CR 87-122

STATE OF WISCONSIN
RECEIVED AND FILED

DEC 17 1987

DOUGLAS LA FOLLETTE
SECRETARY OF STATE

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said office, do hereby certify that the annexed order was issued by this office on December 17, 1987, repealing, amending, recreating, and creating rules relating to establishing a procedure for imposing a surcharge on the premiums and fees of certain high-risk health care providers participating in the Wisconsin health care liability insurance plan and the patients compensation fund.

I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, 17th day of December, 1987.

Robert D. Haase
Commissioner of Insurance

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STATE OF WISCONSIN
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DEC 17 1987
DOUGLAS LA FOLLETTE
SECRETARY OF STATE

ORDER OF THE COMMISSIONER OF INSURANCE

REPEALING, AMENDING AND CREATING A RULE

To repeal Ins 17.25 (12) (a) 13 and (b) 5; to amend Ins 17.03 (intro.) and (1), Ins 17.07, Ins 17.25 (16) and 17.28 (7) (intro.); to repeal and recreate Ins 17.08; and to create Ins 17.25 (12m), 17.28 (6m) and 17.285, relating to establishing a procedure for imposing a surcharge on the premiums and fees of certain high-risk health care providers participating in the Wisconsin health care liability insurance plan and the patients compensation fund.

ANALYSIS BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 655.003 and 655.27 (3) (b), Stats.

Statutes interpreted: ss. 19.35 (1) (a), 19.85 (1) (f), 619.04 (5) (b) and (5m), 655.27 (3) (a) 2m, (b) and (bg) and 655.275, Stats.

1985 Wisconsin Act 340 required the commissioner of insurance, with the approval of the board of governors of the Wisconsin health care liability insurance plan (plan) and the patients compensation fund (fund), to provide for an automatic increase (surcharge) in the plan premium or fund assessment of certain health care providers who exceed either a claims paid threshold or

dollar volume of claims paid threshold, and who therefore present a higher risk of future losses to the plan and the fund. The legislation also created a peer review council of 5 members appointed by the board to review all claims paid on behalf of health care providers by the plan, the fund and private medical malpractice insurers and to make a recommendation to the board of governors as to the imposition of a surcharge.

This proposed rule provides tables, for each type of individual health care provider (physicians and surgeons, podiatrists, nurse anesthetists, nurse midwives, nurse practitioners and cardiovascular perfusionists) and each medical specialty currently participating in the plan and the fund, establishing the percentage increases that will be applied if the board decides that a surcharge should be imposed.

A surcharge is based on the number of claims and amounts paid to claimants by or on behalf of each provider during any 5-year period. It increases with the number of claims paid and the total amounts paid, remains in effect for 3 years and may range from 10% to 200%. The percentage imposed decreases by 50% the 2nd year and by 75% the 3rd year if the provider does not accumulate any additional claims closed with indemnity payments.

The duty of the peer review council is to review each provider's claims record, investigate mitigating circumstances and determine whether each claim paid during the review period should be considered in determining the amount of the surcharge. The council may utilize consultants with expertise in the medical specialty of the provider and in the area of the procedure involved in performing its review. If the council recommends that a surcharge should be imposed, the provider is entitled to an administrative hearing before the board issues its final decision.

The board is required to review the surcharge tables and the results of the surcharge procedures to determine if the peer review council's performance is adequate to address the loss and expense experience of individual providers which results in payments from the plan and the fund.

SECTION 1. Ins 17.03 (intro.) and (1) are amended to read:

Ins 17.03 HOW PROCEEDINGS INITIATED. (ss. 619.04 and 655.003, Stats.) (intro.) Proceedings for a hearing upon a matter may be initiated:

(1) On a complaint, specifying all grounds which the complainant wishes to be considered at the hearing, by any individual, corporation, partnership or association which is aggrieved, filed in triplicate (original and 2 copies) with the commissioner.

SECTION 2. Ins 17.07 is amended to read:

Ins 17.07 PROCEDURE UPON FILING COMPLAINT. (ss. 619.04 and 655.003, Stats.) Upon the filing of a complaint as prescribed by ~~section~~ s. Ins 17.03 ~~Wis. Adm. Code~~ the commissioner or member of the commissioner's staff shall investigate the matter alleged, to determine whether there is sufficient cause for action and shall report the findings to the board for action. If the board determines that there is sufficient cause for action it shall order a hearing. A request for a hearing under s. Ins 17.285 (9) (a) shall be considered sufficient cause for action. If ~~it~~ the board determines that no further action is warranted it shall ~~so~~ notify the complainant in writing of the reasons ~~therefore~~ for its determination.

SECTION 3. Ins 17.08 is repealed and recreated to read:

Ins 17.08 FORMS OF NOTICE. (ss. 619.04 and 655.003, Stats.) (1) A notice of hearing shall include all of the following:

(a) A statement of the issues to be considered.

(b) The names and addresses of the parties.

(c) The date, time and place of the hearing and, if scheduled, the prehearing.

(d) The class of the proceeding under s. 227.01 (3), Stats.

(e) The statutory authority under which the hearing will be conducted.

(f) The date of the notice.

(g) The signature of the chairperson or secretary of the board or subordinate of the commissioner designated by the board.

(2) If the hearing is initiated by the board's own motion or investigation, the notice shall also include a copy of the complaint and the time by which a party is required to answer in writing.

(3) Except in an emergency, a notice of hearing shall be mailed to the parties at least 10 days before the date of the hearing.

SECTION 4. Ins 17.25 (12) (a) 13 and (b) 5 are repealed.

SECTION 5. Ins 17.25 (12m) is created to read:

Ins 17.25 (12m) PREMIUM SURCHARGE TABLES. (a) This subsection implements s. 619.04 (5m) (a), Stats., requiring the establishment of an automatic increase in a provider's plan premium based on loss and expense experience.

(b) In this subsection:

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

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

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

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

(c) The following tables shall be used in making the determinations required under this subsection and s. Ins 17.285 (3) (a), (4) (a), (7) and (9) as to the percentage increase in a provider's plan premium:

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

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

2. For Class 2 physicians and surgeons:

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

3. For Class 3 physicians and surgeons:

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

4. For Class 4 physicians and surgeons:

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

5. For Class 5A physicians and surgeons:

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

6. For Class 5 physicians and surgeons:

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

7. For Class 6 physicians and surgeons:

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

8. For Class 7 physicians and surgeons:

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

9. For Class 9 physicians and surgeons:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or More
Up to $ 627,000	0%	0%	0%	0%	0%
$ 627,001 to $1,103,000	0%	0%	10%	25%	50%
$1,103,001 to $1,558,000	0%	0%	25%	50%	75%
$1,558,001 to $3,371,000	0%	0%	50%	75%	100%
Greater Than $3,371,000	0%	0%	75%	100%	200%

SECTION 6. Ins 17.25 (16) is amended to read:

Ins 17.25 (16) RIGHT OF APPEAL. Any affected person may appeal to the board of governors within 30 days after notice of any final ruling, action or decision of the Plan. Decisions of the board of governors may be further

appealed in accordance with ch. 227, Stats. This subsection does not apply to a decision relating to an automatic increase in a provider's plan premium under sub. (12m), which is appealable as provided under s. Ins 17.285.

SECTION 7. Ins 17.28 (6m) is created to read:

Ins 17.28 (6m) 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 this subsection and s. Ins 17.285 (3) (a), (4) (a), (7) and (9) as to the percentage increase in a provider's fund fee:

1. For Class 1 health care providers specified under s. Ins 17.28 (3) (c) 1 and nurse anesthetists:

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

2. For Class 2 health care providers specified under s. Ins 17.28 (3) (c) 2:

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 Class 3 health care providers specified under s. Ins 17.28 (3) (c) 3:

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 Class 4 health care providers specified under s. Ins 17.28 (3) (c) 4:

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%

SECTION 8. Ins 17.28 (7) (intro.) is amended to read:

Ins 17.28 (7) (intro.) Each health care provider permanently practicing or operating in this state may ~~have the option to~~ pay the assessment in a single lump sum, ~~two~~ 2 semiannual payments~~,~~ or ~~four~~ 4 quarterly payments. In this subsection, "assessment" includes any applicable surcharge imposed under sub. (6m) (b). This subsection implements s. 655.27 (3) (b), Stats.

SECTION 9. Ins 17.285 is created to read:

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 paid to or on behalf of claimants, 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 claim against a provider, or a claim against an employe of a health care provider for which the provider is vicariously liable, which results in any payment to or on behalf of a claimant.

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

(d) "Provider" means a health care provider 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 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 (6m) or both.

(3) EXAMINATION OF CLAIMS PAID. (a) Each month the council shall examine all claims paid reports received under s. 655.26, Stats., to determine whether each provider for whom a closed claim is reported has, during the review period, accumulated enough closed claims and aggregate indemnity to require the imposition of a surcharge, based on the tables under s. Ins 17.25

(12m) (c). In determining the number of closed claims accumulated by a provider, the council shall count all claims arising out of one incident or course of conduct as one claim.

(b) If the board does not have a provider's claims record for the entire review period, the council may request from the provider a statement of the number and amounts of all closed claims that have been paid by or on behalf of the provider during the review period. The request shall include notice of the provisions of par. (c).

(c) If the provider fails to comply with the request under par. (b), the provider shall be assessed a surcharge for a 3-year period as follows:

1. If the provider has practiced in this state for the entire review period, 10 percent of the next annual plan premium, fund fee or both, subject to sub. (11) (d) to (f).

2. If the provider has practiced in any place other than this state for any part of the review period, 50 percent of the next annual plan premium, fund assessment or both, subject to sub. (11) (d) to (f).

(d) A provider who does not comply with the request under par. (b) is not entitled to a review of his or her claims record as provided in this section nor to a hearing on the imposition of a surcharge.

(4) REVIEW REQUIRED; NOTICE TO PROVIDER. (a) If the number of closed claims and the aggregate indemnity of any provider for all closed claims reported under s. 655.26, Stats., and sub. (3) would be sufficient to require the imposition of a surcharge, the council shall review the provider's claims record for the review period to determine whether a surcharge should be imposed.

(b) The council shall notify each provider subject to a review that a surcharge may be imposed and that the surcharge may be reduced or eliminated following a review as provided in this section. The notice shall also include:

1. A description of the procedures specified in this section and a statement that the provider may submit in writing relevant information about any incident involved in the review and a description of mitigating circumstances that may reduce the future risk to the plan, the fund or both.

2. A request that the provider furnish the council with written authorization to obtain, from the claim files of any insurer that provided coverage during the review period and from any defense attorney's files relevant factual information about each closed claim that would aid in making any determination required in this section.

(c) If the provider complies with the request under par. (b) 2, the plan, the fund, private insurers and defense attorneys shall provide photocopies or summaries of any information requested by the council.

(d) If the provider does not comply with the request under par. (b) 2 with respect to any claim, the council shall, without review, include that claim in determining whether to impose a surcharge.

(5) PROCEDURE FOR REVIEW. (a) The council may identify an organization in this state that represents each type of provider included in the plan and the fund and may notify each organization that it may recommend individual providers or a committee of members of the organization as consultants for purposes of par. (b) or (c).

(b) For each review, the council shall do one of the following:

1. If the provider is a physician, refer the matter for consultation to a physician or committee of physicians recommended under par. (a) or to another physician or physicians selected by the council who practice the same

specialty or, if possible, the same subspecialty as the provider. If the provider's specialty or subspecialty is different from that of the medical procedure involved in any incident, the council shall also refer the record relating to that incident to at least one physician who practices that specialty or, if possible, subspecialty.

2. If the provider is a nurse anesthetist, refer the matter for consultation to a nurse anesthetist or a committee of nurse anesthetists recommended under par. (a) or to another nurse anesthetist or nurse anesthetists selected by the council.

(c) If the provider is not a physician or nurse anesthetist, and a consultant for the provider's profession has been recommended under par. (a), the council may refer the matter to that consultant or to any other person with expertise in the area of the specialty or specialties involved in any incident or may review the provider's claims record itself.

(d) In reviewing a closed claim, the council or a consultant may consider any relevant information except information from a juror who participated in a civil action for damages arising out of an incident under review. The council or a consultant may consult with any person except a juror, interview the provider, employes of the provider or other persons involved in an incident or request the provider to furnish additional information or records.

(6) CONSULTANT'S OPINION; COUNCIL DETERMINATION. (a) A consultant shall provide the council with a written opinion as to whether, with respect to each incident reviewed, there are mitigating circumstances which reduce the future risk to the plan, the fund or both, and which warrant a reduction or elimination of the surcharge. Each opinion shall include a description of any mitigating circumstances.

(b) The council, based on any consultants' reports or its own review, shall decide whether or not to include each incident involved in the review in determining whether to recommend imposition of a surcharge.

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

(b) If the council determines that, because of mitigating circumstances, the total number of closed claims and the aggregate indemnity attributable to those claims would not be sufficient to require the imposition of a surcharge, the council shall prepare a written report for the board recommending that no surcharge should be imposed.

(8) NOTICE TO PROVIDER. The council shall furnish the provider with a copy of its report and recommendation to the board and shall also notify the provider of the right to request a contested case hearing under ch. 227, Stats., within 30 days after receipt of the notice.

(9) HEARING. (a) If the provider requests a hearing, the reports of the consultant, if any, and the council are admissible in evidence. If the provider proves by a preponderance of the evidence that, because of mitigating circumstances, one or more of the incidents should not be included in determining the surcharge, and as a result, the total remaining number of closed claims and aggregate indemnity would not be sufficient to require the imposition of a surcharge or would result in a lower surcharge, the hearing examiner's proposed decision shall recommend that no surcharge should be

imposed or that the amount of the recommended surcharge should be reduced appropriately. If the provider fails to meet this burden of proof with respect to any incident, the hearing examiner's proposed decision shall accept the council's recommendation with respect to that incident.

(b) Notice of the hearing examiner's proposed decision shall inform the provider that he or she may submit to the board written objections and arguments regarding the proposed findings of fact, conclusions of law and decision within 20 days after the date of the notice.

(10) FINAL DECISION; JUDICIAL REVIEW. The board shall make the final decision on the imposition of a surcharge. The final decision is reviewable by the circuit court as provided under ch. 227, Stats.

(11) SURCHARGE; IMPOSITION; REFUND; DURATION. (a) A surcharge imposed on a provider's plan premium after a final decision by the board takes effect on the next policy renewal date and remains in effect during any period of judicial review.

(b) A surcharge imposed on a provider's fund fee after a final decision by the board takes effect on the July 1 following the date of the decision and remains in effect during any period of judicial review.

(c) If judicial review results in the imposition of no surcharge or a reduced surcharge, the plan, the fund or both shall refund the excess amount collected from the provider or credit the provider's next annual plan premium, fund fee or both with the excess amount.

(d) A surcharge remains in effect for 3 years. The percentage imposed under par. (a) or (b) shall be reduced by 50% the 2nd year and by 75% the 3rd year, if the provider does not accumulate any additional closed claims during the 3-year period.

(e) If the provider accumulates additional closed claims during the 3-year period, the provider is subject to the higher of the following:

1. The surcharge determined under par. (d).

2. The surcharge determined by the board following a new review of the provider's claims record under sub. (5).

(f) If the provider is a physician who, during the 3-year period, changes from one class to another class specified in s. Ins 17.28, the percentage surcharge imposed by the final decision of the board shall be applied to the plan premium, fund fee or both for the physician's new class effective on the date the class change occurs.

(12) REQUEST FROM PRIVATE INSURER. If the council receives a request for a recommendation under s. 655.275 (5) (a) 3, Stats., from a private insurer, the council shall follow the procedures specified in subs. (3) to (5) and notify the private insurer and the provider of the determination it would make under sub. (6) (b) if the provider's primary insurer were the plan. A provider is not entitled to a hearing on any determination reported under this subsection.

(13) CONFIDENTIALITY. The final decision of the board and all information and records relating to the review procedure are the work product of the board and are confidential.

(14) ANNUAL REVIEW. The board shall annually review the tables under s. Ins 17.25 (12m) (c) and the results of the procedure established in this section to determine if the council's performance adequately addresses the loss and expense experience of individual providers which results in payments from the plan, the fund or both. The board shall recommend to the commissioner any changes needed in the rules that are necessary to address that consideration.

EFFECTIVE DATE: This rule takes effect on January 1, 1988, or the first day of the first month commencing after publication, as provided in s. 227.22 (2) (intro.) or (b), Stats., whichever is later.

Dated at Madison, Wisconsin, this 17th day of December, 1987.

Robert D. Haase
Commissioner of Insurance

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10/16/87

The State of Wisconsin
Office of the Commissioner of Insurance

Robert D. Haase
Commissioner
(608) 266-3585

RECEIVED
DEC 18 1987
Revisor of Statutes
Bureau

DATE: December 17, 1987

TO: Gary Poulson

FROM: Fred Nepple, General Counsel
Office of the Commissioner of Insurance

SUBJECT: Ins 17.25, 17.03, 17.07, 17.25, 17.28, 17.08, 17.285, Clearinghouse No. 87-122

Enclosed are two copies of an Order of the Commissioner of Insurance repealing Ins 17.25, amending Ins 17.03, 17.07, 17.25, and 17.28, repealing and recreating Ins 17.08, and creating Ins 17.25, 17.28 and 17.285, and Clearinghouse No. 87-122, relating to establishing a procedure for imposing a surcharge on the premiums and fees of certain high-risk health care providers participating in the Wisconsin Health Care Liability Insurance Plan and the Patients Compensation Fund.

FN:LH:ry
Enclosure
291-7