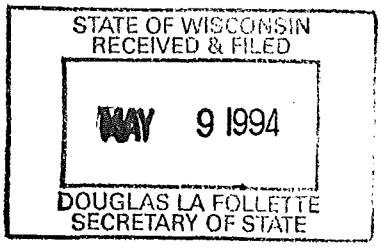
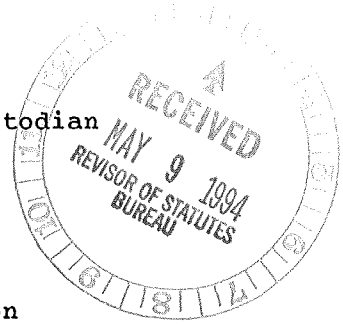
CR 94-42



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



I, Randy Blumer, Deputy Commissioner of Insurance and custodian of the official records of this office, certify that the attached rule-making order affecting ss. Ins 17.01, 17.28, and 17.35, Wis. Adm. Code, relating to patients compensation fund and mediation system fees for the 1994-95 fiscal year, late payment of fees and requirements for allocating claim payments for claims made policies, has been promulgated by this office.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 9th day of May 1994.

Randy Blumer
Deputy Commissioner of Insurance

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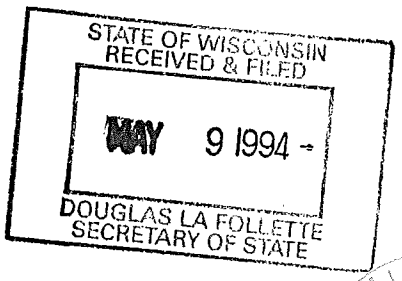
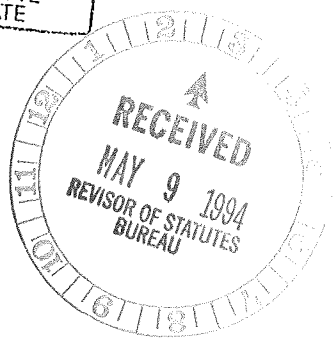




ORDER OF THE BOARD OF GOVERNORS OF THE

PATIENTS COMPENSATION FUND AND THE

OFFICE OF THE COMMISSIONER OF INSURANCE

AMENDING AND CREATING RULES

To amend Ins 17.01 (3) (intro.) and 17.28 (4) (k) and (n) (intro.) and (6); and to create Ins 17.35 (2b), relating to patients compensation fund and mediation system fees for the 1994-95 fiscal year, late payment of fees and requirements for allocating claim payments for claims made policies.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 655.004, 655.27 (3) (b) and 655.61, Stats.

Statutes interpreted: ss. 655.23 (3) (a) and (4), 655.27 (3) (a) and 655.61, Stats.

The commissioner of insurance, with the approval of the board of governors (board) of the patients compensation fund (fund), is required to establish by administrative rule the annual fees which participating health care providers must pay to the fund. This rule establishes those

fees for the fiscal year beginning July 1, 1994. These fees represent a 7.1% increase over the fees paid for the current fiscal year. The board approved this increase at its meeting on February 23, 1994, based on the recommendation of the fund's consulting actuary. This amount is expected to generate enough revenue so that the fund's deficit, currently estimated at approximately $70,000,000, will not increase during the fiscal year.

The rule also changes the method of assessing hospital-affiliated entities that participate in the fund. Currently, such an entity is assessed the greater of $100 or 28.6% of the amount the Wisconsin health care liability insurance plan (WHCLIP) charges or would charge that entity for primary coverage. Because this method is burdensome for WHCLIP, which now has to estimate the premium for each hospital-affiliated entity, whether it is insured by WHCLIP or not, this rule changes the method of assessing the fund fee by charging this kind of entity a percentage of the premium it pays for its primary coverage, no matter who the underlying carrier is, with a minimum fee of $100. The percentage is 15% if the underlying coverage is written on an occurrence basis and 20% if it is claims made coverage.

The rule also provides that if a health care provider pays the fund fee later than the last date specified by the fund in a certified late payment notice sent to the provider, that payment will be applied only prospectively. If the provider wants coverage for the period for which payment is overdue, the procedure specified in the existing rule for requesting retroactive coverage must be followed and the board must approve the request.

The board is also required to promulgate by rule the annual fees for the operation of the patients compensation mediation system, based on the

recommendation of the director of state courts. This rule implements the director's recommendation that fees for the next fiscal year should remain the same, i.e., $50 for physicians and $3 per occupied bed for hospitals.

The statutes require that each health care provider's primary coverage must provide limits of $400,000 per occurrence with a $1,000,000 annual aggregate for each policy year. This rule resolves a difference of interpretation among primary carriers that offer claims made coverage as to how claim payments must be allocated. It requires that the payment on each claim must be allocated to the policy year of the occurrence giving rise to the claim, to ensure that the entire limits for each policy year are available to the insured and the fund, as required by statute.

SECTION 1. Ins 17.01 (3) (intro.) is amended to read:

17.01 FEE SCHEDULE. (intro.) The following fee schedule shall be effective July 1, ~~1993~~ 1994:

SECTION 2. Ins 17.28 (4) (k) and (n) (intro.) are amended to read:

17.28 (4) (k) Prompt payment required. A provider shall pay at least the minimum amount due on or before each due date. If the fund receives payment later than the due date specified in the late payment notice sent to the provider by certified mail, the fund, notwithstanding par. (n) 5, may not apply the payment retroactively to the annual fee unless the board has authorized retroactive coverage under sub. (3s) (b).

(n) Application of payments. (intro.) ~~All~~ Except as provided in par. (k), all payments to the fund shall be applied in chronological order first to previous fiscal years for which a balance is due and then to the

current fiscal year. The amounts for each fiscal year shall be credited in the following order:

SECTION 3. Ins 17.28 (6) is amended to read:

Ins 17.28 (6) FEE SCHEDULE. (intro.) The following fee schedule shall be effective from July 1, ~~1993~~ 1994 to June 30, ~~1994~~ 1995:

(a) Except as provided in pars. (b) to (g), for a physician for whom this state is a principal place of practice:

Class 1	~~$2,941~~	$3,150	Class 3	~~$14,705~~	$15,750
Class 2	~~$5,882~~	$6,300	Class 4	~~$17,646~~	$18,900

(b) For a resident acting within the scope of a residency or fellowship program:

Class 1	~~$1,471~~	$1,575	Class 3	~~$7,353~~	$7,875
Class 2	~~$2,941~~	$3,150	Class 4	~~$8,823~~	$9,450

(c) For a resident practicing part-time outside the scope of a residency or fellowship program:

All classes	~~$1,765~~	$1,890

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

Class 1	~~$1,176~~	$1,260	Class 3	~~$5,882~~	$6,300
Class 2	~~$2,353~~	$2,520	Class 4	~~$7,058~~	$7,560

(g) For a physician who practices fewer than 500 hours during the fiscal year, limited to office practice and nursing home and house calls, and who does not practice obstetrics or surgery or assist in surgical procedures: ~~$735~~ $788

(gm) For a physician for whom this state is not a principal place of practice:

Class 1	~~$1,471~~	$1,575	Class 3	~~$7,353~~	$7,875
Class 2	~~$2,941~~	$3,150	Class 4	~~$8,823~~	$9,450

(h) For a nurse anesthetist for whom this state is a principal place of practice: ~~$788~~ $844

(hm) For a nurse anesthetist for whom this state is not a principal place of practice: ~~$394~~ $422

(i) For a hospital:

1. Per occupied bed ~~$194~~ $208; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available ~~$9.61~~ $10.29

(j) For a nursing home, as described under s. 655.002 (1) (j), 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:

Per occupied bed ~~$36~~ $39

(k) For a partnership comprised of physicians or nurse anesthetists, organized for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of partners and employed physicians or nurse anesthetists is from 2 to 10 ~~$110~~ $118

2. If the total number of partners and employed physicians or nurse anesthetists is from 11 to 100 ~~$1,100~~ $1,178

3. If the total number of partners and employed physicians or nurse anesthetists exceeds 100 ~~$2,750~~ $2,945

(L) For a corporation with more than one shareholder organized under ch. 180, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of shareholders and employed physicians or nurse anesthetists is from 2 to 10 ~~$110~~ $118

2. If the total number of shareholders and employed physicians or nurse anesthetists is from 11 to 100 ~~$1,100~~ $1,178

3. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 ~~$2,750~~ $2,945

(Lm) For a corporation organized under ch. 181, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of employed physicians and nurse anesthetists is from 1 to 10 ~~$110~~ $118

2. If the total number of employed physicians and nurse anesthetists is from 11 to 100 ~~$1,100~~ $1,178

3. If the total number of employed physicians ~~or~~ and nurse anesthetists exceeds 100 ~~$2,750~~ $2,945

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available ~~$0.24~~ $0.26; plus

2. 2.5% of the total annual fees assessed against all of the employed physicians.

(n) For an ambulatory surgery 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.:

Per 100 outpatient visits during the last calendar year for which totals are available ~~$48~~ $51

(o) (intro.) For an entity affiliated with a hospital~~:~~, the greater of $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.~~ whichever of the following applies:

1. 15% of the amount the entity pays as premium for its primary health care liability insurance, if it has occurrence coverage.

2. 20% of the amount the entity pays as premium for its primary health care liability insurance, if it has claims made coverage.

SECTION 4. Ins 17.35 (2b) is created to read:

Ins 17.35 (2b) APPLICATION OF LIMITS; CLAIMS MADE POLICIES. (a) This subsection interprets and implements s. 655.23 (4), Stats.

(b) An insurer shall allocate the amount paid on each claim to the policy year of the occurrence giving rise to the claim and not to the year in which the claim was reported. The per occurrence limit and the total amount of the annual aggregate limit specified in s. 655.23 (4), Stats., as it applied on the date of the occurrence, shall be available for each policy year.

SECTION 5. INITIAL APPLICABILITY. (1) Except as provided in subsections (2) and (3), this rule first applies on the effective date specified in SECTION 6.

(2) The annual fees established in SECTION 3 of this rule first apply on July 1, 1994.

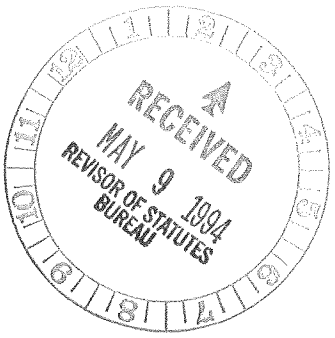
(3) Section Ins 17.35 (2b), as created by this rule, applies to all claims made health care liability insurance policies for which certificates have been filed with the patients compensation fund, whether issued before, on or after the effective date specified in SECTION 6.

SECTION 6. EFFECTIVE DATE. This rule will take effect on the first day of the first month after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 9th day of May 1994.

Randy Blumer

Randy Blumer
Deputy Commissioner of Insurance



826R8
05/06/94

REPORT ON ss. Ins 17.01, 17.28, and 17.35, Relating to Patients Compensation Fund and Mediation Systems Fees for 1994-95, Late Payment of Fees, and Requirements for Allocating Claim Payments for Claims-made Policies
Clearinghouse Rule No. 94-42
Submitted Under s. 227.19 (3), Stats.

A proposed rule-making order of the Commissioner of Insurance is attached.

(a) Statement of need for the proposed rule

The Commissioner is required to promulgate by rule the annual fees for the Patients Compensation Fund and the Mediation system operated by the Director of State Courts. This rule establishes those fees for fiscal year 1994-95. It also creates other provisions necessary for handling late fee payments and ensuring equitable allocation of claim payments by insurers.

(b) Modifications made in proposed rule because of testimony at public hearing

None

(c) Persons who appeared or registered for or against the proposed rule, or for information

Appearances:

For: None

Against: None

For Information: Danford C. Bubolz, chief, Patients Compensation Fund, OCI

John C. Eversman, M.D., and Patricia Chritton, Medical College of Wisconsin

Registrations:

For: None

Against: None

Neither for nor against: None

Letters received:

None

(d) Response to Legislative Council staff recommendations

The recommendations of the Legislative Council staff were all accepted. The provisions regarding confidentiality of arbitration records have been deleted from this draft.

(e) Regulatory flexibility analysis

The Office of the Commissioner of Insurance has determined that this proposed rule will not have a significant economic effect on a substantial number of small businesses and, therefore, a final regulatory flexibility analysis is not required.

(f) Fiscal Effect

See fiscal estimate attached to proposed rule.

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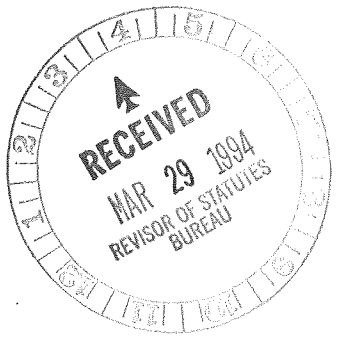
03/29/94



LCRC FORM 2

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CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE 94-42
AN ORDER to amend Ins 17.01 (3) (intro.), 17.275 (title) and (1) and 17.28 (4) (k) and (n) (intro.) and (6); and to create Ins 17.275 (4) and 17.35 (2b), relating to patients compensation fund and mediation system fees for the 1994-95 fiscal year, late payment of fees, requirements for allocating claim payments for claims made policies and confidentiality of certain arbitration records.

Submitted by OFFICE OF THE COMMISSIONER OF INSURANCE.

3- 1-94. Received by Legislative Council.
3-28-94. Report sent to Agency.

RNS:SPH:jt;las

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CLEARINGHOUSE RULE 94-42

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated November 1991.]

1. Statutory Authority

Section Ins 17.275 (4), which provides for the confidentiality of the "proceedings and records" relating to a binding arbitration process to resolve disputes concerning the assessment of negligence of two or more co-defendants, is without statutory authority. A review of the statutes cited in s. Ins 17.275 (1) as authority for this confidentiality provision, including the new, underscored references to s. 19.85 (1) (a) and (g), Stats., is not persuasive. These new references relate to closed sessions of meetings of governmental bodies for the purpose of:

> 19.85 (1) (a) Deliberating concerning a case which was the subject of any judicial or quasi-judicial trial or hearing before that governmental body.
>
> (g) Conferring with legal counsel for the governmental body who is rendering oral or written advice concerning strategy to be adopted by the body with respect to litigation in which it is likely to become involved.

Neither of these exceptions to the open meetings law appear to apply to the binding arbitration process specified in s. Ins 17.275 (4).

4. Adequacy of References to Related Statutes, Rules and Forms

The reference to s. 655.24 (4), Stats., in s. Ins 17.35 (2b) (a) and (b) is incorrect; the correct reference is s. 655.23 (4), Stats.