CHAPTER 655

HEALTH CARE LIABILITY AND PATIENTS COMPENSATION

SUBCHAPTER I

GENERAL PROVISIONS

655.001 Definitions. In this chapter:

(2) "Claimant" means the person filing a submission of controversy under s. 655.04.

(3) "Commissioner" means the commissioner of insurance.

(4) "Department" means the department of health and social services.

(5) "Dependent" means any person legally entitled to support or maintenance by another.

(5m) "Director" means the director of state courts.

(6) "Formal panel" means a 5-member patients compensation panel established under s. 655.03 (1).

(7) "Fund" means the patients compensation fund under s. 655.27.

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

(9) "Informal panel" means a 3-member patients compensation panel established under s. 655.03 (2).

(10) "Patient" means an individual who received or should have received health care services from a health care provider.

(11) "Permanently practicing in this state" means the full-time or part-time practice in this state of a health care provider's profession for more than 240 hours in any fiscal year begin-

ning each July 1 by a health care provider whose principal place of practice is in this state.

(12) "Representative" means the personal representative, spouse, parent, guardian, attorney or other legal agent of a patient.

(13) "Respondent" means the person against whom a submission of controversy is filed under s. 655.04.

History: 1975 c. 37, 79; 1977 c. 26 s. 75; 1977 c. 131; 1977 c. 203 s. 106; Sup. Ct. Order, 88 W (2d) xiii; 1979 c. 124, 185, 355; 1983 a. 189 s. 329 (5)

See note to 655.19, citing State ex rel. Strykowski v. Wilkie, 81 W (2d) 491, 261 NW (2d) 434.

Medical malpractice panels: The Wisconsin approach. Kravat. 61 MLR 55.

Recent developments in Wisconsin medical malpractice law. 1974 WLR 891.

Testing the constitutionality of medical malpractice legislation: The Wisconsin medical malpractice act of 1975. 1977 WLR 838. See also: State ex rel. Strykowski v. Wilkie, 81 W (2d) 491.

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

History: 1975 c. 79, 199; 1977 c. 131.

655.003 Rule-making authority. The director, department and commissioner may promulgate such rules under ch. 227 as are necessary to enable them to perform their responsibilities under this chapter.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii.

655.005 Remedy. (1) (a) On and after July 24, 1975, every patient, every patient's representative and every health care provider shall be conclusively presumed to have accepted to be bound by this chapter.

(b) Except as otherwise specifically provided in this chapter, this subsection also applies to minors.

(2) This chapter does not apply to injuries or death occurring, or services rendered, prior to July 24, 1975.

History: 1975 c. 37.

655.007 Patients' claims. On and after July 24, 1975, any patient or the patient's representative having a claim or any spouse, parent or child of the patient having a derivative claim for injury or death on account of malpractice is subject to this chapter.

History: 1975 c. 37, 199; 1983 a. 253.

This chapter was inapplicable to third-party claim based on contract where no bodily injury was alleged. Northwest General Hospital v. Yee, 115 W (2d) 59, 339 NW (2d) 583 (1983).

655.009 Actions against health care providers. An action to recover damages on account of malpractice shall comply with the following:

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

(2) MEDICAL EXPENSE PAYMENTS. The court or jury, whichever is applicable, shall determine the amounts of medical expense payments previously incurred and for future medical expense payments.

History: 1975 c. 37, 198, 199; 1983 a. 253.

655.01 Forms. The director shall prepare and cause to be printed, and upon request furnish free of charge, such forms and materials as the director deems necessary to facilitate or promote the efficient administration of this chapter.

History: 1975 c. 37, 199; Sup. Ct. Order, 88 W (2d) xiii.

655.013 Attorney's fees. (1) With respect to any act of malpractice after July 24, 1975, the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants is subject to the following:

(a) The determination shall not reflect amounts previously paid for medical expenses by the health care provider or the provider's insurer.

(b) The determination shall not reflect payments for future medical expense in excess of $25,000.

(2) An attorney shall offer to charge any client in a malpractice proceeding or action on a per diem or per hour basis. Any such agreement shall be made at the time of the employment of the attorney. An attorney's fee on a per diem or per hour basis is not subject to the limitations under sub. (1).

History: 1975 c. 37, 199.

655.015 Future medical expenses. If a settlement, panel award or judgment under this chapter provides for future medical expense payments in excess of $25,000, that portion of future medical expense payments in excess of $25,000 shall be paid into the patients compensation fund created under s. 655.27. The commissioner shall develop by rule a system for managing and disbursing those moneys through payments for these expenses. The payments shall be made under the system until

either the amount is exhausted or the patient dies.

History: 1975 c. 37; 1977 c. 29; 1979 c. 34, 154; 1983 a. 158.

SUBCHAPTER II

PATIENTS COMPENSATION PANELS

655.02 Establishment of panels. The director shall establish patients compensation panels situated throughout this state to hear controversies presented under this chapter. The director shall establish as many formal panels under s. 655.03 (1) and informal panels under s. 655.03 (2) as the director deems necessary.

History: 1975 c. 37, 199; Sup. Ct. Order, 88 W (2d) xiii; 1983 a. 253.

655.03 Panel members. (1) FORMAL PANELS. Each formal panel shall be composed of the following members:

(a) One physician licensed to practice medicine in this state, appointed at random by the director for a 6-month term commencing on the date specified in the letter of appointment or for the duration of any assigned case pending at the expiration of such term, from a list submitted by an appropriate statewide organization of physicians as designated by the director.

(b) One additional health care provider to be selected under subd. 1, 2 or 3. In no event may more than one health care provider be selected under this paragraph.

1. If there is only one respondent and that respondent is a physician, one physician licensed to practice medicine in this state who is engaged in a practice of medicine similar to the practice of the respondent, appointed at random by the director from a list submitted by the appropriate statewide organization.

2. If there is only one respondent and the respondent is not a physician, one person licensed or certified in this state in the same field of health care as that of the respondent, appointed at random by the director from a list supplied by the appropriate state examining board or by the department.

3. If there is more than one respondent, one person appointed under either subd. 1 or 2, with the field of health care to be represented determined by the director.

(c) One attorney with trial experience who is licensed to practice law in this state, appointed by the director to serve as the chairperson of the panel.

(d) Two public members appointed by the director from a list submitted by the governor for 2-year terms who are not attorneys and who, at the time of their appointment, are not engaged in or licensed to practice any of the professions or occupations to which this chapter applies. The director may appoint alternates to serve in the event that any public member is unable to serve on a panel for a particular claim or is unable to complete the term for which the person was appointed. No public member or alternate may attend more than 4 formal panel meetings per year.

(e) No person appointed to a panel by the director under par. (a) or (b) may decline to serve on a panel except that the director may for good cause excuse such person. Any physician, podiatrist or nurse anesthetist who declines to serve on a panel without being excused by the director is subject to the penalties provided in s. 441.01 (6) or 448.02 (3). No person may serve on a panel if the person has a professional or personal interest in a claim under consideration. Persons who resign or who are excused or prohibited from serving on a panel shall be replaced as provided in par. (f). No person appointed under par. (a) may serve on more than one panel in a 5-year period as a member appointed under par. (a), unless all other physicians in the area served by the panel have served or have been excused from serving on a panel. No person appointed under par. (d) may serve again on a panel unless at least 5 years elapse since the date on which the person last served on a panel.

(f) If a person is excused or is prohibited from serving on a panel, as provided in par. (e), for a particular claim under consideration, a replacement shall be selected, to serve during the consideration of that claim, in the same manner as the original member was selected, except that if the person was appointed under par. (d), that person's replacement shall be appointed by the director from the list of alternates appointed under par. (d). If any public member or his or her alternate reaches the limit of service of 4 formal panel meetings per year, as specified in par. (d), the director shall appoint a replacement. If a person resigns or is otherwise unable to complete the term for which appointed, that person's replacement shall be selected, to serve for the remainder of the term, in the same manner as the original member was selected, except that if the person was appointed under par. (d), the person's replacement shall be appointed by the director from the list of alternates appointed under par. (d).

(2) INFORMAL PANELS. (a) The director shall select one name from each of the following lists:

1. A list of attorneys with trial experience who are licensed to practice law in this state. The attorney selected shall serve as the chairperson of the panel.

2. A list of health care providers, arranged according to the field of health care of the

health care providers. The list shall be prepared and periodically revised by appropriate statewide organizations of health care providers. The list shall designate the specialty, if any, of each health care provider listed. Such organizations shall assist the director in determining the appropriate specialty or field of practice to be represented on each panel.

3. A list for petit jurors, as provided in s. 756.04, for the county in which a submission of controversy has been filed under s. 655.04.

(b) If any person selected from a list desires not to participate on the informal panel, the director may, for good cause, excuse such person from service. Any physician, podiatrist or nurse anesthetist who declines to serve on a panel without being excused by the director is subject to the penalties provided in s. 441.01 (6) or 448.02 (3). No person may serve on an informal panel if the person has a professional or personal interest in a claim under consideration. A replacement shall be selected in the same manner as the excused person was selected. The selections shall consist of the categories of attorney, of health care provider and of juror.

(d) No person selected from the list of petit jurors under par. (a) 3 may attend more than one informal panel meeting per year.

(3) FORMAL AND INFORMAL PANELS; PROCEDURES. (a) *Meetings; frequency.* Each panel shall meet on the call of the chairperson or a majority of its members. The director shall assign submissions of controversy to each panel and the panel hearing shall be conducted at a location determined by the director. The county board of any county shall provide, upon request of the director or the chairperson of the panel or a majority of its members, suitable facilities for hearings.

(c) *Compensation of panel members.* Each person appointed to a panel under this section shall be paid $150 for each day's actual attendance at a panel meeting plus actual and necessary travel expenses. In addition, each panel chairperson shall receive $35 per hour for office work required to administer the panel.

(4) REMOVAL OF PANEL MEMBERS. The director shall establish procedures through which claimants and respondents may request the removal of any person from a panel for cause. The attorney chairperson shall rule on each request, except that if the removal of the attorney chairperson is requested the director shall rule on the request. The claimant and the respondent each are entitled to one peremptory challenge of a panel member. The director shall establish procedures for exercising peremptory challenges. If more than one respondent is a party to the controversy, the respondents shall resolve among themselves the question of which panel member to remove through peremptory challenge. Replacements for members of formal panels shall be selected as provided in sub. (1) (f). Replacements for members of informal panels shall be selected in the same manner as the person replaced was selected.

History: 1975 c. 37, 199; 1977 c. 131 ss. 9 to 14, 24; 1977 c. 187 s. 135; 1977 c. 418; Sup. Ct. Order, 88 W (2d) xiii; 1981 c. 390 s. 252; 1983 a. 27, 253, 538

655.04 Patients' claims. (1) FILING. (a) On and after July 24, 1975, any person listed in s. 655.007 having a claim or a derivative claim under this chapter for bodily injury or death because of a tort or breach of contract based on professional services rendered or that should have been rendered by a health care provider may, after paying the fee under s. 655.14, file a submission of controversy with the director in accordance with this chapter. The submission of controversy shall be in substantially the following form:

The undersigned, ... (*name of claimant*), of ..... (*city*) in ..... (*county*), being a party to the following matter in difference that might be the subject of a legal action and desiring to avoid the expense of litigation, certifies that:

1) ..... (*Name of patient*) was a patient of ..... (*name of health care provider*), on ..... (*date*).

2) ..... (*Name of health care provider*), in treating ..... (*name of patient*) for ..... (*nature of condition or disease*), was negligent in rendering or failing to render health care services and injured the patient, in that ..... (*short statement of injury*).

3) The injury to the patient entitles the claimant to recovery in the amount of (*$25,000 or less*) (*over $25,000*).

The undersigned claimant requests that a panel be convened under section 655.02 of the Wisconsin Statutes to investigate this matter.

.....(*Name of claimant*)

(b) The director shall assign the controversy to the appropriate panel as determined under sub. (2). No action may be commenced in court unless the controversy has first been heard and findings and an order have been made by the panel.

(2) CHOICE OF PANEL. (a) *Claims of $25,000 or less.* If the claimant states in the submission of controversy that the claimant is entitled to recovery in the amount of $25,000 or less, the controversy shall be heard by an informal panel under s. 655.03 (2), unless all parties stipulate in writing that the controversy shall be heard by a formal panel under s. 655.03 (1).

(b) *Claims of over $25,000.* If the claimant states in the submission of controversy that the claimant is entitled to recovery in an amount

over $25,000, the controversy shall be heard by a formal panel under s. 655.03 (1), unless all parties stipulate in writing that the controversy shall be heard by an informal panel under s. 655.03 (2).

(3) NOTICE. Notice of the filing of the submission of controversy shall be served on all named health care providers by the director by registered mail to the address of the health care provider as designated in the submission of controversy.

(4) PROCEDURE. (a) The director shall schedule a prehearing conference for each submission of controversy, which shall be held within 60 days of the date the submission of controversy is filed under s. 655.04 (1). At the prehearing conference the attorney who chairs the panel shall establish a scheduling order in compliance with the director's procedural guidelines established under par. (d).

(b) If any party fails to comply with the scheduling order under par. (a) without good cause, the attorney who chairs the panel shall set a date to hear arguments why the controversy should not be resolved in favor of the opposing party.

(c) Unless both parties stipulate to a delay, the panel hearing on the controversy shall be held within 210 days after the date of the initial prehearing conference.

(d) The director shall establish procedural guidelines for processing controversies under this chapter. Each panel shall establish its own internal procedures, consistent with the director's guidelines.

(5) APPLICABILITY. This subchapter applies only to claims arising out of health care services provided in this state.

(6) STATUTE OF LIMITATIONS. The filing of the submission of controversy shall toll any applicable statute of limitations, and such statute of limitations shall remain tolled until 60 days after the hearing panel issues its written decision and order, or the jurisdiction of the panel is otherwise terminated.

History: 1975 c. 37, 79, 199; Sup. Ct. Order, 88 W (2d) xiii; 1983 a. 253.

See note to 655.19, citing Tamminen v. Aetna Casualty & Surety Co. 109 W (2d) 536, 327 NW (2d) 55 (1982).

655.05 Panels; assignment of controversies. Each panel shall hear and determine each controversy assigned to it by the director. Less than a full panel may hear and determine any controversy upon written stipulation of all parties. A majority vote of the panel shall be sufficient upon which to base findings, an order or an award.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii.

655.06 Guardian ad litem. (1) FOR WHOM APPOINTED. In every controversy involving a claimant who is a minor or incompetent, the attorney who chairs the panel shall appoint a guardian ad litem to represent this claimant as soon as practicable after the controversy is assigned to the panel for a hearing. A guardian ad litem shall not be appointed or appear in the same controversy for different persons whose interests may be conflicting.

(3) DURATION OF APPOINTMENT. The guardian ad litem shall continue to act until the panel issues its findings, order and award, unless earlier discharged by the attorney who chairs the panel.

(4) WHO MAY SERVE. The guardian ad litem shall be an attorney admitted to practice in this state.

History: 1975 c. 37, 79, 199; 1983 a. 253.

655.065 Panel powers. (1) DISPOSITION WITHOUT A HEARING. All parties shall be afforded opportunity for public hearing after reasonable notice, but disposition of a controversy may be made by compromise, stipulation, agreement or default without hearing.

(2) FINDINGS. Each panel, whether formal or informal, shall determine the following:

(a) Whether the actions or omissions of the health care provider were negligent.

(b) If such actions or omissions were negligent, whether the negligence caused injury or death to the patient.

(3) PANEL ORDERS. After hearing, the panel shall, by a majority vote of the participating panel members, make and file its findings upon the ultimate facts involved in the case, and shall, by a majority vote of the participating panel members, file its order. The order shall state its determination as to the rights of the parties and include any award to be made.

(4) COMPENSATORY AWARDS. (a) If the panel determines that a claimant has suffered bodily injury or has suffered damage from the death or bodily injury of another, the panel shall award compensation and benefits.

1. In any claim which is brought because of the death of the patient, a submission of controversy may be filed by the personal representative of the deceased or by the person to whom any amount awarded belongs.

2. When several claims are brought, any party may petition the panel to consolidate such claims. If the panel determines that the consolidation of all or several of such claims is in the public interest, the affected claims shall be so consolidated that a single panel finding may be made covering all affected health care providers. For the claims so consolidated, the pay-

ment of a single award shall extinguish all separate claims, and no claim ordered consolidated by the panel shall be permitted to proceed individually.

(b) Any award shall be payable by the named health care providers found liable therefor. Each health care provider shall have a right of comparative contribution or indemnity in accordance with the laws of this state.

(c) Any award under this subsection shall be diminished under s. 895.045 in proportion to the amount of negligence attributable to the patient or person entitled to recover.

(5) FILING. Every panel, whether formal or informal, shall file a copy of its findings, order and award in every case with the director.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii; 1983 a. 253 ss. 20, 21, 26.

655.067 Duty of the panel chairperson. The attorney who chairs a panel shall hear and rule upon matters of law before the panel.

History: 1983 a. 253.

655.07 Panel findings; when binding. Upon written stipulation by all parties to any controversy heard by a formal or informal panel, the findings, order and award determined by the panel shall be binding upon the parties and the provisions of s. 655.19 shall not apply.

History: 1975 c. 37.

655.08 Adverse findings. If the panel finds that a hospital has acted negligently, it shall refer the finding and its recommendation for appropriate action to the department of health and social services. If the panel finds that any other health care provider has acted negligently, it shall refer the finding and its recommendation for action to the appropriate examining board.

History: 1975 c. 37.

655.09 Designation of parties. The parties to any submission of controversy before the panel shall be designated the claimant and the respondent. The party filing the submission of controversy with the director shall be designated the claimant and the adverse party the respondent.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii.

655.10 Joinder of parties. Joinder of parties is governed by ss. 655.065 (4) (a) 2, 803.03 and 803.04. The panel may order joinder of the fund or any additional claimant or respondent if joinder is necessary to determine the claim. The panel shall notify the party joined.

History: 1975 c. 37; 1983 a. 158; 1983 a. 253 s. 31.

655.11 Notice; how served. The filing and serving of all pleadings, notices and other papers, unless otherwise directed in this chapter, may be accomplished by 1st class mail. Service by mail is complete upon mailing, subject to s. 801.15 (5). Proof of mailing shall be prima facie evidence of service.

History: 1975 c. 37, 198.

655.12 Answer. A respondent may file an answer of denial to the submission of controversy, and may file any other special defense recognized under the law and not prohibited by this chapter, at any time before the date set for the hearing, but no such answer is required and, if none is filed, the failure to file an answer shall not be deemed acquiescence in the allegations of the submission of controversy. The filing of any special defense after the controversy is set for hearing may be by written leave only, granted by the chairman of the panel.

History: 1975 c. 37.

655.13 Pleading forms. (1) All original pleadings, motions or other papers shall be filed with the director. Sufficient additional copies of the submission of controversy shall be filed to permit service of a copy on each respondent.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii; 1983 a. 253.

655.14 Filing fee. Submissions of controversy filed with the director are subject to a filing fee of $11. The filing fee shall be paid into the patients compensation panels fund created under s. 655.28.

History: 1975 c. 37, 198; Sup. Ct. Order, 88 W (2d) xiii; 1983 a. 158.

655.15 Payments to minors. Payments to minors shall be made in accordance with law.

History: 1975 c. 37.

655.17 Formal panel; hearing. (1) Except as otherwise provided in this chapter, a formal panel shall be bound by the law applicable to civil actions, but shall conduct such hearings and make such investigations in reference to questions at issue before it as in its judgment are best adapted to ascertain and determine the substantial rights of the parties expeditiously and accurately and to carry out justly the spirit of this chapter.

(2) Each formal panel may prescribe the procedures necessary to implement this chapter, order physical examinations under sub. (3), subpoena witnesses, administer oaths, apply to any circuit court having requisite jurisdiction to enforce the attendance and testimony of witnesses and the production and examination of books, papers and records and exercise all other powers and duties conferred upon it by law.

(3) Upon the application of any party or upon its own motion, a formal panel may

appoint a disinterested and duly qualified physician or other professional person or expert to make any necessary professional or expert examination of a claimant or relevant evidentiary matter and to report or testify as a witness in respect thereto. Such a witness shall be allowed actual and necessary traveling expenses and a reasonable fee fixed by the director, to be collected and paid by the party requesting the witness or by the director if the panel makes the request.

(4) In all hearings under this section, proof may be made by oral testimony, deposition or interrogatories. Depositions shall be taken as are depositions in civil actions, and may be introduced into evidence without regard to the availability of the witness to testify at the time of the hearing. Any witness may be subpoenaed by a party to the controversy to testify under the law applicable to civil actions.

(5) Witnesses before the panel shall receive for attendance the fees and mileage allowed for witnesses in civil actions.

(6) Original X-ray photographs and records or duplicates thereof made in the course of a regularly conducted activity by a health care provider or the provider's agent shall be admissible without the necessity of other identification or authentication unless a question is raised as to their authenticity or accuracy.

(7) Any report, deposition or recorded testimony of attending or examining physicians shall be retained in the private records of the panel and shall be open to the inspection of the parties and their attorneys, but not to the general public unless, in the opinion of the panel, the public interest so requires.

(8) In all hearings before a formal panel under this section, costs shall be awarded as provided for civil actions. Allowable costs shall include reasonable expert witness fees.

History: 1975 c. 37, 199; 1977 c. 449; Sup. Ct. Order, 88 W (2d) xiii; 1983 a. 253.

NOTE: See ch. 814 for court costs and fees.

Panel was authorized by 804.12 (2) (a) 3 to dismiss claim for failure to comply with order to submit to medical examination. Mazurek v. Miller, 100 W (2d) 426, 303 NW (2d) 122 (Ct. App. 1981).

Mandamus was appropriate to compel panel to consider motion to reopen under 806.07; limitation period under 655.19 was inapplicable. State ex rel. Lewandowski v. Callaway, 118 W (2d) 165, 346 NW (2d) 457 (1984).

Panel is authorized by 806.07 (1) to reopen case dismissed on the merits by voluntary agreement. 71 Atty. Gen. 1.

655.18 Informal panel; hearing. (1) A hearing before an informal panel shall be without a stenographic record. The panel shall prepare a formal statement of its decision which it shall forward to the parties.

(2) All parties may be represented at the hearing by counsel authorized to act for their respective clients. Failing an appearance, the director may order an investigation.

History: 1975 c. 37; Sup. Ct. Order, 88 W (2d) xiii.

655.19 Court trial. Unless the parties have stipulated in writing under s. 655.07 to be bound by the panel determination, any party to a panel hearing may, within 60 days after the date of an order made by a panel, commence an action for a trial in the circuit court for the county designated as the location of the panel hearing. The provisions of ch. 805 which are not in conflict with this chapter shall apply to the trial. No panel member may participate in the trial either as counsel or witness. Subject to the limitations on recovery under sub. (3), the judgment or order of the circuit court shall supersede any order or award made by a panel in a hearing under this chapter.

(1) FORMAL PANELS. The findings and order, except for damages awarded, of any formal panel shall be admissible in any action in circuit court, and the amount of damages awarded may, at the court's discretion, be admissible in the action. In the case of a trial subsequent to a formal panel hearing, the court may award actual court costs and reasonable attorney fees in excess of statutory limitations to the prevailing party.

(2) INFORMAL PANELS. The findings and order of any informal panel shall not be admissible in any court action. No statement or expression of opinion made in the course of an informal panel hearing is admissible in evidence either as an admission or otherwise in any court action. If the court action is based on a submission of controversy in which the petitioner alleged entitlement to recover $25,000 or less, this limitation on entitlement to recovery is admissible.

(3) LIMITS ON RECOVERY. The amount recoverable in any action under this section based on a submission of controversy under s. 655.04 (1) in which the petitioner alleged entitlement to recover $25,000 or less may not exceed $25,000, unless the court determines by a preponderance of evidence that the petitioner could not have known or determined with reasonable diligence the extent of the injury at the time of filing the submission of controversy.

History: 1975 c. 37; 1977 c. 26 s. 75; 1977 c. 449; 1983 a. 253.

Concurring and dissenting reports are also admissible under (1); jury must be instructed that the panel's findings and order are not binding upon the jury. Ch. 655, as construed herein, does not abridge right to trial by jury. State ex rel. Strykowski v. Wilkie, 81 W (2d) 491, 261 NW (2d) 434.

There is no conflict between 655.04 (6) and 655.19; each statute must be complied with. Statute of limitations for course of negligent medical treatment accrues at time of last negligent act that was part of continuum of malpractice. Tamminen v. Aetna Casualty & Surety Co. 109 W (2d) 536, 327 NW (2d) 55 (1982).

Although time limit under this section is jurisdictional, place of trial provision is one of venue, not jurisdiction. Pep-

linski v. Hearn, 115 W (2d) 550, 340 NW (2d) 565 (Ct. App. 1983).

See note to 655.17, citing Lewandowski v. Callaway, 118 W (2d) 165, 346 NW (2d) 457 (1984).

This section does not divest federal court of diversity jurisdiction nor preclude malpractice litigation in federal court. Martin v. Choudhuri, 563 F Supp. 207 (1983).

655.20 Judgment of circuit court on award. After the passage of time for petitioning the circuit court for a trial under s. 655.19 has passed, any party may file a certified copy of the order containing the award with the circuit court for the county of residency of any respondent named in the order, and the court shall then render judgment in accordance with the order.

History: 1975 c. 37; 1977 c. 449.

655.21 Funding. (1) The patients compensation panels fund created under s. 655.28 shall be financed from fees charged to health care providers. The director shall, by February 1 of each year, determine the revenues needed for the operation of the panels during the succeeding fiscal year and inform the board of governors created under s. 619.04 (3) of that amount. The board of governors shall, by rule, set fees to charge health care providers at a level sufficient to provide these revenues. The board shall charge each health care provider permanently practicing in this state an annual fee and shall charge each hospital an annual fee per occupied bed.

(2) The annual fees under sub. (1) shall be collected in a manner prescribed by rule of the commissioner. The commissioner shall pay all money collected under sub. (1) into the patients compensation panels fund created under s. 655.28.

History: 1975 c. 37; 1977 c. 131, 447; 1979 c. 185; 1983 a. 158.

655.22 Information needed to set fees. The department shall provide the director, the commissioner and the board of governors created under s. 619.04 (3) with information on hospital bed capacity and occupancy rates as needed to set fees under s. 655.21 or 655.27 (3).

History: 1983 a. 158.

SUBCHAPTER III

INSURANCE PROVISIONS

655.23 Limitations of liability; proof of financial responsibility. (1) All health care providers permanently practicing or operating in this state shall pay the yearly assessment into the patients compensation fund under s. 655.27.

(2) Every health care provider permanently practicing or operating in this state shall, once in each year as prescribed by the commissioner, file with the commissioner in a form prescribed by the commissioner, proof of financial responsibility as provided in this section. This requirement does not apply to any health care provider whose insurer files a certificate of insurance under sub. (3) (b). No health care provider who retires or ceases operation after July 24, 1975, shall be eligible for the protection provided under this chapter unless proof of financial responsibility for all claims arising out of acts of malpractice occurring after July 24, 1975, is provided to the commissioner as required in this section.

(3) (a) Every health care provider permanently practicing or operating in this state either shall insure and keep insured the provider's liability by a policy of insurance issued by an insurer authorized to do business in this state or by an unauthorized nondomestic insurer if the commissioner has found the insurer to be reliable and solid as provided in s. 618.41 (6) (d), shall qualify as a self-insurer, or shall furnish to the commissioner a cash or surety bond in accordance with the requirements of this chapter. Such insurance shall be designated "health care providers' professional liability insurance" and shall, in this section and ss. 655.24 and 655.245, be referred to as "health care liability insurance". The submission of a cash or surety bond, or qualification as a self-insurer, shall be subject to the approval of the commissioner and is valid only when approved by the commissioner.

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

(4) Such health care liability insurance or cash or surety bond shall be in amounts of at least $200,000 per claim and $600,000 per year.

(5) While such health care liability insurance, self-insurance or cash or surety bond approved by the commissioner remains in force, the health care provider, the provider's estate and those conducting the provider's business, including the provider's health care liability insurance carrier, are liable for malpractice for no more than $200,000 per claim and $600,000 per year or the maximum liability limit for which the provider is insured, whichever is higher, if the health care provider has met the requirements of this chapter.

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

(6) Whoever violates this section shall forfeit to the state not more than $1,000 for each violation. Each week of delay in compliance with this section shall constitute a new violation. The commissioner may demand and accept any forfeiture imposed under this section, which shall be paid into the common school fund. The commissioner may cause an action to be commenced to recover the forfeiture in an amount to be determined by the court. Before an action is commenced, the commissioner may compromise the forfeiture; after the action is commenced, the attorney general may compromise the forfeiture.

(7) Health care providers permanently practicing or operating in this state shall comply with this section before exercising any rights or privileges conferred by their health care providers' licenses or certificates of registration. The commissioner shall notify the board or agency issuing such licenses or certificates of registration of each health care provider who has not complied with this section. The examining board or agency issuing such licenses or certificates of registration may suspend, or refuse to issue or to renew the license or certificate of registration of any health care provider violating this section.

History: 1975 c. 37, 79, 199; 1977 c. 131; 1983 a. 158.

Insurer is liable under (5) up to policy limits. Patients Fund v. St. Paul Ins. Co. 116 W (2d) 537, 342 NW (2d) 693 (1984).

655.24 Insurance policy forms. (1) No insurer may enter into or issue any policy of health care liability insurance until its policy form has been submitted to and approved by the commissioner. The filing of a policy form by any insurer with the commissioner for approval shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of all provisions of this chapter, and an agreement by it to be bound hereby as to any policy issued by it to any health care provider.

(2) Every policy issued under this chapter shall be deemed conclusively to provide the following:

(a) That the insurer agrees to pay in full all supplementary expenses incurred in the settlement or defense of any claims and any settlement, arbitration award or judgment imposed against the insured under this chapter up to a limit of no less than $100,000 per claim and $300,000 per year; and

(b) That any termination of the policy by cancellation or nonrenewal is not effective as to patients claiming against those covered by the policy unless a written notice giving the date upon which the termination is to become effective has been received by the commissioner and the insured at least 10 days prior to the taking effect of a cancellation or nonrenewal for nonpayment of premium or for loss of license or certificate of registration and at least 60 days prior to the taking effect of a cancellation or nonrenewal for any other reason.

History: 1975 c. 37; 1977 c. 131.

655.245 Insurance policy limitations. (1) No policy of health care liability insurance may permit a health care provider to reject any settlement agreed upon between the claimant and the insurer.

(2) A policy of health care liability insurance may permit the insurer to make payments for medical expenses prior to any determination of fault. Such payments are not an admission of fault. Such payments may be deducted from any judgment or arbitration award, but shall not be repaid regardless of the judgment or award. Nothing in this subsection shall restrict the insurer's right of comparative contribution or indemnity in accordance with the laws of this state.

History: 1975 c. 37.

655.25 Availability and effectiveness for health care liability insurance. (1) No policy of health care liability insurance written under the provisions of s. 619.04 may be canceled or nonrenewed except for nonpayment of premiums unless the health care provider's license is revoked by the appropriate licensing board. A health care provider whose license is revoked shall be permitted to buy out in cases of a claims-made policy.

History: 1975 c. 37.

SUBCHAPTER IV

PATIENTS COMPENSATION FUND

655.27 Patients compensation fund. (1) FUND. There is created a patients compensation fund for the purpose of paying that portion of a medical malpractice claim which is in excess of the limit expressed in s. 655.23 (5) and paying future medical expense payments under s. 655.015. The fund shall provide occurrence coverage for health care providers permanently practicing or operating in this state. The fund shall be liable only for payment of claims against health care providers permanently practicing or operating in this state who have complied with this chapter and reasonable and necessary expenses incurred in payment of

claims and fund administrative expenses. The coverage provided by the fund shall begin July 1, 1975.

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

(3) FEES. (a) *Assessment.* Each health care provider permanently practicing or operating in this state shall pay operating fees, which shall be assessed based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice.

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

3. Risk factors for persons who are semi-retired or part-time professionals.

(b) *Fees established.* The commissioner, after approval by the board of governors, shall by rule set the fees under par. (a). This paragraph does not impose liability on the board of governors for payment of any part of a fund deficit.

(c) *Collection and deposit of fees.* Annual fees under pars. (a) and (b) and future medical expense payments specified for the fund shall be collected by the commissioner for deposit into the fund in a manner prescribed by the commissioner by rule.

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

(4) FUND ACCOUNTING AND AUDIT. (a) Moneys shall be withdrawn from the fund by the commissioner only upon vouchers approved and authorized by the board of governors.

(b) All books, records and audits of the fund shall be open to the general public for reasonable inspection, with the exception of confidential claims information.

(c) Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

(d) Annually after the close of a fiscal year, the board of governors shall furnish a financial report to the commissioner. The report shall be prepared in accordance with accepted accounting procedures and shall include the present value of all claims reserves, including those for incurred but not reported claims as determined by accepted actuarial principles, and such other information as may be required by the commissioner. The board of governors shall furnish an appropriate summary of this report to all fund participants.

(e) Moneys held in the fund shall be invested in short-term fixed return interest-bearing investments by the board of governors through the state investment board. All income derived from such investments shall be credited to the fund.

(f) The board of governors shall submit a functional and progress report to the appropriate committees on insurance and health in both houses of the legislature on or before March 1 of each year.

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

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

3. If after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages paid will exceed $200,000, the fund may appear and actively defend itself when named as a party in the

controversy. In such action, the fund may retain counsel and pay out of the fund attorney fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the board of governors to perform legal services for the board of governors other than those directly connected with the fund. Any judgment affecting the fund may be appealed as provided by law. The fund may not be required to file any undertaking in any judicial action, proceeding or appeal.

(b) It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed that may potentially affect the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding $200,000, or any other amount which could require payment by the fund, may be agreed to unless approved by the board of governors.

(c) It shall be the responsibility of any health care provider choosing to post bond or establish an escrow account under this chapter to provide an adequate defense on any malpractice claim filed that may potentially affect the fund. The health care provider shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding $200,000, or any other amount which could require payment by the fund, may be agreed to unless approved by the board of governors.

(d) A person who has recovered a final judgment or a settlement approved by the board of governors against a health care provider who is covered by the fund may file a claim with the board of governors to recover that portion of such judgment or settlement which is in excess of $200,000. In the event the fund incurs liability exceeding $1,000,000 to any person under a single claim the fund shall pay not more than $500,000 per year from money collected and paid into the fund under sub. (3) and interest thereon until the claim has been paid in full, and any attorney's fees in connection with such claim shall be similarly prorated. Payment of not more than $500,000 per year includes direct or indirect payment or commitment of moneys to or on behalf of any person under a single claim by any funding mechanism.

(e) Claims filed against the fund shall be paid in the order received within 90 days after filing unless appealed by the fund. If the amounts in the fund are not sufficient to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

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

History: 1975 c. 37, 79, 199; 1977 c. 29, 131; 1979 c. 34, 194; 1981 c. 20; 1983 a. 27, 158.

SUBCHAPTER V

PATIENTS COMPENSATION PANELS FUND

655.28 Patients compensation panels fund. **(1)** CREATION OF THE FUND. There is created a patients compensation panels fund to pay the administrative expenses of patients compensation panels created under subch. II.

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

(3) FEES. The fund is financed from fees generated under ss. 655.14 and 655.21.

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

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

(c) The director shall submit a report on the operation of the patients compensation panels and on the status of the fund to the presiding officer of each house of the legislature on or before March 1 of each year.

History: 1983 a. 158.