Chapter Ins 17

HEALTH CARE LIABILITY INSURANCE PATIENTS COMPENSATION FUND

Ins 17.001 Definitions. In this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

(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, 1994:

(a) For physicians — $ 50.00

(b) For hospitals, per occupied bed — $ 3.00

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; emerg. r. and recr. eff. 7-2-86; r. and recr., Register, September, 1986, No. 369, eff. 10-1-86; cr. (2) (f), am. (3), Register, June, 1987, No. 378, eff. 7-1-87; am. (1), (2) (a), (d) and (e), (3), r. and recr. (2) (b), r. (2) (c), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (3), eff. 7-1-91; am. (3) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (3) (a) and (b), Register, October, 1991, No. 430, eff. 11-1-91; emerg. am. (3), eff. 4-28-92; am. (3), Register, July, 1992, No. 439, eff. 8-1-92; emerg. am. (1), (3) (intro.), (a), eff. 7-22-93; am. (1), (3) (intro.), (a), Register, September, 1993, No. 453, eff. 10-1-93; am. (3) (intro.), Register, June, 1994, No. 462, eff. 7-1-94.

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

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

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

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

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

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

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

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

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain

6. The payment due date.

(i) *Billing; partial fiscal year.* The fund shall issue each provider entering the fund after the beginning of a fiscal year an initial bill which shall include all of the following;

1. The total amount due calculated under par. (b).

2. Notice of the provider's right to pay the amount due in full or in instalments.

3. The minimum amount due if the provider elects instalment payments.

4. The payment due date.

(j) *Balance billing.* If a provider pays at least the minimum amount due but less than the total amount due by the due date, the fund shall calculate the remainder due by subtracting the amount paid from the amount due and shall bill the provider for the remainder on a quarterly instalment basis. Each subsequent bill shall include all of the following:

1. The total of the remainder due.

2. Interest on the remainder due. The daily rate of interest shall be the average annualized rate earned by the fund on its short-term funds for the first 3 quarters of the preceding fiscal year, as determined by the state investment board, divided by 360.

3. A $3 administrative service charge.

4. The minimum amount due.

5. The payment due date.

(k) *Prompt payment required.* A provider shall pay at least the minimum amount due on or before each due date. If the fund receives payment later than the due date specified in the late payment notice sent to the provider by certified mail, the fund, notwithstanding par. (n).5, may not apply the payment retroactively to the annual fee unless the board has authorized retroactive coverage under sub. (3s) (b).

(n) *Application of payments.* Except as provided in par. (k), all payments to the fund shall be applied in chronological order first to previous fiscal years for which a balance is due and then to the current fiscal year. The amounts for each fiscal year shall be credited in the following order:

1. Mediation fund fee imposed under s. Ins 17.01.

2. Administrative service charge under par. (j) 3.

3. Interest under par. (j) 2.

4. Surcharge imposed under s. Ins 17.285.

5. Annual fee under sub. (6).

(o) *Waiver of balance.* The fund may waive any balance of $50 or less, if it is in the economic interest of the fund to do so.

(5) FILING OF CERTIFICATES OF INSURANCE. (a) *Electronic filing.* Except as provided in par. (b), each insurer and self-insured provider required under s. 655.23 (3) (b) or (c), Stats., to file a certificate of insur-

ance shall file the certificate electronically in the format specified by the commissioner by the 15th day of the month following the month of original issuance or renewal or a change of class under sub. (6).

(b) *Exemption.* An insurer or self-insured provider may file a written request for an exemption from the requirement of par. (a). The commissioner may grant the exemption if he or she finds that compliance would constitute a financial or administrative hardship. An insurer or self-insured provider granted an exemption under this paragraph shall file a paper certificate in the format specified by the commissioner within 45 days after original issuance or renewal or a change of class under sub. (6).

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1994 to June 30, 1995:

(a) Except as provided in pars. (b) to (g), for a physician for whom this state is a principal place of practice:

Class 1	$3,150	Class 3	$15,750
Class 2	$6,300	Class 4	$18,900

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

Class 1	$1,575	Class 3	$7,875
Class 2	$3,150	Class 4	$9,450

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

All classes	$1,890

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

Class 1	$1,260	Class 3	$6,300
Class 2	$2,520	Class 4	$7,560

(g) For a physician who practices fewer than 500 hours during the fiscal year, limited to office practice and nursing home and house calls, and who does not practice obstetrics or surgery or assist in surgical procedures: $788

(gm) For a physician for whom this state is not a principal place of practice:

Class 1	$1,575	Class 3	$7,875
Class 2	$3,150	Class 4	$9,450

(h) For a nurse anesthetist for whom this state is a principal place of practice: $844

(hm) For a nurse anesthetist for whom this state is not a principal place of practice: $422

(i) For a hospital:

1. Per occupied bed $208; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $10.29

(j) For a nursing home, as described under s. 655.002 (1) (j), 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 $39

(k) For a partnership comprised of physicians or nurse anesthetists, organized for the primary purpose of providing the medical services 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 $118

2. If the total number of partners and employed physicians or nurse anesthetists is from 11 to 100 $1,178

3. If the total number of partners and employed physicians or nurse anesthetists exceeds 100 $2,945

(l) For a corporation with more than one shareholder organized under ch. 180, Stats., for the primary purpose of 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 2 to 10 $118

2. If the total number of shareholders and employed physicians or nurse anesthetists is from 11 to 100 $1,178

3. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 $2,945

(lm) For a corporation organized under ch. 181, Stats., for the primary purpose of 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 $118

2. If the total number of employed physicians and nurse anesthetists is from 11 to 100 $1,178

3. If the total number of employed physicians or nurse anesthetists exceeds 100 $2,945

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.26; plus

2. 2.5% of the total annual fees assessed against all of the employed physicians.

(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 $51

(o) For an entity affiliated with a hospital, the greater of $100 or whichever of the following applies:

1. 15% of the amount the entity pays as premium for its primary health care liability insurance, if it has occurrence coverage.

2. 20% of the amount the entity pays as premium for its primary health care liability insurance, if it has claims made coverage.

(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) Notwithstanding sub. (4) (h), the fund's initial bill for each fiscal year shall be the amount the medical college of Wisconsin affiliated hospitals, inc., estimates will be due for the next fiscal year for all its residents. At the end of the fiscal year, the fund shall adjust the fee to reflect the residents' actual exposure during the fiscal year, as determined by the medical college of Wisconsin affiliated hospitals, inc., and shall bill the medical college of Wisconsin affiliated hospitals, inc., for the balance due, if any, plus accrued interest, as calculated under par. (j) 2, from the beginning of the fiscal year. 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%

Note: Applicability. (1) Except as provided in sub. (2), the treatment of s. Ins 17.28 (4) (b), (c) 1 (intro.) and 2 to 4, (cs) 1, (f) and (h) to (n), (5), (6e) (b) and (7) by the March, 1992 revision first applies to patients compensation fund annual fee bills for fiscal year 1992-93.

(2) If the patients compensation fund's new computerized billing system becomes operational on or before March 1, 1992, the treatment of s. Ins 17.28 (4) (b), (c) 1 (intro.) and 2 to 4, (cs) 1, (f) and (h) to (n), (5), (6e) (b) and (7) by the March, 1992 revision first applies to patients compensation fund annual fee bills for the last quarter of fiscal year 1991-92.

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; am. (4) (b), (c) 1. intro., 2 to 4., (cs) 1. and (f), (5) and (6e) (b), cr. (4) (h) to (o), r. (7), Register, March, 1992, No. 435, eff. 4-1-92; emerg. am. (4) (em), (e) 1., (f), (j) 3., (5), (6) (intro.), (a) to (j), (k) (intro.), (l) (intro.), 1., (lm) (intro.), (m) and (n), r. (3m) (b) and (4) (e) 2., cr. (6) (gm) and (hm), r. and recr. (4) (c), renum. (4) (d), (l) and (m) to be (4) (d) 1., 2. and (e) 2., eff. 4-28-92; am. (4) (em), (e) 1., (f), (j) 3., (5), (6) (intro.), (a) to (j), (k) (intro.), (l), (intro.), 1. (lm) (intro.), (m) and (n), r. (3m) (b) and (4) (e) 2., cr. (6) (gm) and (hm), r. and recr. (4) (c), renum. (4) (d), (l) and (m) to be (4) (d) 1., 2. and (e) 2., Register, July, 1992, No. 439, eff. 8-1-92; emerg. am. (3) (c) (intro.), (6) (intro.), (a) to (d) and (gm) to (n), r. and recr. (3) (c) 1 to 4, (5), (6) (g); am. (3) (c) (intro.), (6) (intro.), (a) to (d) and (gm) to (n), r. and recr. (3) (c) 1 to 4, (5), (6) (g), Register, September, 1993, No. 453, eff. 10-1-93; am. (4) (k) and (n) (intro.) and (6), Register, June, 1994, No. 462, eff. 7-1-94.

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:

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assessment of fees sufficient to cover the costs, including the costs of administration, of the patients compensation fund peer review council appointed under s. 655.275 (2), Stats.

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

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

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

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

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

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

History: Cr. Register, June, 1987, No. 378, eff. 7-1-87; am. (2) (a) 1. and 2., Register, June, 1990, No. 414, eff. 7-1-90.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2b) APPLICATION OF LIMITS; CLAIMS MADE POLICIES. (a) This subsection interprets and implements s. 655.23 (4), Stats.

(b) An insurer shall allocate the amount paid on each claim to the policy year of the occurrence giving rise to the claim and not to the year in which the claim was reported. The per occurrence limit and the total amount of the annual aggregate limit specified in s. 655.23 (4), Stats., as it applied on the date of the occurrence, shall be available for each policy year.

(2e) REQUIREMENTS FOR GROUP COVERAGE. (a) In this section, "provider" means a health care provider, as defined in s. 655.001 (8), Stats.

(b) An insurer or self-insured provider that provides primary coverage under a group policy or self-insured plan shall do all of the following:

1. At the time of original issuance of the policy or when the self-insured plan takes effect, and each time coverage for an individual provider is added:

a. Furnish each covered provider with a copy of the policy or a certificate of coverage specifying the coverage provided and whether the coverage is limited to a specific practice location, to services performed for a specific employer or in any other way.

b. Include on the first page of the policy or the certificate of coverage, or in the form of a sticker, letter or other form included with the policy or certificate of coverage, that it is the responsibility of the individual provider to ensure that he or she has health care liability insurance coverage meeting the requirements of ch. 655, Stats., in effect for all of his or her practice in this state, unless the provider is exempt from the requirements of that chapter.

2. For a policy or self-insured plan in effect on October 1, 1993, furnish the documents specified in subd. 1. a and b to each individual covered provider before the next renewal date or anniversary date of the policy or self-insured plan.

3. Notify each covered provider individually when the policy or self-insured plan is cancelled, nonrenewed or otherwise terminated, or amended to affect the coverage provisions.

4. On the certificate of insurance filed with the fund under s. 655.23 (3) (b) or (c), Stats., and s. Ins 17.28 (5), specify whether the coverage is limited to a specific practice location, to services performed for a specific employer or in any other way.

(2m) RISK RETENTION GROUPS. If the policy is issued by a risk retention group, as defined under s. 600.03 (41e), Stats., each new and renewal application form shall include the following notice in 10-point type:

NOTICE

Under the federal liability risk retention act of 1986 (15 USC 3901 to 3906) the Wisconsin insurance security fund is not available for payment of claims if this risk retention group becomes insolvent. In that event, you will be personally liable for payment of claims up to your limit of liability under s. 655.23 (4), Wis. Stat.

Note: Subsection (2m) first applies to applications taken on October 1, 1991.

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

(a) Criminal acts.

(b) Intentional sexual acts and other intentional torts.

(c) Restraint of trade, anti-trust violations and racketeering.

(d) Defamation.

(e) Employment, religious, racial, sexual, age and other unlawful discrimination.

(f) Pollution resulting in injury to a 3rd party.

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

(h) Incidents occurring while a provider's license to practice is suspended, revoked, surrendered or otherwise terminated.

(i) Criminal and civil fines, forfeitures and other penalties.

(j) Punitive and exemplary damages.

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

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

(m) Liability of others assumed by the insured under a contract or agreement.

(n) Any other exclusion which the commissioner determines is not inconsistent with the coverage required under sub. (2).

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

amount of the deductible or coinsurance from the insured after the insurer's payment obligation is satisfied.

Note: Subsection (2b) applies to all claims made health care liability insurance policies for which certificates have been filed with the patients compensation fund, whether issued before, on or after July 1, 1994.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90; emerg. cr. (2m), eff. 7-1-91; cr. (2m), Register, July, 1991, No. 427, eff. 8-1-91; cr. (2e), Register, September, 1993, No. 453, eff. 10-1-93; cr. (2b), Register, June, 1994, No. 462, eff. 7-1-94.

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 attorney fees, litigation expenses, costs and interest incurred in connection with the settlement or defense of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) Any additional information requested by the office.

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