(f) If an injured person dies and there is a balance in his or her account, the balance shall revert to the insurer or other person responsible for establishing the account.

History: Cr. Register, November, 1976, No. 251, eff. 12-1-76; renum. from Ins 3.37, Register, July, 1979, No. 283, eff. 8-1-79; am. (3), r. (4) (b) and (f), renum. (4) (d), (e), (g) and (h) to be (4) (e) (b), (d) and (f) and am., Register, April, 1984, No. 340, eff. 5-1-84; am. (1), (3) (a) to (c) and (4), r. (2), Register, June, 1990, No. 414, eff. 7-1-90.

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

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

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

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

(3) FINANCIAL REPORTS. The board shall furnish the commissioner with the financial report required by s. 655.27 (4) (d), Stats., within 60 days after the close of each fiscal year. In addition, the board shall furnish the commissioner with quarterly financial reports prepared as of September 30, December 31 and March 31 of each year within 60 days after the close of each reporting period. The board shall prescribe the format for preparing financial reports in accordance with statutory accounting principles for fire and casualty companies. Reserves for reported claims and reserves for incurred but not reported claims shall be maintained on a present value basis with the difference from full value being reported as a contra account to the loss reserve liability. Mediation fund fees collected under s. Ins 17.01 shall be indicated in the financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) DEFINITIONS. In this section:

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

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

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

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

1. Class 1:

Allergy	80254
Allergy (D.O.)	84254
Cardiovascular Disease-no surgery or catheterization	80255
Cardiovascular Disease-no surgery or catheterization (D.O.)	84255
Dermatology-no surgery	80256
Dermatology-no surgery (D.O.)	84256
Endocrinology-no surgery	80238
Endocrinology-no surgery (D.O.)	84238
Family or General Practice-no surgery	80420
Family or General Practice-no surgery (D.O.)	84420
Forensic Medicine-Legal Medicine	80240
Forensic Medicine-Legal Medicine (D.O.)	84240
Gastroenterology-no surgery	80241
Gastroenterology-no surgery (D.O.)	84241
General Preventive Medicine-no surgery	80231
Geriatrics-no surgery	80243
Geriatrics-no surgery (D.O.)	84243
Gynecology-no surgery	80244