(d) If the risk is accepted by the Plan, a policy shall be delivered to the applicant upon payment of the premium. The Plan shall remit any com-

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notice of cancellation or nonrenewal shall allow ample time for application to the Plan and for the issuance of coverage. A copy of such cancellation or nonrenewal notice shall be filed with the office of the commissioner of insurance.

(14) PLAN BUSINESS - CANCELLATION AND NONRENEWAL. (a) The Plan may not cancel or refuse to renew a policy issued under the Plan except for one or more of the following reasons:

1. Nonpayment of premium.

2. Revocation of the license of the insured by the appropriate licensing board.

3. Revocation of accreditation, registration, certification or other approval issued to the insured by a state or federal agency or national board, association or organization.

4. If the insured is not licensed, accredited, registered, certified or otherwise approved, failure to provide evidence that the insured continues to provide health care in accordance with the code of ethics applicable to the insured's profession, if the board requests such evidence.

(b) Notice of cancellation or nonrenewal under par. (a), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in sub. (16).

(15) COMMISSION. Commission to the licensed agent designated by the applicant shall be 15% for each new or renewal policy issued to medical or osteopathic physicians, nurse anesthetists, nurse midwives, cardiovascular perfusionists, podiatrists, and partnerships comprised of or corporations or general partnerships organized for the primary purpose of providing the medical services of physicians, podiatrists, nurse anesthethists, nurse midwives or cardiovascular perfusionists subject to a maximum of $150 per policy; and 5% of the annual premium for each new or renewal policy issued to operating cooperative sickness care plans, or to teaching facilities, or to hospitals, or to entities specified in sub. (5) (a) 7m, or to health care facilities owned and operated by a political subdivision of the state of Wisconsin, not to exceed $2,500.00 per policy period. The agent need not be licensed with the servicing company.

(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.

(17) REVIEW BY COMMISSIONER. The board of governors shall report to the commissioner the name of any member or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the board of governors or to pay within 30 days any assessment levied.

(18) INDEMNIFICATION. Each person serving on the board of governors or any subcommittee thereof, each member of the Plan, and the manager and each officer and employe of the Plan shall be idemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the board of governors, or a member or manager or officer or employe of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful or criminal misconduct in the performance of his or its duties as a member of such board of governors, or a member or manager or officer or employe of the Plan. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the Plan. Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employe may be entitled as a matter of law.

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 6-22-76; am. (1) (b), (2), (4) (b) and (c) and (5) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1)(b), (2), (4)(c), (5)(a), (5)(f), (10)(a) and (15), cr. (4)(h), Register, May, 1977, No. 257, eff. 6-1-77; am. (1)(b), (2), (4)(c), (5)(a), (10)(a) and (15), Register, September, 1977, No. 261, eff. 10-1-77; am. (1)(b), (2), (4)(b) and (c), (5)(a) and (f), and (15), Register, May, 1978, No. 269, eff. 6-1-78; am. (7) (b) 1.a., Register, March, 1979, No. 279, eff. 4-1-79; renum. from. Ins 3.35, am. (1) (b), (2), (5) (a) and (10) (a), Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (5) (a), Register, April, 1980, No. 292, eff. 5-1-80; am. (1) (b), (2), (4) (c), (5) (a), (10) (a), (12) (a) 3. and 4. and (15), r. (12) (a) 11. renum. (12) (a) 5. through 10. and 12. to be 7. through 12. and 13., cr. (12)(a) 5. and 6., Register, May, 1985, No. 353, eff. 6-1-85; emerg. am. (1)(b), (2), (4)(c) and (5)(a) 2., eff. 7-29-86; am. (1)(b), (2), (4)(c) and (5)(a) 2., Register, January, 1987, No. 373, eff. 2-1-87; emerg. am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), cr. (5) (a) 11., (7m) and (14) (a) 3. and 4., renum. (5) (a) 11., (b) and (7) (b) 1. intro. to be (5) (am), (b) (intro.) and (7) (b) and am., r. (7) (b) 1. a. and b. eff. 2-16-87; am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), renum. (5) (a) 11, (b) and (7) (b) 1. to be (5) (am), (b) (intro.) and (7) (b) 1. and am., cr. (5) (a) 7m and 11., (b) 1. to 3., (7) (b) 2m. and (14) (a) 3. and 4., r. (7) (b) 1. a. and b., Register, July, 1987, No. 379, eff. 8-1-87; r. (12) (a) 13. and (b) 5., cr. (5) (a) 2m. and (12m), am. (16), Register, February, 1988, No. 386, eff. 3-1-88; r. (4) (g) and (9) (b), renum. (9) (a) to be (9), Register, March, 1988, No. 387, eff. 4-1-88.

Ins 17.26 Future medical expense funds. (1) PURPOSE. This rule is intended to implement the provisions of s. 655.015, Stats.

(2) SCOPE. This rule shall apply to all insurers, organizations and persons subject to ch. 655, Stats.

(3) DEFINITIONS. In this section:

(a) "Account" means the portion of the fund allocated specifically for future medical expense of an injured person.

(b) "Claimant" means the injured person, the individual legally responsible for any medical expenses sustained by the injured person, or the legally designated representative of such injured person.

(c) "Medical expense" means those charges for medical services, nursing services, medical supplies, drugs or rehabilitation services which are necessary to the comfort and well being of the individual and incidental to the injury sustained.

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the

insurer, organization or person responsible for such payment shall forward to the commissioner the amount in excess of $25,000 within 30 days of any such settlement, award or judgment, and shall enclose an appropriately executed copy of the document setting forth the terms under which the payment is to be made.

(b) The commissioner shall credit each account with a pro rata share of interest earned, if any, based on the remaining value of each account at the time such interest earning is declared by the investment board. The commissioner shall maintain an individual record of each account showing the original allocation, payments made, credits and the balance remaining.

(c) Upon receipt of a request for reimbursement of medical expense of an injured person, the commissioner shall make appropriate investigation and inquiries to determine that the medical supplies or services provided are necessary and incidental to the injury sustained by the person for whom the account was established, and if satisfied that this is the case, shall pay these expenses out of the fund, using standard bookkeeping and accounting records and transactions established by ss. 16.40 (5) and 16.41, Stats.

(d) If the commissioner is not satisfied that a provider of service has been reimbursed for services or supplies provided to the injured person, payments of any medical expense may be made jointly to the claimant and to the provider. The claimant may, in writing, direct that payment be made directly to the provider. If the claimant has paid for medical supplies or services the claimant shall be reimbursed upon receipt of proof of payment.

(e) The commissioner shall not less than once annually inform the claimant of the status to date of the account including the original amount, payments made, and the balance remaining.

(f) Payment shall be made to the claimant for reasonable and necessary medical expense until such time as the allocated amount is exhausted or until the injured person is deceased. Should the injured person become deceased and there is a balance in his account allocation, that amount shall be returned to the insurer, organization or person responsible for establishing the account.

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

Ins 17.27 Filing of financial statement. (1) PURPOSE. This rule is intended to implement and interpret ss. 655.21, 655.27 (3) (b), 655.27 (4) (d) and 655.27 (5) (e), Stats., for the purpose of setting standards and techniques for accounting, valuing, reserving and reporting of data relating to financial transactions of the Patients Compensation Fund.

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

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

(3) FINANCIAL REPORTS. Annual financial reports required by s. 655.27 (4) (d), Stats., shall be furnished within 60 days after the close of each

fiscal year. In addition, quarterly financial reports shall be prepared as of September 30, December 31 and March 31 of each year and furnished within 60 days after the close of each reporting period. These financial reports shall be prepared on a format prescribed by the board of governors in accordance with statutory accounting principles for fire and casualty companies. Reserves for reported claims and reserves for incurred but not reported claims shall be maintained on a present value basis with the difference from full value being reported as a contra account to the loss reserve liability. Any funds for administration of the Patients Compensation Panels derived from fees collected under s. 655.21, Stats., shall be included in these financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

(4) The board of governors shall select one or more actuaries to assist in the determination of reserves and the setting of fees under s. 655.27 (3) (b), Stats. In the event more than one actuary is utilized, the health care providers represented on the board of governors shall jointly select the second actuary. Such actuarial reports shall be submitted on a timely basis.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80.

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

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

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

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

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

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

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

History: Cr. Register, March, 1988, No. 387, eff. 4-1-88.

Ins 17.28 Health care provider fees. (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (3), Stats., relating to fees to be paid by health care providers for participation in the Patients Compensation Fund.

(2) SCOPE. This section applies to fees charged health care providers as defined in s. 655.001 (8), Stats. Nothing in this section shall apply to operating fees charged for operation of the mediation system under s. 655.61, Stats.

(3) DEFINITIONS. (a) "Fiscal year" means each period beginning each July 1 and ending each June 30.

(b) "Fees", "operating fees" or "annual fees" mean those fees charged for each fiscal year of participation, July 1 to June 30.

(c) "Class" of physicians or surgeons means those health care providers whose specialties are similar in their degree of exposure to loss and who are subject to a common fee in accordance with the provisions of s. 655.27 (3) (b) 2., Stats. Classes and included specialties are listed below:

1. Class 1 health care providers are those engaged in the following medical specialties:

Aerospace Medicine
Allergy
Cardiovascular Disease - no surgery
Dermatology - no surgery
Diabetes - no surgery
Endocrinology - no surgery
Family Practice and General Practice - no surgery
Forensic Medicine
Gastroenterology - no surgery
General Preventative Medicine - no surgery
Geriatrics - no surgery
Gynecology - no surgery
Hematology - no surgery
Hypnosis
Infectious Diseases - no surgery
Internal Medicine - no surgery
Laryngology - no surgery
Legal Medicine
Neoplastic Diseases - no surgery
Nephrology - no surgery
Neurology - including child - no surgery
Nuclear Medicine
Nutrition
Occupational Medicine
Ophthalmology - no surgery
Osteopathic Physicians - manipulation only
Otology - no surgery
Otorhinolaryngology - no surgery
Pathology - no surgery
Pediatrics - no surgery
Pharmacology - clinical
Physiatry
Physical Medicine and Rehabilitation
Physicians - no surgery
Psychiatry - including child
Psychoanalysis
Psychosomatic Medicine
Public Health
Pulmonary Diseases - no surgery
Radiology - diagnostic - no surgery
Rheumatology - no surgery
Rhinology - no surgery

Post Graduate Medical Education or Fellowship—This classification applies to all physicians engaged in the first year of post graduate medical education (interns). This classification also applies to physicians engaged in 2 through 6 years of an approved post graduate medical education specialty program (residents) listed above which is not ordinarily involved in the performance of or assisting in the performance of obstetrical procedures or surgical (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) procedures.

2. Class 2 health care providers are those engaged in the following medical specialties:

Broncho-Esophagology
Cardiology - (including catheterization, but not including cardiac surgery)
Cardiovascular Disease - minor surgery
Dermatology - minor surgery
Diabetes - minor surgery

Surgery - plastic
Surgery - plastic - otorhinolaryngology
Surgery - rhinology
Surgery - thoracic
Surgery - traumatic
Surgery - vascular
Weight Control - bariatrics
Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in two through six years of an approved post graduate medical education specialty program indicated above.

4. Class 4 health care providers are those engaged in the following medical specialties:

Surgery - neurology - including child
Surgery - obstetrics and gynecology
Surgery - obstetrics
Post Graduate Medical Education or Fellowship— This classification applies to physicians engaged in two through six years of an approved post graduate medical education specialty program indicated above.

(4) PRO RATA FEES. A health care provider may enter or exit the fund at a date other than July 1 or June 30. In this subsection, "semimonthly period" means the 1st through the 14th day, or the 15th day through the end of each month.

(a) If a health care provider enters the fund subsequent to July 1, the fund shall charge the provider a fee of one-twenty-fourth (1/24) the annual fee for that class of provider for each semimonthly period between the date of entry and the next June 30.

(b) If a health care provider exits the fund prior to June 30, the fund shall issue the provider a refund or credit of one-twenty-fourth (1/24) the annual fee for that class or provider for each full semimonthly period between the date of exit and the next June 30. Retroactive class changes resulting in refunds or credits shall be processed retroactively for a maximum of 60 days from the fund's receipt of the amended or renewal certificate. In no case shall the fund calculate refunds or credits on a previous fiscal year's assessment except to correct an administrative billing error.

(c) If a health care provider changes class or type, which results in an increased assessment, the fund shall charge the provider an adjusted fee, comprised of one-twenty-fourth (1/24) the annual assessment for the old provider class for each full semimonthly period between the original assessment date and the date of change, and one-twenty-fourth (1/24) annual assessment for the new provider class for each semimonthly period between the date of change and next June 30.

(d) If a health care provider changes class or type, which results in a decreased assessment, the fund shall issue the provider an adjusted fee, a refund or a credit to remaining payments comprised of one-twenty-fourth (1/24) the annual assessment for the old provider class for each semimonthly period between the original assessment date and the date of change, and one-twenty-fourth (1/24) the annual assessment for the new provider class for each full semimonthly period between the date of change and the next June 30. Retroactive class changes resulting in refunds or credits shall be processed retroactively for a maximum of 60 days from the fund's receipt of the amended or renewal certificate. In no case shall the fund calculate refunds or credits on a previous fiscal year's assessment except to correct an administrative billing error.

(e) The effective date of the proof of financial responsibility required under s. 655.23 (2), Stats., as it applies to each individual health care provider, shall determine the date of entry to the fund. The cancellation or withdrawal of such proof shall establish the date of exit.

(5) EFFECTIVE DATE AND EXPIRATION DATE OF FEE SCHEDULES. The effective date of the fee schedule contained in this section shall be the current July 1 and shall expire the next subsequent June 30.

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1988 to June 30, 1989:

(a) For physicians and surgeons:

Class 1	$2,316	Class 3	$11,580
Class 2	4,632	Class 4	13,896

(b) For resident physicians and surgeons involved in post graduate medical education or a fellowship:

Class 1	$1,390	Class 3	$6,950
Class 2	2,780	Class 4	8,340

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

All classes	$1,390

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

Class 1	$ 926	Class 3	$4,630
Class 2	1,852	Class 4	5,556

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

Class 1	$ 1,158	Class 3	$5,790
Class 2	2,316	Class 4	6,948

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

Class 1	$1,737	Class 3	8,685
Class 2	3,474	Class 4	10,422

(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 fiscal year: $ 1,390.00

(h) For nurse anesthetists: $ 620.00

(i) For hospitals other than ambulatory surgery centers:

1. Per occupied bed $152.00; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $ 7.60

(j) For nursing homes

Per occupied bed $29.00

(k) For partnerships comprised of physicians or nurse anesthetists: $50.00

(l) For corporations providing the medical services of physicians or nurse anesthetists:

1. With one shareholder $0

2. With more than one shareholder $50.00

(m) For operational cooperative sickness care plans:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.19; plus

2. 2.5% of the total annual fund fees assessed against all physicians employed on July 1 of the previous fiscal year

(n) For ambulatory surgery centers:

Per 100 outpatient visits during the last calendar year for which totals are available $38.00

(o) For an entity owned or controlled by a hospital or hospitals: 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity

(6m) The fund may require any health care provider to report, at the times and in the manner prescribed by the fund, any information necessary for the determination of a fee specified under sub. (6).

(6s) 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 sub. (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%	75%	100%	200%

2. For Class 2 health care providers specified under sub. (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 sub. (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 sub. (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%

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

(a) The fund shall issue an initial billing to each provider showing the assessment due, and the payment schedules available. Once the provider has selected a payment schedule, that schedule shall apply for the remainder of that fiscal year.

(b) All providers shall pay the billed assessment on or before the due date indicated on the assessment billing. Due dates vary according to type of assessment and date of assessment.

1. Renewal assessments. The payment due dates for renewal assessments are:

a. Annual payment - July 1;

b. Semiannual payments - July 1, January 1;

c. Quarterly payments - July 1, October 1, January 1, April 1.

2. Initial assessments or assessments written for providers no longer in exempt status. For a provider who is initially participating in the fund, and for a provider who can no longer claim an exempt status, the number of payment options shall be dependent on the date the fund processes the assessment billing.

a. The first payment, regardless of a lump sum, semiannual, or quarterly payment schedule, shall be due 30 days from the date the fund processes the assessment billing.

b. For semiannual payment schedules, the second payment shall be due on or before January 1. Any provider whose first payment due date is January 1 or later shall not be able to choose the semiannual payment schedule.

c. For quarterly payment schedules, payments shall be due on or before October 1, January 1, and April 1, respectively. In order for the provider to choose 4 quarterly payments, the first payment due date shall fall before October 1. If the first payment due date falls between October 1 and December 31, the provider shall have 3 quarterly payments, with the second and third payments due on or before January 1 and March 31, the provider shall have 2 quarterly payments, with the second payment due on or before April 1. Any provider whose first payment due date is April 1 or later shall not be able to choose the quarterly payment schedule.

3. Increases in assessments. If provider changes class or type, which results in an increased assessment, the first payment resulting from that increase shall be due 30 days from the date the fund processes the increased assessment billing. The provider shall follow the same payment schedule selected with the original assessment billing when making payments for the increased assessment billing.

4. Decreases in assessments. If a provider changes class or type, which results in a decreased assessment, or if a provider leaves the fund or becomes exempt, the provider may be entitled to a refund check or a credit to be applied to future payments during the current fiscal year. If the assessment amount already paid into the fund is greater than the recalculated assessment, the fund shall issue the provider a refund check. If the assessment amount already paid into the fund is less than the recalculated assessment, the fund shall credit the provider's account for any overpayment during the period(s) affected by the decreased assessment.

(c) The fund shall charge interest and an administrative service charge to each provider who chooses the semiannual or quarterly payment schedule. The rate of interest charged by the fund shall be the average annualized rate earned by the fund for the first 3 quarters of the preceding fiscal year as determined by the state investment board. The administrative service charge shall be used to offset costs of administering the payment plan. Interest and administrative service charges are not refundable.

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; am. (7) (a) 2. and (c), r. (7) (a) 5., renum. (7) (a) 3. and 4. to be 4. and 5. and am., cr. (7) (a) 3., Register, December, 1985, No. 360, eff. 1-1-86; emerg. r. and recr. (3) (c) intro., 1. to 9., (4), (6) (intro.), (a) to (k) and (7), eff. 7-2-86; r. and recr. (3) (c) intro. and 1. to 9., (4), (6) (intro.), (a) to (k) and (7), Register, September, 1986, No. 369, eff. 10-1-86; am. (2), (4) (b) and (d), (6) and (7) (intro.), Register, June, 1987, No. 378, eff. 7-1-87; am. (6) (i) and (j), cr. (6) (k) to (o) and (6m), Register, January, 1988, No. 385, eff. 7-1-88; cr. (6s), Register, February, 1988, No. 386, eff. 3-1-88; am. (6) (intro.) to (j), (m) 1. and (n), Register, June, 1988, No. 390, eff. 7-1-88.

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 (6s) 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 % 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% 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.