business collection procedures, claims settlement and salvage activities and other business activities totally unrelated to the solicitation of business for which a charge is made.

(g) Providing, or offering to provide, either directly or indirectly, a "compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by such lending institution to any such person, or for the express or implied purpose of influencing the placement or channeling of title insurance business by such lending institution. This shall not be construed to prohibit the maintenance by a title insurer of such demand deposits or escrow deposits as are reasonably necessary for use in the ordinary course of business of such title insurer.

(h) Paying, or offering to pay, the fees or charges of an outside professional (e.g., an attorney, engineer, appraisor, or surveyor) whose services are required by any such person to structure or complete a particular transaction.

(i) Paying, or offering to pay, all or any part of the salary of any employe of any such person.

(j) Paying, or offering to pay, any fee to any such person for any services unless such fee bears a reasonable relation to the services performed.

(k) Paying for, or offering to pay for, services by any such person which services are required to be performed by such person in his capacity as a real estate or mortgage broker or salesperson or agent.

(l) Furnishing or offering to furnish, or paying or offering to pay for, furniture, office supplies, telephones, equipment or automobiles to any such person, or paying for, or offering to pay for, any portion of the cost of renting, leasing, operating or maintaining any of the aforementioned items. Marketing and title insurance promotional items clearly of an advertising nature of token or nominal value, or supplies such as title insurance application blanks and related forms are not within the purview of this prohibition provided they are made available to all such persons on the same terms and conditions.

(m) Paying for, furnishing, or waiving, or offering to pay for, furnish, or waive, all or any part of the rent for space occupied by any such person.

(n) Renting, or offering to rent, space from any such person, regardless of the purpose, at a rent which is excessive when compared with rents for comparable space in the geographic area, or paying, or offering to pay, rent based in whole or in part on the volume of business generated by any such person except for a bona fide percentage lease based on the total volume of receipts of the title entity when the services of that title entity are offered from that location to the public generally.

(o) Paying for, or offering to pay for, gifts, vacations, business trips, convention expenses, travel expenses, membership fees, registration fees, lodging or meals on behalf of any such person, directly or indirectly, or supplying letters of credit, credit cards or any such benefits to any such person for any purpose whatsoever. This prohibition is directed at 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 advertis-

ing provided the expected benefit to be derived from customers generally is fairly equivalent to the expense incurred.

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

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

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

Ins 3.38 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 par. (a), including not only policies providing hospital, surgical or medical expense benefits, but also all other types of policies described in par. (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 abnormalities 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.

(b) Clear disclosure of any provision which limits benefits or access to service in the exclusions, limitations, and exceptions sections of the policy or certificate. Among the exclusions, limitations and exceptions which shall be disclosed are those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out-of-pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(c) Clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders.

(10) GRIEVANCE PROCEDURE. (a) Each health maintenance organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement under par. (a), each time the health maintenance organization denies a claim or initiates disenrollment proceedings, the health maintenance organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow.

(c) The health maintenance organization shall acknowledge a grievance within 10 days of receiving it.

(d) The health maintenance organization shall retain records of all grievances for 3 years and shall develop a summary each year which shall include the date each grievance was filed, the nature of the grievance, the date of the resolution of the grievance, a summary of the resolution of the grievance, and a comment concerning any administrative changes made as a result of the grievance. This summary shall be filed with the commissioner by February 1 each year for the preceding year.

(11) OTHER NOTICE REQUIREMENTS. (a) Prior to enrolling members, the health maintenance organization shall provide to prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out-of-area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area serviced by the organization.

(b) If a health maintenance organization terminates its relationship with any clinic or medical group it shall notify all subscribers who receive primary health care services from that clinic or medical group at least 30 days in advance of such termination. The health maintenance organization shall notify all subscribers in a geographical area served by the plan of any changes in it affiliations with providers which have a substantial effect on the availability of covered services in the area.

(12) DISENROLLMENT. (a) The health maintenance organization shall clearly disclose in the policy and certificate any circumstances under which the health maintenance organization may disenroll an enrollee.

(b) Except as provided in s. 632.897, Stats., the health maintenance organization may disenroll an enrollee from the health maintenance organization for the following reasons only:

1. The enrollee has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory patient-physician relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) The health maintenance organization may not disenroll an enrollee under par. (b) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

1. Failure of the enrollee to follow a prescribed course of treatment.

2. Administrative actions such as failure to keep an appointment.

(d) A health maintenance organization which has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar alternate insurance coverage to enrollees. In the case of group certificate holders, this insurance coverage shall be continued until the person finds his or her own coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

History: Cr. Register, June, 1986, No. 366, eff. 9-29-86.