(3) COPIES FOR INTERESTED PARTIES. Parties who are impecunious who require and request a transcript for appeal or for other purposes deemed reasonable by the commissioner or hearing officer shall be furnished with a transcript of the hearing at the expense of the office of the commissioner of insurance upon the filing of a verified petition stating the purpose for which the transcription is needed and that the person is without means to purchase a transcript.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.20 Stipulations. (ss. 619.04 and 655.003, Stats.) All stipulations or agreements in reference to a matter the subject of a hearing or entered into at a hearing shall be either dictated at length into the record, or reduced to writing, signed by the persons or parties stipulating, and filed as a part of the record of the proceedings. Controversies, or matters which may be the subject of or cause for a hearing may be disposed of by stipulation, agreed settlement or consent orders.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.21 Motions. (ss. 619.04 and 655.003, Stats.) Except during a hearing, motions shall be made in writing and signed by the party or person authorized and appearing in the proceedings therefor, or if the party is a corporation by an active officer of the corporation. At least 3 days notice thereof shall be given to the board or the hearing examiner, and to each and every other party to the proceeding, served as prescribed by s. Ins 17.16.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.22 Default. (ss. 619.04 and 655.003, Stats.) In case the respondent fails to submit an answer as required by s. Ins 17.08 or fails to appear at a hearing at the time and place fixed therefor, the matters specified shall be taken as true and the board may make findings and enter an order on the basis thereof. The default of a party in answering or in appearing shall not preclude the board from hearing said matter, taking such evidence as necessary and proper, and disposing of the matter.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.23 Arguments. (ss. 619.04 and 655.003, Stats.) The hearing examiner may hear oral arguments and limit the time thereof. All arguments shall be submitted in writing unless otherwise ordered. At least 3 copies of all briefs or written arguments shall be furnished to the board. The time for filing such arguments shall be fixed by the hearing examiner.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.24 Review of classification. (ss. 619.04 and 655.003, Stats.) (1) Any person other than a hospital or a hospital connected with a nursing home, asserting placement in the wrong classification for insurance premium rate purposes may petition for a review of classification. The commissioner shall refer such petition to a committee consisting of 2 physicians and one informed person, all appointed by the commissioner. The decision of such committee shall be reported to the petitioner within 5 working days of the closing of the hearing record.

(2) Any hospital or hospital combined with a nursing home which believes that it has been placed in the wrong classification for insurance premium rate purposes may petition for a review of classification. The commissioner shall refer such petition to a committee consisting of 2 hospital representatives and one informed person; all appointed by the com-

missioner. The decision of such committee shall be reported to the petitioner within 5 working days of the closing of the hearing record.

(3) Any person or hospital who is not satisfied with the determination of the committee may petition for a declaratory ruling under s. Ins 17.02 within 30 days of the date of the written notice of the committee's determination.

(4) At any hearing held pursuant to such petition for a declaratory ruling the committee report shall be considered and the members of the committee have the right to appear and be heard but shall not be required to be present.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner of insurance to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or to call upon the insurance industry to prepare plans for his approval.

(b) Health care liability insurance, liability coverage normally incidental to health care liability insurance or both are not readily available in the voluntary market for the persons specified in sub. (5) (a).

(c) A facility for providing such health care liability insurance should be enacted pursuant to ch. 619, Stats.

(2) PURPOSE. This section is intended to implement and interpret ch. 619, Stats., for the purpose of establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage, liability coverage normally incidental to health care liability insurance or both on a self-supporting basis for the persons specified in sub. (5) (a) and, if necessary, for allied health care personnel employed by any of those persons while working within the scope of such employment. This section is also intended to encourage the improvement in reasonable loss prevention measures and to encourage the maximum use of the existing voluntary market.

(3) SCOPE. This rule shall apply to all insurers authorized to transact in this state on a direct basis insurance against liability resulting from personal injuries, except for town mutuals authorized to transact insurance under ch. 612, Stats.

(4) DEFINITIONS. (a) The Wisconsin health care liability insurance plan, hereinafter referred to as the Plan, means the statutory, nonprofit, unincorporated association established by this rule to provide for the issuance of health care liability insurance and liability coverages normally incidental to health care liability insurance at adequate rate levels for risk sharing subject to the right of recoupment and to assist qualified applicants in securing health care liability insurance and liability coverage normally incidental to health care liability insurance.

(b) Insurance against liability resulting from personal injuries means all insurance coverages against loss by the personal injury or death of any person for which loss the insured is liable. It includes the personal injury liability component of multi-peril policies, but it does not include steam boiler insurance authorized under s. Ins 6.75 (2) (a), worker's com-

pensation insurance authorized under s. Ins 6.75 (2) (k), or medical expense coverage authorized under s. Ins 6.75 (2) (d) or (e).

(c) Health care liability insurance means insurance against loss, expense and liability resulting from errors, omissions or neglect in the performance of any professional service by any person specified in sub. (5) (a).

(d) Liability coverage normally incidental to health care liability insurance shall include owners, landlords and tenants liability insurance; owners and contractors protective liability insurance; completed operations and products liability insurance; contractual liability insurance and personal injury liability insurance.

(e) Premiums written means gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to insurance against liability resulting from personal injuries covering insureds or risks resident or located in this state excluding premiums on risks insured under the Plan.

(f) Servicing company means an insurer which services policies issued on behalf of the Plan.

(g) Confidental claims information means any information relating to the Plan in the possession of the commissioner, the board of governors or an agent thereof which reveals, directly or indirectly, the identity of a health care provider, as defined in s. 655.001 (8), Stats.

(h) Political subdivision means counties, cities, villages and towns.

(5) INSURANCE COVERAGE. (a) All of the following which operate in this state and are equitably entitled to but are otherwise unable to obtain suitable health care liability insurance in the voluntary market shall be eligible to apply for insurance under this plan:

1. All medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats.;

2. Nurse anesthetists or nurse midwives licensed under ch. 441, Stats.;

3. Partnerships comprised of physicians, podiatrists, nurse anesthetists, nurse midwives or cardiovascular perfusionists;

4. Corporations and general partnerships organized for the primary purpose of providing the medical services of physicians, podiatrists, nurse anesthetists, nurse midwives or cardiovascular perfusionists;

5. Operating cooperative sickness care plans organized under s. 185.981 to 185.985, Stats., which directly provide service, in their own facilities with salaried employes;

6. Properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.;

7. All hospitals as defined by s. 50.33 (2) (a) and (c), Stats., including, but not limited to ambulatory surgery centers, as defined in s. HSS 123.14 (2) (a), but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided herein;

7m. An entity operated in connection with one or more hospitals, as defined in s. 50.33 (2) (a) and (c), Stats., which assists the hospital or hospitals in providing diagnosis or treatment of, or care for, patients of the hospital or hospitals, and which is owned by or is an affiliate, as defined under s. 600.03 (1), Stats., of the hospital or hospitals;

8. Nursing homes defined in s. 50.01 (3) (a), Stats., whose functional operations are combined with a hospital as a single entity, whether or not the nursing home operations are physically separate from the hospital operations;

9. Health care facilities owned or operated by a political subdivision of the state of Wisconsin;

10. Corporations organized to manage approved training programs for medical or osteopathic physicians licensed under ch. 448, Stats.;

11. Cardiovascular perfusionists.

(am) Upon request of an insured under par. (a), allied health care personnel employed by the insured and working within the scope of employment are eligible for insurance under the plan.

(b) The maximum limits of coverage for the type of health care liability insurance defined in sub. (4) (c) which may be placed under this Plan are the following:

1. For all occurrences before July 1, 1987, $200,000 for each occurrence and $600,000 per year for all occurrences in any one policy year.

2. For occurrences on or after July 1, 1987, and before July 1, 1988, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year.

3. For occurrences on or after July 1, 1988, $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year.

(c) The maximum limits of coverage for liability coverages normally incidental to health care liability insurance as defined in sub. (4) (d) which may be placed under this Plan are $1,000,000 per claim and $1,000,000 aggregate for all claims in any one policy year.

(d) Health care liability coverage shall be provided in a standard policy form on an occurrence basis, i.e., coverage for any liability based on a treatment, omission or operation which occurs during the term of the policy and which is brought within the time the applicable statute of limitations continues the liability. The board of governors may authorize the issuance of policies on other bases as an option under the Plan subject to such restrictions and rules as it may deem necessary and appropriate in the circumstances.

(e) Any policyholder holding coverage under the Wisconsin Health Care Liability Insurance Plan shall continue to be subject to the rules governing the Plan which were in force when the coverage was obtained. The renewal of any such coverage shall be subject to the provisions of the rule in effect at the time of the renewal. All obligations and liabilities created under such prior rule shall continue in force under the Plan until they are extinguished.

(f) Coverage for hospitals, nursing homes, or health care facilities owned or operated by a political subdivision of the state of Wisconsin

which are eligible for insurance under this plan may include liability coverages normally incidental to health care liability insurance as defined in sub. (4) (d).

(6) MEMBERSHIP. (a) Every insurer, subject to sub. (3), shall be a member of this Plan.

(b) An insurer's membership terminates when the insurer is no longer authorized to write personal injury liability insurance in Wisconsin, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this rule until it completes all of its obligations under the Plan.

(c) Subject to the approval of the commissioner, the board of governors may charge a reasonable membership fee, not to exceed $50.00.

(7) ADMINISTRATION. (a) The Plan shall be administered by a board of governors.

(b) The board of governors shall consist of the commissioner or designated representative, and 10[12] other board members. Each shall have one vote.

1. The commissioner shall appoint 3 board members representing the insurance industry.

2. The state bar association shall appoint one board member.

2m. The Wisconsin academy of trial lawyers shall appoint one board member.

3. The Wisconsin medical society shall appoint 2 board members.

4. The Wisconsin hospital association shall appoint one board member.

5. The Governor shall appoint 4 public board members for staggered 3-year terms at least 2 of whom are not attorneys or physicians and are not professionally affiliated with any hospital or insurance company.

(c) The commissioner or representative shall be chairman of the board of governors.

(d) Board members other than the commissioner or representative shall be compensated at the rate of $50 per diem plus actual necessary travel expenses.

(8) DUTIES OF THE BOARD OF GOVERNORS. (a) The board of governors shall meet as often as may be required to perform the general duties of the administration of the Plan or on the call of the commissioner. Six members of the board shall constitute a quorum.

(b) The board of governors shall be empowered to invest, borrow and disburse funds, budget expenses, levy assessments, cede and assume reinsurance, and perform all other duties provided herein as necessary or incidental to the proper administration of the Plan. The board of governors may appoint a manager or one or more agents to perform such duties as may be designated by the board.

(c) The board of governors shall develop rates, rating plans, rating and underwriting rules, rate classifications, rate territories, and policy forms in accordance with ss. 619.01 (1) (c) 2., 619.04 (5), 625.11, and 625.12, Stats., and sub. (12).

(d) The board of governors shall cause all policies written pursuant to this Plan to be separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium level for each classification of risk, and performing loss prevention and other studies of the operation of the Plan.

(e) The board of governors shall determine, subject to the approval of the commissioner, the eligibility of an insurer to act as a servicing company. If no qualified insurer elects to be a servicing company, the board of governors shall assume such duties on behalf of member companies.

(f) The board of governors shall enter into agreements and contracts as may be necessary for the execution of this rule consistent with its provisions.

(g) The board of governors may appoint advisory committees of interested persons, not limited to members of the Plan, to advise the board in the fulfillment of its duties and functions.

(h) The board of governors shall be empowered to develop, at its option, an assessment credit plan subject to the approval of the commissioner, wherein a member of the Plan receives a credit against an assessment levied, based upon Wisconsin voluntarily written health care liability insurance premiums.

(i) The board of governors of the Plan shall be authorized to take such actions as are consistent with law to provide the appropriate examining boards or the department of health and social services with such claims information as may be appropriate.

(j) The board of governors shall assume all duties and obligations formerly vested in the governing committee whenever it becomes necessary to administer any of the provisions governing the Wisconsin Health Care Liability Insurance Plan, which provisions preceded the adoption of the provisions contained in this rule.

(9) ANNUAL REPORTS AND RECORDS. (a) By May 1 of each year the board of governors shall make a report to the members of the Plan and to the standing committees on health insurance in each house of the legislature summarizing the activities of the Plan in the preceding calendar year.

(b) All books, records, documents or audits relating to the Plan or its operation shall be open to public inspection, with the exception of confidential claims information.

(10) APPLICATION FOR INSURANCE. (a) Any person specified in sub. (5) (a) may submit an application for insurance by the plan directly or through any licensed agent. Such application may include requests for coverage of allied health care providers while working within the scope of such employment.

(b) The Plan may bind coverage.

(c) The Plan shall, within 8 business days from receipt of an application, notify the applicant of the acceptance, rejection or the holding in abeyance of the application pending further investigation. Any individuals rejected by the Plan shall have the right to appeal that judgment within 30 days to the board of governors in accordance with sub. (16).

(d) If the risk is accepted by the Plan, a policy shall be delivered to the applicant upon payment of the premium. The Plan shall remit any com-

mission to the licensed agent designated by the applicant; if no licensed agent is so designated, such commission shall be retained by the Plan.

(11) ASSESSMENTS AND PARTICIPATION. (a) In the event that sufficient funds are not available for the sound financial operation of the Plan, and pending recoupment pursuant to s. 619.01 (1) (c) 2., Stats., all members shall, on a temporary basis, contribute to the financial needs of the Plan in the manner prescribed in par. (b). When such assessment contribution is recouped, it shall be reimbursed to members as their total share of the assessment contribution bears to the aggregate outstanding contributions.

(b) All members of the Plan shall participate in all premiums, other income, losses, expenses, and costs of the Plan in the proportion that the premiums written of each such member [excluding that portion of premiums attributable to the operation of the Plan and giving effect to any assessment credit plan under sub. (8) (h)] during the preceding calendar year bears to the aggregate premiums written in this state by all members of the Plan. Each member's participation in the Plan shall be determined annually on the basis of such premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner of insurance.

(12) RATES, RATE CLASSIFICATIONS, AND FILINGS. Rates, rate classifications, and filings for coverages issued by the Plan shall be generally subject to ch. 625, Stats., and specifically shall meet the requirements of ss. 619.01 (1) (c) 2., 619.04 (5), 625.11, and 625.12, Stats. Information supporting the rates and rate classifications filed with the commissioner shall be made a part of such filing. Rates, rate classifications and filings shall be developed in accordance with the following standards or rules:

(a) *Rates.* 1. Rates shall not be excessive, inadequate or unfairly discriminatory.

2. Rates shall be calculated in accordance with generally accepted actuarial principles, using the best available data and shall be reviewed by the board of governors at least once each year.

3. Rates shall be calculated on a basis which will make the Plan self-supporting. Rates shall be presumed excessive if they produce long run excess funds for the Plan over unpaid losses, unpaid loss adjustment expenses, any additions to the compulsory or security surplus established for the Plan by direction of the commissioner pursuant to s. 619.01 (1) (c) 2., Stats., and acting under ss. 623.11 and 623.12, Stats., the premium assessment imposed each year by s. 619.01 (8m), Stats., and other expenses.

4. Any deficit incurred by the Plan in any one year shall be recouped by actuarially sound rate increases applicable prospectively which take into account any Plan surplus as defined in subd. 5.

5. The Plan shall maintain a compulsory surplus and a security surplus as determined by the commissioner acting under ss. 623.11 and 623.12, Stats. For purposes of this section, the terms "compulsory surplus" and "security surplus" are defined in s. Ins 14.02.

6. Excess funds shall be distributed as follows:

a. If the Plan accumulates funds in excess of the surplus required under s. 619.01 (1) (c) 2., Stats., and incurred liabilities, including reserves for claims incurred but not yet reported, the board of governors shall return

those excess funds to the insureds by means of refunds or prospective rate decreases.

b. The board of governors shall annually determine whether excess funds have accumulated.

c. If it determines that excess funds have accumulated, the board of governors shall specify the method and formula for distributing the excess funds.

7. Rates shall reflect past and prospective loss and expense experience in different areas of practice.

8. Wisconsin loss and expense experience shall be used in establishing and reviewing rates to the extent it is statistically credible supplemented by relevant data from outside the state; relevant data shall include, but not be limited to, data provided by other insurance companies, rate service organizations or governmental agencies.

9. Loss and expense experience used in determining initial or revised rates shall be adjusted to indicate as nearly as possible the loss and expense experience which will emerge on policies issued by the Plan during the period for which the rates were being established; for this purpose loss experience shall include paid and unpaid losses, a provision for incurred but not reported losses, and both allocated and unallocated loss adjustment expenses and consideration shall be given to changes in estimated costs of unpaid claims and to indications of trends in claim frequency, claim severity, and level of loss expense.

10. Review of rates for the Plan shall begin with the experience of the Plan, supplemented first by Wisconsin experience of coverage provided by other insurers, and then, to the extent necessary for statistical credibility, by relevant data from outside the state.

11. Information supporting the rate filing shall indicate the existence, extent and nature of any subjective factors in the rates based on judgment of technical personnel, such as consideration of the reasonableness of the rates compared to the cost of comparable coverage where it is available.

12. Expense provisions included in the rate to be used by the Plan shall reflect reasonable prospective operating expense levels of the Plan.

13. Provision may be made for modification of rates for individual risks in accordance with rating plans or surcharge schedules which establish reasonable standards for measuring probable variation in hazards, expenses, or both.

(b) *Classifications.* 1. Classifications shall reflect past and prospective loss and expense experience in different areas of practice.

2. Classifications shall be established which measure to the extent possible variations in exposure to loss and in expenses based upon the best data available.

3. Classifications shall include recognition of any difference in the exposure to loss of semi-retired or part-time professionals.

4. Classifications shall to the extent possible reflect past and prospective loss and expense experience of risks insured in the Plan and other relevant experience from within and outside this state.

5. Classification schedules may provide for modification of rates for individual risks in accordance with rating plans or surcharge schedules which establish reasonable standards for measuring probable variations in hazards, expenses, or both.

6. Classifications shall be reviewed by the board of governors at least once each year.

(c) *Filings.* 1. All filings of rates, classifications and supporting information of the Plan and all changes and amendments thereof shall be filed with the commissioner within 30 days after they become effective.

2. These filings shall be open to public inspection during the usual business hours of the office of the commissioner of insurance.

(13) VOLUNTARY BUSINESS - CANCELLATION AND NONRENEWAL. Any member cancelling or not renewing voluntarily written health care liability insurance covering any risk eligible under this Plan shall inform the policyholder of the availability of insurance under the Plan. Any such notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage. A copy of such cancellation or nonrenewal notice shall be filed with the office of the commissioner of insurance.

(14) PLAN BUSINESS - CANCELLATION AND NONRENEWAL. (a) The Plan may not cancel or refuse to renew a policy issued under the Plan except for one or more of the following reasons:

1. Nonpayment of premium.

2. Revocation of the license of the insured by the appropriate licensing board.

3. Revocation of accreditation, registration, certification or other approval issued to the insured by a state or federal agency or national board, association or organization.

4. If the insured is not licensed, accredited, registered, certified or otherwise approved, failure to provide evidence that the insured continues to provide health care in accordance with the code of ethics applicable to the insured's profession, if the board requests such evidence.

(b) Notice of cancellation or nonrenewal under par. (a), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in sub. (16).

(15) COMMISSION. Commission to the licensed agent designated by the applicant shall be 15% for each new or renewal policy issued to medical or osteopathic physicians, nurse anesthetists, nurse midwives, cardiovascular perfusionists, podiatrists, and partnerships comprised of or corporations or general partnerships organized for the primary purpose of providing the medical services of physicians, podiatrists, nurse anesthethists, nurse midwives or cardiovascular perfusionists subject to a maximum of $150 per policy; and 5% of the annual premium for each new or renewal policy issued to operating cooperative sickness care plans, or to teaching facilities, or to hospitals, or to entities specified in sub. (5) (a) 7m, or to health care facilities owned and operated by a political subdivision of the state of Wisconsin, not to exceed $2,500.00 per

policy period. The agent need not be licensed with the servicing company.

(16) RIGHT OF APPEAL. Any affected person may appeal to the board of governors within 30 days after notice of any final ruling, action or decision of the Plan. Decisions of the board of governors may be further appealed in accordance with ch. 227, Stats.

(17) REVIEW BY COMMISSIONER. The board of governors shall report to the commissioner the name of any member or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the board of governors or to pay within 30 days any assessment levied.

(18) INDEMNIFICATION. Each person serving on the board of governors or any subcommittee thereof, each member of the Plan, and the manager and each officer and employe of the Plan shall be idemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the board of governors, or a member or manager or officer or employe of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful or criminal misconduct in the performance of his or its duties as a member of such board of governors, or a member or manager or officer or employe of the Plan. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the Plan. Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employe may be entitled as a matter of law.

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 6-22-76; am. (1) (b), (2), (4) (b) and (c) and (5) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1)(b), (2), (4)(c), (5)(a), (5)(f), (10)(a) and (15), cr. (4)(h), Register, May, 1977, No. 257, eff. 6-1-77; am. (1)(b), (2), (4)(c), (5)(a), (10)(a) and (15), Register, September, 1977, No. 261, eff. 10-1-77; am. (1)(b), (2), (4)(b) and (c), (5)(a) and (f), and (15), Register, May, 1978, No. 269, eff. 6-1-78; am. (7) (b) 1.a., Register, March, 1979, No. 279, eff. 4-1-79; renum. from. Ins 3.35, am. (1) (b), (2), (5) (a) and (10) (a), Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (5) (a), Register, April, 1980, No. 292, eff. 5-1-80; am. (1) (b), (2), (4) (c), (5) (a), (10) (a), (12) (a) 3. and 4. and (15), r. (12) (a) 11. renum. (12) (a) 5. through 10. and 12. to be 7. through 12. and 13., cr. (12)(a) 5. and 6., Register, May, 1985, No. 353, eff. 6-1-85; emerg. am. (1)(b), (2), (4)(c) and (5)(a) 2., eff. 7-29-86; am. (1)(b), (2), (4)(c) and (5)(a) 2., Register, January, 1987, No. 373, eff. 2-1-87; emerg. am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), cr. (5) (a) 11., (7m) and (14) (a) 3. and 4., renum. (5) (a) 11., (b) and (7) (b) 1. intro. to be (5) (am), (b) (intro.) and (7) (b) and am., r. (7) (b) 1. a. and b. eff. 2-16-87; am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), renum. (5) (a) 11, (b) and (7) (b) 1. to be (5) (am), (b) (intro.) and (7) (b) 1. and am., cr. (5) (a) 7m and 11., (b) 1. to 3., (7) (b) 2m. and (14) (a) 3. and 4., r. (7) (b) 1. a. and b., Register, July, 1987, No. 379, eff. 8-1-87.

Ins 17.26 Future medical expense funds. (1) PURPOSE. This rule is intended to implement the provisions of s. 655.015, Stats.

(2) SCOPE. This rule shall apply to all insurers, organizations and persons subject to ch. 655, Stats.

(3) DEFINITIONS. In this section:

(a) "Account" means the portion of the fund allocated specifically for future medical expense of an injured person.

(b) "Claimant" means the injured person, the individual legally responsible for any medical expenses sustained by the injured person, or the legally designated representative of such injured person.

(c) "Medical expense" means those charges for medical services, nursing services, medical supplies, drugs or rehabilitation services which are necessary to the comfort and well being of the individual and incidental to the injury sustained.

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the insurer, organization or person responsible for such payment shall forward to the commissioner the amount in excess of $25,000 within 30 days of any such settlement, award or judgment, and shall enclose an appropriately executed copy of the document setting forth the terms under which the payment is to be made.

(b) The commissioner shall credit each account with a pro rata share of interest earned, if any, based on the remaining value of each account at the time such interest earning is declared by the investment board. The commissioner shall maintain an individual record of each account showing the original allocation, payments made, credits and the balance remaining.

(c) Upon receipt of a request for reimbursement of medical expense of an injured person, the commissioner shall make appropriate investigation and inquiries to determine that the medical supplies or services provided are necessary and incidental to the injury sustained by the person for whom the account was established, and if satisfied that this is the case, shall pay these expenses out of the fund, using standard bookkeeping and accounting records and transactions established by ss. 16.40 (5) and 16.41, Stats.

(d) If the commissioner is not satisfied that a provider of service has been reimbursed for services or supplies provided to the injured person, payments of any medical expense may be made jointly to the claimant and to the provider. The claimant may, in writing, direct that payment be made directly to the provider. If the claimant has paid for medical supplies or services the claimant shall be reimbursed upon receipt of proof of payment.

(e) The commissioner shall not less than once annually inform the claimant of the status to date of the account including the original amount, payments made, and the balance remaining.

(f) Payment shall be made to the claimant for reasonable and necessary medical expense until such time as the allocated amount is exhausted or until the injured person is deceased. Should the injured person become deceased and there is a balance in his account allocation, that amount shall be returned to the insurer, organization or person responsible for establishing the account.

History: Cr. Register, November, 1976, No. 251, eff. 12-1-76; renum. from Ins 3.37, Register, July, 1979, No. 283, eff. 8-1-79; am. (3), r. (4) (b) and (f), renum. (4) (d), (e), (g) and (h) to be (4) (e) (b), (d) and (f) and am., Register, April, 1984, No. 340, eff. 5-1-84.

Ins 17.27 Filing of financial statement. (1) PURPOSE. This rule is intended to implement and interpret ss. 655.21, 655.27 (3) (b), 655.27 (4) (d) and 655.27 (5) (e), Stats., for the purpose of setting standards and techniques for accounting, valuing, reserving and reporting of data relating to financial transactions of the Patients Compensation Fund.

(2) DEFINITIONS. (a) "Amounts in the fund" as used in s. 655.27 (5) (e), Stats., means the sum of cash and invested assets as reported in the financial report.

(b) "Fiscal year" as used in s. 655.27 (4) (d) means a year commencing July 1 and ending June 30.

(3) FINANCIAL REPORTS. Annual financial reports required by s. 655.27 (4) (d), Stats., shall be furnished within 60 days after the close of each fiscal year. In addition, quarterly financial reports shall be prepared as of September 30, December 31 and March 31 of each year and furnished within 60 days after the close of each reporting period. These financial reports shall be prepared on a format prescribed by the board of governors in accordance with statutory accounting principles for fire and casualty companies. Reserves for reported claims and reserves for incurred but not reported claims shall be maintained on a present value basis with the difference from full value being reported as a contra account to the loss reserve liability. Any funds for administration of the Patients Compensation Panels derived from fees collected under s. 655.21, Stats., shall be included in these financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

(4) The board of governors shall select one or more actuaries to assist in the determination of reserves and the setting of fees under s. 655.27 (3)

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