

1975 Assembly Bill 725

Date published: July 23, 1975

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CHAPTER 37, Laws of 1975
(Vetoed in Part)

AN ACT to amend 257.19 (2) and 263.03 (3); and to create 20.145 (7), 20.680 (2) (c) and (q), 140.05 (18), 441.01 (6), 448.185, 619.04, chapter 655, [893.235 and 893.236] of the statutes, relating to health care liability and patients compensation, granting rule-making authority and making an appropriation. [Vetoed]

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

SECTION 1. Legislative findings. (1) The legislature finds that:

(a) The number of suits and claims for damages arising from professional patient care has increased tremendously in the past several years and the size of judgments and settlements in connection therewith has increased even more substantially;

(b) The effect of such judgments and settlements, based frequently on newly emerging legal precedents, has been to cause the insurance industry to uniformly and substantially increase the cost and limit the availability of professional liability insurance coverage;

(c) These increased insurance costs are being passed on to patients in the form of higher charges for health care services and facilities;

(d) The increased costs of providing health care services, the increased incidents of claims and suits against health care providers and the size of such claims and judgments has caused many liability insurance companies to withdraw completely from the insuring of health care providers;

(e) The rising number of suits and claims is forcing both individual and institutional health care providers to practice defensively, to the detriment of the health care provider and the patient;

(f) As a result of the current impact of such suits and claims, health care providers are often required, for their own protection, to employ extensive diagnostic procedures for their patients, thereby increasing the cost of patient care;

(g) As another effect of the increase of such suits and claims and the costs thereof, health care providers are reluctant to and may decline to provide certain health care services which might be helpful, but in themselves entail some risk of patient injury;

(h) The cost and the difficulty in obtaining insurance for health care providers discourages and has discouraged young physicians from entering into the practice of medicine in this state;

(i) Inability to obtain, and the high cost of obtaining, such insurance has affected and is likely to further affect medical and hospital services available in this state to the detriment of patients, the public and health care providers;

CHAPTER 37

34

(j) Some health care providers have curtailed or ceased, or may further curtail or cease, their practices because of the nonavailability or high cost of professional liability insurance; and

(k) It therefor appears that the entire effect of such suits and claims is working to the detriment of the health care provider, the patient and the public in general.

SECTION 2. 20.145 (7) of the statutes is created to read:

20.145 (7) HEALTH CARE LIABILITY. (b) *Loan from general fund.* A sum sufficient to carry out the insurance commissioner's responsibilities under s. 655.27 for the fiscal year 1975-76.

(q) *General program operations.* From the patients compensation fund created under s. 655.27, an amount equal to the amount paid into the fund under s. 655.27 (3) to carry out the insurance commissioner's responsibilities under s. 655.27. Of the amounts appropriated under this paragraph, an amount equal to the amounts appropriated under par. (b) shall be transferred to the general fund in calendar year 1976 as reimbursement for moneys appropriated under par. (b).

SECTION 3. 20.680 (2) (c) and (q) of the statutes are created to read:

20.680 (2) (c), *Patients compensation panels; loan from general fund.* A sum sufficient to carry out the administrator of courts' responsibilities under ch. 655 for the fiscal year 1975-76.

(q) *Patients compensation panels.* From the patients compensation fund created under s. 655.27, an amount equal to the amount generated from fees collected under ss. 655.14 and 655.21 to carry out the administrator of courts' responsibilities under ch. 655. Of the amounts appropriated under this paragraph an amount equal to the amounts appropriated under par. (c) shall be transferred to the general fund in calendar year 1976 as reimbursement for moneys appropriated under par. (c).

SECTION 4. 140.05 (18) of the statutes is created to read:

140.05 (18) The department shall investigate any hospital which is found by a panel established under s. 655.02 or by a court to have been responsible for negligent acts.

SECTION 5. 257.19 (2) of the statutes is amended to read:

257.19 (2) ADMINISTRATIVE DIRECTOR. The office of administrator of courts is created with an administrative director, who shall be the head thereof and who shall assist the chief justice of the supreme court or other designated justice in the performance of his duties under s. 251.182, collect such statistics as the supreme court requires, administer patients compensation panels under ch. 655 and perform such other duties as the supreme court directs.

SECTION 6. 263.03 (3) of the statutes is amended to read:

263.03 (3) A demand of the judgment to which the plaintiff supposes himself entitled; if the recovery of money ~~be~~ is demanded, the amount thereof shall be stated except as provided in s. 655.009 (1).

SECTION 7. 441.01 (6) of the statutes is created to read:

441.01 (6) The board shall investigate any nurse anesthetist who is found to have acted negligently by a panel established under s. 655.02 or by a court.

SECTION 8. 448.185 of the statutes is created to read:

448.185 Investigation of malpractice cases. The examining board shall investigate any physician who is found to have acted negligently by a panel established under s. 655.02 or by a court.

SECTION 9. 619.04 of the statutes is created to read:

619.04 Mandatory health care liability risk sharing plans. (1) The commissioner shall promulgate rules establishing a plan of health care liability coverage for all medical or osteopathic physicians licensed under ch. 448 and nurse anesthetists licensed under ch. 441 who practice medicine in this state and all hospitals as defined by s. 140.24 (1) (a) and (c), but excluding those facilities exempted by s. 140.29 (3), which operate in this state.

Vetoed
in Part

~~(2) All insurers providing any type of coverage for liability resulting from personal injury for persons in this state shall participate in the plan, except that the commissioner may exclude certain insurers for administrative convenience or because it is not equitable or practicable to require them to participate in the plan.~~

Vetoed
in Part

(3) The plan shall operate subject to the supervision and approval of a board of governors consisting of representatives of 5 of the insurers participating in the plan, who shall serve at the direction of the commissioner, an attorney to be named by the state bar association, a physician to be named by the Wisconsin medical society, a hospital representative to be named by the Wisconsin hospital association, the commissioner or his designated representative employed by the office of the commissioner and 2 public members who are not attorneys or physicians and who are not professionally affiliated with any hospital or insurance company, appointed by the governor for staggered 3-year terms. The commissioner or his representative shall be the chairman of the board of governors. Board members shall be compensated at the rate of \$50 per diem plus actual and necessary travel expenses.

~~(4) The board shall prepare an annual report on the plan which it shall present to the standing committees on health and insurance in each house of the legislature on or before March 1 of each year.~~

Vetoed
in Part

(5) The plan shall offer professional health care liability coverage in a standard policy form for all hospitals, medical or osteopathic physicians and nurse anesthetists operating or practicing in this state. The plan shall include, but not be limited to, the following:

(a) Rules for the classification of risks and rates which reflect past and prospective loss and expense experience in different areas of practice.

(b) A rating plan which reasonably recognizes the prior loss experience of insureds in the state.

(c) Provisions as to rates for insureds who are semiretired or part-time professionals.

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(d) Optional coverage, available upon request to any insured, for any liability based on a treatment, omission or operation which occurs during the term of the policy and which is brought within the time the applicable statute of limitations continues that liability.

~~(e) Protection in an amount of \$200,000 per claim and \$600,000 for all claims in any one policy year.~~

~~(6) Any deficit in the plan in any year shall be recouped by rate increases for the plan applicable in subsequent years. Any surplus over the loss reserves in the plan in any year shall be distributed by rate decreases for the plan applicable in subsequent years.~~

Vetoed
in Part

(7) The commissioner, after consultation with the board of governors, may direct one or more insurers to provide policy service and claims service in the name of the plan on behalf of all other insurers participating in the plan.

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

(9) Neither the state nor the board of governors shall be liable for any obligation of the plan or of the patients compensation fund under s. 655.27. The board of governors shall be immune from civil prosecution for good faith actions taken within the scope of their duties under this section and s. 655.27.

Vetoed in Part (10) The commissioner may, in his discretion, promulgate rules to effect an orderly transition of coverage for persons insured under s. 619.01 on the effective date of this act (1975) who wish to transfer their coverage to the plan established under this section.

SECTION 10. Chapter 655 of the statutes is created to read:

CHAPTER 655

HEALTH CARE LIABILITY AND PATIENTS COMPENSATION

SUBCHAPTER I

GENERAL PROVISIONS

655.001 Definitions. In this chapter:

- (1) "Administrator" means the state court administrator.
- (2) "Claimant" means the person filing a submission of controversy under s. 655.04.
- (3) "Commissioner" means the commissioner of insurance.
- (4) "Department" means the department of regulation and licensing.
- (5) "Dependent" means any person legally entitled to support or maintenance by another.
- (6) "Formal panel" means a 5-member patients compensation panel established under s. 655.03 (1).
- (7) "Fund" means the patients compensation fund under s. 655.27.
- (8) "Health care provider" means a medical or osteopathic physician licensed under ch. 448, a nurse anesthetist licensed under ch. 441 or a hospital as defined by s. 140.24 (1) (a) and (c), but excluding those facilities exempted by s. 140.29 (3).
- (9) "Informal panel" means a 3-member patients compensation panel established under s. 655.03 (2).
- (10) "Patient" means an individual who received or should have received health care services from a health care provider.
- (11) "Permanently practicing in this state" means the full-time or part-time practice in this state of a health care provider's profession for more than 6 weeks in any calendar year.
- (12) "Representative" means the personal representative, spouse, parent, guardian, attorney or other legal agent of a patient.
- (13) "Respondent" means the person against whom a submission of controversy is filed under s. 655.04.

655.003 Rule-making authority. The administrator, department and commissioner may promulgate such rules under ch. 227 as are necessary to enable them to perform their responsibilities under this chapter.

655.005 Remedy. (1) (a) On and after the effective date of this act (1975), every patient, every patient's representative and every health care provider shall be conclusively presumed to have accepted to be bound by this chapter.

(b) Except as otherwise specifically provided in this chapter, this subsection also applies to minors.

(2) This chapter does not apply to injuries or death occurring, or services rendered, prior to the effective date of this act (1975).

655.007 Patients' claims. On and after the effective date of this act (1975), any patient or his representative, having a claim for injury or death on account of malpractice is subject to this chapter.

655.009 Actions against health care providers. An action to recover damages on account of malpractice shall comply with the following:

(1) **COMPLAINT.** Notwithstanding s. 263.03, the complaint in such action shall not specify the amount of money to which the plaintiff supposes he is entitled except to state whether such amount is \$10,000 or less or is over \$10,000. The complaint shall, if applicable, state that the damages he is entitled to are more than the minimum amount necessary to invoke the jurisdiction of the court.

(2) **MEDICAL EXPENSE PAYMENTS.** The court or jury, whichever is applicable, shall determine the amounts of medical expense payments previously incurred and for future medical expense payments.

655.01 Forms. The administrator shall prepare and cause to be printed, and upon request furnish free of charge, such forms and materials as he deems necessary to facilitate or promote the efficient administration of this chapter.

655.013 Attorney's fees. (1) With respect to any ~~arbitration award or judgment for damages paid or rendered concerning an act of malpractice~~ after the effective date of this act (1975), the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants in such proceeding or action is subject to the following:

**Vetoed
in Part**

(a) The determination shall not reflect amounts previously paid for medical expenses by the health care provider or his insurer.

(b) The determination shall not reflect payments for future medical expense in excess of \$25,000.

(2) An attorney shall offer to charge any client in a malpractice proceeding or action on a per diem or per hour basis. Any such agreement shall be made at the time of the employment of the attorney. An attorney's fee on a per diem or per hour basis is not subject to the limitations under sub. (1).

655.015 Future medical expenses. If a settlement, arbitration award or judgment under this chapter provides for future medical expense payments in excess of \$25,000, that portion of future medical expense payments in excess of \$25,000 shall be paid to the commissioner. The commissioner shall develop by rule a system for managing and disbursing such funds through periodic payments for these expenses. Such payments shall be made under the system until either the amount is exhausted or the patient dies. Such rules shall not be effective until approved by the senate and assembly committees to which health care and insurance legislation is usually referred. ~~If the patient dies, the remainder of the amount shall be paid to the fund.~~

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655.017 Annual training requirement. No medical or osteopathic physician shall be eligible for the protection provided under this chapter unless, at the time of application for a certificate of registration under s. 448.07, he has completed at least 15 hours of continuing education programs or courses of study approved by the medical examining board within the calendar year immediately preceding such application. The medical examining board shall notify the commissioner and the department of all physicians who have met the requirements of this section. The examining board may waive these requirements if it finds that exceptional circumstances such as prolonged illness, disability or other similar circumstances have prevented a physician from meeting the requirements.

SUBCHAPTER II

PATIENTS COMPENSATION PANELS

655.02 Establishment of panels. The administrator shall establish patients compensation panels situated throughout this state to hear controversies presented under this chapter. The administrator shall establish 4 formal panels under s. 655.03 (1) and such informal panels under s. 655.03 (2) as he deems necessary.

655.03 Panel members. (1) **FORMAL PANELS.** Each formal panel shall be composed of the following members:

(a) One physician licensed to practice medicine in this state, appointed at random by the administrator for a 6-month term or for the duration of any case pending at the expiration of such term from a list submitted by the medical examining board.

(b) If any respondent in a panel hearing is a physician, one additional physician licensed to practice medicine in this state and who is engaged in the practice of medicine similar to that of the respondent and appointed at random by the administrator from a list submitted by the medical examining board.

(c) If any respondent in a panel hearing is not a physician, then one person from the same field of health care as that of the respondent who is licensed in this state and appointed at random by the administrator from a list supplied by the appropriate state licensing board or by the department of health and social services. In the event that a claim involves more than one respondent, and that the respondents are specialists in different areas of medical practice, the administrator shall determine the specialty to be represented on the panel.

(d) One attorney licensed to practice law in this state, appointed by the administrator.

(e) Two public members appointed by the governor for 2-year staggered terms who are not attorneys and who, at the time of their appointment, are not engaged in or licensed to practice any of the professions or occupations to which ch. 655 applies.

(f) No person appointed to a panel by the administrator under par. (a) to (c) may decline to serve on a panel except that the administrator may for good cause excuse such person. No person may serve on a panel if he has a professional or personal interest in a claim under consideration. No person appointed under par. (a) or (b) may serve on more than one panel in a 5-year period.

(2) **INFORMAL PANELS.** (a) The administrator shall select 3 names from each of the following lists:

1. A list of attorneys with trial experience. The list shall be prepared and periodically revised by the state bar of Wisconsin.

2. Lists of health care professionals, according to the specialty, if any, of the health care provider involved. The lists shall be prepared and periodically revised by appropriate statewide organizations of health care providers. The lists shall designate the specialty, if any, of each health care provider listed. Such organizations shall assist the administrator in determining the appropriate specialty of health care providers for each panel. The administrator shall select 3 names from the appropriate list for each kind of health care provider named as a defendant.

3. Lists for petit jurors, as provided in s. 255.04, for the county in which a submission of controversy has been filed under s. 655.04.

(b) If any person selected from a list desires not to participate on the informal panel, the administrator may, for good cause, excuse such person from service. No person may serve on an informal panel if he has a professional or personal interest in a claim under consideration. A replacement shall be selected in the same manner as the

excused person was selected. The selections shall consist of the categories of attorney, of each kind of health care provider named under par. (a) 2 and of juror.

(c) The claimant and the respondent shall each strike one name from each of the categories described in par. (b), and the remaining persons shall comprise the informal panel. If there is more than one respondent, the respondents must resolve the question of striking names from the lists among respondents, but may not strike more than one name in each category. The first strike in each category shall be made by the claimant.

(3) FORMAL AND INFORMAL PANELS; PROCEDURES. (a) *Meetings; frequency.* Each panel shall meet on the call of the chairman or a majority of its members. The administrator shall assign submissions of controversy to each panel and the panel hearing shall be conducted at a location determined by the court administrator. The county board of any county shall provide, upon request of the administrator or the chairman of the panel or a majority of its members, suitable facilities for hearings.

(b) *Appointment of officers.* The administrator shall designate the attorney member of each panel as its chairman.

(c) *Compensation of panel members.* Each person appointed to a panel under this section shall be paid \$75 for each day's actual attendance at a panel meeting plus actual and necessary travel expenses.

655.04 Patients' claims. (1) FILING. (a) On and after the effective date of this act (1975), any patient or his representative, having a claim under this chapter for bodily injury or death, on account of a tort or breach of contract based on professional services rendered or which should have been rendered by a health care provider, may, after payment of the fee under s. 655.14, file a submission of controversy with the administrator in accordance with this chapter. The submission of controversy shall be in substantially the following form:

The undersigned, (name of petitioner), of (city) in (county), being a party to the following matter in difference, which might be the subject of a legal action, and desiring to avoid the expense of litigation, hereby certifies that:

- 1) (patient's name) was a patient of (health care provider), on (date); and
- 2) Said (health care provider), in treating said (patient's name) for (nature of condition or disease), committed an act of malpractice in rendering or failing to render health care services, to the injury of (patient's name), in that (short statement of injury); and
- 3) The injury to (patient's name) entitles him to recovery in the amount of (\$10,000 or under) (over \$10,000).

In consequence thereof, the undersigned petitioner hereby respectfully and in good faith requests that a panel be convened under section 655.02 of the Wisconsin Statutes for investigation of this matter.

(petitioner's name)

(b) The administrator shall assign the controversy to the appropriate panel as determined under sub. (2). No action may be commenced in court unless the controversy has first been heard and findings and an order have been made by the panel.

(2) CHOICE OF PANEL. (a) *Claims of \$10,000 or less.* If the petitioner states in his submission of controversy that he is entitled to recovery in the amount of \$10,000 or less, the controversy shall be heard by an informal panel under s. 655.03 (2), unless both parties stipulate in writing that the controversy shall be heard by a formal panel under s. 655.03 (1).

(b) *Claims of over \$10,000.* If the petitioner states in his submission of controversy that he is entitled to recovery in an amount over \$10,000, the controversy

shall be heard by an informal panel under s. 655.03 (2), unless one party requests in writing that the controversy shall be heard by a formal panel under s. 655.03 (1).

(3) NOTICE. Notice of the filing of the submission of controversy shall be served on all named health care providers by the administrator by 1st class mail to the address of the health care provider as designated in the submission of controversy.

(4) PROCEDURE. (a) Within 60 days after the filing of a submission of controversy, the panel shall schedule and notify all parties of the hearing upon the matter. Such hearing shall be held within 60 days of the date on which the panel notifies the parties of the hearing. Within 30 days after the hearing, the panel shall render a decision.

(b) The panel shall determine its own internal procedures.

(c) At least 2 weeks before the date set for hearing, the parties shall submit to the panel all pertinent written material, including pleadings and medical and hospital reports, or authorization to obtain the same. These materials shall be made available to any panel member desiring to see them in advance of the hearing. A transcript of any adverse examination of any party taken before the panel makes its decision shall be submitted to the panel immediately upon preparation by the party conducting the adverse examination.

(5) APPLICABILITY. This chapter applies only to claims arising out of health care services provided in this state.

(6) STATUTE OF LIMITATIONS. The filing of the submission of controversy shall toll any applicable statute of limitations, and such statute of limitations shall remain tolled until 30 days after the hearing panel issues its written decision, or the jurisdiction of the panel is otherwise terminated.

655.05 Panels; assignment of controversies. Each panel shall hear and determine each controversy assigned to it by the administrator. Less than a full panel may hear and determine any controversy upon written stipulation of all parties. A majority vote of the panel shall be sufficient upon which to base findings, an order or an award.

655.06 Guardian ad litem. (1) FOR WHOM APPOINTED. In every controversy involving a victim of alleged malpractice who is a minor or incompetent, the panel shall appoint a guardian ad litem to represent such minor or incompetent. A guardian ad litem shall not be appointed or appear in the same matter for different persons whose interests may be conflicting.

(2) TIME OF APPOINTMENT. The panel shall appoint the guardian ad litem as soon as is practicable after the controversy is assigned to the panel for hearing.

(3) DURATION OF APPOINTMENT. The guardian ad litem shall continue to act until the panel issues its findings, order and award, unless earlier discharged by the panel.

(4) WHO MAY SERVE. The guardian ad litem shall be an attorney admitted to practice in this state.

(5) COMPENSATION. The guardian ad litem shall be compensated for his services at a reasonable rate as determined by the panel. Such expense may, in the panel's discretion, be charged to any or all of the parties or to the patients compensation fund.

655.065 Panel powers. (1) FINDINGS. Each panel, whether formal or informal, shall determine the following:

(a) Whether the actions or omissions of the health care provider were negligent.

(b) If such actions or omissions were negligent, whether the negligence caused injury or death to the patient.

(2) **COMPENSATORY AWARDS.** (a) If the panel determines that a claimant has suffered bodily injury or has suffered damage from the death or bodily injury of another, the panel shall award compensation and benefits.

1. In any claim which is brought because of the death of the patient, a submission of controversy may be filed by the personal representative of the deceased or by the person to whom any amount awarded belongs.

2. When several claims are brought, any party may petition the panel to consolidate such claims. If the panel determines that the consolidation of all or several of such claims is in the public interest, the affected claims shall be so consolidated that a single panel finding may be made covering all affected health care providers. For the claims so consolidated, the payment of a single award shall extinguish all separate claims, and no claim ordered consolidated by the panel shall be permitted to proceed individually.

(b) Any award shall be payable by the named health care providers found liable therefor. Each health care provider shall have a right of comparative contribution or indemnity in accordance with the laws of this state.

(c) Any award under this subsection shall be diminished under s. 895.045 in proportion to the amount of negligence attributable to the patient or person entitled to recover.

(3) **FILING.** Every panel, whether formal or informal, shall file a copy of its findings, order and award in every case with the administrator.

655.07 Panel findings; when binding. Upon written stipulation by all parties to any controversy heard by a formal or informal panel, the findings, order and award determined by the panel shall be binding upon the parties and the provisions of s. 655.19 shall not apply.

655.08 Adverse findings. If the panel finds that a hospital has acted negligently, it shall refer the finding and its recommendation for appropriate action to the department of health and social services. If the panel finds that any other health care provider has acted negligently, it shall refer the finding and its recommendation for action to the appropriate examining board.

655.09 Designation of parties. The parties to any submission of controversy before the panel shall be designated the claimant and the respondent. The party filing the submission of controversy with the administrator shall be designated the claimant and the adverse party the respondent.

655.10 Joinder of parties. Joinder of parties shall be governed by s. 655.065 (2) (a) 2 and the rules of procedure applicable to civil actions. The panel, at any time, upon a proper showing or on its own motion, may order, with appropriate notice as provided in this chapter, that any additional claimant or respondent be joined, when it deems the inclusion of such party necessary and proper to a just determination of the claim.

655.11 Notice; how served. The filing and serving of all pleadings, notices and other papers, unless otherwise directed in this chapter, may be accomplished by 1st class mail. Service by mail is complete upon mailing, subject to s. 269.36. Proof of mailing shall be prima facie evidence of service.

655.12 Answer. A respondent may file an answer of denial to the submission of controversy, and may file any other special defense recognized under the law and not prohibited by this chapter, at any time before the date set for the hearing, but no such answer is required and, if none is filed, the failure to file an answer shall not be deemed acquiescence in the allegations of the submission of controversy. The filing of

any special defense after the controversy is set for hearing may be by written leave only, granted by the chairman of the panel.

655.13 Pleading forms. (1) All pleadings shall be filed on a form prescribed by the administrator and shall be filed in triplicate. Sufficient additional copies of the submission of controversy shall be filed to permit service of a copy on each respondent.

(2) After the submission of controversy is filed with the administrator, all subsequent pleadings, motions or other papers filed with the panel shall contain an affidavit that on or before the day of filing a copy thereof was served on opposing counsel, or on the parties if there is not counsel of record.

655.14 Suit Tax. Submissions of controversy filed with the administrator are subject to a suit tax of \$11. The suit tax shall be paid into the patients compensation fund created under s. 655.27.

655.15 Payments to minors. Payments to minors shall be made in accordance with law.

655.16 Findings, orders and awards. (1) All parties shall be afforded opportunity for public hearing after reasonable notice, but disposition of a controversy may be made by compromise, stipulation, agreement or default without hearing.

(2) After hearing, the panel shall, by a majority vote of the participating panel members, make and file its findings upon the ultimate facts involved in the case, and shall, by a majority vote of the participating panel members, file its order. The order shall state its determination as to the rights of the parties and include any award to be made.

655.17 Formal panel; hearing. (1) Except as otherwise provided in this chapter, a formal panel shall be bound by the law applicable to civil actions, but shall conduct such hearings and make such investigations in reference to questions at issue before it as in its judgment are best adapted to ascertain and determine the substantial rights of the parties expeditiously and accurately and to carry out justly the spirit of this chapter.

(2) Each formal panel may prescribe the procedures necessary to implement this chapter, order physical examinations under sub. (3), subpoena witnesses, administer oaths, apply to any county or circuit court having requisite jurisdiction to enforce the attendance and testimony of witnesses and the production and examination of books, papers and records and exercise all other powers and duties conferred upon it by law.

(3) Upon the application of any party or upon its own motion, a formal panel may appoint a disinterested and duly qualified physician or other professional person or expert to make any necessary professional or expert examination of a claimant or relevant evidentiary matter and to report or testify as a witness in respect thereto. Such a witness shall be allowed actual and necessary traveling expenses and a reasonable fee fixed by the administrator, to be collected and paid by the party requesting the witness or by the administrator if the panel makes the request.

(4) In all hearings under this section, proof may be made by oral testimony, deposition or interrogatories. Depositions shall be taken as are depositions in civil actions, and may be introduced into evidence without regard to the availability of the witness to testify at the time of the hearing. Any witness may be subpoenaed by a party to the controversy to testify under the law applicable to civil actions.

(5) Witnesses before the panel shall receive for attendance the fees and mileage allowed for witnesses in civil actions.

(6) Original X-rays taken and records or duplicates thereof made in the course of a regularly conducted activity by a health care provider or his agent shall be

admissible without the necessity of other identification or authentication unless a question is raised as to their authenticity or accuracy.

(7) Any report, deposition or recorded testimony of attending or examining physicians shall be retained in the private records of the panel and shall be open to the inspection of the parties and their attorneys, but not to the general public unless, in the opinion of the panel, the public interest so requires.

(8) In all hearings before a formal panel under this section, costs shall be awarded as provided for civil actions. Allowable costs shall include reasonable expert witness fees.

655.18 Informal panel; hearing. (1) A hearing before an informal panel shall be without a stenographic record. The panel shall prepare a formal statement of its decision which it shall forward to the parties.

(2) All parties may be represented at the hearing by counsel authorized to act for their respective clients. Failing an appearance, the administrator may order an investigation ~~or make such direction as justice requires.~~

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in Part

655.19 Court trial. Unless the parties have stipulated in writing under s. 655.07 to be bound by the panel determination, any party to a panel hearing may, within 120 days after the date of an order made by a panel, commence an action for a trial in the circuit or county court for the county designated in the submission of controversy under s. 655.04. The provisions of ch. 270 which are not in conflict with this chapter shall apply to such trial. No panel member may participate in the trial either as counsel or witness. The judgment or order of the circuit or county court shall supersede any order or award made by a panel in a hearing under this chapter.

(1) FORMAL PANELS. The findings and order, except for damages awarded, of any formal panel shall be admissible in any action in circuit or county court, and the amount of damages awarded may, at the court's discretion, be admissible in such action. In the case of a trial subsequent to a formal panel hearing, the court may award actual court costs and reasonable attorney fees in excess of statutory limitations to the prevailing party.

(2) INFORMAL PANELS. The findings and order of any informal panel shall not be admissible in any court action. No statement or expression of opinion made in the course of an informal panel hearing is admissible in evidence either as an admission or otherwise in any court action.

655.20 Judgment of county or circuit court on award. After the passage of time for petitioning the county or circuit court for a trial under s. 655.19 has passed, any party may file a certified copy of the order containing the award with the county or circuit court for the county of residency of any respondent named in the order, whereupon the court shall render judgment in accordance therewith.

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

- (a) For each physician permanently practicing in this state, \$40.
- (b) For each hospital, \$10 per bed.

(2) The annual fees under sub. (1) shall be collected by the department of regulation and licensing at dates set to coincide with the annual renewal of the registration or license required for health care providers to practice in this state, and by the department of health and social services at a date set to coincide with the

collection of the annual license fee under s. 140.85 (2). The departments shall pay all moneys so collected into the patients compensation fund created under s. 655.27. At the time of remitting the fee, each health care provider permanently practicing or operating in this state shall submit proof of financial responsibility under s. 655.23.

SUBCHAPTER III

INSURANCE PROVISIONS

655.23 Limitations of liability; proof of financial responsibility. (1) All health care providers permanently practicing or operating in this state shall pay the yearly assessment into the patients compensation fund under s. 655.27 ~~prior to practicing during an year.~~

Vetoed in Part (2) Every health care provider permanently practicing or operating in this state shall, ~~within 30 days after the effective date of this act (1975) and thereafter~~ once in each year as prescribed by the commissioner, file with the commissioner in a form prescribed by him, proof of financial responsibility as provided in this section. No health care provider who retires or ceases operation after the effective date of this act (1975) shall be eligible for the protection provided under this chapter unless proof of financial responsibility for all claims arising out of acts of malpractice occurring after the effective date of this act (1975) is provided to the commissioner as required in this section.

(3) Every health care provider permanently practicing or operating in this state either shall insure and keep insured his liability by a policy of insurance issued in accordance with the laws of this state, shall qualify as a self-insurer, or shall furnish to the commissioner a cash or surety bond in accordance with the requirements of this chapter. Such insurance shall be designated "health care providers' professional liability insurance" and shall, in this section and ss. 655.24 and 655.245, be referred to as "health care liability insurance". The submission of a cash or surety bond, or qualification as a self-insurer, shall be subject to the approval of the commissioner and is valid only when approved by the commissioner.

(4) Such health care liability insurance or cash or surety bond shall be in amounts of at least \$100,000 per claim and \$300,000 per year.

(5) While such health care liability insurance, self-insurance or cash or surety bond approved by the commissioner remains in force, the health care provider, his estate and those conducting his business, including his health care liability insurance carrier, are liable for malpractice for no more than \$200,000 per claim and \$600,000 per year or the maximum liability limit for which he is insured, whichever is higher, if the health care provider has met the requirements of this chapter.

(6) No license or certificate of registration as a health care provider may be issued to any health care provider permanently practicing or operating in this state who does not submit proof of compliance with this section to the board or agency issuing such license or certificate of registration. No health care provider permanently practicing or operating in this state may exercise the rights or privileges conferred by such a license or certificate of registration unless he has complied with this section.

655.24 Insurance policy forms. (1) No insurer may enter into or issue any policy of health care liability insurance until its policy form has been submitted to and approved by the commissioner. The filing of a policy form by any insurer with the commissioner for approval shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of all provisions of this chapter, and an agreement by it to be bound hereby as to any policy issued by it to any health care provider. ~~Any provision in any such policy attempting to limit or modify the liability of the insurer issuing it is void.~~

Vetoed in Part

(2) Every policy issued under this chapter shall be deemed conclusively to provide the following:

(a) That the insurer agrees to pay in full all supplementary expenses incurred in the settlement or defense of any claims and any settlement, arbitration award or judgment imposed against the insured under this chapter up to a limit of no less than \$100,000 per claim and \$300,000 per year; and

(b) That any termination of the policy by cancellation or nonrenewal is not effective as to patients claiming against those covered by the policy unless, at least 60 days prior to the taking effect of the cancellation or nonrenewal, a written notice giving the date upon which the termination is to become effective has been received by the commissioner and the insured.

655.245 Insurance policy limitations. (1) No policy of health care liability insurance may permit a health care provider to reject any settlement agreed upon between the claimant and the insurer.

(2) A policy of health care liability insurance may permit the insurer to make payments for medical expenses prior to any determination of fault. Such payments are not an admission of fault. Such payments may be deducted from any judgment or arbitration award, but shall not be repaid regardless of the judgment or award. Nothing in this subsection shall restrict the insurer's right of comparative contribution or indemnity in accordance with the laws of this state.

655.25 Availability and effectiveness for health care liability insurance. (1) No policy of health care liability insurance written under the provisions of s. 619.04 may be canceled or nonrenewed except for nonpayment of premiums unless the health care provider's license is revoked by the appropriate licensing board. A health care provider whose license is revoked shall be permitted to buy out in cases of a claims-made policy.

~~(2) No company or association providing health care liability insurance may consider a claim made against an individual risk in determining whether to raise his rates or to cancel or nonrenew his health care liability policy unless a patients compensation panel has made an adverse finding against him under this chapter. This subsection shall not apply to any insurance agreement in which coverage for health care providers is provided on a group basis through their professional association.~~

Vetoed
in Part

SUBCHAPTER IV

PATIENTS COMPENSATION FUND

655.27 Patients compensation fund. (1) **FUND.** There is created a patients compensation fund for the purpose of paying that portion of a medical malpractice claim which is in excess of \$200,000 for such claim or which, in combination with other claims in one policy year is in excess of \$600,000. The fund shall be liable only for payment of claims against health care providers permanently practicing or operating in this state who have complied with the provisions of this chapter and reasonable and necessary expenses incurred in payment of claims and fund administrative expenses. The coverage provided by the fund shall begin July 1, 1975, and run thereafter on a fiscal basis.

(2) **FUND ADMINISTRATION AND OPERATION.** Management of the fund shall be vested with the board of governors under s. 619.04 (3). The commissioner shall provide staff services necessary for the operation of the fund.

(3) **FEES AND ASSESSMENTS.** (a) *Base fees.* Each health care provider shall pay the following fees to the department of health and social services or the department of regulation and licensing for deposit into the fund, as a condition of licensing under s. 140.85 (2) or ch. 441 or 448:

CHAPTER 37

46

1. For the first year of the fund's operation, for any individual physician permanently practicing in this state, \$200 plus 10% of the premium he would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year; ~~\$50 for any individual physician not permanently practicing in this state and~~ for any individual nurse anesthetist, and \$75 per bed for any hospital.

2. For the 2nd year of the fund's operation, for any individual physician permanently practicing in this state, \$200 plus 10% of the premium he would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year; ~~\$50 for any physician not permanently practicing in this state;~~ \$40 for any individual nurse anesthetist; and for any hospital, \$50 per bed plus 10% of the premium it would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year.

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

1. Past and prospective loss and expense experience in different types of practice.
2. The prior loss experience of persons or hospitals which resulted in payments of moneys from the patients compensation fund.
3. Risk factors for persons who are semiretired or part-time professionals.

(c) *Fee adjustment.* The fees under par. (b) may be adjusted downward for any fiscal year in which additional fees would not be necessary to maintain the fund at \$10,000,000. ~~The fund shall be maintained at not more than \$10,000,000.~~ Fees shall be set by the commissioner after consultation with the board of governors, but such fees for health care providers permanently practicing or operating in this state may not exceed in any given year 10% of the premium the health care provider would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year. Nothing contained in this paragraph shall be construed as imposing liability for payment of any part of a fund deficit on the board of governors. If the board of governors determines that the amount of money in the fund is not sufficient to satisfy the claims made against the fund in a given fiscal year, it shall certify the amount of the projected insufficiency to the commissioner and shall request the commissioner to levy a deficit assessment against all health care providers permanently practicing or operating in this state for that fiscal year. The commissioner shall levy such deficit assessment against such providers permanently practicing or operating in this state at the time the assessment is made in amounts that fairly reflect the classifications prescribed above and which are sufficient to obtain the money necessary to meet all claims for said fiscal year, but not to exceed in any given year 25% of the premium the health care provider would be charged under the plan established by s. 619.04 for coverage in the amount of \$200,000 per claim and \$600,000 per year.

(d) *Collection and deposit of fees.* All fees under pars. (a) and (b) shall be collected by the secretary of regulation and licensing and the secretary of health and social services at the time of issuance or renewal of certification or licensure, and shall be paid into the patients compensation fund created under this section. Deficit assessments under par. (c) shall be collected by the commissioner in a manner prescribed by him for payment into the fund.

(4) FUND ACCOUNTING AND AUDIT. (a) Moneys shall be withdrawn from the fund by the commissioner only upon vouchers approved and authorized by the board of governors.

(b) All books, records and audits of the fund shall be open to the general public for reasonable inspection, with the exception of confidential claims information.

(c) Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

(d) Annually, the board of governors shall furnish an audited financial report to all fund participants and to the commissioner. The report shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the commissioner.

(e) Moneys held in the fund shall be invested in short-term fixed return interest-bearing investments by the board of governors through the state investment board. All income derived from such investments shall be credited to the fund.

(f) Any health care provider who relinquishes his right to practice or operate in this state may withdraw from participation in the fund at the end of any fiscal year.

(g) The board of governors shall submit a functional and progress report to the appropriate committees on insurance and health in both houses of the legislature on or before March 1 of each year.

(5) CLAIMS PROCEDURES. (a) Any person may file an action for damages arising out of the rendering of medical care or services against a health care provider covered under the fund provided that such person filing the claim shall not recover against the fund any portion of a judgment for damages arising out of the rendering of medical care or services against a health care provider covered under the fund unless the fund was named as a defendant in the suit. If after reviewing the facts upon which the claim is based, it appears reasonably probable that damages paid on the claim will exceed \$200,000, the fund may appear and actively defend itself when named as a defendant in the suit. In such action, the fund may retain counsel and pay out of the fund attorney's fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the board of governors to perform legal services for the board of governors other than those directly connected with the fund. Any judgment affecting the fund may be appealed as provided by law.

(b) It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed that may potentially affect the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding \$200,000, or any other amount which could require payment by the fund, may be agreed to unless approved by the board of governors.

(c) It shall be the responsibility of any health care provider choosing to post bond or establish an escrow account under this chapter to provide an adequate defense on any malpractice claim filed that may potentially affect the fund. The health care provider shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding \$200,000, or any other amount which could require payment by the fund, may be agreed to unless approved by the board of governors.

(d) A person who has recovered a final judgment or a settlement approved by the board of governors against a health care provider who is covered by the fund may file a claim with the board of governors to recover that portion of such judgment or settlement which is in excess of \$200,000. In the event the fund incurs liability

exceeding \$1,000,000 to any person under a single claim the fund shall pay not more than \$500,000 per year until the claim has been paid in full, and any attorney's fees in connection with such claim shall be similarly prorated.

(e) Claims filed against the fund shall be paid in the order received within 90 days after filing unless appealed by the fund. If the amounts in the fund are not sufficient to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

Vetoed in Part (f) If a health care provider covered by the fund has coverage in excess of \$200,000 per claim and \$600,000 per policy year which is in effect on the effective date of this act (1975), he shall be liable for losses up to the amount of his coverage, and he shall receive an appropriate reduction of his base assessment for the fund under sub. (3) (a). Such reduction shall be granted only after that health care provider has proved to the satisfaction of the board of governors that he has such coverage.

(6) AWARD LIMITATIONS. If, at any time after July 1, 1978, the commissioner finds that the amount of money in the fund has fallen below a \$2,500,000 level in any one year or below a \$6,000,000 level for any 2 consecutive years, an automatic limitation on awards of \$500,000 for any one injury or death on account of malpractice shall take effect. This subsection does not apply to injury or death resulting from an incident of malpractice which occurred prior to the date on which such an award limitation takes effect. This subsection does not apply to any payments for medical expenses.

(7) INTEGRITY OF FUND. The fund shall be held in trust for the benefit of insureds and other proper claimants. The fund may not be used for purposes other than those of this chapter.

~~SECTION 11. 893.235 and 893.236 of the statutes are created to read:~~

~~893.235 Health care providers; minors actions. Notwithstanding s. 893.135, any person under the age of 18 who is not under disability by reason of insanity or imprisonment shall bring an action to recover damages for injuries to the person arising from any treatment or operation performed by or any omission by any person who is a health care provider, as defined in s. 655.001 (8), within the time limitation under s. 893.236 or by the time he reaches the age of 8 years, whichever is later. Such an action shall be brought by the parent, guardian, or other person having custody of the minor within the time limit set forth in this section.~~

Vetoed in Part ~~893.236 Health care providers. Notwithstanding s. 893.205, and except as provided by ss. 893.135 and 893.235, an action to recover damages for injuries to the person arising from any treatment or operation performed by or any omission by any person who is a health care provider, as defined in s. 655.001 (8), shall be brought within the later of:~~

- ~~(1) Three years after the date when the injury occurs; or~~
- ~~(2) One year after the earlier of the date when the injury is discovered or the date of the discovery of facts which should reasonably lead to such discovery. No action under this subsection may be brought more than 6 years after the date when the injury occurs.~~

SECTION 12. Program responsibilities. (1) In the list of program responsibilities specified for the department of health and social services under section 15.191 (intro.) of the statutes, reference to sections "655.03, 655.21 and 655.27" is inserted.

(2) In the list of program responsibilities specified for the department of regulation and licensing under section 15.401 (intro.) of the statutes, reference to chapter "655" is inserted.

(3) In the list of program responsibilities specified for the commissioner of insurance under section 15.731 of the statutes, reference to chapter "655" is inserted.

(4) In the list of program responsibilities specified for the investment board under section 15.761 of the statutes, reference to section "655.27 (4) (e)" is inserted.

SECTION 13. Malpractice committee. (1) There is created a malpractice committee to consist of the following members:

(a) Three members of the senate, not all of whom are of the same political party, appointed as are members of standing committees.

(b) Three members of the assembly, not all of whom are of the same political party, appointed as are members of standing committees.

(c) Two physicians, licensed to practice medicine in this state, of whom one shall be appointed by the state medical society of Wisconsin and one shall be appointed by the Wisconsin association of osteopathic physicians.

(d) The commissioner of insurance.

(e) One representative of the insurance industry, to be appointed by the governor.

(f) Two attorneys, admitted to the practice of law in this state, of whom one shall be appointed by the state bar of Wisconsin and one shall be appointed by the Wisconsin academy of trial lawyers.

(g) Two health care providers, to be appointed by the governor.

(h) One representative of hospital associations, to be appointed by the Wisconsin hospital association.

(i) Five persons, not associated with the hospital or insurance industry and not admitted to the practice of law or medicine, to be appointed by the governor. Members under this paragraph shall receive \$25 for each day on which they attend a meeting of the committee.

(j) One registered nurse to be appointed by the Wisconsin nurses' association.

(2) The committee shall meet and organize within 90 days of the effective date of this act, and shall elect its own chairman and secretary.

(3) The legislative council shall provide staff assistance to the committee. The committee may also draw upon existing executive and legislative branch personnel for the provision of staff services to the committee.

(4) Any necessary and reasonable expenses incurred by the committee shall be paid from the appropriation under section 20.765 (1) (a) of the statutes.

(5) The commissioner of insurance shall provide all information and reports at his disposal which the committee requests.

(6) The committee's responsibilities shall include but not be limited to the following:

(a) Investigate systems hospitals may use to reduce medical accidents and to deal with the results of such accidents before the situation becomes a court action.

(b) Evaluate peer review systems. The question of how affected professions improve quality of health care through disciplinary proceedings, continuing education programs, retraining and recertification shall be studied.

(c) Investigate the possibility of self-insurance at hospitals.

(d) Investigate the possibility of health providers developing their own insurance company.

(e) Evaluate the effectiveness of the panels established under section 655.02 of the statutes, the patients compensation fund established under section 655.27 of the statutes, and the risk-sharing plan established under section 619.04 of the statutes, with regard to coverage, premium cost and complaint, settlement, arbitration award and court judgment statistics.

(f) Investigate what types of forms might be used to clarify questions with regard to informed consent. The questions of whether lists should be made containing operations and their expected results and whether such a list, if feasible, should be explained by the health care provider to the patient, shall be studied.

(g) Investigate the use and effectiveness of formal and informal panels to evaluate claims.

(h) Investigate the health care liability insurance business in this state.

(7) The committee shall report its findings and recommendations to the legislature not later than December 31, 1976.

Vetoed in Part SECTION 14. **Effective date.** (1) The treatment of sections ~~619.04 and 655.27~~ of the statutes, by this act, shall take effect as of July 1, 1975.

(2) The treatment of section 655.017 of the statutes by this act shall take effect on January 1, 1977.

(3) The remainder of this act shall take effect on the day after its publication.
