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

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

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

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

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

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

3. Appoint advisory committees of interested persons, not limited to members of the plan, to advise the board in the fulfillment of its duties and functions.

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

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

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

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

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

2. Ensure that all policies written by the plan are separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium level for each classification of risk, and performing loss prevention and other studies of the operation of the plan.

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

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

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

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

(b) The plan may bind coverage.

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

(cm) The board may authorize retroactive coverage by the plan for a health care provider, as defined in s. 655.001 (8), Stats., if the provider submits a timely request for retroactive coverage showing that the failure to procure coverage occurred through no fault of the provider and despite the fact that the provider acted reasonably and in good faith. The provider shall furnish the board with an affidavit describing the necessity for the retroactive coverage and stating that the provider has no notice of any pending claim alleging malpractice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim.

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

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

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

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

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

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

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

8. For Class 7 physicians:

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

9. For Class 9 physicians:

Aggregate Indemnity During Review Period		Number of Closed Claims During Review Period				
		1	2	3	4	5 or more
Up to	$ 627,000	0%	0%	0%	0%	0%
$ 627,001 to	$1,103,000	0%	0%	10%	25%	50%
$1,103,001 to	$1,558,000	0%	0%	25%	50%	75%
$1,558,001 to	$3,371,000	0%	0%	50%	75%	100%
Greater Than	$3,371,000	0%	0%	75%	100%	200%

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

1. Nonpayment of premium.

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

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

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

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

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

1. To a health care provider specified in sub. (5) (a) to (e) or (m), 15% of the premium or $150, whichever is less.

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

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

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

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

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

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

1. A member of the board or any of its committees or subcommittees.

2. A member of or a consultant to the peer review council under s. 655.275, Stats.

3. A member of the plan.

4. The manager or an officer or employe of the plan.

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

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

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

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

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 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; am. (1) (a) and (c), (2), (10) (a), (b), (c) and (d), (12) (a) 2. and 3., (14) (a) (intro.) and 4., (b), r. (3), (4) (a), (c), (d), (f) and (h), (5) (am), (d), (e) and (f), (6) (a), (7), (8) (j), (11) (a), (12) (intro.), (a) 4. to 6. intro., b. and c. and 7., (b), (c) 1., 3. and 6., (12m) (c) and (13), r. and recr. (12) (a) 1., (15), (16) and (18), renum. (4) (b) and (e), (5) (a) (intro.) to 11., (5) (b) and (c), (6) (b) and (c), (8) (a) to (i), (9), (11) (b), (12) (a) 6., 8., to 12., (12) (b) 2. and 4. and (17) to be (6) (a) 1. and 2., (5) (intro.) to (m), (3) (d) and (f), (6) (b) 2. and 3., (7), (8) (a), (b) 1. to 4., (8) (a) 3. to 5., (8) (b) 5., (6) (c), (12) (a) 4. to 6., (12) (a) 5. b., (12) (c), (12) (a) 7., (12) (b) 1. and 2., and (6) (d) and am. except (3) (d) 1. to 4., cr. (3) (a) to (c) and (e), (5) (n), (6) (a) (intro.) and (b) 1., (8) (a) (intro.) and 6., (b) (intro.), (12) (b) (intro.) and (19), Register, June, 1990, No. 414, eff. 7-1-90; am. (10) (cm), Register, April, 1991, No. 424, eff. 5-1-91.

Surgery - obstetrics and gynecology

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The board may authorize retroactive fund coverage for a provider who submits a timely request for retroactive coverage showing that the failure to procure coverage occurred through no fault of the provider and despite the fact that the provider acted reasonably and in good faith. The provider shall furnish 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 period from the date of death to the date the next payment would have been due, except that no refund under this subdivision may exceed the total amount of the most recent annual fee paid by the provider.

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

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

(cs) *Ineligibility for fund coverage; refund.* 1. If a provider who has paid all or part of the annual fee is or becomes ineligible to participate in the fund because he or she is a federal, state, county or municipal employe, or does not practice in this state, the fund shall issue a full refund of any amount the provider paid for fund coverage for which he or she was not eligible.

2. If a provider that has paid all or part of the annual fee is ineligible for fund coverage because the provider is not in compliance with sub. (3e), the fund shall issue a full refund of the amount paid for the period of noncompliance, beginning with the date the noncompliance began.

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

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

(5) FILING OF CERTIFICATES OF INSURANCE. An insurance company required under s. 655.23 (3) (b), Stats., to file a certificate of insurance on

behalf of a provider shall file the certificate with the fund within 45 days after the original issuance and each renewal and within 45 days after a change of class or type that would affect the provider's fee under sub. (4).

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

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

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

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

(b) For a resident acting within the scope of a residency or fellowship program:

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

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

All classes	$1,543

(d) For a medical college of Wisconsin, inc., full-time faculty member:

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

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

(h) For a nurse anesthetist: $688

(i) For a hospital:

1. Per occupied bed $169; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $8.40

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

Per occupied bed $32

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

1. If the total number of partners and employed physicians or nurse anesthetists is from 2 to 10 $100.00

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

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

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

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

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

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

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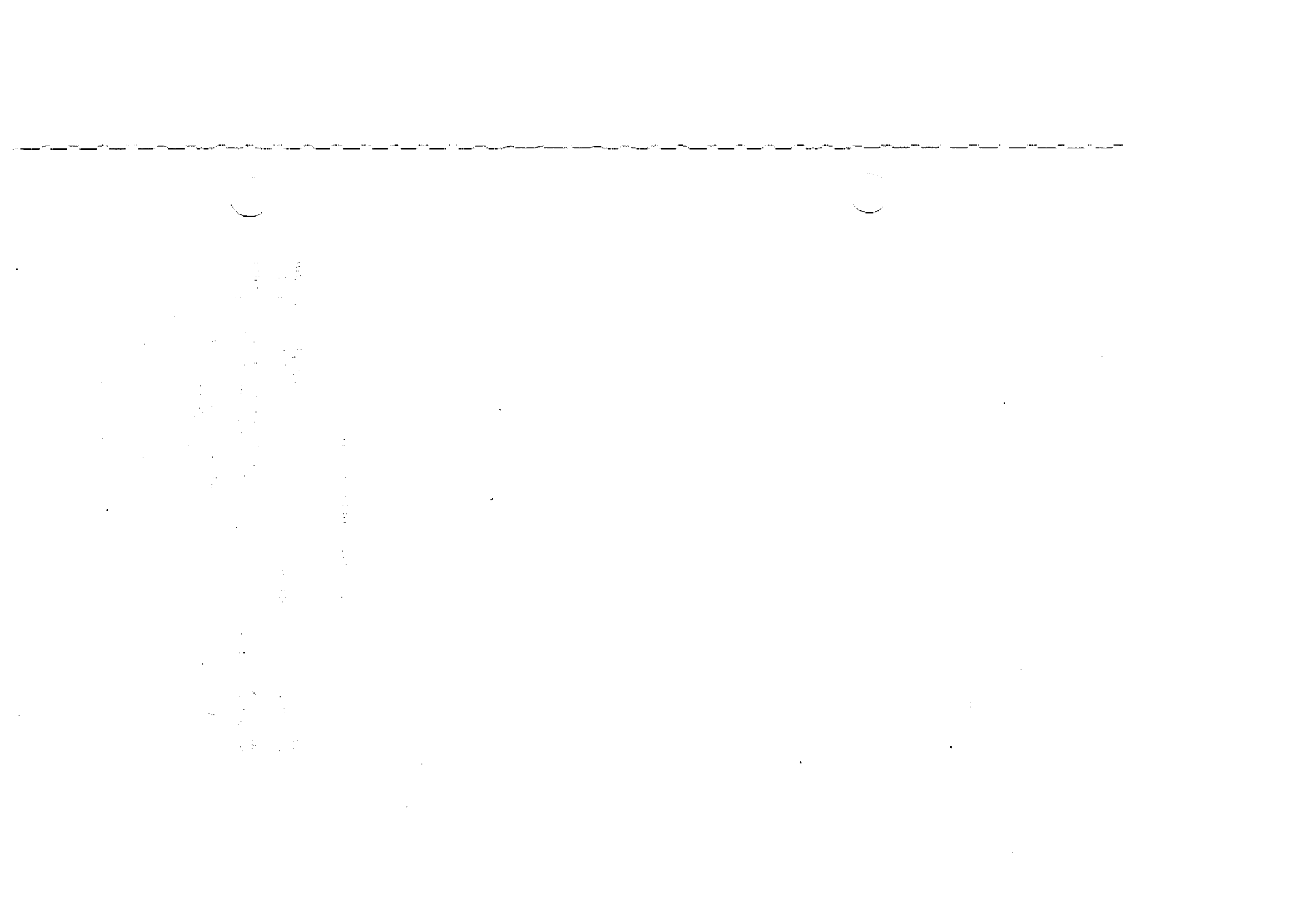

(7) BILLING; PAYMENT SCHEDULES. (a) For each fiscal year, the fund shall issue an initial bill to each provider showing the amount due, including any applicable surcharge imposed under s. Ins 17.285, and the payment schedules available and shall bill the provider according to the payment schedule selected. 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.

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; am. (1), (2), (3) (c) and (f), (3e), (6) (intro.), (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (g), (h), (i) (intro.), (j) (intro.), (k) (intro.), (l) (intro.), (lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), renum. (3m) (a) (intro.), 1., 2., 3. intro., b. and c., and (6m) to be (3m) (intro.), (a), (b), (c), and (6m) (a), r. (3m) (a) 3. a. and (b), r. and recr. (5), (6) (a) (intro.), (b) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (6s) (c) 1. intro., 2. intro., 3. intro. and 4. intro., cr. (3) (intro.) and (hm), (4) (cm) and (g), (6e) and (6m) (b), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (6) (b) and (6e), r. (6) (e) and (f), eff. 7-1-90; am. (6) (b) and (6e), r. (6) (e) and (f), Register, October, 1990, No. 418, eff.11-1-90; cr. (4) (cs), am. and (3s) (b) (4) (g), Register, April, 1991, No. 424, eff. 5-1-91.

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

(2) DEFINITIONS. In this section:

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

(b) "Closed claim" means a claim against a provider, or a claim against an employe of a health care provider for which the provider is vicariously liable, for which there has been a final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

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

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

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

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

(2m) TIME FOR REPORTING. In reporting claims paid under s. 655.26, Stats., each insurer or self-insurer shall report the required information