Date of enactment: **April 20, 1992**
1991 Senate Bill 453 Date of publication*: **May 4, 1992**

1991 WISCONSIN ACT 214

AN ACT ***to repeal*** 13.93 (1) (q), 601.21, 632.755 (1), 632.755 (1m) and 655.23 (1); ***to renumber*** 655.23 (2); ***to amend*** 619.04 (1), 628.10 (1), 628.10 (2) (b), 632.72, 632.755 (1g), 632.755 (2), 655.003 (intro.), (1) and (3), 655.005 (2), 655.015, 655.019, 655.23 (3) (a) and (b), 655.23 (5m) to (7), 655.26 (1) (intro.) and (2), 655.27 (1) and (2), 655.27 (3) (a) (intro.), 655.27 (3) (am), 655.27 (3) (b) 2, 655.27 (3) (b) 2m, 655.27 (5) (a), 655.27 (5) (d), 655.275 (2) and (5) (a), 655.61 (1) and 655.68 (1) (title), (2), (3) and (4); ***to repeal and recreate*** 655.001 (8) and (11) and 655.002; and ***to create*** 49.493, 655.001 (1), (6), (9) and (10m), 655.24 (1m) and 655.61 (1m) of the statutes, **relating to:** uninsured health plans that provide coverage for persons who are eligible for medical assistance; revisions in health care liability insurance and patients compensation fund requirements; discontinuing the list in the statutes of insurance provisions that apply to health care plans; and summary suspension of an insurance marketing intermediary's license.

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

SECTION 1. 13.93 (1) (q) of the statutes is repealed.

SECTION 2. 49.493 of the statutes is created to read:

49.493 Benefits under uninsured health plans. (1) In this section, "uninsured health plan" means a partially or wholly uninsured plan, including a plan that is subject to 29 USC 1001 to 1461, providing health care benefits.

(2) The providing of medical assistance constitutes an assignment to the department, to the extent of the medical assistance benefits provided, for benefits to which the recipient would be entitled under any uninsured health plan.

(3) An uninsured health plan may not do any of the following:

(a) Exclude a person or a person's dependent from coverage under the uninsured health plan because the person or the dependent is eligible for medical assistance.

(b) Terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for medical assistance.

(c) Provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for medical assistance than it provides to persons and their dependents who are not eligible for medical assistance.

(4) Benefits provided by an uninsured health plan shall be primary to those benefits provided under medical assistance.

SECTION 3. 601.21 of the statutes is repealed.

SECTION 4. 619.04 (1) of the statutes is amended to read:

619.04 **(1)** The commissioner shall promulgate rules establishing a plan of health care liability coverage for health care providers as defined in s. 655.001 (8) ~~or who satisfy s. 655.002~~.

SECTION 5. 628.10 (1) of the statutes is amended to read:

628.10 **(1)** GENERAL. An intermediary's license issued under s. 628.04 remains in force until it is revoked~~,~~ ~~suspended~~ or limited under sub. (2), until it is suspended under sub. (2) or s. 227.51 (3), until it is surrendered~~,~~ or until the licensee dies or is adjudicated incompetent as defined in s. 880.01 (4) ~~or until the commissioner finds, after a hearing, that the licensee is unqualified as an intermediary or is not of good character~~.

SECTION 6. 628.10 (2) (b) of the statutes is amended to read:

628.10 **(2)** (b) *For other reasons.* After a hearing, the commissioner may revoke, suspend or limit in whole or in part the license of any intermediary ~~found to be~~ if the commissioner finds that the licensee is unqualified as an intermediary ~~or to have~~, is not of good character or has repeatedly or knowingly violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the intermediary's methods and practices in the conduct of business endanger, or financial resources are inadequate to safeguard, the legitimate interests of customers and the public. Nothing in this paragraph limits the authority of the commissioner to suspend summarily an intermediary's license under s. 227.51 (3).

SECTION 7. 632.72 of the statutes is amended to read:

632.72 Medical assistance; assignment. The providing of medical benefits under s. 49.02 or 49.046 or of medical assistance under s. 49.45, 49.46, 49.465, 49.468 or 49.47 constitutes an assignment to the department of health and social services or the county providing the medical benefits or assistance. The assignment shall be, to the extent of the medical benefits or assistance provided, for benefits to which the recipient would be entitled under any policy of health and disability insurance ~~or under any partially or wholly uninsured health and disability plan, including a plan that is subject to 29 USC 1001 to 1461~~.

SECTION 8. 632.755 (1) of the statutes is repealed.

SECTION 9. 632.755 (1g) of the statutes is amended to read:

632.755 **(1g)** (a) A disability insurance policy ~~or disability plan~~ may not exclude a person or a person's dependent from coverage because the person or the dependent is eligible for assistance under ch. 49.

(b) A disability insurance policy ~~or disability plan~~ may not terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for assistance under ch. 49.

(c) A disability insurance policy ~~or disability plan~~ may not provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for assistance under ch. 49 than it provides to persons and their dependents who are not eligible for assistance under ch. 49.

SECTION 10. 632.755 (1m) of the statutes is repealed.

SECTION 11. 632.755 (2) of the statutes is amended to read:

632.755 **(2)** Benefits provided by a disability insurance policy ~~or disability plan~~ shall be primary to those benefits provided under ch. 49. ~~Benefits provided by a federally regulated disability plan shall be primary to those benefits provided under ss. 49.45 to 49.47.~~

SECTION 12. 655.001 (1), (6), (9) and (10m) of the statutes are created to read:

655.001 **(1)** "Board of governors" means the board created under s. 619.04 (3).

(6) "Fiscal year" means the period beginning on July 1 and ending on the following June 30.

(9) "Nurse anesthetist" means a nurse licensed under ch. 441 who is certified as a nurse anesthetist by the American association of nurse anesthetists.

(10m) "Physician" means a medical or osteopathic physician licensed under ch. 448.

SECTION 13. 655.001 (8) and (11) of the statutes are repealed and recreated to read:

655.001 **(8)** "Health care provider" means a person to whom this chapter applies under s. 655.002 (1) or a person who elects to be subject to this chapter under s. 655.002 (2).

(11) "Principal place of practice" means any of the following:

(a) The state in which a health care provider furnishes health care services to more than 50% of his or her patients in a fiscal year.

(b) The state in which a health care provider derives more than 50% of his or her income in a fiscal year from the practice of his or her profession.

SECTION 14. 655.002 of the statutes is repealed and recreated to read:

655.002 Applicability. (1) MANDATORY PARTICIPATION. Except as provided in s. 655.003, this chapter applies to all of the following:

(a) A physician or a nurse anesthetist for whom this state is a principal place of practice and who practices his or her profession in this state more than 240 hours in a fiscal year.

(b) A physician or a nurse anesthetist for whom Michigan is a principal place of practice, if all of the following apply:

1. The physician or nurse anesthetist is a resident of this state.

2. The physician or nurse anesthetist practices his or her profession in this state or in Michigan or a combination of both more than 240 hours in a fiscal year.

3. The physician or nurse anesthetist performs more procedures in a Michigan hospital than in any other hospital. In this subdivision, "Michigan hospital" means a hospital located in Michigan that is an affiliate of a corporation organized under the laws of this state that maintains its principal office and a hospital in this state.

(c) A physician or nurse anesthetist who is exempt under s. 655.003 (1) or (3), but who practices his or her profession outside the scope of the exemption and who fulfills the requirements under par. (a) in relation to that practice outside the scope of the exemption. For a physician or a nurse anesthetist who is subject to this chapter under this paragraph, this chapter applies only to claims arising out of practice that is outside the scope of the exemption under s. 655.003 (1) or (3).

(d) A partnership comprised of physicians or nurse anesthetists and organized and operated in this state for

the primary purpose of providing the medical services of physicians or nurse anesthetists.

(e) A corporation organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists.

(f) A cooperative sickness care association organized under ss. 185.981 to 185.985 that operates a nonprofit sickness care plan in this state and that directly provides services through salaried employes in its own facility.

(g) An ambulatory surgery center that operates in this state.

(h) A hospital, as defined in s. 50.33 (2) (a) and (c), that operates in this state.

(i) An entity operated in this state that is an affiliate of a hospital and that provides diagnosis or treatment of, or care for, patients of the hospital.

(j) A nursing home, as defined in s. 50.01 (3), whose operations are combined as a single entity with a hospital described in par. (h), whether or not the nursing home operations are physically separate from the hospital operations.

(2) OPTIONAL PARTICIPATION. All of the following may elect, in the manner designated by the commissioner by rule under s. 655.004, to be subject to this chapter:

(a) A physician or nurse anesthetist for whom this state is a principal place of practice but who practices his or her profession fewer than 241 hours in a fiscal year, for a fiscal year, or a portion of a fiscal year, during which he or she practices his or her profession.

(b) Except as provided in sub. (1) (b), a physician or nurse anesthetist for whom this state is not a principal place of practice, for a fiscal year, or a portion of a fiscal year, during which he or she practices his or her profession in this state. For a health care provider who elects to be subject to this chapter under this paragraph, this chapter applies only to claims arising out of practice that is in this state and that is outside the scope of an exemption under s. 655.003 (1) or (3).

SECTION 15. 655.003 (intro.), (1) and (3) of the statutes are amended to read:

655.003 (title) **Exemptions for public employes and facilities and volunteers.** (intro.) ~~This~~ Except as provided in s. 655.002 (1) (c), this chapter does not apply to a health care provider that is any of the following:

(1) A physician or a nurse anesthetist who is a state, county or municipal employe, or federal employe or contractor covered under the federal tort claims act, as amended, and who is acting within the scope of his or her employment or contractual duties.

(3) A ~~medical or osteopathic~~ physician ~~licensed under ch. 448~~ or a nurse anesthetist ~~licensed under ch. 441,~~ who provides professional services under the conditions described in s. 146.89, with respect to those professional services provided by the physician or nurse anesthetist for which he or she is covered by s. 165.25 and considered an agent of the department, as provided in s. 165.25 (6) (b).

SECTION 16. 655.005 (2) of the statutes is amended to read:

655.005 **(2)** 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. This subsection does not apply to an employe of a health care provider if the employe is a ~~medical or osteopathic~~ physician ~~licensed under ch. 448~~ or a nurse anesthetist ~~licensed under ch. 441~~.

SECTION 17. 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 June 14, 1986, 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 18. 655.019 of the statutes is amended to read:

655.019 Information needed to set fees. The department shall provide the director of state courts, 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 19. 655.23 (1) of the statutes is repealed.

SECTION 20. 655.23 (2) of the statutes is renumbered 655.23 (8).

SECTION 21. 655.23 (3) (a) and (b) of the statutes are amended to read:

655.23 **(3)** (a) Except as provided in par. (d), every health care provider ~~permanently practicing or operating in this state~~ either shall insure and keep insured the health care provider's liability by a policy of health care liability insurance issued by an insurer authorized to do business in this state or shall qualify as a self–insurer. Qualification as a self–insurer is subject to conditions established by the commissioner and is valid only when approved by the commissioner.

(b) Each insurance company issuing health care liability insurance that meets the requirements of sub. (4) to any health care provider ~~permanently practicing or operating in this state~~ shall, at the times prescribed by the commissioner, file with the commissioner in a form prescribed by the commissioner a certificate of insurance on

behalf of the health care provider upon original issuance and each renewal.

SECTION 22. 655.23 (5m) to (7) of the statutes are amended to read:

655.23 **(5m)** The limits set forth in sub. (4) shall apply to any joint liability of a physician or nurse anesthetist and his or her corporation or partnership under s. ~~655.001 (8)~~ 655.002 (1) (d) or (e).

(6) Any person who violates this section or s. 655.27 (3) (a) is subject to s. 601.64. For purposes of s. 601.64 (3) (c), each week of delay in compliance with this section or s. 655.27 (3) (a) constitutes a new violation.

(7) ~~Health care providers permanently practicing or operating in this state~~ Each health care provider shall comply with this section and with s. 655.27 (3) (a) before exercising any rights or privileges conferred by ~~their~~ his or her health care ~~providers' licenses~~ provider's license. The commissioner shall notify the ~~examining board or agency issuing~~ board that issued the license of ~~each~~ a health care provider ~~who~~ that has not complied with this section or with s. 655.27 (3) (a). The ~~examining board or agency issuing~~ board that issued the license may suspend, or refuse to issue or to renew the license of any health care provider violating this section or s. 655.27 (3) (a).

SECTION 23. 655.24 (1m) of the statutes is created to read:

655.24 **(1m)** Notwithstanding sub. (1), the issuance of a policy of health care liability insurance by an insurer to a health care provider constitutes, on the part of the insurer, a conclusive and unqualified acceptance of all of the provisions of this chapter, and an agreement by it to be bound under the provisions of this chapter as to any policy issued by it to a health care provider.

SECTION 24. 655.26 (1) (intro.) and (2) of the statutes are amended to read:

655.26 **(1)** (intro.) ~~Beginning on February 15, 1986, and thereafter, in~~ In addition to any information required by the commissioner under s. 601.42, by the 15th day of each month, each insurer that writes ~~medical malpractice~~ health care liability insurance in this state and each self–insurer approved under s. 655.23 (3) (a) shall report the following information to the medical examining board and the board of governors ~~for the fund established under s. 619.04 (3)~~ on each claim paid during the previous month for damages arising out of the rendering of health care services:

(2) ~~Beginning on February 15, 1986, and thereafter, by~~ By the 15th day of each month, the board of governors ~~for the fund~~ shall report the information specified in sub. (1) to the medical examining board for each claim paid by the fund during the previous month for damages arising out of the rendering of health care services by a health care provider or an employe of a health care provider.

SECTION 25. 655.27 (1) and (2) of the statutes are 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 limits expressed in s. 655.23 (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 claims against 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~~ that have complied with this chapter, and against employes of those health care providers, and for 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.

(2) FUND ADMINISTRATION AND OPERATION. Management of the fund shall be vested with the board of governors ~~under s. 619.04 (3)~~. The commissioner shall either provide staff services necessary for the operation of the fund or, with the approval of the board of governors, contract for all or part of these services. Such a contract is subject to s. 16.765, but is otherwise exempt from subch. IV of ch. 16. The commissioner shall adopt rules governing the procedures for creating and implementing these contracts before entering into the contracts. At least annually, the contractor shall report to the commissioner and to the board of governors regarding all expenses incurred and subcontracting arrangements. If the board of governors approves, the contractor may hire legal counsel as needed to provide staff services. The cost of contracting for staff services shall be funded from the appropriation under s. 20.145 (2) (u).

SECTION 26. 655.27 (3) (a) (intro.) of the statutes is amended to read:

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

SECTION 27. 655.27 (3) (am) of the statutes is amended 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~~ health care liability 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 28. 655.27 (3) (b) 2. of the statutes is amended 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.

SECTION 29. 655.27 (3) (b) 2m of the statutes is amended to read:

655.27 **(3)** (b) 2m. In addition to the fees and payment classifications described under subds. 1 and 2, the commissioner, after approval by the board of governors, may by rule establish a separate payment classification for ~~medical and osteopathic~~ physicians satisfying s. 655.002 (1) (b) and a separate fee for nurse anesthetists satisfying s. 655.002 (1) (b) which ~~takes~~ take into account the loss experience of health care providers ~~practicing in~~ for whom Michigan is a principal place of practice.

SECTION 30. 655.27 (5) (a) of the statutes is 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~~ or an employe of a health care provider. A person filing a claim may ~~only~~ recover from the fund only if the health care provider or the employe of the health care provider has coverage under the fund and the fund is named as a party in the ~~controversy~~ action.

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~~ or an employe of a health care provider. A person filing an action may ~~only~~ recover from the fund only if the health care provider or the employe of the health care provider has coverage under the fund and the fund is named as a party in the action ~~or, if~~. If the rules of procedure of the jurisdiction in which the action is brought do not permit ~~including~~ naming the fund as a party, ~~if~~ the person filing the action may recover from the fund only if the health care provider or the employe of the health care provider has coverage under the fund and the fund is notified of the action within 60 days of service of process on the health care provider or the employe of 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 the limits in s. 655.23 (4), the fund may appear and actively defend itself when named as a party in ~~the controversy~~ an action against a health care provider, or an employe of a health care provider, that has coverage under the fund. 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.

SECTION 31. 655.27 (5) (d) of the statutes is amended to read:

655.27 **(5)** (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~~, or an employe of a health care provider, that has coverage under 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 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 June 14, 1986, 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 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 32. 655.275 (2) and (5) (a) of the statutes are amended to read:

655.275 **(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.

(5) (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, a private ~~medical malpractice~~ health care liability insurer or a self–insurer 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~~ health care liability insurer regarding adjustments to premiums assessed against a physician covered by private insurance, based on the paid claim, if requested by the private insurer.

SECTION 33. 655.61 (1) of the statutes is amended to read:

655.61 **(1)** The mediation fund created under s. 655.68 shall be financed from fees charged to health care providers. The director of state courts 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 director of state courts shall also inform the board of governors of the number of requests for mediation involving each type of health care provider set out in s. 655.002 for the most recent fiscal year for which statistics are available. The board of governors shall, by rule, set fees to charge health care providers at a level sufficient to provide ~~these revenues. The board of governors 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~~ the necessary revenue.

SECTION 34. 655.61 (1m) of the statutes is created to read:

655.61 **(1m)** Notwithstanding sub. (1), the board of governors may exempt any type of health care provider set out in s. 655.002 from payment of the annual fee based on a low number of requests for mediation involving that type of health care provider.

SECTION 35. 655.68 (1) (title), (2), (3) and (4) of the statutes are amended to read:

655.68 **(1)** (title) CREATION.

(2) (title) ADMINISTRATION AND OPERATION. Management of the mediation fund is vested with the director of state courts.

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

(4) (title) ACCOUNTING AND FINANCIAL REPORTS. (a) Any person authorized to receive deposits, withdraw moneys, issue vouchers or otherwise disburse mediation fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect mediation fund assets. The cost of the bond shall be paid from the mediation fund.

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

(c) On or before March 1 annually, the director of state courts shall submit a report on the operation of the mediation system and on the status of the mediation fund to the chief clerk of each house of the legislature, for distribution to the appropriate standing committees under s. 13.172 (3).

SECTION 9400. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 619.04 (1), 655.001 (1), (6), (8), (9), (10m) and (11), 655.002, 655.003 (intro.), (1) and (3), 655.005 (2), 655.015, 655.019, 655.23 (1), (2), (3) (a) and (b) and (5m) to (7), 655.24 (1m), 655.26 (1) (intro.) and (2), 655.27 (1), (2), (3) (a) (intro.), (am) and (b) 2. and 2m and (5) (a) and (d), 655.275 (2) and (5) (a), 655.61 (1) and (1m) and 655.68 (1) (title), (2), (3) and (4) of the statutes takes effect on July 1, 1992.