May 1986 Spec. Sess.
Assembly Bill 4

Date of enactment: **June 12, 1986**
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1985 Wisconsin Act 340

AN ACT *to repeal* subchapter II of chapter 655, 20.680 (2) (q), 448.02 (3) (d), 655.001 (5) and (6), 655.001 (9) and 655.28; *to renumber* 15.08 (3); *to renumber and amend* 50.36 (3); *to amend* 15.405 (7), 20.145 (2) (u), 20.145 (2) (v), 20.680 (2) (k), 49.495, 140.05 (18), 146.37 (1), 146.82 (2) (a) 10, 440.03 (6), 441.01 (6), 441.07 (1m), 448.02 (3) (a) to (c) and (e), 448.02 (7) (a) and (b), 619.01 (7) (a), 619.04 (1) and (3), 655.001 (2), 655.001 (8), 655.001 (10), 655.001 (13), 655.002, 655.009 (1), 655.013 (title) and (1) (intro.), 655.013 (2), 655.015, 655.23 (4) and

(5), 655.24 (2) (a) and (b), 655.26 (1) (b), 655.27 (1), 655.27 (3) (a) (intro.) and 2, 655.27 (3) (b) to (d), 655.27 (5) (a) to (d), 655.27 (6), 758.19 (3), 807.01 (5), 893.55 (title), 893.80 (1) (intro.), 893.82 (3) and 893.82 (4) (a) and (b) 1. (intro.); *to repeal and recreate* 619.04 (5) (b); and *to create* subchapter VI of chapter 655, subchapter VII of chapter 655, 15.08 (3) (b), 20.145 (2) (um), 20.680 (2) (qm), 49.45 (2) (a) 12r, 50.36 (3) (c), 146.37 (1m), 440.25, 448.06 (1m), 448.075, 601.427, 609.17, 619.04 (5m), 632.715, 655.004, 655.009 (3), 655.013 (1m) and (1t), 655.017, 655.019, 655.24 (3), 655.24 (4), 655.27 (1m), 655.27 (3) (a) 2m, 655.27 (3) (am), 655.27 (3) (b) 2, (bg), (br) and (e), 655.27 (4) (g), 655.27 (7), 655.275, 893.55 (4), 893.55 (5), 893.80 (1m) and 893.82 (5m) of the statutes, *relating to* revising the laws governing the patients compensation fund, eliminating the patients compensation panels, creating a medical malpractice mediation system, revising the laws governing medical malpractice and health care provider professional discipline, providing for studies, granting rule-making authority and making appropriations.

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

SECTION 1. **Legislative intent.** The legislature intends to provide for an orderly and equitable transfer of pending patients compensation panel controversies to courts under SECTION 73 (2) (c) of this act. To this end, the legislature intends that in the exercise of their equitable jurisdiction the courts liberally construe all filings pursuant to SECTION 73 (2) of this act.

SECTION 1m. 15.08 (3) of the statutes is renumbered 15.08 (3) (a).

SECTION 2. 15.08 (3) (b) of the statutes is created to read:

15.08 (3) (b) The medical examining board shall meet at least 12 times annually.

SECTION 3. 15.405 (7) of the statutes is amended to read:

15.405 (7) MEDICAL EXAMINING BOARD. (a) There is created a medical examining board in the department of regulation and licensing.

(b) The medical examining board shall consist of ~~10~~ the following members appointed for staggered 4-year terms~~.~~:

1. Seven ~~of the members shall be~~ licensed doctors of medicine~~; one member shall be a~~.

2. One licensed doctor of osteopathy~~; and 2 members shall be~~.

3. Two public members.

(c) The chairperson of the patients compensation fund peer review council under s. 655.275 shall serve as a nonvoting member of the medical examining board.

SECTION 4. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

			1985-86	1986-87
20.145	**Insurance, office of the commissioner of**			
(2)	PATIENTS COMPENSATION FUND			
(um)	Peer review council	SEG A	-0-	48,500

SECTION 5. 20.145 (2) (u) of the statutes is amended to read:

20.145 (2) (u) *Administration.* From the patients compensation fund under s. 655.27 (3), the amounts in the schedule for administration, except for costs of the patients compensation fund peer review council and its associated administrative costs assessed under s. 655.27 (3) (am).

SECTION 6. 20.145 (2) (um) of the statutes is created to read:

20.145 (2) (um) *Peer review council.* From the patients compensation fund under s. 655.27 (3) (am), the amounts in the schedule for payment of costs, including costs of administration, incurred by the patients compensation fund peer review council under s. 655.275 (5).

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

20.145 (2) (v) *Operations and benefits.* After deducting the amounts appropriated under ~~par.~~ pars. (u) and (um), the balances of the moneys paid into the patients compensation fund under s. 655.27 (3) to carry out the responsibilities of the commissioner of insurance under s. 655.27 and, with respect to settlements, patients compensation panel awards and judgments entered into or rendered before the effective date of this act .... [revisor inserts date], to pay future medical expenses under s. 655.015.

SECTION 7m. 20.680 (2) (k) of the statutes, as created by 1985 Wisconsin Act 29, is amended to read:

20.680 (2) (k) *Data processing services.* The amounts in the schedule for data processing services. All moneys received from providing those services to the board of attorneys professional competence, the board of attorneys professional responsibility and ~~patients compensation panels~~ the mediation system under ch. 655 shall be credited to this appropriation.

SECTION 8. 20.680 (2) (q) of the statutes is repealed.

SECTION 8m. 20.680 (2) (qm) of the statutes is created to read:

20.680 (2) (qm) *Mediation fund.* From the mediation fund created under s. 655.68, all moneys in the

fund to be used for administrative expenses of the mediation system under subch. VI of ch. 655.

SECTION 10. 49.45 (2) (a) 12r of the statutes is created to read:

49.45 (2) (a) 12r. Notify the medical examining board of any decertification or suspension of a person holding a license granted by the board if the grounds for the decertification or suspension include fraud or a quality of care issue.

SECTION 11. 49.495 of the statutes is amended to read:

49.495 Jurisdiction of the department of justice. The department of justice or the district attorney may institute, manage, control and direct, in the proper county, any prosecution for violation of criminal laws affecting the medical assistance program including but not limited to laws relating to medical assistance contained in this chapter and laws affecting the health, safety and welfare of recipients of medical assistance. For this purpose the department of justice shall have and exercise all powers conferred upon district attorneys in such cases. The department of justice or district attorney shall notify the medical examining board of any such prosecution of a person holding a license granted by the board.

SECTION 12. 50.36 (3) of the statutes is renumbered 50.36 (3) (a) and amended to read:

50.36 (3) (a) Any person granted a license to practice medicine and surgery under ss. 448.05 and 448.06 shall be afforded an equal opportunity to obtain hospital staff privileges. No such person may be denied hospital staff privileges solely for the reason that the person is an osteopathic physician and surgeon. Each individual hospital shall retain the right to determine whether the applicant's training, experience and demonstrated competence is sufficient to justify the granting of ~~medical~~ hospital staff privileges or is sufficient to justify the granting of limited hospital staff privileges.

(b) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board, for any reasons that include the quality of or ability to practice, loses his or her hospital staff privileges ~~for 30 days or more, or~~, has his or her hospital staff privileges reduced ~~for 30 days or more,~~ or resigns from the hospital staff ~~for 30 days or more~~, the hospital shall so notify the medical examining board within 30 days after the loss, reduction or resignation takes effect. Temporary suspension due to incomplete records need not be reported.

SECTION 13. 50.36 (3) (c) of the statutes is created to read:

50.36 (3) (c) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board, for reasons that do not include the quality of or ability to practice, loses his or her hospital staff privileges for 30 days or more, has his or her hospital staff privileges reduced for 30 days or more or resigns from the hospital staff for 30 days or more, the hospital shall so notify the medical examining board within 30 days after the loss, reduction or resignation takes effect. Temporary suspension due to incomplete records need not be reported.

SECTION 13m. 140.05 (18) of the statutes is amended to read:

140.05 (18) The department shall investigate any hospital which is found by a panel established under s. 655.02, 1983 stats., or by a court to have been responsible for negligent acts.

SECTION 13t. 146.37 (1) of the statutes, as affected by 1985 Wisconsin Act 29, is amended to read:

146.37 (1) No person acting in good faith who participates in the review or evaluation of the services of health care providers or facilities or the charges for such services conducted in connection with any program organized and operated to help improve the quality of health care, to avoid improper utilization of the services of health care providers or facilities or to determine the reasonable charges for such services, or who participates in the hospital rate-setting activities under ch. 54, is liable for any civil damages as a result of any act or omission by such person in the course of such review or evaluation. Acts and omissions to which this subsection applies include, but are not limited to, acts or omissions by peer review committees or hospital governing bodies in censuring, reprimanding, limiting or revoking hospital staff privileges or notifying the medical examining board under s. 50.36 or taking any other disciplinary action against a health care provider or facility.

SECTION 14. 146.37 (1m) of the statutes is created to read:

146.37 (1m) The good faith of any person specified in subs. (1) and (3) shall be presumed in any civil action. Any person who asserts that such a person has not acted in good faith has the burden of proving that assertion by clear and convincing evidence.

SECTION 14b. 146.82 (2) (a) 10 of the statutes, as created by 1985 Wisconsin Act 29, is amended to read:

146.82 (2) (a) 10. To persons as provided under s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29, if the patient files a submission of controversy under s. 655.04 (1), 1983 stats., on or after July 20, 1985 and before the effective date of this act .... [revisor inserts date], for the purposes of s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29.

SECTION 14f. 440.03 (6) of the statutes, as created by 1985 Wisconsin Act 29, is amended to read:

440.03 (6) The department shall have access to any information contained in the reports filed with the medical examining board and the board of nursing under ~~ss.~~ s. 655.045, as created by 1985 Wisconsin Act 29, and s. 655.26.

SECTION 14h. 440.25 of the statutes is created to read:

440.25 Judicial review. The department may seek judicial review under ch. 227 of any final disciplinary decision of the medical examining board. The department shall be represented in such review proceedings by an attorney within the department. Upon request of the medical examining board, the attorney general may represent the board. If the attorney general declines to represent the board, the board may retain special counsel which shall be paid for out of the appropriation under s. 20.165 (1) (g).

SECTION 14m. 441.01 (6) of the statutes is amended 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, 1983 stats., or by a court. ~~If the board finds that any nurse anesthetist refuses to serve on a patients compensation panel under s. 655.03 without being excused by the director of state courts, it may warn or reprimand the nurse anesthetist or may limit, suspend or revoke the nurse anesthetist's license or registration.~~

SECTION 14t. 441.07 (1m) of the statutes, as created by 1985 Wisconsin Act 29, is amended to read:

441.07 (1m) The board may use any information obtained by the board or the department under s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29, in investigations and disciplinary proceedings, including public disciplinary proceedings, conducted under this chapter.

SECTION 15. 448.02 (3) (a) to (c) and (e) of the statutes, as affected by 1985 Wisconsin Act 29, are amended to read:

448.02 (3) (a) The board shall investigate allegations of unprofessional conduct and negligence in treatment by persons holding a license or certificate granted by the board. An allegation that a physician has violated s. 448.30 or 450.075 (3) is an allegation of unprofessional conduct. Information contained in reports filed with the board under s. 49.45 (2) (a) 12r or 50.36 (3) (b) shall be investigated by the board. Information contained in a report filed with the board under s. 655.045 (1), as created by 1985 Wisconsin Act 29, which is not a finding of negligence ~~may, within the discretion of the board, be used as the basis of an investigation of a person named as a respondent~~ or in reports filed with the board under s. 50.36 (3) (c), 609.17 or 632.715 or under 42 CFR 474.52 (e) (3) may, within the discretion of the board, be used as the basis of an investigation of the persons named in the reports. The board may require a person holding a license or certificate to undergo and may consider the results of one or more physical, mental or professional competency examinations if the board believes that the results of any such examinations may be useful to the board in conducting its investigation.

(b) After an investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct or negligence in treatment, the board shall hold a hearing on such conduct. The board may use any information obtained by the board or the department under s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29, in an investigation or a disciplinary proceeding, including a public disciplinary proceeding, conducted under this subsection and the board may require a person holding a license or certificate to undergo and may consider the results of one or more physical, mental or professional competency examinations if the board believes that the results of any such examinations may be useful to the board in conducting its hearing. A unanimous finding by a panel established under s. 655.02, 1983 stats., or a finding by a court that a physician has acted negligently in treating a patient is conclusive evidence that the physician is guilty of negligence in treatment. A finding that is not a unanimous finding by a panel established under s. 655.02, 1983 stats., that a physician has acted negligently in treating a patient is presumptive evidence that the physician is guilty of negligence in treatment. A certified copy of the findings of fact, conclusions of law and order of the panel or the order of a court is presumptive evidence that the finding of negligence in treatment was made. The board shall render a decision within 90 days following completion of the hearing.

(c) After a disciplinary hearing, the board may, when it determines that a panel established under s. 655.02, 1983 stats., has unanimously found or a court has found that a person has been negligent in treating a patient or when it finds a person guilty of unprofessional conduct or negligence in treatment, do one or more of the following: warn or reprimand that person, or limit, suspend or revoke any license or certificate granted by the board to that person. The board may condition the removal of limitations on a license or certificate or the restoration of a suspended or revoked license or certificate upon obtaining minimum results specified by the board on one or more physical, mental or professional competency examinations if the board believes that obtaining the minimum results is related to correcting one or more of the bases upon which the limitation, suspension or revocation was imposed.

(e) ~~The board may limit a license or certificate for a period not to exceed 5 years.~~ A person whose license or certificate is limited shall be permitted to continue practice upon condition that the person will refrain from engaging in unprofessional conduct; that the person will appear before the board or its officers or agents at such times and places as may be designated by the board from time to time; that the person will fully disclose to the board or its officers or agents the nature of the person's practice and conduct; that the person will fully comply with the limits placed on his or her practice and conduct by the board; that the person will obtain additional training, education or supervision required by the board; and that the person

will cooperate with the board ~~during the entire period of limitation~~.

SECTION 15m. 448.02 (3) (d) of the statutes, as affected by 1985 Wisconsin Act 29, is repealed.

SECTION 16. 448.02 (7) (a) and (b) of the statutes are amended:

448.02 (7) (a) Within 30 days of receipt of a report under s. 50.36 (3) (c), the board shall notify the licensee, in writing, of the substance of the report. The licensee and the licensee's authorized representative may examine the report and may place into the record a statement, of reasonable length, of the licensee's view of the correctness or relevance of any information in the report. The licensee may institute an action in circuit court to amend or expunge any part of the licensee's record related to the report.

(b) If the board determines that a report submitted under s. 50.36 (3) (c) is without merit or that the licensee has sufficiently improved his or her conduct ~~or competence~~, the board shall remove the report from the licensee's record. If no report about a licensee is filed under s. 50.36 (3) (c) for 2 consecutive years, the licensee may petition the board to remove any prior reports, which did not result in disciplinary action, from his or her record.

SECTION 16m. 448.06 (1m) of the statutes is created to read:

448.06 (1m) GRANT OF LIMITED LICENSE OR CERTIFICATE. If the board finds, based upon considerations of public health and safety, that the applicant has not demonstrated adequate education, training or performance on examinations or in past practice, if any, to qualify for full licensure or certification under sub. (1), the board may grant the applicant a limited license or certificate and shall so notify the applicant.

SECTION 17. 448.075 of the statutes is created to read:

448.075 Podiatrists; malpractice liability insurance. Every licensed podiatrist shall annually submit to the board evidence that the podiatrist has in effect malpractice liability insurance coverage in the amount of at least $1,000,000 per occurrence and $1,000,000 for all occurrences in one year. The board may suspend, revoke or refuse to issue or renew the license of a podiatrist who fails to procure or to submit proof of the malpractice liability insurance coverage required under this section.

SECTION 17m. 601.427 of the statutes is created to read:

601.427 Medical malpractice insurance reports. (1) REQUIREMENT. Each insurer authorized to write medical malpractice insurance shall file an annual medical malpractice insurance report complying with this section with the commissioner on or before May 1 of each year.

(2) CONTENTS. The report filed under sub. (1) shall contain the name of the insurer and all of the following information for policies covering residents of this state for each group of policies with effective dates within a particular calendar year:

(a) The total dollar amount of premiums collected for medical malpractice insurance coverage both for primary coverage and for excess coverage.

(b) The number of insureds from whom medical malpractice insurance coverage premiums were collected.

(c) The number and amount of all reserves established for all of the following:

1. Reported claims other than paid claims.
2. Paid claims that have not been paid in full.
3. Incurred but not reported claims.

(d) The amounts paid in medical malpractice claims.

(e) Net investment gain or loss and other income gain or loss allocated to medical malpractice insurance, computed by the formula used in the annual insurance expenses exhibit for allocation among lines of business.

(f) The actual expenses attributable to medical malpractice insurance reported as loss adjustment expenses and all other expenses.

(g) Total number of claims reported.

(h) Total claims closed without payment.

(i) Total claims closed with payment.

(j) Total number of legal actions filed.

(k) Total number of verdicts or judgments for defendants.

(L) Total number of verdicts or judgments for plaintiffs.

(m) Total amounts awarded plaintiffs.

(2m) BASIS FOR REPORTING. The report filed under sub. (1) shall contain the information required under sub. (2) for each classification used for rating purposes, except that the information required by sub. (2) (c) 3, (e) and (f) shall be reported on a cumulative basis for all classifications.

(3) OTHER INSURANCE EXCLUDED. If medical malpractice insurance coverage includes premises and operations insurance or any other insurance delivered as a part of a package with medical malpractice insurance, only information relating to the medical malpractice insurance portion of the coverage shall be included in the report filed under sub. (1).

(4) PERIOD OF REPORT. The report filed under sub. (1) shall provide all required information updated as of the last day of the calendar year preceding the year in which the report is filed. The report shall include required information for policies with effective dates within calendar years beginning with calendar year 1979 and ending with the 2nd calendar year preceding the year in which the report is filed. Effective with filings in 1991, the report shall exclude required information for policies with effective dates within any calendar year commencing more than 11 years prior to January 1 of the year in which the report is filed.

(5) SUMMARY. The commissioner shall provide a summary of the information contained in the 2 most recent filings of reports under sub. (1) in the biennial report to the governor and the legislature under s. 15.04 (1) (d).

(6) RULES, ADJUSTMENTS AND EXCLUSIONS. The commissioner may, by rule, establish the form of the report filed under sub. (1), including the manner of reporting the elements of the report. The commissioner may, by rule, require reports to include information in addition to that specified in this section. The commissioner may adjust the reporting requirements for any insurer for which the requirements of this section are burdensome. The commissioner may determine that no report need be filed if the medical malpractice insurance issued by an insurer is of such a small amount that its reporting would be burdensome to the insurer or would be of no statistical significance.

(7) PUBLIC RECORDS. Notwithstanding subch. II of ch. 19, the commissioner shall make the reports filed under sub. (1) available to the public in a manner that does not reveal the name of any person involved.

(8) NO LIABILITY OR CAUSE OF ACTION. There shall be no liability on the part of and no cause of action shall arise against any insurer for reporting in good faith under this section or any insurer's agents or employes, or the commissioner for any good faith act or omission under this section.

SECTION 18. 609.17 of the statutes is created to read:

609.17 Reports of disciplinary action. Every health maintenance organization, limited service health organization and preferred provider plan shall notify the medical examining board of any disciplinary action taken against a selected provider who holds a license or certificate granted by the board.

SECTION 19. 619.01 (7) (a) of the statutes is amended to read:

619.01 (7) (a) *Primary coverage plans.* Health care liability insurance plans established under this paragraph shall provide minimum coverage to insureds in the amount of not less than ~~$100,000~~ $200,000 for each occurrence and ~~$300,000~~ $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987 and before July 1, 1988, and $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988, for the protection of persons who are legally entitled to recover damages from the insured for errors, omissions or neglect in the performance of the insured's professional services. If an insured has excess limits liability coverage or such coverage is available to the insured, the coverage provided under such plans shall be equal to the minimum level of such excess limits coverage. If the insured does not have excess limits liability coverage and such coverage is not available to the insured, the commissioner may establish minimum levels of coverage higher than the minimum limits specified in this paragraph for such plans.

SECTION 21. 619.04 (1) and (3) of the statutes are amended to read:

619.04 (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 in this state; for partnerships comprised of such physicians or nurse anesthetists; for corporations organized and operated in this state for the purpose of providing the medical services of physicians or nurse anesthetists; for operating cooperative sickness care plans organized under ss. 185.981 to 185.985 which directly provide services in their own facilities with salaried employes; and for all hospitals as defined by s. 50.33 (2) (a) and (c), but excluding those facilities exempted by s. 50.39 (3), which operate in this state and any entity operated in this state in connection with one or more hospitals and owned or controlled by the hospital or hospitals when the entity is assisting the hospital or hospitals in providing diagnosis or treatment of, or care for, patients of the hospital or hospitals.

(3) The plan shall operate subject to the supervision and approval of a board of governors consisting of 3 representatives of ~~5 of the insurers participating in the plan, who shall serve at the direction~~ the insurance industry appointed by and to serve at the pleasure of the commissioner, ~~an attorney~~ a person to be named by the state bar association, a ~~physician~~ person to be named by the Wisconsin academy of trial lawyers, 2 persons to be named by the Wisconsin medical society, a ~~hospital representative~~ person to be named by the Wisconsin hospital association, the commissioner or a designated representative employed by the office of the commissioner and ~~2~~ 4 public members ~~who~~ at least 2 of whom 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 the commissioner's representative shall be the ~~chairman~~ chairperson of the board of governors. Board members shall be compensated at the rate of $50 per diem plus actual and necessary travel expenses.

SECTION 21g. 619.04 (5) (b) of the statutes is repealed and recreated to read:

619.04 (5) (b) A rating plan which takes into consideration the loss and expense experience of the individual health care provider which resulted in the payment of money, by the plan or other sources, for damages arising out of the rendering of health care by the health care provider or an employe of the health care provider, except that an adjustment to a health care provider's premiums may not be made under this paragraph prior to the receipt of the recommendation of the patients compensation fund peer review council under s. 655.275 (5) (a) and the expiration of the time

period provided, under s. 655.275 (7), for the health care provider to comment or prior to the expiration of the time period under s. 655.275 (5) (a).

SECTION 21r. 619.04 (5m) of the statutes is created to read:

619.04 (5m) (a) Every rule under sub. (5) (b) shall provide for an automatic increase in a health care provider's premiums, except as provided in par. (b), if the loss and expense experience of the plan and other sources with respect to the health care provider or an employe of the health care provider exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, both as established in the rule. The rule shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of awards in excess of the respective thresholds.

(b) The rule shall provide that the automatic increase does not apply if the board determines that the performance of the patients compensation fund peer review council in making recommendations under s. 655.275 (5) (a) adequately addresses the consideration set forth in sub. (5) (b).

SECTION 22. 632.715 of the statutes is created to read:

632.715 Reports of action against health care provider. Every insurer that has taken any action against a person who holds a license granted by the medical examining board that may relate to unprofessional conduct or negligence in treatment by the person shall notify the board of the action taken against the person.

SECTION 22g. 655.001 (2) of the statutes is amended to read:

655.001 (2) "Claimant" means the person filing a ~~submission of controversy~~ request for mediation under s. ~~655.04~~ 655.44 or 655.445.

SECTION 22r. 655.001 (5) and (6) of the statutes are repealed.

SECTION 23. 655.001 (8) of the statutes is amended to read:

655.001 (8) "Health care provider" means a medical or osteopathic physician ~~or podiatrist~~ licensed under ch. 448; a nurse anesthetist licensed or registered under ch. 441; a partnership comprised of such physicians~~, podiatrists~~ or nurse anesthetists; a corporation ~~owned by such physicians, podiatrists or nurse anesthetists~~ organized and operated in this state for the purposes of providing the medical services of physicians or nurse anesthetists; an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 which directly provides services through salaried employes in its own facility; a hospital as defined by s. 50.33 (2) (a) and (c) and any entity operated in this state in connection with one or more hospitals and owned or controlled by the hospital or hospitals when the entity is assisting the hospital or hospitals in providing diagnosis or treatment of, or care for, patients of the hospital or hospitals; or a nursing home as defined by s. 50.01 (3) whose operations are combined as a single entity with a hospital subject to this section, whether or not the nursing home operations are physically separate from hospital operations. It excludes any state, county or municipal employe or federal employe covered under the federal tort claims act, as amended, who is acting within the scope of employment, and any facility exempted by s. 50.39 (3) or operated by any governmental agency, but any state, county or municipal employe or facility so excluded who would otherwise be included in this definition may petition in writing to be afforded the coverage provided by this chapter and upon filing the petition with the commissioner and paying the fee required under s. 655.27 (3) will be subject to this chapter.

SECTION 23m. 655.001 (9) of the statutes is repealed.

SECTION 25. 655.001 (10) of the statutes is amended to read:

655.001 (10) "Patient" means an individual who received or should have received health care services from a health care provider or from an employe of a health care provider acting within the scope of his or her employment.

SECTION 25g. 655.001 (13) of the statutes is amended to read:

655.001 (13) "Respondent" means the person ~~against whom a submission of controversy is~~ alleged to have been negligent in a request for mediation filed under s. ~~655.04~~ 655.44 or 655.445.

SECTION 25m. 655.002 of the statutes is amended to read:

655.002 Exemptions. Any physician licensed under ch. 448 may be exempted from ss. ~~655.21,~~ 655.23 ~~and~~, 655.27 and 655.61 upon petition to the commissioner while a graduate medical student acting within the scope of a resident or fellowship training program. Any such exemption shall not affect the liability of the physician's employer for acts or omissions.

SECTION 26. 655.004 of the statutes is created to read:

655.004 Health care provider employes. Any person listed in s. 655.007 having a claim or a derivative claim against a health care provider or an employe of the health care provider, for damages for bodily injury or death due to acts or omissions of the employe of the health care provider acting within the scope of his or her employment and providing health care services, is subject to this chapter. The fund shall provide coverage, under s. 655.27, for claims against the health care provider or the employe of the health care provider due to the acts or omissions of the employe acting within the scope of his or her employment and providing health care services.

SECTION 27. 655.009 (1) of the statutes is amended to read:

655.009 (1) COMPLAINT. The complaint in such action shall not specify the amount of money to which the plaintiff supposes to be entitled ~~except to state whether such amount is $25,000 or less or is over $25,000. The complaint shall, if applicable, state that the damages the plaintiff is entitled to are more than the minimum amount necessary to invoke the jurisdiction of the court~~.

SECTION 27m. 655.009 (3) of the statutes is created to read:

655.009 (3) VENUE. Venue in a court action under this chapter is in the county where the claimant resides if the claimant is a resident of this state, or in a county specified in s. 801.50 (2) (a) or (c) if the claimant is not a resident of this state.

SECTION 28. 655.013 (title) and (1) (intro.) of the statutes are amended to read:

655.013 (title) **Attorney fees.** (1) (intro.) With respect to any act of malpractice after July 24, 1975, for which a contingency fee arrangement has been entered into before the effective date of this act .... [revisor inserts date], the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants is subject to the following unless a new contingency fee arrangement is entered into that complies with subs. (1m) and (1t):

SECTION 28g. 655.013 (1m) and (1t) of the statutes are created to read:

655.013 (1m) Except as provided in sub. (1t), with respect to any act of malpractice for which a contingency fee arrangement is entered into on and after the effective date of this subsection .... [revisor inserts date], in addition to compensation for the reasonable costs of prosecution of the claim, the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants is subject to the following limitations:

(a) Except as provided in par. (b), 33 1/3% of the first $1,000,000 recovered.

(b) Twenty-five percent of the first $1,000,000 recovered if liability is stipulated within 180 days after the date of filing of the original complaint and not later than 60 days before the first day of trial.

(c) Twenty percent of any amount in excess of $1,000,000 recovered.

(1t) A court may approve attorney fees in excess of the limitations under sub. (1m) upon a showing of exceptional circumstances, including an appeal.

SECTION 28m. 655.013 (2) of the statutes is amended to read:

655.013 (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) or (1m).

SECTION 29. 655.015 of the statutes is amended to read:

655.015 Future medical expenses. If a settlement, panel award or judgment under this chapter entered into or rendered before the effective date of this act .... [revisor inserts date], 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 into the patients compensation fund created under s. 655.27. The commissioner shall develop by rule a system for managing and disbursing those moneys through payments for these expenses. The payments shall be made under the system until either the amount is exhausted or the patient dies.

SECTION 30. 655.017 of the statutes is created to read:

655.017 Limitation on noneconomic damages. The amount of noneconomic damages recoverable by a claimant or plaintiff under this chapter for acts or omissions of a health care provider if the action is filed on or after the effective date of this section .... [revisor inserts date] and before January 1, 1991, and for acts or omissions of an employe of a health care provider, acting within the scope of his or her employment and providing health care services, for actions filed on or after the effective date of this section .... [revisor inserts date] and before January 1, 1991, is subject to the limit under s. 893.55 (4).

SECTION 30m. 655.019 of the statutes is created to read:

655.019 Information needed to set fees. The department shall provide the director, the commissioner and the board of governors created under s. 619.04 (3) with information on hospital bed capacity and occupancy rates as needed to set fees under s. 655.27 (3) or 655.61.

SECTION 51g. Subchapter II of chapter 655 of the statutes, as affected by 1985 Wisconsin Acts 29, 99 and 135, is repealed.

SECTION 52. 655.23 (4) and (5) of the statutes are amended to read:

655.23 (4) Such health care liability insurance or cash or surety bond shall be in amounts of at least $200,000 ~~per claim~~ for each occurrence and $600,000 per year for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987 and before July 1, 1988, and $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988.

(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, the health care provider's estate and those conducting the health care provider's business, including the health care provider's health care liability insurance carrier, are liable for malpractice for no more than ~~$200,000 per claim and $600,000 per year~~ the limits expressed in sub. (4) or the maximum liability limit for which the health care provider is insured, which-

ever is higher, if the health care provider has met the requirements of this chapter.

SECTION 53. 655.24 (2) (a) and (b) of the statutes are amended to read:

655.24 (2) (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~~ the limits expressed in s. 655.23 (4), or the maximum liability limit for which the health care provider is insured, whichever is greater; 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 a written notice complying with sub. (3) and giving the date upon which the termination is to become effective has been received by ~~the commissioner and~~ the insured at least 10 days prior to the taking effect of a cancellation or nonrenewal for nonpayment of premium or for loss of license or certificate of registration and at least 60 days prior to the taking effect of a cancellation or nonrenewal for any other reason.

SECTION 54. 655.24 (3) of the statutes is created to read:

655.24 (3) The notice of cancellation or nonrenewal required under sub. (2) (b) must inform the insured that the insured's license to practice medicine or certificate of registration may be suspended or not renewed if the licensee has no insurance or insufficient insurance. Copies of notices required under sub. (2) (b) shall be retained on file by the insurer for not less than 10 years from the date of mailing or delivery of the notice and furnished to the commissioner upon request.

SECTION 55. 655.24 (4) of the statutes is created to read:

655.24 (4) The insurer shall, upon termination of a policy of health care liability insurance issued under this chapter by cancellation or nonrenewal, notify the commissioner of the termination.

SECTION 56. 655.26 (1) (b) of the statutes, as created by 1985 Wisconsin Act 29, is amended to read:

655.26 (1) (b) Whether the health care provider is a medical or osteopathic physician, ~~a podiatrist,~~ a nurse anesthetist, a partnership, a corporation, an operational cooperative sickness care plan, a hospital or a nursing home.

SECTION 57. 655.27 (1) of the statutes is amended to read:

655.27 (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 the ~~limit~~ limits expressed in s. 655.23 ~~(5) and~~ (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). The fund shall provide occurrence coverage for health care providers permanently practicing or operating in this state. 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 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. The fund shall not be liable for damages for injury or death caused by an intentional crime, as defined under s. 939.12, committed by a health care provider or an employe of a health care provider, whether or not the criminal conduct is the basis for a medical malpractice claim.

SECTION 58. 655.27 (1m) of the statutes is created to read:

655.27 (1m) PEER REVIEW ACTIVITIES. (a) The fund shall pay that portion of a claim described in par. (b) against a health care provider that exceeds the limit expressed in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater.

(b) A health care provider who engages in the activities described in s. 146.37 (1) and (3) shall be liable for not more than the limits expressed under s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, if he or she is found to be liable under s. 146.37, and the fund shall pay the excess amount, unless the health care provider is found not to have acted in good faith during those activities and the failure to act in good faith is found by the trier of fact, by clear and convincing evidence, to be both malicious and intentional.

SECTION 59. 655.27 (3) (a) (intro.) and 2 of the statutes are amended to read:

655.27 (3) (a) *Assessment.* (intro.) Each health care provider permanently practicing or operating in this state shall pay operating fees, which, subject to pars. (b) to (br), shall be assessed based on the following considerations:

2. The ~~prior~~ past and prospective loss and expense experience of ~~persons or hospitals which resulted in payments of moneys from~~ the ~~patients compensation~~ fund.

SECTION 60. 655.27 (3) (a) 2m of the statutes is created to read:

655.27 (3) (a) 2m. The loss and expense experience of the individual health care provider which resulted in the payment of money, from the fund or other sources, for damages arising out of the rendering of medical care by the health care provider or an employe of the health care provider, except that an adjustment to a health care provider's fees may not be made under this subdivision prior to the receipt of the recommendation of the patients compensation fund peer review council under s. 655.275 (5) (a) and the expiration of the time period provided, under s. 655.275 (7), for the health care provider to comment

or prior to the expiration of the time period under s. 655.275 (5) (a).

SECTION 61. 655.27 (3) (am) of the statutes is created to read:

655.27 (3) (am) *Assessments for peer review council.* The fund, a mandatory health care liability risk sharing plan established under s. 619.04 and a private medical malpractice insurer shall be assessed, as appropriate, fees sufficient to cover the costs of the patients compensation fund peer review council, including costs of administration, for reviewing claims paid by the fund, plan and insurer, respectively, under s. 655.275 (5). The fees shall be set by the commissioner by rule, after approval by the board of governors, and shall be collected by the commissioner for deposit in the fund. The costs of the patients compensation fund peer review council shall be funded from the appropriation under s. 20.145 (2) (um).

SECTION 62. 655.27 (3) (b) to (d) of the statutes are amended to read:

655.27 (3) (b) *Fees established.* 1. The commissioner, after approval by the board of governors, shall by rule set the fees under par. (a). The rule shall provide that fees may be paid annually or in semiannual or quarterly instalments. In addition to the prorated portion of the annual fee, semiannual and quarterly instalments shall include an amount sufficient to cover interest not earned and administrative costs incurred because the fees were not paid on an annual basis. This paragraph does not impose liability on the board of governors for payment of any part of a fund deficit.

(c) *Collection and deposit of fees.* ~~Annual fees~~ Fees under pars. (a) and (b) and future medical expense payments specified for the fund by a settlement, panel award or judgment entered into or rendered before the effective date of this act .... [revisor inserts date], shall be collected by the commissioner for deposit into the fund in a manner prescribed by the commissioner by rule.

(d) *Rule not effective; fees.* If the rule establishing fees under par. (b) does not take effect prior to June 2 of any fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the rule subsequently takes effect, the balance for the fiscal year shall be collected or refunded or the remaining semiannual or quarterly instalment payments shall be adjusted except the commissioner may elect not to collect ~~or~~, refund or adjust for minimal amounts.

SECTION 63. 655.27 (3) (b) 2, (bg), (br) and (e) of the statutes are created to read:

655.27 (3) (b) 2. With respect to fees paid by medical and osteopathic physicians licensed under ch. 448, commencing with fees assessed for the fiscal year commencing July 1, 1986, the rule shall provide for not more than 4 payment classifications, based upon the amount of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed.

(bg) *Fee increase.* 1. Every rule under par. (b) shall provide for an automatic increase in a health care provider's fees, except as provided in subd. 2, if the loss and expense experience of the fund and other sources with respect to the health care provider or an employe of the health care provider exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, both as established in the rule. The rule shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of awards in excess of the respective thresholds.

2. The rule shall provide that the automatic increase does not apply if the board determines that the performance of the patients compensation fund peer review council in making recommendations under s. 655.275 (5) (a) adequately addresses the consideration set forth in par. (a) 2m.

(br) *Limit on fees.* Every rule setting fees for a particular fiscal year under par. (b) shall ensure that the fees assessed do not exceed the greatest of the following:

1. The estimated total dollar amount of claims to be paid during that particular fiscal year.

2. The fees assessed for the fiscal year preceding that particular fiscal year, adjusted by the commissioner of insurance to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor.

3. Two hundred percent of the estimated total dollar amount of claims paid during the fiscal year preceding that particular fiscal year.

(e) *Podiatrist fees.* The commissioner, after approval by the board of governors, may by rule assess fees against podiatrists for the purpose of paying the fund's portion of medical malpractice claims and expenses resulting from claims against podiatrists based on occurrences before July 1, 1986.

SECTION 65. 655.27 (4) (g) of the statutes is created to read:

655.27 (4) (g) The board of governors may cede reinsurance to an insurer authorized to do business in this state under ch. 611, 613, 614 or 618 or pursue other loss funding management to preserve the solvency and integrity of the fund, subject to approval by the commissioner. The commissioner may prescribe controls over or other conditions on such use of reinsurance or other loss-funding management mechanisms.

SECTION 66. 655.27 (5) (a) to (d) of the statutes are amended to read:

655.27 (5) (a) 1. Any person may file a claim for damages arising out of the rendering of medical care or services or participation in peer review activities under s. 146.37 within this state against a health care provider covered under the fund. A person filing a claim may only recover from the fund if the fund is named as a party in the controversy.

2. Any person may file an action for damages arising out of the rendering of medical care or services or participation in peer review activities under s. 146.37 outside this state against a health care provider covered under the fund. A person filing an action may only recover from the fund if the fund is named as a party in the action or, if the rules of procedure of the jurisdiction in which the action is brought do not permit including the fund as a party, if the fund is notified of the action within 60 days of service of process on the health care provider. The board of governors may extend this time limit if it finds that enforcement of the time limit would be prejudicial to the purposes of the fund and would benefit neither insureds nor claimants.

3. If after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages paid will exceed ~~$200,000~~ the limits in s. 655.23 (4), the fund may appear and actively defend itself when named as a party in the controversy. In such action, the fund may retain counsel and pay out of the fund attorney 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. The fund may not be required to file any undertaking in any judicial action, proceeding or appeal.

(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 good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding ~~$200,000, or any other~~ an 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 or any claim filed under sub. (1m) that may potentially affect the fund. The health care provider shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding ~~$200,000, or any other~~ an 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~~ the limits in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater. In the event the fund incurs liability exceeding $1,000,000 to any person under a single claim as the result of a settlement, panel award or judgment entered into or rendered under this chapter before the effective date of this act .... [revisor inserts date], the fund shall pay not more than $500,000 per year. Payments shall be made from money collected and paid into the fund under sub. (3) and from interest earned thereon. For claims subject to the $500,000 limit, payments shall be made until the claim has been paid in full, and any ~~attorney's~~ attorney fees in connection with such claim shall be similarly prorated. Payment of not more than $500,000 per year includes direct or indirect payment or commitment of moneys to or on behalf of any person under a single claim by any funding mechanism. No interest may be paid by the fund on the unpaid portion of any claim filed under this paragraph, except as provided under s. 807.01 (4), 814.04 (4) or 815.05 (8).

SECTION 67. 655.27 (6) of the statutes is amended to read:

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

SECTION 67m. 655.27 (7) of the statutes is created to read:

655.27 (7) ACTIONS AGAINST INSURERS OR PROVIDERS. The board may bring an action against an insurer or health care provider for failure to act in good faith or breach of fiduciary responsibility under sub. (5) (b) or (c).

SECTION 68. 655.275 of the statutes is created to read:

655.275 Patients compensation fund peer review council. (1) DEFINITION. In this section, "council" means the patients compensation fund peer review council.

(2) APPOINTMENT. The board of governors established under s. 619.04 (3) shall appoint the members of the council. Section 15.09, except s. 15.09 (4) and (8), does not apply to the council. The board of governors shall designate the chairperson, vice chairperson and secretary of the council and the terms to be served by council members. The council shall consist of 5 persons, not more than 3 of whom are physicians who are actively engaged in the practice of medicine in this state. The chairperson shall be a physician and shall serve as an ex officio nonvoting member of the medical examining board.

(3) MEETINGS. The council shall meet at the call of the chairperson of the board of governors or the chairperson of the council. The council shall meet at the location determined by the person calling the meeting.

(4) REPORTS. The council shall submit to the chairperson of the board of governors, upon request of the chairperson but not more often than annually, a report on the operation of the council.

(5) DUTIES. (a) The council shall review, within one year of the date of first payment on the claim, each claim that is paid by the patients compensation fund established under s. 655.27, a mandatory health care liability risk sharing plan established under s. 619.04 or private medical malpractice insurers for damages arising out of the rendering of medical care by a health care provider or an employe of the health care provider and shall make recommendations to all of the following:

1. The insurance commissioner and the board of governors regarding any adjustments to be made, under s. 655.27 (3) (a) 2m, to patients compensation fund fees assessed against the health care provider based on the paid claim.

2. The insurance commissioner and the board of governors regarding any adjustments to be made, under s. 619.04 (5) (b), to premiums assessed against a physician under a mandatory health care liability risk sharing plan established under s. 619.04, based on the paid claim.

3. A private medical malpractice insurer regarding adjustments to premiums assessed against a physician covered by private insurance, based on the paid claim, if requested by the private insurer.

(b) In developing recommendations under par. (a), the council may consult with any person and shall consult with the following:

1. If a claim was paid for damages arising out of the rendering of care by a physician, with at least one physician from the area of medical specialty of the physician who rendered the care and with at least one physician from the area of medical specialty of the medical procedure involved, if the specialty area of the procedure is different than the specialty area of the physician who rendered the care.

2. If a claim was paid for damages arising out of the rendering of care by a nurse anesthetist, with at least one nurse anesthetist.

(6) FEES. Fees sufficient to cover the council's costs, including costs of administration, shall be collected under s. 655.27 (3) (am).

(7) NOTICE OF RECOMMENDATION. The council shall notify the affected health care provider, in writing, of its recommendations to the commissioner, the board of governors or a private insurer made under sub. (5). The notice shall inform the health care provider that the health care provider may submit written comments on the council's recommendations to the commissioner, the board of governors or the private insurer within a reasonable period of time specified in the notice.

(8) PATIENT RECORDS. The council may obtain any information relating to any claim it reviews under this section that is in the possession of the commissioner or the board of governors. The council shall keep patient health care information confidential as required by s. 146.82 (2) (b).

(9) IMMUNITY; LIABILITY COVERAGE. Sections 146.37 and 655.27 (1m) apply to a member of the council or any person consulting with a council under sub. (5) (b).

(10) MEMBERS' AND CONSULTANTS' EXPENSES. Any person serving on the council and any person consulting with the council under sub. (5) (b) shall be paid $50 for each day's actual attendance at council meetings, plus actual and necessary travel expenses.

SECTION 68m. 655.28 of the statutes is repealed.

SECTION 69m. Subchapter VI of chapter 655 of the statutes is created to read:

CHAPTER 655
SUBCHAPTER VI
MEDIATION SYSTEM

655.42 Establishment of mediation system. (1) LEGISLATIVE INTENT. The legislature intends that the mediation system provide the persons under sub. (2) with an informal, inexpensive and expedient means for resolving disputes without litigation and intends that the director administer the mediation system accordingly.

(2) MEDIATION SYSTEM. The director shall establish a mediation system complying with this subchapter not later than September 1, 1986. The mediation system shall consist of mediation panels that assist in the resolution of disputes, regarding medical malpractice, between patients, their representatives, spouses, parents or children and health care providers.

655.43 Mediation requirement. The claimant and all respondents named in a request for mediation filed under s. 655.44 or 655.445 shall participate in mediation under this subchapter.

655.44 Request for mediation prior to court action. (1) REQUEST AND FEE. Beginning September 1, 1986, any person listed in s. 655.007 having a claim or a derivative claim under this chapter for bodily injury or death because of a tort or breach of contract based on professional services rendered or that should have been rendered by a health care provider may file a request for mediation and shall pay the fee under s. 655.54.

(2) CONTENT OF REQUEST. The request for mediation shall be in writing and shall include all of the following information:

(a) The claimant's name and city, village or town, county and state of residence.

(b) The name of the patient.

(c) The name and address of the health care provider alleged to have been negligent in treating the patient.

(d) The condition or disease for which the health care provider was treating the patient when the alleged negligence occurred and the dates of treatment.

(e) A brief description of the injury alleged to have been caused by the health care provider's negligence.

(3) DELIVERY OR REGISTERED MAIL. The request for mediation shall be delivered in person or sent by registered mail to the director.

(4) STATUTE OF LIMITATIONS. Any applicable statute of limitations is tolled on the date the director receives the request for mediation if delivered in person or on the date of mailing if sent by registered mail. The statute remains tolled until 30 days after the last day of the mediation period under s. 655.465 (7).

(5) NO COURT ACTION COMMENCED BEFORE MEDIATION. Except as provided in s. 655.445, no court action may be commenced unless a request for mediation has been filed under this section and until the expiration of the mediation period under s. 655.465 (7).

(6) NOTICE OF COURT ACTION TO DIRECTOR. A claimant who files a request for mediation under this section and who commences a court action after the expiration of the mediation period under s. 655.465 (7) shall send notice of the court action by 1st class mail to the director.

655.445 Request for mediation in conjunction with court action. (1) COMMENCING ACTION, REQUEST AND FEE. Beginning September 1, 1986, any person listed in s. 655.007 having a claim or a derivative claim under this chapter for bodily injury or death because of a tort or breach of contract based on professional services rendered or that should have been rendered by a health care provider shall, within 15 days after the date of filing an action in court, file a request for mediation. The request shall be prepared and delivered in person or sent by registered mail to the director, in the form and manner required under s. 655.44 (2) and (3), together with a notice that a court action has been commenced and the fee under s. 655.54 shall be paid.

(2) SCHEDULING. All time periods under s. 802.10 (2) and (3) (a) and (b) are tolled on the date of filing the court action. The time periods remain tolled until the expiration of the mediation period under s. 655.465 (7).

(3) NO COURT PROCEEDINGS BEFORE MEDIATION. For actions filed under sub. (1), no discovery may be made and no trial, pretrial conference or scheduling conference may be held until the expiration of the mediation period under s. 655.465 (7).

655.45 Reports to licensing bodies. (1) For the quarter beginning on July 1, 1986, and for each quarter thereafter, the director shall file reports complying with sub. (2) with the medical examining board, the board of nursing and the department, respectively, regarding health care providers licensed by the respective bodies.

(2) The reports under sub. (1) shall set forth all of the following:

(a) The names of all health care providers who are named as defendants in court actions of which the director receives notice under s. 655.44 (6) or 655.445 (1) during the quarter.

(b) Whether any court action of which the director received notice under s. 655.44 (6) or 655.445 (1) was disposed of by settlement, compromise, stipulation agreement, dismissal default or judgment during the quarter and the amount of the settlement or award to the claimant, if any, to the extent the director has any of the information under this paragraph.

655.455 Notice to health care providers. The director shall serve notice of a request for mediation upon all health care providers named in the request, at the respective addresses provided in the request, by registered mail within 7 days after the director receives the request if delivered in person or within 10 days after the date of mailing of the request to the director if sent by registered mail.

655.465 Mediation panels; mediation period. (1) MEDIATION PANEL FOR DISPUTE. The director shall appoint the members of a mediation panel under sub. (2) and send notice to the claimant and all respondents by registered mail. The notice shall inform the claimant and all respondents of the names of the persons appointed to the mediation panel and the date, time and place of the mediation session. The director may change the date, time or place of the mediation session as necessary to accommodate the parties, subject to the requirement that the mediation session be held before the expiration of the mediation period under sub. (7).

(2) APPOINTMENT OF MEDIATORS. Each mediation panel shall consist of the following members appointed by the director:

(a) One public member who is neither an attorney nor a health care provider and who is selected from a list of public member mediators prepared every 2 years, or more frequently upon request of the director, by the governor or, if any person resigns or is unable to serve as a public member mediator, from a list of alternates prepared by the director.

(b) One attorney who is licensed to practice law in this state.

(c) One health care provider as follows:

1. Except as provided in subds. 4 and 5, if all respondents named in the request for mediation are physicians, a physician who is licensed to practice in this state and who is selected from a list prepared by a statewide organization of physicians designated by the director.

2. Except as provided in subds. 4 and 5, if none of the respondents named in the request for mediation is a physician, a health care provider who is licensed to practice in this state in the same health care field as the respondent and who is selected from a list prepared by the department or the examining board that regulates health care providers in that health care field.

3. Except as provided in subds. 4 and 5, if more than one respondent is named in the request for mediation at least one of whom is a physician and at least

one of whom is not, a health care provider who is licensed to practice in this state and who is selected from the list under subd. 1 or 2, as determined by the director.

4. If the director determines that a list under subd. 1 or 2 is inadequate to permit the selection of an appropriate health care provider, a health care provider who is licensed to practice in this state and who is selected from an additional list prepared by the director.

5. If the director determines that lists under subds. 1 or 2 and 4 are inadequate to permit the selection of an appropriate health care provider for a particular dispute, a health care provider who is licensed to practice in this state and who is selected by the director.

(3) FILLING VACANCIES. If a person appointed to a mediation panel under sub. (1) resigns from or is unable to serve on the mediation panel, the director shall appoint a replacement selected in the same manner as the predecessor appointee.

(4) CONFLICT OF INTEREST. No person may serve on a mediation panel if the person has a professional or personal interest in the dispute.

(5) COMPENSATION. Each mediator shall be compensated $150 plus actual and necessary expenses for each day of mediation conducted. Compensation and expenses shall to be paid out of the appropriation under s. 20.680 (2) (qm) upon such authorizations as the director may prescribe.

(6) IMMUNITY AND PRESUMPTION OF GOOD FAITH. (a) A mediator is immune from civil liability for any good faith act or omission within the scope of the mediator's performance of his or her powers and duties under this subchapter.

(b) It is presumed that every act or omission under par. (a) is a good faith act or omission. This presumption may be overcome only by clear and convincing evidence.

(7) MEDIATION PERIOD. The period for mediation shall expire 90 days after the director receives a request for mediation if delivered in person or within 93 days after the date of mailing of the request to the director if sent by registered mail, or within a longer period agreed to by the claimant and all respondents and specified by them in writing for purposes of applying ss. 655.44 (4) and (5) and 655.445 (3).

655.54 Filing fee. Requests for mediation filed with the director are subject to a filing fee of $11. The filing fee shall be paid into the mediation fund under s. 655.68.

655.58 Mediation procedure. (1) NO RECORD. Mediation shall be conducted without a stenographic record or any other transcript.

(2) NO EXAMS, SUBPOENAS, OATHS. No physical examinations or production of records may be ordered, no witnesses may be subpoenaed and no oaths may be administered in mediation, whether by a mediation panel or member thereof or as a result of application to a court by any person.

(3) NO EXPERT WITNESSES; PANEL CONSULTANTS PERMITTED. (a) Except as provided in par. (b), no expert witnesses, opinions or reports may be submitted or otherwise used in mediation.

(b) The mediation panel or any member thereof may consult with any expert, and upon authorization of the director may compensate the expert from the appropriation under s. 20.680 (2) (qm).

(4) PATIENT RECORDS CONFIDENTIAL EXCEPT TO PARTIES. All patient health care records in the possession of a mediation panel shall be kept confidential by all members of the mediation panel and all other persons participating in mediation. Every person participating in mediation shall make available to one another and all members of the mediation panel all patient health care records of the patient named in the request for mediation that are in the person's possession.

(5) COUNSEL PERMITTED. Any person participating in mediation may be represented by counsel authorized to act for his or her respective client.

655.59 Inadmissibility. Filings under ss. 655.44 and 655.445 are not admissible in any court action. No statement or expression of opinion made in the course of a mediation session is admissible, either as an admission or otherwise, in any court action.

655.61 Funding. (1) The mediation fund created under s. 655.68 shall be financed from fees charged to health care providers. The director shall, by February 1 annually, determine the revenues needed for the operation of the mediation system during the succeeding fiscal year and inform the board of governors created under s. 619.04 (3) of that amount. The board of governors shall, by rule, set fees to charge health care providers at a level sufficient to provide these revenues. The board shall charge each health care provider permanently practicing in this state an annual fee and shall charge each hospital an annual fee per occupied bed.

(2) The annual fees under sub. (1) shall be collected in a manner prescribed by rule of the commissioner. The commissioner shall pay all money collected under sub. (1) into the mediation fund created under s. 655.68.

SECTION 69r. Subchapter VII of chapter 655 of the statutes is created to read:

CHAPTER 655
SUBCHAPTER VII
MEDIATION FUND

655.68 Mediation fund. (1) CREATION OF THE FUND. There is created a mediation fund to pay the administrative expenses of the mediation system created under subch. VI.

(2) FUND ADMINISTRATION AND OPERATION. Management of the fund is vested with the director.

(3) FEES. The fund is financed from fees generated under ss. 655.54 and 655.61.

(4) FUND ACCOUNTING AND FINANCIAL REPORTS. (a) Any person authorized to receive deposits, withdraw moneys, issue vouchers or otherwise disburse fund

moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of the bond shall be paid from the fund.

(b) The state investment board shall invest money held in the fund in short-term, fixed-return, interest-bearing investments. All income derived from these investments returns to the fund.

(c) The director shall submit a report on the operation of the mediation system and on the status of the fund to the presiding officer of each house of the legislature on or before March 1 annually.

SECTION 69w. 758.19 (3) of the statutes, as created by 1985 Wisconsin Act 29, is amended to read:

758.19 (3) The director shall establish and charge fees for data processing services provided for the board of attorneys professional competence, the board of attorneys professional responsibility and ~~patients compensation panels~~ the mediation system under ch. 655.

SECTION 70. 807.01 (5) of the statutes is amended to read:

807.01 (5) Subsections (1) to (4) apply to offers which may be made by any party to any other party who demands a judgment or setoff against the offering party. ~~Subsections (1) to (4) also apply to offers made by any party to a submission of controversy under s. 655.04 with the exception that, rather than serving written offers at least 20 days before trial, written offers shall be served at least 60 days after the prehearing conference and at least 20 days before the panel hearing.~~

SECTION 71. 893.55 (title) of the statutes is amended to read:

893.55 (title) **Medical malpractice; limitation of actions; limitation of damages; itemization of damages.**

SECTION 72. 893.55 (4) of the statutes is created to read:

893.55 (4) (a) In this subsection, "noneconomic damages" means moneys intended to compensate for pain and suffering; humiliation; embarrassment; worry; mental distress; noneconomic effects of disability including loss of enjoyment of the normal activities, benefits and pleasures of life and loss of mental or physical health, well-being or bodily functions; loss of consortium, society and companionship; or loss of love and affection.

(b) The total noneconomic damages recoverable under ch. 655 for bodily injury or death, including any action or proceeding based on contribution or indemnification, may not exceed the limit under par. (d) for each occurrence from all health care providers and all employes of health care providers acting within the scope of their employment and providing health care services who are found negligent and from the patients compensation fund for any action filed on or after the effective date of this paragraph .... [revisor inserts date] and before January 1, 1991.

(c) A court in an action tried without a jury shall make a finding as to noneconomic damages without regard to the limit under par. (d). If noneconomic damages in excess of the limit are found, the court shall make any reduction required under s. 895.045 and shall award as noneconomic damages the lesser of the reduced amount or the limit. If an action is before a jury, the jury shall make a finding as to noneconomic damages without regard to the limit under par. (d). If the jury finds that noneconomic damages exceed the limit, the jury shall make any reduction required under s. 895.045 and the court shall award as noneconomic damages the lesser of the reduced amount or the limit.

(d) The limit on total noneconomic damages for each occurrence under par. (b) shall be $1,000,000 for actions filed on or after the effective date of this paragraph .... [revisor inserts date], and shall be adjusted by the director of state courts to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, at least annually thereafter, with the adjusted limit to apply to awards subsequent to such adjustments.

(e) Economic damages recovered under ch. 655 for bodily injury or death, including any action or proceeding based on contribution or indemnification, shall be determined for the period during which the damages are expected to accrue, taking into account the estimated life expectancy of the person, then reduced to present value, taking into account the effects of inflation.

SECTION 72b. 893.55 (5) of the statutes is created to read:

893.55 (5) Every award of damages under ch. 655 shall specify the sum of money, if any, awarded for each of the following for each claimant for the period from the date of injury to the date of award and for the period after the date of award, without regard to the limit under sub. (4) (d):

(a) Pain, suffering and noneconomic effects of disability.

(b) Loss of consortium, society and companionship or loss of love and affection.

(c) Loss of earnings or earning capacity.

(d) Each element of medical expenses.

(e) Other economic injuries and damages.

SECTION 72c. 893.80 (1) (intro.) of the statutes is amended to read:

893.80 (1) (intro.) ~~No~~ Except as provided in sub. (1m), no action may be brought or maintained against any volunteer fire company organized under ch. 213, political corporation, governmental subdivision or agency thereof nor against any officer, official, agent or employe of the corporation, subdivision or agency for acts done in their official capacity or in the course of their agency or employment upon a claim or cause of action unless:

SECTION 72g. 893.80 (1m) of the statutes is created to read:

893.80 (1m) With regard to a claim to recover damages for medical malpractice, the time period under sub. (1) (a) shall be 180 days after discovery of the injury or the date on which, in the exercise of reasonable diligence, the injury should have been discovered, rather than 120 days after the happening of the event giving rise to the claim.

SECTION 72n. 893.82 (3) of the statutes, as affected by 1985 Wisconsin Act 66, is amended to read:

893.82 (3) ~~No~~ Except as provided in sub. (5m), no civil action or civil proceeding may be brought against any state officer, employe or agent for or on account of any act growing out of or committed in the course of the discharge of the officer's, employe's or agent's duties, and no civil action or civil proceeding may be brought against any nonprofit corporation operating a museum under a lease agreement with the state historical society, unless within 120 days of the event causing the injury, damage or death giving rise to the civil action or civil proceeding, the claimant in the action or proceeding serves upon the attorney general written notice of a claim stating the time, date, location and the circumstances of the event giving rise to the claim for the injury, damage or death and the names of persons involved, including the name of the state officer, employe or agent involved. A specific denial by the attorney general is not a condition precedent to bringing the civil action or civil proceeding.

SECTION 72r. 893.82 (4) (a) and (b) 1. (intro.) of the statutes are amended to read:

893.82 (4) (a) Except as provided in par. (b), if the civil action or proceeding under sub. (3) is based on contribution or indemnification, the event under sub. (3) is the underlying cause of action, not the cause of action for contribution or indemnification, and, except as provided in sub. (5m), the 120-day limitation applies to that event.

(b) 1. (intro.) If the claimant under par. (a) establishes that he or she had no actual or constructive knowledge of the underlying cause of action at the time of the event under sub. (3), except as provided in sub. (5m), the 120-day limitation under sub. (3) applies to the earlier of the following:

SECTION 72w. 893.82 (5m) of the statutes is created to read:

893.82 (5m) With regard to a claim to recover damages for medical malpractice, the time periods under subs. (3) and (4) shall be 180 days after discovery of the injury or the date on which, in the exercise of reasonable diligence, the injury should have been discovered, rather than 120 days after the event causing the injury.

SECTION 73. **Nonstatutory provisions.** (1) TRANSITIONAL PROVISIONS; DIRECTOR OF STATE COURTS. (a) *Positions transfer.* All positions funded under section 20.680 (2) (q) of the statutes on the day before the effective date of this paragraph are continued and are funded under section 20.680 (2) (qm) of the statutes, as created by this act.

(b) *Records and equipment transfer.* All records and equipment in the possession of the director of state courts for purposes of administering the patients compensation panels and patients compensation panels fund on the day before the effective date of this paragraph are to be retained for use in the administration of the mediation system and mediation fund created by this act.

(2) TRANSITIONAL PROVISIONS; PANELS, MEDIATION AND COURTS. (a) *Completed panel process.* If a patients compensation panel has filed its findings and order before the effective date of this paragraph, subchapter II of chapter 655, 1983 stats., as affected by 1985 Wisconsin Acts 99 and 135, applies to any subsequent court trial or judgment on the award, except as provided in paragraph (d).

(b) *Completed panel hearing.* If a patients compensation panel has completed its hearing but has not yet filed its findings and order on the effective date of this paragraph, subchapter II of chapter 655, 1983 stats., as affected by 1985 Wisconsin Acts 99 and 135, applies to the making and filing of the panel's findings and order and any subsequent court trial or judgment on the award, except as provided in paragraph (d).

(c) *Panel filing.* 1. If a submission of controversy has been filed under section 655.04, 1983 stats., as affected by 1985 Wisconsin Act 135, but the patients compensation panel has not completed its hearing before the effective date of this paragraph the following provisions apply and the director of state courts shall send notice of these provisions to the claimant and all respondents:

a. If the claimant wishes to proceed with the malpractice claim, the claimant shall file a copy of the submission of controversy, as last amended, within 60 days after receipt of notice from the director, in the circuit court for the county named in the submission of controversy if the claimant is a resident of this state or in a county specified in section 801.50 (2) (a) or (c) of the statutes if the claimant is not a resident of this state. The claimant shall notify all respondents of the filing in circuit court in the manner provided for service of a summons and complaint under section 801.02 (2) of the statutes. Any applicable statute of limitations tolled under section 655.04 (6), 1983 stats., shall remain tolled until the expiration of the 60-day period.

b. The claimant or any respondent may request mediation by filing a request for mediation in the form and manner required under section 655.44 (2) and (3) of the statutes, as created by this act, at any time after filing in the circuit court under subdivision 1. a. If the claimant and all other parties agree, mediation shall be conducted as provided in sections 655.455 to 655.68 of the statutes, as created by this act. If the request for mediation is filed prior to the establishment of the

mediation system under section 655.42 (2) of the statutes, the time periods under section 655.465 (1) and (7) of the statutes shall commence on the date the mediation system is established, but not later than September 1, 1986. Time periods under section 802.10 (2) and (3) (a) and (b) of the statutes are not tolled by the filing under subdivision 1. a, and discovery, trial, pretrial conferences and scheduling conferences may be held during the mediation period.

c. If the claimant is not represented by an attorney and files a request for mediation in the form and manner required under section 655.44 (2) and (3) of the statutes, as created by this act, after filing in the circuit court under subdivision 1. a and within 60 days after receipt of notice from the director, mediation shall be conducted as provided in sections 655.445 (2) and (3) and 655.455 to 655.68 of the statutes, as created by this act. If the request for mediation is filed prior to the establishment of the mediation system under section 655.42 (2) of the statutes, the time periods under section 655.465 (1) and (7) of the statutes shall commence on the date the mediation system is established, but not later than September 1, 1986.

2. The director of state courts shall give first priority in appointing mediation panels and assigning first dates for mediation sessions to mediation conducted pursuant to requests under subdivision 1. b or c.

3. If a claimant files in circuit court under subdivision 1. a, any respondent named in the filing may file a copy of the respondent's answer filed under section 655.12, 1983 stats., or may file an answer under section 802.06 of the statutes or may file neither. If a respondent files neither, the respondent is deemed to have answered by contesting all allegations contained in the claimant's filing.

4. The submission of controversy and answer shall constitute a summons and complaint and answer, respectively, for purposes of any court proceedings under this paragraph, and references to a claimant and respondent subsequent to a filing in court under subdivision 1. a are deemed to refer to a plaintiff and defendant, respectively.

5. Within 30 days after receipt of service of a notice of filing under subdivision 1. a, the respondent may serve a demand on the claimant for service of a complaint conforming to the rules of civil procedure. The claimant shall serve a complaint so conforming within 30 days after receipt of such a demand and the respondent shall answer as provided under the rules of civil procedure.

6. All service under this paragraph may be made upon claimants or respondents or their respective attorneys of record in the panel proceedings.

7. Subchapter II of chapter 655, 1983 stats., as affected by 1985 Wisconsin Acts 99 and 135, applies to court actions under this paragraph, except as provided in this paragraph and paragraph (d).

8. All appointments of guardians ad litem under section 655.06, 1983 stats., continue in any subsequent court trial or judgment on the award.

9. The date of filing of the submission of controversy under section 655.04, 1983 stats., as affected by 1985 Wisconsin Act 135, is deemed to be the date of filing of the court action under section 655.19, 1983 stats., except for purposes of the application of sections 655.017 and 893.55 (4) of the statutes, as created by this act.

(d) *Procedure.* With respect to claims under paragraphs (a) to (c), all of the following apply:

1. All discovery taken in patients compensation panel proceedings is admissible in the circuit court proceedings as if taken in the circuit court proceedings.

2. All items noticed to the parties at the patients compensation panel level that became part of the panel record become part of the circuit court record.

3. Patients compensation panel findings and orders, except for damages awarded, are admissible in circuit court only as follows:

a. Formal panel findings as to whether the actions or omissions of the health care provider were negligent are admissible.

b. If such actions or omissions were negligent, formal panel findings as to whether the negligence caused injury or death to the patient are admissible.

3g. No statement or expression of opinion made in the course of a panel hearing or included as part of a panel finding is admissible, either as an admission or otherwise, in circuit court.

3m. The amount of damages awarded by a formal panel may, in the court's discretion, be admissible in circuit court.

4. All interlocutory motions heard by a patients compensation panel may be brought de novo before the circuit court.

5. No patients compensation panel member may participate in a circuit court proceeding either as counsel or witness.

6. All other statutes and rules of the circuit court relating to matters, including status, pretrial or scheduling conferences and trial dates, apply.

(e) *No panel filing.* 1. If no submission of controversy has been filed under section 655.04, 1983 stats., as affected by 1985 Wisconsin Act 135, before the effective date of this subdivision, no request for mediation is required prior to or in conjunction with filing a court action before September 1, 1986. The rules of civil procedure apply to any court action filed under this paragraph.

2. Any party may request mediation by filing a request for mediation in the form and manner required under section 655.44 (2) and (3) of the statutes, as created by this act, at any time after filing a court action under subdivision 1. If the plaintiff and all other parties agree, mediation shall be conducted

as provided in sections 655.455 to 655.68 of the statutes, as created by this act. If the request for mediation is filed prior to the establishment of the mediation system under section 655.42 (2) of the statutes, the time periods under section 655.465 (1) and (7) of the statutes shall commence on the date the mediation system is established, but not later than September 1, 1986. Time periods under section 802.10 (2) and (3) (a) and (b) of the statutes are not tolled by the filing under subdivision 1 and discovery, trial, pretrial conferences and scheduling conferences may be held during the mediation period.

3. If the plaintiff is not represented by an attorney and files a request for mediation in the form and manner required under section 655.44 (2) and (3) of the statutes, as created by this act, within 60 days after filing in the circuit court under subdivision 1, mediation shall be conducted as provided in sections 655.445 (2) and (3) and 655.455 to 655.68 of the statutes, as created by this act. If the request for mediation is filed prior to the establishment of the mediation system under section 655.42 (2) of the statutes, the time periods under section 655.465 (1) and (7) of the statutes shall commence on the date the mediation system is established, but not later than September 1, 1986.

4. The director shall give 2nd priority in appointing mediation panels and assigning first dates for mediation sessions to mediation conducted pursuant to requests under subdivisions 2 and 3, except that all first dates for mediation sessions shall be before November 1, 1986.

(3) REPORT ON MEDIATION. By May 1, 1987, the director of state courts shall submit a report on the mediation system created by this act to the joint committee on finance and to the chief clerk of each house of the legislature, under section 13.172 (3) of the statutes, for submission to the appropriate standing committees, as determined by the presiding officer of each house. The report shall describe the operations of the mediation system from the effective date of this subsection to March 31, 1987, including:

(a) The following information on the number of requests submitted for mediation:

1. The number of cases pending before the patients compensation panels on the effective date of this subdivision and the number of requests submitted for mediation of those cases under subsection (2) (c).

2. The number of requests for mediation of cases filed on or after the effective date of this subdivision and before September 1, 1986, under subsection (2) (e).

3. The number of requests for mediation filed on or after September 1, 1986, under section 655.44 of the statutes, as created by this act.

4. The number of requests for mediation filed on or after September 1, 1986, under section 655.445 of the statutes, as created by this act.

5. For each of the categories in subdivisions 1 to 4, the number of cases in which the claimant was not represented by an attorney.

(b) The following information for each of the categories under paragraph (a):

1. The number of cases still pending in mediation on March 31, 1987, and a breakdown of those cases according to the length of time since the submission of the request for mediation.

2. The number of cases, if any, in which mediators were not appointed or first mediation sessions were not held within the required time period.

3. The number of cases in which mediation has been completed and for those cases:

a. A breakdown of the cases according to the number of mediation sessions held.

b. A breakdown of the cases according to the number of days from the date of the request for mediation to the completion of the mediation process.

c. The number of mediated settlements.

(4) MEMBERS OF BOARD OF GOVERNORS. (a) Of the 2 additional public members appointed to the board of governors under section 619.04 (3) of the statutes, as affected by this act, one shall be appointed for a term to expire on January 1, 1988, and the other for a term to expire on January 1, 1989.

(b) Members of the board of governors appointed by the commissioner of insurance and named by the state bar association, the Wisconsin academy of trial lawyers and the Wisconsin medical society, all under section 619.04 (3) of the statutes, as affected by this act, shall be appointed or named by July 1, 1986.

(5) STUDIES. (a) *Health care provider study.* The board of governors for the patients compensation fund established under section 619.04 (3) of the statutes shall study the inclusion of health maintenance organizations, independent practice associations, preferred provider plans, limited service health organizations and other similar organizations and health care plans under chapter 655 of the statutes. It shall report, under section 13.172 (3) of the statutes, to the appropriate standing committees of the legislature as determined by the speaker of the assembly or the president of the senate, by January 1, 1987, its recommendations regarding all of the following:

1. The statutory changes necessary to include such organizations under chapter 655 of the statutes.

2. The basis for assessing such organizations fees under the patients compensation fund.

3. The fees to be assessed against such organizations for the first year of their coverage under the fund.

(b) *Study of modifications to the state's self-funded risk management liability insurance program.* 1. The department of administration, in consultation with the departments of health and social services, justice and veterans affairs and the university of Wisconsin system, shall study the current statutory provisions

governing the payment of medical malpractice claims against state-employed health care providers under the state's self-funded risk management liability insurance program.

2. The study shall analyze both current procedures used to pay medical malpractice claims against state-employed health care providers and alternatives to the current procedures, including, but not limited to:

a. Coverage of state hospitals and employes who are physicians or nurse anesthetists, under chapter 655 of the statutes.

b. Modifications to claims limitations under subchapter VIII of chapter 893 of the statutes.

c. Requiring state-employed health care providers to individually maintain medical malpractice insurance coverage under chapter 655 of the statutes.

d. Establishing a separate appropriation under the state's self-funded risk management program for the payment of medical malpractice claims.

3. The department of administration shall prepare a report setting forth its analyses and any recommendations regarding alternatives and shall submit its report to the joint committee on finance by March 1, 1987.

(c) *Health care data collection.* The office of the commissioner of insurance, in consultation with the department of health and social services and representatives of consumers, health care providers and purchasers of health care services, shall study the development and expansion of health care data collection and analysis programs. The office of the commissioner of insurance shall report its findings and recommendations by January 1, 1987, to the appropriate standing committee of each house of the legislature, as determined by the presiding officer, under section 13.172 (3) of the statutes. The report shall include recommendations for improved collection and dissemination of health care data, including morbidity, mortality and cost information.

SECTION 73m. **Appropriation changes.** (1) PANELS AND MEDIATION TRANSFER. All moneys remaining in the appropriation under section 20.680 (2) (q) of the statutes on the day before the effective date of this subsection are transferred to the appropriation under section 20.680 (2) (qm) of the statutes, as created by this act, on the effective date of this subsection. Moneys so transferred shall be used first to pay any outstanding administrative expenses of the patients compensation panels, notwithstanding section 20.680 (2) (qm) of the statutes, as created by this act, whether incurred prior to the effective date of this subsection, or subsequent thereto under SECTION 73 (2).

(2) PATIENTS COMPENSATION FUND. The appropriation to the office of the commissioner of insurance under section 20.145 (2) (u) of the statutes, as affected by the acts of 1985, is increased by $93,200 for fiscal year 1986-87.

(3) SUPERVISION OF THE INSURANCE INDUSTRY. The dollar amount in the schedule under section 20.005 (3) of the statutes for the appropriation to the office of the commissioner of insurance under section 20.145 (1) (g) of the statutes, as affected by the acts of 1985, is increased by $23,900 for fiscal year 1986-87.

SECTION 74p. **Program responsibility changes.** In the sections of the statutes listed in Column A, the program responsibilities references shown in Column B are deleted and the program responsibilities references shown in Column C are inserted:

A	B	C
Statute Sections	References Deleted	References Inserted
14.011 (intro.)	none	655.465 (2)(a)
15.251 (intro.)	none	440.25

SECTION 75. **Initial applicability.** (1) The treatment of section 146.37 (1m) of the statutes by this act first applies to claims arising from peer review activities that occur on the effective date of this subsection.

(2) The treatment of section 440.25 of the statutes by this act first applies to final disciplinary decisions made on the effective date of this subsection.

(3) The treatment of section 448.02 (3) (a) to (c) (with regard to competency examinations) of the statutes by this act first applies to investigations and hearings regarding, and limitations, suspensions and revocations of, licenses or certificates of persons regarding whom investigations are commenced on the effective date of this subsection.

(4) The treatment of section 448.02 (3) (a) (with regard to reports used for investigations) and (7) (a) and (b) of the statutes by this act first applies to reports filed on the effective date of this subsection.

(5) The treatment of section 448.02 (3) (e) of the statutes by this act first applies to persons whose licenses or certificates are limited on the effective date of this subsection.

(6) The treatment of section 448.06 (1m) of the statutes by this act first applies to findings of the medical examining board made on the effective date of this subsection.

(7) The treatment of section 619.04 (1) of the statutes by this act first applies to partnerships, corporations and facilities on July 1, 1986.

(8) The treatment of sections 619.04 (5) (b) and (5m) and 655.27 (3) (a) 2m, (bg) and (br) of the statutes by this act first applies to fiscal year 1986-87.

(9) The treatment of section 655.009 (1) of the statutes by this act first applies to claims filed on the effective date of this subsection.

(10) The treatment of section 655.24 (2) (b), (3) and (4) of the statutes by this act first applies to notices of cancellation and nonrenewal issued on the first day of the 7th month beginning after the effective date of this subsection.

(11) The treatment of section 655.27 (1) (with regard to peer review activities); (1m); and (5) (a) 1 and 2 and (c) (with regard to peer review activities) of the statutes by this act first applies to claims arising from peer review activities that occur on July 1, 1986.

(12) The treatment of section 655.27 (3) (a) 2 of the statutes by this act first applies to assessments made on July 1, 1986.

(13) The treatment of section 893.55 (4) (e) and (5) of the statutes by this act first applies to awards made on the effective date of this subsection.

(14) The treatment of sections 893.80 (1) (intro.) and (1m) and 893.82 (3), (4) (a) and (b) 1. (intro.) and (5m) of the statutes by this act first applies to claims arising from occurrences on the effective date of this subsection.

SECTION 76. **Effective dates.** (1) Except as provided in subsection (2), this act takes effect on the day following publication.

(2) The treatment of sections 448.02 (3) (d), 448.075, 655.001 (8) (with regard to podiatrists) and 655.26 (1) (b) of the statutes takes effect on July 1, 1986.