Chapter Ins 17

PATIENTS COMPENSATION FUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) For physicians — $-0-$

(b) For hospitals — $-0-$

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

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

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

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

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

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

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

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

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

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

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

Ins 17.05 Caption of pleadings and notice. (ss. 619.04 and 655.003, Stats.) All pleading, notices, orders and other papers filed in reference to

any hearings shall be captioned "Before the Board of Governors of the Wisconsin Health Care Liability Insurance Plan and Wisconsin Patients Compensation Fund" and shall be entitled "In the Matter of . . . . . (here insert the matter that is involved)."

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

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

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

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

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

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

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

(b) The names and addresses of the parties.

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

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

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

(f) The date of the notice.

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

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

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

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

Ins 17.09 Answer. (ss. 619.04 and 655.003, Stats.) The respondent shall be required to answer any notice within the time therein specified and failure to do so shall constitute a default. The commissioner may, upon proper showing, excuse such failure to answer upon such terms as the commissioner determines to be just and permit the party to make answer

within such time as the commissioner prescribes, provided, however, that no party shall be relieved from such default after a hearing has been concluded and an order entered or other disposition made of the matter. The answer shall be verified by the respondent individually, or if a corporation by a proper officer of such corporation, unless an admission of the allegations might subject the person or party to prosecution for a felony, and shall be filed with the commissioner in triplicate (original and 2 copies) within the time prescribed in the notice of hearing.

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

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

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

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

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(3) Every material allegation not controverted as prescribed shall be taken as true, but any new matter set forth in the answer shall be deemed controverted without any reply being served or filed.

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

Ins 17.11 Hearing examiner. (ss. 619.04 and 655.003, Stats.) (1) The board may designate the commissioner or any employe on the commissioner's staff or borrowed from another agency pursuant to ss. 16.24 or 20.901, Stats., as a hearing examiner to preside over any case. Such examiner may:

(a) Administer oaths and affirmations.

(b) Issue subpoenas authorized by law.

(c) Rule on offers of proof and receive relevant evidence.

(d) Take depositions or have depositions taken when permitted by law.

(e) Regulate the course of the hearing.

(f) Hold conferences for the settlement or simplification of the issues by consent of the parties.

(g) Dispose of procedural requests or similar matters.

(h) Make or recommend findings of fact, conclusions of law and decisions to the extent permitted by law.

(i) Take other action authorized by agency rule consistent with this chapter.

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

Ins 17.12 Rules of hearing. (ss. 619.04 and 655.003, Stats.) All hearings shall be conducted pursuant to ss. 227.07 - 277.08, Stats.

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

Ins 17.13 Continuances. (ss. 619.04 and 655.003, Stats.) Continuances and adjournments of hearings may be granted for cause by the board or the hearing examiner.

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

Ins 17.14 Hearing public. (ss. 619.04 and 655.003, Stats.) All hearings shall be open to the public, except where otherwise specifically provided by statute or ordered by the board or the person conducting the same.

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

Ins 17.15 Subpoenas. (ss. 619.04 and 655.003, Stats.) The commissioner may sign and issue subpoenas for the attendance of a party or any witness at a hearing whether conducting the hearing or not. The hearing examiner may sign and issue subpoenas for the attendance of witnesses or parties at such hearing.

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

Ins 17.16 Service. (ss. 619.04 and 655.003, Stats.) Service of notice of hearing, notice of order of the board, and of any other notices during the process of and in relation to a hearing shall be given as provided by ch.

227, Stats. Services of any notice, paper or document in a proceeding after the entry of an appearance as provided by this section shall be made in such manner and may be on the party or on any agent, employe, officer or attorney appearing for or with such party as last entered in the record of such proceedings or furnished and in modification thereof shall be conclusive as the proper and correct mail address.

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

Ins 17.17 Appearances. (ss. 619.04 and 655.003, Stats.) Parties may appear in person or by a regularly employed employe or agent, or by an attorney, and if a corporation by any of its active officers. Upon an appearance at a hearing the name and mail address of the party appearing and the name and mail address of any agent, employe, officer or attorney appearing with or for such party shall be furnished and entered in the record of the proceedings, and the appearance so made and the mail addresses so given shall be binding on the party unless and except as modified by written notice to the board or the person conducting the hearing and to all other parties appearing therein served as provided by s. Ins. 17.15 which when so modified shall in turn have the same force and effect as in the first instance.

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

Ins 17.18 Examination of witnesses. (ss. 619.04 and 655.003, Stats.) Witnesses may be examined on behalf of the board by the commissioner or the hearing examiner, or by an employe of the board with the permission of the hearing examiner, or by a representative of the attorney general acting as counsel for the board or the state. Such witnesses may be cross-examined by a party or any one authorized and appearing therefor, but no more than one individual, whether the party or an agent, employe, officer or attorney appearing with or for such party, shall cross-examine a witness except by permission of the hearing examiner. The commissioner, the hearing examiner, any employe of the board or any representative of the attorney general who shall be acting at said hearing, may call adversely any party, officer, agent or employe of a party and any witness on behalf of any party and may cross-examine any witness or party testifying at such hearing. All witnesses shall be sworn by the commissioner or the hearing examiner before testifying in the same manner as is provided by a statute in respect to the swearing of witnesses testifying in proceedings before courts of record.

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

Ins 17.19 Record. (ss. 619.04 and 655.003, Stats.) (1) Method. All the proceedings at a hearing in a contested case shall be recorded either mechanically, electronically or stenographically. The typed transcript of the record will be prepared when deemed necessary by the board or hearing examiner or when requested as set out in sub. (2). The record in a contested cases shall include the material listed in s. 227.07 (6), Stats.

(2) Copies. If a transcript of the hearing is prepared for the board or hearing examiner, copies will be furnished to all persons upon request upon payment of the fee authorized by s. 601.31 (21), Stats. If no transcript has been prepared by the commissioner or other hearing officer and a party requests that one be prepared, that party shall be responsible for all costs of transcript either dictated at length into the record, or reduced to writing signed by the persons or parties stipulating, and filed as a part of the record of the proceedings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Cardiovascular perfusionists.

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

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

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

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

3. 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.

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

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

(e) Any policyholder holding coverage under the Wisconsin Health Care Liability Insurance Plan shall continue to be subject to the rules governing the Plan which were in force when the coverage was obtained. The renewal of any such coverage shall be subject to the provisions of the

rule in effect at the time of the renewal. All obligations and liabilities created under such prior rule shall continue in force under the Plan until they are extinguished.

(f) Coverage for hospitals, nursing homes, or health care facilities owned or operated by a political subdivision of the state of Wisconsin which are eligible for insurance under this plan may include liability coverages normally incidental to health care liability insurance as defined in sub. (4) (d).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The board of governors shall be empowered to invest, borrow and disburse funds, budget expenses, levy assessments, cede and assume rein-

surance, and perform all other duties provided herein as necessary or incidental to the proper administration of the Plan. The board of governors may appoint a manager or one or more agents to perform such duties as may be designated by the board.

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

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

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

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

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

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

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

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

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

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

(b) The Plan may bind coverage.

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

(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 occurence that might give rise to such a claim.

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

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

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

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

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

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

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

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

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

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

6. Excess funds shall be distributed as follows:

a. If the Plan accumulates funds in excess of the surplus required under s. 619.01 (1) (c) 2., Stats., and incurred liabilities, including reserves for claims incurred but not yet reported, the board of governors shall return those excess funds to the insureds by means of refunds or prospective rate decreases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) In this subsection:

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

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

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

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

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

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

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

2. For Class 2 physicians and surgeons:

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

3. For Class 3 physicians and surgeons:

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

4. For Class 4 physicians and surgeons:

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

5. For Class 5A physicians and surgeons:

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

6. For Class 5 physicians and surgeons:

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

7. For Class 6 physicians and surgeons:

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

8. For Class 7 physicians and surgeons:

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

9. For Class 9 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 627,000	0%	0%	0%	0%	0%
$ 627,001 to $1,103,000	0%	0%	10%	25%	50%
$1,103,001 to $1,558,000	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%

(13) VOLUNTARY BUSINESS - CANCELLATION AND NONRENEWAL. Any member cancelling or not renewing voluntarily written health care liability insurance covering any risk eligible under this Plan shall inform the policyholder of the availability of insurance under the Plan. Any such

notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage. A copy of such cancellation or nonrenewal notice shall be filed with the office of the commissioner of insurance.

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

1. Nonpayment of premium.

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

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

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

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

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

(16) RIGHT OF APPEAL. Any affected person may appeal to the board of governors within 30 days after notice of any final ruling, action or decision of the Plan. Decisions of the board of governors may be further appealed in accordance with ch. 227, Stats. This subsection does not apply to a decision relating to an automatic increase in a provider's plan premium under sub. (12m), which is appealable as provided under s. Ins 17.285.

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

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

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 6-22-76; am. (1) (b), (2), (4) (b) and (c) and (5) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1)(b), (2), (4)(c), (5)(a), (5)(f), (10)(a) and (15), cr. (4)(h), Register, May, 1977, No. 257, eff. 6-1-77; am. (1)(b), (2), (4)(c), (5)(a), (10)(a) and (15), Register, September, 1977, No. 261, eff. 10-1-77; am. (1)(b), (2), (4)(b) and (c), (5)(a) and (f), and (15), Register, May, 1978, No. 269, eff. 6-1-78; am. (7) (b) 1.a., Register, March, 1979, No. 279, eff. 4-1-79; renum. from. Ins 3.35, am. (1) (b), (2), (5) (a) and (10) (a), Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (5) (a), Register, April, 1980, No. 292, eff. 5-1-80; am. (1) (b), (2), (4) (c), (5) (a), (10) (a), (12) (a) 3. and 4. and (15), r. (12) (a) 11. renum. (12) (a) 5. through 10. and 12. to be 7. through 12. and 13., cr. (12)(a) 5. and 6., Register, May, 1985, No. 353, eff. 6-1-85; emerg. am. (1)(b), (2), (4)(c) and (5)(a) 2., eff. 7-29-86; am. (1)(b), (2), (4)(c) and (5)(a) 2., Register, January, 1987, No. 373, eff. 2-1-87; emerg. am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), cr. (5) (a) 11., (7m) and (14) (a) 3. and 4., renum. (5) (a) 11., (b) and (7) (b) 1. intro. to be (5) (am), (b) (intro.) and (7) (b) and am., r. (7) (b) 1. a. and b. eff. 2-16-87; am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), renum. (5) (a) 11, (b) and (7) (b) 1. to be (5) (am), (b) (intro.) and (7) (b) 1. and am., cr. (5) (a) 7m and 11., (b) 1. to 3., (7) (b) 2m. and (14) (a) 3. and 4., r. (7) (b) 1. a. and b., Register, July, 1987, No. 379, eff. 8-1-87; r. (12) (a) 13. and (b) 5., cr. (5) (a) 2m. and (12m), am. (16), Register, February, 1988, No. 386, eff. 3-1-88; 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.

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

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

(3) DEFINITIONS. In this section:

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

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

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

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the

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

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

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

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

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

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

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

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

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

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

(3) FINANCIAL REPORTS. Annual financial reports required by s. 655.27 (4) (d), Stats., shall be furnished within 60 days after the close of each

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

(4) The board of governors shall select one or more actuaries to assist in the determination of reserves and the setting of fees under s. 655.27 (3) (b), Stats. In the event more than one actuary is utilized, the health care providers represented on the board of governors shall jointly select the second actuary. Such actuarial reports shall be submitted on a timely basis.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80.

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.

History: Cr. Register, March, 1988, No. 387, eff. 4-1-88.

Ins 17.28 Health care provider fees. (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (3), Stats., relating to fees to be paid by health care providers for participation in the Patients Compensation Fund.

(2) SCOPE. This section applies to fees charged health care providers as defined in s. 655.001 (8), Stats. Nothing in this section shall apply to operating fees charged for operation of the mediation system under s. 655.61, Stats.

(3) DEFINITIONS. (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" of physicians or surgeons means those health care providers whose specialties are similar in their degree of exposure to loss and who are subject to a common fee in accordance with the provisions of s. 655.27 (3) (b) 2., Stats. Classes and included specialties are listed below:

1. Class 1 health care providers are those engaged in the following medical specialties:

Aerospace Medicine
Allergy
Cardiovascular Disease - no surgery
Dermatology - no surgery
Diabetes - no surgery
Endocrinology - no surgery
Family Practice and General Practice - no surgery
Forensic Medicine
Gastroenterology - no surgery
General Preventative Medicine - no surgery
Geriatrics - no surgery
Gynecology - no surgery
Hematology - no surgery
Hypnosis
Infectious Diseases - no surgery
Internal Medicine - no surgery
Laryngology - no surgery
Legal Medicine
Neoplastic Diseases - no surgery
Nephrology - no surgery
Neurology - including child - no surgery
Nuclear Medicine
Nutrition
Occupational Medicine
Ophthalmology - no surgery
Osteopathic Physicians - manipulation only
Otology - no surgery
Otorhinolaryngology - no surgery
Pathology - no surgery
Pediatrics - no surgery
Pharmacology - clinical
Physiatry
Physical Medicine and Rehabilitation
Physicians - no surgery
Psychiatry - including child
Psychoanalysis
Psychosomatic Medicine
Public Health
Pulmonary Diseases - no surgery
Radiology - diagnostic - no surgery
Rheumatology - no surgery
Rhinology - no surgery

Post Graduate Medical Education or Fellowship—This classification applies to all physicians engaged in the first year of post graduate medical education (interns). This classification also applies to physicians engaged in 2 through 6 years of an approved post graduate medical education specialty program (residents) listed above which is not ordinarily involved in the performance of or assisting in the performance of obstetrical procedures or surgical (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) procedures.

2. Class 2 health care providers are those engaged in the following medical specialties:

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 — This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue 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 - This classification applies to any general practitioner or 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
Otology - 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 facilities

Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in 2 through 6 years of an approved post graduate medical education specialty program listed above.

3. Class 3 health care providers are those engaged in the following medical specialties:

Anesthesiology -This classification applies to all providers who perform general anesthesia or acupuncture anesthesia
Emergency Medicine - including major surgery
Surgery - abdominal
Surgery - cardiac
Surgery - cardiovascular disease
Surgery - plastic
Surgery - plastic - otorhinolaryngology
Surgery - rhinology
Surgery - general (specialists in general surgery)
Surgery - gynecology
Surgery - hand
Surgery - head and neck
Surgery - laryngology
Surgery - orthopedic
Surgery - otorhinolaryngology (no plastic surgery)
Surgery - thoracic
Surgery - traumatic
Surgery - vascular
Weight Control - bariatrics

Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in two through six years of an approved post graduate medical education specialty program indicated above.

4. Class 4 health care providers are those engaged in the following medical specialties: Surgery - neurology - including child

Surgery - obstetrics and gynecology
Surgery - obstetrics Post Graduate Medical Education or Fellowship—This classification applies to physicians engaged in two through six years of an approved post graduate medical education specialty program indicated above.

(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 practicing 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.

(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 subject to ch. 655, Stats., 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; NOTICE TO FUND. (a) 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:

1. The provider will not practice more than 240 hours in the fiscal year.

2. The provider is a federal, state, county or municipal employe.

3. During the fiscal year:

a. More than 50% of the provider's practice will be performed outside this state;

b. More than 50% of the income from the provider's practice will be derived from outside this state; or

c. More than 50% of the provider's patients will be seen outside this state.

(b) If a provider does not claim an exemption under par. (a) 1 by the date of the first payment due under sub. (7) (b) 1 or 2, the provider waives the right to claim the exemption for that fiscal year.

(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 malpractice 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 per-

iod 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.

(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.

(5) EFFECTIVE DATE AND EXPIRATION DATE OF FEE SCHEDULES. The effective date of the fee schedule contained in this section shall be the current July 1 and shall expire the next subsequent June 30.

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1989 to June 30, 1990:

(a) For physicians and surgeons:

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

(b) For resident physicians and surgeons involved in post graduate medical education or a fellowship:

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

(c) For resident physicians and surgeons who practice outside residency or fellowship:

All classes	$1,543

(d) For Medical College of Wisconsin full time faculty:

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

(e) For Medical College of Wisconsin resident physicians and surgeons:

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

(f) For government employes — state, federal, municipal:

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

(g) For retired or part-time physicians and surgeons with an office practice only and no hospital admissions who practice less than 500 hours per fiscal year: $1,543

(h) For nurse anesthetists: $688

(i) For hospitals:

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 nursing homes:

Per occupied bed $32

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

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) For corporations organized under ch. 180, Stats., providing the medical services of physicians or nurse anesthetists:

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 corporations organized under ch. 181, Stats.:

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 operational cooperative sickness care plans:

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 ambulatory surgery centers:

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

(o) For an entity owned or controlled by a hospital or hospitals: $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.

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

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

(b) In this subsection:

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

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

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

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

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

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

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

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

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or More
Up to $ 123,000	0%	0%	0%	0%

123,001 to $ 468,000	0%	10%	25%	50%
468,001 to $1,179,000	0%	25%	50%	100%
Greater Than $1,179,000	0%	50%	100%	200%

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

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

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

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

(7) 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. 333, eff. 10-1-83; am. (6) (intro.), (a) to (h), (j) and (r), Register, June, 1984, No. 342, eff. 7-1-94; am. (6) (i), Register, August, 1984, No. 344, eff. 9-1-84; am. (3) (c) and (6) (intro.), (a) to (e) 1., (f) to (h), (j) and (k), r. (intro.), cr. (3) (c) 1. to 9. and (7), Register, July, 1985, No. 355, eff. 8-1-85; am. (7) (a) 2. and (c), r. (7) (a) 5., renum. (7) (a) 3. and 4. to be 4. and 5. and am., cr. (7) (a) 3., Register, December, 1985, No. 360, eff. 1-1-86; emerg. r. and recr. (3) (c) intro., 1. to 9., (4), (6) (intro.), (a) to (k) and (7), eff. 7-2-86; r. and recr. (3) (c) intro. and 1. to 9., (4), (6) (intro.), (a) to (k) and (7), Register, September, 1986, No. 369, eff. 10-1-86; am. (2), (4) (b) and (d), (6) and (7) (intro.), Register, June, 1987, No. 378, eff. 7-1-87; am. (6) (i) and (j), cr. (6) (k) to (o) and (6m), Register, January, 1988, No. 385, eff. 7-1-88; cr. (6s), Register, February, 1988, No. 386, eff. 3-1-88; 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) (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., Register, July, 1989, No. 403, eff. 8-1-89.

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

(2) DEFINITIONS. In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Hiring legal counsel.

2. Establishment and revision of case reserves.

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

4. Investigation and evaluation of claims.

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

6. Filing of reports to the board.

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

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

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

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

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

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

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

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

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

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

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.

(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 attor-

ney 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.

History: Cr. Register, December, 1989, No. 408, eff. 1-1-90.