Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

Chapter Ins 17

HEALTH CARE LIABILITY INSURANCE PATIENTS COMPENSATION FUND

Ins 17.001 Definitions.
Ins 17.005 Purpose.
Ins 17.01 Payment of mediation fund fees.
Ins 17.24 Review of classification.
Ins 17.25 Wisconsin health care liability insurance plan.
Ins 17.26 Payments for future medical expenses.
Ins 17.27 Filing of financial report.
Ins 17.275 Claims information; confidentiality.
Ins 17.28 Health care provider fees.
Ins 17.285 Peer review council.
Ins 17.29 Servicing agent.
Ins 17.30 Peer review council assessments.
Ins 17.35 Primary coverage; requirements; permissible exclusions; deductibles.
Ins 17.40 Notice to fund of filing of action outside this state.
Ins 17.50 Self-insured plans for health care providers.

Note: Corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, June, 1997, No. 498.

Ins 17.001 Definitions. In this chapter:

(1) "Board" means the board of governors established under s. 619.04 (3), Stats.

(1m) "Commissioner" means the commissioner of insurance or deputy commissioner acting under s. 601.11 (1) (b), Stats.

(2) "Fund" means the patients compensation fund established under s. 655.27 (1), Stats.

(3) "Hearing" means a contested case, as defined in s. 227.01 (3), Stats.

(4) "Plan" means the Wisconsin health care liability insurance plan, a nonprofit, unincorporated association established under s. 619.01 (1) (a), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) to (4), cr. (1m), Register, June, 1990, No. 414, eff. 7-1-90; r. and recr. (3), Register, March, 1996, No. 483, eff. 4-1-96.

Ins 17.005 Purpose. This chapter implements ss. 619.01 and 619.04, Stats., and ch. 655, Stats.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.01 Payment of mediation fund fees. (1) PURPOSE. This section implements s. 655.61, Stats., relating to the payment of mediation fund fees.

(2) FEE. (a) Each physician subject to ch. 655, Stats., except a resident, and each hospital subject to ch. 655, Stats., shall pay to the commissioner an annual fee to finance the mediation system created by s. 655.42, Stats.

(b) The fund shall bill a physician or hospital subject to this section under s. Ins 17.28 (4). The entire annual fee under this section is due and payable 30 days after the fund mails the bill.

(d) The fund shall notify the medical examining board of each physician who has not paid the fee as required under par. (b).

(e) The fund shall notify the department of health services of each hospital which has not paid the fee as required under par. (b).

(f) Fees collected under this section are not refundable except to correct an administrative billing error.

(3) FEE SCHEDULE. The following fee schedule shall be effective July 1, 2013:

(a) For physicians — $0.

(b) For hospitals, per occupied bed — $0.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; emerg. r. and recr. eff. 7-2-86; r. and recr., Register, September, 1986, No. 369, eff. 10-1-86; cr. (2) (f), am. (3), Register, June, 1987, No. 378, eff. 7-1-87; am. (1), (2) (a), (d) and (e), (3), r. and recr. (2) (b), r. (2) (c), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (3), eff. 7-1-91; am. (3) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (3) (a) and (b), Register, October, 1991, No. 430, eff. 11-1-91; emerg. am. (3), eff. 4-28-92; am. (3), Register, July, 1992, No. 439, eff. 8-1-92; emerg. am. (1), (3) (intro.), (a), eff. 7-22-93; am. (1) (3) (intro.), (a), Register, September, 1993, No. 453, eff. 10-1-93; am. (3) (intro.), Register, June, 1994, No. 462, eff. 7-1-94; emerg. am. (3) (intro.) and (a), eff. 6-14-95; am. (3) (intro.) and (a), Register, December, 1995, No. 480, eff. 1-1-96; emerg. am. (3) (intro.), eff. 5-28-96; am. (3) (intro.), Register, September, 1996, No. 489, eff. 10-1-96; emerg. am. (3) (intro.), eff. 8-12-97; am. (3) (intro.), Register, November, 1997, No. 503, eff. 12-1-97; emerg. am. (intro.), (a) and (b), eff. 6-1-98; emerg. am. (3), eff. 6-1-98; emerg. am. (3), eff. 6-19-98; am. (3), Register, August, 1998, No. 512, eff. 9-1-98; emerg. am. (3) (intro.), eff. 7-1-99; am. (3) (intro.), Register, September, 1999, No. 535, eff. 10-1-99; emerg. am. (3), eff. 7-1-00; am. (3), Register, August, 2000, No. 536, eff. 9-1-00; emerg. am. (3), eff. 7-1-01; CR 01-035: am. (3) (intro.), Register September 2001 No. 549, eff. 10-1-01; emerg. am. (3), eff. 7-1-02; CR 02-035: am. (3), Register September 2002 No. 561, eff. 10-1-02; CR 03-039: am. (3) Register October 2003 No. 574, eff. 11-1-03; CR 04-032: am. (3) Register January 2005 No. 589, eff. 2-1-05; emerg. am. (3), eff. 7-1-05; CR 05-028: am. (3) Register October 2005 No. 598, eff. 11-1-05; CR 06-002: am. (3) Register June 2006 No. 606, eff. 7-1-06; CR 07-002: am. (3), Register June 2007 No. 618, eff. 7-1-07; CR 08-006: am. (3) Register June 2008 No. 630, eff. 7-1-08; CR 09-004: am. (3) Register June 2009 No. 642, eff. 7-1-09; correction in (2) (e) made under s. 13.92 (4) (b) 6., Stats., Register June 2009 No. 642; EmR1020: emerg. am. (3), eff. 6-15-10; CR 10-065: am. (3) Register November 2010 No. 659, eff. 12-1-10; EmR1108: emerg. am. (3), eff. 6-10-11; CR 11-015: am. (3) Register August 2011 No. 668, eff. 9-1-11; EmR1306: emerg. am. (3), eff. 6-3-13; CR 13-044: am. (3) Register June 2014 No. 702, eff. 7-1-14.

Ins 17.24 Review of classification. (1) Any person insured by the plan or covered by the fund may petition the board for a review of its classification by the plan or fund. The petition shall state the basis for the petitioner's belief that its classification is incorrect. The board shall refer a petition for review to either of the following:

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

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

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

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

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

(4) At the hearing held pursuant to a petition under sub. (3), the committee report shall be considered and the members of the committee may appear and be heard.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (1) and (2), cr. (2m), am. (3) and (4), Register, June, 1990, No. 414, eff. 7-1-90.

Published under s. 35.93, Stats. Updated on the first day of each month. Entire code is always current. The Register date on each page is the date the chapter was last published.

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or to call upon the insurance industry to prepare plans for the commissioner's approval.

(b) Health care liability insurance, liability coverage normally incidental to health care liability insurance or both are not readily available in the voluntary market for the persons specified in sub. (5) (a).

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

(2) PURPOSE. This section implements ss. 619.01 and 619.04, Stats., by establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage and liability coverage normally incidental to health care liability insurance on a self-supporting basis for the persons specified in sub. (5) (a) and for their employees acting within the scope of their employment and providing health care services. This section is also intended to encourage improvement in reasonable loss prevention measures and to encourage the maximum use of the voluntary market.

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

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

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

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

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

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

1. Criminal acts.

2. Intentional sexual acts and other intentional torts.

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

4. Defamation.

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

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

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

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

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

10. Punitive and exemplary damages.

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

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

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

(d) The maximum limits of liability for coverage under par. (a) are the following:

1. For all occurrences before July 1, 1987, $200,000 for each occurrence and $600,000 per year for all occurrences in any one policy year.

2. For occurrences on or after July 1, 1987, and before July 1, 1988, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year.

3. Except as provided in subds. 4. and 5., for occurrences on or after July 1, 1988, and before July 1, 1997, $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year.

4. Except as provided in subd. 5., for occurrences on or after July 1, 1997, $1,000,000 for each occurrence and $3,000,000 for all occurrences in any one policy year.

5. For podiatrists licensed under ch. 448, Stats., for occurrences on and after November 1, 1989, $1,000,000 for each occurrence and $1,000,000 for all occurrences in any one policy year.

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

1. Owners, landlords and tenants liability insurance.

2. Owners and contractors protective liability insurance.

3. Completed operations and products liability insurance.

4. Contractual liability insurance.

5. Personal injury liability insurance.

(f) The maximum limits of liability for coverage under par. (e) are $1,000,000 per claim and $3,000,000 aggregate for all claims in any one policy year.

(5) ELIGIBILITY FOR PLAN COVERAGE. All of the following are eligible for insurance under the plan:

(a) A medical or osteopathic physician or podiatrist licensed under ch. 448, Stats.

(b) A nurse anesthetist or nurse midwife licensed under ch. 441, Stats.

(c) A nurse practitioner licensed under ch. 441, Stats., who meets at least one of the requirements specified under s. DHS 105.20 (1).

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

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

(f) An operational cooperative sickness care plan organized under ss. 185.981 to 185.985, Stats., which directly provides services through salaried employees in its own facility.

(g) An accredited teaching facility conducting approved training programs for medical or osteopathic physicians licensed or to be licensed under ch. 448, Stats., or for nurses licensed or to be licensed under ch. 441, Stats.

(h) A hospital, as defined in s. 50.33 (2) (a) and (c), Stats., but excluding facilities exempted by s. 50.39 (3), Stats., except as provided in par. (k).

(i) An entity operated in this state that is an affiliate of a hos-

pital 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), Stats., whose operations are combined as a single entity with a hospital, whether or not the nursing home operations are physically separate from the hospital operations.

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

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

(m) A cardiovascular perfusionist.

(n) An ambulatory surgery center, as defined in s. DHS 101.03 (10).

(6) DEFINITIONS. (a) In this subsection:

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

2. "Premiums written" means gross direct premiums less return premiums, dividends paid or credited to policyholders and the unused or unabsorbed portions of premium deposits, with respect to personal injury liability insurance covering insureds or risks residing or located in this state.

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

2. An insurer's membership in the plan terminates if the insurer is no longer authorized to write personal injury liability insurance in this state. The effective date of termination shall be the last day of the plan's current fiscal year. A terminated insurer shall continue to be governed by this subsection until it completes all of its obligations under the plan.

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

(c) If the funds available to the plan at any time are not sufficient for the sound financial operation of the plan, the board shall assess the members an amount sufficient to remedy the insufficiency. Each member shall contribute according to the proportion that that member's premiums written during the preceding calendar year bears to the aggregate premiums written by all members during the preceding calendar year. The amounts of premiums written shall be determined on the basis of the annual statements and other reports filed by the members with the commissioner. Assessments are subject to any credit plan developed under sub. (8) (a) 4. When the amount of the assessment is recouped under s. 619.01 (1) (c) 2., Stats., each member shall be reimbursed the amount of that member's assessment.

(d) The board shall report to the commissioner the name of any member that fails to pay within 30 days any assessment levied under par. (c).

(7) BOARD MEETINGS; QUORUM. The board shall meet as often as required to perform the general duties of supervising the administration of the plan, or at the call of the commissioner. Seven members of the board shall constitute a quorum.

(8) POWERS AND DUTIES OF THE BOARD. The board may do any of the following:

(a) 1. Invest, borrow and disburse funds, budget expenses, levy assessments and cede and assume reinsurance.

2. Appoint a manager or one or more agents to perform the duties designated by the board.

3. Appoint advisory committees of interested persons, not limited to members of the plan, to advise the board in the fulfillment of its duties and functions.

4. Develop an assessment credit plan subject to the approval of the commissioner, by which a member of the plan receives a credit against an assessment levied under sub. (6) (c), based on voluntarily written health care liability insurance premiums in this state.

5. Take any action consistent with law to provide the appropriate examining boards or the department of health services with appropriate claims information.

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

(b) The board shall do all of the following:

1. Develop rates, rating plans, rating and underwriting rules, rate classifications, rate territories and policy forms for the plan.

2. Ensure that all policies written by the plan are separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium level for each classification of risk, and performing loss prevention and other studies of the operation of the plan.

3. Subject to the approval of the commissioner, determine the eligibility of an insurer to act as a servicing company to issue and service the plan's policies. If no qualified insurer elects to be a servicing company, the board shall assume these duties on behalf of member companies.

4. Enter into agreements and contracts as necessary for the execution of this section.

5. By May 1 of each year, report to the members of the plan and to the standing committees on insurance in each house of the legislature summarizing the activities of the plan in the preceding calendar year.

(10) APPLICATION FOR INSURANCE. (a) Any person specified in sub. (5) may submit an application for insurance by the plan directly or through any licensed agent. Each application shall request coverage for the applicant's partnership or corporation, if any, and for the applicant's employees acting within the scope of their employment and providing health care services, unless the partnership, corporation or employees are covered by other professional liability insurance.

(b) The plan may bind coverage.

(c) Within 8 business days after receiving an application, the plan shall notify the applicant whether the application is accepted, rejected or held pending further investigation. Any applicant rejected by the plan may appeal the decision to the board as provided in sub. (16).

(cm) The board may authorize retroactive coverage by the plan for a health care provider, as defined in s. 655.001 (8), Stats., if the provider submits a timely request for retroactive coverage showing that the failure to procure coverage occurred through no fault of the provider and despite the fact that the provider acted reasonably and in good faith. The provider shall furnish the board with an affidavit describing the necessity for the retroactive coverage and stating that the provider has no notice of any pending claim alleging malpractice or knowledge of

a threatened claim or of any occurrence that might give rise to such a claim.

(d) If the application is accepted, the plan shall deliver a policy to the applicant upon payment of the premium.

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

2. Rates shall be calculated in accordance with generally accepted actuarial principles, using the best available data.

3. Rates shall be calculated on a basis which will make the plan self-supporting but may not be excessive. Rates shall be presumed excessive if they produce long-term excess funds over the total of the plan's unpaid losses, including reserves for losses incurred but not yet reported, unpaid loss adjustment expenses, additions to the surplus established under s. 619.01 (1) (c) 2., Stats., and s. Ins 51.80 (3) and (4), the premium assessment under s. 619.01 (8m), Stats., and other expenses.

4. The board shall annually determine if the plan has accumulated excess funds as described under subd. 3. and, if so, the board shall return the excess funds to the insureds by means of refunds or prospective rate decreases according to a distribution method and formula established by the board.

5. a. In establishing the plan's rates, the board shall use loss and expense experience in this state to the extent it is statistically credible supplemented by relevant data from outside this state including, but not limited to, data provided by other insurance companies, rate service organizations or governmental agencies.

b. The board shall annually review the plan's rates using the experience of the plan, supplemented first by the experience of coverage provided in this state by other insurers and, to the extent necessary for statistical credibility, by relevant data from outside this state.

6. The loss and expense experience used in establishing and revising rates shall be adjusted to indicate as nearly as possible the loss and expense experience which will emerge on policies issued by the plan during the period for which the rates were being established. For this purpose loss experience shall include paid and unpaid losses, a provision for incurred but not reported losses and both allocated and unallocated loss adjustment expenses, giving consideration to changes in estimated costs of unpaid claims and to indications of trends in claim frequency, claim severity and level of loss expense.

7. Expense provisions included in the plan's rates shall reflect reasonable prospective operating costs of the plan.

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

1. Measure variations in exposure to loss and in expenses based upon the best data available.

2. Reflect the past and prospective loss and expense experience of risks insured in the plan and other relevant experience from this and other states.

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

(12m) PREMIUM SURCHARGE TABLES. (a) This subsection implements s. 619.04 (5m) (a), Stats., requiring the establishment of an automatic increase in a provider's plan premium based on loss and expense experience.

(b) In this subsection:

1. "Aggregate indemnity" has the meaning given under s. Ins 17.285 (2) (a).

2. "Closed claim" has the meaning given under s. Ins 17.285 (2) (b).

3. "Provider" has the meaning given under s. Ins 17.285 (2) (d).

4. "Review period" has the meaning given under s. Ins 17.285 (2) (e).

(c) The following tables shall be used in making the determinations required under s. Ins 17.285 as to the percentage increase in a provider's plan premium:

1. For a class 1 and class 8 physician, podiatrist, nurse anesthetist, nurse midwife, nurse practitioner or cardiovascular perfusionist:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $ 118,000	0%	0%	0%	0%
$118,001 to $ 585,000	0%	10%	25%	50%
$585,001 to $1,571,000	0%	25%	50%	100%
Greater Than $1,571,000	0%	50%	100%	200%

2. For a class 2 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $ 193,000	0%	0%	0%	0%
$193,001 to $ 779,000	0%	10%	25%	50%
$779,001 to $1,836,000	0%	25%	50%	100%
Greater Than $1,836,000	0%	50%	100%	200%

3. For a class 3 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $ 211,000	0%	0%	0%	0%
$211,001 to $ 852,000	0%	10%	25%	50%
$852,001 to $2,215,000	0%	25%	50%	100%
Greater Than $2,215,000	0%	50%	100%	200%

4. For a class 4 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $ 302,000	0%	0%	0%	0%
$302,001 to $1,012,000	0%	10%	25%	50%
$1,012,001 to $2,886,000	0%	25%	50%	100%
Greater Than $2,886,000	0%	50%	100%	200%

5. For a class 5A physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $ 244,000	0%	0%	0%	0%
$244,001 to $ 892,000	0%	10%	25%	50%
$892,001 to $2,328,000	0%	25%	50%	100%
Greater Than $2,328,000	0%	50%	100%	200%

6. For a class 5 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $ 676,000	0%	0%	0%	0%	0%
$676,001 to $1,033,000	0%	0%	10%	25%	50%
$1,033,001 to $1,769,000	0%	0%	25%	50%	75%
$1,769,001 to $3,923,000	0%	0%	50%	75%	100%
Greater Than $3,923,000	0%	0%	75%	100%	200%

7. For a class 6 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $ 731,000	0%	0%	0%	0%	0%
$731,001 to $1,163,000	0%	0%	10%	25%	50%
$1,163,001 to $1,982,000	0%	0%	25%	50%	75%
$1,982,001 to $4,215,000	0%	0%	50%	75%	100%
Greater Than $4,215,000	0%	0%	75%	100%	200%

8. For a class 7 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $ 804,000	0%	0%	0%	0%	0%
$804,001 to $1,292,000	0%	0%	10%	25%	50%
$1,292,001 to $2,194,000	0%	0%	25%	50%	75%
$2,194,001 to $4,482,000	0%	0%	50%	75%	100%
Greater Than $4,482,000	0%	0%	75%	100%	200%

9. For a class 9 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $1,861,000	0%	0%	0%	0%	0%
$1,861,001 to $2,616,000	0%	0%	10%	25%	50%
$2,616,001 to $4,467,000	0%	0%	25%	50%	75%
$4,467,001 to $10,294,000	0%	0%	50%	75%	100%
Greater Than $10,294,000	0%	0%	75%	100%	200%

(14) PLAN BUSINESS; CANCELLATION AND NONRENEWAL. (a) The plan may not cancel or refuse to renew a policy except for one or more of the following reasons:

1. Nonpayment of premium.

2. Revocation of the license of the insured by the appropriate licensing board.

3. Revocation of accreditation, registration, certification or other approval issued to the insured by a state or federal agency or national board, association or organization.

4. If the insured is not licensed, accredited, registered, certified or otherwise approved, failure to provide evidence that the insured continues to provide health care services in accordance with the code of ethics applicable to the insured's profession, if the board requests such evidence.

(b) Each notice of cancellation or nonrenewal under par. (a) shall include a statement of the reason for the cancellation or nonrenewal and a conspicuous statement that the insured has the right to a hearing as provided in sub. (16).

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

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

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

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

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

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

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

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

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

3. A member of the plan.

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

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

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

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

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

History: Emerg. cr. eff. 3-20-75; cr. Register, June, 1975, No. 234, eff. 7-1-75; emerg. am. eff. 7-28-75; emerg. r. and recr. eff. 11-1-75; r. and recr. Register, January, 1976, No. 241, eff. 2-1-76; am. (1) (b), (2), (4) (c), and (5) (a), Register, May, 1976, No. 245, eff. 6-1-76; emerg. am. (4) (b), eff. 6-22-76; am. (1) (b), (2), (4) (b) and (c) and (5) (a), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) (b), (2), (4) (c), (5) (a), (5) (f), (10) (a) and (15), cr. (4) (h), Register, May, 1977, No. 257, eff. 6-1-77; am. (1) (b), (2), (4) (c), (5) (a), (10) (a) and (15), Register, September, 1977, No. 261, eff. 10-1-77; am. (1) (b), (2), (4) (b) and (c), (5) (a) and (f), and (15), Register, May, 1978, No. 269, eff. 6-1-78; am. (7) (b) 1.a., Register, March, 1979, No. 279, eff. 4-1-79; renum. from. Ins 3.35, am. (1) (b), (2), (5) (a) and (10) (a), Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (5) (a), Register, April, 1980, No. 292, eff. 5-1-80; am. (1) (b), (2), (4) (c), (5) (a), (10) (a), (12) (a) 3. and 4. and (15), r. (12) (a) 11. renum. (12) (a) 5. through 10. and 12. to be 7. through 12. and 13., cr. (12) (a) 5. and 6., Register, May, 1985, No. 353, eff. 6-1-85; emerg. am. (1) (b), (2), (4) (c) and (5) (a) 2., eff. 7-29-86; am. (1) (b), (2), (4) (c) and (5) (a) 2., Register, January, 1987, No. 373, eff. 2-1-87; emerg. am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), cr. (5) (a) 11., (7m) and (14) (a) 3. and 4., renum. (5) (a) 11., (b) and (7) (b) 1. intro. to be (5) (am), (b) (intro.) and (7) (b) and am., r. (7) (b) 1. a. and b. eff. 2-16-87; am. (1) (b), (2), (4) (c), (5) (a) 3., 4. and 7., (7) (b) 2., 3. and 5., (10) (a), (12) (intro.), (14) (a) (intro.) and 1. and (15), renum. (5) (a) 11., (b) and (7) (b) 1. to be (5) (am), (b) (intro.) and (7) (b) 1. and am., cr. (5) (a) 7m and 11., (b) 1. to 3., (7) (b) 2m. and (14) (a) 3. and 4., r. (7) (b) 1. a. and b., Register, July, 1987, No. 379, eff. 8-1-87; r. (12) (a) 13. and (b) 5., cr. (5) (a) 2m. and (12m), am. (16), Register, February, 1988, No. 386, eff. 3-1-88; r. (4) (g) and (9) (b), renum. (9) (a) to be (9), Register, March, 1988, No. 387, eff. 4-1-88; cr. (10) (cm), Register, April, 1989, No. 400, eff. 5-1-89; emerg. am. (5) (b) 3., cr. (5) (b) 4., eff. 10-16-89; am. (5) (b) 3., cr. (5) (b) 4., Register, March, 1990, No. 411, eff. 4-1-90; am. (1) (a) and (c), (2), (10) (a), (b), (c) and (d), (12) (a) 2. and 3., (14) (a) (intro.) and 4., (b), r. (3), (4) (a), (c), (d), (f) and (h), (5) (am), (d), (e) and (f), (6) (a), (7), (8) (j), (11) (a), (12) (intro.), (a) 4. to 6. intro., b. and c. and 7., (b), (c) 1., 3. and 6., (12m) (c) and (13), r. and recr. (12) (a) 1., (15), (16) and (18), renum. (4) (b) and (e), (5) (a) (intro.) to 11., (5) (b) and (c), (6) (b) and (c), (8) (a) to (i), (9), (11) (b), (12) (a) 6., 8., to 12., (12) (b) 2. and 4. and (17) to be (6) (a) 1. and 2., (5) (intro.) to (m), (3) (d) and (f), (6) (b) 2. and 3., (7), (8) (a), (b) 1. to 4., (8) (a) 3. to 5., (8) (b) 5., (6) (c), (12) (a) 4. to 6., (12) (a) 5. b., (12) (c), (12) (a) 7., (12) (b) 1. and 2., and (6) (d) and am. except (3) (d) 1. to 4., cr. (3) (a) to (c) and (e), (5) (n), (6) (a) (intro.) and (b) 1., (8) (a) (intro.) and 6., (b) (intro.), (12) (b) (intro.) and (19), Register, June, 1990, No. 414, eff. 7-1-90; am. (10) (cm), Register, April, 1991, No. 424, eff. 5-1-91; am. (12m) (c) (intro.), Register, January, 1992, No. 433, eff. 2-1-92; correction in (5) (c) and (n) made under s. 13.93 (2m) (b) 7., Stats., Register, January, 1997, No. 498; correction in (12) (a) 3. made under s. 13.93 (2m) (b) 7., Stats., Register, September, 1999, No. 525; emerg. am. (3) (d) 3., renum. (3) (d) 4. to be 5. and cr. (3) (d) 4., eff. 7-1-02; CR 02-035: am. (3) (d) 3., renum. (3) (d) 4. to be (3) (d) 5., cr. (3) (d) 4., Register September 2002 No. 561, eff. 10-1-02; corrections in (5) (c) and (n) made under s. 13.93 (2m) (b) 7., Stats., Register October 2003 No. 574; CR 07-001: am. (12m), Register June 2007 No. 618, eff. 7-1-07; corrections in (5) (c), (n), and (8) (a) 5. made under s. 13.92 (4) (b) 6. and 7., Stats., Register June 2009 No. 642.

Note: See the table of Appellate Court Citations for Wisconsin appellate cases citing s. Ins 17.25.

Ins 17.26 Payments for future medical expenses.

(1) PURPOSE. This section implements s. 655.015, Stats.

(3) DEFINITIONS. In this section:

(a) "Account" means a portion of the fund allocated specifically for the medical expenses of an injured person.

(b) "Claimant" means the injured person, the individual legally responsible for the injured person's medical expenses or the injured person's legal representative.

(c) "Medical expenses" means charges for medical services, nursing services, medical supplies, drugs and rehabilitation services that are incurred after the date of a settlement, panel award or judgment.

(4) ADMINISTRATION. (a) If a settlement or judgment is subject to s. 655.015, Stats., the insurer or other person responsible for payment shall, within 30 days after the date of the settlement or judgment, pay the fund the amount in excess of $100,000 and shall provide the fund with an executed copy of the document setting forth the terms under which payments for medical expenses are to be made.

(b) The fund shall credit each account with a proportional share of any interest earned by the fund, based on the remaining value of the account at the time the investment board declares the interest earnings. The fund shall maintain an individual record of each account as provided in s. 16.41, Stats.

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

(d) 1. If the fund is not satisfied that a provider has actually been paid for services or supplies provided to an injured person, the fund may make payments jointly to the claimant and the provider.

2. A claimant may, in writing, authorize direct payment to a provider.

(e) The fund shall at least annually report to each claimant the status of the injured person's account, including the original amount, payments made since the last report and the balance remaining.

(f) If an injured person dies and there is a balance in his or her account, the balance shall revert to the insurer or other person responsible for establishing the account.

History: Cr. Register, November, 1976, No. 251, eff. 12-1-76; renum. from Ins 3.37, Register, July, 1979, No. 283, eff. 8-1-79; am. (3), r. (4) (b) and (f), renum. (4) (d), (e), (g) and (h) to be (4) (e) (b), (d) and (f) and am., Register, April, 1984, No. 340, eff. 5-1-84; am. (1), (3) (a) to (c) and (4), r. (2), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (4) (a), eff. 5-28-96; am. (4) (a), Register, September, 1996, No. 489, eff. 10-1-96.

Note: See the table of Appellate Court Citations for Wisconsin appellate cases citing s. Ins 17.26.

Ins 17.27 Filing of financial report. (1) PURPOSE. This section implements s. 655.27 (3) (b), (4) (d) and (5) (e), Stats., for the purpose of setting standards and techniques for accounting, valuing, reserving and reporting of data relating to the financial transactions of the fund.

(2) DEFINITIONS. In this section:

(a) "Amounts in the fund," as used in s. 655.27 (5) (e), Stats., means the sum of cash and invested assets as reported in a financial report under sub. (3).

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

(3) FINANCIAL REPORTS. The board shall furnish the commissioner with the financial report required by s. 655.27 (4) (d), Stats., within 60 days after the close of each fiscal year. In addition, the board shall furnish the commissioner with quarterly financial reports prepared as of September 30, December 31 and March 31 of each year within 60 days after the close of each reporting period. The board shall prescribe the format for preparing financial reports in accordance with statutory accounting principles for fire and casualty companies. Reserves for reported claims and reserves for incurred but not reported claims shall be maintained on a present value basis with the difference from full value being reported as a contra account to the loss reserve liability. Mediation fund fees collected under s. Ins 17.01 shall be indicated in the financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

(4) SELECTION OF ACTUARIES. The board shall select one or more actuaries to assist in determining reserves and setting fees under s. 655.27 (3) (b), Stats. If more than one actuary is selected, the board members named by the Wisconsin medical society and the Wisconsin hospital association shall jointly select the 2nd actuary.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80; am. (1), (2) (a) and (b) to (4), cr. (2) (intro.), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.275 Claims information; confidentiality. (1) PURPOSE. This section interprets ss. 19.35 (1) (a), 19.85 (1) (f), 146.82, 655.26 and 655.27 (4) (b), Stats.

(2) OPEN RECORDS; PRIVILEGED OR CONFIDENTIAL FUND RECORDS. Except as provided in s. 601.427 (7), Stats., records of the fund are subject to subch. II of ch. 19, Stats., and are open to inspection as required under subch. II of ch. 19, Stats. The fund may withhold and retain as confidential any record which may be withheld and retained as confidential under subch. II of ch. 19, Stats., including, but not limited to, a record which may be withheld or which is privileged under any law or the rules of evidence, as attorney work product under the rules of civil procedure, as attorney-client privileged material under s. 905.03, Stats., as a medical record under ss. 146.81 to 146.84, Stats., or as privileged under s. 601.465, Stats.

(3) DEFINITION. In this section, "confidential claims information" means any document or information relating to a claim against a plan-insured health care provider in the possession of the commissioner, the board or an agent thereof, including claims records of the plan.

(4) DISCLOSURE. Confidential claims information may be disclosed only as follows:

(a) To the medical examining board as provided under s. 655.26, Stats.

(b) As needed by the peer review council, consultants and the board under s. 655.275, Stats., and rules promulgated under that section.

(c) As provided under s. 804.01, Stats.

(d) To an individual, organization or agency required by law or designated by the commissioner or board to conduct a management or financial audit.

(e) With a written authorization from the plan-insured health care provider on whose behalf the claim was defended or paid.

(f) To the risk manager for the fund, as needed to perform the duties specified in its contract. The risk manager may not disclose confidential claims information to any 3rd party, unless the board expressly authorizes the disclosure. The board may authorize disclosure of patient health care records subject to ss. 146.81 to 146.84, Stats., only as provided in those sections.

History: Cr. Register, March, 1988, No. 387, eff. 4-1-88; cr. (3) (e), Register, June, 1990, No. 414, eff. 7-1-90; cr. (3) (f), Register, May, 1995, No. 473, eff. 6-1-95; am., Register, September, 1999, No. 525, eff. 10-1-99.

Note: See the table of Appellate Court Citations for Wisconsin appellate cases citing s. Ins 17.275.

Ins 17.28 Health care provider fees. (1) PURPOSE. This section implements s. 655.27 (3), Stats.

(2) SCOPE. This section applies to fees charged to providers for participation in the fund, but does not apply to fees charged for operation of the mediation system under s. 655.61, Stats.

(3) DEFINITIONS. In this section:

(a) "Annual fee" means the amount established under sub. (6) for each class or type of provider.

(b) "Begin operation" means for a provider other than a natural person to start providing health care services in this state.

(bm) "Begin practice" means to start practicing in this state as a medical or osteopathic physician or nurse anesthetist or to become ineligible for an exemption from ch. 655, Stats.

(c) "Class" means a group of physicians whose specialties or types of practice are similar in their degree of exposure to loss. The specialties and types of practice and the applicable Insurance Services Office, Inc., codes included in each fund class are the following:

1. Class 1:

Administrative Medicine	80120
Aerospace Medicine	80230
Allergy	80254
Allergy (D.O.)	84254
Cardiovascular Disease — no surgery or catheterization	80255
Cardiovascular Disease — no surgery or catheterization (D.O.)	84255
Dermatology — no surgery	80256
Dermatology — no surgery (D.O.)	84256
Diabetes — no surgery	80237
Endocrinology — no surgery	80238
Endocrinology — no surgery (D.O.)	84238
Family or General Practice — no surgery	80420
Family or General Practice — no surgery (D.O.)	84420
Forensic Medicine — Legal Medicine	80240
Forensic Medicine — Legal Medicine (D.O.)	84240
Gastroenterology — no surgery	80241
Gastroenterology — no surgery (D.O.)	84241
General Preventive Medicine — no surgery	80231
General Preventive Medicine — no surgery (D.O.)	84231
Geriatrics — no surgery	80243
Geriatrics — no surgery (D.O.)	84243
Gynecology — no surgery	80244
Gynecology — no surgery (D.O.)	84244
Hematology — no surgery	80245
Hematology — no surgery (D.O.)	84245
Hypnosis	80232
Infectious Diseases — no surgery	80246
Infectious Diseases — no surgery (D.O.)	84246
Internal Medicine — no surgery	80257
Internal Medicine — no surgery (D.O.)	84257
Laryngology — no surgery	80258
Manipulator (D.O.)	84801
Neoplastic Disease — no surgery	80259
Nephrology — no surgery	80260
Nephrology — no surgery (D.O.)	84260
Neurology — no surgery	80261
Neurology — no surgery (D.O.)	84261
Nuclear Medicine	80262
Nuclear Medicine (D.O.)	84262
Nutrition	80248
Occupation Medicine	80233
Occupation Medicine (D.O.)	84233
Oncology — no surgery	80302
Oncology — no surgery (D.O.)	84302
Ophthalmology — no surgery	80263
Ophthalmology — no surgery (D.O.)	84263
Osteopathy — manipulation only	84801
Otology — no surgery	80264
Otorhinolaryngology — no surgery	80265
Otorhinolaryngology — no surgery (D.O.)	84265
Pain Management — no surgery	80208
Pain Management — no surgery (D.O.)	84208
Pathology — no surgery	80266
Pathology — no surgery (D.O.)	84266
Pediatrics — no surgery	80267
Pediatrics — no surgery (D.O.)	84267
Pharmacology — Clinical	80234
Physiatry — Physical Medicine (D.O.)	84235
Physiatry — Physical Medicine & Rehabilitation	80235
Physicians — no surgery	80268
Physicians — no surgery (D.O.)	84268
Psychiatry	80249
Psychiatry — (D.O.)	84249
Psychoanalysis	80250
Psychosomatic Medicine	80251
Psychosomatic Medicine (D.O.)	84251
Public Health	80236
Pulmonary Disease — no surgery	80269
Pulmonary Disease — no surgery (D.O.)	84269
Radiology — diagnostic	80253
Radiology — diagnostic (D.O.)	84253
Radiology — includes Mammography w/ Telemed	80472
Radiopaque dye	80449
Radiopaque dye (D.O.)	84449
Rheumatology — no surgery	80252
Rheumatology — no surgery (D.O.)	84252
Rhinology — no surgery	80247
Shock Therapy	80431
Shock Therapy (D.O.)	84431
Shock Therapy — insured	80162
Urgent Care — Walk-in or After Hours	80424
Urgent Care — Walk-in or After Hours (D.O.)	84424
Urology — no surgery	80121

2. Class 2:

Acupuncture	80437
Acupuncture (D.O.)	84437
Anesthesiology	80151
Anesthesiology (D.O.)	84151
Angiography-Arteriography — catheterization	80422
Angiography-Arteriography — catheterization (D.O.)	84422
Broncho-Esophagology	80101
Cardiovascular Disease — minor surgery	80281
Cardiovascular Disease — minor surgery (D.O.)	84281
Colonoscopy-ERCP-Pneu or mech esoph dil (D.O.)	84443
Colonoscopy-ERCP-pneu. or mech.	80443
Dermatology — minor surgery	80282
Dermatology — minor surgery (D.O.)	84282
Diabetes — minor surgery	80271
Diabetes — minor surgery (D.O.)	84271
Emergency Medicine — No Major Surgery	80102
Emergency Medicine — No Major Surgery (DO)	84102
Employed Physician or Surgeon	80177
Employed Physician or Surgeon (D.O.)	84177
Endocrinology — minor surgery	80272

Endocrinology — minor surgery (D.O.)	84272
Family Practice — and general practice minor surgery — No OB	80423
Family Practice — and general practice minor surgery — No OB (D.O.)	84423
Family or General Practice — including OB (D.O.)	84421
Family or General Practice — including OB	80421
Gastroenterology — minor surgery	80274
Gastroenterology — minor surgery (D.O.)	84274
Geriatrics — minor surgery	80276
Geriatrics — minor surgery (D.O.)	84276
Gynecology — minor surgery	80277
Gynecology — minor surgery (D.O.)	84277
Hematology — minor surgery	80278
Hematology — minor surgery (D.O.)	84278
Hospitalist	80296
Hospitalist (D.O.)	84296
Infectious Diseases — minor surgery	80279
Intensive Care Medicine	80283
Intensive Care Medicine (D.O.)	84283
Internal Medicine — minor surgery	80284
Internal Medicine — minor surgery (D.O.)	84284
Laparoscopy	80440
Laparoscopy (D.O.)	84440
Laryngology — minor surgery	80285
Myelography–Discogram-Pneumoencephalo	80428
Myelography–Discogram-Pneumoencephalo (D.O.)	84428
Needle Biopsy	80446
Needle Biopsy (D.O.)	84446
Nephrology — minor surgery	80287
Neonatology	80804
Neonatology (D.O.)	84804
Neoplastic Disease — minor surgery	80286
Neurology — minor surgery	80288
Neurology — minor surgery (D.O.)	84288
Oncology — minor surgery	80301
Oncology — minor surgery (D.O.)	84301
Ophthalmology — minor surgery	80289
Ophthalmology — minor surgery (D.O.)	84289
Otology — minor surgery	80290
Otorhinolaryngology — minor surgery	80291
Otorhinolaryngology — minor surgery (D.O.)	84291
Pain Management — Basic procedures	80182
Pain Management — Basic procedures (D.O.)	84182
Pathology — minor surgery	80292
Pathology — minor surgery (D.O.)	84292
Pediatrics — minor surgery	80293
Pediatrics — minor surgery (D.O.)	84293
Phlebography-Lymphangeography	80434
Phlebography-Lymphangeography (D.O.)	84434
Physicians — minor surgery	80294
Physicians — minor surgery (D.O.)	84294
Radiation Therapy — lasers	80425
Radiation Therapy — lasers (D.O.)	84425
Radiation Therapy — other than lasers	80165
Radiology — diagnostic-interventional procedures	80280
Radiology — diagnostic-interventional procedures (D.O.)	84280
Rhinology — minor surgery	80270
Surgery — Colon & Rectal	80115
Surgery — Endocrinology	80103
Surgery — Gastroenterology	80104
Surgery — Gastroenterology (D.O.)	84104
Surgery — General Practice or Family Practice	80117
Surgery — General Practice or Family Practice (D.O.)	84117
Surgery — Geriatrics	80105
Surgery — Neoplastic	80107
Surgery — Nephrology	80108
Surgery — Ophthalmology	80114
Surgery — Ophthalmology (D.O.)	84114
Surgery — Urological	80145
Surgery — Urological (D.O.)	84145

3. Class 3:

Emergency Medicine — includes major surgery	80157
Emergency Medicine — includes major surgery (D.O.)	84157
Otology — surgery	80158
Pain Management — Neurology, Adv Proc	80298
Pain Management — Neurology, Adv Proc (D.O.)	84298
Radiation Therapy — employed physician	80163
Radiation Therapy — employed physician (D.O.)	84163
Shock Therapy — employed physician	80161
Shock Therapy — employed physician (D.O.)	84161
Surgery — Abdominal	80166
Surgery — Bariatrics	80476
Surgery — Bariatrics (D.O.)	84476
Surgery — Cardiac	80141
Surgery — Cardiac (D.O.)	84141
Surgery — Cardiovascular Disease	80150
Surgery — Cardiovascular Disease (D.O.)	84150
Surgery — General	80143
Surgery — General (D.O.)	84143
Surgery — Gynecology	80167
Surgery — Gynecology (D.O.)	84167
Surgery — Hand	80169
Surgery — Head & Neck	80170
Surgery — Laryngology	80106
Surgery — Orthopedic	80154
Surgery — Orthopedic (D.O.)	84154
Surgery — Otorhinolaryngology-no plastic surgery	80159
Surgery — Plastic	80156
Surgery — Plastic (D.O.)	84156
Surgery — Plastic-Otorhinolaryngology	80155
Surgery — Plastic-Otorhinolaryngology (D.O.)	84155
Surgery — Rhinology	80160
Surgery — Thoracic	80144
Surgery — Thoracic (D.O.)	84144
Surgery — Traumatic	80171
Surgery — Traumatic (D.O.)	84171
Surgery — Vascular	80146
Surgery — Vascular (D.O.)	84146
Weight Control — Bariatrics	80180

4. Class 4:

Surgery — Neurology	80152
Surgery — Neurology (D.O.)	84152
Surgery — Obstetrics	80168
Surgery — OB/GYN	80153
Surgery — OB/GYN (D.O.)	84153

(d) "Fiscal year" means each period beginning each July 1 and ending each June 30.

(e) "Permanently cease operation" means for a provider other than a natural person to stop providing health care services with the intent not to resume providing such services in this state.

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

(g) "Primary coverage" means health care liability insurance meeting the requirements of subch. III of ch. 655, Stats.

(h) "Provider" means a health care provider, as defined in s. 655.001 (8), Stats.

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

(i) "Temporarily cease practice" means to stop practicing in this state for any period of time because of the suspension or revocation of a provider's license, or to stop practicing for at least 90 consecutive days for any other reason.

(3e) PRIMARY COVERAGE REQUIRED. Each provider shall ensure that primary coverage for the provider and the provider's employees other than employees excluded from fund coverage under par. (b), is in effect on the date the provider begins practice or operation and for all periods during which the provider practices or operates in this state. A provider does not have fund coverage for any of the following:

(a) Any period during which primary coverage is not in effect.

(b) Any employee who is a health care practitioner under the circumstances described in s. 655.005 (2), Stats.

(3h) SUPERVISION AND DIRECTION. For the purposes of clarifying s. 655.005 (2) (a), Stats., health care services that are "under the direction and supervision of a physician or nurse anesthetist" include, but are not limited to the health care services being provided pursuant to and within the scope of the health care practitioner's professional license and:

(a) The health care practitioner is subject to a quality assurance program, peer review process, or other similar program or process that is implemented for and designed to ensure the provision of competent and quality patient care and that program or process also includes participation by a physician or a nurse anesthetist; or

(b) The health care services are provided by the health care practitioner within the scope of standing orders, protocols, procedures or clinical practice guidelines established or approved by a physician or nurse anesthetist.

(3m) EXEMPTIONS; ELIGIBILITY. A medical or osteopathic physician licensed under ch. 448, Stats., or a nurse anesthetist licensed under ch. 441, Stats., may claim an exemption from ch. 655, Stats., if at least one of the following conditions applies:

(a) The provider will not practice more than 240 hours in the fiscal year.

(c) During the fiscal year, the provider will derive more than 50% of the income from his or her practice from outside this state or will attend to more than 50% of his or her patients outside this state.

(3s) LATE ENTRY TO FUND. (a) A provider that begins or resumes practice or operation during a fiscal year, has claimed an exemption or has failed to comply with sub. (3e) may obtain fund coverage during a fiscal year by giving the fund advance written notice of the date on which fund coverage should begin.

(b) The board may authorize retroactive fund coverage for a provider who submits a timely request for retroactive coverage showing that the failure to procure coverage occurred through no fault of the provider and despite the fact that the provider acted reasonably and in good faith. The provider shall furnish the board with an affidavit describing the necessity for the retroactive coverage and stating that the provider has no notice of any pending claim alleging malpractice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim. The authorization shall be in writing, specifying the effective date of fund coverage.

(4) ANNUAL FEES; BILLING PROCEDURES. (a) *Definition.* In this subsection, "semimonthly period" means the 1st through the 14th day of a month or the 15th day through the end of a month.

(b) *Entry during fiscal year; prorated annual fee.* If a provider begins practice or operation or enters the fund under sub. (3s) (b) after the beginning of a fiscal year, the fund shall charge the provider one twenty-fourth of the annual fee for each semimonthly period or part of a semimonthly period from the date fund coverage begins to the next June 30.

(c) *Ceasing practice or operation; refunds.* A provider or person acting on the provider's behalf shall notify the fund in the form specified by the fund if any of the following occurs:

1. The provider is exempt under sub. (3m) (a) or (c).

2. The provider is no longer eligible to participate in the fund under s. 655.003 (1) or (3), Stats.

3. This state is no longer a principal place of practice for the provider.

4. The provider has temporarily or permanently ceased practice or has ceased operation.

5. The provider's classification under sub. (6) has changed.

(cm) *Eligibility for exemption; refund.* If a provider claims an exemption after paying all or part of the annual fee, the fund shall issue a refund equal to one twenty-fourth of the provider's annual fee for each full semi-monthly period from the date the provider becomes eligible for the exemption to the due date of the next payment. The refund for any past exemption period will be limited to the current fiscal year and the immediate prior fiscal year.

(cs) *Ineligibility for fund coverage; refund.* 1. If a provider who has paid all or part of the annual fee is or becomes ineligible to participate in the fund under s. 655.003 (1) or (3), Stats., or because he or she does not practice in this state, the fund shall issue a full refund of any amount the provider paid for fund coverage for which he or she was not eligible.

2. If a provider that has paid all or part of the annual fee is ineligible for fund coverage because the provider is not in compliance with sub. (3e), the fund shall issue a full refund of the amount paid for the period of noncompliance, beginning with the date the noncompliance began.

(d) *Change of classification; increased annual fee.* 1. If a provider's change of classification under sub. (6) during a fiscal year results in an increased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

a. One twenty-fourth of the annual fee for the provider's former classification for each full semimonthly period from the due date of the provider's first payment during the current fiscal year to the date of the change.

b. One twenty-fourth of the annual fee for the provider's new classification for each full or partial semimonthly period from the date of the change to the next June 30.

2. The fund shall bill the provider for the total amount of the increase under subd. 1. if the provider has already paid the total annual fee, or shall prorate the increase over the remaining installment payments.

(e) *Change of classification; decreased annual fee.* 1. If a provider's change of classification under sub. (6) during a fiscal year results in a decreased annual fee, the fund shall adjust the provider's annual fee to equal the sum of the following:

a. One twenty-fourth of the annual fee for the provider's former classification for each full or partial semimonthly period from the due date of the provider's first payment during the current fiscal year to the date of the change.

b. One twenty-fourth of the annual fee for the provider's new classification for each full semimonthly period from the date of the change to the next June 30.

2. The fund shall credit the amount of the decrease under subd. 1. over any remaining installment payments. If the provider has already paid the total annual fee, the fund shall issue a refund if the amount of the refund is more than $10. The fund shall credit any amount of $10 or less to the provider's account. If the provider no longer participates in the fund, a credit of $10 or less shall lapse to the fund.

(f) *Refund of other charges.* If a provider is entitled to a refund or credit under this subsection, the fund shall also issue a refund or credit of the unearned portion of any amounts paid as surcharges using the same method used to calculate a refund or credit of an annual fee. A mediation fund fee is refundable only if the provider did not participate in the injured patients and families compensation fund for any part of the fiscal year.

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

(h) *Billing; entire fiscal year.* Except as provided in sub. (6e) (b), for each fiscal year, the fund shall issue to each provider participating in the fund an initial bill which shall include all of the following:

1. The total annual fee due for the fiscal year.

2. Any applicable surcharge imposed under s. Ins 17.285.

3. The balance and accrued interest, if any, due from a prior fiscal year.

4. Notice of the provider's right to pay the amount due in full or in instalments.

5. The minimum amount due if the provider elects installment payments.

6. The payment due date.

(i) *Billing; partial fiscal year.* The fund shall issue each provider entering the fund after the beginning of a fiscal year an initial bill which shall include all of the following;

1. The total amount due calculated under par. (b).

2. Notice of the provider's right to pay the amount due in full or in instalments.

3. The minimum amount due if the provider elects installment payments.

4. The payment due date.

(j) *Balance billing.* If a provider pays at least the minimum amount due but less than the total amount due by the due date, the fund shall calculate the remainder due by subtracting the amount paid from the amount due and shall bill the provider for the remainder on a quarterly installment basis. Each subsequent bill shall include all of the following:

1. The total of the remainder due.

2. Interest on the remainder due. The daily rate of interest shall be the average annualized rate earned by the fund on its short-term funds for the first 3 quarters of the preceding fiscal year, as determined by the state investment board, divided by 360.

3. A $3 administrative service charge.

4. The minimum amount due.

5. The payment due date.

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

(n) *Application of payments.* Except as provided in par. (k), all payments to the fund shall be applied in chronological order first to previous fiscal years for which a balance is due and then to the current fiscal year. The amounts for each fiscal year shall be credited in the following order:

1. Mediation fund fee imposed under s. Ins 17.01.

2. Administrative service charge under par. (j) 3.

3. Interest under par. (j) 2.

4. Surcharge imposed under s. Ins 17.285.

5. Annual fee under sub. (6).

(o) *Waiver of balance.* The fund may waive any balance of $50 or less, if it is in the economic interest of the fund to do so.

(5) FILING OF CERTIFICATES OF INSURANCE. (a) *Electronic filing.* Except as provided in par. (b), each insurer and self-insured provider required under s. 655.23 (3) (b) or (c), Stats., to file a certificate of insurance shall file the certificate electronically in the format specified by the commissioner by the 15th day of the month following the month of original issuance or renewal or a change of class under sub. (6).

(b) *Exemption.* An insurer or self-insured provider may file a written request for an exemption from the requirement of par. (a). The commissioner may grant the exemption if he or she finds that compliance would constitute a financial or administrative hardship. An insurer or self-insured provider granted an exemption under this paragraph shall file a paper certificate in the format specified by the commissioner within 45 days after original issuance or renewal or a change of class under sub. (6).

(c) *Late filing fee.* A late fee in the amount of $100.00 per certificate shall be paid to the fund by each insurer and self-insured provider who fails to file a certificate of insurance in accordance with the requirements of this subsection. An additional $100.00 late fee shall be paid per certificate for each additional week, or portion thereof, the certificate is not in compliance with this subsection.

(6) FEE SCHEDULE. The following fee schedule is in effect from July 1, 2013 to June 30, 2014:

(a) Except as provided in pars. (b) to (f) and sub. (6e), for a physician for whom this state is a principal place of practice:

Class 1	$1,457	Class 3	$5,828
Class 2	$2,623	Class 4	$9,616

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

Class 1	$ 729	Class 3	$2,916
Class 2	$1,312	Class 4	$4,811

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

All classes........$874

(d) For a Medical College of Wisconsin, Inc., full-time faculty member:

Class 1	$583	Class 3	$2,332
Class 2	$1,049	Class 4	$3,848

(e) For physicians who practice part-time:

1. For a physician who practices fewer than 500 hours during the fiscal year, limited to office practice and nursing home

and house calls, and who does not practice obstetrics or surgery or assist in surgical procedures: ....$ 364

2. For a physician who practices 1,040 hours or less during the fiscal year, including those who practice fewer than 500 hours during the fiscal year whose practice is not limited to office practice, nursing homes or house calls or who do practice obstetrics, surgery or assist in surgical procedures:

Class 1 ....$ 874 Class 3 ....$3,496

Class 2 ....$1,573 Class 4 ....$5,768

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

Class 1 ....$ 729 Class 3 ....$2,916

Class 2 ....$1,312 Class 4 ....$4,811

(g) For a nurse anesthetist for whom this state is a principal place of practice: ....$ 358

(h) For a nurse anesthetist for whom this state is not a principal place of practice:...$ 179

(i) For a hospital, all of the following fees:

1. Per occupied bed..$ 87

2. Per 100 outpatient visits during the last calendar year for which totals are available:... $ 4.35

(j) For a nursing home, as described under s. 655.002 (1) (j), Stats., that is wholly owned and operated by a hospital and that has health care liability insurance separate from that of the hospital by which it is owned and operated:

Per occupied bed...$ 17

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

1. a. If the total number of partners and employed physicians and nurse anesthetists is from 2 to 10 ....$ 51

b. If the total number of partners and employed physicians and nurse anesthetists is from 11 to 100 .... $ 503

c. If the total number of partners and employed physicians and nurse anesthetists exceeds 100 ....$1,252

2. The following fee for each full-time equivalent allied health care professional employed by the partnership as of the most recent completed survey submitted:

Employed Health Care Professionals	Fund Fee
Nurse Practitioners	$ 364
Advanced Nurse Practitioners	510
Nurse Midwives	3,205
Advanced Nurse Midwives	3,351
Advanced Practice Nurse Prescribers	510
Chiropractors	583
Dentists	291
Oral Surgeons	2,186
Podiatrists-Surgical	6,192
Optometrists	291
Physician Assistants	291

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

1. a. If the total number of shareholders and employed physicians and nurse anesthetists is from 2 to 10.........$ 51

b. If the total number of shareholders and employed physicians and nurse anesthetists is from 11 to 100............$ 503

c. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 ....$1,252

2. The following fee for each full-time equivalent allied health care professional employed by the corporation as of the most recent completed survey submitted:

Employed Health Care Professionals	Fund Fee
Nurse Practitioners	$ 364
Advanced Nurse Practitioners	510
Nurse Midwives	3,205
Advanced Nurse Midwives	3,351
Advanced Practice Nurse Prescribers	510
Chiropractors	583
Dentists	291
Oral Surgeons	2,186
Podiatrists-Surgical	6,192
Optometrists	291
Physician Assistants	291

(m) For a corporation organized under ch. 181, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of employed physicians and nurse anesthetists is from 1 to 10 .... $ 51

b. If the total number of employed physicians and nurse anesthetists is from 11 to 100 .... $ 503

c. If the total number of employed physicians or nurse anesthetists exceeds 100 .... $1,252

2. The following fee for each full-time equivalent allied health care professional employed by the corporation as of the most recent completed survey submitted:

Employed Health Care Professionals	Fund Fee
Nurse Practitioners	$ 364
Advanced Nurse Practitioners	510
Nurse Midwives	3,205
Advanced Nurse Midwives	3,351
Advanced Practice Nurse Prescribers	510
Chiropractors	583
Dentists	291
Oral Surgeons	2,186
Podiatrists-Surgical	6,192
Optometrists	291
Physician Assistants	291

(n) For an operational cooperative sickness care plan as described under s. 655.002 (1) (f), Stats., all of the following fees:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.11

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

3. The following fee for each full-time equivalent allied health care professional employed by the operational cooperative sickness plan as of the most recent completed survey submitted:

Employed Health Care Professionals	Fund Fee
Nurse Practitioners	$ 364
Advanced Nurse Practitioners	510
Nurse Midwives	3,205
Advanced Nurse Midwives	3,351
Advanced Practice Nurse Prescribers	510
Chiropractors	583
Dentists	291

Oral Surgeons 2,186
Podiatrists-Surgical 6,192
Optometrists 291
Physician Assistants...291

(o) For a freestanding ambulatory surgery center, as defined in s. DHS 120.03 (13), per 100 outpatient visits during the last calendar year for which totals are available: ....$ 22.73

(p) For an entity affiliated with a hospital, the greater of $100 or whichever of the following applies:

1. 7.0% of the amount the entity pays as premium for its primary health care liability insurance, if it has occurrence coverage.

2. 10.0% of the amount the entity pays as premium for its primary health care liability insurance, if it has claims-made coverage.

(q) For an organization or enterprise not specified as a partnership or corporation that is organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of employed physicians and nurse anesthetists is from 1 to 10..$ 51

b. If the total number of employed physicians and nurse anesthetists is from 11 to 100 .... $ 503

c. If the total number of employed physicians or nurse anesthetists exceeds 100 ....$ 1,252

2. The following for each full-time equivalent allied health care professional employed by the organization or enterprise not specified as a partnership, corporation, or an operational cooperative health care plan as of the most recent completed survey submitted:

Employed Health Care Professionals	Fund Fee
Nurse Practitioners	$ 364
Advanced Nurse Practitioners	510
Nurse Midwives	3,205
Advanced Nurse Midwives	3,351
Advanced Practice Nurse Prescribers	510
Chiropractors	583
Dentists	291
Oral Surgeons	2,186
Podiatrists-Surgical	6,192
Optometrists	291
Physician Assistants	291

(6d) PRIMARY PURPOSE PRESUMPTION. For purposes of s. 655.002 (1) (e), Stats., and this section, it is presumed:

(a) A corporation organized and operated in this state of which 50% or more of its shareholders are physicians or nurse anesthetists is organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists.

(b) Conclusively that a corporation organized and operated in this state of which less than 50% of its shareholders are physicians or nurse anesthetists is not organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists.

Note: A person who disputes the application of this presumption to the person may be entitled to a hearing on the issue in accordance with s. 227.42, Stats.

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

(b) Notwithstanding sub. (4) (h), the fund's initial bill for each fiscal year shall be the amount the medical college of Wisconsin affiliated hospitals, inc., estimates will be due for the next fiscal year for all its residents. At the end of the fiscal year, the fund shall adjust the fee to reflect the residents' actual exposure during the fiscal year, as determined by the medical college of Wisconsin affiliated hospitals, inc., and shall bill the medical college of Wisconsin affiliated hospitals, inc., for the balance due, if any, plus accrued interest, as calculated under sub. (4) (j) 2., from the beginning of the fiscal year. The fund shall refund the amount of an overpayment, if any.

(6m) REPORTING. (a) The fund may require any provider to report, at the times and in the manner prescribed by the fund, any information necessary for the determination of a fee specified under sub. (6).

(b) For purposes of sub. (6) (k) to (m), a partnership or corporation shall report the number of partners, shareholders and employed physicians and nurse anesthetists on July 1 of the previous fiscal year.

(6s) SURCHARGE. (a) This subsection implements s. 655.27 (3) (bg) 1., Stats., requiring the establishment of an automatic increase in a provider's fund fee based on loss and expense experience.

(b) In this subsection:

1. "Aggregate indemnity" has the meaning given under s. Ins 17.285 (2) (a).

2. "Closed claim" has the meaning given under s. Ins 17.285 (2) (b).

3. "Provider" has the meaning given under s. Ins 17.285 (2) (d).

4. "Review period" has the meaning given under s. Ins 17.285 (2) (e).

(c) The following tables shall be used in making the determinations required under s. Ins 17.285 as to the percentage increase in a provider's fund fee:

1. For a class 1 physician or a nurse anesthetist:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $118,000	0%	0%	0%	0%
$118,001 to $585,000	0%	10%	25%	50%
$585,001 to $1,571,000	0%	25%	50%	100%
Greater Than $1,571,000	0%	75%	100%	200%

2. For a class 2 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $226,000	0%	0%	0%	0%
$226,001 to $859,000	0%	10%	25%	50%
$859,001 to $2,212,000	0%	25%	50%	100%
Greater Than $2,212,000	0%	50%	100%	200%

3. For a class 3 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $676,000	0%	0%	0%	0%	0%
$676,001 to $1,066,000	0%	0%	10%	25%	50%
$1,066,001 to $1,822,000	0%	0%	25%	50%	75%
$1,822,001 to $3,996,000	0%	0%	50%	75%	100%
Greater Than $3,996,000	0%	0%	75%	100%	200%

4. For a class 4 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $931,000	0%	0%	0%	0%	0%
$931,001 to $1,451,000	0%	0%	10%	25%	50%
$1,451,001 to $2,467,000	0%	0%	25%	50%	75%
$2,467,001 to $5,179,000	0%	0%	50%	75%	100%
Greater Than $5,179,000	0%	0%	75%	100%	200%

Note: For a complete history of s. Ins 17.28 from June 1980 through August 31, 2000, see the History note following s. Ins 17.28 published in Register August 2000 No. 536.

History: Cr. Register, June, 1980, No. 294, emerg. r. and recr. (6) and am. (6a), eff. 7-1-00; r. and recr. (6) and am. (6a), Register, August, 2000, No. 536, eff. 9-1-00; emerg. r. and recr. (6) and am. (6a), eff. 7-1-01; CR 01-035: r. and recr. (6) and am. (6a), Register September 2001 No. 549, eff. 10-1-01; emerg. r. and recr. (6), r. (6a), eff. 7-1-02; CR 02-035: r. and recr. (6), r. (6a), Register September 2002 No. 561, eff. 10-1-02; CR 03-039: r. and recr. (6) Register October 2003 No. 574, eff. 11-1-03; CR 04-032: r. and recr. (6) Register January 2005 No. 589, eff. 2-1-05; emerg. r. and recr. (6), eff. 7-1-05; CR 05-028: r. and recr. (6) Register October 2005 No. 598, eff. 11-1-05; CR 06-002: am. (3) (c) 1. and 2. and r. and recr. (6) Register June 2006 No. 606, eff. 7-1-06; CR 07-002: am. (6), Register June 2007 No. 618, eff. 7-1-07; CR 07-002: am. (6e), Register June 2007 No. 618, eff. 7-1-07; CR 08-006: am. (6) (intro.), (k) 2., (L) 2., (m) 2., (n) 3. and (q) 2. Register June 2008 No. 630, eff. 7-1-08; CR 09-004: am. (3) (c), r. and recr. (6) Register June 2009 No. 642, eff. 7-1-09; correction in (6) (o) made under s. 13.92 (4) (b) 7., Stats., Register June 2009 No. 642; CR 09-055: cr. (3h) Register March 2010 No. 651, eff. 4-1-10; EmR1020: emerg. r. and recr. eff. 6-15-10; CR 10-065: r. and recr. Register November 2010 No. 659, eff. 12-1-10; correction in (6) (o) made under s. 13.92 (4) (b) 7., Stats., Register November 2010 No. 659; EmR1108: emerg. am. (3) (c), r. and recr. (6) eff. 6-10-11; CR 11-015: am. (3) (c), r. and recr. (6) and Register August 2011 No. 668, eff. 9-1-11; EmR1306: emerg. am. (3) (c) 1. to 3., r. and recr. (6), eff. 6-3-13; CR 13-044: am. (3) (c) 1. to 3., r. and recr. (6) Register June 2014 No. 702, eff. 7-1-14; CR 19-119 am. (3) (c) 1. to 3., (4) (f) Register July 2020 No. 775, eff. 8-1-20.

Ins 17.285 Peer review council. **(1)** PURPOSE. This section implements ss. 619.04 (5) (b) and (5m) (b), 655.27 (3) (a) 2m. and (bg) 2. and 655.275, Stats.

(2) DEFINITIONS. In this section:

(a) "Aggregate indemnity" means the total amount attributable to an individual provider that is paid or owing to or on behalf of claimants for all closed claims arising out of one incident or course of conduct, including amounts held by the fund under s. 655.015, Stats. "Aggregate indemnity" does not include any expenses paid in the defense of the claim.

(b) "Closed claim" means a medical malpractice claim against a provider, or a claim against an employee of a health care provider for which the provider is vicariously liable, for which there has been either of the following:

1. A final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

2. A payment to a claimant by the provider or another person on the provider's behalf.

(c) "Council" means the peer review council appointed under s. 655.275, Stats.

(cg) "Health care provider" has the meaning given in s. 146.81 (1), Stats.

(cr) "Patient health care records" has the meaning given in s. 146.81 (4), Stats.

(d) "Provider," when used without further qualification, means a health care provider subject to ch. 655, Stats., who is a natural person. "Provider" does not include a hospital or other facility or entity that provides health care services.

(e) "Review period" means the 5-year period ending with the date of the first payment on the most recent closed claim reported under s. 655.26, Stats., for a specific provider.

(f) "Surcharge" means the automatic increase in a provider's plan premium or fund fee established under s. Ins 17.25 (12m) or 17.28 (6s) or both.

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

(2s) INFORMATION FOR PROVIDER. Upon receipt of a report under sub. (2m), the council shall mail to the provider who is the subject of the report all of the following:

(a) A copy of the report, with a statement that the provider may contact the insurer that filed the report if the provider believes it contains inaccurate information.

(b) A statement that the council may use its authority under s. 146.82 (2) (a) 5., Stats., to obtain any patient health care records necessary for use in making determinations under this section.

(c) A request that the provider sign and return to the council an authorization for release of information form, authorizing the provider's insurer to provide the council with relevant factual information about the closed claim for use in making determinations under this section. A copy of the form shall be enclosed with the mailing.

(d) If necessary, a request that the provider verify the council's closed claim record and furnish the council with information on any additional closed claims not known to the council that have been paid by or on behalf of the provider during the review period.

(e) Notice that if the provider does not comply with a request under par. (c) or (d) within 40 days after the date of the request, the provider is in violation of s. 601.42 (4), Stats., and may be subject to a forfeiture of up to $1,000 for each week of continued violation, as provided in s. 601.64 (3), Stats.

(3) DETERMINATION OF NEED FOR REVIEW. Based on reports received under sub. (2m) and any additional closed claims reported in response to a request under sub. (2s) (d), the council, using the tables under ss. Ins 17.25 (12m) (c) and 17.28 (6s) (c), shall determine when a provider has, during a review period, accumulated enough closed claims and aggregate indemnity to consider the imposition of a surcharge.

(4) RECORDS REQUESTS; NOTICE TO PROVIDER. (a) When the council makes a determination under sub. (3), it may request any of the following:

1. From any health care provider, patient health care records related to each closed claim subject to review as provided in s. 146.82 (2) (a) 5., Stats.

2. From the provider's insurer, relevant factual information about each closed claim subject to review. This subdivision applies only if the provider has complied with the request under sub. (2s) (c).

(b) A request under par. (a) shall be in writing and shall specify a reasonable time for response. Each person receiving a request shall provide the council with the records and information requested, unless the person no longer maintains or has access to them. If a person is unable to comply with a request, the person shall notify the council in writing of the reason for the inability to comply.

(c) The council shall notify a provider for whom a determination is made under sub. (3) that, after reviewing the patient health care records, consultants' opinions and other relevant information submitted by the provider and the provider's insurer, the council may recommend that a surcharge be imposed on the provider's plan premium, fund fee or both, and that the surcharge may be reduced or eliminated following a review as provided in this section. The notice shall include a description of

the procedures specified in this section and a statement that the provider may submit in writing relevant information about any closed claim involved in the review and a description of mitigating circumstances that may reduce the future risk to the plan, the fund or both.

(5) PROCEDURE FOR REVIEW. (a) The council or a single council member may conduct a preliminary review of the records and information relating to each of a provider's closed claims. If the council or council member is able to determine, without a consultant, that the provider met the appropriate standard of care with respect to any closed claim, the council shall not refer that closed claim to a consultant and shall not use that closed claim in determining whether to impose a surcharge on that provider.

(b) Unless a determination under par. (a) reduces the number of closed claims and aggregate indemnity so that the provider is no longer subject to the imposition of a surcharge, the council shall refer all records and information relating to closed claims subject to review, including records and information in the custody of the plan and the fund, to one or more specialists as provided in s. 655.275 (5) (b), Stats.

(c) Each specialist consulted under par. (b) shall provide the council with a written opinion as to whether the provider met the appropriate standard of care with respect to each closed claim reviewed.

(d) At least 30 days before the meeting at which the council will decide whether or not to recommend that a surcharge should be imposed on a provider, the council shall notify the provider of the date of the meeting and furnish the provider with a copy of the consultant's opinions and a list of any other documents on which the recommendation will be based. The council shall make all documents available to the provider upon request for inspection and copying, as provided under s. 19.35, Stats.

(e) In reviewing a closed claim, the council or a consultant may consider any relevant information except information from a juror who participated in a civil action for damages arising out of an incident under review. The council or a consultant may consult with any person except a juror, interview the provider, employees of the provider or other persons involved in an incident or request the provider to furnish additional information or records.

(f) The council, after taking into consideration all available information, shall decide whether each closed claim reviewed should be counted in recommending whether to impose a surcharge on the provider.

(7) REPORT TO BOARD. (a) If the total number of closed claims which the council determines should be included and the aggregate indemnity attributable to those claims would be sufficient to require the imposition of a surcharge under s. Ins 17.25 (12m) (c), 17.28 (6s) (c) or both, the council shall prepare a written report for the board recommending the surcharge that should be imposed. The report shall include the factual basis for the determination on each incident involved in the review and a description of any mitigating circumstances.

(b) If the council determines that one or more closed claims should not be counted and, as a result, the total number of closed claims remaining and the aggregate indemnity attributable to those claims is not sufficient to require the imposition of a surcharge, the council shall prepare a written report for the board recommending that no surcharge should be imposed. The report shall include a brief summary of the basis for the recommendation.

(c) The council shall furnish the provider with a copy of its report and recommendation to the board and with notice of the right to a hearing as provided in sub. (9).

(9) HEARING. (a) A provider has the right to a hearing under ch. 227, Stats., and ch. Ins 5 on the council's recommendation, if the provider requests a hearing within 30 days after receiving the notice under sub. (7) (c).

(am) The reports of the consultant and any other documents relied on by the council in making its recommendation to the board are admissible in evidence at a hearing under this section.

(b) Notice of the hearing examiner's proposed decision shall inform the provider that he or she may submit to the board written objections and arguments regarding the proposed findings of fact, conclusions of law and decision within 20 days after the date of the notice.

(10) FINAL DECISION; JUDICIAL REVIEW. The board shall make the final decision on the imposition of a surcharge. The final decision is reviewable by the circuit court as provided under ch. 227, Stats.

(11) SURCHARGE; IMPOSITION; REFUND; DURATION. (a) A surcharge imposed on a provider's plan premium, fund fee or both after a final decision by the board takes effect on the next billing date and remains in effect during any period of judicial review.

(c) If judicial review results in the imposition of no surcharge or a reduced surcharge, the plan, the fund or both shall refund the excess amount collected from the provider or apply a credit to the provider's next plan premium or fund fee bill or both.

(d) A surcharge remains in effect for 36 months. The percentage imposed shall be reduced by 50% for the 2nd 12 months and by 75% for the 3rd 12 months, if the provider does not accumulate any additional closed claims before the expiration of the surcharge. The time periods specified in this paragraph are tolled on the date a provider stops practicing in this state and remain tolled until the provider resumes practice in this state.

(e) If the provider accumulates additional closed claims while a surcharge is in effect, the provider is subject to the higher of the following:

1. The surcharge imposed under sub. (10) and par. (d).

2. The surcharge determined by the board following a new review of the provider's claims record under sub. (5).

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

(12) REQUEST FROM PRIVATE INSURER. If the council receives a request for a recommendation under s. 655.275 (5) (a) 3., Stats., from a private insurer, the council shall follow the procedures specified in subs. (3) to (5) and notify the private insurer and the provider of the determination it would make under sub. (5) (f) if the provider's primary insurer were the plan. A provider is not entitled to a hearing on any determination reported under this subsection.

(13) CONFIDENTIALITY. The final decision of the board and all information and records relating to the review procedure are the work product of the board and are confidential.

(14) MEMBER AND CONSULTANT COMPENSATION. Council members and consultants shall be paid $250 per meeting at-

tended or $250 per report filed by a consultant based on the consultant's review of a file under s. 655.275 (5) (b), Stats.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88; am. (2) (a) and (b), (3) (a) and (c) 2., (5) (b) (intro.), (7) (a), (8), (9) (a), (11) (f) and (14), cr. (2m) and (4) (c) 2., renum. (4) (c) to be (4) (c) 1., Register, June, 1990, No. 414, eff. 7-1-90; am. (2) (a), (b), (d) and (e), (7) (b), (11) (a), (c) to (e) (intro.) and 1., (f) and (12), renum. (3) (a), (4) (b) (intro.) and 1., (5) (d), (8) to be (3), (4) (c), (5) (e) and (7) (c) and am. (3), (4) (c) and (7) (c), r. (3) (b) and (d), (4) (b) 2., (c) (d), (6) and (11) (b), cr. (2) (cg) and (cr), (2s), (4) (b), (5) (d) and (f), (9) (am), r. and recr. (4) (a), (5) (a) to (c) and (9) (a), Register, January, 1992, No. 433, eff. 2-1-92; CR 03-039: cr. (14) Register October 2003 No. 574, eff. 11-1-03.

Ins 17.29 Servicing agent. (1) PURPOSE. This section implements s. 655.27 (2), Stats., relating to contracting for claim services for the fund.

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

(3) SELECTION. The commissioner, with the approval of the board, shall select a servicing agent through the competitive negotiation process.

(4) CONTRACT TERM. The commissioner, with the approval of the board, shall establish the term of the contract with the servicing agent. The contract shall include a provision for its cancellation if performance or delivery is not made in accordance with its terms and conditions.

(5) The servicing agent shall perform all of the following functions:

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

(b) Establishing and revising case reserves.

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

(d) Investigating and evaluating claims.

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

(f) Filing with the commissioner and the board the annual report required under s. 655.27 (2), Stats., and any other report requested by the commissioner or the board.

(g) Reviewing court orders, verdicts and judgments and making recommendations on appeals.

(h) All other functions specified in the contract.

History: Cr. Register, February, 1984, No. 338, eff. 3-1-84; am. (1), (3) and (4), r. and recr. (2), r. (5) (a), renum. (5) (b) to be (5) and am. (5) (intro.), (b) to (g), cr. (5) (am) and (h), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.30 Peer review council assessments. (1) PURPOSE. This section implements ss. 655.27 (3) (am) and 655.275 (6), Stats., relating to the assessment of fees sufficient to cover the costs, including the costs of administration, of the patients compensation fund peer review council appointed under s. 655.275 (2), Stats.

(2) ASSESSMENTS. (a) The following fees shall be assessed annually beginning with fiscal year 1986-87:

1. Against the fund, one-half of the actual cost of operating the council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

2. Against the plan, one-half of the actual cost of operating the council for each fiscal year, less one-half of the amounts, if any, collected under subd. 3.

3. Against a private medical malpractice insurer, the actual cost incurred by the council for its review of any claim paid by the private insurer, if the private insurer requests a recommendation on premium adjustments with respect to that claim under s. 655.275 (5) (a) 3., Stats.

(b) Amounts collected under par. (a) 3. shall be applied to reduce, in equal amounts, the assessments under par. (a) 1. and 2. for the same fiscal year.

(3) PAYMENT. Each assessment under sub. (2) shall be paid within 30 days after the billing date.

History: Cr. Register, June, 1987, No. 378, eff. 7-1-87; am. (2) (a) 1. and 2., Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.35 Primary coverage; requirements; permissible exclusions; deductibles. (1) PURPOSE. This section implements ss. 631.20 and 655.24, Stats., relating to the approval of policy forms for health care liability insurance subject to s. 655.23, Stats.

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

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

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

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

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

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

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

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

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

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

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

4. A prominent notice that the insurer will notify the commissioner if the insured does not purchase the extended reporting endorsement and that the insured, if a natural person, may be subject to administrative action by his or her licensing board.

(2b) AGGREGATE LIMITS; UNLIMITED EXTENDED REPORTING ENDORSEMENTS. (a) This subsection interprets and implements s. 655.23 (4), Stats.

(b) *Highest aggregate limit applies.* 1. 'Claims-made coverage.' The aggregate limit applicable to all claims reported during a reporting year of a claims-made policy shall be the highest limit specified in s. 655.23 (4) (b), Stats., that applies during the reporting year.

2. 'Occurrence coverage.' The limit applicable to all occur-

rences during an occurrence year of an occurrence policy shall be the highest limit specified in s. 655.23 (4), Stats., that applies during the occurrence year.

(c) *Unlimited extended reporting endorsements issued before January 1, 1999.* Before January 1, 1999, the aggregate limit applicable to an unlimited extended reporting endorsement shall be one of the following:

1. The total amount of the annual aggregate limit specified in s. 655.23 (4), Stats., as it applied on the date of the occurrence, shall be available for each occurrence year, less amounts previously paid under any policy for that occurrence year.

2. The following minimum percentage of the annual aggregate limit specified in s. 655.23 (4), Stats., as it applied to the last reporting year of the canceled or nonrenewed claims-made policy shall be available for all claims reported under the extended reporting endorsement: 100% when the policy was in effect for 1 year or less, including any retroactive coverage period; 130% when the policy was in effect for more than 1 year, but less than or equal to 2 years, including any retroactive coverage period; 150% when the policy was in effect for more than 2 years, but less than or equal to 3 years, including any retroactive coverage period; 160% when the policy was in effect for more than 3 years, including any retroactive coverage period.

(d) *Unlimited extended reporting endorsements issued on and after January 1, 1999.* On and after January 1, 1999 the minimum aggregate limit applicable to an unlimited extended reporting endorsement shall be that specified in par. (c) 2.

(2e) REQUIREMENTS FOR GROUP COVERAGE. (a) In this section, "provider" means a health care provider, as defined in s. 655.001 (8), Stats.

(b) An insurer or self-insured provider that provides primary coverage under a group policy or self-insured plan shall do all of the following:

1. At the time of original issuance of the policy or when the self-insured plan takes effect, and each time coverage for an individual provider is added:

a. Furnish each covered provider with a copy of the policy or a certificate of coverage specifying the coverage provided and whether the coverage is limited to a specific practice location, to services performed for a specific employer or in any other way.

b. Include on the first page of the policy or the certificate of coverage, or in the form of a sticker, letter or other form included with the policy or certificate of coverage, that it is the responsibility of the individual provider to ensure that he or she has health care liability insurance coverage meeting the requirements of ch. 655, Stats., in effect for all of his or her practice in this state, unless the provider is exempt from the requirements of that chapter.

2. For a policy or self-insured plan in effect on October 1, 1993, furnish the documents specified in subd. 1. a. and b. to each individual covered provider before the next renewal date or anniversary date of the policy or self-insured plan.

3. Notify each covered provider individually when the policy or self-insured plan is cancelled, nonrenewed or otherwise terminated, or amended to affect the coverage provisions.

4. On the certificate of insurance filed with the fund under s. 655.23 (3) (b) or (c), Stats., and s. Ins 17.28 (5), specify whether the coverage is limited to a specific practice location, to services performed for a specific employer or in any other way.

(2m) RISK RETENTION GROUPS. If the policy is issued by a risk retention group, as defined under s. 600.03 (41e), Stats., each new and renewal application form shall include the following notice in 10-point type:

NOTICE

Under the federal liability risk retention act of 1986 (15 USC 3901 to 3906) the Wisconsin insurance security fund is not available for payment of claims if this risk retention group becomes insolvent. In that event, you will be personally liable for payment of claims up to your limit of liability under s. 655.23 (4), Wis. Stat.

Note: Subsection (2m) first applies to applications taken on October 1, 1991.

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

(a) Criminal acts.

(b) Intentional sexual acts and other intentional torts.

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

(d) Defamation.

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

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

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

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

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

(j) Punitive and exemplary damages.

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

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

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

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

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

Note: Subsection (2b) applies to all claims made health care liability insurance policies for which certificates have been filed with the patients compensation fund, whether issued before, on or after July 1, 1994.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90; emerg. cr. (2m), eff. 7-1-91; cr. (2m), Register, July, 1991, No. 427, eff. 8-1-91; cr. (2e), Register, September, 1993, No. 453, eff. 10-1-93; cr. (2b), Register, June, 1994, No. 462, eff. 7-1-94; emerg. r. and recr. (2b) (b) and cr. (2b) (c) and (d), eff. 6-1-98; r. and recr. (2b) (b) and cr. (2b) (c) and (d), Register, August, 1998, No. 512, eff. 9-1-98.

Note: See the table of Appellate Court Citations for Wisconsin appellate cases citing s. Ins 17.35.

Ins 17.40 Notice to fund of filing of action outside this state. (1) PURPOSE. This section implements s. 655.27 (5) (a) and (b), Stats., relating to the requirement that the fund be notified of an action filed outside this state within 60 days of service of process on the health care provider or the employee of the health care provider and relating to the duty of the insurer or self-insurer of the provider to provide an adequate defense of the fund and act in good faith and in a fiduciary relationship with respect to any claim affecting the fund.

(2) PRIMARY INSURER OR SELF-INSURER TO GIVE NOTICE TO FUND. A primary insurer or self-insurer for a health care provider or employee of a health care provider shall notify the fund in writing within 60 days of the insurer or self-insurer's

first notice of the filing of an action outside this state alleging medical malpractice against its insured health care provider or the employee of its insured health care provider or within 60 days of service of process on the insured health care provider or employee thereof, whichever is later. The notice shall provide at a minimum the names and addresses of the parties plaintiff and defendant, the court in which the action is filed, the case number, and copies, if available, of the complaint in the action and answer filed on behalf of the defendant provider.

(3) FAILURE TO GIVE NOTICE. If the primary insurer or self-insurer fails to give notice to the fund as required in sub. (2), the board shall deny fund coverage for the action filed outside this state unless the primary insurer demonstrates, and the board finds, all of the following:

(a) The fund was not prejudiced by the failure to give notice as required, and

(b) It was not reasonably possible to give notice within the time limit.

(4) FAILURE TO ACT IN GOOD FAITH. If the board denies coverage pursuant to sub. (3), then failure to give notice to the fund of the filing of an action outside this state as required in sub. (2) constitutes a failure to act in good faith on the part of the insurer or self-insurer in violation of s. 655.27 (5) (b), Stats.

History: CR 03-038: cr. Register October 2003 No. 574, eff. 11-1-03.

Ins 17.50 Self-insured plans for health care providers. (1) PURPOSE. This section implements s. 655.23 (3) (a), Stats.

(2) DEFINITIONS. In this section:

(a) "Actuarial" means prepared by an actuary meeting the requirements of s. Ins 6.12 who has experience in the field of medical malpractice liability insurance.

(am) "Affiliated health care providers" means two or more health care providers delivering services as described in s. 655.002 (1), Stats., and who satisfy all of the following:

1. The health care providers are either legal entities or are employed by one or more separate legal entities over which operating control is exercised by a common controlling legal entity. The controlling legal entity need not be a health care provider.

2. The incomes of the health care providers are consolidated with the controlling legal entity in audited financial statements prepared under generally accepted accounting principles.

(b) "Level of confidence" means a percentage describing the probability that a certain funding level will be adequate to cover actual losses.

(c) "Occurrence coverage" means coverage for acts or omissions occurring during the period in which a self-insured plan is in effect.

(d) "Office" means the office of the commissioner of insurance.

(e) "Provider," when used without modification, means a health care provider as defined in s. 655.001 (8), Stats., or affiliated health care providers as defined in par. (am), responsible for the establishment and operation of a self-insured plan.

(f) "Risk margin" means the amount that must be added to estimated liabilities to achieve a specified confidence level.

(g) "Self-insured plan" means a method, other than through the purchase of insurance, by which a provider may furnish professional liability coverage which meets the requirements of ch. 655, Stats.

(h) "Year" means the self-insured plan's fiscal year.

(3) COVERAGE. (a) A self-insured plan shall provide professional liability occurrence coverage with limits of liability in the amounts specified in s. 655.23 (4), Stats., for the provider, the provider's employees, other than employees who are natural persons defined as health care providers under s. 655.001 (8), Stats., and any other person for whom the provider is legally responsible while the employee or other person is acting within the scope of his or her duties for the provider.

(b) A self-insured plan may also provide occurrence coverage for any natural person who is a health care provider, as defined in s. 655.001 (8), Stats., and who is an employee, partner or shareholder of the provider. The self-insured plan shall provide separate limits of liability in the amounts specified in s. 655.23 (4), Stats., for each such natural person covered.

(c) A self-insured plan shall also provide for supplemental expenses in addition to the limits of liability in s. 655.23 (4), Stats., including attorney fees, litigation expenses, costs and interest incurred in connection with the settlement or defense of claims.

(d) A self-insured plan may not provide coverage for anything other than the professional liability coverage required under ch. 655, Stats., or for any other person than those specified in pars. (a) and (b).

(4) INITIAL FILING. A provider that intends to establish a self-insured plan shall file with the office a proposal which shall include all of the following:

(a) If the provider is not a natural person, the history and organization of the provider.

(b) If the provider is not a natural person, a resolution adopted by the provider's governing body approving the establishment and operation of a self-insured plan.

(c) A description of the proposed method of establishing and operating the self-insured plan.

(d) An actuarial estimate of the liabilities that will be incurred by the self-insured plan in the first year of operation, an actuarial review of the cost of the first year's funding and a description of how the self-insured plan will be funded.

(e) If prior acts coverage is required under sub. (6) (f) 1., an actuarial estimate of the liabilities of the provider and any natural person covered under sub. (3) (b) for prior acts, an actuarial review of the cost of funding the coverage and a description of how the coverage will be funded.

(f) An actuarial feasibility study which includes a 5-year projection of expected results.

(g) The identity of the bank that will act as trustee for the self-insured plan and a proposed trust agreement between the provider and the bank.

(h) Any proposed investment policy that will be applicable to the investment of the trust's assets.

(i) A description of the provider's existing or proposed risk management program.

(j) The estimated number and the professions of natural persons that the self-insured plan will cover under sub. (3) (b).

(k) A description of the proposed contractual arrangements with administrators, claims adjusters and other persons that will be involved in the operation of the self-insured plan.

(L) The provider's most recent audited annual financial statement prepared under generally accepted accounting principles that includes, if applicable, all affiliated health care providers covered under the self-insured plan on a consolidated basis.

(m) A proposed draft of a letter of credit, if the provider intends to use one as part of the initial funding, except for affili-

ated health care providers who are prohibited from using a letter of credit for initial funding.

(n) Any additional information requested by the office.

(5) REVIEW OF PROPOSAL; APPROVAL. (a) After reviewing a proposal submitted under sub. (4), the office may approve the proposal if all of the following conditions are met:

1. The initial filing is complete.

2. The proposal is actuarially sound.

3. The proposal complies with ch. 655, Stats.

4. The proposal ensures the provider's continuing ability to meet the financial responsibility requirements of s. 655.23, Stats.

5. The provider is sound, reliable and entitled to public confidence and may reasonably be expected to perform its obligations continuously in the future.

(b) If any of the conditions specified under par. (a) is not met, the office may request the provider to submit additional information in writing or may assist the provider in revising the proposal.

(c) A self-insured plan may not begin operation without the written approval of the office which specifies the earliest date operation may begin.

(6) FUNDING REQUIREMENTS FOR PROVIDERS: PROHIBITIONS. (a) The minimum initial funding required for a self-insured plan is $2,000,000.

(b) Before a self-insured plan begins operation, the provider shall establish a trust with a Wisconsin-chartered or federally-chartered bank with trust powers which is located in this state.

(c) For self-insured plans except a self-insured plan for affiliated health care providers, the provider shall provide all of the following:

1. If the actuarial estimate under sub. (4) (d) is less than $2,000,000, the provider shall, before the self-insured plan begins operation, deposit in the trust cash equal to the first year's estimated liabilities plus a letter of credit equal to the difference between the cash funding and $2,000,000 except as provided under sub. (4) (m).

2. In each of the next 3 years, the provider shall make quarterly cash payments to the trust in amounts sufficient to keep the estimated liabilities fully funded and shall keep in effect a letter of credit equal to the difference between the total estimated liabilities and $2,000,000.

3. If the total estimated liabilities for the 5th year of operation are less than $2,000,000, the provider shall, during that year, make quarterly cash payments to the trust in amounts sufficient to ensure that, by the end of that year, the trust's cash assets equal $2,000,000, except that if the provider files a written request with the commissioner before the beginning of that year, the commissioner may permit the provider to continue using a letter of credit equal to the difference between the total estimated liabilities and $2,000,000. This permission may be renewed annually if the provider files a written request with the commissioner before the beginning of each subsequent fiscal year.

4. A letter of credit under this subsection shall meet all of the following conditions:

a. It shall be irrevocable.

b. It shall be issued by a Wisconsin-chartered or federally-chartered bank located in this state.

c. It shall be issued solely for the purpose of satisfying the funding requirements of the trust.

d. It shall describe the procedure by which the trustee may draw upon it.

(d) If the actuarial estimate under sub. (4) (d) is greater than $2,000,000, the provider shall, before the self-insured plan begins operation, deposit $2,000,000 cash in the trust. The provider shall make quarterly cash payments to the trust so that at the end of the first year of operation, the trust's cash assets equal the first year's estimated liabilities.

(e) In each subsequent year of the self-insured plan's operation, the provider shall make quarterly cash payments to the trust in amounts sufficient to ensure that the total cash assets of the trust at the end of each year are not less than the estimated liabilities reported under sub. (8) (a) 1.

(f) 1. If the provider or any natural person covered under sub. (3) (b) had claims-made coverage before the self-insured plan was established and did not purchase an extended reporting endorsement from the previous carrier, the self-insured plan shall provide coverage for prior acts by means of cash payments to the trust in addition to the funding required for the occurrence coverage.

2. If the actuarial estimate under sub. (4) (e) is less than $500,000, the provider shall, before the self-insured plan begins operation, deposit in the trust the entire amount of the estimate in cash.

3. If the actuarial estimate under sub. (4) (e) is greater than $500,000, the provider shall, before the self-insured plan begins operation, deposit in the trust $500,000 or the first year's estimated payments, whichever is greater. The provider shall make quarterly cash payments to the trust so that at the end of the first year, the trust's assets include the total estimated liabilities for prior acts.

(g) Quarterly cash payments under this subsection shall be in equal amounts except that the amount of the last quarter's payment shall be adjusted by the amounts of the trust's investment income and actual expenses incurred, and except that the first quarter's payment shall not be less than the amount of a quarterly payment for the previous year before adjustment for income and expenses.

(h) 1. A provider may not deposit in the trust, and the trustee may not pay from the trust, any funds other than those intended to meet the financial responsibility requirements of ch. 655, Stats., and to pay the administrative expenses of operating the self-insured plan and the trust.

2. The trustee may not invest any of the trust's assets in securities or real property of the provider or any of its affiliates.

(i) If the assets of the trust at any time are insufficient to pay all claims against the self-insured plan, the liabilities are those of the provider without recourse against any employee, partner or shareholder covered by the self-insured plan.

(6m) FUNDING REQUIREMENTS FOR AFFILIATED HEALTH CARE PROVIDERS. The minimum initial funding required for a self-insured plan is the greater of $2,000,000 or the actuarial estimate under sub. (4) (d).

(7) FILING PRIOR TO OPERATION OF SELF-INSURED PLAN. Before an approved self-insured plan begins operation, the provider shall file with the office all of the following:

(a) Certified copies of the executed self-insured plan document and trust agreement.

(b) If the provider is not a natural person, a certified copy of an executed resolution adopted by the provider's governing body approving the self-insured plan and trust agreement.

(c) A certified copy of any trust investment policy adopted by the provider or the provider's governing body.

(d) The trustee's certification that the initial amount of cash required under sub. (6) has been deposited in the trust.

(e) A certified copy of any letter of credit held by the trustee.

(f) If any part of the operation of the self-insured plan is conducted by a person other than the provider or an employee, partner or shareholder of the provider, a certified copy of an executed contract with each such person.

(8) FINANCIAL REPORTING. (a) Within 120 days after the end of a year, the self-insured plan shall submit to the office all of the following:

1. Actuarial estimates of the projected liabilities for the current year and of the total liabilities for all prior years covered by the self-insured plan and the risk margin for all projected and incurred claims, and an actuarial opinion of the reasonableness of the estimates.

2. A description of the proposed method of funding for the current year.

3. The provider's audited annual financial statement.

4. The self-insured plan's audited annual financial statement.

(b) Within 60 days after the end of each quarter, the self-insured plan shall submit to the office the most recent quarterly financial statement of the trust.

(9) OTHER REPORTING REQUIREMENTS. (a) After a self-insured plan begins operation, the provider shall report to the office any proposed change in the self-insured plan document, trust agreement, trust investment policy, letter of credit or any other document on file with the office if the change would materially affect the operation of the self-insured plan or its funding. No proposed change may take effect without the written approval of the office.

(b) The provider shall annually file with the patients compensation fund proof of financial responsibility under s. 655.23, Stats., in the form specified by the office. The provider shall also file proof of financial responsibility on behalf of each natural person covered under sub. (3) (b).

(c) The provider shall immediately notify the patients compensation fund if either of the following occurs:

1. A claim filed with the self-insured plan has a reserve of 50% or more of the limit specified in s. 655.23 (4), Stats., for one occurrence.

2. The self-insured plan's total aggregate reserves for the provider or for any natural person covered under sub. (3) (b) for a single year exceed 66% of the limit specified in s. 655.23 (4), Stats., for all occurrences in one year.

3. A claim filed with the self-insured plan creates potential exposure for the patients compensation fund, regardless of the amount reserved.

(d) The provider shall ensure that all claims paid by the self-insured plan are reported to the medical examining board and the board of governors of the patients compensation fund as required under s. 655.26, Stats.

(10) DISCOUNTING PROHIBITED. All actuarial estimates required under this section shall be reported on a nondiscounted basis.

(11) LEVELS OF CONFIDENCE. (a) The risk margin used in determining the initial funding under sub. (6) shall be at not less than a 90% level of confidence and, except as provided in pars. (b) and (c), shall remain at that level.

(b) After a self-insured plan has operated for at least 5 years and experience can be reasonably predicted, the office may permit the use of a risk margin of less than a 90%, but not less than a 75%, level of confidence in determining annual funding of the trust. For at least 5 years after such permission is granted, the provider shall fund the difference between the cash required at the lower level of confidence and the 90% level of confidence with funds restricted by the provider or the provider's governing body for the purpose of paying obligations of the self-insured plan. The restricted funds may be part of the provider's operating budget rather than assets of the trust.

(c) After a self-insured plan has operated for at least 5 years under par. (b), the office may permit the use of a risk margin of not less than a 75% level of confidence without additional restricted funds if the self-insured plan's actuary states that the self-insured plan's exposure base is stable enough to estimate the required liabilities.

(12) MONITORING; ORDERS. (a) If the office determines that a self-insured plan's operation does not ensure that the provider can continue to satisfy the conditions specified in sub. (5) (a), the commissioner may order the provider to take any action necessary to ensure compliance with those conditions.

(b) If the provider does not comply with the commissioner's order within the time specified in the order, the commissioner may order the provider to terminate the self-insured plan and the office may take whatever action is necessary to ensure the continued existence of the trust for a sufficient length of time to meet all of the obligations of the self-insured plan.

(13) EXISTING SELF-INSURED PLANS; COMPLIANCE. After this section takes effect, the office may review any approved self-insured plan to determine if it complies with this section. If the office determines that any self-insured plan is not in compliance, the commissioner may order the provider to take any action necessary to achieve compliance.

History: Cr. Register, December, 1989, No. 408, eff. 1-1-90; CR 16-024: cr. (2) (am), am. (2) (e), (4) (L), (m), (6) (title), cr. (6) (c) (intro.), am. (6) (c) 1., cr. (6m) Register September 2016 No. 729, eff. 10-1-16.