

# State of Wisconsin



2015 Senate Bill 287

Date of enactment: **November 11, 2015**  
Date of publication\*: **November 12, 2015**

## 2015 WISCONSIN ACT 90

AN ACT *to repeal* 601.422, 601.425, 601.428, 612.14 (1) to (12), 612.31 (5), 612.31 (6), 612.32 (4), 612.53 (1) (title), 612.53 (2), 612.71, 623.06 (1c), 628.81, 635.13 (title), 635.13 (2) and 646.51 (3) (am) 1.; *to renumber* 612.53 (1) and 635.13 (1); *to renumber and amend* 612.14 (intro.), 620.04 (1), 623.06 (1f), 623.06 (8) and 632.43 (6m) (a) 3.; *to consolidate, renumber and amend* 646.51 (3) (am) (intro.) and 2.; *to amend* 600.01 (1) (b) 10. b., 605.21 (2), 611.07 (4), 611.56 (5), 611.63 (4), 612.02 (2) (a), 612.13 (3), 612.13 (4), 612.31 (4) (m), 612.32 (1), 612.32 (2) (a), 612.33 (1), 612.33 (2) (b), 623.06 (2) (intro.), 628.07, 628.10 (2) (a), 628.10 (2) (am), 628.347 (1) (a), 628.347 (4) (c), 628.347 (4m) (b) 3. c., 631.95 (3) (a), 632.43 (6m) (e) 3. f., 632.43 (6m) (e) 3. g., 632.62 (2), 632.62 (3), 632.62 (4) (a), 632.62 (4) (b), 632.89 (3c) (b), 646.51 (3) (b), 646.51 (4) (a), 646.51 (9) (a), 646.51 (9) (b), 655.27 (3) (b) 1., 655.27 (3) (b) 2., 655.27 (3) (b) 2m., 655.27 (3) (bg) 1., 655.27 (3) (bg) 2., 655.27 (3) (br) (intro.), 655.27 (3) (d), 655.27 (3) (e) and 655.61 (1); *to repeal and recreate* 623.06 (1) (f); and *to create* 227.01 (13) (pm), 601.465 (1m) (c) 8., 601.465 (1m) (c) 9., 601.465 (3) (d), 620.04 (1) (b), 623.06 (1), 623.06 (1f) (b), 623.06 (1m) (intro.), 623.06 (1r), 623.06 (8m), 623.06 (9), 623.06 (10), 623.06 (11), 623.06 (12), 623.06 (13) (b), 632.43 (6m) (a) 3. b., 632.43 (6m) (a) 4m., 645.675, 646.51 (3) (ar), 646.51 (10), 655.27 (3) (bt) and 655.61 (3) of the statutes; **relating to:** various miscellaneous changes to the insurance statutes and granting rule-making authority.

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

**SECTION 1.** 227.01 (13) (pm) of the statutes is created to read:

227.01 (13) (pm) Relates to setting fees under s. 655.27 (3) for the injured patients and families compensation fund or setting fees under s. 655.61 for the mediation fund.

**SECTION 2.** 600.01 (1) (b) 10. b. of the statutes is amended to read:

600.01 (1) (b) 10. b. The exemption under subd. 10. a. does not apply if the services offered by the care management organization include hospital, physician or other acute health care services other than mental health and alcohol and other drug abuse treatment services.

**SECTION 3.** 601.422 of the statutes is repealed.

**SECTION 4.** 601.425 of the statutes is repealed.

**SECTION 5.** 601.428 of the statutes is repealed.

**SECTION 6.** 601.465 (1m) (c) 8. of the statutes is created to read:

601.465 (1m) (c) 8. The International Association of Insurance Supervisors.

**SECTION 7.** 601.465 (1m) (c) 9. of the statutes is created to read:

601.465 (1m) (c) 9. An agent or employee of the International Association of Insurance Supervisors.

**SECTION 8.** 601.465 (3) (d) of the statutes is created to read:

601.465 (3) (d) Any information defined as confidential information under s. 623.06 (12) (am), which is

\* Section 991.11, WISCONSIN STATUTES: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication."

subject only to the confidentiality provisions in s. 623.06 (12).

**SECTION 9.** 605.21 (2) of the statutes is amended to read:

605.21 (2) **PREMIUM PAYMENT.** Upon receipt of certification of premium due, the premium shall be paid into the state treasury for the benefit of the property fund, within ~~60~~ 30 days after the date of certification or the effective date of the policy, whichever is the later. Premiums for property insured effective at a later date shall be paid within ~~60~~ 30 days after the effective date of each addition. The amount of a premium in default shall be a special charge against the local governing unit, and be included in the next certification of state taxes and charged and collected as other special charges are collected, with interest from the due date at a rate set by the commissioner by rule or, in the absence of a rule, at twice the most common prime rate charged by major banks in this state.

**SECTION 10.** 611.07 (4) of the statutes is amended to read:

611.07 (4) **WAIVER OF NOTICE AND INFORMAL ACTION BY SHAREHOLDERS, POLICYHOLDERS OR DIRECTORS.** Sections 180.0704, 180.0706, 180.0821, and 180.0823 apply to stock corporations and ss. 181.0704, 181.0706, 181.0821, and 181.0823 apply to mutuals. Section 180.0821 also applies to a committee of the board of a stock corporation and s. 181.0821 also applies to a committee of the board of a mutual, except that, in both cases, references to "board" shall be read as "committee" and "directors" shall mean members of the board appointed to serve on the committee.

**SECTION 11.** 611.56 (5) of the statutes is amended to read:

611.56 (5) **QUORUM MEETINGS, QUORUM, AND VOTING.** Section Sections 180.0820, 180.0821, and 180.0824 applies apply to a committee of the board of a stock corporation, except that references in s. 180.0824 to a committee "created under s. 180.0825" shall be read as a committee "created under this section". Sections 181.0820, 181.0821, and 181.0824 apply to a committee of the board of a mutual, except that references to "board" shall be read as "committee", "majority" in s. 181.0824 (1) shall mean a majority of the members of the board appointed to serve on the committee, and "majority" in s. 181.0824 (2) shall mean a majority of the members of the board appointed to serve on the committee who are present at the meeting.

**SECTION 11m.** 611.63 (4) of the statutes is amended to read:

611.63 (4) **ANNUAL REPORT TO COMMISSIONER.** The amount of all direct and indirect remuneration for services, including retirement and other deferred compensation benefits and stock options, paid or accrued each year for the benefit of each director and each officer and employee member of executive management, as defined

by the commissioner, whose remuneration exceeds an amount established by the commissioner, and for all directors and officers as a group shall be included in the annual report made to the commissioner.

**SECTION 12.** 612.02 (2) (a) of the statutes is amended to read:

612.02 (2) (a) The name of the corporation ~~which shall contain the words "Town Mutual";~~

**SECTION 13.** 612.13 (3) of the statutes is amended to read:

612.13 (3) **DUTIES.** The board shall ~~manage~~ direct the business and affairs of the corporation and shall not delegate its power or responsibility to any person except as specifically provided otherwise in this chapter.

**SECTION 14.** 612.13 (4) of the statutes is amended to read:

612.13 (4) **ADJUSTMENT COMMITTEE.** The directors shall may annually appoint from their own number an adjustment committee of at least 3 persons, to adjust or supervise the adjustment of losses under s. 612.53. If no adjustment committee is appointed, the entire board shall act as the adjustment committee to adjust or supervise the adjustment of losses under s. 612.53.

**SECTION 15.** 612.14 (intro.) of the statutes is renumbered 612.14 and amended to read:

**612.14 Reports.** ~~The secretary and the treasurer~~ An officer or person designated by an officer of the company shall present to the annual meeting written reports showing the condition of the town mutual on the previous December 31 and its activity during the preceding calendar year, including: any information required to be presented by the articles or bylaws or by the commissioner. The officer or person designated by an officer shall include in the reports a sufficient level of information to reasonably inform members about the financial condition of the town mutual.

**SECTION 16.** 612.14 (1) to (12) of the statutes are repealed.

**SECTION 17.** 612.31 (4) (m) of the statutes is amended to read:

612.31 (4) (m) Assuming reinsurance, ~~except under sub. (6); or~~

**SECTION 18.** 612.31 (5) of the statutes is repealed.

**SECTION 19.** 612.31 (6) of the statutes is repealed.

**SECTION 20.** 612.32 (1) of the statutes is amended to read:

612.32 (1) **REAL PROPERTY OUTSIDE TERRITORY.** Town mutuals may insure real property and contents in villages and cities partially located in the specified territory, real property and contents in an immediately adjoining county owned by a member immediately adjoining and contiguous to land owned by the same member which is who has real property and contents insured by the town mutual within the specified territory, and real property and contents used exclusively by the member and his or her family for recreational purposes.

**SECTION 21.** 612.32 (2) (a) of the statutes is amended to read:

612.32 (2) (a) *Farm property.* A town mutual may provide coverage for livestock, while temporarily located outside the town mutual's territory, for farm products, while temporarily located for a period not exceeding 2 years outside the town mutual's territory, and for farm machinery and farm vehicles while temporarily located, for a period not exceeding 6 months, one year outside its territory, subject to limitations in the policy or in the articles or bylaws with respect to the distance from the territory to which the property may be removed without suspension of the coverage.

**SECTION 22.** 612.32 (4) of the statutes is repealed.

**SECTION 23.** 612.33 (1) of the statutes is amended to read:

612.33 (1) PERMITTED AND PROHIBITED REINSURANCE. A town mutual may cede reinsurance only ~~under s. 612.31 (6), or~~ to an insurer authorized to do business in this state under s. ~~612.71 or~~ ch. 611 or 618, or under arrangements which are approved in advance by the commissioner and which are subject to the controls the commissioner prescribes.

**SECTION 24.** 612.33 (2) (b) of the statutes is amended to read:

612.33 (2) (b) *Nonproperty insurance.* To the extent that a town mutual provides insurance under s. 612.31 (3), it shall obtain reinsurance of at least a 90% proportional share of each risk or it shall obtain excess of loss reinsurance with a retention in a similar dollar amount with an insurer authorized to do such business in this state, in either instance not to exceed \$25,000 on each risk. The commissioner may permit a town mutual to retain a larger percentage or have a greater excess of loss retention level if he or she finds that the interests of the members will not be endangered thereby, or may require it to reinsure a larger percentage or obtain a lesser excess of loss retention level if he or she finds that the interests of the members make it advisable. The commissioner may by rule require other reinsurance.

**SECTION 25.** 612.53 (1) (title) of the statutes is repealed.

**SECTION 26.** 612.53 (1) of the statutes is renumbered 612.53.

**SECTION 27.** 612.53 (2) of the statutes is repealed.

**SECTION 28.** 612.71 of the statutes is repealed.

**SECTION 29.** 620.04 (1) of the statutes is renumbered 620.04 (1) (intro.) and amended to read:

620.04 (1) ADDITIONAL RESTRICTIONS. (intro.) If the commissioner finds that by reason of investment conditions generally or of the financial condition or current investment practice of an individual insurer, the interests of insureds, creditors, or the public are or may be endangered, the commissioner may do any of the following:

(a) For insurers that are not restricted under s. 620.03, impose reasonable and temporary restrictions upon the

investments of an individual insurer, including prohibition or divestment of a particular investment.

**SECTION 30.** 620.04 (1) (b) of the statutes is created to read:

620.04 (1) (b) For insurers that are subject to s. 620.03, impose reasonable restrictions upon the investments of an individual insurer, including prohibition or divestment of a particular investment.

**SECTION 31.** 623.06 (1) of the statutes is created to read:

623.06 (1) In this section:

(a) "Accident and health insurance contract" means a contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(b) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in sub. (1r).

(c) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(d) "Law enforcement agency," "National Association of Insurance Commissioners," or "regulatory agency" includes the employees, agents, consultants, and contractors of each such entity.

(e) "Life insurance," "life insurance contract," "life insurance policy," or "plan of life insurance" means a contract that incorporates mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(f) "Operative date of the valuation manual" means the date determined under sub. (9) (b).

(g) "Principle-based valuation" means a reserve valuation that uses one or more methods, or one or more assumptions, determined by the insurer and that is required to comply with sub. (10) as specified in the valuation manual.

(h) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American academy of actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual, if the valuation manual is in effect, and any other requirements that the commissioner may by rule specify.

(i) "Tail risk" means a risk that occurs either when the frequency of low probability events is higher than expected under a normal probability distribution or when there are observed events of very significant size or magnitude.

(j) "Valuation manual" means the manual of valuation instructions as adopted by the National Association of Insurance Commissioners under sub. (9) or as subsequently amended.

**SECTION 32.** 623.06 (1) (f) of the statutes, as created by 2015 Wisconsin Act .... (this act), is repealed and recreated to read:

623.06 (1) (f) “Operative date of the valuation manual” means the effective date of this paragraph .... [LRB inserts date], as determined under sub. (9) (b).

**SECTION 33.** 623.06 (1c) of the statutes is repealed.

**SECTION 34.** 623.06 (1f) of the statutes is renumbered 623.06 (1f) (a) and amended to read:

623.06 (1f) (a) The For policies and contracts issued before the operative date of the valuation manual, the commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state, except that in the case of an alien company, such valuation shall be limited to its United States business, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest and methods (net level premium method or other) used in the calculation of such reserves. In calculating such reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves herein required of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when if such valuation complies with the minimum standard herein provided and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction. Subsections (2) to (7) apply to all policies and contracts issued before the operative date of the valuation manual.

**SECTION 35.** 623.06 (1f) (b) of the statutes is created to read:

623.06 (1f) (b) For policies and contracts issued on or after the operative date of the valuation manual, the commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health insurance contracts, and deposit-type contracts of every insurer doing business in this state. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction if the valuation complies with the minimum standard provided in this section. Subsections (9) and (10) apply to all policies and contracts issued on or after the operative date of the valuation manual.

**SECTION 36.** 623.06 (1m) (intro.) of the statutes is created to read:

623.06 (1m) (intro.) Before the operative date of the valuation manual, all of the following apply:

**SECTION 37.** 623.06 (1r) of the statutes is created to read:

623.06 (1r) Beginning on the operative date of the valuation manual, all of the following apply:

(a) Every insurance company that has outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and that is subject to regulation by the commissioner shall submit to the commissioner, as prescribed in par. (c), the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of those outstanding contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The valuation manual shall prescribe the specifics of this opinion, including any items that are necessary to its scope.

(b) Every insurance company that has outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and that is subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required under par. (a) an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company’s obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts. The opinion required under this paragraph shall be governed by the following:

1. A memorandum, in form and substance as specified in the valuation manual and acceptable to the commissioner, shall be prepared to support each actuarial opinion.

2. If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual, or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(c) All opinions required under this subsection shall be governed by the following:

1. The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

2. The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending after the operative date of the valuation manual.

3. The opinion shall apply to all policies and contracts described in pars. (a) and (b), plus other actuarial liabilities as may be specified in the valuation manual.

4. The opinion shall be based on standards adopted from time to time by the actuarial standards board or its successor and on any additional standards prescribed in the valuation manual.

5. With respect to an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

6. Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

**SECTION 38.** 623.06 (2) (intro.) of the statutes is amended to read:

623.06 (2) (intro.) Except as provided in subs. (2a) and (2m), the minimum standard for the valuation of all such policies and contracts specified by the commissioner under sub. (1m) (a) 1. issued prior to the effective date of this section [see sub. (8) (13) and s. 632.43 (9)] shall be that provided by the laws in effect immediately prior to such date. Except as provided in subs. (2a) and (2m), the minimum standard for the valuation of all such policies and contracts issued on or after the effective date of this section shall be the commissioner's reserve valuation methods defined in subs. (3) to (4m) and (7), with 3.5 percent interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after June 19, 1974, and prior to November 8, 1977, 4 percent interest, and for policies issued on or after November 8, 1977, 4.5 percent interest and the following tables:

**SECTION 39.** 623.06 (8) of the statutes is renumbered 623.06 (13) (a) and amended to read:

623.06 (13) (a) ~~This~~ Except for subs. (1), (1f) (b), (1r), and (8m) to (12), this section shall become effective on the same date as does s. 632.43.

(c) The provisions of this section shall supersede all provisions of law inconsistent or in conflict therewith.

**SECTION 40.** 623.06 (8m) of the statutes is created to read:

623.06 (8m) For accident and health insurance contracts issued on or after the effective date of this subsec-

tion .... [LRB inserts date], but before the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the commissioner by rule. For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual shall be the minimum standard of valuation required under sub. (1f) (b).

**SECTION 41.** 623.06 (9) of the statutes is created to read:

623.06 (9) (a) For policies and contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under sub. (1f) (b), except as provided in pars. (e) and (g).

(b) The operative date of the valuation manual is January 1 of the first calendar year beginning after the first July 1 as of which all of the following have occurred:

1. The valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote of at least 42 members or three-fourths of the members voting, whichever is greater.

2. The standard valuation law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing more than 75 percent of the direct premiums written as reported in all of the following annual statements submitted for 2008:

- Life, accident, and health annual statements.
- Health annual statements.
- Fraternal annual statements.

3. The standard valuation law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions:

- The 50 states of the United States.
- American Samoa.
- The American Virgin Islands.
- The District of Columbia.
- Guam.
- Puerto Rico.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on the first January 1 after the date when such changes have been adopted by the National Association of Insurance Commissioners by an affirmative vote representing all of the following:

1. At least three-fourths of the members of the National Association of Insurance Commissioners voting, but not less than a majority of the total membership.

2. Members of the National Association of Insurance Commissioners representing the jurisdictions specified in par. (b) 3. with more than 75 percent of the direct premiums written as reported in all of the following annual

statements most recently available before the vote under subd. 1.:

- a. Life, accident, and health annual statements.
- b. Health annual statements.
- c. Fraternal annual statements.

(d) The valuation manual must specify all of the following:

1. Minimum valuation standards for and definitions of the policies and contracts subject to sub. (1f) (b). The minimum valuation standards shall be all of the following:

a. The commissioners reserve valuation method for life insurance contracts, other than annuity contracts, subject to sub. (1f) (b).

b. The commissioners annuity reserve valuation method for annuity contracts subject to sub. (1f) (b).

c. Minimum reserves for all other policies and contracts subject to sub. (1f) (b).

2. Which policies or contracts, or types of policies or contracts, are subject to the requirements of a principle-based valuation in sub. (10) (a) and the minimum valuation standards consistent with those requirements.

3. For policies and contracts subject to a principle-based valuation under sub. (10), all of the following:

a. Requirements for the format of reports to the commissioner under sub. (10) (b) 3., which reports shall include information necessary to determine if the valuation is appropriate and in compliance with this section.

b. Requirements regarding the treatment of risks over which the insurance company does not have significant control or influence.

c. Procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of such procedures.

4. The minimum valuation standard for policies not subject to a principle-based valuation under sub. (10), which minimum valuation standard shall be the greater of the following:

a. Reserves that are consistent with the minimum standard of valuation before the operative date of the valuation manual.

b. Reserves that quantify the benefits, guarantees, and funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring. This does not preclude, for policies with significant tail risk, reflecting in the reserve condition appropriately adverse to quantify that tail risk.

5. Other requirements, including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of insurance company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules, and internal controls.

6. The data and form of the data required under sub. (11) and to whom the data must be submitted. The valua-

tion manual may specify other related requirements, including data analyses and reporting of analyses.

(e) In the absence of a specific valuation requirement, or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this section, the insurance company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by rule.

(f) The commissioner may engage a qualified actuary, at the expense of the insurance company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement in this section. The commissioner may rely on the opinion, regarding provisions in this section, of a qualified actuary engaged by the commissioner of another state or district or territory of the United States. As used in this paragraph, the term "engage" includes both "employ" and "contract with."

(g) The commissioner may require an insurance company to make any change to an assumption or method that, in the opinion of the commissioner, is necessary to comply with the requirements of the valuation manual or this section. An insurance company shall adjust the reserves as required by the commissioner. The commissioner may take any disciplinary action permitted under ss. 601.41 (4) and 601.64.

(h) 1. The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Wisconsin from the requirements of this subsection if all of the following are satisfied:

a. The commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing.

b. The company computes reserves using assumptions and methods used before the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by rule.

2. For policy forms and product lines for which a company is granted an exemption under subd. 1., subs. (1f) (a), (1m), and (2) to (7) apply, and any reference to the valuation manual does not apply.

**SECTION 42.** 623.06 (10) of the statutes is created to read:

**623.06 (10)** (a) For policies and contracts issued on or after the operative date of the valuation manual, an insurer must establish reserves for policies and contracts as specified in the valuation manual using a principle-based valuation that does all of the following:

1. Quantifies the benefits, guarantees, and funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of

occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, the principle-based valuation should reflect conditions appropriately adverse to quantify the tail risk.

2. Incorporates assumptions, risk analysis methods and financial models, and management techniques that are consistent with, but not necessarily identical with, those used within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

3. Incorporates assumptions that are derived in one of the following ways:

a. The assumption is prescribed in the valuation manual.

b. For an assumption that is not prescribed in the valuation manual, the assumption is established using the company's available experience to the extent it is relevant and statistically credible. To the extent that company data is not available, relevant, or statistically credible, the assumption is established using other relevant, statistically credible experience.

4. Provides margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty, the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall do all of the following:

1. Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

2. Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. The internal controls shall be designed to ensure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

3. Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) A principle-based valuation may include a prescribed formulaic reserve component.

**SECTION 43.** 623.06 (11) of the statutes is created to read:

623.06 (11) Beginning on the operative date of the valuation manual, a company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data for all policies and contracts in force as prescribed in the valuation manual.

**SECTION 44.** 623.06 (12) of the statutes is created to read:

623.06 (12) (a) In this subsection:

1. "Experience data" means any documents, materials, data, or other information submitted by a company under sub. (11).

2. "Experience materials" means any documents, materials, data, or other information, including all working papers and copies of working papers, created or produced in connection with experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner, together with any experience data.

(am) For purposes of pars. (b) and (c), all of the following are confidential information:

1. A memorandum in support of an opinion submitted under sub. (1m) or (1r) and any other documents, materials, or other information, including all working papers and copies of working papers, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the memorandum.

2. All documents, materials, and other information, including all working papers and copies of working papers, created, produced, or obtained by or disclosed to the commissioner or any other person in the course of an examination made under sub. (9) (f), except that if an examination report or other material prepared in connection with an examination made under ss. 601.43 and 601.44 is not held as private and confidential information under s. 601.465 (1m) (b), an examination report or other material prepared in connection with an examination made under sub. (9) (f) is not confidential information to the same extent as if the examination report or other material had been prepared under ss. 601.43 and 601.44.

3. Any reports, documents, materials, or other information developed by a company in support of, or in connection with, an annual certification by the company under sub. (10) (b) 2. evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, or other information, including all working papers and copies of working papers, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the reports, documents, materials, and other information.

4. Any principle-based valuation report developed under sub. (10) (b) 3. and any other documents, materials, or other information, including all working papers and copies of working papers, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with the report.

5. Experience data, experience materials, and any other documents, materials, data, or other information, including all working papers and copies of working

papers, created, produced, or obtained by or disclosed to the commissioner or any other person in connection with experience materials.

(b) 1. Information described as confidential under par. (am) is confidential and privileged; is not subject to receipt, inspection, or copying under s. 19.35 (1); is not subject to subpoena; and is not subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

2. Neither the commissioner nor any person who received confidential information while acting under the authority of the commissioner may testify in any private civil action concerning any confidential information.

3. a. In furtherance of the performance of the commissioner's regulatory duties, the commissioner may share confidential information with other state, federal, and international regulatory agencies; the National Association of Insurance Commissioners and its affiliates and subsidiaries; the Actuarial Board for Counseling and Discipline or its successor, in the case of confidential information under par. (am) 1. and 4. only, upon request stating that the confidential information is required for the purposes of professional disciplinary proceedings; and state, federal, and international law enforcement agencies.

b. Confidential information may be shared under subd. 3. a. only if the recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner.

c. The commissioner may receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, data, or information from the National Association of Insurance Commissioners and its affiliates and subsidiaries, from regulatory or law enforcement agencies of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor, and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

d. The commissioner may enter into agreements governing sharing and use of information consistent with this subsection.

e. No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure of such information or documents to the commissioner under this subsection or as a result of the commissioner sharing such information or documents as authorized in this subsection.

f. A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(c) Notwithstanding par. (b), any confidential information specified in par. (am) 1. and 4. is subject to all of the following:

1. The confidential information may be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under sub. (1m) or (1r) or the principle-based valuation report developed under sub. (10) (b) 3. by reason of an action required by this section or rules promulgated under this section.

2. The confidential information may otherwise be released by the commissioner with the written consent of the company.

3. If any portion of a memorandum in support of an opinion submitted under sub. (1m) or (1r) or any portion of the principle-based valuation report developed under sub. (10) (b) 3. is cited by the company in its marketing, is publicly volunteered to or before a government agency other than a state insurance department, or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

**SECTION 45.** 623.06 (13) (b) of the statutes is created to read:

623.06 (13) (b) Subsections (1), (1f) (b), (1r), and (8m) to (12) shall become effective on the effective date of this paragraph .... [LRB inserts date].

**SECTION 46.** 628.07 of the statutes is amended to read:

**628.07 Licensing of nonresidents.** The commissioner ~~may shall~~ waive the any examination requirement ~~of an examination~~ for a nonresident applicant under s. 628.04 if ~~the jurisdiction of the applicant's residence has imposed upon the applicant requirements substantially as rigorous as those of this state and has enforced them with comparable rigor~~ home state or state of residence has issued the applicant a license for which the qualifications are equivalent to the qualifications for a license issued by this state and if that license is in good standing at the time of application.

**SECTION 47.** 628.10 (2) (a) of the statutes is amended to read:

628.10 (2) (a) *For failure to comply with continuing education or annual training requirements.* The license of any intermediary or individual navigator who fails to produce evidence of compliance with continuing education standards set by the commissioner or with annual training requirements is revoked, effective on the date on which the evidence of compliance is due. At least 60 days before that date, the commissioner shall ~~send by 1st class mail to the intermediary's or navigator's address that is~~

~~on file with the commissioner notice~~ notify the intermediary or navigator of the date by which the evidence of compliance is due and that the intermediary's or navigator's license will be revoked if the evidence is not received by that date. An intermediary or navigator whose license is revoked under this paragraph may have his or her license reinstated, or may be relicensed, as provided in sub. (5).

**SECTION 48.** 628.10 (2) (am) of the statutes is amended to read:

628.10 (2) (am) *Nonpayment of fees.* The license of an intermediary or individual navigator who fails to pay a fee when due is revoked, effective on the date on which the fee is due. At least 60 days before that date, the commissioner shall ~~send by 1st class mail to the intermediary's or navigator's address that is on file with the commissioner notice~~ notify the intermediary or navigator of the date by which the fee is due and that the intermediary's or navigator's license will be revoked if timely payment is not made. An intermediary who is a natural person, or an individual navigator, whose license is revoked under this paragraph may have his or her license reinstated, or may be relicensed, as provided in sub. (5).

**SECTION 49.** 628.347 (1) (a) of the statutes is amended to read:

628.347 (1) (a) "Annuity" means ~~a fixed or variable~~ an annuity that is an insurance product that is individually solicited, whether the product is classified as an individual or group annuity.

**SECTION 50.** 628.347 (4) (c) of the statutes is amended to read:

628.347 (4) (c) This subsection applies to FINRA broker-dealer sales of ~~variable annuities and fixed~~ annuities if the suitability and supervision are similar to those applied to variable annuity sales.

**SECTION 51.** 628.347 (4m) (b) 3. c. of the statutes is amended to read:

628.347 (4m) (b) 3. c. How ~~fixed, variable, and indexed~~ product-specific annuity contract ~~provisions~~ features affect consumers.

**SECTION 52.** 628.81 of the statutes is repealed.

**SECTION 53.** 631.95 (3) (a) of the statutes is amended to read:

631.95 (3) (a) *Disability insurance.* In establishing premiums for an individual or group disability insurance policy or a certificate of group disability insurance, an insurer may inquire about a person's existing medical condition and, based on the opinion of a qualified actuary, as defined in s. 623.06 ~~(4e)~~ (1) (h), use information related to a person's existing medical condition, regardless of whether that condition is or may have been caused by abuse or domestic abuse.

**SECTION 54.** 632.43 (6m) (a) 3. of the statutes is renumbered 632.43 (6m) (a) 3. (intro.) and amended to read:

632.43 (6m) (a) 3. (intro.) "Nonforfeiture interest rate" means ~~125% either of the following:~~

a. For all policies other than those described in subd. 3. b., 125 percent of the applicable calendar year valuation interest rate under s. 623.06 rounded to the nearest ~~0.25%~~ 0.25 percent, but in no case less than 4 percent.

**SECTION 55.** 632.43 (6m) (a) 3. b. of the statutes is created to read:

632.43 (6m) (a) 3. b. For policies issued on or after the operative date of the valuation manual, the rate per annum provided in the valuation manual.

**SECTION 56.** 632.43 (6m) (a) 4m. of the statutes is created to read:

632.43 (6m) (a) 4m. "Operative date of the valuation manual" has the meaning given in s. 623.06 (1) (f).

**SECTION 57.** 632.43 (6m) (e) 3. f. of the statutes is amended to read:

632.43 (6m) (e) 3. f. ~~Any~~ For policies issued before the operative date of the valuation manual, any ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the commissioners 1980 standard ordinary mortality table with or without 10-year select mortality factors or for the commissioners 1980 extended term insurance table. For policies issued on or after the operative date of the valuation manual, the valuation manual provides the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table with or without 10-year select mortality factors or for the commissioners 1980 extended term insurance table. If the commissioner approves, by rule, any ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

**SECTION 58.** 632.43 (6m) (e) 3. g. of the statutes is amended to read:

632.43 (6m) (e) 3. g. ~~Any~~ For policies issued before the operative date of the valuation manual, any industrial mortality tables adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. For policies issued on or after the operative date of the valuation manual, the valuation manual provides the commissioners standard mortality table for use in determining the minimum non-

forfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or for the commissioners 1961 industrial extended term insurance table. If the commissioner approves, by rule, any industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

**SECTION 59.** 632.62 (2) of the statutes is amended to read:

632.62 (2) PARTICIPATION. Every participating policy shall by its terms ~~give its holder full right to participate annually in the part of the surplus accumulations from the participating business of the insurer that are to be distributed~~ make its holder eligible to share annually in the part of the surplus to be distributed as provided in sub. (4) (b).

**SECTION 60.** 632.62 (3) of the statutes is amended to read:

632.62 (3) ACCOUNTING. Every insurer issuing both participating and nonparticipating policies shall separately account for the 2 classes of business and no part of the ~~amounts accumulated or credited~~ surplus allocated to the participating class may be voluntarily transferred to the nonparticipating class.

**SECTION 61.** 632.62 (4) (a) of the statutes is amended to read:

632.62 (4) (a) *Deferred dividends.* No life insurance policy or certificate may be issued in which the ~~accounting, apportionment and distribution of surplus dividends, if any,~~ is deferred for a period longer than one year.

**SECTION 62.** 632.62 (4) (b) of the statutes is amended to read:

632.62 (4) (b) *Payment.* Every insurer doing a participating business shall annually ascertain the surplus over required reserves and other liabilities. After setting aside such ~~contingency reserves~~ amounts as may be ~~lawful and~~ considered necessary and be lawful, such reasonable nondistributable surplus as is needed to permit orderly growth, by the insurer's board of directors for providing for the growth of the company and for protecting the ability to meet ongoing and future claims and other obligations and needs under both normal and stressed environments, and after making provision for the payment of reasonable dividends upon capital stock ~~as determined by the insurer's board of directors~~ and such sums as are required by prior contracts to be held on account of deferred dividend policies, ~~the remaining surplus shall be equitably apportioned and returned as a dividend to the participating policyholders or certificate holders entitled to share therein~~ an insurer shall distribute as dividends the remaining surplus, if any, attributable to participating life insurance and annuity policies in such amounts, including zero, and in such allocations among the partici-

pating life insurance and annuity policies as its board of directors determines to be reasonably proportioned to its calculation of the life insurance and annuity policies' contribution to the distributable surplus. A dividend may be conditioned on the payment of the succeeding year's premium only on the first and second anniversaries of the policy.

**SECTION 63.** 632.89 (3c) (b) of the statutes is amended to read:

632.89 (3c) (b) A cost increase specified under par. (a) may not be determined until the employer's group health benefit plan or self-insured health plan has complied with the requirements under sub. (3) for at least the first 6 months of the plan year for which the increase is to be determined. The cost increase shall be determined, and certified, by a qualified actuary, as defined in s. 623.06 (1e) (1) (h). A copy of the actuary's determination, and all underlying documentation that the actuary relied on in making the determination, shall be filed with and, in accordance with rules promulgated by the commissioner, retained by the insurer issuing the group health benefit plan or by the self-insured health plan.

**SECTION 64.** 635.13 (title) of the statutes is repealed.

**SECTION 65.** 635.13 (1) of the statutes is renumbered 635.13.

**SECTION 66.** 635.13 (2) of the statutes is repealed.

**SECTION 67.** 645.675 of the statutes is created to read:

**645.675 Qualified financial contracts.** (1) In this section:

(a) "Actual direct compensatory damages" includes normal and reasonable costs of cover or other reasonable measures of damages used in the derivatives, securities, or other markets for the contract and agreement claims. "Actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity, or damages for pain and suffering.

(b) "Business day" means any day other than a Saturday, a Sunday, or a day on which the New York Stock Exchange, or the Federal Reserve Bank of New York is closed.

(c) "Commodity contract" means any of the following:

1. A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the federal Commodity Exchange Act, 7 USC 1, et seq., or a board of trade outside the United States.

2. An agreement that is subject to regulation under the federal Commodity Exchange Act, 7 USC 23, and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract.

3. An agreement or transaction that is subject to regulation under the federal Commodity Exchange Act, 7 USC 6c, and that is commonly known to the commodities trade as a commodity option.

4. Any combination of agreements or transactions specified in subds. 1. to 3.

5. Any option to enter into an agreement or transaction specified in subds. 1. to 3.

(d) “Contractual right” includes any right established in a rule or bylaw, or in a resolution, of the governing board of a derivatives clearing organization or board of trade as defined in the federal Commodity Exchange Act, 7 USC 1, et seq.; a multilateral clearing organization, as defined in the federal Deposit Insurance Corporation Improvement Act of 1991, 12 USC 4402; a national securities exchange, a national securities association, a securities clearing agency, or a control market designated under the federal Commodity Exchange Act, 7 USC 1, et seq.; or a derivatives transaction execution facility registered under the federal Commodity Exchange Act, 7 USC 1, et seq., or any right, regardless whether it is in writing, arising under statutory or common law, or under the uniform commercial code, or by reason of normal business practice.

(e) “Counterparty” means a person who enters into a qualified financial contract with an insurer.

(f) “Credit insurance” means insurance against loss arising from failure of debtors to meet financial obligations to creditors, except mortgage guaranty insurance.

(g) “Credit life insurance” means insurance on the lives of borrowers or purchasers of goods in connection with specific loans or credit transactions when all or a portion of the insurance is payable to the creditor to reduce or extinguish the debt.

(h) “Disability insurance” means insurance covering injury or death of persons caused by accident or insurance covering the health of persons.

(i) “Financial guaranty insurance” means a surety bond, insurance policy, indemnity contract, or any similar guarantee issued by an insurer under which a loss is payable upon proof of occurrence of financial loss to an insured claimant. “Financial guaranty insurance” does not include credit insurance, credit life insurance, disability insurance, mortgage guaranty insurance, or long-term care insurance.

(j) “First-method provision” means a contract provision in which the nondefaulting party is not required to pay if a net or settlement amount is owed to the defaulting party.

(k) “Forward contract” has the meaning given in 12 USC 1821 (e) (8) (D).

(L) “Mortgage guaranty insurance” means insurance against loss arising from any of the following:

1. Debtors to meet financial obligations to creditors under evidences of indebtedness that are secured by any of the following:

a. A first lien or charge on residential real estate designed for occupancy by not more than 4 families.

b. A first lien of charge on residential real estate designed for occupancy by 5 or more families.

c. A first lien or charge on real estate designed for industrial or commercial purposes.

d. A junior lien or charge on residential real estate.

2. Lessees to make payment on rentals under leases of real estate in which the lease extends for 3 years or longer.

(m) “Netting agreement” means any of the following:

1. A contract or agreement, or terms and conditions in a contract or agreement, including a master agreement together with all schedules, confirmations, definitions, and addenda, that documents one or more transactions between the parties to the agreement for, or involving, one or more qualified financial contracts and that provides for either the netting, liquidation, setoff, termination, acceleration, or close-out under, or in connection with, one or more qualified financial contracts or present or future payment or delivery obligations or entitlements, including related liquidation or close-out values, among the parties to the netting agreement.

2. Any master agreement or bridge agreement for one or more master agreements described in subd. 1.

3. Any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation related to any contract or agreement described in subd. 1. or 2.

(n) “Qualified financial contract” means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, or any similar agreement that the commissioner determines by rule or order to be a qualified financial contract.

(o) “Repurchase agreement” has the meaning given in 12 USC 1821 (e) (8) (D).

(p) “Second-method provision” means a contract provision requiring a nondefaulting party to pay if a net or settlement amount is owed to the defaulting party.

(q) “Securities contract” has the meaning given in 12 USC 1821 (e) (8) (D).

(r) “Swap agreement” has the meaning given in 12 USC 1821 (e) (8) (D).

(s) “Two-way payment provision” means a contract provision under which both parties to the contract may have payment obligations to each other.

(t) “Walkaway clause” means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party’s position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation, or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party, in whole or in part, solely because of the party’s status as a nondefaulting party.

(2) (a) On or after 5 p.m. central time on the business day following the date of appointment of a receiver, with regard to qualified financial contracts with an insurer that are subject to a proceeding under this chapter, no person

may be stayed or prohibited from exercising any of the following rights, unless that person has received written notice that the contract has been sold or transferred under s. 645.33 (2) or 645.46 (9):

1. A contractual right to cause the termination, liquidation, acceleration, or close-out of obligations under, or in connection with, any netting agreement or qualified financial contract with an insurer on account of any of the following:

a. The insolvency, financial condition, or default of the insurer at any time, if the right is enforceable under applicable law other than this chapter.

b. The commencement of a formal delinquency proceeding under this chapter.

2. Any right under a pledge, security, collateral, reimbursement, or guarantee agreement or arrangement, or any other similar security agreement or arrangement or other credit enhancement, relating to one or more netting agreements or qualified financial contracts.

3. Subject to s. 645.56 (2), any right to set-off or net-out any termination value, payment amount, or other transfer obligation arising under, or in connection with, one or more qualified financial contracts in which the counterparty or its guarantor is organized under the laws of the United States or a state or foreign jurisdiction approved by the National Association of Insurance Commissioners office responsible for securities validation as eligible for netting.

(b) If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this chapter terminates, liquidates, closes-out, or accelerates the agreement or contract, damages will be measured as of the date of the termination, liquidation, close-out, or acceleration. The amount of a claim for damages is the actual direct compensatory damages calculated in accordance with sub. (6).

(3) Upon termination of a netting agreement or qualified financial contract, notwithstanding any walkaway clause in the netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a non-defaulting party to an insurer against which an application or petition has been filed under this chapter shall be transferred to the receiver of the insurer or as directed by the receiver of the insurer, even if the insurer is the defaulting party. Any limited 2-way payment provision or first-method provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be considered to be a full 2-way payment provision or 2nd-method provision as against the defaulting insurer. Any such property or amount is a general asset of the insurer, except to the extent that it is subject to one or more secondary liens or encumbrances or rights of netting or setoff.

(4) (a) With respect to transferring a netting agreement or qualified financial contract of an insurer that is

the subject of a proceeding under this chapter, the receiver of the insurer shall do one of the following:

1. Transfer to one party, other than an insurer subject to a proceeding under this chapter, all netting agreements and qualified financial contracts between the counterparty and the insurer that is subject to a proceeding under this chapter, including all of the following:

a. All rights and obligations of each party under each netting agreement and qualified financial contract.

b. All property, including any guarantee or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract.

2. Transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in subd. 1. with respect to the counterparty.

(b) If a receiver of an insurer transfers a netting agreement or qualified financial contract, the receiver shall use its best efforts to notify any person who is a party to the netting agreement or qualified financial contract of the transfer by noon, central time, on the business day following the transfer.

(5) Notwithstanding s. 645.52 or 645.54, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a formal delinquency proceeding under this chapter.

(6) (a) In exercising the rights of disaffirmance or repudiation with respect to a netting agreement or qualified financial contract between a counterparty and an insurer that is the subject of a proceeding under this chapter, the receiver of the insurer shall do one of the following:

1. Disaffirm or repudiate all netting agreements and qualified financial contracts between the counterparty and the insurer.

2. Disaffirm or repudiate none of the netting agreements or qualified financial contracts between the counterparty and the insurer.

(b) Notwithstanding any provision of this section to the contrary, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date on which the petition for liquidation was filed or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date on which the petition for conservation or rehabi-

litigation was filed. The amount of the claim is the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

(7) All rights of counterparties under this chapter that apply to netting agreements and qualified financial contracts entered into on behalf of a general account are available only to counterparties of netting agreements and qualified financial contracts entered into on behalf of that general account. All rights of counterparties under this chapter that apply to netting agreements and qualified financial contracts entered into on behalf of a separate account are available only to counterparties of netting agreements and qualified financial contracts entered into on behalf of that separate account.

(8) (a) This section does not apply to persons who are affiliates of an insurer subject to a proceeding under this chapter.

(b) This section does not apply to qualified financial contracts entered into with an insurer authorized to write financial guaranty insurance.

**SECTION 68.** 646.51 (3) (am) (intro.) and 2. of the statutes are consolidated, renumbered 646.51 (3) (am) and amended to read:

646.51 (3) (am) *General.* Except as provided in pars. (ar), (b) and (c), assessments shall be calculated as follows: ~~2. For assessments authorized by the board on or after April 30, 2004,~~ as a percentage of premium written in this state by each insurer in the classes protected by the accounts for the year preceding the year in which the assessment is authorized by the board.

**SECTION 69.** 646.51 (3) (am) 1. of the statutes is repealed.

**SECTION 70.** 646.51 (3) (ar) of the statutes is created to read:

646.51 (3) (ar) *Disability.* Except as provided in par. (c), with respect to disability insurance policies, including policies issued by health maintenance organization insurers, assessments shall be calculated as follows:

1. For assessments authorized by the board before the effective date of this subdivision .... [LRB inserts date], as a percentage of average annual premium received in this state by each insurer in the classes protected by the accounts for the 3 most recent years preceding the year of entry of the order of liquidation.

2. For assessments authorized by the board on or after the effective date of this subdivision .... [LRB inserts date], as a percentage of premium written in this state by each insurer in the classes protected by the accounts for the year preceding the year in which the assessment is authorized by the board.

**SECTION 71.** 646.51 (3) (b) of the statutes is amended to read:

646.51 (3) (b) *Life and health annuities.* Except as provided in par. (c), with respect to annuity contracts or life ~~or disability~~ insurance policies, including policies

~~issued by health maintenance organizations,~~ assessments shall be calculated as a percentage of average annual premium received in this state by each insurer in the classes protected by the accounts for the 3 most recent years preceding the year of the entry of the order of liquidation.

**SECTION 72.** 646.51 (4) (a) of the statutes is amended to read:

646.51 (4) (a) Subject to pars. (b) and (d), the total of all assessments for an amount authorized by the board under this section with respect to an insurer may not, in one calendar year, exceed 2 percent of the insurer's assessable premiums under sub. (3) (am), ~~(ar)~~, or (b) on the types of policies and contracts that are covered by the account.

**SECTION 73.** 646.51 (9) (a) of the statutes is amended to read:

646.51 (9) (a) Except as provided in par. (b), if an insurer's license or certificate of authority to do business in this state terminates ~~or expires~~, or is surrendered, the insurer's obligation to pay assessments under this section ceases beginning on the day after the insurer's license or certificate of authority terminates ~~or expires~~, or is surrendered.

**SECTION 74.** 646.51 (9) (b) of the statutes is amended to read:

646.51 (9) (b) An insurer whose license or certificate of authority to do business in this state terminates ~~or expires~~, or is surrendered remains liable after the termination ~~or expiration~~, or surrender to pay all of the following:

1. Assessments authorized or called before the insurer's license or certificate of authority terminated ~~or expired~~, or was surrendered.

2. Assessments authorized or called after the insurer's license or certificate of authority terminated ~~or expired~~, or was surrendered that relate to a liquidation order entered before the insurer's license or certificate of authority terminated ~~or expired~~, or was surrendered.

**SECTION 75.** 646.51 (10) of the statutes is created to read:

646.51 (10) **ASSESSMENT OF CONVERTING INSURERS.** When an insurer converts to a different type of entity or license and the effect of the conversion is to subject the insurer to the liabilities of a different account or accounts of the fund, the converting insurer's obligation to pay assessments is as follows:

(a) *Assessments authorized prior to or during the year of conversion.* For assessments authorized by the board prior to or during the year in which the insurer's conversion to a different type of entity or license is effective, the insurer is liable for assessments to cover the obligations of the account or accounts to which it was subject prior to conversion.

(b) *Assessments authorized after the year of conversion.* For assessments authorized by the board after the year in which the insurer's conversion to a different type

of entity or license is effective, the insurer is liable for assessments to cover the obligations of the account or accounts to which it is subject after conversion.

**SECTION 76.** 655.27 (3) (b) 1. of the statutes is amended to read:

655.27 (3) (b) 1. The commissioner, after approval by the board of governors, shall ~~by rule~~ set the fees under par. (a). ~~The rule shall provide that~~ fees may be paid annually or in semiannual or quarterly installments. In addition to the prorated portion of the annual fee, semi-annual and quarterly installments shall include an amount sufficient to cover interest not earned and administrative costs incurred because the fees were not paid on an annual basis. This paragraph does not impose liability on the board of governors for payment of any part of a fund deficit.

**SECTION 77.** 655.27 (3) (b) 2. of the statutes is amended to read:

655.27 (3) (b) 2. With respect to fees paid by physicians, the rule commissioner shall provide for not more than 4 payment classifications, based upon the amount of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed.

**SECTION 78.** 655.27 (3) (b) 2m. of the statutes is amended to read:

655.27 (3) (b) 2m. In addition to the fees and payment classifications described under subds. 1. and 2., the commissioner, after approval by the board of governors, may ~~by rule~~ establish a separate payment classification for physicians satisfying s. 655.002 (1) (b) and a separate fee for nurse anesthetists satisfying s. 655.002 (1) (b) which take into account the loss experience of health care providers for whom Michigan is a principal place of practice.

**SECTION 79.** 655.27 (3) (bg) 1. of the statutes is amended to read:

655.27 (3) (bg) 1. ~~Every rule under par. (b)~~ The commissioner shall provide for an automatic increase in a health care provider's fees, except as provided in subd. 2., if the loss and expense experience of the fund and other sources with respect to the health care provider or an employee of the health care provider exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, both as established ~~in the rule~~ by the commissioner. ~~The rule commissioner~~ shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of awards in excess of the respective thresholds.

**SECTION 80.** 655.27 (3) (bg) 2. of the statutes is amended to read:

655.27 (3) (bg) 2. The rule commissioner shall provide that the automatic increase does not apply if the board of governors determines that the performance of the injured patients and families compensation fund peer review council in making recommendations under s. 655.275 (5) (a) adequately addresses the consideration set forth in par. (a) 2m.

**SECTION 81.** 655.27 (3) (br) (intro.) of the statutes is amended to read:

655.27 (3) (br) *Limit on fees.* (intro.) ~~Every rule~~ The commissioner, in setting fees for a particular fiscal year under par. (b), shall ensure that the fees assessed do not exceed the greatest of the following:

**SECTION 82.** 655.27 (3) (bt) of the statutes is created to read:

655.27 (3) (bt) *Report to joint committee on finance.* Annually, no later than April 1, the commissioner shall send to the cochairpersons of the joint committee on finance a report detailing the proposed fees set for the next fiscal year under par. (b) and under s. 655.61 (1). If, within 14 working days after the date that the commissioner submits the report, the cochairpersons of the committee notify the commissioner that the committee has scheduled a meeting for the purpose of reviewing the proposed fees, the commissioner may not impose the fees until the committee approves the report. If the cochairpersons of the committee do not notify the commissioner, the commissioner may impose the proposed fees. In addition to any other method prescribed by rule for advising health care providers of the amount of the fees, the commissioner shall post the fees set under par. (b) for the next fiscal year on the office's Internet site and the director of state courts shall post the fees set under s. 655.61 (1) for the next fiscal year on the mediation fund's Internet site.

**SECTION 83.** 655.27 (3) (d) of the statutes is amended to read:

655.27 (3) (d) ~~Rule not effective; Late establishment or approval of fees.~~ Late establishment or approval of fees. If the ~~rule establishing~~ fees under par. (b) ~~does not take effect prior to~~ for any particular fiscal year are not established by the commissioner, approved by the board of governors, or approved under par. (bt) by the joint committee on finance before June 2 of any that fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the ~~rule fees for that fiscal year are~~ subsequently takes effect established by the commissioner, approved by the board of governors, or approved under par. (bt) by the joint committee on finance, the balance for the fiscal year shall be collected or refunded or the remaining semiannual or quarterly installment payments shall be adjusted except the commissioner may elect not to collect, refund, or adjust for minimal amounts.

**SECTION 84.** 655.27 (3) (e) of the statutes is amended to read:

655.27 (3) (e) *Podiatrist fees.* The commissioner, after approval by the board of governors, may ~~by rule~~ assess fees against podiatrists for the purpose of paying the fund's portion of medical malpractice claims and expenses resulting from claims against podiatrists based on occurrences before July 1, 1986.

**SECTION 85.** 655.61 (1) of the statutes is amended to read:

655.61 (1) The mediation fund created under s. 655.68 shall be financed from fees charged to health care providers. The director of state courts shall, by February 1 annually, determine the revenues needed for the operation of the mediation system during the succeeding fiscal year and inform the board of governors of that amount. The director of state courts shall also inform the board of governors of the number of requests for mediation involving each type of health care provider set out in s. 655.002 for the most recent fiscal year for which statistics are available. The board of governors shall, ~~by rule,~~ set fees to charge health care providers at a level sufficient to provide the necessary revenue.

**SECTION 86.** 655.61 (3) of the statutes is created to read:

655.61 (3) If the fees under sub. (1) for any particular fiscal year are not established by the board of governors or approved by the joint committee on finance under s. 655.27 (3) (bt) before June 2 of that fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the

fees for that fiscal year are subsequently established by the board of governors or approved by the joint committee on finance under s. 655.27 (3) (bt), the balance for the fiscal year shall be collected or refunded, except that the commissioner may elect not to collect or refund minimal amounts.

**SECTION 87. Nonstatutory provisions.**

(1) OPERATIVE DATE OF THE VALUATION MANUAL. AS soon as possible after the requirements under section 623.06 (9) (b) of the statutes, as created by this act, are met, the office of the commissioner of insurance shall submit to the legislative reference bureau for publication in the Wisconsin Administrative Register a notice specifying the date that is the operative date of the valuation manual, as provided in section 623.06 (9) (b) of the statutes, as created by this act.

**SECTION 88. Effective dates.** This act takes effect on the day after publication, except as follows:

(1) OPERATIVE DATE OF VALUATION MANUAL. The repeal and recreation of section 623.06 (1) (f) of the statutes takes effect on the date specified in the notice published in the Wisconsin Administrative Register under SECTION 87 (1) of this act.

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