(c) For resident physicians and surgeons who practice outside residency or fellowship:

All classes	$1,397.00

(d) For Medical College of Wisconsin full time faculty:

Class 1	$ 741.00	Class 5	$3,815.00
Class 2	1,484.00	Class 6	4,579.00
Class 3	1,908.00	Class 7	5,343.00
Class 4	2,290.00	Class 9	8,014.00

(e) For Medical College of Wisconsin resident physicians and surgeons:

1.	Class 1	$ 904.00	Class 5	$4,653.00
	Class 2	1,809.00	Class 6	5,584.00
	Class 3	2,328.00	Class 7	6,515.00
	Class 4	2,793.00	Class 9	9,774.00

2. The assessment paid by medical college of Wisconsin shall be determined by multiplying the resident class fee by the number of resident physician exposures in that class as determined by audit by the primary insurance carrier.

3. Initial assessments, payable on issuance of the policy, shall be computed on the basis of the number of exposures per class during the prior participation period. Final assessments, payable at the end of the policy period, shall be the initial assessment adjusted for actual physician exposures during the participation period as determined by audit by the primary insurance carrier.

(f) For government employes—state, federal, municipal:

Class 1	$1,357.00	Class 6	$8,377.00
Class 2	2,713.00	Class 7	9,774.00
Class 3	3,490.00	Class 8	678.00
Class 4	4,188.00	Class 9	14,659.00
Class 5	6,981.00		

(g) For retired or part time physicians and surgeons with an office practice only and no hospital admissions who practice less than 500 hours per year:

Class 1	Physicians	$1,085.00
Class 8	Osteopathic physicians	543.00

(h) For nurse anesthetists $ 542.00

(i) For podiatrists, nonsurgical $ 459.00
For podiatrists, surgical $2,578.00

For retired or part time podiatrists, nonsurgical office practice only, less than 500 hours practice per annum $ 276.00

For residents in post graduate podiatric medical education $1,547.00

(j) For hospitals—per occupied bed $154.00

(k) For nursing homes—per occupied bed $ 29.00

(7) COLLECTION OF FEES. In the event that the effective date for the rule establishing the fees for fiscal year 1985-1986 does not take effect prior to June 2, 1985, (a) for all health care providers permanently practicing or operating in the state on July 1, 1985, the commissioner shall

1. On July 1, 1985, or as soon as feasible thereafter, bill health care providers for the fees assessed for fiscal year 1984-1985 for the provider's particular class;

2. On January 1, 1986, or as soon as feasible thereafter, bill all health care providers except podiatrists one-half the difference between the fee assessment for the provider's particular class for fiscal year 1985-1986 and the fee assessment for the provider's class for fiscal year 1984-1985;

3. On April 1, 1986, or as soon as feasible thereafter, bill all health care providers except podiatrists one-half the difference between the fee assessment for the provider's particular class for fiscal year 1985-1986 and the fee assessment for the provider's class for fiscal year 1984-1985.

4. Include with the January 1, 1986, and the April 1, 1986, billing statements a fee assessment for one-half the interest the Fund could reasonably have expected to earn had the fee assessment for 1985-1986 been paid in total at the beginning of the fiscal year. The rate of interest shall be the average annualized rate earned by the Fund for the preceding fiscal year as determined by the state Investment Board;

5. Include with the January 1, 1986, and the April 1, 1986, billing statements a fee assessment for one-half the health care provider's share of the administrative expense incurred by the Fund during fiscal year 1985-1986 to develop and administer a three part payment system. The administrative expenses shall be apportioned on an equal basis to all providers who are practicing or operating on December 31, 1985.

(b) No refunds due to changes in classification shall be given to health care providers until after January 1, 1986. Refunds due to death, retirement, or change of residence shall be determined on a pro rata basis of the fee assessments for fiscal year 1985-1986.

(c) Health care providers except podiatrists who begin practicing or operating at any time after July 1, 1985, and before December 31, 1985, shall be assessed and shall pay in one sum the pro-rata fee subject to sub. (4) for fiscal year 1985-1986 from the date the provider begins practicing or operating through December 31, 1985. On January 1, 1986, and again on April 1, 1986, or as soon as possible thereafter, the commissioner shall bill all health care providers except podiatrists who entered the Fund after July 1, 1985, one-fourth of the fee assessment for fiscal year 1985-1986. Interest shall be assessed in accordance with par. (a) 4. An administrative fee assessment shall be assessed in accordance with par. (a) 5.

(d) Health care providers who begin practicing or operating at any time after January 1, 1986, and before June 30, 1986, shall be assessed and shall pay in one sum the pro-rata fee subject to sub. (4) for fiscal year 1985-1986 from the date the provider begins practicing or operating through June 30, 1986.

(e) Podiatrists who begin operating or practicing at any time after July 1, 1985 and before June 30, 1986 shall be assessed and shall pay in

one sum the pro rata fee subject to sub. (4) for fiscal year 1984-1985 for the podiatrist's classification.

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.

Ins 17.29 Servicing agent. (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (2), Stats., relating to contracting for patients compensation fund services.

(2) SCOPE. This section applies to adminstration and staff services for the fund.

(3) SELECTION. The selection of a servicing agent shall conform with s. 16.765, Stats. The commissioner, with the approval of the board, shall select a servicing agent through the competitive negotiation process to provide services for the fund based on criteria established by the board.

(4) TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS. The term served by the servicing agent shall be as established by the commissioner with the approval of the board but the contract shall include a provision for its cancellation if performance or delivery is not made in accordance with its terms and conditions.

(5) FUNCTIONS. (a) The servicing agent shall perform functions agreed to in the contract between the servicing agent and the office of the commissioner of insurance as approved by the board. The contract shall provide for an annual report to the commissioner and board of all expenses incurred and subcontracting arrangements.

(b) Additional functions to be performed by the servicing agent may include but are not limited to:

1. Hiring legal counsel.

2. Establishment and revision of case reserves.

3. Contracting for annuity payments as part of structured settlements.

4. Investigation and evaluation of claims.

5. Negotiation to settlement of all claims made against the fund except those responsibilities retained by the claim committee of the board.

6. Filing of reports to the board.

7. Review of panel decisions and court verdicts and recommendations of appeals as needed.

History: Cr. Register, February, 1984, No. 338, eff. 3-1-84.

(a) The formula for determining the prevailing charge in the locality where the service is provided shall be developed by the administering carrier and approved by the board.

(b) The medical necessity of the service shall be determined by the administering carrier and shall be subject to board review under the grievance procedures established by the board under s. 619.15 (3) (a), Stats.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) Premiums, deductibles and coinsurance shall conform with ss. 619.14 (5) and 619.17, Stats.

(b) 1. The schedule of premiums, based on data compiled from the health insurance industry, shall be as follows:

Major Medical Plan

Male Age Group	Annual	Semi-annual	Quarterly
	Zone 1		
0-18	$ 752.00	$ 376.00	$188.00
19-29	752.00	376.00	188.00
30-39	912.00	456.00	228.00
40-44	1,104.00	552.00	276.00
45-49	1,352.00	676.00	338.00
50-54	1,628.00	814.00	407.00
55-59	1,980.00	990.00	495.00
60-64	2,376.00	1,188.00	594.00
	Zone 2		
0-18	$ 640.00	$320.00	$160.00
19-29	640.00	320.00	160.00
30-39	776.00	388.00	194.00
40-44	940.00	470.00	235.00
45-49	1,148.00	574.00	287.00
50-54	1,384.00	692.00	346.00
55-59	1,684.00	842.00	421.00
60-64	2,020.00	1,010.00	505.00

Female Age Group	Annual	Semi-annual	Quarterly
	Zone 1		
0-18	$ 752.00	$376.00	$188.00
19-29	1,152.00	576.00	288.00
30-39	1,324.00	662.00	331.00
40-44	1,464.00	732.00	366.00
45-49	1,576.00	788.00	394.00
50-54	1,712.00	856.00	428.00
55-59	1,844.00	922.00	461.00
60-64	2,116.00	1,058.00	529.00

Zone 2

0-18	$ 640.00	$320.00	$160.00
19-29	980.00	490.00	245.00
30-39	1,124.00	562.00	281.00
40-44	1,244.00	622.00	311.00
45-49	1,340.00	670.00	335.00
50-54	1,456.00	728.00	364.00
55-59	1,568.00	784.00	392.00
60-64	1,800.00	900.00	450.00

Medicare Plan

	Annual	Semi-annual	Quarterly
	Zone 1		
All Policyholders	$1,032.00	$516.00	$258.00
	Zone 2		
All Policyholders	$876.00	$438.00	$219.00

2. For the purposes of this paragraph, Zone 1 shall contain all of the Wisconsin postal zip codes whose first 3 digits are: 530, 531, 532, 534, 537, 540 and 547. Zone 2 shall contain all other Wisconsin postal zip code areas.

(c) Premiums shall be set by rule by the commissioner, based on all available data, including industry experience and actual plan experience. The commissioner shall have on file an actuarial report detailing the process whereby rates were determined.

(d) The annual report of the board to standing committees of the legislature required by s. 619.15 (2), Stats., and Ins 18.08 (2) shall include a section describing premium rate setting in detail. In order to fulfill this requirement, the board may appoint an actuarial committee under the powers granted to the board in s. 619.15 (5) and Ins 18.08 (3) (d) and (e).

(6) PRE-EXISTING CONDITIONS. Pre-existing conditions limitations shall conform with s. 619.14 (6), Stats. Determinations of what constitutes a pre-existing condition shall be made by the administering carrier and shall be subject to board review under the grievance procedures established by the board under s. 619.15 (3) (a), Stats.

(7) COORDINATION OF BENEFITS. There shall be coordination of benefits as provided in s. 619.14 (7), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.; r. and recr. (5) (b), Register, June, 1982, No. 318, eff. 7-1-82; r. and recr. (5) (b), Register, December, 1983, No. 336, eff. 1-1-84; r. and recr. (5) (b) 1., Register, December, 1984, No. 348, eff. 1-1-85.

Ins 18.08 Board of governors. The board shall be appointed and shall operate pursuant to s. 619.15, Stats.

(1) BOARD APPOINTMENTS. The board shall be appointed pursuant to s. 619.15 (1), Stats.

(2) ANNUAL REPORT. The board shall make an annual report to the members of the plan and to standing committees on health and insurance in each house of the legislature pursuant to s. 619.15 (2), Stats.

(3) BOARD FUNCTIONS. Board functions shall conform with ss. 619.15 (3), (4) and (5), Stats.

(a) The board shall carry out the functions required in s. 619.15 (3), Stats.

(b) The board may carry out the functions authorized in s. 619.15 (4), Stats.

(c) The board may provide for agent commissions and require agents and companies to provide assistance in filing applications under the powers granted in s. 619.15 (5), Stats.

(d) The board may establish subcommittees and appoint members who do not serve on the board to these subcommittees in order to carry out its functions under s. 619.15, Stats.

(e) The board may hire consultants in order to carry out its functions under s. 619.15, Stats.

(f) The board shall contract with the administering carrier of the plan to provide those services enumerated in s. 619.16 (3), Stats., as well as any other functions enumerated in the contract between the board and the administering carrier, in order to carry out its functions under s. 619.15, Stats.

(g) The board may defer payment of administrative expenses to the administering carrier, in accordance with the terms set forth in the contract between the board and the administering carrier.

(h) The board shall develop a detailed written policy regarding confidentiality of records.

(i) The board may adopt and amend from time to time reasonable operating procedures which are not inconsistent with the statutory requirements and ch. Ins 18, for the management and operation of the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. (1), Register, December, 1983, No. 336, eff. 1-1-84.

Ins 18.09 Administering carrier. The selection, term and functions of the administering carrier shall conform with s. 619.16, Stats.

(1) SELECTION. The board shall select an insurer through a competitive bidding process to administer the plan based on criteria established by the board which shall conform with the requirements of s. 619.16 (1), Stats.

(2) TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS. The term served by the administering carrier and the selection of the administering carrier for succeeding periods shall conform with s. 619.16 (2), Stats.

(3) FUNCTIONS. The administering carrier shall perform the functions enumerated in s. 619.16 (3), Stats., and any other functions agreed to in the contract between the board and the administering carrier.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.10 Notice of mandatory risk-sharing plan. Notice of the plan shall conform with s. 632.785, Stats.

(1) WHEN NOTICE REQUIRED. If an insurer takes one or more of the actions enumerated in s. 632.785 (1), Stats., the insurer shall notify all persons covered or to be covered by the policy, including parents and guardians in cases involving minor children and individuals adjudged incompetent, of the existence of the plan, as well as the eligibility requirements and the method of applying for coverage under the plan, in accordance with s. 632.785 (1), Stats.

(2) FORM OF NOTICE REQUIRED. "Health Insurance Risk-Sharing Plan", an informational pamphlet prepared by and available through the Office of the Commissioner of Insurance and endorsed by the board, shall satisfy the notice requirements set forth in s. 632.785 (1), Stats. Any other notice given in accordance with s. 632.785 (1), Stats., shall substantially conform to this pamphlet in type size and readability and shall be subject to the prior approval of the commissioner of insurance.

(3) STATEMENT OF REASONS FOR REJECTION, TERMINATION, CANCELLATION OR IMPOSITION OF UNDERWRITING RESTRICTIONS. The insurer's rejection, termination, cancellation or imposition of underwriting restrictions under s. 632.785 (1) shall, pursuant to s. 632.785 (2), state the specific medical reason for the insurer's action.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.11 Confidentiality and access to records. (1) CONFIDENTIALITY. Information regarding plan applicants and plan participants shall be kept confidential by the administering carrier and the board. A detailed written policy regarding confidentiality shall be developed by the board pursuant to s. 619.15 (5), Stats., and Ins 18.08 (3) (h).

(2) ACCESS TO RECORDS BY PLAN APPLICANTS AND PARTICPANTS. Plan applicants and participants shall have access to all of their medical records held by the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.12 Effective date. This chapter shall take effect January 1, 1981.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.