

1977 Assembly Bill 704

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**CHAPTER 131, Laws of 1977**

AN ACT to repeal 655.017 and 655.03 (1) (c); to renumber 655.03 (1) (d), (e) and (f); to renumber and amend 619.01 (7); to amend 448.07 (1) (d), 619.04 (9),

655.001 (4), (8) and (11), 655.002, 655.03 (1) (a) and (2) (a) 3, (b) and (c), 655.24 (2) (b) and 655.27 (3) (a) (intro.), 1 and 2 and (b) (intro.) and (4) (d); to repeal and recreate 655.03 (1) (b) and (2) (a) 2, 655.21, 655.23 (6) and 655.27 (3) (d); and to create 448.13, 619.01 (7) (b), 655.23 (7) and 655.27 (3) (b) 4 of the statutes, relating to continuing medical education, health care liability insurance, health care liability and patients compensation.

*The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:*

SECTION 1. 448.07 (1) (d) of the statutes is amended to read:

448.07 (1) (d) No registration may be permitted by the secretary of the board in the case of any physician who has failed to meet the requirements of s. 448.13 or any person whose license or certificate has been suspended or revoked and the registration of any such person shall be deemed automatically annulled upon receipt by the secretary of the board of a verified report of such suspension or revocation, subject to ~~such~~ the licensee's right of appeal. A person whose license or certificate has been suspended or revoked and subsequently restored shall be registered by the board upon tendering a verified report of such restoration of the license or certificate, together with an application for registration and the registration fee.

SECTION 2. 448.13 of the statutes is created to read:

**448.13 Triennial training requirement.** Each physician shall, in each 3rd year at the time of application for a certificate of registration under s. 448.07, submit proof of attendance at and completion of continuing education programs or courses of study approved for at least 45 hours of credit by the board within the 3 calendar years preceding the calendar year for which the registration is effective. The board may waive this requirement if it finds that exceptional circumstances such as prolonged illness, disability or other similar circumstances have prevented a physician from meeting the requirement.

SECTION 3. 619.01 (7) of the statutes is renumbered 619.01 (7) (a) and amended to read:

619.01 (7) **HEALTH CARE LIABILITY POLICY LIMITS.** (a) (title) *Primary coverage plans.* Health care liability insurance plans established under this ~~section~~ paragraph shall provide minimum coverage to insureds in the amount of not less than \$100,000 for each occurrence and \$300,000 for all occurrences in any one policy year for the protection of persons who are legally entitled to recover damages from the insured for errors, omissions or neglect in the performance of the insured's professional services. If an insured has excess limits liability coverage or such coverage is available to the insured, the coverage provided under such plans shall be equal to the minimum level of such excess limits coverage. If the insured does not have excess limits liability coverage and such coverage is not available to the insured, the commissioner may establish minimum levels of coverage higher than the minimum limits specified in this ~~subsection~~ paragraph for such plans.

SECTION 4. 619.01 (7) (b) of the statutes is created to read:

619.01 (7) (b) *Supplemental liability coverage plans.* Health care liability insurance plans of the kind authorized under par. (a) may be established by the commissioner under this paragraph to provide coverage to supplement primary coverage provided by insurers authorized under ch. 611 or 618. Such plans may be in an amount no greater than \$100,000 for each occurrence and \$300,000 for all occurrences in any one policy year, but the total combined primary and supplemental coverage may not exceed the limits established by s. 655.23 (5).

SECTION 5. 619.04 (9) of the statutes is amended to read:

619.04 (9) Neither the state nor the board of governors shall be liable for any obligation of the plan or of the patients compensation fund under s. 655.27. The board of governors and members of any committee or subcommittee thereof shall be immune

from civil prosecution for good faith actions taken within the scope of their duties under this section and s. 655.27.

SECTION 6. 655.001 (4), (8) and (11) of the statutes are amended to read:

655.001 (4) "Department" means the department of ~~regulation and licensing~~ health and social services.

(8) "Health care provider" means a medical or osteopathic physician licensed under ch. 448; a nurse anesthetist licensed or registered under ch. 441; a partnership comprised of such physicians or nurse anesthetists; a corporation owned by such physicians or nurse anesthetists and operated for the purposes of providing medical services; an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 which directly provides services through salaried employes in its own facility; ~~or a hospital as defined by s. 140.24 50.33 (1) (a) and (c); but excluding or a nursing home as defined by s. 50.02 (1) (a) whose operations are combined as a single entity with a hospital subject to this section, whether or not the nursing home operations are physically separate from hospital operations. It excludes any state, county or municipal employes employe or federal employes employe covered under the federal tort claims act, as amended, while who is acting within the scope of their employment, and those facilities any facility exempted by s. 140.29 50.39 (3) or operated by any governmental agency, but any state, county or municipal employe or facility so excluded who would otherwise be included in this definition may petition in writing to be afforded the coverage provided by this chapter and upon filing the petition with the commissioner and paying the fee required under s. 655.27 (3) will be subject to this chapter.~~

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

SECTION 7. 655.002 of the statutes is amended to read:

**655.002 Exemptions.** Any physician licensed under ch. 448 may be exempted from ss. 655.21, 655.23 and 655.27 upon petition to the ~~department of regulation and licensing~~ commissioner while a graduate medical student acting within the scope of a resident or fellowship training program. Any such exemption shall not affect the liability of the physician's employer for acts or omissions.

SECTION 8. 655.017 of the statutes is repealed.

SECTION 9. 655.03 (1) (a) of the statutes is amended to read:

655.03 (1) (a) One physician licensed to practice medicine in this state, appointed at random by the administrator for a 6-month term or for the duration of any case pending at the expiration of such term from a list submitted by ~~the medical examining board~~ an appropriate statewide organization of physicians as designated by the administrator.

SECTION 10. 655.03 (1) (b) of the statutes is repealed and recreated to read:

655.03 (1) (b) One additional health care provider to be selected under subd. 1, 2 or 3. In no event may more than one health care provider be selected under this paragraph.

1. If there is only one respondent and that respondent is a physician, one physician licensed to practice medicine in this state who is engaged in a practice of medicine similar to the practice of the respondent, appointed at random by the administrator from a list submitted by the appropriate statewide organization.

2. If there is only one respondent and the respondent is not a physician, one person licensed or certified in this state in the same field of health care as that of the respondent, appointed at random by the administrator from a list supplied by the appropriate state examining board or by the department.

3. If there is more than one respondent, one person appointed under either subd. 1 or 2, with the field of health care to be represented determined by the administrator.

SECTION 11. 655.03 (1) (c) of the statutes is repealed.

SECTION 12. 655.03 (1) (d), (e) and (f) of the statutes are renumbered 655.03 (1) (c), (d) and (e).

SECTION 13. 655.03 (2) (a) 2 of the statutes is repealed and recreated to read:

655.03 (2) (a) 2. A list of health care providers, arranged according to the field of health care of the health care providers. The list shall be prepared and periodically revised by appropriate statewide organizations of health care providers. The list shall designate the specialty, if any, of each health care provider listed. Such organizations shall assist the administrator in determining the appropriate specialty or field of practice to be represented on each panel. The administrator shall select 3 names from the list to represent adequately the field of health care of the respondent or respondents.

SECTION 14. 655.03 (2) (a) 3, (b) and (c) of the statutes are amended to read:

655.03 (2) (a) 3. ~~Lists~~ A list for petit jurors, as provided in s. 255.04, for the county in which a submission of controversy has been filed under s. 655.04.

(b) If any person selected from a list desires not to participate on the informal panel, the administrator may, for good cause, excuse such person from service. No person may serve on an informal panel if the person has a professional or personal interest in a claim under consideration. A replacement shall be selected in the same manner as the excused person was selected. The selections shall consist of the categories of attorney, of ~~each kind of health care provider named under par. (a) 2~~ and of juror.

(c) The claimant and the respondent shall each strike one name from each of the categories described in par. (b), and the 3 remaining persons shall comprise the informal panel. If there is more than one respondent, the respondents must resolve the question of striking names from the lists among respondents, but may not strike more than one name in each category. The first strike in each category shall be made by the claimant. In no event may any panel be composed of more than one member chosen from each of the 3 lists specified in par. (a).

SECTION 15. 655.21 of the statutes is repealed and recreated to read:

**655.21 Funding.** (1) The patients compensation panel shall be financed from fees charged to health care providers. The department and the commissioner shall biennially report under s. 16.42 the revenue received from the various types of health care providers. Until otherwise provided by law on the basis of documented cost experience, the annual fees are established as follows:

(a) For each physician permanently practicing in this state, \$40.

(b) For each hospital, \$10 per bed.

(2) The annual fees under sub. (1) (a) shall be collected in a manner prescribed by rule of the commissioner. The annual fees under sub. (1) (b) shall be collected by the department in a manner prescribed by rule of that department. The commissioner and the department shall pay all money so collected under sub. (1) into the patients compensation fund created under s. 655.27. At the time of remitting the fee, each health care provider permanently practicing or operating in this state shall submit proof of financial responsibility under s. 655.23 in a manner prescribed by rule of the commissioner.

SECTION 16. 655.23 (6) of the statutes is repealed and recreated to read:

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

amount to be determined by the court. Before an action is commenced, the commissioner may compromise the forfeiture; after the action is commenced, the attorney general may compromise the forfeiture.

SECTION 17. 655.23 (7) of the statutes is created to read:

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

SECTION 18. 655.24 (2) (b) of the statutes is amended to read:

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

SECTION 19. 655.27 (3) (a) (intro.), 1 and 2 and (b) (intro.) of the statutes are amended to read:

655.27 (3) (a) *Base fees.* (intro.) Each health care provider shall pay the following fees to the department of health and social services or the department of regulation and licensing commissioner for deposit into the fund, ~~as a condition of licensing under s. 140.85 (2) or ch. 441 or 448 in a manner prescribed by them by rule:~~

1. For the first fiscal year of the fund's operation, for any individual physician permanently practicing in this state, 10% of the premium the physician would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year; \$50 for any individual nurse anesthetist, and \$75 per bed for any hospital.

2. For the 2nd fiscal year of the fund's operation, for any individual physician permanently practicing in this state, 10% of the premium the physician would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year; \$40 for any individual nurse anesthetist; and \$75 per bed for any hospital, ~~\$50 per bed plus 10% of the premium it would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year.~~

(b) *Operating fees.* (intro.) In addition, after the 2nd year of operation each health care provider permanently practicing or operating in this state shall pay operating fees to the department of health and social services or the department of regulation and licensing commissioner for deposit into the fund, ~~as a condition of licensing under s. 140.85 (2) or ch. 441 or 448 in a manner prescribed by them by rule.~~ Such operating fees shall be assessed based on the following considerations:

SECTION 20. 655.27 (3) (b) 4 of the statutes is created to read:

655.27 (3) (b) 4. During the 2nd year of the fund's operation, operating fees assessed for nursing home beds covered under s. 655.001 (8) shall be no more than 50% of the fees assessed for hospital beds and shall be experience-rated for all subsequent years.

SECTION 21. 655.27 (3) (d) of the statutes is repealed and recreated to read:

655.27 (3) (d) *Collection and deposit of fees.* All fees under pars: (a), (b) and (c) shall be collected by the commissioner or the department for deposit into the fund in a manner prescribed by them by rule.

SECTION 22. 655.27 (4) (d) of the statutes is amended to read:

655.27 (4) (d) Annually after the close of a fiscal year, the board of governors shall furnish an audited financial report to ~~all fund participants and to~~ the commissioner. The report shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the commissioner. The board of governors shall furnish an appropriate summary of this report to all fund participants.

SECTION 23. **Program responsibilities.** (1) In the program responsibilities listed for the department of health and social services under section 15.191 (intro.) of the statutes, delete reference to sections "655.03", "655.21" and "655.27", and insert reference to "ch. 655".

(2) In the program responsibilities listed for the department of regulation and licensing under section 15.401 (intro.) of the statutes, delete reference to "ch. 655".

SECTION 24. **Cross reference changes.** In the sections of the statutes listed in Column A, the cross references shown in Column B are changed to the cross references shown in Column C:

A	B	C
Statute Sections 655.03 (1)(e), as renumbered	Old Cross References 655.03 (1)(a) to (c)	New Cross References 655.03 (1)(a) or (b)

SECTION 25. **Effective date.** The treatment of sections 448.07 (1) (d), 448.13 and 655.017 of the statutes by this act shall take effect for all registrations issued for calendar year 1980 and thereafter.

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