PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE REPEALING, RENUMBERING CONSOLIDATING AND AMENDING, AMENDING, AND CREATING A RULE

Office of the Commissioner of Insurance – Agency 145

The Office of the Commissioner of Insurance proposes an order to repeal Ins 3.70, 5.45 (1) (b), 6.52 Form B, 8.42 (4) (a), (b) and (7) (c) (1), 8.59 (4), 8.60 (1) (a), (d) and (e), 8.61 (2) and (6), 8.68 (3) (b) and (c) and 9.40 (1) (a), (5) and (6); to renumber, consolidate and amend Ins 8.42 (4) (intro.) and (c) and 8.42 (4), 9.40 (1) (intro.) and (b) and 9.40 (1); to amend Ins 3.651 (2) (Note), 3.75 (6), 6.52 (5), ch. 6 Appendix 1 and Appendix 2, 7.02, 7.06 (Note), 8.40, 8.42 (13), 8.68 (4), 16.01 (4) (c), (6) (a) and (7) (a) and (b), 50.01 (1r) and 50.14 (2); and to create Ins 16.01 (7) (c), 50.01 (6g), 50.15 (2m), 50.155 and 50.18 (8), Wis. Adm. Code, relating to certain reporting requirements, electronic filing and obtaining information, increasing minimum annual assessment for OCI insurer examinations, other technical corrections and affecting small business.

The statement of scope for this rule SS 069-15 was approved by the Governor on July 23, 2015, published in Register No. 716A2 on August 10, 2015, and approved by the Deputy Commissioner on August 26, 2015.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   ss. 601.41 (3), 601.42, 601.45 (1), Stats.

2. **Statutory authority:**

   ss. 601.41 (3), 601.42 (2), 611.54 (1), 631.28, 609.20 (1m), 601.45 (1), 623.02, 623.03 and 623.04, Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   The statutory authority for these rules are ss. 227.11 (2) (a) and 601.41(3), Stats., which provide the commissioner's rulemaking authority in general.

   Specifically, s. 611.54 (1), Stats., provides authority for the commissioner's rulemaking authority for s. Ins 6.52 rule change regarding insurer reporting requirements of biographical data on insurance company officers and directors. Section 611.54 (1) states "the name of any person selected as a director or principal officer of a [insurance] corporation, together with such pertinent biographical and other data as the commissioner requires by rule shall be reported to the commissioner immediately after selection."

Specific rulemaking authority for Ins 6.85 rule change: Section 631.28(1), Stats., requires all insurers to provide notice to its insureds of the right to file a complaint with OCI. Section 631.28 (2), Stats., states: "The commissioner shall promulgate rules specifying the contents of the notice… under sub. (1)… The rules shall describe how a policyholder, insured or other person may make a complaint with the office…"

Specific rulemaking authority for Ins Chapter 7 and (Note): Section 227.01 (13), Stats., defines a "rule" to mean "a regulation, standard, statement of policy,… which has the effect of law and which is issued by the agency to implement, interpret, or make specific legislation enforced of administered by the agency…" Section 227.01 (3), Stats., further provides the definition of a "rule" "does not include …any action or inaction of an agency… which:

(j) Relates to the form and contents of reports, records or accounts of a state…agency.

(q) Is a form the content or substantive requirements of which are prescribed by a rule or statute."

Also, s. 227.23, Stats., provides: "A form imposing a requirement which meets the definition of a rule shall be treated as a rule for the purposes of this chapter, except that: (3) It need not be published in the code and register in its entirety, but may be listed by title or description together with a statement as to how it may be obtained."

Specific rulemaking authority for Ins 9.40 rule changes: Section 609.20 (1m), Stats., provides the commissioner "may promulgate rules relating to …defined network plans" to effectuate certain purposes of Chapter 609 of the statutes. Further, s. 609.38, Stats., provides "the commissioner shall by rule develop standards for defined network plans for compliance with the requirements of this chapter."

Specific rulemaking authority for Ins 16.01 (4) (c), 6 (a) and (7) (a), (b), (c) rule changes: Section 601.45 (1), Stats., provides the "reasonable costs of examinations … shall be paid by examinees… as the commissioner may by rule prescribe."

Specific rulemaking authority for Ins. 50.14 (2), Ins 50.15, 50.155, and 50.18 rule changes: Section 601.42, Stats., authorizes the commissioner to request statements, reports, and other information from regulated persons. Section 601.42 (2), Stats., authorizes the commissioner to prescribe forms for these reports. Sections 623.03 and 623.04, Stats., authorize the commissioner to promulgate rules regarding the valuation of assets and liabilities. Section 623.02 allows the commissioner to promulgate standards for accounting rules.

4. Related statutes or rules:

Please see listing of rules and related statutes noted in #3 above.

5. The plain language analysis and summary of the proposed rule:

This proposed rule makes a number of technical corrections to a number of current rules by inserting OCI's current mailing address, adding OCI's website so consumers may make complaints and obtain insurance forms electronically. This proposed rule deletes insurance forms no longer in use from the rule that lists insurance forms and repeals all rule references to the Health Insurance Risk Sharing Plan (HIRSP) which was eliminated by 2013 Act 20. Currently OCI has two different forms required to

be filed by domestic insurers providing biographical information on new officers and directors –- one for an insurer *before* it is organized and a second form for new officers and directors *after* the insurer is organized. The proposed rule eliminates one form (form B) and replaces it with the more informative current form A. Therefore, the proposed rule requires form A to be filed for new officers and directors of insurers both before and after the insurer is organized.

This proposed rule eliminates as unnecessary in the current health insurance marketplace a requirement that all HMOs annually submit HEDIS (Health Plan Employer Data and Information Set) quality assurance data to OCI. Also eliminated is a requirement that a very limited number of defined network plans submit annually to OCI a "standardized data set" of quality outcome data.

Under current rules, each year OCI bills domestic insurers for their proportionate share of the estimated total cost of administering that year's examinations program in an amount generally determined by comparing each insurer's premium volume. The current rule provides that "in the event the sum of the previous year's assessment exceeds the actual cost of administering the insurer examinations program, the amount of the excess shall be applied as an offset to the estimated cost for the next year's examination program." The proposed rule change provides that if the sum of a year's billings for insurer examinations by OCI "differs" from the actual cost of administering the examinations program, the difference (*plus or minus*) will be applied as an "adjustment" to the estimated cost for the next year's examinations program. The proposed rule also modernizes a rule section by making clear that the commissioner may obtain CPA work papers pertaining to an insurer's annual audit in electronic form.

OCI financial examiners perform a financial examination of all domestic insurers at a minimum of once every five years. The proposed rule increases the minimum annual amount OCI may charge for its examinations of domestic insurers to an amount that more accurately reflects the actual minimum administrative costs of OCI examining domestic insurers. The new minimum amounts will also more equitably distribute the examination costs among insurers. The current minimum annual billing for OCI examinations is $1,000 for domestic insurers located primarily out of state and $300 for all other domestic insurers. These amounts have not been updated since 1999 and 1977, respectively. The proposed rule increases the annual minimum amount for domestic insurers located primarily out of state to $10,000 and the minimum amount for all other domestic insurers to $3,000 per year. This proposed rule change will not result in an increase to the aggregate amount charged the domestic insurance industry for administering OCI's examinations program.

Finally, the proposed rule adopts an NAIC model law requiring large insurers (with over $500,000,000 of gross annual premiums) to have an independent internal audit function with an effective date of January 1, 2018. This is a good business and solvency practice, which most large insurers already have in place, to OCI's knowledge. The rule is also anticipated to be an NAIC accreditation requirement. NAIC accreditation is an important benefit to the domestic insurance industry as it ensures that Wisconsin insurers are only subject to financial examination by Wisconsin as other state regulators will adopt Wisconsin's financial examination if Wisconsin is an NAIC accredited state.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

OCI is unaware of any proposed or existing federal regulation that is intended to address the activities to be regulated by this proposed rule.

7. Comparison of similar rules in adjacent states as found by OCI:

a) With respect to a minimum annual assessment for insurer examinations:

Illinois: 215 ILCS 5/Sec 3, 6, 7 and 9. Illinois does not have a set minimum assessment based on actual minimum cost of an examination in the way Wisconsin does. Illinois assesses all insurers, domestic and non-domestic, licensed to do business in the state. The assessment funds the cost of financial examinations and financial condition analyses and funds the costs and expenses of the Interstate Receivership Commission.

For domestic insurers, annual assessment amounts are variable and based on the amount of an insurer's nationwide direct premiums or admitted assets (whichever is greater) and, in some cases, reinsurance assumed premiums. For example, on the low end, if the premium is less than $500,000 and there is no reinsurance assumed premium, the annual assessment equals $150. On the high end, if the premium is $100,000,000 or more, the annual assessment equals $37,500.

For non-domestic insurers, annual assessment amounts are also variable, and are based on the amount of an insurer's Illinois direct premiums and nationwide reinsurance assumed premiums. Again, the minimum assessment is $150 on the low end of direct premium amount and $37,500 on the high end. Also, assessments billed to non-domestic insurers within the same affiliated group cannot exceed $250,000.

In addition to annual assessments, Illinois bills insurers for the following additional examination-related expenses:

1. Electronic data processing costs;
2. Lodging and travel expenses;
3. Outside consultants/contractors used in examinations; and
4. Performance examination costs (e.g. market regulation exams).

Iowa: Chptr 507.8, Iowa Code. Iowa does not use an annual assessment, so has no minimum assessment. Rather, upon completing an examination, the Iowa commissioner prepares a bill of all costs incurred in performing the examination and in preparing the subsequent report. The examined insurer is then responsible for paying the charged amount. Iowa uses outside contractors to conduct some of its out of state examinations.

Michigan: 500.224, mcl. Michigan assesses all insurers, domestic and non-domestic, licensed to do business in the state. The assessments fund the state's insurance department operations, with two-thirds of every assessment going toward solvency regulation.

Annual assessment amounts are variable and based on a formula that accounts for all in-state annuity considerations written and all in-state direct premiums underwritten. Regardless of the formula output, the assessment cannot exceed 80% of the gross

appropriations for the insurance bureau. Also, the minimum fee is $250, regardless of the formula output.

Furthermore, Michigan bills out-of-state insurers for the expenses and reasonable costs incurred in conducting an examination, for which Michigan often uses outside consultants/contractors.

Minnesota: 60A.03 subd 5, Minnesota Statutes. Minnesota does not use an annual assessment and so has no minimum annual assessment. Minnesota uses all outside contractors to conduct its examinations. All examined insurers are required to pay the "necessary expenses" of the persons engaged in the examination, including the per diem salaries of those persons.

b) With respect to proposed rule adopting NAIC model law section requiring large insurance companies to have internal audit function:

Illinois: Has not yet taken action to adopt the NAIC internal audit function requirement for larger insurers.

Iowa: Has not yet taken action to adopt the internal audit function requirement.

Michigan: Has not yet taken action to adopt the internal audit function requirement.

Minnesota: Has not yet taken action to adopt the internal audit function requirement.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

With regard to increasing the minimum assessment amount for insurer examinations, there has been no increase in the minimum assessment amount since 1999 for domestic insurers primarily located out of state, and no increase since 1977 for all other domestic insurers. OCI made calculations resulting in a determination that its minimum cost to do an examination of a domestic company primarily located out of state is $10,000 per year and its minimum cost to do an examination of an in-state company is $3,000 per year.

OCI has determined that 14 of a total of 119 in-state companies were billed the current minimum assessment amount of $300 for 2016's examinations program. Also, 19 of a total of 61 domestic insurers located primarily out-of-state were billed the current minimum of $1,000 for 2016's assessment. The new minimum assessment amounts will more fairly and equitably distribute the costs of the examinations program among insurers.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

The proposed increase in minimum assessment amounts would have an impact on some domestic insurers. However, based on revenue and ownership structure, very few, if any, domestic insurers meet the definition of small businesses. Furthermore, OCI has delayed the applicability date of the rule changes increasing the minimum assessment amounts and the internal audit function requirement to February 1, 2018 and January 1, 2018, respectively, to allow insurers to make adjustments to comply with these two rule changes. Finally, a possible exemption may be available for a small business insurer under s. 601.45 (4), Stats., which provides that upon insurer

request (or on commissioner's own motion) the commissioner may pay all or a part of an examination from the appropriation under

s. 20.145 (1) (g) 1., Stats., when "the commissioner finds that imposition of the costs would place an unreasonable burden on the examinee."

10. See the attached Private Sector Fiscal Analysis.

The rule changes will have no significant effect on the private sector regulated by OCI.

11. A description of the Effect on Small Business:

This rule will have little or no effect on small businesses since few, if any, domestic insurers meet the definition of a small business. Furthermore, OCI has delayed the applicability date of the rule changes increasing the minimum assessment amounts and the internal audit function requirement to February 1, 2018 and January 1, 2018, respectively, to allow insurers to make adjustments to comply with these two rule changes, particularly the increase in minimum assessment amount. Finally, as stated earlier, a possible exemption may be available under s. 20.145 (1) (g) 1., Stats., if a small business insurer demonstrates to the commissioner's satisfaction that imposition of the minimum assessment costs places "an unreasonable burden on the examinee."

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at:
https://oci.wi.gov/Pages/Regulation/RulesCurrentlyPending.aspx

or by contacting Karyn Culver, OCI Legal Unit, at:

Phone: (608) 267-9586
Email: karyn.culver@wisconsin.gov
Address: 125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail: PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on May 10, 2017.

Mailing address:

Alice M. Shuman-Johnson
Legal Unit - OCI Rule Comment for Rule Ins 3.651
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Alice M. Shuman-Johnson
Legal Unit - OCI Rule Comment for Rule Ins 3.651
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Alice M. Shuman-Johnson
alice.shumanjohnson@wisconsin.gov

Web site: https://oci.wi.gov/Pages/Regulation/RulesCurrentlyPending.aspx

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The proposed rule changes are:

SECTION 1. Ins 3.651 (2) (Note) is amended to read:

Ins 3.651 (2) (Note) **Note:** The claim adjustment reason codes referenced in subsections (2), (3) (b) 4. i., (4) (a) 5. f. and (5), form OCI 17-007, may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, ~~121 East Wilson Street,~~ Madison, Wisconsin 53707-7873 or on the Office of the Commissioner of Insurance website at http://oci.wi.gov/.

SECTION 2. Ins 3.70 is repealed.

SECTION 3. Ins 3.75 (6) is amended to read:

Ins 3.75 (6) PORTABILITY~~; HIRSP~~. For an individual who elects continuation of coverage under this section, the period, if any, from the date of the termination of the individual's group policy coverage to the commencement of continuation of coverage under this section shall be disregarded for the purpose of determining the 63-day period under s. 632.746 (3) (b) Stats.~~, and determining eligibility as an eligible individual under ch. 149, Stats.~~

SECTION 4. Ins 5.45 (1) (b) is repealed.

SECTION 5. Ins 6.52 (5) is amended to read:

Ins 6.52 (5) REPORTING WITH RESPECT TO NEW OFFICERS AND DIRECTORS SUBSEQUENT TO ORGANIZATION OR ADMISSION. A report shall be provided by each domestic insurer to which this rule applies with respect to the appointment or election of any new director, trustee or officer elected or appointed within 15 days after such appointment or election. Such report shall be prepared by the company in form and substance substantially in accordance with Form ~~B~~ A, shown at the end of this rule.

SECTION 6. Ins 6.52 Form B is repealed.

SECTION 7. Ins 6 Appendix 1 is amended to read:

Ins 6 Appendix 1

APPENDIX I

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE?—If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

(INSURER NAME)
(CUSTOMER SERVICE)
(ADDRESS)
(CITY, STATE, ZIP)
(TOLL FREE TELEPHONE NUMBER, if available)
(TELEPHONE NUMBER)

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can ~~contact~~ file a complaint electronically with the **OFFICE OF THECOMMISSIONER OF INSURANCE** ~~by contacting~~

at its website at http://oci.wi.gov/,

or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

SECTION 8. Ins 6 Appendix 2 is amended to read:

Ins 6 Appendix 2

APPENDIX 2

You may resolve your problem by taking the steps outlined in your HMO grievance procedure. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can ~~contact~~ file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/,

or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

SECTION 9. Ins 7.02 is amended to read:

Ins 7.02 Bureau of financial analysis and examinations forms.

Form Number **Title**

~~21−001 Application for Certificate of Authority—Nondomestic~~
21−002 Application for Certificate of Authority—Domestic Nonprofit HMO
~~21−003 Application for Certificate of Authority—Gift Annuities~~
21−004 Application for Limited Certificate of Authority Warranty Plans
21−005 Application for Certificate of Authority—Domestic
21−030 Application for Certificate of Authority—Domestic Nonprofit LSHO
21−031 Application for Certificate of Authority—Nondomestic HMO
21−032 Application for Certificate of Authority—Domestic for Profit HMO
21−040 Application for Certificate of Authority—Fraternals
21−050 Initial Registration for Vehicle Protection Product Warranty
21−051 Vehicle Protection Product Warranty Annual Registration
21−063 Application for Continuing Care Permit
21−064 Application for Initial and Renewal Life Settlement Provider License
21−190 Application for Admission—Motor Clubs
~~22−001 Instructions to Prepare Annual Statement Blank According to NAIC Form, Instructions, and Accounting Standards~~
~~22−006 Investments in Parents, Subsidiaries, and Affiliates—Quarterly~~
22−007 Comparative Balance Sheet
22−008 P&C Compulsory and Security Surplus Calculation—Quarterly Statement
22−009 Life Compulsory and Security Surplus Calculation—Quarterly Statement
22−010 Fire and Casualty—Domestic Annual Statement Packet
22−011 Fire and Casualty—Nondomestic Annual Statement Packet
22−020 Title Annual Statement Packet
22−030 Fraternal Annual Statement Packet
22−040 Life and Accident & Health—Domestic Annual Statement Packet
22−041 Life and Accident & Health—Nondomestic Annual Statement Packet
22−050 Hospital, Medical & Dental Service or Indemnity Corporation—Annual Statement Packet
22−051 Life Settlement Provider Annual Statement Packet
22−055 Employee Welfare Funds Annual Statement Packet
22−060 Health Maintenance Organization Insurer Annual Statement Packet
22−065 Limited Service Health Organization Annual Statement Packet
22−070 Town Mutual Annual Statement Packet
~~22−080 Gift Annuity Annual Statement Packet~~
22−090 Mortgage Guaranty—Domestic Annual Statement Packet
22−091 Mortgage Guaranty—Nondomestic Annual Statement Packet
22−093 Mortgage Guaranty Insurers Report of Policyholders Position—Quarterly Statement
22−510 Election of Exemption (Opt−Out) 22−520 Election to be Subject to Restrictions (Opt−In)
22−530 Termination of Exemption (Termination of Opt−Out)
22−540 Termination of Election to be Subject to Restrictions (Termination of Opt−In)
26−003 Amendment to Articles of Organization (or Incorporation)—Town Mutual Insurance Companies
28−060 HMO Companies Compulsory and Security Surplus Calculation—Quarterly

SECTION 10. Ins 7.06 (Note) is amended to read:

Ins 7.06 (Note) **Note:** These forms and all other forms currently in use may be obtained from the Office of the Commissioner of Insurance at its website at http://oci.wi.gov/, or by writing to P.O. Box 7873, Madison, WI 53707-7878.

SECTION 11. Ins 8.40 is amended to read:

Ins 8.40 Purpose. This subchapter interprets and implements ch. 635, Stats.~~, and s. 149.12 (2) (e), Stats.~~

SECTION 12. Ins 8.42 (4) (intro.) and (c) are consolidated, renumbered Ins 8.42 (4) and amended to read:

Ins 8.42 (4) "Late enrollee" means an eligible employee, or dependent of an eligible employee, who does not request coverage under a policy during an enrollment period in which the individual is entitled to enroll in the policy, and who subsequently requests coverage under the policy, regardless of whether the enrollment period was held prior to, on or after the law's effective date. "Late enrollee" does not include an individual who~~: (c) Is~~ is a new entrant under sub. (7) (b) or (c).

SECTION 13. Ins 8.42 (4) (a) and (b) and (7) (c) 1. are repealed.

SECTION 14. Ins 8.42 (13) is amended to read:

Ins 8.42 (13) "Underwritten individual" means an individual who, prior to the law's effective date, requested but was excluded from coverage, or denied coverage, under a policy, whether issued by the current insurer or a preceding insurer, and continued to be and is an eligible employee, or dependent of an eligible employee, of the small employer. ~~"Underwritten individual" does not include a person who is covered under the plan established under ch. 149, Stats., on February 1, 1994.~~

SECTION 15. Ins 8.59 (4) is repealed.

SECTION 16. Ins 8.60 (1) (a), (d), and (e) are repealed.

SECTION 17. Ins 8.61 (2) and (6) are repealed.
SECTION 18. Ins 8.68 (3) (b) and (c) are repealed.

SECTION 19. Ins 8.68 (4) is amended to read:

Ins 8.68 (4) A small employer insurer shall provide written notice of the information described under sub. (3) (a) ~~to (c)~~ to each small employer who applies for a basic health benefit plan within 10 working days of the date the small employer insurer receives the small employer's application. The small employer insurer shall provide the notice directly or through an authorized insurance intermediary. The small employer insurer shall provide the employer with sufficient copies of the notice to distribute to each eligible employee and shall ask the employer to promptly distribute a copy to each eligible employee. The small employer insurer shall make reasonable efforts to obtain, within 20 business days after the small employer insurer issues a basic health benefit plan to a small employer, certification that the small employer promptly distributed the notice to all eligible employees.

SECTION 20. Ins 9.40 (1) (intro.) and (b) are consolidated, renumbered Ins 9.40 (1) and amended to read:

Ins. 9.40 Required quality assurance and remedial action plans. (1) In this section~~: (b) "Quality~~ "quality assurance" means the measurement and evaluation of the quality and outcomes of medical care provided.

SECTION 21. Ins 9.40 (1) (a), (5), and (6) are repealed.

SECTION 22. Ins 16.01 (4) (c) is amended to read:

Ins 16.01 (4) (c) In the event that the sum of a year's billings under this rule ~~exceeds~~ differs from the actual cost of administering the insurer examinations program, the amount of the ~~excess~~ difference shall be applied as an ~~offset~~ adjustment to the estimated cost for the next year's examinations program.

SECTION 23. Ins. 16.01 (6) (a) is amended to read:

Ins. 16.01 (6) (a) The amount to be billed each domestic insurer subject to this rule shall be determined so that the billing is equal to a constant of proportionality times the square root of the insurer's premiums, where the constant of proportionality is determined each year so that the total of all billings equals the estimated cost of administering the insurer examinations program described in sub. (4). The formula is stated algebraically as follows:

$$A = \text{~~kxP~~ } k \times \sqrt{P}$$

where A = Annual Amount to be billed each domestic insurer
k = Constant of Proportionality
P = Net Premiums Earned or Premiums and Annuity Considerations Reported in the applicable annual statement, for business of the second calendar year preceding the year of billing.

SECTION 24. Ins 16.01 (7) (a) and (b) are amended to read:

Ins 16.01 (7) (a) The maximum annual billing for any insurer shall be 1% of net premiums earned or premiums and annuity considerations reported in the applicable annual statement listed in s. Ins. 7.02 for business of the second calendar year preceding the year of billing~~, subject to a requirement that the minimum bill is $1000 for domestic insurers located primarily out of state for examination purposes and $300 for all other domestic insurers~~.

(b) The annual bill for any insurer billed the previous year shall not exceed 1.2 times the immediately preceding year's bill adjusted for premium growth by multiplying by a factor equal to the second prior year's premium divided by the third prior year's premium. In calculating this adjustment, the year a billing is due shall be considered the current year. This paragraph does not apply if the second prior year's premium is less than the third prior year's premium.

SECTION 25. Ins 16.01 (7) (c) is created to read:

Ins 16.01 (7) (c) Notwithstanding the limitations in pars. (a) and (b), the minimum annual bill shall be $10,000 for domestic insurers located primarily out of state for examination purposes and $3,000 for all other domestic insurers. This paragraph first applies to annual billings beginning February 1, 2018.

SECTION 26. Ins 50.01 (1r) is amended to read:

Ins 50.01 (1r) "Audit committee" means a committee or equivalent body established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of the controlled insurers solely for the purposes of this chapter at the election of the controlling person under s. Ins 50.15 (6). If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

SECTION 27. Ins 50.01 (6g) is created to read:

Ins 50.01 (6g) "Internal audit function" means a person or persons who provide independent, objective, and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

SECTION 28. Ins 50.14 (2) is amended to read:

Ins 50.14 (2) The commissioner may ~~photocopy~~ obtain copies of work papers and retain the copies. If copies of work papers are requested in electronic format, the electronic copies must be as fully functional as the original documents. Password protection is acceptable for access to electronic work papers, but passwords on individual documents, or that disable features of individual documents, are not permitted. All working papers and communications obtained by the commissioner under this section may be treated by the commissioner as confidential under s. 601.465, Stats.

SECTION 29. Ins 50.15 (2m) is created to read:

Ins 50.15 (2m) The audit committee shall be responsible for overseeing the insurer's internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by s. Ins 50.155.

SECTION 30. Ins 50.155 and is created to read:

Ins 50.155 Internal audit function requirements. (1) An insurer is exempt from the requirements of this section if both of the following conditions are true:

(a) The insurer has total annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000.

(b) The insurer is a member of a group of insurers and the group has total annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(2) An insurer or group of insurers shall establish an internal audit function providing independent, objective, and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management, and internal controls. This assurance shall be provided by performing general and specific audits, reviews, and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(3) In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and the insurer or group of insurers shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

(4) The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits, and the appropriateness of corrective actions implemented by management as a result of audit findings.

(5) If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level.

SECTION 31. Ins 50.18 (8) is created to read:

Ins 50.18 (8) The requirements of s. Ins 50.155 first apply on January 1, 2018. If an insurer or group of insurers that was exempt under s. Ins 50.155 (1) no longer qualifies for such exemption, it shall have one year following the year the threshold is exceeded to comply with the internal audit requirements.

SECTION 32. Effective Date. These changes will take effect on the first day of the month after publication in the Wisconsin Administrative Register, as provided in s. 227.22 (2) (intro.), Stats.