Chapter Ins 17

PATIENTS COMPENSATION FUND

Ins 17.001 Definitions. (ss. 619.04 and 655.003, Stats.) As used in this chapter:

(1) "Board" means the board of governors established pursuant to s. 619.04 (3), Stats.;

(2) "Fund" means the patients compensation fund established pursuant to s. 655.27 (1), Stats., except as defined in s. Ins 17.24;

(3) "Hearing" includes both hearings and rehearings, and these rules shall cover both so far as applicable, except where otherwise specifically provided by statute or in ch. Ins 17.

(4) "Plan" means the Wisconsin health care liability insurance plan established by s. Ins 17.25 pursuant to s. 619.01 (1) (a), Stats.;

(5) "Commissioner" means the commissioner of insurance or deputy whenever detailed by the commissioner or discharging the duties and exercising the powers of the commissioner during an absence or a vacancy in the office of the commissioner, as provided by s. 601.11 (1) (b), Stats.

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

Ins 17.01 Payment of mediation fund fees. (1) PURPOSE. This rule implements the provisions of ch. 655.61, Stats., relating to the payment of mediation fund fees.

(2) PAYMENT OF FEES TO FINANCE THE MEDIATION SYSTEM. (a) Every physician practicing in the state, subject to ch. 655, Stats., excluding those in a residency or fellowship training program, and every hospital operating in the state, subject to ch. 655, Stats., shall pay to the commissioner of insurance an annual fee to finance the mediation system created by s. 655.42, Stats. The commissioner of insurance shall deposit all such fees collected in the mediation fund created by s. 655.68, Stats.

(b) The fee is due and payable upon receipt of the billing by the physician or hospital.

(c) Any physician or hospital who has not paid the fee within 30 days from the date the billing is received shall be deemed to be in noncompliance with s. 655.61 (1), Stats.

(d) The commissioner shall notify the department of regulation and licensing of each physician who has not paid the fee, and who is, therefore, in noncompliance with s. 655.61 (1), Stats.

(e) The commissioner shall notify the department of health and social services of each hospital which has not paid the fee, and which is, therefore, in noncompliance with s. 655.61 (1), Stats.

(f) Fees collected under this section are not refundable except to correct an administrative billing error.

(3) FEE SCHEDULE. The following fee schedule shall be effective July 1, 1987:

(a) For physicians — $-0-$

(b) For hospitals — $-0-$

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; emerg. r. and recr. eff. 7-2-86; r. and recr., Register, September, 1986, No. 369, eff. 10-1-86; cr. (2) (f), am. (3), Register, June, 1987, No. 378, eff. 7-1-87.

Ins 17.02 Petition for declaratory rulings. (ss. 619.04 and 655.003, Stats.) (1) Petitions for declaratory rulings shall be governed by s. 227.06, Stats.

(2) Such petitions shall be filed with the commissioner who shall investigate, give notice, etc.

(3) All final determinations shall be made by the board.

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

Ins 17.03 How proceedings initiated. (ss. 619.04 and 655.003, Stats.) Proceedings for a hearing upon a matter may be initiated:

(1) On a complaint, specifying all grounds which the complainant wishes to be considered at the hearing, by any individual, corporation, partnership or association which is aggrieved, filed in triplicate (original and 2 copies) with the commissioner.

(2) By the board on its own motion whenever its investigation discloses probable ground therefore.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) and (1), Register, February, 1988, No. 386, eff. 3-1-88.

Ins 17.04 General rules of pleading. (ss. 619.04 and 655.003, Stats.) All pleadings shall be governed by s. 802.02, Stats., where applicable.

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

Ins 17.05 Caption of pleadings and notice. (ss. 619.04 and 655.003, Stats.) All pleading, notices, orders and other papers filed in reference to any hearings shall be captioned "Before the Board of Governors of the Wisconsin Health Care Liability Insurance Plan and Wisconsin Patients

Compensation Fund" and shall be entitled "In the Matter of . . . . . (here insert the matter that is involved)."

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

Ins 17.06 Service of papers. (ss. 619.04 and 655.003, Stats.) A copy of all papers filed at or in reference to any hearing shall be served, or furnished as the case may be, on or to each other party or person interested who enters an appearance in the proceedings.

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

Ins 17.07 Procedure upon filing complaint. (ss. 619.04 and 655.003, Stats.) Upon the filing of a complaint as prescribed by s. Ins 17.03 the commissioner or member of the commissioner's staff shall investigate the matter alleged, to determine whether there is sufficient cause for action and shall report the findings to the board for action. If the board determines that there is sufficient cause for action it shall order a hearing. A request for a hearing under s. Ins 17.285 (9) (a) shall be considered sufficient cause for action. If the board determines that no further action is warranted it shall notify the complainant in writing of the reasons for its determination.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. Register, February, 1988, No. 386, eff. 3-1-88.

Ins 17.08 Forms of notice. (ss. 619.04 and 655.003, Stats.) (1) A notice of hearing shall include all of the following:

(a) A statement of the issues to be considered.

(b) The names and addresses of the parties.

(c) The date, time and place of the hearing and, if scheduled, the prehearing.

(d) The class of the proceeding under s. 277.01 (3), Stats.

(e) The statutory authority under which the hearing will be conducted.

(f) The date of the notice.

(g) The signature of the chairperson or secretary of the board or subordinate of the commissioner designated by the board.

(2) If the hearing is initiated by the board's own motion or investigation, the notice shall also include a copy of the complaint and the time by which a party is required to answer in writing.

(3) Except in an emergency, a notice of hearing shall be mailed to the parties at least 10 days before the date of the hearing.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. Register, February, 1988, No. 386, eff. 3-1-88.

Ins 17.09 Answer. (ss. 619.04 and 655.003, Stats.) The respondent shall be required to answer any notice within the time therein specified and failure to do so shall constitute a default. The commissioner may, upon proper showing, excuse such failure to answer upon such terms as the commissioner determines to be just and permit the party to make answer within such time as the commissioner prescribes, provided, however, that no party shall be relieved from such default after a hearing has been

concluded and an order entered or other disposition made of the matter. The answer shall be verified by the respondent individually, or if a corporation by a proper officer of such corporation, unless an admission of the allegations might subject the person or party to prosecution for a felony, and shall be filed with the commissioner in triplicate (original and 2 copies) within the time prescribed in the notice of hearing.

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

Ins 17.10 Contents of answer. (ss. 619.04 and 655.003, Stats.) The answer must contain:

(1) A specific denial of each material allegation of the charges, factual situations or matters which the respondent controverts.

(2) A statement of any new matter constituting a defense or mitigating the offense or matter charged, which the respondent wishes to have considered.

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.;

2m. Nurse practitioners registered under ch. 441, Stats., who meet at least one of the requirements specified under s. HSS 105.20 (2) (b);

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

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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.

(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.

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.

(12m) PREMIUM SURCHARGE TABLES. (a) This subsection implements s. 619.04 (5m) (a), Stats., requiring the establishment of an automatic increase in a provider's plan premium based on loss and expense experience.

(b) In this subsection:

1. "Aggregate indemnity" has the meaning given under s. Ins 17.285 (2) (a).

2. "Closed claim" has the meaning given under s. Ins 17.285 (2) (b).

3. "Provider" has the meaning given under s. Ins 17.285 (2) (d).

4. "Review period" has the meaning given under s. Ins 17.285 (2) (e).

(c) The following tables shall be used in making the determinations required under this subsection and s. Ins 17.285 (3) (a), (4) (a), (7) and (9) as to the percentage increase in a provider's plan premium:

1. For Class 1 and Class 8 physicians and surgeons, podiatrists, nurse anesthetists, nurse midwives, nurse practitioners and cardiovascular perfusionists:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 67,000	0%	0%	0%	0%
$ 67,001 to $ 231,000	0%	10%	25%	50%
$ 231,001 to $ 781,000	0%	25%	50%	100%
Greater Than $ 781,000	0%	50%	100%	200%

2. For Class 2 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 92,000	0%	0%	0%	0%
$ 92,001 to $ 276,000	0%	10%	25%	50%
$ 276,001 to $1,071,000	0%	25%	50%	100%
Greater Than $1,071,000	0%	50%	100%	200%

3. For Class 3 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 143,000	0%	0%	0%	0%
$ 143,001 to $ 584,000	0%	10%	25%	50%
$ 584,001 to $1,216,000	0%	25%	50%	100%
Greater Than $1,216,000	0%	50%	100%	200%

4. For Class 4 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 160,000	0%	0%	0%	0%
$ 160,001 to $ 714,000	0%	10%	25%	50%
$ 714,001 to $1,383,000	0%	25%	50%	100%
Greater Than $1,383,000	0%	50%	100%	200%

5. For Class 5A physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 319,000	0%	0%	0%	0%
$ 319,001 to $ 744,000	0%	10%	25%	50%
$ 744,001 to $1,550,000	0%	25%	50%	100%
Greater Than $1,550,000	0%	50%	100%	200%

6. For Class 5 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 415,000	0%	0%	0%	0%	0%
$ 415,001 to $ 659,000	0%	0%	10%	25%	50%
$ 659,001 to $1,240,000	0%	0%	25%	50%	75%
$1,240,001 to $1,948,000	0%	0%	50%	75%	100%
Greater Than $1,948,000	0%	0%	75%	100%	200%

7. For Class 6 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 419,000	0%	0%	0%	0%	0%
$ 419,001 to $ 776,000	0%	0%	10%	25%	50%
$ 776,001 to $1,346,000	0%	0%	25%	50%	75%
$1,346,001 to $2,345,000	0%	0%	50%	75%	100%
Greater Than $2,345,000	0%	0%	75%	100%	200%

8. For Class 7 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 486,000	0%	0%	0%	0%	0%
$ 486,001 to $ 895,000	0%	0%	10%	25%	50%
$ 895,001 to $1,452,000	0%	0%	25%	50%	75%
$1,452,001 to $2,428,000	0%	0%	50%	75%	100%
Greater Than $2,428,000	0%	0%	75%	100%	200%

9. For Class 9 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 627,000	0%	0%	0%	0%	0%
$ 627,001 to $1,103,000	0%	0%	10%	25%	50%
$1,103,001 to $1,658,000	0%	0%	25%	50%	75%
$1,658,001 to $3,371,000	0%	0%	50%	75%	100%
Greater Than $3,371,000	0%	0%	75%	100%	200%

(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 anesthetists, 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. This subsection does not apply to a decision relating to an automatic increase in a provider's plan premium under sub. (12m), which is appealable as provided under s. Ins 17.285.

(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; r. (12) (a) 13. and (b) 5., cr. (5) (a) 2m. and (12m), am. (16), Register, February, 1988, No. 386, eff. 3-1-88.

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 for-

ward 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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(k) For partnerships comprised of physicians or nurse anesthetists: $50.00

(l) For corporations providing the medical services of physicians or nurse anesthetists:

1. With one shareholder $0

2. With more than one shareholder $50.00

(m) For operational cooperative sickness care plans:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.17; plus

2. 2.5% of the total annual fund fees assessed against all physicians employed on July 1 of the previous fiscal year

(n) For ambulatory surgery centers:

Per 100 outpatient visits during the last calendar year for which totals are available $33.75

(o) For an entity owned or controlled by a hospital or hospitals: 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity

(6m) The fund may require any health care provider to report, at the times and in the manner prescribed by the fund, any information necessary for the determination of a fee specified under sub. (6).

(6s) SURCHARGE. (a) This subsection implements s. 655.27 (3) (bg) 1, Stats., requiring the establishment of an automatic increase in a provider's fund fee based on loss and expense experience.

(b) In this subsection:

1. "Aggregate indemnity" has the meaning given under s. Ins 17.285 (2) (a).

2. "Closed claim" has the meaning given under s. Ins 17.285 (2) (b).

3. "Provider" has the meaning given under s. Ins 17.285 (2) (d).

4. "Review period" has the meaning given under s. Ins 17.285 (2) (e).

(c) The following tables shall be used in making the determinations required under this subsection and s. Ins 17.285 (3) (a), (4) (a), (7) and (9) as to the percentage increase in a provider's fund fee:

1. For Class 1 health care providers specified under sub. (3) (c) 1 and nurse anesthetists:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 67,000	0%	0%	0%	0%
$ 67,001 to $ 231,000	0%	10%	25%	50%
$ 231,001 to $ 781,000	0%	25%	50%	100%
Greater Than $ 781,000	0%	75%	100%	200%

2. For Class 2 health care providers specified under sub. (3) (c) 2:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 123,000	0%	0%	0%	0%
$ 123,001 to $ 468,000	0%	10%	25%	50%
$ 468,001 to $1,179,000	0%	25%	50%	100%
Greater Than $1,179,000	0%	50%	100%	200%

3. For Class 3 health care providers specified under sub. (3) (c) 3:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 416,000	0%	0%	0%	0%	0%
$ 416,001 to $ 698,000	0%	0%	10%	25%	50%
$ 698,001 to $1,275,000	0%	0%	25%	50%	75%
$1,275,001 to $2,080,000	0%	0%	50%	75%	100%
Greater Than $2,080,000	0%	0%	75%	100%	200%

4. For Class 4 health care providers specified under sub. (3) (c) 4:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 503,000	0%	0%	0%	0%	0%
$ 503,001 to $ 920,000	0%	0%	10%	25%	50%
$ 920,001 to $1,465,000	0%	0%	25%	50%	75%
$1,465,001 to $2,542,000	0%	0%	50%	75%	100%
Greater Than $2,542,000	0%	0%	75%	100%	200%

(7) Each health care provider permanently practicing or operating in this state may pay the assessment in a single lump sum, 2 semiannual payments or 4 quarterly payments. In this subsection, "assessment" includes any applicable surcharge imposed under sub. (6s) (b). This subsection implements s. 655.27 (3) (b), Stats.

(a) The fund shall issue an initial billing to each provider showing the assessment due, and the payment schedules available. Once the provider has selected a payment schedule, that schedule shall apply for the remainder of that fiscal year.

(b) All providers shall pay the billed assessment on or before the due date indicated on the assessment billing. Due dates vary according to type of assessment and date of assessment.

1. Renewal assessments. The payment due dates for renewal assessments are:

a. Annual payment - July 1;

b. Semiannual payments - July 1, January 1;

c. Quarterly payments - July 1, October 1, January 1, April 1.

2. Initial assessments or assessments written for providers no longer in exempt status. For a provider who is initially participating in the fund, and for a provider who can no longer claim an exempt status, the number of payment options shall be dependent on the date the fund processes the assessment billing.

a. The first payment, regardless of a lump sum, semiannual, or quarterly payment schedule, shall be due 30 days from the date the fund processes the assessment billing.

b. For semiannual payment schedules, the second payment shall be due on or before January 1. Any provider whose first payment due date is January 1 or later shall not be able to choose the semiannual payment schedule.

c. For quarterly payment schedules, payments shall be due on or before October 1, January 1, and April 1, respectively. In order for the provider to choose 4 quarterly payments, the first payment due date shall fall before October 1. If the first payment due date falls between October 1 and December 31, the provider shall have 3 quarterly payments, with the second and third payments due on or before January 1 and March 31, the provider shall have 2 quarterly payments, with the second payment due on or before April 1. Any provider whose first payment due date is April 1 or later shall not be able to choose the quarterly payment schedule.

3. Increases in assessments. If provider changes class or type, which results in an increased assessment, the first payment resulting from that increase shall be due 30 days from the date the fund processes the increased assessment billing. The provider shall follow the same payment schedule selected with the original assessment billing when making payments for the increased assessment billing.

4. Decreases in assessments. If a provider changes class or type, which results in a decreased assessment, or if a provider leaves the fund or becomes exempt, the provider may be entitled to a refund check or a credit to be applied to future payments during the current fiscal year. If the assessment amount already paid into the fund is greater than the recalculated assessment, the fund shall issue the provider a refund check. If the assessment amount already paid into the fund is less than the recalculated assessment, the fund shall credit the provider's account for any overpayment during the period(s) affected by the decreased assessment.

(c) The fund shall charge interest and an administrative service charge to each provider who chooses the semiannual or quarterly payment schedule. The rate of interest charged by the fund shall be the average annualized rate earned by the fund for the first 3 quarters of the preceding fiscal year as determined by the state investment board. The administrative service charge shall be used to offset costs of administering the payment plan. Interest and administrative service charges are not refundable.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80; am. (6), Register, June, 1981, No. 306, eff. 7-1-81; r. and recr. (6), Register, June, 1982, No. 318, eff. 7-1-82; am. (6) (h) and (i), Register, August, 1982, No. 320, eff. 9-1-82, am. (6), Register, June, 1983, No. 330, eff. 7-1-83; am. (6) (i), Register, September, 1983, No. 333, eff. 10-1-83; am. (6) (intro.), (a) to (h), (j) and (r), Register, June, 1984, No. 342, eff. 7-1-94; am. (6) (i), Register, August, 1984, No. 344, eff. 9-1-84; am. (3) (c) and (6) (intro.), (a) to (e) 1., (f) to (h), (j) and (k), r. (intro.), cr. (3) (c) 1. to 9. and (7), Register, July, 1985, No. 355, eff. 8-1-85; am. (7) (a) 2. and (c), r. (7) (a) 5., renum. (7) (a) 3. and 4. to be 4. and 5. and am., cr. (7) (a) 3., Register, December, 1985, No. 360, eff. 1-1-86; emerg. r. and recr. (3) (c) intro., 1. to 9., (4), (6) (intro.), (a) to (k) and (7), eff. 7-2-86; r. and recr. (3) (c) intro. and 1. to 9., (4), (6) (intro.), (a) to (k) and (7), Register, September, 1986, No. 369, eff. 10-1-86; am. (2), (4) (b) and (d), (6) and (7) (intro.), Register, June, 1987, No. 378, eff. 7-1-87; am. (6) (i) and (j), cr. (6) (k) to (o) and (6m), Register, January, 1988, No. 385, eff. 7-1-88; cr. (6s), Register, February, 1988, No. 386, eff. 3-1-88.

Ins 17.285 Peer review council. (1) PURPOSE. This section implements ss. 619.04 (5) (b) and (5m) (b), 655.27 (3) (a) 2m and (bg) 2 and 655.275, Stats.

(2) DEFINITIONS. In this section:

(a) "Aggregate indemnity" means the total amount paid to or on behalf of claimants, including amounts held by the fund under s. 655.015, Stats. "Aggregate indemnity" does not include any expenses paid in the defense of the claim.

(b) "Closed claim" means a claim against a provider, or a claim against an employe of a health care provider for which the provider is vicariously liable, which results in any payment to or on behalf of a claimant.

(c) "Council" means the peer review council appointed under s. 655.275, Stats.

(d) "Provider" means a health care provider who is a natural person. "Provider" does not include a hospital or other facility or entity that provides health care services.

(e) "Review period" means the 5-year period ending with the date of the most recent closed claim reported under s. 655.26, Stats., for a specific provider.

(f) "Surcharge" means the automatic increase in a provider's plan premium or fund fee established under s. Ins 17.25 (12m) or 17.28 (6s) or both.

(3) EXAMINATION OF CLAIMS PAID. (a) Each month the council shall examine all claims paid reports received under s. 655.26, Stats., to determine whether each provider for whom a closed claim is reported has, during the review period, accumulated enough closed claims and aggregate indemnity to require the imposition of a surcharge, based on the tables under s. Ins 17.25 (12m) (c). In determining the number of closed claims accumulated by a provider, the council shall count all claims arising out of one incident or course of conduct as one claim.

(b) If the board does not have a provider's claims record for the entire review period, the council may request from the provider a statement of the number and amounts of all closed claims that have been paid by or on behalf of the provider during the review period. The request shall include notice of the provisions of par. (c).

(c) If the provider fails to comply with the request under par. (b), the provider shall be assessed a surcharge for a 3-year period as follows:

1. If the provider has practiced in this state for the entire review period, 10 % of the next annual plan premium, fund fee or both, subject to sub. (11) (d) to (f).

2. If the provider has practiced in any place other than this state for any part of the review period, 50% of the next annual plan premium, fund assessment or both, subject to sub. (11) (d) to (f).

(d) A provider who does not comply with the request under par. (b) is not entitled to a review of his or her claims record as provided in this section nor to a hearing on the imposition of a surcharge.

(4) REVIEW REQUIRED; NOTICE TO PROVIDER. (a) If the number of closed claims and the aggregate indemnity of any provider for all closed claims reported under s. 655.26, Stats., and sub. (3) would be sufficient to require the imposition of a surcharge, the council shall review the provider's claims record for the review period to determine whether a surcharge should be imposed.

(b) The council shall notify each provider subject to a review that a surcharge may be imposed and that the surcharge may be reduced or eliminated following a review as provided in this section. The notice shall also include:

1. A description of the procedures specified in this section and a statement that the provider may submit in writing relevant information about any incident involved in the review and a description of mitigating circumstances that may reduce the future risk to the plan, the fund or both.

2. A request that the provider furnish the council with written authorization to obtain, from the claim files of any insurer that provided coverage during the review period and from any defense attorney's files relevant factual information about each closed claim that would aid in making any determination required in this section.

(c) If the provider complies with the request under par. (b) 2, the plan, the fund, private insurers and defense attorneys shall provide photocopies or summaries of any information requested by the council.

(d) If the provider does not comply with the request under par. (b) 2 with respect to any claim, the council shall, without review, include that claim in determining whether to impose a surcharge.

(5) PROCEDURE FOR REVIEW. (a) The council may identify an organization in this state that represents each type of provider included in the plan and the fund and may notify each organization that it may recommend individual providers or a committee of members of the organization as consultants for purposes of par. (b) or (c).

(b) For each review, the council shall do one of the following:

1. If the provider is a physician, refer the matter for consultation to a physician or committee of physicians recommended under par. (a) or to another physician or physicians selected by the council who practice the same specialty or, if possible, the same subspecialty as the provider. If the provider's specialty or subspecialty is different from that of the medical procedure involved in any incident, the council shall also refer the record relating to that incident to at least one physician who practices that specialty or, if possible, subspecialty.

2. If the provider is a nurse anesthetist, refer the matter for consultation to a nurse anesthetist or a committee of nurse anesthetists recommended under par. (a) or to another nurse anesthetist or nurse anesthetists selected by the council.

(c) If the provider is not a physician or nurse anesthetist, and a consultant for the provider's profession has been recommended under par. (a), the council may refer the matter to that consultant or to any other person with expertise in the area of the specialty or specialties involved in any incident or may review the provider's claims record itself.

(d) In reviewing a closed claim, the council or a consultant may consider any relevant information except information from a juror who participated in a civil action for damages arising out of an incident under review. The council or a consultant may consult with any person except a juror, interview the provider, employes of the provider or other persons involved in an incident or request the provider to furnish additional information or records.

(6) CONSULTANT'S OPINION; COUNCIL DETERMINATION. (a) A consultant shall provide the council with a written opinion as to whether, with respect to each incident reviewed, there are mitigating circumstances which reduce the future risk to the plan, the fund or both, and which warrant a reduction or elimination of the surcharge. Each opinion shall include a description of any mitigating circumstances.

(b) The council, based on any consultants' reports or its own review, shall decide whether or not to include each incident involved in the review in determining whether to recommend imposition of a surcharge.

(7) REPORT TO BOARD. (a) If the total number of closed claims which the council determines should be included and the aggregate indemnity attributable to those claims would be sufficient to require the imposition of a surcharge under s. Ins 17.25 (12m) (c), the council shall prepare a written report for the board recommending the surcharge that should be imposed. The report shall include the factual basis for the determination on each incident involved in the review and a description of any mitigating circumstances.

(b) If the council determines that, because of mitigating circumstances, the total number of closed claims and the aggregate indemnity attributable to those claims would not be sufficient to require the imposition of a surcharge, the council shall prepare a written report for the board recommending that no surcharge should be imposed.

(8) NOTICE TO PROVIDER. The council shall furnish the provider with a copy of its report and recommendation to the board and shall also notify the provider of the right to request a contested case hearing under ch. 227, Stats., within 30 days after receipt of the notice.

(9) HEARING. (a) If the provider requests a hearing, the reports of the consultant, if any, and the council are admissible in evidence. If the provider proves by a preponderance of the evidence that, because of mitigating circumstances, one or more of the incidents should not be included in determining the surcharge, and as a result, the total remaining number of closed claims and aggregate indemnity would not be sufficient to require the imposition of a surcharge or would result in a lower surcharge, the hearing examiner's proposed decision shall recommend that no surcharge should be imposed or that the amount of the recommended surcharge should be reduced appropriately. If the provider fails to meet this burder of proof with respect to any incident, the hearing examiner's proposed decision shall accept the council's recommendation with respect to that incident.

(b) Notice of the hearing examiner's proposed decision shall inform the provider that he or she may submit to the board written objections and arguments regarding the proposed findings of fact, conclusions of law and decision within 20 days after the date of the notice.

(10) FINAL DECISION; JUDICIAL REVIEW. The board shall make the final decision on the imposition of a surcharge. The final decision is reviewable by the circuit court as provided under ch. 227, Stats.

(11) SURCHARGE; IMPOSITION; REFUND; DURATION. (a) A surcharge imposed on a provider's plan premium after a final decision by the board takes effect on the next policy renewal date and remains in effect during any period of judicial review.

(b) A surcharge imposed on a provider's fund fee after a final decision by the board takes effect on the July 1 following the date of the decision and remains in effect during any period of judicial review.

(c) If judicial review results in the imposition of no surcharge or a reduced surcharge, the plan, the fund or both shall refund the excess amount collected from the provider or credit the provider's next annual plan premium, fund fee or both with the excess amount.

(d) A surcharge remains in effect for 3 years. The percentage imposed under par. (a) or (b) shall be reduced by 50% the 2nd year and by 75% the 3rd year, if the provider does not accumulate any additional closed claims during the 3-year period.

(e) If the provider accumulates additional closed claims during the 3-year period, the provider is subject to the higher of the following:

1. The surcharge determined under par. (d).

2. The surcharge determined by the board following a new review of the provider's claims record under sub. (5).

(f) If the provider is a physician who, during the 3-year period, changes from one class to another class specified in s. Ins 17.28, the percentage surcharge imposed by the final decision of the board shall be applied to the plan premium, fund fee or both for the physician's new class effective on the date the class change occurs.

(12) REQUEST FROM PRIVATE INSURER. If the council receives a request for a recommendation under s. 655.275 (5) (a) 3, Stats., from a private insurer, the council shall follow the procedures specified in subs. (3) to (5) and notify the private insurer and the provider of the determination it would make under sub. (6) (b) if the provider's primary insurer were the plan. A provider is not entitled to a hearing on any determination reported under this subsection.

(13) CONFIDENTIALITY. The final decision of the board and all information and records relating to the review procedure are the work product of the board and are confidential.

(14) ANNUAL REVIEW. The board shall annually review the tables under s. Ins 17.25 (12m) (c) and the results of the procedure established in this section to determine if the council's performance adequately addresses the loss and expense experience of individual providers which results in payments from the plan, the fund or both. The board shall recommend to the commissioner any changes needed in the rules that are necessary to address that consideration.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88.

Ins 17.29 Servicing agent. (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (2), Stats., relating to contracting for patients compensation fund services.

(2) SCOPE. This section applies to adminstration and staff services for the fund.

(3) SELECTION. The selection of a servicing agent shall conform with s. 16.765, Stats. The commissioner, with the approval of the board, shall select a servicing agent through the competitive negotiation process to provide services for the fund based on criteria established by the board.

(4) TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS. The term served by the servicing agent shall be as established by the commissioner with the approval of the board but the contract shall include a provision for its cancellation if performance or delivery is not made in accordance with its terms and conditions.

(5) FUNCTIONS. (a) The servicing agent shall perform functions agreed to in the contract between the servicing agent and the office of the commissioner of insurance as approved by the board. The contract shall provide for an annual report to the commissioner and board of all expenses incurred and subcontracting arrangements.

(b) Additional functions to be performed by the servicing agent may include but are not limited to:

1. Hiring legal counsel.

2. Establishment and revision of case reserves.

3. Contracting for annuity payments as part of structured settlements.

4. Investigation and evaluation of claims.

5. Negotiation to settlement of all claims made against the fund except those responsibilities retained by the claim committee of the board.

6. Filing of reports to the board.

7. Review of panel decisions and court verdicts and recommendations of appeals as needed.

History: Cr. Register, February, 1984, No. 338, eff. 3-1-84.

Ins 17.30 Peer review council assessments. (1) PURPOSE. This section implements ss. 655.27 (3) (am) and 655.275 (6), Stats., relating to the assessment of fees sufficient to cover the costs, including the costs of administration, of the patients compensation fund peer review council appointed under s. 655.275 (2), Stats.

(2) ASSESSMENTS. (a) The following fees shall be assessed annually beginning with fiscal year 1986-87:

1. Against the patients compensation fund, one-half of the actual cost of the patients compensation fund peer review council for each fisal year, less one-half of the amounts, if any, collected under subd. 3.

2. Against the Wisconsin health care liability insurance plan, one-half of the actual cost of the patients compensation fund peer review council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

3. Against a private medical malpractice insurer, the actual cost incurred by the council for its review of any claim paid by the private insurer, if the private insurer requests a recommendation on premium adjustments with respect to that claim under s. 655.275 (5) (a) 3, Stats.

(b) Amounts collected under par. (a) 3 shall be applied to reduce, in equal amounts, the assessments under par. (a) 1 and 2 for the same fiscal year.

(3) PAYMENT. Each assessment under sub. (2) shall be paid within 30 days after the billing date.

History: Cr. Register, June, 1987, No. 378, eff. 7-1-87.