# Chapter Ins 17

## PATIENTS COMPENSATION FUND



**Ins 17.001 Definitions.** (ss. 619.04 and 655.003, Stats.) As used in this chapter:

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

(2) "Fund" means the patients compensation fund established pursuant to s. 655.27 (1), Stats., except as defined in section Ins 17.24 Wis. Adm. Code;

(3) "Hearing" includes both hearings and rehearings, and these rules shall cover both so far as applicable, except where otherwise specifically provided by statute or in chapter Ins 17.

(4) "Plan" means the Wisconsin health care liability insurance plan established by section Ins 17.25 Wis. Adm. Code pursuant to s. 619.01 (1) (a), Stats.;

(5) "Commissioner" means the commissioner of insurance or deputy whenever detailed by the commissioner or discharging the duties and exercising the powers of the commissioner during an absence or a vacancy in the office of the commissioner, as provided by s. 601.11 (1) (b), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

**Ins 17.01 Payment of compensation fund fees** (ss. 655.21 and 655.27, Stats.) (1) PURPOSE. This rule implements the provisions of ch. 655, Stats., relating to the payment of fees to the patients compensation fund.

(2) SCOPE. This rule applies to each health care provider as defined in s. 655.001, Stats., except hospitals, nursing homes or other facilities subject to regulation by the department of health and social services.

(3) DEFINITIONS. For the purpose of this rule the definition of terms used shall be those definitions set forth in s. 655.001, Stats.

(4) PAYMENT OF FEES TO FINANCE PATIENTS COMPENSATION PANELS. (a) Once in each fiscal year each physician operating in this state shall pay, in accordance with a billing schedule adopted by the commissioner, the annual fee established by s. 655.21 (1) (a), Stats.

(b) Such fee is due and payable upon receipt of the billing by the physician.

(c) Any physician who has not paid the fee within 30 days from the date the billing is received shall be deemed to be in noncompliance with s. 655.21 (1) (a), Stats.

(d) The commissioner shall notify the department of regulation and licensing of each physician who has not paid the fee and who is, therefore, in noncompliance with s. 655.21 (1) (a), Stats.

(e) The commissioner may upon a showing of sufficient cause extend the period for a payment for an additional period of time to be determined by the commissioner.

(5) PAYMENT OF OPERATING FEES TO PATIENTS COMPENSATION FUND. (a) Once in each fiscal year each health care provider, except hospitals, nursing homes or other facilities subject to regulation by the department of health and social services, shall pay in accordance with a billing schedule adopted by the commissioner the annual fee determined in accordance with s. 655.27 (3) (c), Stats.

(b) Such fees are due and payable upon receipt of the billing by the health care provider.

(c) Any health care provider who has not paid the fee within thirty days from the date the billing is received shall be deemed to be in noncompliance with s. 655.23 (1), Stats., and subject to the penalty provisions of s. 655.23 (6) and (7), Stats.

(d) The commissioner shall notify the department of regulation and licensing of each health care provider who has not paid the fee and who is, therefore, in noncompliance with s. 655.23 (1), Stats.

(e) The commissioner may upon a showing of sufficient cause extend the period for payment of fees for an additional period of time to be determined by the commissioner.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

**Ins 17.02 Petition for declaratory rulings.** (ss. 619.04 and 655.003, Stats.) (1) Petitions for declaratory rulings shall be governed by s. 227.06, Stats.

(2) Such petitions shall be filed with the commissioner who shall investigate, give notice, etc.

(3) All final determinations shall be made by the board.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79.

**Ins 17.03 How proceedings initiated.** (ss. 619.04 and 655.003, Stats.) Proceedings for a hearing upon a matter may be initiated: (1) On a complaint by any individual, corporation, partnership or association

which is aggrieved, filed in triplicate (original and 2 copies) with the commissioner.

(3) DEFINITIONS. The following definitions shall apply in the administration of this rule:

(a) Fund shall mean the future medical expense fund, Fund No. 35 established by the bureau of financial operations, department of administration under the provisions of ss. 16.40 (5) and 16.41, Stats., to receive payments under s. 655.015, Stats.

(b) Account shall mean that portion of such fund allocated specifically for the benefit of an injured person.

(c) Claimant shall mean the injured person, the individual legally responsible for any medical expenses sustained by the injured person, or the legally designated representative of such injured person.

(d) Medical expense shall mean those charges for medical services, nursing services, medical supplies, drugs or rehabilitation services which are necessary to the comfort and well being of the individual and incidental to the injury sustained.

(4) ADMINISTRATION. (a) When any settlement, award or judgement provides an amount in excess of $25,000 for future medical expense, the insurer, organization or person responsible for such payment shall forward to the commissioner the amount in excess of $25,000 within 30 days of any such settlement, award or judgment, and shall enclose an appropriately executed copy of the document setting forth the terms under which the payment is to be made.

(b) The commissioner shall cause the monies so received to be paid into the future medical expense fund to be invested by the state of Wisconsin investment board under the authority of s. 25.17 (1) (zm), Stats.

(c) Upon receipt of a request for reimbursement of medical expense of an injured person, the commissioner shall make appropriate investigation and inquiries to determine that the medical supplies or services provided are necessary and incidental to the injury sustained by the person for whom the account was established, and if satisfied that this is the case, shall pay these expenses out of the fund, using standard bookkeeping and accounting records and transactions established by ss. 16.40 (5) and 16.41, Stats.

(d) The commissioner shall not less that once annually inform the claimant of the status of the account including the original amount, payments made, and the balance remaining.

(e) The commissioner shall maintain an individual file record of each account showing the original allocation, payments made, credits and the balance remaining. The commissioner shall further keep an account of the total balance in the fund and the allocations to each account.

(f) The commissioner shall credit each account with a pro rata share of interest earned, if any, based on the remaining value of each account at the time such interest earning is declared by the investment board, and using procedures established by that board.

(g) If the commissioner is satisfied that a third party provider of service has not been reimbursed for services or supplies rendered to the injured person, payments of any medical expense may be made jointly to the claimant and the provider of such medical supplies or services.

(h) Payment shall be made to the claimant for reasonable and necessary medical expense until such time as the allocated amount is exhausted or until the injured person is deceased. Should the injured person become deceased and there is a balance in his account allocation, that amount shall be returned to the insurer, organization or 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.

**Ins 17.27 Filing of financial statement.** (1) PURPOSE. This rule is intended to implement and interpret ss. 655.21, 655.27 (3) (b), 655.27 (4) (d) and 655.27 (5) (e), Stats., for the purpose of setting standards and techniques for accounting, valuing, reserving and reporting of data relating to financial transactions of the Patients Compensation Fund.

(2) DEFINITIONS. (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 the financial report.

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

(3) FINANCIAL REPORTS. Annual financial reports required by s. 655.27 (4) (d), Stats., shall be furnished within 60 days after the close of each fiscal year. In addition, quarterly financial reports shall be prepared as of September 30, December 31 and March 31 of each year and furnished within 60 days after the close of each reporting period. These financial reports shall be prepared on a format prescribed by the board of governors 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. Any funds for administration of the Patients Compensation Panels derived from fees collected under s. 655.21, Stats., shall be included in these financial reports but shall not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims.

(4) The board of governors shall select one or more actuaries to assist in the determination of reserves and the setting of fees under s. 655.27 (3) (b), Stats. In the event more than one actuary is utilized, the health care providers represented on the board of governors shall jointly select the second actuary. Such actuarial reports shall be submitted on a timely basis.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80.

**Ins 17.28 Health care provider fees.** (s. 655.27) (1) PURPOSE. The purpose of this section is to implement and interpret the provisions of s. 655.27 (3), Stats., relating to fees to be paid by health care providers for participation in the Patients Compensation Fund.

(2) SCOPE. This section applies to fees charged health care providers as defined in s. 655.001 (8), Stats. Nothing in this section shall apply to operating fees charged for operation of the Patients Compensation Panels under s. 655.21, Stats.

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

(b) "Fees", "operating fees" or "annual fees" means those fees charged for each fiscal year of participation, July 1 to June 30.

(c) "Class" of physicians or surgeons means those classes currently in use by the Wisconsin Health Care Liability Insurance Plan, as authorized by section Ins 17.25 (12) (b), Wis. Adm. Code.

(4) PRO RATA FEES. A health care provider may enter or exit the Fund at a date other than July 1 or June 30. (a) If a health care provider enters the Fund subsequent to July 1, the provider shall be charged a fee of one-twelfth the annual fee for that class of provider for each month or part of month between the date of entry and the next June 30.

(b) Notwithstanding the provisions of paragraph (a) no fee shall be charged for entry to the Fund after each June 1.

(c) If a health care provider exits the Fund prior to June 30, the provider shall be entitled to a refund of one-twelfth the annual fee for that class for each full month between the date of exit and the next June 30.

(d) The effective date of the proof of financial responsibility required under s. 655.23 (2), Stats., as it applies to each individual health care provider, shall determine the date of entry to the Fund. The cancellation or withdrawal of such proof shall establish the date of exit.

(5) EFFECTIVE DATE AND EXPIRATION DATE OF FEE SCHEDULES. The effective date of the fee schedule contained in this section shall be the current July 1 and shall expire the next subsequent June 30.

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1980 to June 30, 1981.

(a) For physicians and surgeons

| | |
|---|---|
| Class 1 | $ 194.00 |
| Class 2 | 350.00 |
| Class 3 | 600.00 |
| Class 4 | 798.00 |
| Class 5 | 1000.00 |
| Class 6 | 1200.00 |
| Class 7 | 1600.00 |
| Class 8 | 98.00 |

(b) For resident physicians and surgeons (or fellowships)

| | |
|---|---|
| Class 1 | $116.00 |
| Class 2 | 210.00 |
| Class 3 | 360.00 |
| Class 4 | 478.00 |
| Class 5 | 600.00 |
| Class 6 | 726.00 |
| Class 7 | 960.00 |

(c) For resident physicians and surgeons (practice outside residency or fellowship)

| | |
|---|---|
| All classes | $150.00 |

(d) For Medical College of Wisconsin full time faculty

| | |
|---|---|
| Class 1 | $ 80.00 |
| Class 2 | 144.00 |
| Class 3 | 246.00 |
| Class 4 | 326.00 |
| Class 5 | 410.00 |
| Class 6 | 492.00 |
| Class 7 | 656.00 |

(e) For Medical College of Wisconsin resident physicians and surgeons

The fee shall be $25,136. The fee may be adjusted based on the final audit as of June 30, 1980, of the actual risk exposures by the primary carrier. The adjusted fee shall equal 20% of the final audited premium of the primary carrier for Medical College of Wisconsin residents.

(f) For government employes (state, federal, municipal)

| | |
|---|---|
| Class 1 | $ 145.00 |
| Class 2 | 262.00 |
| Class 3 | 450.00 |
| Class 4 | 598.00 |
| Class 5 | 750.00 |
| Class 6 | 900.00 |
| Class 7 | 1200.00 |
| Class 8 | 73.00 |

(g) For retired or part time physicians and surgeons (office practice only, less than 500 hours per annum)

| | |
|---|---|
| Class 1 | $116.00 |
| Class 8 | 58.00 |

| | |
|---|---|
| (h) For nurse anesthetists | $ 50.00 |
| (i) For podiatrists (non surgical) | $152.00 |
| For podiatrists (surgical) | 305.00 |
| (j) For hospitals—per occupied bed | $ 84.00 |
| (k) For nursing homes—per occupied bed | $ 29.00 |

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80.