

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 chapter 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 compensation fund fees (ss. 655.21 and 655.27, Stats.) (1) **PURPOSE.** This rule implements the provisions of ch. 655, Stats., relating to the payment of fees to the patients compensation fund.

(2) **SCOPE.** This rule applies to each health care provider as defined in s. 655.001, Stats., except hospitals, nursing homes or other facilities subject to regulation by the department of health and social services.

(3) **DEFINITIONS.** For the purpose of this rule the definition of terms used shall be those definitions set forth in s. 655.001, Stats.

(4) **PAYMENT OF FEES TO FINANCE PATIENTS COMPENSATION PANELS.**
(a) Once in each fiscal year each physician operating in this state shall

pay, in accordance with a billing schedule adopted by the commissioner, the annual fee established by s. 655.21 (1) (a), Stats.

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

(c) Any physician 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. 655.21 (1) (a), 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. 655.21 (1) (a), Stats.

(e) The commissioner may upon a showing of sufficient cause extend the period for a payment for an additional period of time to be determined by the commissioner.

(5) PAYMENT OF OPERATING FEES TO PATIENTS COMPENSATION FUND.

(a) Once in each fiscal year each health care provider, except hospitals, nursing homes or other facilities subject to regulation by the department of health and social services, shall pay in accordance with a billing schedule adopted by the commissioner the annual fee determined in accordance with s. 655.27 (3) (c), Stats.

(b) Such fees are due and payable upon receipt of the billing by the health care provider.

(c) Any health care provider who has not paid the fee within thirty days from the date the billing is received shall be deemed to be in noncompliance with s. 655.23 (1), Stats., and subject to the penalty provisions of s. 655.23 (6) and (7), Stats.

(d) The commissioner shall notify the department of regulation and licensing of each health care provider who has not paid the fee and who is, therefore, in noncompliance with s. 655.23(1), Stats.

(e) The commissioner may upon a showing of sufficient cause extend the period for payment of fees for an additional period of time to be determined by the commissioner.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

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 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.

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 any hearings shall be captioned "Before the Board of Governors of the Wisconsin Health Care Liability Insurance Plan and Wisconsin Patients Compensation Fund" and shall be entitled "In the Matter of (here insert the matter that is involved)."

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

Ins 17.06 Service of papers. (ss. 619.04 and 655.003, Stats.) A copy of all papers filed at or in reference to any hearing shall be served, or furnished as the case may be, on or to each other party or person interested who enters an appearance in the proceedings.

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

Ins 17.07 Procedure upon filing complaint. (ss. 619.04 and 655.003, Stats.) Upon the filing of a complaint as prescribed by section 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. If it determines that no further action is warranted it shall so notify the complainant in writing of the reasons therefore.

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

Ins 17.08 Forms of notice. (ss. 619.04 and 655.003, Stats.) Notices of hearing shall include a statement of issues and shall be in substantially the following form: (1) If on a complaint filed with the commissioner a copy thereof shall be attached to a notice in the following form:

"To: (Name)

(Street Address)

(City) (State) (Zip)

Take notice that a hearing will be held on the _____ day of _____, 19____ at the office of the Commissioner of Insurance, 123 West Washington Avenue, Madison, Wisconsin (or other proper designation of the place where the hearing will be held) at _____ o'clock in the _____ m. or as soon thereafter as the matter may be reached, on the (here to be stated briefly the substance of the subject of the hearing).

This is a class proceeding as defined by Wisconsin Statute section 227.01 (2).

This hearing will be conducted under the authority granted the Board by Chapter 655 and by section 227.01 (1) of the Wisconsin Statutes.

Dated at Madison, Wisconsin this day of , 19 .

BOARD OF GOVERNORS OF THE
WISCONSIN HEALTH CARE LIABILITY INSURANCE PLAN AND
WISCONSIN PATIENTS COMPENSATION FUND

(Signature)

Chairman or Secretary

(2) If initiated on the board's own motion or investigation the form of notice shall be as set forth in subsection (1), but altered by inserting the following:

"The issues involved and the matters there to be considered are set forth in the attached copy of the complaint to which you are required to make answer in writing at least . . . days before the time set for said hearing."

(3) Except in the case of an emergency such notice shall be mailed to the known interested parties at least 10 days prior to the hearing.

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

Ins 17.09 Answer. (ss. 619.04 and 655.003, Stats.) The respondent shall be required to answer any notice within the time therein specified and failure to do so shall constitute a default. The commissioner may, upon proper showing, excuse such failure to answer upon such terms as the commissioner determines to be just and permit the party to make answer within such time as the commissioner prescribes, provided, however, that no party shall be relieved from such default after a hearing has been concluded and an order entered or other disposition made of the matter. The answer shall be verified by the respondent individually, or if a corporation by a proper officer of such corporation, unless an admission of the allegations might subject the person or party to prosecution for a felony, and shall be filed with the commissioner in triplicate (original and 2 copies) within the time prescribed in the notice of hearing.

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

Ins 17.10 Contents of answer. (ss. 619.04 and 655.003, Stats.) The answer must contain: (1) A specific denial of each material allegation of the charges, factual situations or matters which the respondent controverts.

(2) A statement of any new matter constituting a defense or mitigating the offense or matter charged, which the respondent wishes to have considered.

(3) Every material allegation not controverted as prescribed shall be taken as true, but any new matter set forth in the answer shall be deemed controverted without any reply being served or filed.

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

Ins 17.11 Hearing examiner. (ss. 619.04 and 655.003, Stats.) (1) The board may designate the commissioner or any employe on the commissioner's staff or borrowed from another agency pursuant to ss. 16.24 or 20.901, Stats., as a hearing examiner to preside over any case. Such examiner may:

- (a) Administer oaths and affirmations.
- (b) Issue subpoenas authorized by law.
- (c) Rule on offers of proof and receive relevant evidence.
- (d) Take depositions or have depositions taken when permitted by law.
- (e) Regulate the course of the hearing.
- (f) Hold conferences for the settlement or simplification of the issues by consent of the parties.
- (g) Dispose of procedural requests or similar matters.
- (h) Make or recommend findings of fact, conclusions of law and decisions to the extent permitted by law.
- (i) Take other action authorized by agency rule consistent with this chapter.

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

Ins 17.12 Rules of hearing. (ss. 619.04 and 655.003, Stats.) All hearings shall be conducted pursuant to ss. 227.07 - 277.08, Stats.

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

Ins 17.13 Continuances. (ss. 619.04 and 655.003, Stats.) Continuances and adjournments of hearings may be granted for cause by the board or the hearing examiner.

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

Ins 17.14 Hearing public. (ss. 619.04 and 655.003, Stats.) All hearings shall be open to the public, except where otherwise specifically provided by statute or ordered by the board or the person conducting the same.

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

Ins 17.15 Subpoenas. (ss. 619.04 and 655.003, Stats.) The commissioner may sign and issue subpoenas for the attendance of a party or any witness at a hearing whether conducting the hearing or not. The hearing examiner may sign and issue subpoenas for the attendance of witnesses or parties at such hearing.

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

Ins 17.16 Service. (ss. 619.04 and 655.003, Stats.) Service of notice of hearing, notice of order of the board, and of any other notices during the process of and in relation to a hearing shall be given as provided by ch. 227, Stats. Services of any notice, paper or document in a proceeding after the entry of an appearance as provided by this section shall be made in such manner and may be on the party or on any agent, employe, officer or attorney appearing for or with such party as last entered in the

record of such proceedings or furnished and in modification thereof shall be conclusive as the proper and correct mail address.

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

Ins 17.17 Appearances. (ss. 619.04 and 655.003, Stats.) Parties may appear in person or by a regularly employed employe or agent, or by an attorney, and if a corporation by any of its active officers. Upon an appearance at a hearing the name and mail address of the party appearing and the name and mail address of any agent, employe, officer or attorney appearing with or for such party shall be furnished and entered in the record of the proceedings, and the appearance so made and the mail addresses so given shall be binding on the party unless and except as modified by written notice to the board or the person conducting the hearing and to all other parties appearing therein served as provided by section Ins. 17.15 Wis. Adm. Code which when so modified shall in turn have the same force and effect as in the first instance.

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

Ins 17.18 Examination of witnesses. (ss. 619.04 and 655.003, Stats.) Witnesses may be examined on behalf of the board by the commissioner or the hearing examiner, or by an employe of the board with the permission of the hearing examiner, or by a representative of the attorney general acting as counsel for the board or the state. Such witnesses may be cross-examined by a party or any one authorized and appearing therefor, but no more than one individual, whether the party or an agent, employe, officer or attorney appearing with or for such party, shall cross-examine a witness except by permission of the hearing examiner. The commissioner, the hearing examiner, any employe of the board or any representative of the attorney general who shall be acting at said hearing, may call adversely any party, officer, agent or employe of a party and any witness on behalf of any party and may cross-examine any witness or party testifying at such hearing. All witnesses shall be sworn by the commissioner or the hearing examiner before testifying in the same manner as is provided by a statute in respect to the swearing of witnesses testifying in proceedings before courts of record.

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

Ins 17.19 Record. (ss. 619.04 and 655.003, Stats.) (1) Method. All the proceedings at a hearing in a contested case shall be recorded either mechanically, electronically or stenographically. The typed transcript of the record will be prepared when deemed necessary by the board or hearing examiner or when requested as set out in subsection (2). The record in a contested cases shall include the material listed in s. 227.07 (6), Stats.

(2) Copies. If a transcript of the hearing is prepared for the board or hearing examiner, copies will be furnished to all persons upon request upon payment of the fee authorized by s. 601.31 (21), Stats. If no transcript has been prepared by the commissioner or other hearing officer and a party requests that one be prepared, that party shall be responsible for all costs of transcript either dictated at length into the record, or reduced to writing signed by the persons or parties stipulating, and filed as a part of the record of the proceedings.

(3) Copies for Interested Parties. Parties who are impecunious who require and request a transcript for appeal or for other purposes deemed reasonable by the commissioner or hearing officer shall be furnished

with a transcript of the hearing at the expense of the office of the commissioner of insurance upon the filing of a verified petition stating the purpose for which the transcription is needed and that the person is without means to purchase a transcript.

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

Ins 17.20 Stipulations. (ss. 619.04 and 655.003, Stats.) All stipulations or agreements in reference to a matter the subject of a hearing or entered into at a hearing shall be either dictated at length into the record, or reduced to writing, signed by the persons or parties stipulating, and filed as a part of the record of the proceedings. Controversies, or matters which may be the subject of or cause for a hearing may be disposed of by stipulation, agreed settlement or consent orders.

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

Ins 17.21 Motions. (ss. 619.04 and 655.003, Stats.) Except during a hearing, motions shall be made in writing and signed by the party or person authorized and appearing in the proceedings therefor, or if the party is a corporation by an active officer of the corporation. At least 3 days notice thereof shall be given to the board or the hearing examiner, and to each and every other party to the proceeding, served as prescribed by section Ins 17.16 Wis. Adm. Code.

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

Ins 17.22 Default. (ss. 619.04 and 655.003, Stats.) In case the respondent fails to submit an answer as required by section Ins 17.08 Wis. Adm. Code or fails to appear at a hearing at the time and place fixed therefor, the matters specified shall be taken as true and the board may make findings and enter an order on the basis thereof. The default of a party in answering or in appearing shall not preclude the board from hearing said matter, taking such evidence as necessary and proper, and disposing of the matter.

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

Ins 17.23 Arguments. (ss. 619.04 and 655.003, Stats.) The hearing examiner may hear oral arguments and limit the time thereof. All arguments shall be submitted in writing unless otherwise ordered. At least 3 copies of all briefs or written arguments shall be furnished to the board. The time for filing such arguments shall be fixed by the hearing examiner.

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

Ins 17.24 Review of classification. (ss. 619.04 and 655.003, Stats.)
(1) Any person other than a hospital or a hospital connected with a nursing home, asserting placement in the wrong classification for insurance premium rate purposes may petition for a review of classification. The commissioner shall refer such petition to a committee consisting of 2 physicians and one informed person, all appointed by the commissioner. The decision of such committee shall be reported to the petitioner within 5 working days of the closing of the hearing record.

(2) Any hospital or hospital combined with a nursing home which believes that it has been placed in the wrong classification for insurance premium rate purposes may petition for a review of classification. The commissioner shall refer such petition to a committee consisting of 2 hospital representatives and one informed person; all appointed by the

commissioner. The decision of such committee shall be reported to the petitioner within 5 working days of the closing of the hearing record.

(3) Any person or hospital who is not satisfied with the determination of the committee may petition for a declaratory ruling under section Ins 17.02 Wis. Adm. Code within 30 days of the date of the written notice of the committee's determination.

(4) At any hearing held pursuant to such petition for a declaratory ruling the committee report shall be considered and the members of the committee have the right to appear and be heard but shall not be required to be present.

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

Ins 17.25 Wisconsin health care liability insurance plan. (1)

FINDINGS. (a) Legislation has been enacted authorizing the commissioner of insurance to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or to call upon the insurance industry to prepare plans for his approval.

(b) Health care liability insurance for medical or osteopathic physicians or podiatrists, licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state and for operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employes, and for properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats., is not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding, except as otherwise provided herein, those facilities exempted by s. 50.39 (3), Stats., which operate in this state are not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for those nursing homes as defined in s. 50.01 (3) (a), Stats., which operate in this state and whose functional operations are combined with a hospital as herein defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations, are not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for health care facilities owned or operated by a political subdivision of the state of Wisconsin are not readily available in the voluntary market.

(c) A facility for providing such health care liability insurance should be enacted pursuant to ch. 619, Stats.

(2) **PURPOSE.** This rule is intended to implement and interpret ch. 619, Stats., for the purpose of establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage on a self-supporting basis for medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; for operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide service in their own facilities with

salaried employees; and for properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.; and to provide health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for all hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided herein, which operate in this state. Health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for those nursing homes as defined in s. 50.01 (3) (a), Stats., which operate in this state and whose functional operations are combined with a hospital as herein defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations is also provided. Health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for those health care facilities owned or operated by a political subdivision of the state of Wisconsin is also provided. Health care liability insurance coverage for allied health care personnel employed by any of these health care providers while working within scope of such employment may also be provided. This rule is also intended to encourage the improvement in reasonable loss prevention measures and to encourage the maximum use of the existing voluntary market.

(3) **SCOPE.** This rule shall apply to all insurers authorized to transact in this state on a direct basis insurance against liability resulting from personal injuries, except for town mutuals authorized to transact insurance under ch. 612, Stats.

(4) **DEFINITIONS.** (a) *The Wisconsin health care liability insurance plan*, hereinafter referred to as the Plan, means the statutory, nonprofit, unincorporated association established by this rule to provide for the issuance of health care liability insurance and liability coverages normally incidental to health care liability insurance at adequate rate levels for risk sharing subject to the right of recoupment and to assist qualified applicants in securing health care liability insurance and liability coverage normally incidental to health care liability insurance.

(b) Insurance against liability resulting from personal injuries means all insurance coverages against loss by the personal injury or death of any person for which loss the insured is liable. It includes the personal injury liability component of multi-peril policies, but it does not include steam boiler insurance authorized under section Ins 6.75 (2) (a), worker's compensation insurance authorized under section Ins 6.75 (2) (k), or medical expense coverage authorized under section Ins 6.75 (2) (d) or (e).

(c) Health care liability insurance means insurance against loss, expense and liability resulting from errors, omissions or neglect in the performance of any professional service by any medical or osteopathic physician or podiatrist licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; by operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employees; by properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.

licensed under ch. 441, Stats.; by all hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided; by those nursing homes as defined in s. 50.01 (3) (a), Stats., whose functional operations are combined with a hospital as herein defined as a single entity, whether or not nursing home operations are physically separate from the hospital operations, which operate in this state; and by health care facilities owned or operated by a political subdivision of the state of Wisconsin.

(d) Liability coverage normally incidental to health care liability insurance shall include owners, landlords and tenants liability insurance; owners and contractors protective liability insurance; completed operations and products liability insurance; contractual liability insurance and personal injury liability insurance.

(e) Premiums written means gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to insurance against liability resulting from personal injuries covering insureds or risks resident or located in this state excluding premiums on risks insured under the Plan.

(f) Servicing company means an insurer which services policies issued on behalf of the Plan.

(g) Confidential claims information means any information relating to the Plan in the possession of the commissioner, the board of governors or an agent thereof which reveals, directly or indirectly, the identity of a health care provider, as defined in s. 655.001 (8), Stats.

(h) Political subdivision means counties, cities, villages and towns.

(5) INSURANCE COVERAGE. (a) All of the following which operate in this state and are equitably entitled to but are otherwise unable to obtain suitable health care liability insurance in the voluntary market shall be eligible to apply for insurance under this plan:

1. All medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats.;

2. Nurse anesthetists licensed under ch. 441, Stats.;

3. Operating cooperative sickness case plans organized under s. 185.981 to 185.985, Stats., which directly provide service, in their own facilities with salaried employees;

4. Properly accredited teaching facilities conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.;

5. All hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided herein;

6. Nursing homes defined in s. 50.01 (3) (a), Stats., whose functional operations are combined with a hospital as a single entity, whether or not the nursing home operations are physically separate from the hospital operations;

7. Health care facilities owned or operated by a political subdivision of the state of Wisconsin;

8. Corporations organized to manage approved training programs for medical or osteopathic physicians licensed under ch. 448, Stats.;

9. Upon request of an insured under subds. 1 to 8 allied health care personnel employed by such insured and working within the scope of such employment.

(b) The maximum limits of coverage for the type of health care liability insurance defined in subsection (4) (c) which may be placed under this Plan are \$200,000 per claim and \$600,000 aggregate for all claims in any one policy year.

(c) The maximum limits of coverage for liability coverages normally incidental to health care liability insurance as defined in subsection (4) (d) which may be placed under this Plan are \$1,000,000 per claim and \$1,000,000 aggregate for all claims in any one policy year.

(d) Health care liability coverage shall be provided in a standard policy form on an occurrence basis, i.e., coverage for any liability based on a treatment, omission or operation which occurs during the term of the policy and which is brought within the time the applicable statute of limitations continues the liability. The board of governors may authorize the issuance of policies on other bases as an option under the Plan subject to such restrictions and rules as it may deem necessary and appropriate in the circumstances.

(e) Any policyholder holding coverage under the Wisconsin Health Care Liability Insurance Plan shall continue to be subject to the rules governing the Plan which were in force when the coverage was obtained. The renewal of any such coverage shall be subject to the provisions of the rule in effect at the time of the renewal. All obligations and liabilities created under such prior rule shall continue in force under the Plan until they are extinguished.

(f) Coverage for hospitals, nursing homes, or health care facilities owned or operated by a political subdivision of the state of Wisconsin which are eligible for insurance under this plan may include liability coverages normally incidental to health care liability insurance as defined in subsection (4) (d).

(6) MEMBERSHIP. (a) Every insurer, subject to subsection (3) shall be a member of this Plan.

(b) An insurer's membership terminates when the insurer is no longer authorized to write personal injury liability insurance in Wisconsin, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this rule until it completes all of its obligations under the Plan.

(c) Subject to the approval of the commissioner, the board of governors may charge a reasonable membership fee, not to exceed \$50.00.

(7) ADMINISTRATION. (a) The Plan shall be administered by a board of governors.

(b) The board of governors shall consist of the commissioner or his designated representative, and 10 other board members. Each shall have one vote.

1. The commissioner shall appoint 5 board members from insurers who are members of the Plan.

a. The following associations shall at the direction of the commissioner nominate board members:

American Insurance Association
Alliance of American Insurers
National Association of Independent Insurers
Wisconsin Insurance Alliance

b. The commissioner shall appoint one board member from other insurers not members of the associations in subdivision a.

2. The state bar association shall appoint one board member who shall be an attorney.

3. The Wisconsin medical society shall appoint one board member who shall be a physician.

4. The Wisconsin Hospital Association shall appoint one board member.

5. The Governor shall appoint 2 public board members for staggered three-year terms who are not attorneys or physicians and who are not professionally affiliated with any hospital or insurance company.

(c) The commissioner or his representative shall be chairman of the board of governors.

(d) Board members other than the commissioner or his representative shall be compensated at the rate of \$50 per diem plus actual necessary travel expenses.

(8) DUTIES OF THE BOARD OF GOVERNORS. (a) The board of governors shall meet as often as may be required to perform the general duties of the administration of the Plan or on the call of the commissioner. Six members of the board shall constitute a quorum.

(b) The board of governors shall be empowered to invest, borrow and disburse funds, budget expenses, levy assessments, cede and assume reinsurance, and perform all other duties provided herein as necessary or incidental to the proper administration of the Plan. The board of governors may appoint a manager or one or more agents to perform such duties as may be designated by the board.

(c) The board of governors shall develop rates, rating plans, rating and underwriting rules, rate classifications, rate territories, and policy forms in accordance with ss. 619.01 (1) (c) 2., 619.04 (5), 625.11, and 625.12, Stats., and subsection (12) of this rule.

(d) The board of governors shall cause all policies written pursuant to this Plan to be separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium level for each classification of risk, and performing loss prevention and other studies of the operation of the Plan.

(e) The board of governors shall determine, subject to the approval of the commissioner, the eligibility of an insurer to act as a servicing company. If no qualified insurer elects to be a servicing company, the board of governors shall assume such duties on behalf of member companies.

(f) The board of governors shall enter into agreements and contracts as may be necessary for the execution of this rule consistent with its provisions.

(g) The board of governors may appoint advisory committees of interested persons, not limited to members of the Plan, to advise the board in the fulfillment of its duties and functions.

(h) The board of governors shall be empowered to develop, at its option, an assessment credit plan subject to the approval of the commissioner, wherein a member of the Plan receives a credit against an assessment levied, based upon Wisconsin voluntarily written health care liability insurance premiums.

(i) The board of governors of the Plan shall be authorized to take such actions as are consistent with law to provide the appropriate examining boards or the department of health and social services with such claims information as may be appropriate.

(j) The board of governors shall assume all duties and obligations formerly vested in the governing committee whenever it becomes necessary to administer any of the provisions governing the Wisconsin Health Care Liability Insurance Plan, which provisions preceded the adoption of the provisions contained in this rule.

(9) ANNUAL REPORTS AND RECORDS. (a) By May 1 of each year the board of governors shall make a report to the members of the Plan and to the standing committees on health insurance in each house of the legislature summarizing the activities of the Plan in the preceding calendar year.

(b) All books, records, documents or audits relating to the Plan or its operation shall be open to public inspection, with the exception of confidential claims information.

(10) APPLICATION FOR INSURANCE. (a) Any medical or osteopathic physician, podiatrist, nurse anesthetist, operating cooperative sickness care plan, teaching facility, hospital, nursing home, or health care facility owned or operated by a political subdivision of the state of Wisconsin eligible for insurance under this plan may submit an application for insurance by the plan directly or through any licensed agent. Such application may include requests for coverage of allied health care providers while working within the scope of such employment.

(b) The Plan may bind coverage.

(c) The Plan shall, within 8 business days from receipt of an application, notify the applicant of the acceptance, rejection or the holding in abeyance of the application pending further investigation. Any individuals rejected by the Plan shall have the right to appeal that judgment within 30 days to the board of governors in accordance with subsection (16).

(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

commission to the licensed agent designated by the applicant; if no licensed agent is so designated, such commission shall be retained by the Plan.

(11) **ASSESSMENTS AND PARTICIPATION.** (a) In the event that sufficient funds are not available for the sound financial operation of the Plan, and pending recoupment pursuant to s. 619.01 (1) (c) 2., Stats., all members shall, on a temporary basis, contribute to the financial needs of the Plan in the manner prescribed in paragraph (b). When such assessment contribution is recouped, it shall be reimbursed to members as their total share of the assessment contribution bears to the aggregate outstanding contributions.

(b) All members of the Plan shall participate in all premiums, other income, losses, expenses, and costs of the Plan in the proportion that the premiums written of each such member [excluding that portion of premiums attributable to the operation of the Plan and giving effect to any assessment credit plan under subsection (8) (h)] during the preceding calendar year bears to the aggregate premiums written in this state by all members of the Plan. Each member's participation in the Plan shall be determined annually on the basis of such premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner of insurance.

(12) **RATES, RATE CLASSIFICATIONS, AND FILINGS.** Rates, rate classifications, and filings for coverages issued by the Plan shall be generally subject to ch. 625, Stats., and specifically shall meet the requirements of ss. 619.01 (1) (c) 2., 619.04 (5), 625.11, and 625.12, Stats. Rates and rate classifications shall not discriminate on the basis of the insured's sex, marital status, race, color, creed or national origin. Information supporting the rates and rate classifications filed with the commissioner shall be made a part of such filing. Rates, rate classifications and filings shall be developed in accordance with the following standards or rules:

(a) *Rates.* 1. Rates shall not be excessive, inadequate or unfairly discriminatory.

2. Rates shall be calculated in accordance with generally accepted actuarial principles, using the best available data and shall be reviewed by the board of governors at least once each year.

3. Rates shall be calculated on a basis which will make the Plan self-supporting and shall be presumed excessive if they produce a long run profit or surplus for the Plan over losses and expenses, and loss reserves (including contingency reserves).

4. Any deficit incurred by the Plan in any one year shall be recouped by rate increases applicable prospectively, or any surplus over the loss reserves of the Plan in any one year shall be distributed by rate decreases applicable prospectively.

5. Rates shall reflect past and prospective loss and expense experience in different areas of practice.

6. Wisconsin loss and expense experience shall be used in establishing and reviewing rates to the extent it is statistically credible supplemented by relevant data from outside the state; relevant data shall include, but not be limited to, data provided by other insurance companies, rate service organizations or governmental agencies.

7. Loss and expense experience used in determining initial or revised rates shall be adjusted to indicate as nearly as possible the loss and expense experience which will emerge on policies issued by the Plan during the period for which the rates were being established; for this purpose loss experience shall include paid and unpaid losses, a provision for incurred but not reported losses, and both allocated and unallocated loss adjustment expenses and consideration shall be given to changes in estimated costs of unpaid claims and to indications of trends in claim frequency, claim severity, and level of loss expense.

8. Review of rates for the Plan shall begin with the experience of the Plan, supplemented first by Wisconsin experience of coverage provided by other insurers, and then, to the extent necessary for statistical credibility, by relevant data from outside the state.

9. Information supporting the rate filing shall indicate the existence, extent and nature of any subjective factors in the rates based on judgment of technical personnel, such as consideration of the reasonableness of the rates compared to the cost of comparable coverage where it is available.

10. Expense provisions included in the rate to be used by the Plan shall reflect reasonable prospective operating expense levels of the Plan.

11. All accumulated net income, including investment income under the Plan, shall be used to modify the indicated rates promulgated in accordance with the foregoing criteria.

12. Provision may be made for modification of rates for individual risks in accordance with rating plans or surcharge schedules which establish reasonable standards for measuring probable variation in hazards, expenses, or both.

(b) *Classifications.* 1. Classifications shall reflect past and prospective loss and expense experience in different areas of practice.

2. Classifications shall be established which measure to the extent possible variations in exposure to loss and in expenses based upon the best data available.

3. Classifications shall include recognition of any difference in the exposure to loss of semi-retired or part-time professionals.

4. Classifications shall to the extent possible reflect past and prospective loss and expense experience of risks insured in the Plan and other relevant experience from within and outside this state.

5. Classification schedules may provide for modification of rates for individual risks in accordance with rating plans or surcharge schedules which establish reasonable standards for measuring probable variations in hazards, expenses, or both.

6. Classifications shall be reviewed by the board of governors at least once each year.

(c) *Filings.* 1. All filings of rates, classifications and supporting information of the Plan and all changes and amendments thereof shall be filed with the commissioner within 30 days after they become effective.

2. These filings shall be open to public inspection during the usual business hours of the office of the commissioner of insurance.

(13) **VOLUNTARY BUSINESS - CANCELLATION AND NONRENEWAL.** Any member cancelling or not renewing voluntarily written health care liability insurance covering any risk eligible under this Plan shall inform the policyholder of the availability of insurance under the Plan. Any such 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 shall not cancel or refuse to renew a policy issued under the Plan except for:

1. Nonpayment of premium; or
2. Revocation of the license of the insured by the appropriate licensing board.

(b) Notice of cancellation or nonrenewal under paragraph (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 subsection (16).

(15) **COMMISSION.** Commission to the licensed agent designated by the applicant shall be \$125.00 for each new or renewal policy issued to medical or osteopathic physicians; \$15.00 for each new or renewal policy issued to nurse anesthetists; \$40 for each new or renewal policy issued to podiatrists; 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 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.

(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 indemnified 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.

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.

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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 17.28 Health care provider fees. (s. 655.27) (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 Patients Compensation Panels under s. 655.21, 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" means those fees charged for each fiscal year of participation, July 1 to June 30.

(c) "Class" of physicians or surgeons means those classes currently in use by the Wisconsin Health Care Liability Insurance Plan, as authorized by s. Ins 17.25 (12) (b).

(4) PRO RATA FEES. A health care provider may enter or exit the Fund at a date other than July 1 or June 30.

(a) If a health care provider enters the Fund subsequent to July 1, the provider shall be charged a fee of one-twelfth the annual fee for that class of provider for each month or part of month between the date of entry and the next June 30.

(b) Notwithstanding the provisions of par. (a) no fee shall be charged for entry to the Fund after each June 1.

(c) If a health care provider exits the Fund prior to June 30, the provider shall be entitled to a refund of one-twelfth the annual fee for that class for each full month between the date of exit and the next June 30.

(d) 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, 1984 to June 30, 1985.

(a) For physicians and surgeons

Class 1	\$ 952.00	Class 6	\$5,878.00
Class 2	1,905.00	Class 7	6,858.00
Class 3	2,449.00	Class 8	476.00
Class 4	2,939.00	Class 9	10,287.00
Class 5	4,899.00		

(b) For resident physicians and surgeons, or fellowships, in post graduate medical education.

Class 1	\$ 571.00	Class 5	\$2,939.00
Class 2	1,143.00	Class 6	3,527.00
Class 3	1,470.00	Class 7	4,115.00
Class 4	1,764.00	Class 9	6,172.00

(c) For resident physicians and surgeons, practice outside residency or fellowship.

All classes	\$ 735.00
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(d) For medical college of Wisconsin full time faculty

Class 1	\$ 390.00	Class 5	\$2,008.00
Class 2	781.00	Class 6	2,410.00
Class 3	1,004.00	Class 7	2,812.00
Class 4	1,205.00	Class 9	4,218.00

(e) For medical college of Wisconsin resident physicians and surgeons

1. Class 1	\$ 476.00	Class 5	\$2,449.00
Class 2	952.00	Class 6	2,939.00
Class 3	1,225.00	Class 7	3,429.00
Class 4	1,470.00	Class 9	5,144.00

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

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

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

Class 1	\$ 714.00	Class 6	\$4,409.00
Class 2	1,428.00	Class 7	5,144.00
Class 3	1,837.00	Class 8	357.00
Class 4	2,204.00	Class 9	7,715.00
Class 5	3,674.00		

(g) For retired or part time physicians and surgeons, office practice only, less than 500 hours per annum.

Class 1	Physicians	\$ 571.00
Class 8	Osteopathic physicians	286.00

(h) For nurse anesthetists \$ 285.00

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

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

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

(j) For hospitals—per occupied bed \$ 81.00

(k) For nursing homes—per occupied bed \$ 15.00

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. 7-1-84; am. (6) (i), Register, August, 1984, No. 344, eff. 9-1-84.

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

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

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

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

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

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

1. Hiring legal counsel.
2. Establishment and revision of case reserves.
3. Contracting for annuity payments as part of structured settlements.
4. Investigation and evaluation of claims.
5. Negotiation to settlement of all claims made against the fund except those responsibilities retained by the claim committee of the board.
6. Filing of reports to the board.
7. Review of panel decisions and court verdicts and recommendations of appeals as needed.

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