

Chapter Ins 17

HEALTH CARE LIABILITY INSURANCE
PATIENTS COMPENSATION FUND

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Ins 17.001 Definitions. In this chapter:

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

(1m) "Commissioner" means the commissioner of insurance or deputy commissioner acting under s. 601.11 (1) (b), Stats.

(2) "Fund" means the patients compensation fund established under s. 655.27 (1), Stats.

(3) "Hearing" has the meaning given in s. Ins 5.01 (1).

(4) "Plan" means the Wisconsin health care liability insurance plan, a nonprofit, unincorporated association established under s. 619.01 (1) (a), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) to (4), cr. (1m), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.005 Purpose. This chapter implements ss. 619.01 and 619.04 and ch. 655, Stats.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.01 Payment of mediation fund fees. (1) PURPOSE. This section implements s. 655.61 (2), Stats., relating to the payment of mediation fund fees.

(2) (a) Each physician subject to ch. 655, Stats., except a resident, and each hospital subject to ch. 655, Stats., shall pay to the commissioner an annual fee to finance the mediation system created by s. 655.42, Stats.

(b) The fund shall bill a physician or hospital subject to this section under s. Ins 17.28 (7) (a). The entire annual fee under this section is due and payable 30 days after the fund mails the bill.

(d) The fund shall notify the medical examining board of each physician who has not paid the fee as required under par. (b).

(e) The fund shall notify the department of health and social services of each hospital which has not paid the fee as required under par. (b).

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(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, 1990:

(a) For physicians — \$40.00

(b) For hospitals, per occupied bed — \$ 2.00

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; am. (1), (2) (a), (d) and (e), (3), r. and recr. (2) (b), r. (2) (c), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.02 Petition for declaratory rulings. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.03 How proceedings initiated. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) and (1), Register, February, 1988, No. 386, eff. 3-1-88; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.04 General rules of pleading. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.05 Caption of pleadings and notice. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.06 Service of papers. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.07 Procedure upon filing complaint. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. Register, February, 1988, No. 386, eff. 3-1-88; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.08 Forms of notice. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. Register, February, 1988, No. 386, eff. 3-1-88; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.09 Answer. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.10 Contents of answer. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.11 Hearing examiner. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.12 Rules of hearing. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.13 Continuances. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.14 Hearing public. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.15 Subpoenas. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.16 Service. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.17 Appearances. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.18 Examination of witnesses. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.19 Record. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.20 Stipulations. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

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Ins 17.21 Motions. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.22 Default. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.23 Arguments. History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.24 Review of classification. (1) Any person insured by the plan or covered by the fund may petition the board for a review of its classification by the plan or fund. The petition shall state the basis for the petitioner's belief that its classification is incorrect. The board shall refer a petition for review to either of the following:

(a) If the petitioner is a hospital or a nursing home or other entity affiliated with a hospital, to a committee appointed by the commissioner consisting of 2 representatives of hospitals, other than the petitioner's hospital, and one other person who is knowledgeable about insurance classification.

(b) If the petitioner is any person other than a person specified in par. (a), to a committee appointed by the commissioner consisting of 2 physicians who are not directly or indirectly affiliated or associated with the petitioner and one other person who is knowledgeable about insurance classification.

(2) The plan, the fund or both shall provide the committee with any information needed to review the classification.

(2m) The committee shall review the classification and report its recommendation to the petitioner and the board within 5 days after completing the review.

(3) Any person that is not satisfied with the recommendation of the committee may petition for a hearing under ch. 227, Stats., and ch. Ins 5 within 30 days after the date of receipt of written notice of the committee's recommendation.

(4) At the hearing held pursuant to a petition under sub. (3), the committee report shall be considered and the members of the committee may appear and be heard.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (1) and (2), cr. (2m), am. (3) and (4), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner 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 the commissioner's 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 plan for providing health care liability insurance and liability coverage normally incidental to health care liability insurance should be enacted pursuant to ch. 619, Stats.

(2) **PURPOSE.** This section implements ss. 619.01 and 619.04, Stats., by establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage and liability coverage normally incidental to health care liability insurance on a self-supporting basis for the persons specified in sub. (5) (a) and for their employes acting within the scope of their employment and providing health care services. This section is also intended to encourage improvement in reasonable loss prevention measures and to encourage the maximum use of the voluntary market.

(3) **COVERAGE; EXCLUSIONS.** (a) Each policy of health care liability insurance coverage issued by the plan shall provide occurrence coverage for all of the following:

1. Providing or failing to provide health care services to a patient.

2. Peer review, accreditation and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by the insured or an employe of the insured.

3. Utilization review, quality assurance and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by the insured or an employe of the insured.

(b) Each policy issued by the plan shall also provide for supplemental payments in addition to the limits of liability under par. (d), including attorney fees, litigation expenses, costs and interest.

(c) The health care liability insurance coverage issued by the plan shall exclude coverage for all of the following:

1. Criminal acts.

2. Intentional sexual acts and other intentional torts.

3. Restraint of trade, anti-trust violations and racketeering.

4. Defamation.

5. Employment, religious, racial, sexual, age and other unlawful discrimination.

6. Pollution resulting in injury to a 3rd party.

7. Acts that occurred before the effective date of the policy of which the insured was aware or should have been aware.

8. Incidents occurring while and insured's license to practice is suspended, revoked, surrendered or otherwise terminated.

9. Criminal and civil fines, forfeitures and other penalties.

10. Punitive and exemplary damages.

11. Liability of the insured covered by other insurance, such as worker's compensation, automobile, fire or general liability.

12. Liability arising out of the ownership, operation or supervision by the insured of a hospital, nursing home or other health care facility or business enterprise.

13. Liability of others assumed by the insured under a contract or agreement.

(d) The maximum limits of liability for coverage under par. (a) 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. Except as provided in subd. 4, for occurrences on and after July 1, 1988, \$400,000 for each occurrence and \$1,000,000 for all occurrences in any one policy year.

4. For podiatrists licensed under ch. 448, Stats., for occurrences on and after November 1, 1989, \$1,000,000 for each occurrence and \$1,000,000 for all occurrences in any one policy year.

(e) The plan may also issue liability coverage normally incidental to health care liability insurance including all of the following:

1. Owners, landlords and tenants liability insurance.
2. Owners and contractors protective liability insurance.
3. Completed operations and products liability insurance.
4. Contractual liability insurance.
5. Personal injury liability insurance.

(f) The maximum limits of liability for coverage under par. (e) are \$1,000,000 per claim and \$3,000,000 aggregate for all claims in any one policy year.

(5) ELIGIBILITY FOR PLAN COVERAGE. All of the following are eligible for insurance under the plan:

(a) A medical or osteopathic physician or podiatrist licensed under ch. 448, Stats.

(b) A nurse anesthetist or nurse midwife licensed under ch. 441, Stats.

(c) A nurse practitioner licensed under ch. 441, Stats., who meets at least one of the requirements specified under s. HSS 105.20 (2) (b).

(d) A partnership comprised of, and organized and operated in this state for the primary purpose of providing the medical services of, physicians, podiatrists, nurse anesthetists, nurse midwives, nurse practitioners or cardiovascular perfusionists.

(e) A corporation or general partnership organized and operated in this state for the primary purpose of providing the medical services of physicians, podiatrists, nurse anesthetists, nurse midwives, nurse practitioners or cardiovascular perfusionists.

(f) An operational cooperative sickness care plan organized under ss. 185.981 to 185.985, Stats., which directly provides services through salaried employees in its own facility.

(g) An accredited teaching facility 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.

(h) A hospital, as defined in s. 50.33 (2) (a) and (c), Stats., but excluding facilities exempted by s. 50.39 (3), Stats., except as provided in par. (k).

(i) An entity operated in this state that is an affiliate of a hospital and that provides diagnosis or treatment of, or care for, patients of the hospital.

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

(k) A health care facility owned or operated by a county, city, village or town in this state, or by a county department established under s. 51.42 or 51.437, Stats., if the facility would otherwise be eligible for coverage under this subsection.

(l) A corporation organized to manage approved training programs for medical or osteopathic physicians licensed under ch. 448, Stats.

(m) A cardiovascular perfusionist.

(n) An ambulatory surgery center, as defined in s. HSS 123.14 (2) (a).

(6) DEFINITIONS. (a) In this subsection:

1. "Personal injury liability insurance" means any insurance coverage against loss by the personal injury or death of any person for which loss the insured is liable. "Personal injury liability insurance" includes the personal injury liability component of multi-peril policies, but does not include steam boiler insurance authorized under s. Ins 6.75 (2) (a), worker's compensation insurance authorized under s. Ins 6.75 (2) (k) or medical expense coverage authorized under s. Ins 6.75 (2) (d) or (e).

2. "Premiums written" means gross direct premiums less return premiums, dividends paid or credited to policyholders and the unused or unabsorbed portions of premium deposits, with respect to personal injury liability insurance covering insureds or risks residing or located in this state.

(b) 1. Each insurer authorized in this state to write personal injury liability insurance, except a town mutual organized under ch. 612, Stats., is a member of the plan.

2. An insurer's membership in the plan terminates if the insurer is no longer authorized to write personal injury liability insurance in this state. The effective date of termination shall be the last day of the plan's current fiscal year. A terminated insurer shall continue to be governed by this subsection until it completes all of its obligations under the plan.

3. Subject to the approval of the commissioner, the board may charge a reasonable annual membership fee, not to exceed \$50.00.

(c) If the funds available to the plan at any time are not sufficient for the sound financial operation of the plan, the board shall assess the mem-

bers an amount sufficient to remedy the insufficiency. Each member shall contribute according to the proportion that that member's premiums written during the preceding calendar year bears to the aggregate premiums written by all members during the preceding calendar year. The amounts of premiums written shall be determined on the basis of the annual statements and other reports filed by the members with the commissioner. Assessments are subject to any credit plan developed under sub. (8) (a) 4. When the amount of the assessment is recouped under s. 619.01 (1) (c) 2, Stats., each member shall be reimbursed the amount of that member's assessment.

(d) The board shall report to the commissioner the name of any member that fails to pay within 30 days any assessment levied under par. (c).

(7) **BOARD MEETINGS; QUORUM.** The board shall meet as often as required to perform the general duties of supervising the administration of the plan, or at the call of the commissioner. Seven members of the board shall constitute a quorum.

(8) **POWERS AND DUTIES OF THE BOARD.** The board may do any of the following:

(a) 1. Invest, borrow and disburse funds, budget expenses, levy assessments and cede and assume reinsurance.

2. Appoint a manager or one or more agents to perform the duties designated by the board.

3. 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.

4. Develop an assessment credit plan subject to the approval of the commissioner, by which a member of the plan receives a credit against an assessment levied under sub. (6) (c), based on voluntarily written health care liability insurance premiums in this state.

5. Take any action consistent with law to provide the appropriate examining boards or the department of health and social services with appropriate claims information.

6. Perform any other act necessary or incidental to the proper administration of the plan.

(b) The board shall do all of the following:

1. Develop rates, rating plans, rating and underwriting rules, rate classifications, rate territories and policy forms for the plan.

2. Ensure that all policies written by the plan are 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.

3. Subject to the approval of the commissioner, determine the eligibility of an insurer to act as a servicing company to issue and service the plan's policies. If no qualified insurer elects to be a servicing company, the board shall assume these duties on behalf of member companies.

4. Enter into agreements and contracts as necessary for the execution of this section.

5. By May 1 of each year, report to the members of the plan and to the standing committees on insurance in each house of the legislature summarizing the activities of the plan in the preceding calendar year.

(10) APPLICATION FOR INSURANCE. (a) Any person specified in sub. (5) may submit an application for insurance by the plan directly or through any licensed agent. Each application shall request coverage for the applicant's partnership or corporation, if any, and for the applicant's employees acting within the scope of their employment and providing health care services, unless the partnership, corporation or employees are covered by other professional liability insurance.

(b) The plan may bind coverage.

(c) Within 8 business days after receiving an application, the plan shall notify the applicant whether the application is accepted, rejected or held pending further investigation. Any applicant rejected by the plan may appeal the decision to the board as provided in sub. (16).

(cm) The board may authorize retroactive coverage by the plan for a health care provider, as defined in s. 655.001 (8), Stats., if the provider furnishes the board with an affidavit describing the necessity for the retroactive coverage and stating that the provider has no notice of any pending claim alleging malpractice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim.

(d) If the application is accepted, the plan shall deliver a policy to the applicant upon payment of the premium.

(12) RATES, RATE CLASSIFICATIONS AND FILINGS. (a) 1. In developing rates and rate classifications, as provided under sub. (8) (b) 1, the board shall ensure that the plan complies with ss. 619.01 (1) (c) 2 and 619.04 (5) and ch. 625, Stats.

2. Rates shall be calculated in accordance with generally accepted actuarial principles, using the best available data.

3. Rates shall be calculated on a basis which will make the plan self-supporting but may not be excessive. Rates shall be presumed excessive if they produce long-term excess funds over the total of the plan's unpaid losses, including reserves for losses incurred but not yet reported, unpaid loss adjustment expenses, additions to the surplus established under s. 619.01 (1) (c) 2, Stats., and s. Ins 14.02 (3) and (4), the premium assessment under s. 619.01 (8m), Stats., and other expenses.

4. The board shall annually determine if the plan has accumulated excess funds as described under subd. 3 and, if so, the board shall return the excess funds to the insureds by means of refunds or prospective rate decreases according to a distribution method and formula established by the board.

5. a. In establishing the plan's rates, the board shall use loss and expense experience in this state to the extent it is statistically credible supplemented by relevant data from outside this state including, but not limited to, data provided by other insurance companies, rate service organizations or governmental agencies.

b. The board shall annually review the plan's rates using the experience of the plan, supplemented first by the experience of coverage pro-

vided in this state by other insurers and, to the extent necessary for statistical credibility, by relevant data from outside this state.

6. The loss and expense experience used in establishing and revising 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, giving consideration to changes in estimated costs of unpaid claims and to indications of trends in claim frequency, claim severity and level of loss expense.

7. Expense provisions included in the plan's rates shall reflect reasonable prospective operating costs of the plan.

(b) The board shall establish and annually review plan classifications which, in addition to the requirements under s. 619.04 (5), Stats., do all of the following to the extent possible:

1. Measure variations in exposure to loss and in expenses based upon the best data available.

2. Reflect the past and prospective loss and expense experience of risks insured in the plan and other relevant experience from this and other states.

(c) With each rate and classification filing, the board shall submit supporting information including, in the case of rate filings, the existence, extent and nature of any subjective factors in the rates based on the judgment of technical personnel, such as consideration of the reasonableness of the rates compared with the cost of comparable available coverage.

(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, 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:

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:

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:

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:

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:

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:

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:

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:

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	\$1,558,000	0%	0%	25%	50%	75%
\$1,558,001 to	\$3,371,000	0%	0%	50%	75%	100%
Greater Than	\$3,371,000	0%	0%	75%	100%	200%

(14) **PLAN BUSINESS; CANCELLATION AND NONRENEWAL.** (a) The plan may not cancel or refuse to renew a policy 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 services in accordance with the code of ethics applicable to the insured's profession, if the board requests such evidence.

(b) Each notice of cancellation or nonrenewal under par. (a) shall include a statement of the reason for the cancellation or nonrenewal and a conspicuous statement that the insured has the right to a hearing as provided in sub. (16).

(15) **COMMISSION.** (a) If the application designates a licensed agent, the plan shall pay the agent a commission for each new or renewal policy issued, as follows:

1. To a health care provider specified in sub. (5) (a) to (e) or (m), 15% of the premium or \$150, whichever is less.
2. To a health care provider specified in sub. (5) (f) to (l) or (n), 5% of the annual premium or \$2,500 per policy period, whichever is less.

(b) An agent need not be listed by the insurer that acts as the plan's servicing company to receive a commission under par. (a).

(c) If the applicant does not designate an agent on the application, the plan shall retain the commission.

(16) **RIGHT TO HEARING.** Any person satisfying the conditions specified in s. 227.42 (1), Stats., may request a hearing under ch. Ins 5 within 30

days after receiving notice of the plan's action or failure to act with respect to a matter affecting the person.

(18) INDEMNIFICATION. (a) The plan shall indemnify against any cost, settlement, judgment and expense actually and necessarily incurred in connection with the defense of any action, suit or proceeding in which a person is made a party because of the person's position as any of the following:

1. A member of the board or any of its committees or subcommittees.
2. A member of or a consultant to the peer review council under s. 655.275, Stats.
3. A member of the plan.
4. The manager or an officer or employe of the plan.

(b) Paragraph (a) does not apply if the person is judged, in the action, suit or proceeding, to be liable because of wilful or criminal misconduct in the performance of the person's duties under par. (a) 1 to 4.

(c) Paragraph (a) does not apply to any loss, cost or expense on a policy claim under the plan.

(d) Indemnification under par. (a) does not exclude any other legal right of the person indemnified.

(19) APPLICABILITY. Each person insured by the plan is subject to this section as it existed on the effective date of the person's policy. Any change in this section during the policy term applies to the insured as of the renewal date.

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. 8-22-76; 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) i.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) 2. 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; r. (4) (g) and (9) (b), renum. (9) (a) to be (9), Register, March, 1988, No. 387, eff. 4-1-88; cr. (10) (cm), Register, April, 1989, No. 400, eff. 5-1-89; emerg. am. (5) (b) 3., cr. (5) (b) 4., eff. 10-16-89; am. (5) (b) 3., cr. (5) (b) 4., Register, March, 1990, No. 411, eff. 4-1-90; am. (1) (a) and (c), (2), (10) (a), (b), (c) and (d), (12) (a) 2. and 3., (14) (a) (intro.) and 4., (b), r. (3), (4) (a), (c), (d), (f) and (h), (5) (am), (d), (e) and (f), (6) (a), (7), (8) (j), (11) (a), (12) (intro.), (a) 4. to 6. intro., b. and c. and 7., (b), (c) 1., 3. and 6., (12m) (c) and (13), r. and recr. (12) (a) 1., (15), (16) and (18), renum. (4) (b) and (e), (5) (a) (intro.) to 11., (5) (b) and (c), (6) (b) and (c), (8) (a) to (i), (9), (11) (b), (12) (a) 6., 8., to 12., (12) (b) 2. and 4. and (17) to be (6) (a) 1. and 2., (5) (intro.) to (m), (3) (d) and (f), (6) (b) 2. and 3., (7), (8) (a), (b) 1. to 4., (8) (a) 3. to 5., (8) (b) 5., (6) (c), (12) (a) 4. to 6., (12) (a) 5. b., (12) (c), (12) (a) 7., (12) (b) 1. and 2., and (6) (d) and am. except (3) (d) 1. to 4., cr. (8) (a) to (c) and (e), (5) (n), (6) (a) (intro.) and (b) 1., (8) (a) (intro.) and 6., (b) (intro.), (12) (b) (intro.) and (19), Register, June, 1990, No. 414, eff. 7-1-90.

Register, June, 1990, No. 414

Ins 17.26 Payments for future medical expenses. (1) PURPOSE. This section implements s. 655.015, Stats.

(3) **DEFINITIONS.** In this section:

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

(b) "Claimant" means the injured person, the individual legally responsible for the injured person's medical expenses or the injured person's legal representative.

(c) "Medical expenses" means charges for medical services, nursing services, medical supplies, drugs and rehabilitation services that are incurred after the date of a settlement, panel award or judgment.

(4) **ADMINISTRATION.** (a) If a settlement, panel award or judgment is subject to s. 655.015, Stats., the insurer or other person responsible for payment shall, within 30 days after the date of the settlement, panel award or judgment, pay the fund the amount in excess of \$25,000 and shall provide the fund with an executed copy of the document setting forth the terms under which payments for medical expenses are to be made.

(b) The fund shall credit each account with a proportional share of any interest earned by the fund, based on the remaining value of the account at the time the investment board declares the interest earnings. The fund shall maintain an individual record of each account as provided in s. 16.41, Stats.

(c) Upon receipt of a claimant's request for reimbursement of medical expenses, the fund, after determining that the supplies or services provided were necessary and incidental to the injury sustained by the injured person and that the provider of the supplies or services has actually been paid, shall pay the claim from the appropriate account.

(d) 1. If the fund is not satisfied that a provider has actually been paid for services or supplies provided to an injured person, the fund may make payments jointly to the claimant and the provider.

2. A claimant may, in writing, authorize direct payment to a provider.

(e) The fund shall at least annually report to each claimant the status of the injured person's account, including the original amount, payments made since the last report and the balance remaining.

(f) If an injured person dies and there is a balance in his or her account, the balance shall revert to the insurer or other 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; am. (1), (3) (a) to (c) and (4), r. (2), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.27 Filing of financial report. (1) PURPOSE. This section implements ss. 655.27 (3) (b), (4) (d) and (5) (e), Stats., for the purpose of setting standards and techniques for accounting, valuing, reserving and reporting of data relating to the financial transactions of the fund.

(2) **DEFINITIONS.** (a) In this section:

"Amounts in the fund," as used in s. 655.27 (5) (e), Stats., means the sum of cash and invested assets as reported in a financial report under sub. (3).

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

(3) **FINANCIAL REPORTS.** The board shall furnish the commissioner with the financial report required by s. 655.27 (4) (d), Stats., within 60 days after the close of each fiscal year. In addition, the board shall furnish the commissioner with quarterly financial reports prepared as of September 30, December 31 and March 31 of each year within 60 days after the close of each reporting period. The board shall prescribe the format for preparing financial reports 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. Mediation fund fees collected under s. Ins 17.01 shall be indicated in the financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

(4) **SELECTION OF ACTUARIES.** The board shall select one or more actuaries to assist in determining reserves and setting fees under s. 655.27 (3) (b), Stats. If more than one actuary is selected, the board members named by the Wisconsin medical society and the Wisconsin hospital association shall jointly select the 2nd actuary.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80; am. (1), (2) (a) and (b) to (4), cr. (2) (intro.), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.275 Claims information; confidentiality. (1) **PURPOSE.** This section interprets ss. 19.35 (1) (a), 19.85 (1) (f), 146.82, 655.26 and 655.27 (4) (b), Stats.

(2) **DEFINITION.** In this section, "confidential claims information" means any document or information relating to a claim against a health care provider in the possession of the commissioner, the board or an agent thereof, including claims records of the fund and the plan and claims paid reports submitted under s. 655.26, Stats.

(3) **DISCLOSURE.** Confidential claims information may be disclosed only as follows:

(a) To the medical examining board as provided under s. 655.26, Stats.

(b) As needed by the peer review council, consultants and the board under s. 655.275, Stats., and rules promulgated under that section.

(c) As provided under s. 804.01, Stats.

(d) To an individual, organization or agency required by law or designated by the commissioner or board to conduct a management or financial audit.

(e) With a written authorization from the health care provider on whose behalf the claim was paid. Disclosure under this paragraph is limited to the number of judgments against and settlements entered into on

behalf of the provider and the number and amounts of claims paid by the plan, the fund or both.

History: Cr. Register, March, 1988, No. 387, eff. 4-1-88; cr. (3) (e), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.28 Health care provider fees. (1) PURPOSE. This section implements s. 655.27 (3), Stats.

(2) SCOPE. This section applies to fees charged to providers for participation in the fund, but does not apply to fees charged for operation of the mediation system under s. 655.61, Stats.

(3) DEFINITIONS. In this section:

(a) "Annual fee" means the amount established under sub. (6) for each class or type of provider.

(b) "Begin operation" means for a provider other than a natural person to start providing health care services in this state.

(bm) "Begin practice" means to start practicing in this state as a medical or osteopathic physician or nurse anesthetist or to become ineligible for an exemption from ch. 655, Stats.

(c) "Class" means a group of physicians whose specialties or types of practice are similar in their degree of exposure to loss. The specialties and types of practice included in each fund class are the following:

1. Class 1:

Administrative medicine	Neurology - including child - no surgery
Aerospace medicine	Nuclear medicine
Allergy	Nutrition
Cardiovascular disease - no catheterization or surgery	Occupational medicine
Dermatology - no surgery	Ophthalmology - no surgery
Diabetes - no surgery	Osteopathy - manipulation only
Endocrinology - no surgery	Otology - no surgery
Family practice and general practice - no surgery	Otorhinolaryngology - no surgery
Forensic medicine	Pathology - no surgery
Gastroenterology - no surgery	Pediatrics - no surgery
General preventative medicine - no surgery	Pharmacology - clinical
Geriatrics - no surgery	Physiatry
Gynecology - no surgery	Physical medicine and rehabilitation
Hematology - no surgery	Physicians - no surgery
Hypnosis	Psychiatry - including child
Infectious diseases - no surgery	Psychoanalysis
Internal medicine - no surgery	Psychosomatic medicine
Laryngology - no surgery	Public health
Legal medicine	Pulmonary diseases - no surgery
Neoplastic diseases - no surgery	Radiology - diagnostic - no surgery
Nephrology - no surgery	Rheumatology - no surgery
	Rhinology - no surgery

2. Class 2:

- Broncho-esophagology
 Cardiology - including catheterization, but not including cardiac surgery
 Cardiovascular disease - minor surgery
 Dermatology - minor surgery
 Diabetes - minor surgery
 Emergency medicine - no major surgery — applicable to any family or general practitioner or other specialist primarily engaged in emergency practice at a clinic, hospital or other facility who does not perform major surgery
 Endocrinology - minor surgery
 Family practice and general practice - minor surgery - no obstetrics
 Family practice or general practice - including obstetrics
 Gastroenterology - minor surgery
 Geriatrics - minor surgery
 Gynecology - minor surgery
 Hematology - minor surgery
 Infectious diseases - minor surgery
 Intensive care medicine - applicable to any family or general practitioner or other specialist employed in an intensive care hospital unit.
- Internal medicine - minor surgery
 Laryngology - minor surgery
 Neoplastic diseases - minor surgery
 Nephrology - minor surgery
 Neurology - including child- minor surgery
 Ophthalmology - minor surgery
 Otolaryngology - minor surgery
 Otorhinolaryngology - minor surgery
 Pathology - minor surgery
 Pediatrics - minor surgery
 Physicians - minor surgery
 Radiology - diagnostic - minor surgery
 Rhinology - minor surgery
 Surgery - colon and rectal
 Surgery - endocrinology
 Surgery - gastroenterology
 Surgery - general practice or family practice - not primarily engaged in major surgery
 Surgery - geriatrics
 Surgery - neoplastic
 Surgery - nephrology
 Surgery - ophthalmology
 Surgery - urological
 Urgent care - practice in urgent care, walk-in or after hours facility

3. Class 3:

- Anesthesiology - applicable to all providers who perform general anesthesia or acupuncture anesthesia
 Emergency medicine - including major surgery
 General surgery - as a specialty
 Surgery - abdominal
 Surgery - cardiac
 Surgery - cardiovascular disease
 Surgery - gynecology
 Surgery - hand
 Surgery - head and neck
- Surgery - laryngology
 Surgery - orthopedic
 Surgery - otology
 Surgery - otorhinolaryngology - no plastic surgery
 Surgery - plastic
 Surgery - plastic - otorhinolaryngology
 Surgery - rhinology
 Surgery - thoracic
 Surgery - traumatic
 Surgery - vascular
 Weight control - bariatrics

4. Class 4:

- Surgery - neurology - including child
 Surgery - obstetrics

Surgery - obstetrics and
gynecology

(d) "Fiscal year" means each period beginning each July 1 and ending each June 30.

(e) "Permanently cease operation" means for a provider other than a natural person to stop providing health care services with the intent not to resume providing such services in this state.

(f) "Permanently cease practice" means to stop practicing as a medical or osteopathic physician or nurse anesthetist with the intent not to resume that type of practice in this state.

(g) "Primary coverage" means health care liability insurance meeting the requirements of subch. III of ch. 655, Stats.

(h) "Provider" means a health care provider, as defined in s. 655.001 (8), Stats.

(hm) "Resident" means a licensed physician engaged in an approved postgraduate medical education or fellowship program in any specialty specified in par. (c) 1 to 4.

(i) "Temporarily cease practice" means to stop practicing in this state for any period of time because of the suspension or revocation of a provider's license, or to stop practicing for at least 90 consecutive days for any other reason.

(3e) PRIMARY COVERAGE REQUIRED. Each provider shall ensure that primary coverage is in effect on the date the provider begins practice or operation and for all periods during which the provider practices or operates in this state. A provider does not have fund coverage for any period during which primary coverage is not in effect.

(3m) EXEMPTIONS; ELIGIBILITY. A medical or osteopathic physician licensed under ch. 448, Stats., or a nurse anesthetist licensed under ch. 441, Stats., may claim an exemption from ch. 655, Stats., if at least one of the following conditions applies:

(a) The provider will not practice more than 240 hours in the fiscal year.

(b) The provider is a federal, state, county or municipal employee.

(c) During the fiscal year, the provider will derive more than 50% of the income from his or her practice from outside this state or will attend to more than 50% of his or her patients outside this state.

(3s) LATE ENTRY TO FUND. (a) A provider that begins or resumes practice or operation during a fiscal year, has claimed an exemption or has failed to comply with sub. (3e) may obtain fund coverage during a fiscal year by giving the fund advance written notice of the date on which fund coverage should begin.

(b) The board may authorize retroactive fund coverage for a provider who shows that circumstances previously unknown to him or her require retroactive participation in the fund if the provider furnishes the board with an affidavit describing the necessity for the retroactive coverage and stating that the provider has no notice of any pending claim alleging mal-

practice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim. The authorization shall be in writing, specifying the effective date of fund coverage.

(4) BEGINNING AND CEASING PRACTICE AND OPERATION; LATE ENTRY; CLASS CHANGES; REFUNDS; PRORATED FEES. (a) *Definition.* In this subsection, "semimonthly period" means the 1st through the 14th day of a month or the 15th day through the end of a month.

(b) *Entry during fiscal year; prorated annual fee.* If a provider's fund coverage begins after July 1, the fund shall charge the provider one twenty-fourth of the annual fee for each semimonthly period or part of a semimonthly period from the date fund coverage begins to the next June 30.

(c) *Ceasing practice or operation; refunds.* 1. If a provider is in compliance with sub. (7) (b) and one of the following conditions exists, the fund shall issue a refund equal to one twenty-fourth of the provider's annual fee for each full semimonthly period from the date practice or operation ceased to the due date of the next payment:

a. The provider has temporarily or permanently ceased practice or has permanently ceased operation and has given the fund advance written notice of the cessation.

c. The provider's license to practice medicine and surgery or nursing has been revoked or suspended and the provider has given the fund written notice within 45 days of the revocation or suspension.

d. The provider has temporarily ceased practice because of a physical or mental impairment and has given the fund written notice within 135 days of the cessation.

2. If a provider that temporarily or permanently ceases practice or operation is in compliance with sub. (7) (b), but none of the conditions described in subd. 1 exists, the fund shall issue a refund equal to one twenty-fourth of the provider's fee for each full semimonthly period from the date the fund receives notice of the cessation of practice or operation, plus a retroactive refund equal to no more than 3 twenty-fourths of the provider's annual fee.

3. If a provider that temporarily or permanently ceases practice or operation is not in compliance with sub. (7) (b), the fund shall reduce the provider's arrearage for the remainder of the fiscal year by any amount that would be due as a refund under subd. 1 or 2 if the provider were in compliance with sub. (7) (b).

4. If a provider who was in compliance with sub. (7) (b) dies, the fund, upon receipt of notice of the death, shall issue a refund equal to one twenty-fourth of the provider's annual fee for each full semimonthly period from the date of death to the date the next payment would have been due, except that no refund under this subdivision may exceed the total amount of the most recent annual fee paid by the provider.

(cm) *Eligibility for exemption; refund.* If a provider becomes eligible for an exemption under sub. (3m) (a) after paying all or part of the annual fee, the fund shall issue a refund equal to one twenty-fourth of the provider's annual fee for each full semimonthly period from the date the provider becomes eligible for the exemption or the date the fund receives

the provider's signed exemption form, whichever is later, to the due date of the next payment.

(d) *Change of class or type; increased annual fee.* If a provider changes class or type, including a change from part-time to full-time practice, resulting in an increased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

1. One twenty-fourth of the annual fee for the provider's former class or type for each full semimonthly period from the due date of the provider's first payment during the current fiscal year to the date of the change.

2. One twenty-fourth of the annual fee for the provider's new class or type for each full or partial semimonthly period from the date of the change to the next June 30.

(e) *Change of class or type; decreased annual fee.* 1. If a provider changes class or type, including a change from full-time to part-time practice, resulting in a decreased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

a. One twenty-fourth of the annual fee for the provider's former class or type for each full or partial semimonthly period from the due date of the provider's first payment during the current fiscal year to the date of the change.

b. One twenty-fourth of the annual fee for the provider's new class or type for each full semimonthly period from the date of the change to the next June 30.

2. The fund may issue a refund or may credit the provider's account for amounts due under subd. 1. If the provider or the provider's insurer does not give the fund advance notice of the change, the refund or credit may not exceed 3 twenty-fourths of the annual fee for the provider's former class.

(f) If a provider entitled to a refund or credit under this subsection has paid interest under sub. (7) (c) 1, the fund shall issue a refund or credit of the interest using the same method used to calculate a refund or credit of an annual fee.

(g) In addition to any refund authorized under par. (c), (e) or (f), the fund may issue a refund to correct an administrative error in the current or any previous fiscal year.

(5) **FILING OF CERTIFICATES OF INSURANCE.** An insurance company required under s. 655.23 (3) (b), Stats., to file a certificate of insurance on behalf of a provider shall file the certificate with the fund within 45 days after the original issuance and each renewal and within 45 days after a change of class or type that would affect the provider's fee under sub. (4).

Note: Subsection (5) is applicable on September 1, 1990.

(6) **FEE SCHEDULE.** The following fee schedule shall be effective from July 1, 1990 to June 30, 1991:

(a) Except as provided in pars. (b) to (g), for a physician:

Class 1	\$2,571	Class 3	\$12,854
Class 2	5,142	Class 4	15,425

(b) Except as provided in par. (e), for a resident acting within the scope of a residency or fellowship program:

Class 1	\$1,543	Class 3	\$7,715
Class 2	3,086	Class 4	9,258

(c) For a resident practicing part-time outside the scope of a residency or fellowship program:

All classes	\$1,543
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(d) For a medical college of Wisconsin, inc., full-time faculty member:

Class 1	\$1,028	Class 3	\$5,140
Class 2	2,056	Class 4	6,168

(e) For a medical college of Wisconsin affiliated hospitals, inc., resident acting within the scope of a residency or fellowship program:

Class 1	\$1,286	Class 3	\$6,427
Class 2	2,572	Class 4	7,716

(f) For a physician employed by this state or a county or municipality acting within the scope of that employment:

Class 1	\$1,928	Class 3	\$9,640
Class 2	3,856	Class 4	7,716

(g) For a part-time physician with an office practice only and no hospital admissions who practices less than 500 hours in a fiscal year: \$643

(h) For a nurse anesthetist: \$688

(i) For a hospital:

1. Per occupied bed \$169; plus
2. Per 100 outpatient visits during the last calendar year for which totals are available \$8.40

(j) For a nursing home, as described under s. 655.001 (8), Stats., which is wholly owned and operated by a hospital and which has health care liability insurance separate from that of the hospital by which it is owned and operated:

Per occupied bed \$32

(k) For a partnership comprised of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of partners and employed physicians or nurse anesthetists is from 2 to 10 \$100.00
2. If the total number of partners and employed physicians or nurse anesthetists is from 11 to 100 \$1,000.00
3. If the total number of partners and employed physicians or nurse anesthetists exceeds 100 \$2,500.00

(l) (intro.) For a corporation organized under ch. 180, Stats., providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of shareholders and employed physicians or nurse anesthetists is from 1 to 10 \$100.00

2. If the total number of shareholders and employed physicians or nurse anesthetists is from 11 to 100 \$1,000.00

3. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 \$2,500.00

(lm) For a corporation organized under ch. 181, Stats., providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of employed physicians and nurse anesthetists is from 1 to 10 \$100.00

2. If the total number of employed physicians and nurse anesthetists is from 11 to 100 \$1,000.00

3. If the total number of employed physicians and nurse anesthetists exceeds 100 \$2,500.00

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available \$0.21; 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 an ambulatory surgery center, as defined in s. HSS 123.14 (2) (a), which is a separate entity not part of a hospital, partnership or corporation subject to ch. 655, Stats.:

Per 100 outpatient visits during the last calendar year for which totals are available \$42

(o) For an entity affiliated with a hospital: \$100 or 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity, whichever is greater.

(6e) MEDICAL COLLEGE RESIDENTS' FEES. (a) The fund shall calculate the total amount of fees for all residents under sub. (6) (e) on a full-time-equivalent basis, taking into consideration the proportion of time spent by the residents in practice which is not covered by the fund, including practice in federal, state, county and municipal facilities, as determined by the medical college of Wisconsin affiliated hospitals, inc.

(b) The fund's initial bill, payable under sub. (7), shall be the amount paid during the previous fiscal year by the medical college of Wisconsin affiliated hospitals, inc., for all its residents. At the end of the fiscal year, the fund shall adjust the fee to reflect the actual exposure during the current fiscal year, as determined by the medical college of Wisconsin affiliated hospitals, inc.

(6m) (a) The fund may require any 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).

(b) For purposes of sub. (6) (k), (l) and (m), a partnership or corporation shall report the number of partners, shareholders and employed physicians and nurse anesthetists on July 1 of the previous fiscal year.

(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 a class 1 physician or a nurse anesthetist:

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 a class 2 physician:

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 a class 3 physician:

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 a class 4 physician:

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) BILLING; PAYMENT SCHEDULES. (a) For each fiscal year, the fund shall issue an initial bill to each provider showing the amount due, including any applicable surcharge imposed under s. Ins 17.285, and the payment schedules available and shall bill the provider according to the payment schedule selected. Each bill shall indicate the payment due dates. Once the provider has selected a payment schedule, that schedule shall apply for the remainder of that fiscal year.

(b) A provider shall pay the amount due on or before each due date.

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

a. Annual payment - 30 days after the fund mails the initial bill.

b. Semiannual payments - 30 days after the fund mails the initial bill; January 1.

c. Quarterly payments - 30 days after the fund mails the initial bill; October 1; January 1; April 1.

2. Fees for providers that begin practice or operation after the beginning of a fiscal year. For a provider that begins practice or operation or enters the fund under sub. (3s) (b) after July 1 of any fiscal year, the due dates are as follows:

a. The first payment is due 30 days from the date the fund mails the initial bill.

b. For semiannual payment schedules, the 2nd payment is due on January 1. Any provider whose first payment due date is January 1 or later may not choose the semiannual payment schedule.

c. For quarterly payment schedules, if the first payment is due before October 1, the subsequent payments are due on October 1, January 1 and April 1. If the first payment is due from October 1 to December 31, the subsequent payments are due on January 1 and April 1. If the first payment is due from January 1 to March 31, the subsequent payment is due on April 1. Any provider whose first payment is due after March 31 may not choose the quarterly payment schedule.

3. Increased annual fees. If a provider changes class or type, which results in an increased annual fee, the first payment resulting from that increase is due 30 days from the date the fund mails the bill for the adjusted annual fee.

(c) 1. The fund shall charge interest and an administrative service charge of \$3 to each provider who chooses the semiannual or quarterly payment schedule.

2. The fund shall charge interest and a late payment fee of \$10 to each provider whose payment is not received on or before a due date or whose fund coverage is retroactive under sub. (3s) (b).

3. The daily rate of interest under subds. 1 and 2 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, divided by 360. Late payment fees and administrative service charges are not refundable.

Note: Initial applicability. The treatment of s. Ins 17.28 (3) (e), (f), and (i), (3m), (4) and (7) first applies to patients compensation fund fees for fiscal year 1989-90.

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. 338, eff. 10-1-83; am. (6) (intro.), (a) to (h), (j) and (r), Register, June, 1984, No. 342, eff. 7-1-84; 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) (e) 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; am. (6) (intro.) to (j), (m) 1. and (n), Register, June, 1988, No. 390, eff. 7-1-88; renum. (3) (a) to be (3) (d), cr. (3) (a), (bm), (e) to (i), (3e), (3m) and (3s), r. and recr. (3) (b) and (4), r. (7) (intro.) and (b) 4., am. (7) (a), (b) (intro.) to 3. and (c), Register, April, 1989, No. 400, eff. 5-1-89; emerg. r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., eff. 6-1-89; r. (4) (c) 1. b., am. (4) (e) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., Register, July, 1989, No. 403, eff. 8-1-89; am. (1), (2), (3) (c) and (f), (3e), (6) (intro.), (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (g), (h), (i) (intro.), (j) (intro.), (k) (intro.), (l) (intro.), (lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), renum. (3m) (a) (intro.), 1., 2., 3. intro., b. and c., and (6m) to be (3m) (intro.), (a), (b), (c), and (6m) (a), r. (3m) (a) 3. a. and (b), r. and recr. (5), (6) (a) (intro.), (b) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (6s) (e) 1. intro., 2. intro., 3. intro. and 4. intro., cr. (3) (intro.) and (lm), (4) (cm) and (g), (6e) (e) 1. intro., (6m) (b), Register, June, 1990, No. 414, eff. 7-1-90.

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 or owing to or on behalf of any claimant, 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, for which there has been a final determination based on a settlement, award or judgment that indemnity will be paid 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.

(2m) **TIME FOR REPORTING.** In reporting claims paid under s. 655.26, Stats., each insurer or self-insurer shall report the required information Register, June, 1990, No. 414

by the 15th day of the month following the date on which there has been a final determination of the aggregate indemnity to be paid to or on behalf of any claimant.

(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 ss. Ins 17.25 (12m) (c) and 17.28 (6s) (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 fee 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) Unless the council determines, after a preliminary review, that no surcharge should be imposed, 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) 1. 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.

2. If a private insurer or defense attorney is unable to comply with the council's request under subd. 1, or if the information provided is inadequate, the council shall notify the provider that it will proceed under subs. (5) to (7) using only the available information. A provider does not have a right to a hearing under sub. (9) on the grounds that a private insurer or defense attorney was unable to comply with the council's request under subd. 1, or provided inadequate information.

(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), 17.28 (6s) (c) or both, 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, except as provided in sub. (4) (c) 2, shall also notify the provider of the right to request a hearing under ch. 227, Stats., and ch. Ins 5 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 burden 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 ss. Ins 17.25 (12m) (c) or 17.28 (6s) (c), 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 ss. Ins 17.25 (12m) (c) and 17.28 (6s) (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 rule changes that are necessary to address that consideration.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88; am. (2) (a) and (b), (3) (a) and (c) 2., (5) (b) (intro.), (7) (a), (8), (9) (a), (11) (f) and (14), cr. (2m) and (4) (c) 2., renum. (4) (c) to be (4) (c) 1., Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.29 Servicing agent. (1) **PURPOSE.** This section implements s. 655.27 (2), Stats., relating to contracting for claim services for the fund.

(2) **CRITERIA.** The board shall establish the criteria for the selection of the servicing agent prior to the expiration of each contract term.

(3) **SELECTION.** The commissioner, with the approval of the board, shall select a servicing agent through the competitive negotiation process.

(4) **CONTRACT TERM.** The commissioner, with the approval of the board, shall establish the term of the contract with the servicing agent.

The contract shall include a provision for its cancellation if performance or delivery is not made in accordance with its terms and conditions.

(5) The servicing agent shall perform all of the following functions:

(am) Reporting to the claims committee of the board on claim files identified by that committee, at the times and in the manner specified by that committee.

(b) Establishing and revising case reserves.

(c) Contracting for annuity payments as part of structured settlements under guidelines adopted by the board.

(d) Investigating and evaluating claims.

(e) Negotiating to settlement all claims made against the fund except in cases where this responsibility is retained by the claims committee of the board.

(f) Filing with the commissioner and the board the annual report required under s. 655.27 (2), Stats., and any other report requested by the commissioner or the board.

(g) Reviewing court orders, verdicts and judgments and making recommendations on appeals.

(h) All other functions specified in the contract.

History: Cr. Register, February, 1984, No. 338, eff. 3-1-84; am. (1), (3) and (4), r. and recr. (2), r. (5) (a), renum. (5) (b) to be (5) and am. (5) (intro.), (b) to (g), cr. (5) (am) and (h), Register, June, 1990, No. 414, eff. 7-1-90.

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 fund, one-half of the actual cost of operating the council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

2. Against the plan, one-half of the actual cost of operating the 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; am. (2) (a) 1. and 2., Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.35 Primary coverage; requirements; permissible exclusions; deductibles. (1) **PURPOSE.** This section implements ss. 631.20 and 655.24, Stats., relating to the approval of policy forms for health care liability insurance subject to s. 655.23, Stats.

(2) **REQUIRED COVERAGE.** To qualify for approval under s. 631.20, Stats., a policy shall at a minimum provide all of the following:

(a) Coverage for providing or failing to provide health care services to a patient.

(b) Coverage for peer review, accreditation and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by an insured.

(c) Coverage for utilization review, quality assurance and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by an insured.

(d) Indemnity limits of not less than the amounts specified in s. 655.23 (4), Stats.

(e) Coverage for supplemental payments in addition to the indemnity limits, including attorney fees, litigation expenses, costs and interest.

(f) That the insurer will provide a defense of the insured and the fund until there has been a determination that coverage does not exist under the policy or unless otherwise agreed to by the insurer and the fund.

(g) If the policy is a claims-made policy:

1. A guarantee that the insured can purchase an unlimited extended reporting endorsement upon cancellation or nonrenewal of the policy.

2. If the policy is a group policy, a provision that any health care provider, as defined under s. 655.001 (8), Stats., whose participation in the group terminates has the right to purchase an individual unlimited extended reporting endorsement.

3. A prominent notice that the insured has the obligation under s. 655.23 (3) (a), Stats., to purchase the extended reporting endorsement unless other insurance is available to ensure continuing coverage for the liability of all insureds under the policy for the term the claims-made policy was in effect.

4. A prominent notice that the insurer will notify the commissioner if the insured does not purchase the extended reporting endorsement and that the insured, if a natural person, may be subject to administrative action by his or her licensing board.

(3) **PERMISSIBLE EXCLUSIONS.** A policy may exclude coverage, or permit subrogation against or recovery from the insured, for any of the following:

(a) Criminal acts.

- (b) Intentional sexual acts and other intentional torts.
- (c) Restraint of trade, anti-trust violations and racketeering.
- (d) Defamation.
- (e) Employment, religious, racial, sexual, age and other unlawful discrimination.
- (f) Pollution resulting in injury to a 3rd party.
- (g) Acts that occurred before the effective date of the policy of which the insured was aware or should have been aware.
- (h) Incidents occurring while a provider's license to practice is suspended, revoked, surrendered or otherwise terminated.
- (i) Criminal and civil fines, forfeitures and other penalties.
- (j) Punitive and exemplary damages.
- (k) Liability of the insured covered by other insurance, such as worker's compensation, automobile, fire or general liability.
- (l) Liability arising out of the ownership, operation or supervision by the insured of a hospital, nursing home or other health care facility or business enterprise.
- (m) Liability of others assumed by the insured under a contract or agreement.
- (n) Any other exclusion which the commissioner determines is not inconsistent with the coverage required under subd. (2).

(4) DEDUCTIBLES. If a policy includes a deductible or coinsurance clause, the insurer is responsible for payment of the total amount of indemnity up to the limits under s. 655.23 (4), Stats., but may recoup the amount of the deductible or coinsurance from the insured after the insurer's payment obligation is satisfied.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.50 Self-insured plans for health care providers. (1) PURPOSE. This section implements s. 655.23 (3) (a), Stats.

(2) DEFINITIONS. In this section:

- (a) "Actuarial" means prepared by an actuary meeting the requirements of s. Ins. 6.12 who has experience in the field of medical malpractice liability insurance.
- (b) "Level of confidence" means a percentage describing the probability that a certain funding level will be adequate to cover actual losses.
- (c) "Occurrence coverage" means coverage for acts or omissions occurring during the period in which a self-insured plan is in effect.
- (d) "Office" means the office of the commissioner of insurance.
- (e) "Provider," when used without modification, means a health care provider, as defined in s. 655.001 (8), Stats., that is responsible for the establishment and operation of a self-insured plan.

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(f) "Risk margin" means the amount that must be added to estimated liabilities to achieve a specified confidence level.

(g) "Self-insured plan" means a method, other than through the purchase of insurance, by which a provider may furnish professional liability coverage which meets the requirements of ch. 655, Stats.

(h) "Year" means the self-insured plan's fiscal year.

(3) COVERAGE. (a) A self-insured plan shall provide professional liability occurrence coverage with limits of liability in the amounts specified in s. 655.23 (4), Stats., for the provider, the provider's employes, other than employes who are natural persons defined as health care providers under s. 655.001 (8), Stats., and any other person for whom the provider is legally responsible while the employe or other person is acting within the scope of his or her duties for the provider.

(b) A self-insured plan may also provide occurrence coverage for any natural person who is a health care provider, as defined in s. 655.001 (8), Stats., and who is an employe, partner or shareholder of the provider. The self-insured plan shall provide separate limits of liability in the amounts specified in s. 655.23 (4), Stats., for each such natural person covered.

(c) A self-insured plan shall also provide for supplemental expenses in addition to the limits of liability in s. 655.23 (4), Stats., including attorney fees, litigation expenses, costs and interest incurred in connection with the settlement or defense of claims.

(d) A self-insured plan may not provide coverage for anything other than the professional liability coverage required under ch. 655, Stats., or for any other person than those specified in pars. (a) and (b).

(4) INITIAL FILING. A provider that intends to establish a self-insured plan shall file with the office a proposal which shall include all of the following:

(a) If the provider is not a natural person, the history and organization of the provider.

(b) If the provider is not a natural person, a resolution adopted by the provider's governing body approving the establishment and operation of a self-insured plan.

(c) A description of the proposed method of establishing and operating the self-insured plan.

(d) An actuarial estimate of the liabilities that will be incurred by the self-insured plan in the first year of operation, an actuarial review of the cost of the first year's funding and a description of how the self-insured plan will be funded.

(e) If prior acts coverage is required under sub. (6) (f) 1, an actuarial estimate of the liabilities of the provider and any natural person covered under sub. (3) (b) for prior acts, an actuarial review of the cost of funding the coverage and a description of how the coverage will be funded.

(f) An actuarial feasibility study which includes a 5-year projection of expected results.

(g) The identity of the bank that will act as trustee for the self-insured plan and a proposed trust agreement between the provider and the bank.

(h) Any proposed investment policy that will be applicable to the investment of the trust's assets.

(i) A description of the provider's existing or proposed risk management program.

(j) The estimated number and the professions of natural persons that the self-insured plan will cover under sub. (3) (b).

(k) A description of the proposed contractual arrangements with administrators, claims adjusters and other persons that will be involved in the operation of the self-insured plan.

(l) The provider's most recent audited annual financial statement.

(m) A proposed draft of a letter of credit, if the provider intends to use one as part of the initial funding.

(n) Any additional information requested by the office.

(5) REVIEW OF PROPOSAL; APPROVAL. (a) After reviewing a proposal submitted under sub. (4), the office may approve the proposal if all of the following conditions are met:

1. The initial filing is complete.
2. The proposal is actuarially sound.
3. The proposal complies with ch. 655, Stats.
4. The proposal ensures the provider's continuing ability to meet the financial responsibility requirements of s. 655.23, Stats.
5. The provider is sound, reliable and entitled to public confidence and may reasonably be expected to perform its obligations continuously in the future.

(b) If any of the conditions specified under par. (a) is not met, the office may request the provider to submit additional information in writing or may assist the provider in revising the proposal.

(c) A self-insured plan may not begin operation without the written approval of the office which specifies the earliest date operation may begin.

(6) FUNDING REQUIREMENTS; PROHIBITIONS. (a) The minimum initial funding required for a self-insured plan is \$2,000,000.

(b) Before a self-insured plan begins operation, the provider shall establish a trust with a Wisconsin-chartered or federally-chartered bank with trust powers which is located in this state.

(c) 1. If the actuarial estimate under sub. (4) (d) is less than \$2,000,000, the provider shall, before the self-insured plan begins operation, deposit in the trust cash equal to the first year's estimated liabilities plus a letter of credit equal to the difference between the cash funding and \$2,000,000.

2. In each of the next 3 years, the provider shall make quarterly cash payments to the trust in amounts sufficient to keep the estimated liabilities fully funded and shall keep in effect a letter of credit equal to the difference between the total estimated liabilities and \$2,000,000.

3. If the total estimated liabilities for the 5th year of operation are less than \$2,000,000, the provider shall, during that year, make quarterly cash payments to the trust in amounts sufficient to ensure that, by the end of that year, the trust's cash assets equal \$2,000,000, except that if the provider files a written request with the commissioner before the beginning of that year, the commissioner may permit the provider to continue using a letter of credit equal to the difference between the total estimated liabilities and \$2,000,000. This permission may be renewed annually if the provider files a written request with the commissioner before the beginning of each subsequent fiscal year.

4. A letter of credit under this subsection shall meet all of the following conditions:

a. It shall be irrevocable.

b. It shall be issued by a Wisconsin-chartered or federally-chartered bank located in this state.

c. It shall be issued solely for the purpose of satisfying the funding requirements of the trust.

d. It shall describe the procedure by which the trustee may draw upon it.

(d) If the actuarial estimate under sub. (4) (d) is greater than \$2,000,000, the provider shall, before the self-insured plan begins operation, deposit \$2,000,000 cash in the trust. The provider shall make quarterly cash payments to the trust so that at the end of the first year of operation, the trust's cash assets equal the first year's estimated liabilities.

(e) In each subsequent year of the self-insured plan's operation, the provider shall make quarterly cash payments to the trust in amounts sufficient to ensure that the total cash assets of the trust at the end of each year are not less than the estimated liabilities reported under sub. (8) (a) 1.

(f) 1. If the provider or any natural person covered under sub. (3) (b) had claims-made coverage before the self-insured plan was established and did not purchase an extended reporting endorsement from the previous carrier, the self-insured plan shall provide coverage for prior acts by means of cash payments to the trust in addition to the funding required for the occurrence coverage.

2. If the actuarial estimate under sub. (4) (e) is less than \$500,000, the provider shall, before the self-insured plan begins operation, deposit in the trust the entire amount of the estimate in cash.

3. If the actuarial estimate under sub. (4) (e) is greater than \$500,000, the provider shall, before the self-insured plan begins operation, deposit in the trust \$500,000 or the first year's estimated payments, whichever is greater. The provider shall make quarterly cash payments to the trust so that at the end of the first year, the trust's assets include the total estimated liabilities for prior acts.

(g) Quarterly cash payments under this subsection shall be in equal amounts except that the amount of the last quarter's payment shall be adjusted by the amounts of the trust's investment income and actual expenses incurred, and except that the first quarter's payment shall not be less than the amount of a quarterly payment for the previous year before adjustment for income and expenses.

(h) 1. A provider may not deposit in the trust, and the trustee may not pay from the trust, any funds other than those intended to meet the financial responsibility requirements of ch. 655, Stats., and to pay the administrative expenses of operating the self-insured plan and the trust.

2. The trustee may not invest any of the trust's assets in securities or real property of the provider or any of its affiliates.

(i) If the assets of the trust at any time are insufficient to pay all claims against the self-insured plan, the liabilities are those of the provider without recourse against any employe, partner or shareholder covered by the self-insured plan.

(7) FILING PRIOR TO OPERATION OF SELF-INSURED PLAN. Before an approved self-insured plan begins operation, the provider shall file with the office all of the following:

(a) Certified copies of the executed self-insured plan document and trust agreement.

(b) If the provider is not a natural person, a certified copy of an executed resolution adopted by the provider's governing body approving the self-insured plan and trust agreement.

(c) A certified copy of any trust investment policy adopted by the provider or the provider's governing body.

(d) The trustee's certification that the initial amount of cash required under sub. (6) has been deposited in the trust.

(e) A certified copy of any letter of credit held by the trustee.

(f) If any part of the operation of the self-insured plan is conducted by a person other than the provider or an employe, partner or shareholder of the provider, a certified copy of an executed contract with each such person.

(8) FINANCIAL REPORTING. (a) Within 120 days after the end of a year, the self-insured plan shall submit to the office all of the following:

1. Actuarial estimates of the projected liabilities for the current year and of the total liabilities for all prior years covered by the self-insured plan and the risk margin for all projected and incurred claims, and an actuarial opinion of the reasonableness of the estimates.

2. A description of the proposed method of funding for the current year.

3. The provider's audited annual financial statement.

4. The self-insured plan's audited annual financial statement.

(b) Within 60 days after the end of each quarter, the self-insured plan shall submit to the office the most recent quarterly financial statement of the trust.

(9) OTHER REPORTING REQUIREMENTS. (a) After a self-insured plan begins operation, the provider shall report to the office any proposed change in the self-insured plan document, trust agreement, trust investment policy, letter of credit or any other document on file with the office if the change would materially affect the operation of the self-insured plan or its funding. No proposed change may take effect without the written approval of the office.

(b) The provider shall annually file with the patients compensation fund proof of financial responsibility under s. 655.23, Stats., in the form specified by the office. The provider shall also file proof of financial responsibility on behalf of each natural person covered under sub. (3) (b).

(c) The provider shall immediately notify the patients compensation fund if either of the following occurs:

1. A claim filed with the self-insured plan has a reserve of 50% or more of the limit specified in s. 655.23 (4), Stats., for one occurrence.

2. The self-insured plan's total aggregate reserves for the provider or for any natural person covered under sub. (3) (b) for a single year exceed 66% of the limit specified in s. 655.23 (4), Stats., for all occurrences in one year.

3. A claim filed with the self-insured plan creates potential exposure for the patients compensation fund, regardless of the amount reserved.

(d) The provider shall ensure that all claims paid by the self-insured plan are reported to the medical examining board and the board of governors of the patients compensation fund as required under s. 655.26, Stats.

(10) DISCOUNTING PROHIBITED. All actuarial estimates required under this section shall be reported on a nondiscounted basis.

(11) LEVELS OF CONFIDENCE. (a) The risk margin used in determining the initial funding under sub. (6) shall be at not less than a 90% level of confidence and, except as provided in pars. (b) and (c), shall remain at that level.

(b) After a self-insured plan has operated for at least 5 years and experience can be reasonably predicted, the office may permit the use of a risk margin of less than a 90%, but not less than a 75%, level of confidence in determining annual funding of the trust. For at least 5 years after such permission is granted, the provider shall fund the difference between the cash required at the lower level of confidence and the 90% level of confidence with funds restricted by the provider or the provider's governing body for the purpose of paying obligations of the self-insured plan. The restricted funds may be part of the provider's operating budget rather than assets of the trust.

(c) After a self-insured plan has operated for at least 5 years under par. (b), the office may permit the use of a risk margin of not less than a 75% level of confidence without additional restricted funds if the self-insured plan's actuary states that the self-insured plan's exposure base is stable enough to estimate the required liabilities.

(12) **MONITORING; ORDERS.** (a) If the office determines that a self-insured plan's operation does not ensure that the provider can continue to satisfy the conditions specified in sub. (5) (a), the commissioner may order the provider to take any action necessary to ensure compliance with those conditions.

(b) If the provider does not comply with the commissioner's order within the time specified in the order, the commissioner may order the provider to terminate the self-insured plan and the office may take whatever action is necessary to ensure the continued existence of the trust for a sufficient length of time to meet all of the obligations of the self-insured plan.

(13) **EXISTING SELF-INSURED PLANS; COMPLIANCE.** After this section takes effect, the office may review any approved self-insured plan to determine if it complies with this section. If the office determines that any self-insured plan is not in compliance, the commissioner may order the provider to take any action necessary to achieve compliance.

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