

## Chapter Ins 17

## PATIENTS COMPENSATION FUND

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Ins 17.001 Definitions. (ss. 619.04 and 655.003, Stats.) As used in this chapter:

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

(2) "Fund" means the patients compensation fund established pursuant to s. 655.27 (1), Stats., except as defined in s. Ins 17.24;

(3) "Hearing" includes both hearings and rehearings, and these rules shall cover both so far as applicable, except where otherwise specifically provided by statute or in ch. Ins 17.

(4) "Plan" means the Wisconsin health care liability insurance plan established by s. Ins 17.25 pursuant to s. 619.01 (1) (a), Stats.;

(5) "Commissioner" means the commissioner of insurance or deputy whenever detailed by the commissioner or discharging the duties and exercising the powers of the commissioner during an absence or a vacancy in the office of the commissioner, as provided by s. 601.11 (1) (b), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

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

(2) PAYMENT OF FEES TO FINANCE THE MEDIATION SYSTEM. (a) Every physician practicing in the state, subject to ch. 655, Stats., excluding those in a residency or fellowship training program, and every hospital operating in the state, subject to ch. 655, Stats., shall pay to the commissioner of insurance an annual fee to finance the mediation system created by s. 655.42, Stats. The commissioner of insurance shall deposit all such fees collected in the mediation fund created by s. 655.68, Stats.

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(b) The fee is due and payable upon receipt of the billing by the physician or hospital.

(c) Any physician or hospital who has not paid the fee within 30 days from the date the billing is received shall be deemed to be in noncompliance with s. 655.61 (1), Stats.

(d) The commissioner shall notify the department of regulation and licensing of each physician who has not paid the fee, and who is, therefore, in noncompliance with s. 655.61 (1), Stats.

(e) The commissioner shall notify the department of health and social services of each hospital which has not paid the fee, and which is, therefore, in noncompliance with s. 655.61 (1), Stats.

(f) Fees collected under this section are not refundable except to correct an administrative billing error.

(3) **FEE SCHEDULE.** The following fee schedule shall be effective July 1, 1987:

(a) For physicians — \$-0-

(b) For hospitals — \$-0-

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; emerg. r. and recr. eff. 7-2-86; r. and recr., Register, September, 1986, No. 369, eff. 10-1-86; cr. (2) (f), am. (3), Register, June, 1987, No. 378, eff. 7-1-87.

**Ins 17.02 Petition for declaratory rulings.** (ss. 619.04 and 655.003, Stats.) (1) Petitions for declaratory rulings shall be governed by s. 227.06, Stats.

(2) Such petitions shall be filed with the commissioner who shall investigate, give notice, etc.

(3) All final determinations shall be made by the board.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

**Ins 17.03 How proceedings initiated.** (ss. 619.04 and 655.003, Stats.) 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.

(2) By the board on its own motion whenever its investigation discloses probable ground therefore.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) and (1), Register, February, 1988, No. 386, eff. 3-1-88.

**Ins 17.04 General rules of pleading.** (ss. 619.04 and 655.003, Stats.) All pleadings shall be governed by s. 802.02, Stats., where applicable.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

**Ins 17.05 Caption of pleadings and notice.** (ss. 619.04 and 655.003, Stats.) All pleading, notices, orders and other papers filed in reference to Register, December, 1989, No. 408

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

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

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

History: Cr. Register, June, 1987, No. 378; eff. 7-1-87.

**Ins 17.50 Self-insured plans for health care providers. (1) PURPOSE.** This section implements s. 655.23 (3) (a), Stats.

(2) DEFINITIONS. In this section:

(a) "Actuarial" means prepared by an actuary meeting the requirements of s. Ins. 6.12 who has experience in the field of medical malpractice liability insurance.

(b) "Level of confidence" means a percentage describing the probability that a certain funding level will be adequate to cover actual losses.

(c) "Occurrence coverage" means coverage for acts or omissions occurring during the period in which a self-insured plan is in effect.

(d) "Office" means the office of the commissioner of insurance.

(e) "Provider," when used without modification, means a health care provider, as defined in s. 655.001 (8), Stats., that is responsible for the establishment and operation of a self-insured plan.

(f) "Risk margin" means the amount that must be added to estimated liabilities to achieve a specified confidence level.

(g) "Self-insured plan" means a method, other than through the purchase of insurance, by which a provider may furnish professional liability coverage which meets the requirements of ch. 655, Stats.

(h) "Year" means the self-insured plan's fiscal year.

(3) COVERAGE. (a) A self-insured plan shall provide professional liability occurrence coverage with limits of liability in the amounts specified in s. 655.23 (4), Stats., for the provider, the provider's employes, other than employes who are natural persons defined as health care providers under s. 655.001 (8), Stats., and any other person for whom the provider is legally responsible while the employe or other person is acting within the scope of his or her duties for the provider.

(b) A self-insured plan may also provide occurrence coverage for any natural person who is a health care provider, as defined in s. 655.001 (8), Stats., and who is an employe, partner or shareholder of the provider. The self-insured plan shall provide separate limits of liability in the amounts specified in s. 655.23 (4), Stats., for each such natural person covered.

(c) A self-insured plan shall also provide for supplemental expenses in addition to the limits of liability in s. 655.23 (4), Stats., including attor-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) Any additional information requested by the office.

(5) REVIEW OF PROPOSAL; APPROVAL. (a) After reviewing a proposal submitted under sub. (4), the office may approve the proposal if all of the following conditions are met:

1. The initial filing is complete.

2. The proposal is actuarially sound.
3. The proposal complies with ch. 655, Stats.
4. The proposal ensures the provider's continuing ability to meet the financial responsibility requirements of s. 655.23, Stats.
5. The provider is sound, reliable and entitled to public confidence and may reasonably be expected to perform its obligations continuously in the future.

(b) If any of the conditions specified under par. (a) is not met, the office may request the provider to submit additional information in writing or may assist the provider in revising the proposal.

(c) A self-insured plan may not begin operation without the written approval of the office which specifies the earliest date operation may begin.

(6) **FUNDING REQUIREMENTS; PROHIBITIONS.** (a) The minimum initial funding required for a self-insured plan is \$2,000,000.

(b) Before a self-insured plan begins operation, the provider shall establish a trust with a Wisconsin-chartered or federally-chartered bank with trust powers which is located in this state.

(c) 1. If the actuarial estimate under sub. (4) (d) is less than \$2,000,000, the provider shall, before the self-insured plan begins operation, deposit in the trust cash equal to the first year's estimated liabilities plus a letter of credit equal to the difference between the cash funding and \$2,000,000.

2. In each of the next 3 years, the provider shall make quarterly cash payments to the trust in amounts sufficient to keep the estimated liabilities fully funded and shall keep in effect a letter of credit equal to the difference between the total estimated liabilities and \$2,000,000.

3. If the total estimated liabilities for the 5th year of operation are less than \$2,000,000, the provider shall, during that year, make quarterly cash payments to the trust in amounts sufficient to ensure that, by the end of that year, the trust's cash assets equal \$2,000,000, except that if the provider files a written request with the commissioner before the beginning of that year, the commissioner may permit the provider to continue using a letter of credit equal to the difference between the total estimated liabilities and \$2,000,000. This permission may be renewed annually if the provider files a written request with the commissioner before the beginning of each subsequent fiscal year.

4. A letter of credit under this subsection shall meet all of the following conditions:

- a. It shall be irrevocable.
- b. It shall be issued by a Wisconsin-chartered or federally-chartered bank located in this state.
- c. It shall be issued solely for the purpose of satisfying the funding requirements of the trust.
- d. It shall describe the procedure by which the trustee may draw upon it.

(d) If the actuarial estimate under sub. (4) (d) is greater than \$2,000,000, the provider shall, before the self-insured plan begins operation, deposit \$2,000,000 cash in the trust. The provider shall make quarterly cash payments to the trust so that at the end of the first year of operation, the trust's cash assets equal the first year's estimated liabilities.

(e) In each subsequent year of the self-insured plan's operation, the provider shall make quarterly cash payments to the trust in amounts sufficient to ensure that the total cash assets of the trust at the end of each year are not less than the estimated liabilities reported under sub. (8) (a) 1.

(f) 1. If the provider or any natural person covered under sub. (3) (b) had claims-made coverage before the self-insured plan was established and did not purchase an extended reporting endorsement from the previous carrier, the self-insured plan shall provide coverage for prior acts by means of cash payments to the trust in addition to the funding required for the occurrence coverage.

2. If the actuarial estimate under sub. (4) (e) is less than \$500,000, the provider shall, before the self-insured plan begins operation, deposit in the trust the entire amount of the estimate in cash.

3. If the actuarial estimate under sub. (4) (e) is greater than \$500,000, the provider shall, before the self-insured plan begins operation, deposit in the trust \$500,000 or the first year's estimated payments, whichever is greater. The provider shall make quarterly cash payments to the trust so that at the end of the first year, the trust's assets include the total estimated liabilities for prior acts.

(g) Quarterly cash payments under this subsection shall be in equal amounts except that the amount of the last quarter's payment shall be adjusted by the amounts of the trust's investment income and actual expenses incurred, and except that the first quarter's payment shall not be less than the amount of a quarterly payment for the previous year before adjustment for income and expenses.

(h) 1. A provider may not deposit in the trust, and the trustee may not pay from the trust, any funds other than those intended to meet the financial responsibility requirements of ch. 655, Stats., and to pay the administrative expenses of operating the self-insured plan and the trust.

2. The trustee may not invest any of the trust's assets in securities or real property of the provider or any of its affiliates.

(i) If the assets of the trust at any time are insufficient to pay all claims against the self-insured plan, the liabilities are those of the provider without recourse against any employee, partner or shareholder covered by the self-insured plan.

(7) FILING PRIOR TO OPERATION OF SELF-INSURED PLAN. Before an approved self-insured plan begins operation, the provider shall file with the office all of the following:

(a) Certified copies of the executed self-insured plan document and trust agreement.

(b) If the provider is not a natural person, a certified copy of an executed resolution adopted by the provider's governing body approving the self-insured plan and trust agreement.

(c) A certified copy of any trust investment policy adopted by the provider or the provider's governing body.

(d) The trustee's certification that the initial amount of cash required under sub. (6) has been deposited in the trust.

(e) A certified copy of any letter of credit held by the trustee.

(f) If any part of the operation of the self-insured plan is conducted by a person other than the provider or an employe, partner or shareholder of the provider, a certified copy of an executed contract with each such person.

(8) **FINANCIAL REPORTING.** (a) Within 120 days after the end of a year, the self-insured plan shall submit to the office all of the following:

1. Actuarial estimates of the projected liabilities for the current year and of the total liabilities for all prior years covered by the self-insured plan and the risk margin for all projected and incurred claims, and an actuarial opinion of the reasonableness of the estimates.

2. A description of the proposed method of funding for the current year.

3. The provider's audited annual financial statement.

4. The self-insured plan's audited annual financial statement.

(b) Within 60 days after the end of each quarter, the self-insured plan shall submit to the office the most recent quarterly financial statement of the trust.

(9) **OTHER REPORTING REQUIREMENTS.** (a) After a self-insured plan begins operation, the provider shall report to the office any proposed change in the self-insured plan document, trust agreement, trust investment policy, letter of credit or any other document on file with the office if the change would materially affect the operation of the self-insured plan or its funding. No proposed change may take effect without the written approval of the office.

(b) The provider shall annually file with the patients compensation fund proof of financial responsibility under s. 655.23, Stats., in the form specified by the office. The provider shall also file proof of financial responsibility on behalf of each natural person covered under sub. (3) (b).

(c) The provider shall immediately notify the patients compensation fund if either of the following occurs:

1. A claim filed with the self-insured plan has a reserve of 50% or more of the limit specified in s. 655.23 (4), Stats., for one occurrence.

2. The self-insured plan's total aggregate reserves for the provider or for any natural person covered under sub. (3) (b) for a single year exceed 66% of the limit specified in s. 655.23 (4), Stats., for all occurrences in one year.

3. A claim filed with the self-insured plan creates potential exposure for the patients compensation fund, regardless of the amount reserved.

(d) The provider shall ensure that all claims paid by the self-insured plan are reported to the medical examining board and the board of governors of the patients compensation fund as required under s. 655.26, Stats.

(10) **DISCOUNTING PROHIBITED.** All actuarial estimates required under this section shall be reported on a nondiscounted basis.

(11) **LEVELS OF CONFIDENCE.** (a) The risk margin used in determining the initial funding under sub. (6) shall be at not less than a 90% level of confidence and, except as provided in pars. (b) and (c), shall remain at that level.

(b) After a self-insured plan has operated for at least 5 years and experience can be reasonably predicted, the office may permit the use of a risk margin of less than a 90%, but not less than a 75%, level of confidence in determining annual funding of the trust. For at least 5 years after such permission is granted, the provider shall fund the difference between the cash required at the lower level of confidence and the 90% level of confidence with funds restricted by the provider or the provider's governing body for the purpose of paying obligations of the self-insured plan. The restricted funds may be part of the provider's operating budget rather than assets of the trust.

(c) After a self-insured plan has operated for at least 5 years under par. (b), the office may permit the use of a risk margin of not less than a 75% level of confidence without additional restricted funds if the self-insured plan's actuary states that the self-insured plan's exposure base is stable enough to estimate the required liabilities.

(12) **MONITORING; ORDERS.** (a) If the office determines that a self-insured plan's operation does not ensure that the provider can continue to satisfy the conditions specified in sub. (5) (a), the commissioner may order the provider to take any action necessary to ensure compliance with those conditions.

(b) If the provider does not comply with the commissioner's order within the time specified in the order, the commissioner may order the provider to terminate the self-insured plan and the office may take whatever action is necessary to ensure the continued existence of the trust for a sufficient length of time to meet all of the obligations of the self-insured plan.

(13) **EXISTING SELF-INSURED PLANS; COMPLIANCE.** After this section takes effect, the office may review any approved self-insured plan to determine if it complies with this section. If the office determines that any self-insured plan is not in compliance, the commissioner may order the provider to take any action necessary to achieve compliance.

History: Cr. Register, December, 1989, No. 408, eff. 1-1-90.