(3) COPIES FOR INTERESTED PARTIES. Parties who are impecunious who require and request a transcript for appeal or for other purposes deemed reasonable by the commissioner or hearing officer shall be furnished with a transcript of the hearing at the expense of the office of the commissioner of insurance upon the filing of a verified petition stating the purpose for which the transcription is needed and that the person is without means to purchase a transcript.

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

Ins 17.20 Stipulations. (ss. 619.04 and 655.003, Stats.) All stipulations or agreements in reference to a matter the subject of a hearing or entered into at a hearing shall be either dictated at length into the record, or reduced to writing, signed by the persons or parties stipulating, and filed as a part of the record of the proceedings. Controversies, or matters which may be the subject of or cause for a hearing may be disposed of by stipulation, agreed settlement or consent orders.

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

Ins 17.21 Motions. (ss. 619.04 and 655.003, Stats.) Except during a hearing, motions shall be made in writing and signed by the party or person authorized and appearing in the proceedings therefor, or if the party is a corporation by an active officer of the corporation. At least 3 days notice thereof shall be given to the board or the hearing examiner, and to each and every other party to the proceeding, served as prescribed by s. Ins 17.16.

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

Ins 17.22 Default. (ss. 619.04 and 655.003, Stats.) In case the respondent fails to submit an answer as required by s. Ins 17.08 or fails to appear at a hearing at the time and place fixed therefor, the matters specified shall be taken as true and the board may make findings and enter an order on the basis thereof. The default of a party in answering or in appearing shall not preclude the board from hearing said matter, taking such evidence as necessary and proper, and disposing of the matter.

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

Ins 17.23 Arguments. (ss. 619.04 and 655.003, Stats.) The hearing examiner may hear oral arguments and limit the time thereof. All arguments shall be submitted in writing unless otherwise ordered. At least 3 copies of all briefs or written arguments shall be furnished to the board. The time for filing such arguments shall be fixed by the hearing examiner.

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

Ins 17.24 Review of classification. (ss. 619.04 and 655.003, Stats.) (1) Any person other than a hospital or a hospital connected with a nursing home, asserting placement in the wrong classification for insurance premium rate purposes may petition for a review of classification. The commissioner shall refer such petition to a committee consisting of 2 physicians and one informed person, all appointed by the commissioner. The decision of such committee shall be reported to the petitioner within 5 working days of the closing of the hearing record.

(2) Any hospital or hospital combined with a nursing home which believes that it has been placed in the wrong classification for insurance

premium rate purposes may petition for a review of classification. The commissioner shall refer such petition to a committee consisting of 2 hospital representatives and one informed person; all appointed by the commissioner. The decision of such committee shall be reported to the petitioner within 5 working days of the closing of the hearing record.

(3) Any person or hospital who is not satisfied with the determination of the committee may petition for a declaratory ruling under s. Ins 17.02 within 30 days of the date of the written notice of the committee's determination.

(4) At any hearing held pursuant to such petition for a declaratory ruling the committee report shall be considered and the members of the committee have the right to appear and be heard but shall not be required to be present.

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

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner of insurance 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 his approval.

(b) Health care liability insurance is not readily available in the voluntary market for medical or osteopathic physicians or podiatrists, licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; for partnerships comprised of such physicians, podiatrists or nurse anesthetists; for corporations owned by such physicians, podiatrists or nurse anesthetists and operated for the purposes of providing medical services; for operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employes, and for properly accredited teaching facilities 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. Health care liability insurance and liability coverage normally incidental to health care liability insurance for hospitals as defined by s. 50.33 (1)(a) and (c), Stats., but excluding, except as otherwise provided herein, those facilities exempted by s. 50.39 (3), Stats., which operate in this state are not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for those nursing homes as defined in s. 50.01 (3)(a), Stats., which operate in this state and whose functional operations are combined with a hospital as herein defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations, are not readily available in the voluntary market. Health care liability insurance and liability coverage normally incidental to health care liability insurance for health care facilities owned or operated by a political subdivision of the state of Wisconsin are not readily available in the voluntary market.

(c) A facility for providing such health care liability insurance should be enacted pursuant to ch. 619, Stats.

(2) PURPOSE. This rule is intended to implement and interpret ch. 619, Stats., for the purpose of establishing procedures and requirements for a mandatory risk sharing plan to provide health care liability insurance coverage on a self-supporting basis for medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; partnerships comprised of such physicians, podiatrists or nurse anesthetists; corporations owned by such physicians, podiatrists or nurse anesthetists and operated for the purposes of providing medical services; for operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide service in their own facilities with salaried employes; and for properly accredited teaching facilities 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.; and to provide health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for all hospitals as defined by s. 50.33 (1)(a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided herein, which operate in this state. Health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for those nursing homes as defined in s. 50.01 (3)(a), Stats., which operate in this state and whose functional operations are combined with a hospital as herein defined as a single entity, whether or not the nursing home operations are physically separate from the hospital operations is also provided. Health care liability insurance coverage and liability coverages normally incidental to health care liability insurance on a self-supporting basis for those health care facilities owned or operated by a political subdivision of the state of Wisconsin is also provided. Health care liability insurance coverage for allied health care personnel employed by any of these health care providers while working within scope of such employment may also be provided. This rule is also intended to encourage the improvement in reasonable loss prevention measures and to encourage the maximum use of the existing voluntary market.

(3) SCOPE. This rule shall apply to all insurers authorized to transact in this state on a direct basis insurance against liability resulting from personal injuries, except for town mutuals authorized to transact insurance under ch. 612, Stats.

(4) DEFINITIONS. (a) The Wisconsin health care liability insurance plan, hereinafter referred to as the Plan, means the statutory, nonprofit, unincorporated association established by this rule to provide for the issuance of health care liability insurance and liability coverages normally incidental to health care liability insurance at adequate rate levels for risk sharing subject to the right of recoupment and to assist qualified applicants in securing health care liability insurance and liability coverage normally incidental to health care liability insurance.

(b) Insurance against liability resulting from personal injuries means all insurance coverages against loss by the personal injury or death of any person for which loss the insured is liable. It includes the personal injury liability component of multi-peril policies, but it 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).

(c) Health care liability insurance means insurance against loss, expense and liability resulting from errors, omissions or neglect in the performance of any professional service by any medical or osteopathic physician or podiatrist licensed under ch. 448, Stats., and nurse anesthetists licensed under ch. 441, Stats., who practice in this state; by a partnership comprised of such physicians, podiatrists or nurse anesthetists; by a corporation owned by such physicians, podiatrists or nurse anesthetists and operated for the purposes of providing medical services; by operating cooperative sickness care plans organized under ss. 185.981 to 185.985, Stats., which directly provide services in their own facilities with salaried employes; by properly accredited teaching facilities 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.; by all hospitals as defined by s. 50.33 (1) (a) and (c), Stats., but excluding those facilities exempted by s. 50.39 (3), Stats., except as otherwise provided; by those nursing homes as defined in s. 50.01 (3)(a), Stats., whose functional operations are combined with a hospital as herein defined as a single entity, whether or not nursing home operations are physically separate from the hospital operations, which operate in this state; and by health care facilities owned or operated by a political subdivision of the state of Wisconsin.

(d) Liability coverage normally incidental to health care liability insurance shall include owners, landlords and tenants liability insurance; owners and contractors protective liability insurance; completed operations and products liability insurance; contractual liability insurance and personal injury liability insurance.

(e) Premiums written means gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to insurance against liability resulting from personal injuries covering insureds or risks resident or located in this state excluding premiums on risks insured under the Plan.

(f) Servicing company means an insurer which services policies issued on behalf of the Plan.

(g) Confidental claims information means any information relating to the Plan in the possession of the commissioner, the board of governors or an agent thereof which reveals, directly or indirectly, the identity of a health care provider, as defined in s. 655.001 (8), Stats.

(h) Political subdivision means counties, cities, villages and towns.

(5) INSURANCE COVERAGE. (a) All of the following which operate in this state and are equitably entitled to but are otherwise unable to obtain suitable health care liability insurance in the voluntary market shall be eligible to apply for insurance under this plan:

1. All medical or osteopathic physicians or podiatrists licensed under ch. 448, Stats.;

2. Nurse anesthetists licensed under ch. 441, Stats.;

3. Partnerships comprised of physicians, podiatrists or nurse anesthetists;

(b) Notice of cancellation or nonrenewal under par. (a), containing a statement of the reasons therefor, shall be sent to the insured with a copy to the Plan. Any cancellation or nonrenewal notice to the insured shall be accompanied by a conspicuous statement that the insured has a right of appeal as provided in sub. (16).

(15) COMMISSION. Commission to the licensed agent designated by the applicant shall be 15% for each new or renewal policy issued to medical or osteopathic physicians, nurse anesthetists, podiatrists, and partnerships comprised of or corporations owned by physicians, podiatrists or nurse anesthethists subject to a maximum of $150 per policy; and 5% of the annual premium for each new or renewal policy issued to operating cooperative sickness care plans, or to teaching facilities, or to hospitals, or to health care facilities owned and operated by a political subdivision of the state of Wisconsin, not to exceed $2,500.00 per policy period. The agent need not be licensed with the servicing company.

(16) RIGHT OF APPEAL. Any affected person may appeal to the board of governors within 30 days after notice of any final ruling, action or decision of the Plan. Decisions of the board of governors may be further appealed in accordance with ch. 227, Stats.

(17) REVIEW BY COMMISSIONER. The board of governors shall report to the commissioner the name of any member or agent which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the board of governors or to pay within 30 days any assessment levied.

(18) INDEMNIFICATION. Each person serving on the board of governors or any subcommittee thereof, each member of the Plan, and the manager and each officer and employe of the Plan shall be idemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the board of governors, or a member or manager or officer or employe of the Plan except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful or criminal misconduct in the performance of his or its duties as a member of such board of governors, or a member or manager or officer or employe of the Plan. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the Plan. Indemnification hereunder shall not be exclusive of other rights to which the member, manager, officer, or employe may be entitled as a matter of law.

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., Register, May, 1985, No. 353, eff. 6-1-85.

Ins 17.26 Future medical expense funds. (1) PURPOSE. This rule is intended to implement the provisions of s. 655.015, Stats.

(2) SCOPE. This rule shall apply to all insurers, organizations and persons subject to ch. 655, Stats.

(3) DEFINITIONS. In this section:

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

(b) "Claimant" means 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.

(c) "Medical expense" means 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 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. The commissioner shall maintain an individual record of each account showing the original allocation, payments made, credits and the balance remaining.

(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) If the commissioner is not satisfied that a provider of service has been reimbursed for services or supplies provided to the injured person, payments of any medical expense may be made jointly to the claimant and to the provider. The claimant may, in writing, direct that payment be made directly to the provider. If the claimant has paid for medical supplies or services the claimant shall be reimbursed upon receipt of proof of payment.

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

(f) 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; 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.

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)

Next page is numbered 397