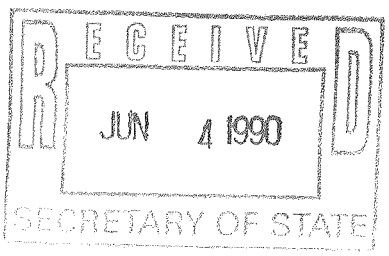
CR 90-47



RECEIVED
JUN 4 1990
4:00pm
Revisor of Statutes
Bureau

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

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said Office, do hereby certify that the annexed order repealing Ins 17.01 (2) (c), 17.02 to 17.23, 17.25 (3), (4) (a), (c), (d), (f) and (h), (5) (am), (d), (e) and (f), (6) (a), (7), (8) (j), (9) (title), (11) (title) and (a), (12) (intro.), (a) 4, 5, 6 (intro.) b and c, 7 and (c), (12) (b) 1, 3 and 6, (13) and (17) (title), 17.26 (2), 17.28 (3m) (a) 3. a and (b) and 17.29 (5) (a); renumbering Ins 17.28 (3m) (a) (intro.), 1 and 2 and 17.285 (4) (c); renumbering and amending Ins 17.001 (5), 17.25 (4) (b) and (e), (5) (a) (intro.) and 1 to 11, (b) and (c), (6) (b) and (c), (8) (a), (b), (c) to (f), (g) to (i), (9), (11) (b), (12) (a) 2, 3, 6. a, 8, 9, 10, 11 and 12 and (b) 2 and 4 and (17) and 17.29 (5) (b); consolidating, renumbering and amending Ins 17.28 (3m) (a) 3 (intro.), b and c; amending ch. 17 (title), 17.001 (intro.), (1) and (2) to (4), 17.01 (1) and (2) (a), (d) and (e), 17.24 (3) and (4), 17.25 (1) (a) and (c), (2), (8) (title), (10) (a), (b), (c) and (d), (12) (title) and (14) (title), (a) (intro.) and 4 and (b), 17.26 (title) and (1), (3) (a) to (c) and (4), 17.27 (title) and (1), (2) (a) and (b), (3) and (4), 17.28 (1), (2) and (3) (c) and (f), (3e), (3m) (title), (6) (c) (intro.),

7-1-90

(g) (intro.), (h) (intro.), (i) (intro.), (j) (intro.), (k) (intro.), (L) (intro.), (Lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), 17.285 (2) (a) and (b), (3) (a) and (c) 2, (4) (c), (5) (b) (intro.), (7) (a), (8), (9) (a), (11) (f) and (14), 17.29 (1), (3) and (4) and 17.30 (2) (a) 1 and 2; repealing and recreating Ins 17.01 (2) (b), 17.24 (1) and (2), 17.25 (12) (a) 1, (15), (16) and (18), 17.28 (5), (6) (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.) and (f) (intro.) and (6s) (c) 1 (intro.), 2 (intro.), 3 (intro.) and 4 (intro.) and 17.29 (2); and creating Ins 17.005, 17.24 (2m), 17.25 (3) (title), (a) to (c) and (e), (5) (n), (6) (a) (intro.) and (b) 1, (8) (a) (intro.) and 6 and (b) (intro.), 17.25 (12) (b) (intro.) and (19), 17.27 (2) (intro.) and (4) (title), 17.275 (3) (e), 17.28 (3) (intro.) and (hm), (4) (cm) and (g) and (6e), 17.285 (2m) and (4) (c) 2, 17.29 (5) (am) and (h) and 17.35, relating to the Wisconsin Health Care Liability Insurance Plan, the Patients Compensation Fund and the Patients Compensation Fund Peer Review Council, and to hearings conducted by the Office of the Commissioner of Insurance was issued by this Office on June 1, 1990.

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

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 1st day of June, 1990.

Robert D. Haase
Commissioner of Insurance

12539T

ORDER OF THE COMMISSIONER OF INSURANCE

REPEALING, RENUMBERING, RENUMBERING AND AMENDING,

CONSOLIDATING, RENUMBERING AND AMENDING, AMENDING,

REPEALING AND RECREATING AND CREATING RULES

To repeal Ins 17.01 (2) (c), 17.02 to 17.23, 17.25 (3), (4) (a), (c), (d), (f) and (h), (5) (am), (d), (e) and (f), (6) (a), (7), (8) (j), (9) (title), (11) (title) and (a), (12) (intro.), (a) 4, 5, 6 (intro.) b and c, 7 and (c), (12) (b) 1, 3 and 6, (13) and (17) (title), 17.26 (2), 17.28 (3m) (a) 3. a and (b) and 17.29 (5) (a); to renumber Ins 17.28 (3m) (a) (intro.), 1 and 2 and 17.285 (4) (c); to renumber and amend Ins 17.001 (5), 17.25 (4) (b) and (e), (5) (a) (intro.) and 1 to 11, (b) and (c), (6) (b) and (c), (8) (a), (b), (c) to (f), (g) to (i), (9), (11) (b), (12) (a) 2, 3, 6. a, 8, 9, 10, 11 and 12 and (b) 2 and 4 and (17) and 17.29 (5) (b); to consolidate, renumber and amend Ins 17.28 (3m) (a) 3 (intro.), b and c; to amend ch. 17 (title), 17.001 (intro.), (1) and (2) to (4), 17.01 (1) and (2) (a), (d) and (e), 17.24 (3) and (4), 17.25 (1) (a) and (c), (2), (8) (title), (10) (a), (b), (c) and (d), (12) (title) and (14) (title), (a) (intro.) and 4 and (b), 17.26 (title) and (1), (3) (a) to (c) and (4), 17.27 (title) and (1), (2) (a) and (b), (3) and (4), 17.28 (1), (2) and (3) (c) and (f), (3e), (3m) (title), (6) (c) (intro.), (g) (intro.), (h) (intro.), (i) (intro.), (j) (intro.), (k) (intro.), (L) (intro.), (Lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), 17.285 (2) (a) and (b), (3) (a) and (c) 2, (4) (c), (5) (b) (intro.), (7) (a), (8),

(9) (a), (11) (f) and (14), 17.29 (1), (3) and (4) and 17.30 (2) (a) 1 and 2; to repeal and recreate Ins 17.01 (2) (b), 17.24 (1) and (2), 17.25 (12) (a) 1, (15), (16) and (18), 17.28 (5), (6) (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.) and (f) (intro.) and (6s) (c) 1 (intro.), 2 (intro.), 3 (intro.) and 4 (intro.) and 17.29 (2); and to create Ins 17.005, 17.24 (2m), 17.25 (3) (title), (a) to (c) and (e), (5) (n), (6) (a) (intro.) and (b) 1, (8) (a) (intro.) and 6 and (b) (intro.), 17.25 (12) (b) (intro.) and (19), 17.27 (2) (intro.) and (4) (title), 17.275 (3) (e), 17.28 (3) (intro.) and (hm), (4) (cm) and (g) and (6e), 17.285 (2m) and (4) (c) 2, 17.29 (5) (am) and (h) and 17.35, relating to the Wisconsin health care liability insurance plan, the patients compensation fund and the patients compensation fund peer review council and to hearings conducted by the office of the commissioner of insurance.

Statutory Authority: ss. 601.41 (3) and 655.004, Stats.

Statutes interpreted: ss. 619.01 and 619.04 and ch. 655, Stats.

This rule has three main purposes: to codify several substantive changes approved by the board of governors (board) of the Wisconsin health care liability insurance plan (plan) and the patients compensation fund (fund); to update and make changes in ch. Ins 17 so that the rules are current and in the drafting style required by s. 227.14 (1), Stats.; and to make various technical corrections in ch. Ins 17.

This rule makes the following changes in the rules governing the plan, the fund and the peer review council (council):

1. Specifies the coverages required for primary insurance underlying the fund, the permissible exclusions from coverage, and other requirements for policy form approval.

2. Defines the scope of coverage for and exclusions from the plan.

3. Permits the council to review a provider's claim history as soon as the amount of indemnity has been determined; to recommend a surcharge on a provider's plan premium or fund fee on the basis of available information; and to recommend that no surcharge should be imposed after a preliminary review of a provider's claim history.

4. Requires primary insurers to offer tail coverage to health care providers with claims-made policies and to notify providers of the obligation to obtain tail coverage.

5. Permits the release of certain claims information with the consent of the health care provider who is the subject of the information.

6. Specifies that health care providers must provide primary liability coverage for their employes.

7. Requires a primary insurer that offers a policy with a deductible or coinsurance provision to provide first dollar coverage with a right to recoup the amount of the deductible or coinsurance from the insured.

8. Adds administrative medicine to the list of specialties included in the category of class 1 physicians and surgery-otology to the list of class 3 physicians for fund purposes.

9. Raises the annual aggregate on the amount of general liability insurance the plan may offer from $1,000,000 to $3,000,000.

10. Requires insurers to file certificates of insurance within 45 days after a policy is issued, renewed or materially changed.

11. Repeals the separate administrative hearing procedures for appealing from decisions of the plan and the fund and incorporates them into the hearing procedures applicable to other agency proceedings.

12. Defines the types of nursing homes and ambulatory surgery centers which are eligible for plan and fund coverage.

13. Clarifies the method of charging fund fees for medical college of Wisconsin resident physicians.

14. Clarifies the processing of fund fee refunds and credits.

15. Repeals an unused provision relating to obligations of insurer members of the plan.

16. Repeals various provisions which unnecessarily repeat statutory language.

SECTION 1. Chapter Ins 17 (title) is amended to read:

Chapter Ins 17

HEALTH CARE LIABILITY INSURANCE

PATIENTS COMPENSATION FUND

SECTION 2. Ins 17.001 (intro.) is amended to read:

INS 17.001 DEFINITIONS. ~~(ss.-619.04-and-655.003,-Stats.)-As-used-in~~ In this chapter:

SECTION 3. Ins 17.001 (1) and (2) to (4) are amended to read:

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

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

(3) "Hearing" ~~includes-both-hearings-and-rehearings,-and-these-rules-shall-cover-both-so-far-as-applicable,-except-where-otherwise-specifically-provided-by-statute-or-in-ch.-Ins-17;~~ has the meaning given in s. Ins 5.01 (1).

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

SECTION 4. Ins 17.001 (5) is renumbered Ins 17.001 (1m) and amended to read:

Ins 17.001 (1m) "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~~ acting under s. 601.11 (1) (b), Stats.

SECTION 5. Ins 17.005 is created to read:

INS 17.005 PURPOSE. This chapter implements ss. 619.01 and 619.04 and ch. 655, Stats.

SECTION 6. Ins 17.01 (1) and (2) (a) are amended to read:

Ins 17.01 (1) PURPOSE. This ~~rule~~ section implements ~~the provisions of ch.~~ s. 655.61 (2), Stats., relating to the payment of mediation fund fees.

(2) (a) ~~Every~~ Each physician ~~practicing in the state,~~ subject to ch. 655, Stats., ~~excluding those in a residency or fellowship training program~~ except a resident, and ~~every~~ each hospital ~~operating in the state,~~ subject to ch. 655, Stats., shall pay to the commissioner ~~of insurance~~ an annual fee to finance the mediation system created by s. 655.42, Stats. ~~The commissioner of insurance shall deposit all such fees collected in the mediation fund created by s. 655.68, Stats.~~

SECTION 7. Ins 17.01 (2) (b) is repealed and recreated to read:

Ins 17.01 (2) (b) The fund shall bill a physician or hospital subject to this section under s. Ins 17.28 (7) (a). The entire annual fee under this section is due and payable 30 days after the fund mails the bill.

SECTION 8. Ins 17.01 (2) (c) is repealed.

SECTION 9. Ins 17.01 (2) (d) and (e) are amended to read:

(d) The ~~commissioner~~ fund shall notify the ~~department of regulation and licensing~~ medical examining board of each physician who has not paid the

~~fee, and who is, therefore, in noncompliance with s. 655.61 (1), Stats~~ as required under par. (b).

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

SECTION 10. Ins 17.02 to 17.23 are repealed.

SECTION 11. Ins 17.24 (1) and (2) are repealed and recreated to read:

(1) Any person insured by the plan or covered by the fund may petition the board for a review of its classification by the plan or fund. The petition shall state the basis for the petitioner's belief that its classification is incorrect. The board shall refer a petition for review to either of the following:

(a) If the petitioner is a hospital or a nursing home or other entity affiliated with a hospital, to a committee appointed by the commissioner consisting of 2 representatives of hospitals, other than the petitioner's hospital, and one other person who is knowledgeable about insurance classification.

(b) If the petitioner is any person other than a person specified in par. (a), to a committee appointed by the commissioner consisting of 2 physicians who are not directly or indirectly affiliated or associated with the petitioner and one other person who is knowledgeable about insurance classification.

(2) The plan, the fund or both shall provide the committee with any information needed to review the classification.

SECTION 12. Ins 17.24 (2m) is created to read:

Ins 17.24 (2m) The committee shall review the classification and report its recommendation to the petitioner and the board within 5 days after

completing the review.

SECTION 13. Ins 17.24 (3) and (4) are amended to read:

(3) Any person ~~or hospital who~~ that is not satisfied with the ~~determination~~ recommendation of the committee may petition for a ~~declaratory ruling~~ hearing under ~~s. Ins 17.02~~ ch. 227, Stats., and ch. Ins 5 within 30 days ~~of~~ after the date of ~~the~~ receipt of written notice of the committee's ~~determination~~ recommendation.

(4) At ~~any~~ the hearing held pursuant to ~~such~~ a petition ~~for a declaratory ruling~~ under sub. (3), the committee report shall be considered and the members of the committee ~~have the right to~~ may appear and be heard ~~but shall not be required to be present~~.

SECTION 14. Ins 17.25 (1) (a) and (c) are amended to read:

Ins 17.25 (1) (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~~ the commissioner's approval.

(c) A ~~facility~~ plan for providing ~~such~~ health care liability insurance and liability coverage normally incidental to health care liability insurance should be enacted pursuant to ch. 619, Stats.

SECTION 15. Ins 17.25 (2) is amended to read:

Ins 17.25 (2) PURPOSE. This section ~~is intended to implement and interpret ch. 619~~ implements ss. 619.01 and 619.04, Stats., ~~for the purpose of~~ by establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage~~,~~ and liability coverage normally incidental to health care liability insurance ~~or both~~ on a self-supporting basis for the persons specified in sub. (5) (a) and~~,~~ ~~if~~

~~necessary,~~ for ~~allied-health-care-personnel-employed-by-any-of-those-persons while-working~~ their employes acting within the scope of ~~such~~ their employment and providing health care services. This section is also intended to encourage ~~the~~ improvement in reasonable loss prevention measures and to encourage the maximum use of the ~~existing~~ voluntary market.

SECTION 16. Ins 17.25 (3) is repealed.

SECTION 17. Ins 17.25 (3) (title), (a) to (c) and (e) are created to read:

Ins 17.25 (3) (title) COVERAGE; EXCLUSIONS. (a) Each policy of health care liability insurance coverage issued by the plan shall provide occurrence coverage for all of the following:

1. Providing or failing to provide health care services to a patient.

2. Peer review, accreditation and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by the insured or an employe of the insured.

3. Utilization review, quality assurance and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by the insured or an employe of the insured.

(b) Each policy issued by the plan shall also provide for supplemental payments in addition to the limits of liability under par. (d), including attorney fees, litigation expenses, costs and interest.

(c) The health care liability insurance coverage issued by the plan shall exclude coverage for all of the following:

1. Criminal acts.

2. Intentional sexual acts and other intentional torts.

3. Restraint of trade, anti-trust violations and racketeering.

4. Defamation.

5. Employment, religious, racial, sexual, age and other unlawful discrimination.

6. Pollution resulting in injury to a 3rd party.

7. Acts that occurred before the effective date of the policy of which the insured was aware or should have been aware.

8. Incidents occurring while an insured's license to practice is suspended, revoked, surrendered or otherwise terminated.

9. Criminal and civil fines, forfeitures and other penalties.

10. Punitive and exemplary damages.

11. Liability of the insured covered by other insurance, such as worker's compensation, automobile, fire or general liability.

12. Liability arising out of the ownership, operation or supervision by the insured of a hospital, nursing home or other health care facility or business enterprise.

13. Liability of others assumed by the insured under a contract or agreement.

(e) The plan may also issue liability coverage normally incidental to health care liability insurance including all of the following:

1. Owners, landlords and tenants liability insurance.

2. Owners and contractors protective liability insurance.

3. Completed operations and products liability insurance.

4. Contractual liability insurance.

5. Personal injury liability insurance.

SECTION 18. Ins 17.25 (4) (a), (c), (d), (f) and (h) are repealed.

SECTION 19. Ins 17.25 (4) (b) and (e) are renumbered Ins 17.25 (6) (a) 1 and 2, respectively, and amended to read:

Ins 17.25 (6) (a) 1. ~~(b) Insurance against liability resulting from personal injuries~~ "Personal injury liability insurance" means ~~all~~ any

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

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

SECTION 20. Ins 17.25 (5) (title) is repealed and recreated to read:

Ins 17.25 (5) (title) ELIGIBILITY FOR PLAN COVERAGE.

SECTION 21. Ins 17.25 (5) (a) (intro.) and 1 to 11 are renumbered Ins 17.25 (5) (intro.) and (a) to (m) and amended to read:

Ins 17.25 (5) (intro.) 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~~ are eligible ~~to apply~~ for insurance under ~~this~~ the plan:

(a) ~~All~~ A medical or osteopathic ~~physicians~~ physician or ~~podiatrists~~ podiatrist licensed under ch. 448, Stats.~~;~~

(b) ~~Nurse anesthetists or~~ A nurse ~~midwives~~ anesthetist or nurse midwife licensed under ch. 441, Stats.~~;~~

(c) ~~Nurse practitioners registered~~ A nurse practitioner licensed under ch. 441, Stats., who ~~meet~~ meets at least one of the requirements specified under s. HSS 105.20 (2) (b)~~;~~.

(d) ~~Partnerships~~ A partnership comprised of, and organized and operated in this state for the primary purpose of providing the medical services of, physicians, podiatrists, nurse anesthetists, nurse midwives, nurse practitioners or cardiovascular perfusionists~~;~~.

(e) ~~Corporations and~~ A corporation or general ~~partnerships~~ partnership organized and operated in this state for the primary purpose of providing the medical services of physicians, podiatrists, nurse anesthetists, nurse midwives, nurse practitioners or cardiovascular perfusionists~~;~~.

(f) ~~Operating~~ An operational cooperative sickness care ~~plans~~ plan organized under ss. 185.981 to 185.985, Stats., which directly ~~provide service, in their~~ provides services through salaried employes in its own ~~facilities with salaried employes;~~ facility.

(g) ~~Properly~~ An accredited teaching ~~facilities~~ facility 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.~~;~~

(h) ~~All hospitals~~ A hospital, as defined ~~by~~ in s. 50.33 (2) (a) and (c), Stats., ~~including, but not limited to ambulatory surgery centers, as defined in s. HSS 123.14 (2) (a),~~ but excluding ~~those~~ facilities exempted by s. 50.39 (3), Stats., except as ~~otherwise~~ provided ~~herein;~~ in par. (k).

(i) An entity operated in ~~connection with one or more hospitals, as defined in s. 50.33 (2) (a) and (c), Stats., which assists the~~ this state that is an affiliate of a hospital ~~or hospitals in providing~~ and that provides diagnosis or treatment of, or care for, patients of the hospital ~~or hospitals, and which is owned by or is an affiliate, as defined under s. 600.03 (1), Stats., of the hospital or hospitals~~;.

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

(k) ~~Health~~ A health care ~~facilities~~ facility owned or operated by a ~~political subdivision of the~~ county, city, village or town in this state ~~of Wisconsin;~~, or by a county department established under s. 51.42 or 51.437, Stats., if the facility would otherwise be eligible for coverage under this subsection.

(l) ~~Corporations~~ A corporation organized to manage approved training programs for medical or osteopathic physicians licensed under ch. 448, Stats.~~;~~.

(m) ~~Cardiovascular perfusionists~~ A cardiovascular perfusionist.

SECTION 22. Ins 17.25 (5) (am), (d), (e) and (f) are repealed.

SECTION 23. Ins 17.25 (5) (b) and (c) are renumbered Ins 17.25 (3) (d) and (f) and Ins 17.25 (3) (d) (intro.) and (f), as renumbered, are amended to read:

Ins 17.25 (3) (d) (intro.) The maximum limits of ~~coverage for the type of health care~~ liability ~~insurance defined in sub. (4) (c) which may be placed under this Plan~~ for coverage under par. (a) are the following:

(f) The maximum limits of ~~coverage for~~ liability ~~coverages normally incidental to health care liability insurance as defined in sub. (4) (d) which may be placed under this Plan~~ for coverage under par. (e) are $1,000,000 per claim and ~~$1,000,000~~ $3,000,000 aggregate for all claims in any one policy year.

SECTION 24. Ins 17.25 (5) (n) is created to read:

Ins 17.25 (5) (n) An ambulatory surgery center, as defined in s. HSS 123.14 (2) (a).

SECTION 25. Ins 17.25 (6) (a) is repealed.

SECTION 26. Ins 17.25 (6) (a) (intro.) is created to read:

Ins 17.25 (6) (a) (intro.) In this subsection:

SECTION 27. Ins 17.25 (6) (b) and (c) are renumbered Ins 17.25 (6) (b) 2 and 3, respectively, and amended to read:

Ins 17.25 (6) (b) 2. An insurer's membership in the plan terminates ~~when~~ if the insurer is no longer authorized to write personal injury liability insurance in ~~Wisconsin, but the~~ this state. The effective date of termination shall be the last day of the plan's current fiscal year ~~of the Plan in which termination occurs. Any~~. A terminated insurer ~~so terminated~~ shall continue to be governed by ~~the provisions of~~ this ~~rule~~ subsection until it completes all of its obligations under the ~~Plan~~ plan.

3. Subject to the approval of the commissioner, the board ~~of governors~~ may charge a reasonable annual membership fee, not to exceed $50.00.

SECTION 28. Ins 17.25 (6) (b) 1 is created to read:

Ins 17.25 (6) (b) 1. Each insurer authorized in this state to write personal injury liability insurance, except a town mutual organized under ch. 612, Stats., is a member of the plan.

SECTION 29. Ins 17.25 (7) is repealed.

SECTION 30. Ins 17.25 (8) (title) is amended to read:

Ins 17.25 (8) (title) POWERS AND DUTIES OF THE BOARD.

SECTION 31. Ins 17.25 (8) (a) is renumbered Ins 17.25 (7) and amended to read:

Ins 17.25 (7) (title) BOARD MEETINGS; QUORUM. The board ~~of governors~~ shall meet as often as ~~may be~~ required to perform the general duties of supervising the administration of the ~~Plan~~ plan, or ~~on~~ at the call of the commissioner. ~~Six~~ Seven members of the board shall constitute a quorum.

SECTION 32. Ins 17.25 (8) (a) (intro.) and 6 are created to read:

Ins 17.25 (8) (a) (intro.) The board may do any of the following:

6. Perform any other act necessary or incidental to the proper administration of the plan.

SECTION 33. Ins 17.25 (8) (b) is renumbered Ins 17.25 (8) (a) and amended to read:

Ins 17.25 (8) (a) ~~The board of governors shall be empowered to invest~~

1. Invest, borrow and disburse funds, budget expenses, levy assessments~~,~~ and 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~~

2. Appoint a manager or one or more agents to perform ~~such~~ the duties ~~as may be~~ designated by the board.

SECTION 34. Ins 17.25 (8) (b) (intro.) is created to read:

Ins 17.25 (8) (b) (intro.) The board shall do all of the following:

SECTION 35. Ins 17.25 (8) (c) to (f) are renumbered Ins 17.25 (8) (b) 1 to 4, respectively, and, as renumbered, are amended to read:

Ins 17.25 (8) (b) 1. ~~The board of governors shall develop~~ 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, an 625.12, Stats., and sub. (12)~~ for the plan.

2. ~~The board of governors shall cause~~ Ensure that all policies written ~~pursuant to this Plan to be~~ by the plan are 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~~ plan.

3. ~~The board of governors shall determine, subject~~ Subject to the approval of the commissioner, determine the eligibility of an insurer to act

as a servicing company to issue and service the plan's policies. If no qualified insurer elects to be a servicing company, the board ~~of governors~~ shall assume ~~such~~ these duties on behalf of member companies.

4. ~~The board of governors shall enter~~ Enter into agreements and contracts as ~~may be~~ necessary for the execution of this ~~rule consistent with its provisions~~ section.

SECTION 36. Ins 17.25 (8) (g) to (i) are renumbered Ins 17.25 (8) (a) 3 to 5, respectively, and amended to read:

Ins 17.25 (8) (a) 3. ~~The board of governors may appoint~~ Appoint advisory committees of interested persons, not limited to members of the ~~Plan~~ plan, to advise the board in the fulfillment of its duties and functions.

4. ~~The board of governors shall be empowered to develop, at its option,~~ Develop an assessment credit plan subject to the approval of the commissioner, ~~wherein~~ by which a member of the ~~Plan~~ plan receives a credit against an assessment levied under sub. (6) (c), based ~~upon Wisconsin~~ on voluntarily written health care liability insurance premiums in this state.

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

SECTION 37. Ins 17.25 (8) (j) is repealed.

SECTION 38. Ins 17.25 (9) (title) is repealed.

SECTION 39. Ins 17.25 (9) is renumbered Ins 17.25 (8) (b) 5 and amended to read:

Ins 17.25 (8) (b) 5. By May 1 of each year ~~the board of governors shall make a~~, report to the members of the ~~Plan~~ plan and to the standing committees on ~~health~~ insurance in each house of the legislature summarizing the activities of the ~~Plan~~ plan in the preceding calendar year.

SECTION 40. Ins 17.25 (10) (a), (b), (c) and (d) are amended to read:

Ins 17.25 (10) (a) Any person specified in sub. (5) ~~(a)~~ 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~~ Each application shall request coverage for the applicant's partnership or corporation, if any, and for the applicant's employes acting within the scope of their employment and providing health care services, unless the partnership, corporation or employes are covered by other professional liability insurance.

(b) The ~~Plan~~ plan may bind coverage.

(c) ~~The Plan shall, within~~ Within 8 business days ~~from receipt of~~ after receiving an application, the plan shall notify the applicant ~~of the acceptance, rejection or the holding in abeyance of the application~~ whether the application is accepted, rejected or held pending further investigation. Any ~~individuals~~ applicant rejected by the ~~Plan shall have the right to~~ plan may appeal ~~that judgment within 30 days~~ the decision to the board ~~of governors in accordance with~~ as provided in sub. (16).

(d) If the ~~risk~~ application is accepted ~~by the Plan~~, the plan shall deliver 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.~~

SECTION 41. Ins 17.25 (11) (title) and (a) are repealed.

SECTION 42. Ins 17.25 (11) (b) is renumbered Ins 17.25 (6) (c) and amended to read:

Ins 17.25 (6) (c) ~~All members of the Plan shall participate in all premiums, other income, losses, expenses, and costs of the Plan in~~ If the funds available to the plan at any time are not sufficient for the sound

financial operation of the plan, the board shall assess the members an amount sufficient to remedy the insufficiency. Each member shall contribute according to the proportion that ~~the~~ that member's 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 sub. (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~~ during the preceding calendar year. The amounts of premiums written 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~~ members with the commissioner ~~of insurance~~. Assessments are subject to any credit plan developed under sub. (8) (a) 4. When the amount of the assessment is recouped under s. 619.01 (1) (c) 2, Stats., each member shall be reimbursed the amount of that member's assessment.

SECTION 43. Ins 17.25 (12) (title) is amended to read:

Ins 17.25 (12) (title) RATES, RATE CLASSIFICATIONS AND FILINGS.

SECTION 44. Ins 17.25 (12) (intro.), (a) 4, 5, 6 (intro.), b and c, 7 and (c) are repealed.

SECTION 45. Ins 17.25 (12) (a) 1 is repealed and recreated to read:

Ins 17.25 (12) (a) 1. In developing rates and rate classifications, as provided under sub. (8) (b) 1, the board shall ensure that the plan complies with ss. 619.01 (1) (c) 2 and 619.04 (5) and ch. 625, Stats.

SECTION 46. Ins 27.25 (12) (a) 2 and 3 are renumbered Ins 17.25 (12) (a) 2 and 3 and amended to read:

Ins 17.25 (12) (a) 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 one each year.~~

3. Rates shall be calculated on a basis which will make the ~~Plan~~ plan self-supporting but may not be excessive. Rates shall be presumed excessive if they produce ~~long-run~~ long-term excess funds ~~for the Plan~~ over the total of the plan's unpaid losses, including reserves for losses incurred but not yet reported, unpaid loss adjustment expenses, ~~any~~ additions to the ~~compulsory or security~~ surplus established ~~for the Plan by direction of the commissioner pursuant to~~ under s. 619.01 (1) (c) 2~~.~~, Stats., ~~and acting under ss. 623.11 and 623.12, Stats.,~~ and s. Ins 14.02 (3) and (4), the premium assessment ~~imposed each year by~~ under s. 619.01 (8m), Stats., and other expenses.

SECTION 47. Ins 17.25 (12) (a) 6. a is renumbered Ins 17.25 (12) (a) 4 and amended to read:

Ins 17.25 (12) (a) 4. ~~If the Plan accumulates~~ The board shall annually determine if the plan has accumulated excess funds ~~in excess of the surplus required under s. 619.01 (1) (c) 2., Stats., and incurred liabilities, including reserves for claims incurred but not yet reported~~ as described under subd. 3 and, if so, the board ~~of governors~~ shall return ~~those~~ the excess funds to the insureds by means of refunds or prospective rate decreases according to a distribution method and formula established by the board.

SECTION 48. Ins 17.25 (12) (a) 8 is renumbered Ins 17.25 (12) (a) 5. a and amended to read:

Ins 17.25 (12) (a) 5. a. ~~Wisconsin~~ In establishing the plan's rates, the board shall use loss and expense experience ~~shall be used in establishing and reviewing rates~~ in this state to the extent it is statistically credible supplemented by relevant data from outside ~~the~~ this state~~;~~ ~~relevant data shall include~~ including, but not ~~be~~ limited to, data provided by other insurance companies, rate service organizations or governmental agencies.

SECTION 49. Ins 17.25 (12) (a) 9 is renumbered Ins 17.25 (12) (a) 6 and amended to read:

Ins 17.25 (12) (a) 6. ~~Loss~~ The loss and expense experience used in ~~determining initial or revised~~ establishing and revising rates shall be adjusted to indicate as nearly as possible the loss and expense experience which will emerge on policies issued by the ~~Plan~~ plan during the period for which the rates were being established~~;~~ ~~for~~. 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~~, giving 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.

SECTION 50. Ins 17.25 (12) (a) 10 is renumbered Ins 17.25 (12) (a) 5. b and amended to read:

Ins 17.25 (12) (a) 5. b. ~~Review of~~ The board shall annually review the plan's rates ~~for the Plan shall begin with~~ using the experience of the ~~Plan~~ plan, supplemented first by ~~Wisconsin~~ the experience of coverage provided in this state by other insurers~~,~~ and ~~then~~, to the extent necessary for statistical credibility, by relevant data from outside ~~the~~ this state.

SECTION 51. Ins 17.25 (12) (a) 11 is renumbered Ins 17.25 (12) (c) and amended to read:

Ins 17.25 (12) (c) ~~Information supporting the~~ With each rate and classification filing, the board shall ~~indicate~~ submit supporting information including, in the case of rate filings, the existence, extent and nature of any subjective factors in the rates based on the judgment of technical personnel, such as consideration of the reasonableness of the rates compared ~~to~~ with the cost of comparable available coverage ~~where it is available~~.

SECTION 52. Ins 17.25 (12) (a) 12 is renumbered Ins 17.25 (12) (a) 7 and amended to read:

Ins 17.25 (12) (a) 7. Expense provisions included in the ~~rate to be used by the Plan~~ plan's rates shall reflect reasonable prospective operating ~~expense levels~~ costs of the ~~Plan~~ plan.

SECTION 53. Ins 17.25 (12) (b) (intro.) is created to read:

Ins 17.25 (12) (b) (intro.) The board shall establish and annually review plan classifications which, in addition to the requirements under s. 619.04 (5), Stats., do all of the following to the extent possible:

SECTION 54. Ins 17.25 (12) (b) 1, 3 and 6 are repealed.

SECTION 55. Ins 17.25 (12) (b) 2 and 4 are renumbered Ins 17.25 (12) (b) 1 and 2 and amended to read:

Ins 17.25 (12) (b) 1. ~~Classifications shall be established which measure to the extent possible~~ Measure variations in exposure to loss and in expenses based upon the best data available.

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

SECTION 56. Ins 17.25 (13) is repealed.

SECTION 57. Ins 17.25 (14) (title), (a) (intro.) and 4 and (b) are amended to read:

Ins 17.25 (14) (title) PLAN BUSINESS; CANCELLATION AND NONRENEWAL.

(a) (intro.) The ~~Plan~~ plan may not cancel or refuse to renew a policy ~~issued under the Plan~~ except for one or more of the following reasons:

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 services in accordance with the code of ethics applicable to the insured's profession, if the board requests such evidence.

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

SECTION 58. Ins 17.25 (15) is repealed and recreated to read:

Ins 17.25 (15) COMMISSION. (a) If the application designates a licensed agent, the plan shall pay the agent a commission for each new or renewal policy issued, as follows:

1. To a health care provider specified in sub. (5) (a) to (e) or (m), 15% of the premium or $150, whichever is less.

2. To a health care provider specified in sub. (5) (f) to (L) or (n), 5% of the annual premium or $2,500 per policy period, whichever is less.

(b) An agent need not be listed by the insurer that acts as the plan's servicing company to receive a commission under par. (a).

(c) If the applicant does not designate an agent on the application, the plan shall retain the commission.

SECTION 59. Ins 17.25 (16) is repealed and recreated to read:

Ins 17.25 (16) RIGHT TO HEARING. Any person satisfying the conditions specified in s. 227.42 (1), Stats., may request a hearing under ch. Ins 5 within 30 days after receiving notice of the plan's action or failure to act with respect to a matter affecting the person.

SECTION 60. Ins 17.25 (17) (title) is repealed.

SECTION 61. Ins 17.25 (17) is renumbered Ins 17.25 (6) (d) and amended to read:

Ins 17.25 (6) (d) The board ~~of governors~~ shall report to the commissioner the name of any member ~~or agent which~~ that 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 under par. (c).

SECTION 62. Ins 17.25 (18) is repealed and recreated to read:

Ins 17.25 (18) INDEMNIFICATION. (a) The plan shall indemnify against any cost, settlement, judgment and expense actually and necessarily incurred in connection with the defense of any action, suit or proceeding in which a person is made a party because of the person's position as any of the following:

1. A member of the board or any of its committees or subcommittees.

2. A member of or a consultant to the peer review council under s. 655.275, Stats.

3. A member of the plan.

4. The manager or an officer or employe of the plan.

(b) Paragraph (a) does not apply if the person is judged, in the action, suit or proceeding, to be liable because of wilful or criminal misconduct in the performance of the person's duties under par. (a) 1 to 4.

(c) Paragraph (a) does not apply to any loss, cost or expense on a policy claim under the plan.

(d) Indemnification under par. (a) does not exclude any other legal right of the person indemnified.

SECTION 63. Ins 17.25 (19) is created to read:

Ins 17.25 (19) APPLICABILITY. Each person insured by the plan is subject to this section as it existed on the effective date of the person's policy. Any change in this section during the policy term applies to the insured as of the renewal date.

SECTION 64. Ins 17.26 (title) and (1) are amended to read:

INS 17.26 (title) PAYMENTS FOR FUTURE MEDICAL EXPENSES. (1) PURPOSE. This ~~rule is intended to implement the provisions of~~ section implements s. 655.015, Stats.

SECTION 65. Ins 17.26 (2) is repealed.

SECTION 66. Ins 17.26 (3) (a) to (c) and (4) are amended to read:

Ins 17.26 (3) (a) "Account" means ~~the~~ a portion of the fund allocated specifically for ~~future~~ the medical ~~expense~~ expenses of an injured person.

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

(c) "Medical ~~expense~~ expenses" means ~~those~~ charges for medical services, nursing services, medical supplies, drugs ~~or~~ and rehabilitation services ~~which are necessary to the comfort and well being of the individual and incidental to the injury sustained~~ that are incurred after the date of a settlement, panel award or judgment.

(4) ADMINISTRATION. (a) ~~When any~~ If a settlement, panel award or ~~judgement provides an amount in excess of $25,000 for future medical expense~~ judgment is subject to s. 655.015, Stats., the insurer~~, organization~~ or other person responsible for ~~such~~ payment shall ~~forward to the commissioner the amount in excess of $25,000,~~ within 30 days ~~of any such~~ after the date of the settlement, panel award or judgment, ~~and shall enclose an appropriately~~ pay the fund the amount in excess of $25,000 and shall provide the fund with an executed copy of the document setting forth the terms under which ~~the payment is~~ payments for medical expenses are to be made.

(b) The ~~commissioner~~ fund shall credit each account with a ~~pro rata~~ proportional share of any interest earned~~, if any~~ by the fund, based on the

remaining value of ~~each~~ the account at the time ~~such~~ the investment board declares the interest ~~earning is declared by the investment board~~ earnings. The ~~commissioner~~ fund shall maintain an individual record of each account ~~showing the original allocation, payments made, credits and the balance remaining~~ as provided in s. 16.41, Stats.

(c) Upon receipt of a claimant's request for reimbursement of medical ~~expense of an injured person~~ expenses, the ~~commissioner shall make appropriate investigation and inquiries to determine~~ fund, after determining that the ~~medical~~ supplies or services provided ~~are~~ were necessary and incidental to the injury sustained by the injured 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~~ and that the provider of the supplies or services has actually been paid, shall pay the claim from the appropriate account.

(d) 1. If the ~~commissioner~~ fund is not satisfied that a provider ~~of service~~ has ~~been reimbursed~~ actually been paid for services or supplies provided to ~~the~~ an injured person, the fund may make payments ~~of any medical expense may be made~~ jointly to the claimant and ~~to~~ the provider. ~~The~~

2. A claimant may, in writing, ~~direct that~~ authorize direct payment ~~be made directly~~ to ~~the~~ a 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~~ fund shall ~~not less than once~~ at least annually ~~inform the~~ report to each claimant ~~of~~ the status ~~to date~~ of the injured person's account, including the original amount, payments made, since the last report 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~~ If an injured person ~~become deceased~~ dies and there is a balance in his or her account ~~allocation, that amount shall be returned~~ the balance shall revert to the insurer~~,~~ ~~organization~~ or other person responsible for establishing the account.

SECTION 67. Ins 17.27 (title) and (1) are amended to read:

INS 17.27 (title) FILING OF FINANCIAL REPORT. (1) PURPOSE. This ~~rule is intended to implement and interpret~~ section implements 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 the financial transactions of the ~~Patients Compensation Fund~~ fund.

SECTION 68. Ins 17.27 (2) (intro.) and (4) (title) are created to read:

Ins 17.27 (2) (intro.) In this section:

(4) (title) SELECTION OF ACTUARIES.

SECTION 69. Ins 17.27 (2) (a) and (b), (3) and (4) are amended to read:

Ins 17.27 (2) (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~~ a financial report under sub. (3).

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

(3) FINANCIAL REPORTS. ~~Annual~~ The board shall furnish the commissioner with the financial ~~reports~~ report required by s. 655.27 (4) (d), Stats., ~~shall be furnished~~ within 60 days after the close of each fiscal

year. In addition, the board shall furnish the commissioner with 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~~ The board shall prescribe the format for preparing 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~~ Mediation fund fees collected under s. ~~655.21, Stats.,~~ Ins 17.01 shall be ~~included~~ indicated in ~~these~~ the 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~~ determining reserves and ~~the~~ setting ~~of~~ fees under s. 655.27 (3) (b), Stats. ~~In the event~~ If more than one actuary is ~~utilized~~ selected, the ~~health care providers represented on the~~ board ~~of governors~~ members named by the Wisconsin medical society and the Wisconsin hospital association shall jointly select the ~~second~~ 2nd actuary. ~~Such actuarial reports shall be submitted on a timely basis.~~

SECTION 70. Ins 17.275 (3) (e) is created to read:

Ins 17.275 (3) (e) With a written authorization from the health care provider on whose behalf the claim was paid. Disclosure under this paragraph is limited to the number of judgments against and settlements entered into on behalf of the provider and the number and amounts of claims paid by the plan, the fund or both.

SECTION 71. Ins 17.28 (1) and (2) are amended to read:

Ins 17.28 (1) PURPOSE. ~~The purpose of this~~ This section ~~is to implement and interpret the provisions of~~ implements 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~~ to providers ~~as defined in s. 655.001 (8), Stats. Nothing in this section shall~~ for participation in the fund, but does not apply to ~~operating~~ fees charged for operation of the mediation system under s. 655.61, Stats.

SECTION 72. Ins 17.28 (3) (intro.) is created to read:

Ins 17.28 (3) (intro.) In this section:

SECTION 73. Ins 17.28 (3) (c) is amended to read:

(c) (intro.) "Class" means a group of physicians ~~or surgeons means those health care providers~~ whose specialities or types of practice 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~~. The specialties and types of practice included in each fund class are ~~listed below~~ the following:

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

Administrative medicine
Aerospace ~~Medicine~~ medicine
Allergy
Cardiovascular ~~Disease~~ disease - no catheterization or surgery
Dermatology - no surgery
Diabetes - no surgery
Endocrinology - no surgery
Family ~~Practice-and-General-Practice~~ practice and general practice - no surgery
Forensic ~~Medicine~~ medicine
Gastroenterology - no surgery
General ~~Preventive-Medicine~~ preventive medicine - no surgery
Geriatrics - no surgery
Gynecology - no surgery
Hematology - no surgery
Hypnosis
Infectious ~~Diseases~~ diseases - no surgery
Internal ~~Medicine~~ medicine - no surgery
Laryngology - no surgery
Legal ~~Medicine~~ medicine
Neoplastic ~~Diseases~~ diseases - no surgery
Nephrology - no surgery
Neurology - including child - no surgery
Nuclear ~~Medicine~~ medicine
Nutrition
Occupational ~~Medicine~~ medicine
Ophthalmology - no surgery
~~Osteopathic-Physicians~~ Osteopathy - manipulation only
Otology - no surgery
Otorhinolaryngology - no surgery
Pathology - no surgery
Pediatrics - no surgery
Pharmacology - clinical
Physiatry
Physical ~~Medicine-and-Rehabilitation~~ medicine and rehabilitation
Physicians - no surgery
Psychiatry - including child
Psychoanalysis
Psychosomatic ~~Medicine~~ medicine
Public ~~Health~~ health
Pulmonary ~~Diseases~~ 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~~ esophagology
Cardiology - ~~(~~including catheterization, but not including cardiac surgery~~)~~
Cardiovascular ~~Disease~~ disease - minor surgery
Dermatology - minor surgery
Diabetes - minor surgery
Emergency ~~Medicine~~ medicine - no major surgery - ~~This classification applies~~ applicable to any family or general practitioner or other specialist primarily engaged in emergency practice at a clinic, hospital or ~~rescue~~ other facility who does not perform major surgery~~.~~
Endocrinology - minor surgery
Family ~~Practice and General Practice~~ practice and general practice - minor surgery - no obstetrics
Family ~~Practice or General Practice~~ practice or general practice ~~(~~ - including obstetrics
Gastroenterology - minor surgery
Geriatrics - minor surgery
Gynecology - minor surgery
Hematology - minor surgery
Infectious ~~Diseases~~ diseases - minor surgery
Intensive ~~Care Medicine---This classification applies~~ care medicine - applicable to any family or general practitioner or other specialist employed in an intensive care hospital unit.
Internal ~~Medicine~~ medicine - minor surgery
Laryngology - minor surgery
Neoplastic ~~Diseases~~ diseases - minor surgery
Nephrology - minor surgery
Neurology - including child - minor surgery
Ophthalmology - minor surgery
Otology - minor surgery
Otorhinolaryngology - minor surgery
Pathology - minor surgery
Pediatrics - minor surgery
Physicians - minor surgery
Radiology - diagnostic - minor surgery
Rhinology - minor surgery
Surgery - colon and rectal
Surgery - endocrinology
Surgery - gastroenterology
Surgery - general practice or family practice ~~(~~ - not primarily engaged in major surgery~~)~~
Surgery - geriatrics
Surgery - neoplastic
Surgery - nephrology
Surgery - ophthalmology
Surgery - urological
Urgent ~~Care~~ care - practice in urgent care, walk-in or after hours ~~facilities~~ facility

~~Post-Graduate-Medical-Education-or-Fellowship--This-classification-applies-to all-physicians-engaged-in-2-through-6-years-of-an-approved-post-graduate medical-education-specialty-program-listed-above.~~

3. Class 3 ~~health-care-providers-are-those-engaged-in-the-following medical-specialties:~~

Anesthesiology - ~~This classification applies~~ applicable to all providers who perform general anesthesia or acupuncture anesthesia
Emergency ~~Medicine~~ medicine - including major surgery
General surgery - as a specialty
Surgery - abdominal
Surgery - cardiac
Surgery - cardiovascular disease
~~Surgery---plastic~~
~~Surgery---plastic--otorhinolaryngology~~
~~Surgery---rhinology~~
~~Surgery---general (specialists in general surgery)~~
Surgery - gynecology
Surgery - hand
Surgery - head and neck
Surgery - laryngology
Surgery - orthopedic
Surgery - otology
Surgery - otorhinolaryngology
~~(~~ - no plastic surgery~~)~~
Surgery - plastic
Surgery - plastic - otorhinolaryngology
Surgery - rhinology
Surgery - thoracic
Surgery - traumatic
Surgery - vascular
Weight ~~Control~~ 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

Surgery - obstetrics and gynecology

~~Surgery---obstetrics-Post-Graduate-Medical-Education-or Fellowship--This-classification-applies-to-physicians-engaged-in-two-through six-yearts-of-an-approved-post-graduate-medical-education-specialty-program indicated-above.~~

SECTION 74. Ins 17.28 (3) (hm) is created to read:

Ins 17.28 (3) (hm) "Resident" means a licensed physician engaged in an approved postgraduate medical education or fellowship program in any specialty specified in par. (c) 1 to 4.

SECTION 75. Ins 17.28 (3) (f) is amended to read:

Ins 17.28 (3) (f) "Permanently cease practice" means to stop practicing as a medical or osteopathic physician or nurse anesthetist with the intent not to resume ~~practicing~~ that type of practice in this state.

SECTION 76. Ins 17.28 (3e) is amended to read:

(3e) PRIMARY COVERAGE REQUIRED. Each provider ~~subject to ch. 655, stats.,~~ shall ensure that primary coverage is in effect on the date the provider begins practice or operation and for all periods during which the provider practices or operates in this state. A provider does not have fund coverage for any period during which primary coverage is not in effect.

SECTION 77. Ins 17.28 (3m) (title) is amended to read:

Ins 17.28 (3m) (title). EXEMPTIONS; ELIGIBILITY.

SECTION 78. Ins 17.28 (3m) (a) (intro.) is renumbered Ins 17.28 (3m) (intro.).

SECTION 79. Ins 17.28 (3m) (a) 3. a and (b) are repealed.

SECTION 80. Ins 17.28 (3m) (a) 1 and 2 are renumbered Ins 17.28 (3m) (a) and (b).

SECTION 81. Ins 17.28 (3m) (a) 3 (intro.), b and c are consolidated, renumbered Ins 17.28 (3m) (c) and amended to read:

Ins 27.28 (3m) (c) During the fiscal year~~: b. More~~, the provider will derive more than 50% of the income from ~~the provider's~~ his or her practice ~~will be derived~~ from outside this state; or ~~c. more~~ will attend to more than 50% of ~~the provider's~~ his or her patients ~~will be seen~~ outside this state.

SECTION 82. Ins 17.28 (4) (cm) and (g) are created to read:

Ins 17.28 (4) (cm) Eligibility for exemption; refund. If a provider becomes eligible for an exemption under sub. (3m) (a) after paying all or part of the annual fee, the fund shall issue a refund equal to one twenty-fourth of

the provider's annual fee for each full semimonthly period from the date the provider becomes eligible for the exemption or the date the fund receives the provider's signed exemption form, whichever is later, to the due date of the next payment.

(g) In addition to any refund authorized under par. (c), (e) or (f), the fund may issue a refund to correct an administrative error in the current or any previous fiscal year.

SECTION 83. Ins 17.28 (5) is repealed and recreated to read:

Ins 17.28 (5) FILING OF CERTIFICATES OF INSURANCE. An insurance company required under s. 655.23 (3) (b), Stats., to file a certificate of insurance on behalf of a provider shall file the certificate with the fund within 45 days after the original issuance and each renewal and within 45 days after a change of class or type that would affect the provider's fee under sub. (4).

SECTION 84. Ins 17.28 (6) (a) (intro.), (b) (intro.), (d) (intro.), (e) (intro.) and (f) (intro.) are repealed and recreated to read:

Ins 17.28 (6) (a) (intro.) Except as provided in pars. (b) to (g), for a physician:

(b) (intro.) Except as provided in par. (e), for a resident acting within the scope of a residency or fellowship program:

(d) (intro.) For a medical college of Wisconsin, inc., full-time faculty member:

(e) (intro.) For a medical college of Wisconsin affiliated hospitals, inc., resident acting within the scope of a residency or fellowship program:

(f) (intro.) For a physician employed by this state or a county or municipality acting within the scope of that employment:

SECTION 85. Ins 17.28 (6e) is created to read:

Ins 17.28 (6e) MEDICAL COLLEGE RESIDENTS' FEES. (a) The fund shall calculate the total amount of fees for all residents under sub. (6) (e) on a full-time-equivalent basis, taking into consideration the proportion of time spent by the residents in practice which is not covered by the fund, including practice in federal, state, county and municipal facilities, as determined by the medical college of Wisconsin affiliated hospitals, inc.

(b) The fund's initial bill, payable under sub. (7), shall be the amount paid during the previous fiscal year by the medical college of Wisconsin affiliated hospitals, inc., for all its residents. At the end of the fiscal year, the fund shall adjust the fee to reflect the actual exposure during the current fiscal year, as determined by the medical college of Wisconsin affiliated hospitals, inc.

SECTION 86. Ins 17.28 (6) (c) (intro.), (g) (intro.), (h) (intro.), (i) (intro.), (j) (intro.), (k) (intro.), (L) (intro.), (Lm) (intro.), (m) (intro.), (n) (intro.) and (o) are amended to read:

Ins 17.28 (6) (c) (intro.) For ~~resident physicians and surgeons who practice~~ a resident practicing part-time outside the scope of a residency or fellowship program:

(g) (intro.) For ~~retired or~~ a part-time ~~physicians and surgeons~~ physician with an office practice only and no hospital admissions who ~~practice~~ practices less than 500 hours ~~per~~ in a fiscal year:

(h) (intro.) For a nurse ~~anesthetists~~ anesthetist:

(i) (intro.) For ~~hospitals~~ a hospital:

(j) (intro.) For a nursing ~~homes~~ home, as described under s. 655.001 (8), Stats., which is wholly owned and operated by a hospital and which has health care liability insurance separate from that of the hospital by which it is owned and operated:

(k) (intro.) For ~~partnerships~~ a partnership comprised of physicians or nurse anesthetists:

(L) (intro.) For ~~corporations~~ a corporation organized under ch. 180, Stats., providing the medical services of physicians or nurse anesthetists:

(Lm) (intro.) For ~~corporations~~ a corporation organized under ch. 181, Stats., providing the medical services of physicians or nurse anesthetists:

(m) (intro.) For an operational cooperative sickness care ~~plans~~ plan:

(n) (intro.) For an ambulatory surgery ~~centers~~ center, as defined in s. HSS 123.14 (2) (a), which is a separate entity not part of a hospital, partnership or corporation subject to ch. 655, Stats.:

(o) For an entity ~~owned or controlled by~~ affiliated with a hospital ~~or hospitals~~: $100 or 28.6% of the amount that is or would be paid to the plan for primary liability coverage for the specific type of entity, whichever is greater.

SECTION 87. Ins 17.28 (6m) is amended to read:

Ins 17.28 (6m) (title) REPORTING REQUIRED. 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).

SECTION 88. Ins 17.28 (6s) (c) 1 (intro.), 2 (intro.), 3 (intro.) and 4 (intro.) are repealed and recreated to read:

Ins 17.28 (6s) (c) 1. (intro.) For a class 1 physician or a nurse anesthetist:

2. (intro.) For a class 2 physician:

3. (intro.) For a class 3 physician:

4. (intro.) For a class 4 physician:

SECTION 89. Ins 17.285 (2) (a) and (b) are amended to read:

Ins 17.285 (2) (a) "Aggregate indemnity" means the total amount paid or owing to or on behalf of ~~claimants~~ any claimant, 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, for which ~~results in any payment~~ there has been a final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

SECTION 90. Ins 17.285 (2m) is created to read:

Ins 17.285 (2m) TIME FOR REPORTING. In reporting claims paid under s. 655.26, Stats., each insurer or self-insurer shall report the required information by the 15th day of the month following the date on which there has been a final determination of the aggregate indemnity to be paid to or on behalf of any claimant.

SECTION 91. Ins 17.285 (3) (a) and (c) 2, (5) (b) (intro.), (7) (a), (8), (9) (a), (11) (f) and (14) are amended to read:

Ins 17.285 (3) (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.~~ ss. Ins 17.25 (12m) (c) and 17.28 (6s) (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.

(c) 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~~ fee or both, subject to sub. (11) (d) to (f).

(5) (b) (intro.) ~~For~~ Unless the council determines, after a preliminary review, that no surcharge should be imposed, for each review, the council shall do one of the following:

(7) (a) If the total number of closed claims which the council determines should be included and the aggregate indemnity attributable to those claims would be sufficient to require the imposition of a surcharge under s. Ins 17.25 (6s) (c), 17.28 (6s) (c) or both, the council shall prepare a written report for the board recommending the surcharge that should be imposed. The report shall include the factual basis for the determination on each incident involved in the review and a description of any mitigating circumstances.

(8) NOTICE TO PROVIDER. The council shall furnish the provider with a copy of its report and recommendation to the board and, except as provided in sub. (4) (c) 2, shall also notify the provider of the right to request a ~~contested case~~ hearing under ch. 227, Stats., and ch. Ins 5 within 30 days after receipt of the notice.

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

respect to any incident, the hearing examiner's proposed decision shall accept the council's recommendation with respect to that incident.

(11) (f) If the provider is a physician who, during the 3-year period, changes from one class to another class specified in s. Ins 17.25 (12m) (c) or 17.28 (6s) (c), the percentage surcharge imposed by the final decision of the board shall be applied to the plan premium, fund fee or both for the physician's new class effective on the date the class change occurs.

(14) ANNUAL REVIEW. The board shall annually review the tables under ~~s.~~ ss. Ins 17.25 (12m) (c) and 17.28 (6s) (c) and the results of the procedure established in this section to determine if the council's performance adequately addresses the loss and expense experience of individual providers which results in payments from the plan, the fund or both. The board shall recommend to the commissioner any rule changes ~~needed in the rules~~ that are necessary to address that consideration.

SECTION 92. Ins 17.285 (4) (c) is renumbered Ins 17.285 (4) (c) 1.

SECTION 93. Ins 17.285 (4) (c) 2 is created to read:

Ins 17.285 (4) (c) 2. If a private insurer or defense attorney is unable to comply with the council's request under subd. 1, or if the information provided is inadequate, the council shall notify the provider that it will proceed under subs. (5) to (7) using only the available information. A provider does not have a right to a hearing under sub. (9) on the grounds that a private insurer or defense attorney was unable to comply with the council's request under subd. 1, or provided inadequate information.

SECTION 94. Ins 17.29 (1), (3) and (4) are amended to read:

Ins 17.29 (1) PURPOSE. ~~The purpose of this~~ This section ~~is to implement and interpret the provisions of~~ implements s. 655.27 (2), Stats., relating to contracting for ~~patients compensation fund~~ claim 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) (title) CONTRACT TERM. The ~~term served by the servicing agent shall be as established by the~~ commissioner, with the approval of the board ~~but the~~, shall establish the term of the contract with the servicing agent. The contract shall include a provision for its cancellation if performance or delivery is not made in accordance with its terms and conditions.

SECTION 95. Ins 17.29 (2) is repealed and recreated to read:

Ins 17.29 (2) CRITERIA. The board shall establish the criteria for the selection of the servicing agent prior to the expiration of each contract term.

SECTION 96. Ins 17.29 (5) (a) is repealed.

SECTION 97. Ins 17.29 (5) (b) is renumbered Ins 17.29 (5) and Ins 17.29 (5) (intro.) and (b) to (g), as renumbered, are amended to read:

Ins 17.29 (5) (intro.) ~~Additional functions to be performed by the~~ The servicing agent ~~may include but are not limited to~~ shall perform all of the following functions:

(b) ~~Establishment~~ Establishing and ~~revision of~~ revising case reserves.

(c) Contracting for annuity payments as part of structured settlements under guidelines adopted by the board.

(d) ~~Investigation~~ Investigating and ~~evaluation of~~ evaluating claims.

(e) ~~Negotiation~~ Negotiating to settlement ~~of~~ all claims made against the fund except ~~those responsibilities~~ in cases where this responsibility is retained by the ~~claim~~ claims committee of the board.

(f) Filing ~~of reports to~~ with the commissioner and the board the annual report required under s. 655.27 (2), Stats., and any other report

requested by the commissioner or the board.

(g) ~~Review of panel decisions and~~ Reviewing court orders, verdicts and judgments and making recommendations ~~of~~ on appeals ~~as needed~~.

SECTION 98. Ins 17.29 (5) (am) and (h) are created to read:

Ins 17.29 (5) (am) Reporting to the claims committee of the board on claim files identified by that committee, at the times and in the manner specified by that committee.

(h) All other functions specified in the contract.

SECTION 99. Ins 17.30 (2) (a) 1 and 2 are amended to read:

Ins 17.30 (2) (a) 1. Against the ~~patients compensation~~ fund, one-half of the actual cost of operating the ~~patients compensation fund peer review~~ council for each ~~fiscal~~ fiscal year, less one-half of the amounts, if any, collected under subd. 3.

2. Against the ~~Wisconsin health care liability insurance~~ plan, one-half of the actual cost of operating the ~~patients compensation fund peer review~~ council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

SECTION 100. Ins 17.35 is created to read:

Ins 17.35 PRIMARY COVERAGE; REQUIREMENTS; PERMISSIBLE EXCLUSIONS; DEDUCTIBLES. (1) PURPOSE. This section implements ss. 631.20 and 655.24, Stats., relating to the approval of policy forms for health care liability insurance subject to s. 655.23, Stats.

(2) REQUIRED COVERAGE. To qualify for approval under s. 631.20, Stats., a policy shall at a minimum provide all of the following:

(a) Coverage for providing or failing to provide health care services to a patient.

(b) Coverage for peer review, accreditation and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by an insured.

(c) Coverage for utilization review, quality assurance and similar professional activities in conjunction with and incidental to the provision of health care services, when conducted in good faith by an insured.

(d) Indemnity limits of not less than the amounts specified in s. 655.23 (4), Stats.

(e) Coverage for supplemental payments in addition to the indemnity limits, including attorney fees, litigation expenses, costs and interest.

(f) That the insurer will provide a defense of the insured and the fund until there has been a determination that coverage does not exist under the policy or unless otherwise agreed to by the insurer and the fund.

(g) If the policy is a claims-made policy:

1. A guarantee that the insured can purchase an unlimited extended reporting endorsement upon cancellation or nonrenewal of the policy.

2. If the policy is a group policy, a provision that any health care provider, as defined under s. 655.001 (8), Stats., whose participation in the group terminates has the right to purchase an individual unlimited extended reporting endorsement.

3. A prominent notice that the insured has the obligation under s. 655.23 (3) (a), Stats., to purchase the extended reporting endorsement unless other insurance is available to ensure continuing coverage for the liability of all insureds under the policy for the term the claims-made policy was in effect.

4. A prominent notice that the insurer will notify the commissioner if the insured does not purchase the extended reporting endorsement and that

the insured, if a natural person, may be subject to administrative action by his or her licensing board.

(3) PERMISSIBLE EXCLUSIONS. A policy may exclude coverage, or permit subrogation against or recovery from the insured, for any of the following:

(a) Criminal acts.

(b) Intentional sexual acts and other intentional torts.

(c) Restraint of trade, anti-trust violations and racketeering.

(d) Defamation.

(e) Employment, religious, racial, sexual, age and other unlawful discrimination.

(f) Pollution resulting in injury to a 3rd party.

(g) Acts that occurred before the effective date of the policy of which the insured was aware or should have been aware.

(h) Incidents occurring while a provider's license to practice is suspended, revoked, surrendered or otherwise terminated.

(i) Criminal and civil fines, forfeitures and other penalties.

(j) Punitive and exemplary damages.

(k) Liability of the insured covered by other insurance, such as worker's compensation, automobile, fire or general liability.

(l) Liability arising out of the ownership, operation or supervision by the insured of a hospital, nursing home or other health care facility or business enterprise.

(m) Liability of others assumed by the insured under a contract or agreement.

(n) Any other exclusion which the commissioner determines is not inconsistent with the coverage required under subd. (2).

(4) DEDUCTIBLES. If a policy includes a deductible or coinsurance clause, the insurer is responsible for payment of the total amount of indemnity up to the limits under s. 655.23 (4), Stats., but may recoup the amount of the deductible or coinsurance from the insured after the insurer's payment obligation is satisfied.

SECTION 101. TERMINOLOGY CHANGE. Wherever "physicians and surgeons" appears in the following sections of the Wisconsin administrative code, "physicians" is substituted: Ins 17.25 (12m) (c).

SECTION 102. INITIAL APPLICABILITY. The treatment of section Ins 17.28 (5) of the Wisconsin administrative code by this rule first applies on the first day of the 3rd month following publication.

SECTION 103. EFFECTIVE DATE. Pursuant to s. 227.22 (2) (intro.), Stats., this rule shall take effect on the first day of the month following publication.

Dated at Madison, Wisconsin, this 1st day of June, 1990.

Robert D. Haase
Commissioner of Insurance

586R42
06/01/90