CHAPTER 655

HEALTH CARE LIABILITY AND PATIENTS COMPENSATION

SUBCHAPTER I

GENERAL PROVISIONS

655.001 Definitions. In this chapter:

(2) "Claimant" means the person filing a request for mediation under s. 655.44 or 655.445.

(3) "Commissioner" means the commissioner of insurance.

(4) "Department" means the department of health and social services.

(5m) "Director" means the director of state courts.

(7) "Fund" means the patients compensation fund under s. 655.27.

(8) "Health care provider" means a medical or osteopathic physician licensed under ch. 448; a nurse anesthetist licensed or registered under ch. 441; a partnership comprised of such physicians or nurse anesthetists; a corporation organized and operated in this state for the purposes of providing the medical services of physicians or nurse anesthetists; an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 which directly provides services through salaried employes in its own facility; a hospital as defined by s. 50.33 (2) (a) and (c) and any entity operated in this state in connection with one or more hospitals and owned or controlled by the hospital or hospitals when the entity is assisting the hospital or hospitals in providing diagnosis or treatment of, or care for, patients of the hospital or hospitals; or a nursing home as defined by s. 50.01 (3) whose operations are combined as a single entity with a hospital subject to this section, whether or not the nursing home operations are physically separate from hospital operations. It excludes any state, county or municipal employe or federal employe covered under the federal tort claims act, as amended, who is acting within the scope of employment, and any facility exempted by s. 50.39 (3) or operated by any governmental agency, but any state, county or municipal employe or facility so excluded who would otherwise be included in this definition may petition in writing to be afforded the coverage provided by this chapter and upon filing the petition with the commissioner and paying the fee required under s. 655.27 (3) will be subject to this chapter.

(10) "Patient" means an individual who received or should have received health care services from a health care provider or from an employe of a health care provider acting within the scope of his or her employment.

(11) "Permanently practicing in this state" means the full-time or part-time practice in this state of a health care provider's profession for more than 240 hours in any fiscal year beginning each July 1 by a health care provider whose principal place of practice is in this state.

(12) "Representative" means the personal representative, spouse, parent, guardian, attorney or other legal agent of a patient.

(13) "Respondent" means the person alleged to have been negligent in a request for mediation filed under s. 655.44 or 655.445.

History: 1975 c. 37, 79; 1977 c. 26 s. 75; 1977 c. 131; 1977 c. 203 s. 106; Sup. Ct. Order, 88 W (2d) xiii; 1979 c. 124, 185, 355; 1983 a. 189 s. 329 (5); 1985 a. 340.

See note to 655.19, citing State ex rel. Strykowski v. Wilkie, 81 W (2d) 491, 261 NW (2d) 434.

Medical malpractice panels: The Wisconsin approach. Kravat. 61 MLR 55.

Recent developments in Wisconsin medical malpractice law. 1974 WLR 891.

Testing the constitutionality of medical malpractice legislation: The Wisconsin medical malpractice act of 1975. 1977 WLR 838. See also: State ex rel. Strykowski v. Wilkie, 81 W (2d) 491.

655.002 Exemptions. Any physician licensed under ch. 448 may be exempted from ss. 655.23, 655.27 and 655.61 upon petition to the commissioner while a graduate medical student acting within the scope of a resident or fellowship training program. Any such exemption shall not affect the liability of the physician's employer for acts or omissions.

History: 1975 c. 79, 199; 1977 c. 131; 1985 a. 340.

655.003 Rule-making authority. The director, department and commissioner may promulgate such rules under ch. 227 as are necessary to enable them to perform their responsibilities under this chapter.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii.

655.004 Health care provider employes. Any person listed in s. 655.007 having a claim or a derivative claim against a health care provider or an employe of the health care provider, for damages for bodily injury or death due to acts or omissions of the employe of the health care provider acting

within the scope of his or her employment and providing health care services, is subject to this chapter. The fund shall provide coverage, under s. 655.27, for claims against the health care provider or the employe of the health care provider due to the acts or omissions of the employe acting within the scope of his or her employment and providing health care services.

History: 1985 a. 340.

655.005 Remedy. (1) (a) On and after July 24, 1975, every patient, every patient's representative and every health care provider shall be conclusively presumed to have accepted to be bound by this chapter.

(b) Except as otherwise specifically provided in this chapter, this subsection also applies to minors.

(2) This chapter does not apply to injuries or death occurring, or services rendered, prior to July 24, 1975.

History: 1975 c. 37.

655.007 Patients' claims. On and after July 24, 1975, any patient or the patient's representative having a claim or any spouse, parent or child of the patient having a derivative claim for injury or death on account of malpractice is subject to this chapter.

History: 1975 c. 37, 199; 1983 a. 253.

This chapter was inapplicable to third-party claim based on contract where no bodily injury was alleged. Northwest General Hospital v. Yee, 115 W (2d) 59, 339 NW (2d) 583 (1983).

655.009 Actions against health care providers. An action to recover damages on account of malpractice shall comply with the following:

(1) COMPLAINT. The complaint in such action shall not specify the amount of money to which the plaintiff supposes to be entitled.

(2) MEDICAL EXPENSE PAYMENTS. The court or jury, whichever is applicable, shall determine the amounts of medical expense payments previously incurred and for future medical expense payments.

(3) VENUE. Venue in a court action under this chapter is in the county where the claimant resides if the claimant is a resident of this state, or in a county specified in s. 801.50 (2) (a) or (c) if the claimant is not a resident of this state.

History: 1975 c. 37, 198, 199; 1983 a. 253; 1985 a. 340.

655.01 Forms. The director shall prepare and cause to be printed, and upon request furnish free of charge, such forms and materials as the director deems necessary to facilitate or promote the efficient administration of this chapter.

History: 1975 c. 37, 199; Sup. Ct. Order, 88 W (2d) xiii.

655.013 Attorney fees. (1) With respect to any act of malpractice after July 24, 1975, for which a contingency fee arrangement has been entered into before June 14, 1986, the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants is subject to the following unless a new contingency fee arrangement is entered into that complies with subs. (1m) and (1t):

(a) The determination shall not reflect amounts previously paid for medical expenses by the health care provider or the provider's insurer.

(b) The determination shall not reflect payments for future medical expense in excess of $25,000.

(1m) Except as provided in sub. (1t), with respect to any act of malpractice for which a contingency fee arrangement is entered into on and after June 14, 1986, in addition to compensation for the reasonable costs of prosecution of the claim, the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants is subject to the following limitations:

(a) Except as provided in par. (b), 33 1/3% of the first $1,000,000 recovered.

(b) Twenty-five percent of the first $1,000,000 recovered if liability is stipulated within 180 days after the date of filing of the original complaint and not later than 60 days before the first day of trial.

(c) Twenty percent of any amount in excess of $1,000,000 recovered.

(1t) A court may approve attorney fees in excess of the limitations under sub. (1m) upon a showing of exceptional circumstances, including an appeal.

(2) An attorney shall offer to charge any client in a malpractice proceeding or action on a per diem or per hour basis. Any such agreement shall be made at the time of the employment of the attorney. An attorney's fee on a per diem or per hour basis is not subject to the limitations under sub. (1) or (1m).

History: 1975 c. 37, 199; 1985 a. 340.

655.015 Future medical expenses. If a settlement, panel award or judgment under this chapter entered into or rendered before June 14, 1986, provides for future medical expense payments in excess of $25,000, that portion of future medical expense payments in excess of $25,000 shall be paid into the patients compensation fund created under s. 655.27. The commissioner shall develop by rule a system for managing and disbursing those moneys through payments for these expenses. The payments shall be made under the system until either the amount is exhausted or the patient dies.

History: 1975 c. 37; 1977 c. 29; 1979 c. 34, 154; 1983 a. 158; 1985 a. 340.

655.017 Limitation on noneconomic damages. The amount of noneconomic damages recoverable by a claimant or plaintiff under this chapter for acts or omissions of a health care provider if the action is filed on or after June 14, 1986 and before January 1, 1991, and for acts or omissions of an employe of a health care provider, acting within the scope of his or her employment and providing health care services, for actions filed on or after June 14, 1986 and before January 1, 1991, is subject to the limit under s. 893.55 (4).

History: 1985 a. 340.

655.019 Information needed to set fees. The department shall provide the director, the commissioner and the board of governors created under s. 619.04 (3) with information on hospital bed capacity and occupancy rates as needed to set fees under s. 655.27 (3) or 655.61.

History: 1985 a. 340.

SUBCHAPTER III

INSURANCE PROVISIONS

655.23 Limitations of liability; proof of financial responsibility. (1) All health care providers permanently practicing or operating in this state shall pay the yearly assessment into the patients compensation fund under s. 655.27.

(2) Every health care provider permanently practicing or operating in this state shall, once in each year as prescribed by the commissioner, file with the commissioner in a form prescribed by the commissioner, proof of financial responsibility as provided in this section. This requirement does not apply to any health care provider whose insurer files a certificate of insurance under sub. (3) (b). No health care provider who retires or ceases operation after July 24, 1975, shall be eligible for the protection provided under this chapter unless proof of financial responsibility for all claims arising

out of acts of malpractice occurring after July 24, 1975, is provided to the commissioner as required in this section.

(3) (a) Every health care provider permanently practicing or operating in this state either shall insure and keep insured the provider's liability by a policy of insurance issued by an insurer authorized to do business in this state or by an unauthorized nondomestic insurer if the commissioner has found the insurer to be reliable and solid as provided in s. 618.41 (6) (d), shall qualify as a self-insurer, or shall furnish to the commissioner a cash or surety bond in accordance with the requirements of this chapter. Such insurance shall be designated "health care providers' professional liability insurance" and shall, in this section and ss. 655.24 and 655.245, be referred to as "health care liability insurance". The submission of a cash or surety bond, or qualification as a self-insurer, shall be subject to the approval of the commissioner and is valid only when approved by the commissioner.

(b) Each insurance company issuing health care liability insurance that meets the requirements of sub. (4) to any health care provider permanently practicing or operating in this state shall, at the times prescribed by the commissioner, file with the commissioner in a form prescribed by the commissioner a certificate of insurance on behalf of the health care provider upon original issuance and each renewal.

(4) Such health care liability insurance or cash or surety bond shall be in amounts of at least $200,000 for each occurrence and $600,000 per year for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987 and before July 1, 1988, and $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988.

(5) While such health care liability insurance, self-insurance or cash or surety bond approved by the commissioner remains in force, the health care provider, the health care provider's estate and those conducting the health care provider's business, including the health care provider's health care liability insurance carrier, are liable for malpractice for no more than the limits expressed in sub. (4) or the maximum liability limit for which the health care provider is insured, whichever is higher, if the health care provider has met the requirements of this chapter.

(5m) The limits set forth in sub. (5) shall apply to any joint liability of a physician or nurse anesthetist and his or her corporation or partnership under s. 655.001 (8).

(6) Whoever violates this section shall forfeit to the state not more than $1,000 for each violation. Each week of delay in compliance with this section shall constitute a new violation. The commissioner may demand and accept any forfeiture imposed under this section, which shall be paid into the common school fund. The commissioner may cause an action to be commenced to recover the forfeiture in an amount to be determined by the court. Before an action is commenced, the commissioner may compromise the forfeiture; after the action is commenced, the attorney general may compromise the forfeiture.

(7) Health care providers permanently practicing or operating in this state shall comply with this section before exercising any rights or privileges conferred by their health care providers' licenses or certificates of registration. The commissioner shall notify the board or agency issuing such licenses or certificates of registration of each health care provider who has not complied with this section. The examining board or agency issuing such licenses or certificates of registration may suspend, or refuse to issue or to renew the license or certificate of registration of any health care provider violating this section.

History: 1975 c. 37, 79, 199; 1977 c. 131; 1983 a. 158; 1985 a. 340.

Insurer is liable under (5) up to policy limits. Patients Fund v. St. Paul Ins. Co. 116 W (2d) 537, 342 NW (2d) 693 (1984).

655.24 Insurance policy forms. (1) No insurer may enter into or issue any policy of health care liability insurance until its policy form has been submitted to and approved by the commissioner. The filing of a policy form by any insurer with the commissioner for approval shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of all provisions of this chapter, and an agreement by it to be bound hereby as to any policy issued by it to any health care provider.

(2) Every policy issued under this chapter shall be deemed conclusively to provide the following:

(a) That the insurer agrees to pay in full all supplementary expenses incurred in the settlement or defense of any claims and any settlement, arbitration award or judgment imposed against the insured under this chapter up to the limits expressed in s. 655.23 (4), or the maximum liability limit for which the health care provider is insured, whichever is greater; and

(b) That any termination of the policy by cancellation or nonrenewal is not effective as to patients claiming against those covered by the policy unless a written notice complying with sub. (3) and giving the date upon which the termination is to become effective has been received by the insured at least 10 days prior to the taking effect of a cancellation or nonrenewal for nonpayment of premium or for loss of license or certificate of registration and at least 60 days prior to the taking effect of a cancellation or nonrenewal for any other reason.

(3) The notice of cancellation or nonrenewal required under sub. (2) (b) must inform the insured that the insured's license to practice medicine or certificate of registration may be suspended or not renewed if the licensee has no insurance or insufficient insurance. Copies of notices required under sub. (2) (b) shall be retained on file by the insurer for not less than 10 years from the date of mailing or delivery of the notice and furnished to the commissioner upon request.

(4) The insurer shall, upon termination of a policy of health care liability insurance issued under this chapter by cancellation or nonrenewal, notify the commissioner of the termination.

History: 1975 c. 37; 1977 c. 131; 1985 a. 340.

655.245 Insurance policy limitations. (1) No policy of health care liability insurance may permit a health care provider to reject any settlement agreed upon between the claimant and the insurer.

(2) A policy of health care liability insurance may permit the insurer to make payments for medical expenses prior to any determination of fault. Such payments are not an admission of fault. Such payments may be deducted from any judgment or arbitration award, but shall not be repaid regardless of the judgment or award. Nothing in this subsection shall restrict the insurer's right of comparative contribution or indemnity in accordance with the laws of this state.

History: 1975 c. 37.

655.25 Availability and effectiveness for health care liability insurance. (1) No policy of health care liability insurance written under the provisions of s. 619.04 may be canceled or nonrenewed except for nonpayment of premiums unless the health care provider's license is revoked by the appropriate licensing board. A health care provider whose

license is revoked shall be permitted to buy out in cases of a claims-made policy.

History: 1975 c. 37.

655.26 Reports on claims paid. (1) Beginning on February 15, 1986, and thereafter, in addition to any information required by the commissioner under s. 601.42, by the 15th day of each month, a health care provider liability insurer shall report the following information to the medical examining board and the board of governors for the fund established under s. 619.04 (3) on each claim paid by the insurer during the previous month for damages arising out of the rendering of health care services by a health care provider or an employe of a health care provider:

(a) The health care provider's name and address.

(b) Whether the health care provider is a medical or osteopathic physician, a nurse anesthetist, a partnership, a corporation, an operational cooperative sickness care plan, a hospital or a nursing home.

(c) The health care provider's medical specialty, if the provider is a physician.

(d) A description of the injury, including its cause and severity.

(e) Whether the claim was paid as a result of a settlement, a patients compensation panel award or a court award.

(f) The amount of the payment.

(g) The number and amounts of any previous claims paid by the insurer for damages arising out of the rendering of health care services by the health care provider or the provider's employes. Only claims paid on or after July 20, 1985, are required to be reported under this paragraph.

(h) Any additional information requested by the medical examining board or the board of governors.

(2) Beginning on February 15, 1986, and thereafter, by the 15th day of each month, the board of governors for the fund shall report the information specified in sub. (1) to the medical examining board for each claim paid by the fund during the previous month for damages arising out of the rendering of health care services by a health care provider or an employe of a health care provider.

(3) If more than one payment will be made on a claim, the first report filed under sub. (1) or (2) after the first payment is made on the claim shall include the total amount of the award or settlement and the projected schedule and amounts of payments.

(4) Any person who in good faith provides information to the medical examining board or the board of governors under this section is immune from civil liability for his or her acts or omissions in providing such information.

History: 1985 a. 29, 340.

SUBCHAPTER IV

PATIENTS COMPENSATION FUND

655.27 Patients compensation fund. (1) FUND. There is created a patients compensation fund for the purpose of paying that portion of a medical malpractice claim which is in excess of the limits expressed in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). The fund shall provide occurrence coverage for health care providers permanently practicing or operating in this state. The fund shall be liable only for payment of claims against health care providers permanently practicing or operating in this state who have complied with this chapter and reasonable and necessary expenses incurred in payment of claims and fund administrative expenses. The coverage provided by the fund shall begin July 1, 1975. The fund shall not be liable for damages for injury or death caused by an intentional crime, as defined under s. 939.12, committed by a health care provider or an employe of a health care provider, whether or not the criminal conduct is the basis for a medical malpractice claim.

(1m) PEER REVIEW ACTIVITIES. (a) The fund shall pay that portion of a claim described in par. (b) against a health care provider that exceeds the limit expressed in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater.

(b) A health care provider who engages in the activities described in s. 146.37 (1) and (3) shall be liable for not more than the limits expressed under s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, if he or she is found to be liable under s. 146.37, and the fund shall pay the excess amount, unless the health care provider is found not to have acted in good faith during those activities and the failure to act in good faith is found by the trier of fact, by clear and convincing evidence, to be both malicious and intentional.

(2) FUND ADMINISTRATION AND OPERATION. Management of the fund shall be vested with the board of governors under s. 619.04 (3). The commissioner shall either provide staff services necessary for the operation of the fund or, with the approval of the board of governors, contract for all or part of these services. Such a contract is subject to s. 16.765, but is otherwise exempt from subch. IV of ch. 16. The commissioner shall adopt rules governing the procedures for creating and implementing these contracts before entering into the contracts. At least annually, the contractor shall report to the commissioner and to the board of governors regarding all expenses incurred and subcontracting arrangements. If the board of governors approves, the contractor may hire legal counsel as needed to provide staff services. The cost of contracting for staff services shall be funded from the appropriation under s. 20.145 (2) (u).

(3) FEES. (a) *Assessment.* Each health care provider permanently practicing or operating in this state shall pay operating fees, which, subject to pars. (b) to (br), shall be assessed based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice.

2. The past and prospective loss and expense experience of the fund.

2m. The loss and expense experience of the individual health care provider which resulted in the payment of money, from the fund or other sources, for damages arising out of the rendering of medical care by the health care provider or an employe of the health care provider, except that an adjustment to a health care provider's fees may not be made under this subdivision prior to the receipt of the recommendation of the patients compensation fund peer review council under s. 655.275 (5) (a) and the expiration of the time period provided, under s. 655.275 (7), for the health care provider to comment or prior to the expiration of the time period under s. 655.275 (5) (a).

3. Risk factors for persons who are semiretired or part-time professionals.

(am) *Assessments for peer review council.* The fund, a mandatory health care liability risk sharing plan established under s. 619.04 and a private medical malpractice insurer shall be assessed, as appropriate, fees sufficient to cover the costs of the patients compensation fund peer review council, including costs of administration, for reviewing claims paid by the fund, plan and insurer, respectively, under s. 655.275

(5). The fees shall be set by the commissioner by rule, after approval by the board of governors, and shall be collected by the commissioner for deposit in the fund. The costs of the patients compensation fund peer review council shall be funded from the appropriation under s. 20.145 (2) (um).

(b) *Fees established.* 1. The commissioner, after approval by the board of governors, shall by rule set the fees under par. (a). The rule shall provide that fees may be paid annually or in semiannual or quarterly instalments. In addition to the prorated portion of the annual fee, semiannual and quarterly instalments shall include an amount sufficient to cover interest not earned and administrative costs incurred because the fees were not paid on an annual basis. This paragraph does not impose liability on the board of governors for payment of any part of a fund deficit.

2. With respect to fees paid by medical and osteopathic physicians licensed under ch. 448, commencing with fees assessed for the fiscal year commencing July 1, 1986, the rule shall provide for not more than 4 payment classifications, based upon the amount of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed.

(bg) *Fee increase.* 1. Every rule under par. (b) shall provide for an automatic increase in a health care provider's fees, except as provided in subd. 2, if the loss and expense experience of the fund and other sources with respect to the health care provider or an employe of the health care provider exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, both as established in the rule. The rule shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of awards in excess of the respective thresholds.

2. The rule shall provide that the automatic increase does not apply if the board determines that the performance of the patients compensation fund peer review council in making recommendations under s. 655.275 (5) (a) adequately addresses the consideration set forth in par. (a) 2m.

(br) *Limit on fees.* Every rule setting fees for a particular fiscal year under par. (b) shall ensure that the fees assessed do not exceed the greatest of the following:

1. The estimated total dollar amount of claims to be paid during that particular fiscal year.

2. The fees assessed for the fiscal year preceding that particular fiscal year, adjusted by the commissioner of insurance to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor.

3. Two hundred percent of the estimated total dollar amount of claims paid during the fiscal year preceding that particular fiscal year.

(c) *Collection and deposit of fees.* Fees under pars. (a) and (b) and future medical expense payments specified for the fund by a settlement, panel award or judgment entered into or rendered before June 14, 1986, shall be collected by the commissioner for deposit into the fund in a manner prescribed by the commissioner by rule.

(d) *Rule not effective; fees.* If the rule establishing fees under par. (b) does not take effect prior to June 2 of any fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the rule subsequently takes effect, the balance for the fiscal year shall be collected or refunded or the remaining semiannual or quarterly instalment payments shall be adjusted except the commissioner may elect not to collect, refund or adjust for minimal amounts.

(e) *Podiatrist fees.* The commissioner, after approval by the board of governors, may by rule assess fees against podiatrists for the purpose of paying the fund's portion of medical malpractice claims and expenses resulting from claims against podiatrists based on occurrences before July 1, 1986.

(4) FUND ACCOUNTING AND AUDIT. (a) Moneys shall be withdrawn from the fund by the commissioner only upon vouchers approved and authorized by the board of governors.

(b) All books, records and audits of the fund shall be open to the general public for reasonable inspection, with the exception of confidential claims information.

(c) Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

(d) Annually after the close of a fiscal year, the board of governors shall furnish a financial report to the commissioner. The report shall be prepared in accordance with accepted accounting procedures and shall include the present value of all claims reserves, including those for incurred but not reported claims as determined by accepted actuarial principles, and such other information as may be required by the commissioner. The board of governors shall furnish an appropriate summary of this report to all fund participants.

(e) Moneys held in the fund shall be invested in short-term fixed return interest-bearing investments by the board of governors through the state investment board. All income derived from such investments shall be credited to the fund.

(f) The board of governors shall submit a functional and progress report to the appropriate committees on insurance and health in both houses of the legislature on or before March 1 of each year.

(g) The board of governors may cede reinsurance to an insurer authorized to do business in this state under ch. 611, 613, 614 or 618 or pursue other loss funding management to preserve the solvency and integrity of the fund, subject to approval by the commissioner. The commissioner may prescribe controls over or other conditions on such use of reinsurance or other loss-funding management mechanisms.

(5) CLAIMS PROCEDURES. (a) 1. Any person may file a claim for damages arising out of the rendering of medical care or services or participation in peer review activities under s. 146.37 within this state against a health care provider covered under the fund. A person filing a claim may only recover from the fund if the fund is named as a party in the controversy.

2. Any person may file an action for damages arising out of the rendering of medical care or services or participation in peer review activities under s. 146.37 outside this state against a health care provider covered under the fund. A person filing an action may only recover from the fund if the fund is named as a party in the action or, if the rules of procedure of the jurisdiction in which the action is brought do not permit including the fund as a party, if the fund is notified of the action within 60 days of service of process on the health care provider. The board of governors may extend this time limit if it finds that enforcement of the time limit would be prejudicial to the purposes of the fund and would benefit neither insureds nor claimants.

3. If after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages paid will exceed the limits in s. 655.23 (4), the fund may appear and actively defend itself when named as a party in the controversy. In such action, the fund may retain counsel and pay out of the fund attorney fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or

employed by the board of governors to perform legal services for the board of governors other than those directly connected with the fund. Any judgment affecting the fund may be appealed as provided by law. The fund may not be required to file any undertaking in any judicial action, proceeding or appeal.

(b) It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed that may potentially affect the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding an amount which could require payment by the fund may be agreed to unless approved by the board of governors.

(c) It shall be the responsibility of any health care provider choosing to post bond or establish an escrow account under this chapter to provide an adequate defense on any malpractice claim filed or any claim filed under sub. (1m) that may potentially affect the fund. The health care provider shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding an amount which could require payment by the fund may be agreed to unless approved by the board of governors.

(d) A person who has recovered a final judgment or a settlement approved by the board of governors against a health care provider who is covered by the fund may file a claim with the board of governors to recover that portion of such judgment or settlement which is in excess of the limits in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater. In the event the fund incurs liability exceeding $1,000,000 to any person under a single claim as the result of a settlement, panel award or judgment entered into or rendered under this chapter before June 14, 1986, the fund shall pay not more than $500,000 per year. Payments shall be made from money collected and paid into the fund under sub. (3) and from interest earned thereon. For claims subject to the $500,000 limit, payments shall be made until the claim has been paid in full, and any attorney fees in connection with such claim shall be similarly prorated. Payment of not more than $500,000 per year includes direct or indirect payment or commitment of moneys to or on behalf of any person under a single claim by any funding mechanism. No interest may be paid by the fund on the unpaid portion of any claim filed under this paragraph, except as provided under s. 807.01 (4), 814.04 (4) or 815.05 (8).

(e) Claims filed against the fund shall be paid in the order received within 90 days after filing unless appealed by the fund. If the amounts in the fund are not sufficient to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

(6) INTEGRITY OF FUND. The fund shall be held in trust for the purposes of this chapter and may not be used for purposes other than those of this chapter.

(7) ACTIONS AGAINST INSURERS OR PROVIDERS. The board may bring an action against an insurer or health care provider for failure to act in good faith or breach of fiduciary responsibility under sub. (5) (b) or (c).

History: 1975 c. 37, 79, 199; 1977 c. 29, 131; 1979 c. 34, 194; 1981 c. 20; 1983 a. 27, 158; 1985 a. 340.

655.275 Patients compensation fund peer review council. **(1)** DEFINITION. In this section, "council" means the patients compensation fund peer review council.

(2) APPOINTMENT. The board of governors established under s. 619.04 (3) shall appoint the members of the council. Section 15.09, except s. 15.09 (4) and (8), does not apply to the council. The board of governors shall designate the chairperson, vice chairperson and secretary of the council and the terms to be served by council members. The council shall consist of 5 persons, not more than 3 of whom are physicians who are actively engaged in the practice of medicine in this state. The chairperson shall be a physician and shall serve as an ex officio nonvoting member of the medical examining board.

(3) MEETINGS. The council shall meet at the call of the chairperson of the board of governors or the chairperson of the council. The council shall meet at the location determined by the person calling the meeting.

(4) REPORTS. The council shall submit to the chairperson of the board of governors, upon request of the chairperson but not more often than annually, a report on the operation of the council.

(5) DUTIES. (a) The council shall review, within one year of the date of first payment on the claim, each claim that is paid by the patients compensation fund established under s. 655.27, a mandatory health care liability risk sharing plan established under s. 619.04 or private medical malpractice insurers for damages arising out of the rendering of medical care by a health care provider or an employe of the health care provider and shall make recommendations to all of the following:

1. The insurance commissioner and the board of governors regarding any adjustments to be made, under s. 655.27 (3) (a) 2m, to patients compensation fund fees assessed against the health care provider based on the paid claim.

2. The insurance commissioner and the board of governors regarding any adjustments to be made, under s. 619.04 (5) (b), to premiums assessed against a physician under a mandatory health care liability risk sharing plan established under s. 619.04, based on the paid claim.

3. A private medical malpractice insurer regarding adjustments to premiums assessed against a physician covered by private insurance, based on the paid claim, if requested by the private insurer.

(b) In developing recommendations under par. (a), the council may consult with any person and shall consult with the following:

1. If a claim was paid for damages arising out of the rendering of care by a physician, with at least one physician from the area of medical specialty of the physician who rendered the care and with at least one physician from the area of medical specialty of the medical procedure involved, if the specialty area of the procedure is different than the specialty area of the physician who rendered the care.

2. If a claim was paid for damages arising out of the rendering of care by a nurse anesthetist, with at least one nurse anesthetist.

(6) FEES. Fees sufficient to cover the council's costs, including costs of administration, shall be collected under s. 655.27 (3) (am).

(7) NOTICE OF RECOMMENDATION. The council shall notify the affected health care provider, in writing, of its recommendations to the commissioner, the board of governors or a private insurer made under sub. (5). The notice shall inform the health care provider that the health care provider may submit written comments on the council's recommendations to the commissioner, the board of governors or the private insurer within a reasonable period of time specified in the notice.

(8) PATIENT RECORDS. The council may obtain any information relating to any claim it reviews under this section that is in the possession of the commissioner or the board of governors. The council shall keep patient health care information confidential as required by s. 146.82 (2) (b).

(9) IMMUNITY; LIABILITY COVERAGE. Sections 146.37 and 655.27 (1m) apply to a member of the council or any person consulting with a council under sub. (5) (b).

(10) MEMBERS' AND CONSULTANTS' EXPENSES. Any person serving on the council and any person consulting with the council under sub. (5) (b) shall be paid $50 for each day's actual attendance at council meetings, plus actual and necessary travel expenses.

History: 1985 a. 340.

NOTE: Subchapter V (title), patients compensation panels fund, is not shown as 1985 Wis. Act 340 repealed s. 655.28, the only section in the subchapter.

SUBCHAPTER VI

MEDIATION SYSTEM

655.42 Establishment of mediation system. (1) LEGISLATIVE INTENT. The legislature intends that the mediation system provide the persons under sub. (2) with an informal, inexpensive and expedient means for resolving disputes without litigation and intends that the director administer the mediation system accordingly.

(2) MEDIATION SYSTEM. The director shall establish a mediation system complying with this subchapter not later than September 1, 1986. The mediation system shall consist of mediation panels that assist in the resolution of disputes, regarding medical malpractice, between patients, their representatives, spouses, parents or children and health care providers.

History: 1985 a. 340.

655.43 Mediation requirement. The claimant and all respondents named in a request for mediation filed under s. 655.44 or 655.445 shall participate in mediation under this subchapter.

History: 1985 a. 340.

655.44 Request for mediation prior to court action. (1) REQUEST AND FEE. Beginning September 1, 1986, any person listed in s. 655.007 having a claim or a derivative claim under this chapter for bodily injury or death because of a tort or breach of contract based on professional services rendered or that should have been rendered by a health care provider may file a request for mediation and shall pay the fee under s. 655.54.

(2) CONTENT OF REQUEST. The request for mediation shall be in writing and shall include all of the following information:

(a) The claimant's name and city, village or town, county and state of residence.

(b) The name of the patient.

(c) The name and address of the health care provider alleged to have been negligent in treating the patient.

(d) The condition or disease for which the health care provider was treating the patient when the alleged negligence occurred and the dates of treatment.

(e) A brief description of the injury alleged to have been caused by the health care provider's negligence.

(3) DELIVERY OR REGISTERED MAIL. The request for mediation shall be delivered in person or sent by registered mail to the director.

(4) STATUTE OF LIMITATIONS. Any applicable statute of limitations is tolled on the date the director receives the request for mediation if delivered in person or on the date of mailing if sent by registered mail. The statute remains tolled until 30 days after the last day of the mediation period under s. 655.465 (7).

(5) NO COURT ACTION COMMENCED BEFORE MEDIATION. Except as provided in s. 655.445, no court action may be commenced unless a request for mediation has been filed under this section and until the expiration of the mediation period under s. 655.465 (7).

(6) NOTICE OF COURT ACTION TO DIRECTOR. A claimant who files a request for mediation under this section and who commences a court action after the expiration of the mediation period under s. 655.465 (7) shall send notice of the court action by 1st class mail to the director.

History: 1985 a. 340.

655.445 Request for mediation in conjunction with court action. (1) COMMENCING ACTION, REQUEST AND FEE. Beginning September 1, 1986, any person listed in s. 655.007 having a claim or a derivative claim under this chapter for bodily injury or death because of a tort or breach of contract based on professional services rendered or that should have been rendered by a health care provider shall, within 15 days after the date of filing an action in court, file a request for mediation. The request shall be prepared and delivered in person or sent by registered mail to the director, in the form and manner required under s. 655.44 (2) and (3), together with a notice that a court action has been commenced and the fee under s. 655.54 shall be paid.

(2) SCHEDULING. All time periods under s. 802.10 (2) and (3) (a) and (b) are tolled on the date of filing the court action. The time periods remain tolled until the expiration of the mediation period under s. 655.465 (7).

(3) NO COURT PROCEEDINGS BEFORE MEDIATION. For actions filed under sub. (1), no discovery may be made and no trial, pretrial conference or scheduling conference may be held until the expiration of the mediation period under s. 655.465 (7).

History: 1985 a. 340.

655.45 Reports to licensing bodies. (1) For the quarter beginning on July 1, 1986, and for each quarter thereafter, the director shall file reports complying with sub. (2) with the medical examining board, the board of nursing and the department, respectively, regarding health care providers licensed by the respective bodies.

(2) The reports under sub. (1) shall set forth all of the following:

(a) The names of all health care providers who are named as defendants in court actions of which the director receives notice under s. 655.44 (6) or 655.445 (1) during the quarter.

(b) Whether any court action of which the director received notice under s. 655.44 (6) or 655.445 (1) was disposed of by settlement, compromise, stipulation agreement, dismissal default or judgment during the quarter and the amount of the settlement or award to the claimant, if any, to the extent the director has any of the information under this paragraph.

History: 1985 a. 340.

655.455 Notice to health care providers. The director shall serve notice of a request for mediation upon all health care providers named in the request, at the respective addresses provided in the request, by registered mail within 7 days after the director receives the request if delivered in person or within 10 days after the date of mailing of the request to the director if sent by registered mail.

History: 1985 a. 340.

655.465 Mediation panels; mediation period. (1) MEDIATION PANEL FOR DISPUTE. The director shall appoint the mem-

bers of a mediation panel under sub. (2) and send notice to the claimant and all respondents by registered mail. The notice shall inform the claimant and all respondents of the names of the persons appointed to the mediation panel and the date, time and place of the mediation session. The director may change the date, time or place of the mediation session as necessary to accommodate the parties, subject to the requirement that the mediation session be held before the expiration of the mediation period under sub. (7).

(2) APPOINTMENT OF MEDIATORS. Each mediation panel shall consist of the following members appointed by the director:

(a) One public member who is neither an attorney nor a health care provider and who is selected from a list of public member mediators prepared every 2 years, or more frequently upon request of the director, by the governor or, if any person resigns or is unable to serve as a public member mediator, from a list of alternates prepared by the director.

(b) One attorney who is licensed to practice law in this state.

(c) One health care provider as follows:

1. Except as provided in subds. 4 and 5, if all respondents named in the request for mediation are physicians, a physician who is licensed to practice in this state and who is selected from a list prepared by a statewide organization of physicians designated by the director.

2. Except as provided in subds. 4 and 5, if none of the respondents named in the request for mediation is a physician, a health care provider who is licensed to practice in this state in the same health care field as the respondent and who is selected from a list prepared by the department or the examining board that regulates health care providers in that health care field.

3. Except as provided in subds. 4 and 5, if more than one respondent is named in the request for mediation at least one of whom is a physician and at least one of whom is not, a health care provider who is licensed to practice in this state and who is selected from the list under subd. 1 or 2, as determined by the director.

4. If the director determines that a list under subd. 1 or 2 is inadequate to permit the selection of an appropriate health care provider, a health care provider who is licensed to practice in this state and who is selected from an additional list prepared by the director.

5. If the director determines that lists under subds. 1 or 2 and 4 are inadequate to permit the selection of an appropriate health care provider for a particular dispute, a health care provider who is licensed to practice in this state and who is selected by the director.

(3) FILLING VACANCIES. If a person appointed to a mediation panel under sub. (1) resigns from or is unable to serve on the mediation panel, the director shall appoint a replacement selected in the same manner as the predecessor appointee.

(4) CONFLICT OF INTEREST. No person may serve on a mediation panel if the person has a professional or personal interest in the dispute.

(5) COMPENSATION. Each mediator shall be compensated $150 plus actual and necessary expenses for each day of mediation conducted. Compensation and expenses shall to be paid out of the appropriation under s. 20.680 (2) (qm) upon such authorizations as the director may prescribe.

(6) IMMUNITY AND PRESUMPTION OF GOOD FAITH. (a) A mediator is immune from civil liability for any good faith act or omission within the scope of the mediator's performance of his or her powers and duties under this subchapter.

(b) It is presumed that every act or omission under par. (a) is a good faith act or omission. This presumption may be overcome only by clear and convincing evidence.

(7) MEDIATION PERIOD. The period for mediation shall expire 90 days after the director receives a request for mediation if delivered in person or within 93 days after the date of mailing of the request to the director if sent by registered mail, or within a longer period agreed to by the claimant and all respondents and specified by them in writing for purposes of applying ss. 655.44 (4) and (5) and 655.445 (3).

History: 1985 a. 340.

655.54 Filing fee. Requests for mediation filed with the director are subject to a filing fee of $11. The filing fee shall be paid into the mediation fund under s. 655.68.

History: 1985 a. 340.

655.58 Mediation procedure. (1) NO RECORD. Mediation shall be conducted without a stenographic record or any other transcript.

(2) NO EXAMS, SUBPOENAS, OATHS. No physical examinations or production of records may be ordered, no witnesses may be subpoenaed and no oaths may be administered in mediation, whether by a mediation panel or member thereof or as a result of application to a court by any person.

(3) NO EXPERT WITNESSES; PANEL CONSULTANTS PERMITTED. (a) Except as provided in par. (b), no expert witnesses, opinions or reports may be submitted or otherwise used in mediation.

(b) The mediation panel or any member thereof may consult with any expert, and upon authorization of the director may compensate the expert from the appropriation under s. 20.680 (2) (qm).

(4) PATIENT RECORDS CONFIDENTIAL EXCEPT TO PARTIES. All patient health care records in the possession of a mediation panel shall be kept confidential by all members of the mediation panel and all other persons participating in mediation. Every person participating in mediation shall make available to one another and all members of the mediation panel all patient health care records of the patient named in the request for mediation that are in the person's possession.

(5) COUNSEL PERMITTED. Any person participating in mediation may be represented by counsel authorized to act for his or her respective client.

History: 1985 a. 340.

655.59 Inadmissibility. Filings under ss. 655.44 and 655.445 are not admissible in any court action. No statement or expression of opinion made in the course of a mediation session is admissible, either as an admission or otherwise, in any court action.

History: 1985 a. 340.

655.61 Funding. (1) The mediation fund created under s. 655.68 shall be financed from fees charged to health care providers. The director shall, by February 1 annually, determine the revenues needed for the operation of the mediation system during the succeeding fiscal year and inform the board of governors created under s. 619.04 (3) of that amount. The board of governors shall, by rule, set fees to charge health care providers at a level sufficient to provide these revenues. The board shall charge each health care provider permanently practicing in this state an annual fee and shall charge each hospital an annual fee per occupied bed.

(2) The annual fees under sub. (1) shall be collected in a manner prescribed by rule of the commissioner. The commis-

sioner shall pay all money collected under sub. (1) into the mediation fund created under s. 655.68.

History: 1985 a. 340.

SUBCHAPTER VII

MEDIATION FUND

655.68 Mediation fund. (1) CREATION OF THE FUND. There is created a mediation fund to pay the administrative expenses of the mediation system created under subch. VI.

(2) FUND ADMINISTRATION AND OPERATION. Management of the fund is vested with the director.

(3) FEES. The fund is financed from fees generated under ss. 655.54 and 655.61.

(4) FUND ACCOUNTING AND FINANCIAL REPORTS. (a) Any person authorized to receive deposits, withdraw moneys, issue vouchers or otherwise disburse fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of the bond shall be paid from the fund.

(b) The state investment board shall invest money held in the fund in short-term, fixed-return, interest-bearing investments. All income derived from these investments returns to the fund.

(c) The director shall submit a report on the operation of the mediation system and on the status of the fund to the presiding officer of each house of the legislature on or before March 1 annually.

History: 1985 a. 340.