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

6. The loss and expense experience used in establishing and revising rates shall be adjusted to indicate as nearly as possible the loss and expense experience which will emerge on policies issued by the plan during the period for which the rates were being established. For this purpose loss experience shall include paid and unpaid losses, a provision for incurred but not reported losses and both allocated and unallocated loss adjustment expenses, giving consideraton to changes in estimated costs of unpaid claims and to indications of trends in claim frequency, claim severity and level of loss expense.

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

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

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

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

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

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

(b) In this subsection:

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

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

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

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

(c) The following tables shall be used in making the determinations required under s. Ins 17.285 as to the percentage increase in a provider's plan premium:

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

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

2. For Class 2 physicians:

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

3. For Class 3 physicians:

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

4. For Class 4 physicians:

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

5. For Class 5A physicians:

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

6. For Class 5 physicians:

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

7. For Class 6 physicians:

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

8. For Class 7 physicians:

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

9. For Class 9 physicians:

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

(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; am. (12m) (c) (intro.), Register, January, 1992, No. 433, eff. 2-1-92.

(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

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

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

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

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

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.21; plus

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

(n) For an ambulatory surgery center, as defined in s. HSS 123.14 (2) (a), which is a separate entity not part of a hospital, partnership or corporation subject to ch. 655, Stats.:

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

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

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

(b) Before the beginning of each fiscal year, the medical college of Wisconsin affiliated hospitals, inc., shall estimate the total amount of fund fees for the next fiscal year for all its residents and shall pay that amount to the fund. At the end of the fiscal year, the medical college of Wisconsin affiliated hospitals, inc., shall determine the residents' actual exposure during the fiscal year and shall pay the fund the amount of an deficiency, plus interest as determined under sub. (7) (c) 3. The fund shall refund the amount of an overpayment, if any.

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

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

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

(b) In this subsection:

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

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

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

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

(c) The following tables shall be used in making the determinations required under s. Ins 17.285 as to the percentage increase in a provider's fund fee:

1. For a class 1 physician or a nurse anesthetist:

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

2. For a class 2 physician:

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

3. For a class 3 physician:

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

4. For a class 4 physician:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The daily rate of interest under subds. 1 and 2 shall be the average annualized rate earned by the fund for the first 3 quarters of the preceding fiscal year as determined by the state investment board, divided by 360. Late payment fees and administrative service charges are not refundable.

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; emerg. am. (3) (c) 2. and 3., (6) (intro.), eff. 7-1-91; am. (3) (c) 2. and 3., (6) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (6s) (c) (intro.), Register, January, 1992, No. 433, eff. 2-1-92.

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 attributable to an individual provider that is paid or owing to or on behalf of claimants for all closed claims arising out of one incident or course of conduct, 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 medical malpractice 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 either of the following:

1. A final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

2. A payment to a claimant by the provider or another person on the provider's behalf.

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

(cg) "Health care provider" has the meaning given in s. 146.81 (1), Stats.

(cr) "Patient health care records" has the meaning given in s. 146.81 (4), Stats.

(d) "Provider," when used without further qualification, means a health care provider subject to ch. 655, Stats., 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 first payment on 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 by the 15th day of the month following the date on which there has been a final determination of the aggregate indemnity to be paid to or on behalf of any claimant.

(2s) INFORMATION FOR PROVIDER. Upon receipt of a report under sub. (2m), the council shall mail to the provider who is the subject of the report all of the following:

(a) A copy of the report, with a statement that the provider may contact the insurer that filed the report if the provider believes it contains inaccurate information.

(b) A statement that the council may use its authority under s. 146.82 (2) (a) 5, Stats., to obtain any patient health care records necessary for use in making determinations under this section.

(c) A request that the provider sign and return to the council an authorization for release of information form, authorizing the provider's insurer to provide the council with relevant factual information about the closed claim for use in making determinations under this section. A copy of the form shall be enclosed with the mailing.

(d) If necessary, a request that the provider verify the council's closed claim record and furnish the council with information on any additional closed claims not known to the council that have been paid by or on behalf of the provider during the review period.

(e) Notice that if the provider does not comply with a request under par. (c) or (d) within 40 days after the date of the request, the provider is in violation of s. 601.42 (4), Stats., and may be subject to a forfeiture of up to $1,000 for each week of continued violation, as provided in s. 601.64 (3), Stats.

(3) DETERMINATION OF NEED FOR REVIEW. Based on reports received under sub. (2m) and any additional closed claims reported in response to a request under sub. (2s) (d), the council, using the tables under ss. 17.25

(12m) (c) and 17.28 (6s) (c), shall determine when a provider has, during a review period, accumulated enough closed claims and aggregate indemnity to consider the imposition of a surcharge.

(4) RECORDS REQUESTS; NOTICE TO PROVIDER. (a) When the council makes a determination under sub. (3), it may request any of the following:

1. From any health care provider, patient health care records related to each closed claim subject to review as provided in s. 146.82 (2) (a) 5, Stats.

2. From the provider's insurer, relevant factual information about each closed claim subject to review. This subdivision applies only if the provider has complied with the request under sub. (2s) (c).

(b) A request under par. (a) shall be in writing and shall specify a reasonable time for response. Each person receiving a request shall provide the council with the records and information requested, unless the person no longer maintains or has access to them. If a person is unable to comply with a request, the person shall notify the council in writing of the reason for the inability to comply.

(c) The council shall notify a provider for whom a determination is made under sub. (3) that, after reviewing the patient health care records, consultants' opinions and other relevant information submitted by the provider and the provider's insurer, the council may recommend that a surcharge be imposed on the provider's plan premium, fund fee or both, and that the surcharge may be reduced or eliminated following a review as provided in this section. The notice shall include a description of the procedures specified in this section and a statement that the provider may submit in writing relevant information about any closed claim involved in the review and a description of mitigating circumstances that may reduce the future risk to the plan, the fund or both.

(5) PROCEDURE FOR REVIEW. (a) The council or a single council member may conduct a preliminary review of the records and information relating to each of a provider's closed claims. If the council or council member is able to determine, without a consultant, that the provider met the appropriate standard of care with respect to any closed claim, the council shall not refer that closed claim to a consultant and shall not use that closed claim in determining whether to impose a surcharge on that provider.

(b) Unless a determination under par. (a) reduces the number of closed claims and aggregate indemnity so that the provider is no longer subject to the imposition of a surcharge, the council shall refer all records and information relating to closed claims subject to review, including records and information in the custody of the plan and the fund, to one or more specialists as provided in s. 655.275 (5) (b), Stats.

(c) Each specialist consulted under par. (b) shall provide the council with a written opinion as to whether the provider met the appropriate standard of care with respect to each closed claim reviewed.

(d) At least 30 days before the meeting at which the council will decide whether or not to recommend that a surcharge should be imposed on a provider, the council shall notify the provider of the date of the meeting and furnish the provider with a copy of the consultant's opinions and a

list of any other documents on which the recommendation will be based. The council shall make all documents available to the provider upon request for inspection and copying, as provided under s. 19.35, Stats.

(e) 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.

(f) The council, after taking into consideration all available information, shall decide whether each closed claim reviewed should be counted in recommending whether to impose a surcharge on the provider.

(7) REPORT TO BOARD. (a) If the total number of closed claims which the council determines should be included and the aggregate indemnity attributable to those claims would be sufficient to require the imposition of a surcharge under s. Ins 17.25 (12m) (c), 17.28 (6s) (c) or both, the council shall prepare a written report for the board recommending the surcharge that should be imposed. The report shall include the factual basis for the determination on each incident involved in the review and a description of any mitigating circumstances.

(b) If the council determines that one or more closed claims should not be counted and, as a result, the total number of closed claims remaining and the aggregate indemnity attributable to those claims is not 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. The report shall include a brief summary of the basis for the recommendation.

(c) The council shall furnish the provider with a copy of its report and recommendation to the board and with notice of the right to a hearing as provided in sub. (9).

(9) HEARING. (a) A provider has the right to a hearing under ch. 227, Stats., and ch. Ins 5 on the council's recommendation, if the provider requests a hearing within 30 days after receiving the notice under sub. (7) (c).

(am) The reports of the consultant and any other documents relied on by the council in making its recommendation to the board are admissible in evidence at a hearing under this section.

(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, fund fee or both after a final decision by the board takes effect on the next billing date 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 apply a credit to the provider's next plan premium or fund fee bill or both.

(d) A surcharge remains in effect for 36 months. The percentage imposed shall be reduced by 50% for the 2nd 12 months and by 75% for the 3rd 12 months, if the provider does not accumulate any additional closed claims before the expiration of the surcharge. The time periods specified in this paragraph are tolled on the date a provider stops practicing in this state and remain tolled until the provider resumes practice in this state.

(e) If the provider accumulates additional closed claims while a surcharge is in effect, the provider is subject to the higher of the following:

1. The surcharge imposed under sub. (10) and 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 changes from one class to another class specified in s. Ins 17.25 (12m) (c) or 17.28 (6s) (c) while a surcharge is in effect, the percentage 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. (5) (f) 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.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88; am. (2) (a) and (b), (3) (a) and (c) 2., (5) (b) (intro.), (7) (a), (8), (9) (a), (11) (f) and (14), cr. (2m) and (4) (c) 2., renum. (4) (c) to be (4) (c) 1., Register, June, 1990, No. 414, eff. 7-1-90; am. (2) (a), (b), (d) and (e), (7) (b), (11) (a), (c) to (e) (intro.) and 1., (f) and (12), renum. (3) (a), (4) (b) (intro.) and 1., (5) (d), (8) to be (3), (4) (c), (5) (e) and (7) (c) and am. (3), (4) (c) and (7) (c), r. (3) (b) and (d), (4) (b) 2., (c) (d), (6) and (11) (b), cr. (2) (cg) and (cr), (2s), (4) (b), (5) (d) and (f), (9) (am), r. and recr. (4) (a), (5) (a) to (c) and (9) (a), Register, January, 1992, No. 433, eff. 2-1-92.

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

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

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

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

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