CHAPTER 655

HEALTH CARE LIABILITY AND INJURED PATIENTS AND FAMILIES COMPENSATION

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Cross-reference: See also ch. Ins 17, Wis. adm. code.

SUBCHAPTER I

GENERAL PROVISIONS

655.001 Definitions. In this chapter:

(1g) "Advanced practice registered nurse" means an individual who is licensed under s. 441.09, who has qualified to practice independently in his or her recognized role under s. 441.09 (3m) (b), and who practices advanced practice registered nursing, as defined under s. 441.001 (1c), outside of a collaborative relationship with a physician or dentist, as described under s. 441.09 (3m) (a) 1., or other employment relationship.

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

(2) "Claimant" means the person filing a request for mediation under s. 655.44 or 655.445.

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

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

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

(7m) "Graduate medical education program" means a program approved by the medical examining board that provides postgraduate medical education and training for a person who possesses a diploma from a medical or osteopathic college or who has the equivalent education and experience from a foreign medical school recognized by the Education Commission for Foreign Medical Graduates.

(7t) "Health care practitioner" means a health care professional, as defined in s. 180.1901 (1m), who is an employee of a health care provider described in s. 655.002 (1) (d), (e), (em), or (f) and who has the authority to provide health care services that are not under the direction and supervision of a physician or advanced practice registered nurse.

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

(8c) "Insurer" includes a foreign insurer that is a risk retention group that issues health care liability insurance under this chapter.

(10) "Patient" means an individual who received or should have received health care services from a health care provider or from an employee of a health care provider acting within the scope of his or her employment.

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

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

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

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

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

(13) "Respondent" means the person alleged to have been negligent in a request for mediation filed under s. 655.44 or 655.445.

(14) "Self-insurance plan" means a plan approved by the commissioner to self-insure health care providers against medical malpractice claims in accordance with this chapter. A "self-insurance plan" may provide coverage to a single health care provider or affiliated health care providers.

History: 1975 c. 37, 79; 1977 c. 26 s. 75; 1977 c. 131; 1977 c. 203 s. 106; Sup. Ct. Order, 88 Wis. 2d xiii (1979); 1979 c. 124, 185, 355; 1983 a. 189 s. 329 (5); 1985 a. 340; 1987 a. 27, 182, 264, 403; 1989 a. 187; 1991 a. 214; 1993 a. 473; 1995 a. 27 s. 9126 (19); 1999 a. 22; 2001 a. 52; 2003 a. 111; 2005 a. 36, 51; 2007 a. 20 s. 9121 (6) (a); 2013 a. 20; 2015 a. 55; 2017 a. 135; 2025 a. 17.

This chapter is a constitutionally valid enactment. State ex rel. Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978).

Medical Malpractice Panels: The Wisconsin Approach. Kravat. 61 MLR 55 (1977).

Testing the Constitutionality of Medical Malpractice Legislation: The Wisconsin Medical Malpractice Act of 1975. Mathy. 1977 WLR 838.

A summary of the new statutes governing medical malpractice. Saichek. WBB Oct. 1986.

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

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

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

1. The physician or advanced practice registered nurse is a resident of this state.

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

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

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

(d) A partnership comprised of physicians or advanced practice registered nurses and organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced practice registered nurses.

(e) A corporation organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced practice registered nurses.

(em) Any organization or enterprise not specified under par. (d) or (e) that is organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced practice registered nurses.

(f) A cooperative health care association organized under s. 185.981 that operates nonprofit health care plans in this state and that directly provides services through salaried employees in its own facility.

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

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

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

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

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

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

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

(c) A graduate medical education program that operates in this state. For a graduate medical education program that elects to be subject to this chapter under this paragraph, this chapter applies only to claims arising out of practice that is in this state and that is outside the scope of an exemption under s. 655.003 (1) or (3).

History: 1987 a. 27; 1991 a. 214; 2005 a. 36, 51; 2009 a. 165; 2025 a. 17.

In an action governed by this chapter, no claim may be brought by adult children for loss of society and companionship of an adult parent; s. 895.04 is inapplicable to actions under this chapter. Dziadosz v. Zirneski, 177 Wis. 2d 59, 501 N.W.2d 828 (Ct. App. 1993).

In an action governed by this chapter, no recovery may be had by a parent for the loss of society and companionship of an adult child. Estate of Wells v. Mount Sinai Medical Center, 183 Wis. 2d 667, 515 N.W.2d 705 (1994).

This chapter does not control all actions against health maintenance organizations (HMO). It applies only to negligent medical acts or decisions made in the course of rendering medical care. A bad faith tort action may be prosecuted against an HMO that has denied a request for coverage without a legal basis. McEvoy v. Group Health Cooperative of Eau Claire, 213 Wis. 2d 507, 570 N.W.2d 397 (1997), 96-0908.

When applicable, this chapter constitutes the exclusive procedure and remedy for medical malpractice in this state. However, this chapter applies only to a specifically defined list of health care providers under this section. It is clear from the plain text of this section and the definition and regulation of service providers under ch. 50, from which this chapter derives its legal definitions, that hospitals, nursing homes, and community-based residential facilities (CBRFs) are different operations with different meanings. While this chapter covers hospitals and certain nursing homes, it unambiguously does not cover CBRFs, even ones that share common ownership with hospitals and nursing homes. Andruss v. Divine Savior Healthcare Inc., 2022 WI 27, 401 Wis. 2d 368, 973 N.W.2d 435, 20-0202.

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

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

(2) A facility that is exempt under s. 50.39 (3) or operated by any governmental agency.

(3) Except for a physician or advanced practice registered nurse who meets the criteria under s. 146.89 (5) (a), a physician or an advanced practice registered nurse who provides professional services under the conditions described in s. 146.89, with respect to those professional services provided by the physician or advanced practice registered nurse for which he or she is covered by s. 165.25 and considered an agent of the department, as provided in s. 165.25 (6) (b).

History: 1989 a. 187, 206; 1991 a. 214; 2013 a. 241; 2025 a. 17.

655.004 Rule-making authority. The director of state courts, 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 Wis. 2d xiii (1979); 1987 a. 27; Stats. 1987 s. 655.004; 1989 a. 187 s. 28.

Cross-reference: See also ch. DC 1, Wis. adm. code.

655.005 Health care provider employees. (1) Any person listed in s. 655.007 having a claim or a derivative claim against a health care provider or an employee of the health care provider, for damages for bodily injury or death due to acts or omissions of the employee of the health care provider acting within the scope of his or her employment and providing health care services, is subject to this chapter.

(2) The fund shall provide coverage, under s. 655.27, for claims against the health care provider or the employee of the health care provider due to the acts or omissions of the employee acting within the scope of his or her employment and providing

health care services. This subsection does not apply to any of the following:

(a) An employee of a health care provider if the employee is a physician or an advanced practice registered nurse or is a health care practitioner who is providing health care services that are not under the direction and supervision of a physician or advanced practice registered nurse.

(b) A service corporation organized under s. 180.1903 by health care professionals, as defined under s. 180.1901 (1m), if the board of governors determines that it is not the primary purpose of the service corporation to provide the medical services of physicians or advanced practice registered nurses. The board of governors may not determine under this paragraph that it is not the primary purpose of a service corporation to provide the medical services of physicians or advanced practice registered nurses unless more than 50 percent of the shareholders of the service corporation are neither physicians nor advanced practice registered nurses.

(2t) Subsection (2) does not affect the liability of a health care provider described in s. 655.002 (1) (d), (e), (em), or (f) for the acts of its employees.

History: 1985 a. 340; 1987 a. 27; Stats. 1987 s. 655.005; 1989 a. 187; 1991 a. 214; 1993 a. 473; 1995 a. 167; 2001 a. 52; 2005 a. 36; 2025 a. 17.

Although not a health care provider, because an unlicensed first-year resident physician was a borrowed employee of the hospital where the resident allegedly performed negligent acts, the relation of employer and employee existed between the resident and hospital, and accordingly, the resident was an employee of a health care provider within the meaning of this chapter and s. 893.55 (4). Phelps v. Physicians Insurance Co. of Wisconsin, 2009 WI 74, 319 Wis. 2d 1, 768 N.W.2d 615, 06-2599.

This chapter does not permit claims other than those listed in sub. (1) and s. 655.007. Because this chapter exclusively governs all claims arising out of medical malpractice against health care providers and their employees, and because the legislature did not include bystander claims in sub. (1) or s. 655.007, negligent infliction of emotional distress claims arising out of medical malpractice are not actionable under Wisconsin law. Phelps v. Physicians Insurance Co. of Wisconsin, 2009 WI 74, 319 Wis. 2d 1, 768 N.W.2d 615, 06-2599.

Like bystander negligent infliction of emotional distress claims, direct negligent infliction of emotional distress claims are not derivative, do not fall within the scope of allowable medical malpractice recovery under this chapter, and are not recognized by Wisconsin law. Cox v. Medical College of Wisconsin Inc., 651 F. Supp. 3d 965 (2023).

655.006 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; 1987 a. 27; Stats. 1987 s. 655.006.

655.007 Patients' claims. On and after July 24, 1975, any patient or the patient's representative having a claim or any spouse, parent, minor sibling 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; 1997 a. 89.

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

In this section, "child" refers to a minor child. An adult child cannot assert a claim based on medical malpractice committed against the adult child's parent. Ziulkowski v. Nierengarten, 210 Wis. 2d 98, 565 N.W.2d 164 (Ct. App. 1997), 95-1708.

Section 893.55 (4) (f) makes the limits on damages applicable to medical malpractice death cases, but does not incorporate classification of wrongful death claimants entitled to bring such actions, which is controlled by this section. As such, adult children do not have standing to bring such an action. The exclusion of adult children does not violate the guarantee of equal protection. Czapinski v. St. Francis Hospital, Inc., 2000 WI 80, 236 Wis. 2d 316, 613 N.W.2d 120, 98-2437.

A mother who suffers the stillbirth of her infant as a result of medical malpractice has a personal injury claim involving negligent infliction of emotional distress, which includes the distress arising from the injuries and stillbirth of her daughter, in addition to her derivative claim for wrongful death of the infant. That the sources of the mother's emotional injuries cannot be segregated does not mean that there is a single claim of medical malpractice subject to the single cap for noneconomic damages. Pierce v. Physicians Insurance Co. of Wisconsin, 2005 WI 14, 278 Wis. 2d 82, 692 N.W.2d 558, 01-2710.

Under ss. 895.01 (1) (o) [now s. 895.01 (1) (bm)] and 895.04 (2), a wrongful death claim does not survive the death of the claimant. In a non-medical malpractice wrongful death case, under s. 895.04 (2), a new cause of action is available to the next claimant in the statutory hierarchy. In a medical malpractice wrongful death case, eligible claimants under this section are not subject to a statutory hierarchy like claimants under s. 895.04 (2). However, in a medical malpractice wrongful death case, adult children of the deceased are not listed as eligible claimants and are therefore not eligible because of the exclusivity of this section, as interpreted in *Czapinski*, 2000 WI 80. Lornson v. Siddiqui, 2007 WI 92, 302 Wis. 2d 519, 735 N.W.2d 55, 05-2315.

The plaintiff's claim that the hospital staff failed to adequately search his wife upon her return to an inpatient psychiatric unit when she carried in a gun and ammunition she used to kill herself alleged negligence in the performance of custodial care, not medical malpractice governed by this chapter. While the decision to place the patient on the unit involved medical decisions made in the course of rendering professional medical care, the search itself was a matter of custodial care. The staff's search was not the result of special orders nor did it involve the exercise of professional medical judgment. Snyder v. Injured Patients & Families Compensation Fund, 2009 WI App 86, 320 Wis. 2d 259, 768 N.W.2d 271, 08-1611.

A tortfeasor's insurer's subrogation claim against the injured party's doctor asserting that the doctor rendered unnecessary medical treatment for which the insurer is responsible amounts to an action for medical malpractice, which is governed by this chapter. Neither the tortfeasor nor the insurer are patients or patient's representatives under this section and thus do not have standing to bring a malpractice claim. The application of this chapter to bar the insurer's subrogation claim does not violate equal protection guarantees. Konkel v. Acuity, 2009 WI App 132, 321 Wis. 2d 306, 775 N.W.2d 258, 08-2156.

This chapter applies only to negligent medical acts or decisions made in the course of rendering professional medical care. To hold otherwise would exceed the bounds of the chapter and grant seeming immunity from non-ch. 655 suits to those with a medical degree. Plaintiff's claims arose from the discriminatory provision of medical care. This chapter does not apply when the provider engages in discriminatory acts on the basis of a patient's disability. Rose v. Cahee, 727 F. Supp. 2d 728 (2010).

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.

(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.

(3) VENUE. Venue in a court action under this chapter is in the county where the claimant resides if the claimant is a resident of this state, or in a county specified in s. 801.50 (2) (a) or (c) if the claimant is not a resident of this state.

History: 1975 c. 37, 198, 199; 1983 a. 253; 1985 a. 340.

Discretionary changes of venue under s. 801.52 are applicable to actions under this chapter. Hoffman v. Memorial Hospital of Iowa County, 196 Wis. 2d 505, 538 N.W.2d 627 (Ct. App. 1995), 94-2490.

655.01 Forms. The director of state courts 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 Wis. 2d xiii (1979); 1989 a. 187 s. 28.

655.013 Attorney fees. (1) With respect to any act of malpractice after July 24, 1975, for which a contingency fee arrangement has been entered into before June 14, 1986, 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 unless a new contingency fee arrangement is entered into that complies with subs. (1m) and (1t):

(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.

(1m) Except as provided in sub. (1t), with respect to any act of malpractice for which a contingency fee arrangement is en-

tered into on and after June 14, 1986, in addition to compensation for the reasonable costs of prosecution of the claim, 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 limitations:

(a) Except as provided in par. (b), 33 1/3 percent of the first $1,000,000 recovered.

(b) Twenty-five percent of the first $1,000,000 recovered if liability is stipulated within 180 days after the date of filing of the original complaint and not later than 60 days before the first day of trial.

(c) Twenty percent of any amount in excess of $1,000,000 recovered.

(1t) A court may approve attorney fees in excess of the limitations under sub. (1m) upon a showing of exceptional circumstances, including an appeal.

(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) or (1m).

History: 1975 c. 37, 199; 1985 a. 340.

655.015 Future medical expenses. If a settlement or judgment under this chapter resulting from an act or omission that occurred on or after May 25, 1995, provides for future medical expense payments in excess of $100,000, that portion of future medical expense payments in excess of an amount equal to $100,000 plus an amount sufficient to pay the costs of collection attributable to the future medical expense payments, including attorney fees reduced to present value, shall be paid into the fund. The commissioner shall develop by rule a system for managing and disbursing those moneys through payments for these expenses, which shall include a provision for the creation of a separate accounting for each claimant's payments and for crediting each claimant's account with a proportionate share of any interest earned by the fund, based on that account's proportionate share of the fund. The commissioner shall promulgate a rule specifying the criteria that shall be used to determine the medical expenses related to the settlement or judgment, taking into consideration developments in the provision of health care. The payments shall be made under the system until either the account is exhausted or the patient dies.

History: 1975 c. 37; 1977 c. 29; 1979 c. 34, 154; 1983 a. 158; 1985 a. 340; 1991 a. 214; 1995 a. 10.

Cross-reference: See also s. Ins 17.26, Wis. adm. code.

655.016 Claim by minor sibling for loss of society and companionship. Subject to s. 655.017, a sibling of a person who dies as a result of malpractice has a cause of action for damages for loss of society and companionship if the sibling was a minor at the time of the deceased sibling's death. This section does not affect any other claim available under this chapter.

History: 1997 a. 89.

655.017 Limitation on noneconomic damages. The amount of noneconomic damages recoverable by a claimant or plaintiff under this chapter for acts or omissions of a health care provider if the act or omission occurs on or after April 6, 2006, and for acts or omissions of an employee of a health care provider, acting within the scope of his or her employment and providing health care services, for acts or omissions occurring on or after April 6, 2006, is subject to the limits under s. 893.55 (4) (d) and (f).

History: 1985 a. 340; 1995 a. 10; 2005 a. 183.

A mother who suffers the stillbirth of her infant as a result of medical malpractice has a personal injury claim involving negligent infliction of emotional distress, which includes the distress arising from the injuries and stillbirth of her daughter, in addition to her derivative claim for wrongful death of the infant. That the sources of the mother's emotional injuries cannot be segregated does not mean that there is a single claim of medical malpractice subject to the single cap for noneconomic damages. Pierce v. Physicians Insurance Co. of Wisconsin, 2005 WI 14, 278 Wis. 2d 82, 692 N.W.2d 558, 01-2710.

Non-Economic-Damage Award Caps in Wisconsin: Why *Ferdon* Was (Almost) Right and the Law Is Wrong. Stutz. 2009 WLR 105.

Tort Reform: It's Not About Victims...It's About Lawyers. Scoptur. Wis. Law. June 1995.

655.019 Information needed to set fees. The department shall provide the director of state courts, the commissioner and the board of governors with information on hospital bed capacity and occupancy rates as needed to set fees under s. 655.27 (3) or 655.61.

History: 1985 a. 340; 1989 a. 187 s. 28; 1991 a. 214.

SUBCHAPTER III

INSURANCE PROVISIONS

655.23 Limitations of liability; proof of financial responsibility. (3) (a) Except as provided in par. (d), every health care provider either shall insure and keep insured the health care provider's liability by a policy of health care liability insurance issued by an insurer authorized to do business in this state or shall qualify as a self-insurer. Qualification as a self-insurer is subject to conditions established by the commissioner and is valid only when approved by the commissioner. The commissioner may establish conditions that permit a self-insurer to self-insure for claims that are against employees who are health care practitioners and that are not covered by the fund. An approved self-insurance plan may provide coverage for all affiliated health care providers under a controlling legal entity.

Cross-reference: See also s. Ins 17.50, Wis. adm. code.

(am) For purposes of par. (a) only, a foreign insurer that is a risk retention group and that has not been issued a certificate of authority under s. 618.12 is authorized to do business in this state if the risk retention group is registered with the commissioner, is approved by the commissioner to provide health care liability insurance coverage under this chapter, and has and maintains a risk-based capital ratio of at least 300 percent as determined under the risk-based capital instructions adopted by the National Association of Insurance Commissioners.

(b) Each insurance company issuing health care liability insurance that meets the requirements of sub. (4) to any health care provider 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.

(c) Each self-insured health care provider furnishing coverage that meets the requirements of sub. (4) shall, at the times and in the form prescribed by the commissioner, file with the commissioner a certificate of self-insurance and a separate certificate of insurance for each additional health care provider covered by the self-insured plan.

(d) If a cash or surety bond furnished by a health care provider for the purpose of insuring and keeping insured the health care provider's liability was approved by the commissioner before April 25, 1990, par. (a) does not apply to the health care provider while the cash or surety bond remains in effect. A cash or surety bond remains in effect unless the commissioner, at the request of the health care provider or the surety, approves its cancellation.

(4) (a) A cash or surety bond under sub. (3) (d) shall be in amounts of at least $200,000 for each occurrence and $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987, and before July 1, 1988, and $400,000 for each oc-

currence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988.

(b) 1. Except as provided in par. (c), before July 1, 1997, health care liability insurance may have provided either occurrence or claims-made coverage. The limits of liability shall have been as follows:

a. For occurrence coverage, at least $200,000 for each occurrence and $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987, and before July 1, 1988, and $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988, and before July 1, 1997.

b. For claims-made coverage, at least $200,000 for each claim arising from an occurrence before July 1, 1987, regardless of when the claim is made, and $600,000 for all claims in any one reporting year for claims made before July 1, 1987, $300,000 for each claim arising from an occurrence on or after July 1, 1987, and before July 1, 1988, regardless of when the claim is made, and $900,000 for all claims in any one reporting year for claims made on or after July 1, 1987, and before July 1, 1988, and $400,000 for each claim arising from an occurrence on or after July 1, 1988, and before July 1, 1997, regardless of when the claim is made, and $1,000,000 for all claims in any one reporting year for claims made on or after July 1, 1988, and before July 1, 1997.

2. Except as provided in par. (c), on and after July 1, 1997, health care liability insurance may provide either occurrence or claims-made coverage. The limits of liability shall be as follows:

a. For occurrence coverage, at least $1,000,000 for each occurrence and $3,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1997.

b. For claims-made coverage, at least $1,000,000 for each claim arising from an occurrence on or after July 1, 1997, and $3,000,000 for all claims in any one reporting year for claims made on or after July 1, 1997.

(c) 1. Except as provided in subd. 2., self-insurance shall be in amounts of at least $200,000 for each occurrence and $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987, and before July 1, 1988, $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988, and before July 1, 1997, and $1,000,000 for each occurrence and $3,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1997.

2. Notwithstanding subd. 1., in the discretion of a self-insured health care provider, self-insurance may be in an amount that is less than $1,000,000 but not less than $600,000 for each occurrence on or after July 1, 1997, and before July 1, 1999, and less than $1,000,000 but not less than $800,000 for each occurrence on or after July 1, 1999, and before July 1, 2001.

(d) The commissioner may promulgate such rules as the commissioner considers necessary for the application of the liability limits under par. (b) to reporting years following termination of claims-made coverage, including rules that provide for the use of actuarial equivalents.

(5) While health care liability insurance, self-insurance or a cash or surety bond under sub. (3) (d) remains in force, the health care provider, the health care provider's estate and those conducting the health care provider's business, including the health care provider's health care liability insurance carrier, are liable for malpractice for no more than the limits expressed in sub. (4) or the maximum liability limit for which the health care 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. (4) shall apply to any joint liability of a physician or advanced practice registered nurse and his or her corporation, partnership, or other organization or enterprise under s. 655.002 (1) (d), (e), or (em).

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

(7) Each health care provider shall comply with this section and with s. 655.27 (3) (a) before exercising any rights or privileges conferred by his or her health care provider's license. The commissioner shall notify the board that issued the license of a health care provider that has not complied with this section or with s. 655.27 (3) (a). The board that issued the license may suspend, or refuse to issue or to renew the license of any health care provider violating this section or s. 655.27 (3) (a).

(8) 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 in the form prescribed by the commissioner.

History: 1975 c. 37, 79, 199; 1977 c. 131; 1983 a. 158; 1985 a. 340; 1989 a. 56 s. 259; 1989 a. 187 ss. 14 to 19, 29; 1989 a. 332; 1991 a. 214; 1993 a. 473; 1997 a. 11; 2005 a. 36; 2013 a. 20; 2015 a. 55; 2025 a. 17.

An insurer is liable under sub. (5) up to its policy limits. Wisconsin Patients Compensation Fund v. St. Paul Fire & Marine Insurance Co., 116 Wis. 2d 537, 342 N.W.2d 693 (1984).

That a self-insurance plan could have or should have been approved is irrelevant. Under sub. (3) (a), the plan must actually be approved for a provider to be qualified as a self-insurer. Wisconsin Patients Compensation Fund v. St. Mary's Hospital of Milwaukee, 209 Wis. 2d 17, 561 N.W.2d 797 (Ct. App. 1997), 95-3294.

Any liability of a person who is not a health care provider under this chapter, while doing a provider's business, together with the liability of the health care provider itself, is limited to the amount of primary coverage mandated by sub. (4). Since the Wisconsin Patients Compensation Fund is obligated to pay any amounts above this limit, the fund does not have subrogation rights against a non-provider or the non-provider's insurer. Patients Compensation Fund v. Lutheran Hospital-LaCrosse, Inc., 223 Wis. 2d 439, 588 N.W.2d 35 (1999), 96-1344.

Pursuant to *Lutheran Hospital*, 223 Wis. 2d 439 (1999), any liability for a nurse's negligence belongs to the responsible health care provider and its insurer. The provider's insurer may not seek contribution from the nurse, and thus it may not seek it from the employer who provided the nurse's services to the provider through a staffing agreement, or the employer's insurer. Rogers v. Saunders, 2008 WI App 53, 309 Wis. 2d 238, 750 N.W.2d 477, 07-0306.

This section is not preempted by federal law. Ophthalmic Mutual Insurance Co. v. Musser, 143 F.3d 1062 (1998).

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 under s. 631.20 (1) (a). 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.

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

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

(a) That the insurer agrees to pay in full all of the following:

1. Attorney fees and other costs incurred in the settlement or defense of any claims.

2. Any settlement, arbitration award or judgment imposed against the insured under this chapter up to the limits expressed in

s. 655.23 (4), or the maximum liability limit for which the health care provider is insured, whichever is greater.

3. Any portion or all of the interest, as determined by the board of governors, on an amount recovered against the insured under this chapter for which the insured is liable under s. 807.01 (4), 814.04 (4) or 815.05 (8).

(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 the insured has been notified as provided in sub. (3) and s. 631.36, except that an insurer may cancel a health care provider's policy under s. 631.36 (2) if the health care provider is no longer licensed to practice medicine or nursing.

(3) A notice of cancellation or nonrenewal that is required under sub. (2) (b) issued to a health care provider who is a natural person must inform the health care provider that his or her license to practice medicine or nursing may be suspended or not renewed if the health care provider has no insurance or insufficient insurance. The insurer shall retain a copy of each notice issued under sub. (2) (b) for not less than 10 years from the date of mailing or delivery of the notice and shall furnish a copy to the commissioner upon request.

(4) The insurer shall, upon termination of a policy of health care liability insurance issued under this chapter by cancellation or nonrenewal, notify the commissioner of the termination.

History: 1975 c. 37; 1977 c. 131; 1985 a. 340; 1989 a. 187; 1991 a. 214; 1999 a. 9.

Cross-reference: See also s. Ins 17.35, Wis. adm. code.

Based on sub. (2) (a) 3. and applicable administrative rules, the Wisconsin Injured Patients and Families Compensation Fund's obligation to cover the amount of the judgment in excess of the policy or statutory limit is not triggered until the primary insurer's policy limits and supplemental payments, including interest, have been exhausted. Jandre v. Physicians Insurance Co. of Wisconsin, 2010 WI App 136, 330 Wis. 2d 50, 792 N.W.2d 558, 08-1972.

Affirmed on other grounds. 2012 WI 39, 340 Wis. 2d 31, 813 N.W.2d 627, 08-1972.

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. 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; 1995 a. 85.

655.26 Reports on claims paid. (1) In addition to any information required by the commissioner under s. 601.42, by the 15th day of each month, each insurer that writes health care liability insurance in this state and each self-insurer approved under s. 655.23 (3) (a) shall report the following information to the medical examining board and the board of governors on each claim paid during the previous month for damages arising out of the rendering of health care services:

(a) The name and address of the policyholder or self-insured entity and the name and address of any individual on whose behalf the claim was paid.

(b) The profession of the individual or the type of facility or entity on whose behalf the claim was paid.

(c) The health care provider's medical specialty, if the provider is a physician.

(d) A description of the injury, including its cause and severity.

(e) Whether the claim was paid as a result of a settlement, a patients compensation panel award or a court award.

(f) The amount of the payment.

(g) The number and amounts of any previous claims paid by the insurer or self-insurer for damages arising out of the rendering of health care services by the insured, the self-insurer or the employees of the insured or self-insurer. Only claims paid on or after July 20, 1985, are required to be reported under this paragraph.

(h) Any additional information requested by the medical examining board or the board of governors.

(2) By the 15th day of each month, the board of governors shall report the information specified in sub. (1) to the medical examining board for each claim paid by the fund or from the appropriation under s. 20.145 (2) (a) during the previous month for damages arising out of the rendering of health care services by a health care provider or an employee of a health care provider.

(3) If more than one payment will be made on a claim, the first report filed under sub. (1) or (2) after the first payment is made on the claim shall include the total amount of the award or settlement and the projected schedule and amounts of payments.

(4) Any person who in good faith provides information to the medical examining board or the board of governors under this section is immune from civil liability for his or her acts or omissions in providing such information.

History: 1985 a. 29, 340; 1989 a. 187; 1991 a. 214; 2007 a. 20.

Cross-reference: See also s. Ins 17.275, Wis. adm. code.

SUBCHAPTER IV

INJURED PATIENTS AND FAMILIES COMPENSATION FUND

655.27 Injured patients and families compensation fund. (1) FUND. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim which is in excess of the limits expressed in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, paying future medical expense payments under s. 655.015, and paying claims under sub. (1m). The fund shall provide occurrence coverage for claims against health care providers that have complied with this chapter, and against employees of those health care providers, and for reasonable and necessary expenses incurred in payment of claims and fund administrative expenses. The coverage provided by the fund shall begin July 1, 1975. The fund shall not be liable for damages for injury or death caused by an intentional crime, as defined under s. 939.12, committed by a health care provider or an employee of a health care provider, whether or not the criminal conduct is the basis for a medical malpractice claim.

(1m) PEER REVIEW ACTIVITIES. (a) The fund shall pay that portion of a claim described in par. (b) against a health care provider that exceeds the limit expressed in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater.

(b) A health care provider who engages in the activities described in s. 146.37 (1g) and (3) shall be liable for not more than the limits expressed under s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, if he or she is found to be liable under s. 146.37, and the fund shall pay the excess amount, unless the health care provider is found not to have acted in good faith during those activities and the failure to act in good faith is found by the trier of fact, by clear and convincing evidence, to be both malicious and intentional.

(2) FUND ADMINISTRATION AND OPERATION. Management of the fund shall be vested with the board of governors. 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). The fund shall pay to the commissioner amounts charged for organizational support services, which shall be credited to the appropriation account under s. 20.145 (1) (g) 2.

(3) FEES. (a) *Assessment.* Each health care provider shall pay an annual assessment, which, subject to pars. (b) to (br), shall be based on the following considerations:

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

2. The past and prospective loss and expense experience of the fund.

2m. The loss and expense experience of the individual health care provider which resulted in the payment of money, from the fund or other sources, for damages arising out of the rendering of medical care by the health care provider or an employee of the health care provider, except that an adjustment to a health care provider's fees may not be made under this subdivision prior to the receipt of the recommendation of the injured patients and families compensation fund peer review council under s. 655.275 (5) (a) and the expiration of the time period provided, under s. 655.275 (7), for the health care provider to comment or prior to the expiration of the time period under s. 655.275 (5) (a).

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

4. For a health care provider described in s. 655.002 (1) (d), (e), (em), or (f), risk factors and past and prospective loss and expense experience attributable to employees of that health care provider other than employees licensed as a physician or advanced practice registered nurse.

5. The supplemental appropriation under s. 20.145 (2) (a) for payment of claims.

(am) *Assessments for peer review council.* The fund, a mandatory health care liability risk-sharing plan established under s. 619.04, and a private health care liability insurer shall be assessed, as appropriate, fees sufficient to cover the costs of the injured patients and families compensation fund peer review council, including costs of administration, for reviewing claims paid by the fund or from the appropriation under s. 20.145 (2) (a), by the plan, and by the insurer, respectively, under s. 655.275 (5). The fees shall be set by the commissioner by rule, after approval by the board of governors, and shall be collected by the commissioner for deposit in the fund. The costs of the injured patients and families compensation fund peer review council shall be funded from the appropriation under s. 20.145 (2) (um).

(b) *Fees established.* 1. The commissioner, after approval by the board of governors, shall set the fees under par. (a). The fees may be paid annually or in semiannual or quarterly installments. In addition to the prorated portion of the annual fee, semiannual and quarterly installments shall include an amount sufficient to cover interest not earned and administrative costs incurred because the fees were not paid on an annual basis. This paragraph does not impose liability on the board of governors for payment of any part of a fund deficit.

2. With respect to fees paid by physicians, the commissioner shall provide for no fewer than 4 payment classifications, based upon the amount of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed, by reference to the applicable Insurance Services Office, Inc., codes for specialties and types of practice that are similar in the degree of exposure to loss.

2m. In addition to the fees and payment classifications described under subds. 1. and 2., the commissioner, after approval by the board of governors, may establish a separate payment classification for physicians satisfying s. 655.002 (1) (b) and a separate fee for advanced practice registered nurses satisfying s. 655.002 (1) (b) which take into account the loss experience of health care providers for whom Michigan is a principal place of practice.

(bg) *Fee increase.* 1. The commissioner shall provide for an automatic increase in a health care provider's fees, except as provided in subd. 2., if the loss and expense experience of the fund and other sources with respect to the health care provider or an employee of the health care provider exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, both as established by the commissioner. The commissioner shall specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of awards in excess of the respective thresholds.

2. The commissioner shall provide that the automatic increase does not apply if the board of governors determines that the performance of the injured patients and families compensation fund peer review council in making recommendations under s. 655.275 (5) (a) adequately addresses the consideration set forth in par. (a) 2m.

(br) *Limit on fees.* The commissioner, in setting fees for a particular fiscal year under par. (b), shall ensure that the fees assessed do not exceed the greatest of the following:

1. The estimated total dollar amount of claims to be paid during that particular fiscal year.

2. The fees assessed for the fiscal year preceding that particular fiscal year, adjusted by the commissioner of insurance to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor.

3. Two hundred percent of the total dollar amount disbursed for claims during the calendar year preceding that particular fiscal year.

(bt) *Report to joint committee on finance.* Annually, no later than April 1, the commissioner shall send to the cochairpersons of the joint committee on finance a report detailing the proposed fees and payment classifications set for the next fiscal year under par. (b) and under s. 655.61 (1). If, within 14 working days after the date that the commissioner submits the report, the cochairpersons of the committee notify the commissioner that the committee has scheduled a meeting for the purpose of reviewing the proposed fees and payment classifications, the commissioner may not impose the fees or payment classifications until the commit-

tee approves the report. If the cochairpersons of the committee do not notify the commissioner, the commissioner may impose the proposed fees and payment classifications. In addition to any other method prescribed by rule for advising health care providers of the amount of the fees and payment classifications, the commissioner shall post the fees and payment classifications set under par. (b) for the next fiscal year on the office's Internet site and the director of state courts shall post the fees set under s. 655.61 (1) for the next fiscal year on the mediation fund's Internet site.

(c) *Collection and deposit of fees.* Fees under pars. (a) and (b) and future medical expense payments specified for the fund under s. 655.015 shall be collected by the commissioner for deposit into the fund in a manner prescribed by the commissioner by rule.

(d) *Late establishment or approval of fees.* If the fees under par. (b) for any particular fiscal year are not established by the commissioner, approved by the board of governors, or approved under par. (bt) by the joint committee on finance before June 2 of that fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the fees for that fiscal year are subsequently established by the commissioner, approved by the board of governors, or approved under par. (bt) by the joint committee on finance, the balance for the fiscal year shall be collected or refunded or the remaining semiannual or quarterly installment payments shall be adjusted except the commissioner may elect not to collect, refund, or adjust for minimal amounts.

(e) *Podiatrist fees.* The commissioner, after approval by the board of governors, may assess fees against podiatrists for the purpose of paying the fund's portion of medical malpractice claims and expenses resulting from claims against podiatrists based on occurrences before July 1, 1986.

(4) FUND ACCOUNTING AND AUDIT. (a) Moneys shall be withdrawn from the fund, or paid from the appropriation under s. 20.145 (2) (a), 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) The board of governors shall submit a quarterly report to the state investment board and the department of administration projecting the future cash flow needs of the fund. The state investment board shall invest moneys held in the fund in investments with maturities and liquidity that are appropriate for the needs of the fund as reported by the board of governors in its quarterly reports under this paragraph. 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 chief clerk of each house of the legislature, for distribution to the appropriate standing committees under s. 13.172 (3), on or before March 1 of each year.

(g) The board of governors may cede reinsurance to an insurer authorized to do business in this state under ch. 611, 613, 614 or 618 or pursue other loss funding management to preserve the solvency and integrity of the fund, subject to approval by the commissioner. The commissioner may prescribe controls over or other conditions on such use of reinsurance or other loss-funding management mechanisms.

(5) CLAIMS PROCEDURES. (a) 1. Any person may file a claim for damages arising out of the rendering of medical care or services or participation in peer review activities under s. 146.37 within this state against a health care provider or an employee of a health care provider. A person filing a claim may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced.

2. Any person may file an action for damages arising out of the rendering of medical care or services or participation in peer review activities under s. 146.37 outside this state against a health care provider or an employee of a health care provider. A person filing an action may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced. If the rules of procedure of the jurisdiction in which the action is brought do not permit naming the fund as a party, the person filing the action may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund and the fund is notified of the action within 60 days of service of process on the health care provider or the employee of the health care provider. The board of governors may extend this time limit if it finds that enforcement of the time limit would be prejudicial to the purposes of the fund and would benefit neither insureds nor claimants.

3. If, after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages paid will exceed the limits in s. 655.23 (4), the fund may appear and actively defend itself when named as a party in an action against a health care provider, or an employee of a health care provider, that has coverage under the fund. In such action, the fund may retain counsel and pay out of the fund attorney fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the board of governors to perform legal services for the board of governors other than those directly connected with the fund. Any judgment affecting the fund may be appealed as provided by law. The fund may not be required to file any undertaking in any judicial action, proceeding or appeal.

(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 of the fund on any claim filed that may potentially affect the fund with respect to such insurance contract or self-insurance contract. The insurer or self-insurer shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding an 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 with a cash or surety bond in effect under s. 655.23 (3) (d) to provide an adequate defense of the fund on any malpractice claim filed or any claim filed under sub. (1m) that may potentially af-

fect the fund. The health care provider shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding an 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, or an employee of a health care provider, that has coverage under the fund may file a claim with the board of governors to recover that portion of such judgment or settlement which is in excess of the limits in s. 655.23 (4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater. In the event the fund incurs liability for future payments exceeding $1,000,000 to any person under a single claim as the result of a settlement or judgment that is entered into or rendered under this chapter for an act or omission that occurred on or after May 25, 1995, the fund shall pay, after deducting the reasonable costs of collection attributable to the remaining liability, including attorney fees reduced to present value, the full medical expenses each year, plus an amount not to exceed $500,000 per year that will pay the remaining liability over the person's anticipated lifetime, or until the liability is paid in full. If the remaining liability is not paid before the person dies, the fund may pay the remaining liability in a lump sum. Payments shall be made from money collected and paid into the fund under sub. (3) and from interest earned thereon. For claims subject to a periodic payment made under this paragraph, payments shall be made until the claim has been paid in full, except as provided in s. 655.015. Periodic payments made under this paragraph include direct or indirect payment or commitment of moneys to or on behalf of any person under a single claim by any funding mechanism. No interest may be paid by the fund on the unpaid portion of any claim filed under this paragraph, except as provided under s. 807.01 (4), 814.04 (4) or 815.05 (8).

(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 paid from the appropriation under s. 20.145 (2) (a).

(6) PURPOSE AND INTEGRITY OF FUND. The fund is established to curb the rising costs of health care by financing part of the liability incurred by health care providers as a result of medical malpractice claims and to ensure that proper claims are satisfied. The fund, including any net worth of the fund, is held in irrevocable trust for the sole benefit of health care providers participating in the fund and proper claimants. Moneys in the fund may not be used for any other purpose of the state.

(7) ACTIONS AGAINST INSURERS, SELF-INSURERS OR PROVIDERS. The board of governors may bring an action against an insurer, self-insurer or health care provider for failure to act in good faith or breach of fiduciary responsibility under sub. (5) (b) or (c).

History: 1975 c. 37, 79, 199; 1977 c. 29, 131; 1979 c. 34, 194; 1981 c. 20; 1983 a. 27, 158; 1985 a. 340; 1987 a. 27, 186, 247, 399; 1989 a. 102, 187, 332; 1991 a. 214, 315; 1993 a. 473; 1995 a. 10; 2001 a. 65; 2003 a. 111; 2005 a. 36, 410; 2007 a. 20; 2015 a. 90; 2019 a. 66; 2021 a. 114, 267; 2025 a. 17.

Cross-reference: See also ss. Ins 17.27, 17.28, 17.29, and 17.40, Wis. adm. code.

The Wisconsin Patients Compensation Fund has the authority to sue an insurer that refuses to contribute to the settlement of a claim against its insured. Wisconsin Patients Compensation Fund v. Wisconsin Health Care Liability Insurance Plan, 200 Wis. 2d 599, 547 N.W.2d 578 (1996), 95-0865.

The denial of a postverdict motion to add the Wisconsin Patients Compensation Fund to an action in which an excess verdict was returned was appropriate. Granting the motion would have denied the fund's right under sub. (5) to appear and actively defend itself in the action. Goff v. Seldera, 202 Wis. 2d 600, 550 N.W.2d 144 (Ct. App. 1996), 95-0135.

Sub. (4) (b) does not provide an "explicit and unequivocal" exemption to the open records law. Any denial of an open records request under this section must state with "sufficient specificity" a public policy reason for refusing to release the requested records. Chvala v. Bubolz, 204 Wis. 2d 82, 552 N.W.2d 892 (Ct. App. 1996), 95-3120.

When a hospital's violation of the federal Emergency Medical Treatment and Active Labor Act for failure to provide treatment results from a negligent medical act or a decision made in rendering care, the Wisconsin Patients Compensation Fund has an obligation to provide excess coverage. When the hospital's violation results from an economic decision, the fund has no duty to provide coverage. Burks v. St. Joseph's Hospital, 227 Wis. 2d 811, 596 N.W.2d 391 (1999), 97-0466.

A medical malpractice plaintiff is required to name the Wisconsin Patients Compensation Fund as a party but may do so after the period prescribed in s. 893.55 has passed so long as the health care providers are sued before the statute of limitations has run. Anderson v. Sauk Prairie Memorial Hospital, 2000 WI App 108, 235 Wis. 2d 249, 612 N.W.2d 369, 99-2052.

The requirement in sub. (5) (b) that the primary insurer provide the Wisconsin Patient's Compensation Fund an adequate defense does not require that the insurer's attorneys must assume an attorney-client relationship with the fund. Wisconsin Patients Compensation Fund v. Physicians Insurance Co. of Wisconsin, 2000 WI App 248, 239 Wis. 2d 360, 620 N.W.2d 457, 99-1322.

Under s. 895.045 (1), the liability of each person found to be less than 51 percent causally negligent is limited to the percentage of the total causal negligence attributed to that person. Thus, insurers of doctors less than 51 percent causally negligent can be liable for no more than their insureds. Estate of Capistrant v. Froedtert Memorial Lutheran Hospital, Inc., 2003 WI App 213, 267 Wis. 2d 455, 671 N.W.2d 400, 03-0014.

Health care providers have a constitutionally protected property interest in the Injured Patients and Families Compensation Fund. Sub. (6) defines the fund as an irrevocable trust, and the structure and purpose of the fund satisfy all the elements necessary to establish a formal trust. Because the health care providers are specifically named as beneficiaries of the trust, they have equitable title to the assets of the fund. The transfer of $200 million from the fund to another fund was an unconstitutional taking of private property without just compensation. Wisconsin Medical Society, Inc. v. Morgan, 2010 WI 94, 328 Wis. 2d 469; 787 N.W.2d 22, 09-0728.

655.275 Injured patients and families compensation fund peer review council.

(1) DEFINITION. In this section, "council" means the injured patients and families compensation fund peer review council.

(2) APPOINTMENT. The board of governors shall appoint the members of the council. Section 15.09, except s. 15.09 (4) and (8), does not apply to the council. The board of governors shall designate the chairperson, who shall be a physician, the vice chairperson, and the secretary of the council and the terms to be served by council members. The council shall consist of 5 or 7 persons, not more than 3 of whom are physicians who are licensed and in good standing to practice medicine in this state and one of whom is an advanced practice registered nurse who is licensed and in good standing to practice nursing in this state. The chairperson or another peer review council member designated by the chairperson shall serve as an ex officio nonvoting member of the medical examining board and may attend meetings of the medical examining board, as appropriate.

(3) MEETINGS. The council shall meet at the call of the chairperson of the board of governors or the chairperson of the council. The council shall meet at the location determined by the person calling the meeting.

(4) REPORTS. The council shall submit to the chairperson of the board of governors, upon request of the chairperson but not more often than annually, a report on the operation of the council.

(5) DUTIES. (a) The council shall review, within one year of the date of first payment on the claim, each claim that is paid by the fund or from the appropriation under s. 20.145 (2) (a), by a mandatory health care liability risk-sharing plan established under s. 619.04, by a private health care liability insurer, or by a self-insurer for damages arising out of the rendering of medical care by a health care provider or an employee of the health care provider and shall make recommendations to all of the following:

1. The commissioner and the board of governors regarding any adjustments to be made, under s. 655.27 (3) (a) 2m., to fund fees assessed against the health care provider, based on the paid claim.

2. The commissioner and the board of governors regarding any adjustments to be made, under s. 619.04 (5) (b), to premiums assessed against a physician under a mandatory health care liability risk-sharing plan established under s. 619.04, based on the paid claim.

3. A private health care liability insurer regarding adjustments to premiums assessed against a physician covered by private insurance, based on the paid claim, if requested by the private insurer.

(b) In developing recommendations under par. (a), the council may consult with any person and shall consult with the following:

1. If a claim was paid for damages arising out of the rendering of care by a physician, with at least one physician from the area of medical specialty of the physician who rendered the care and with at least one physician from the area of medical specialty of the medical procedure involved, if the specialty area of the procedure is different than the specialty area of the physician who rendered the care.

2. If a claim was paid for damages arising out of the rendering of care by an advanced practice registered nurse, with at least one advanced practice registered nurse.

(6) FEES. Fees sufficient to cover the council's costs, including costs of administration, shall be collected under s. 655.27 (3) (am).

(7) NOTICE OF RECOMMENDATION. The council shall notify the affected health care provider, in writing, of its recommendations to the commissioner, the board of governors or a private insurer made under sub. (5). The notice shall inform the health care provider that the health care provider may submit written comments on the council's recommendations to the commissioner, the board of governors or the private insurer within a reasonable period of time specified in the notice.

(8) PATIENT RECORDS. The council may obtain any information relating to any claim it reviews under this section that is in the possession of the commissioner or the board of governors. The council shall keep patient health care records confidential as required by s. 146.82.

(9) IMMUNITY. Members of the council and persons consulting with the council under sub. (5) (b) are immune from civil liability for acts or omissions while performing their duties under this section.

(10) MEMBERS' AND CONSULTANTS' EXPENSES. Notwithstanding s. 15.09 (6), any person serving on the council and any person consulting with the council under sub. (5) (b) shall be paid at a rate established by the commissioner by rule.

History: 1985 a. 340; 1989 a. 187; 1991 a. 214, 315; 1999 a. 9; 2003 a. 111; 2007 a. 20, 108; 2019 a. 66; 2021 a. 114; 2021 a. 239 s. 74; 2025 a. 17.

Cross-reference: See also ss. Ins 17.285 and 17.30, Wis. adm. code.

SUBCHAPTER VI

MEDIATION SYSTEM

655.42 Establishment of mediation system. (1) LEGISLATIVE INTENT. The legislature intends that the mediation system provide the persons under sub. (2) with an informal, inexpensive and expedient means for resolving disputes without litigation and intends that the director of state courts administer the mediation system accordingly.

(2) MEDIATION SYSTEM. The director of state courts shall establish a mediation system complying with this subchapter not later than September 1, 1986. The mediation system shall consist of mediation panels that assist in the resolution of disputes, regarding medical malpractice, between patients, their representatives, spouses, parents or children and health care providers.

History: 1985 a. 340; 1989 a. 187 s. 28.

655.43 Mediation requirement. The claimant and all respondents named in a request for mediation filed under s. 655.44 or 655.445 shall participate in mediation under this subchapter.

History: 1985 a. 340.

655.44 Request for mediation prior to court action. (1) REQUEST AND FEE. Beginning September 1, 1986, 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 file a request for mediation and shall pay the fee under s. 655.54.

(2) CONTENT OF REQUEST. The request for mediation shall be in writing and shall include all of the following information:

(a) The claimant's name and city, village or town, county and state of residence.

(b) The name of the patient.

(c) The name and address of the health care provider alleged to have been negligent in treating the patient.

(d) The condition or disease for which the health care provider was treating the patient when the alleged negligence occurred and the dates of treatment.

(e) A brief description of the injury alleged to have been caused by the health care provider's negligence.

(3) DELIVERY OR REGISTERED MAIL. The request for mediation shall be delivered in person or sent by registered mail to the director of state courts.

(4) STATUTE OF LIMITATIONS. Any applicable statute of limitations is tolled on the date the director of state courts receives the request for mediation if delivered in person or on the date of mailing if sent by registered mail. The statute remains tolled until 30 days after the last day of the mediation period under s. 655.465 (7).

(5) NO COURT ACTION COMMENCED BEFORE MEDIATION. Except as provided in s. 655.445, no court action may be commenced unless a request for mediation has been filed under this section and until the expiration of the mediation period under s. 655.465 (7).

(6) NOTICE OF COURT ACTION TO DIRECTOR OF STATE COURTS. A claimant who files a request for mediation under this section and who commences a court action after the expiration of the mediation period under s. 655.465 (7) shall send notice of the court action by 1st class mail to the director of state courts.

History: 1985 a. 340; 1989 a. 187 s. 28.

A request for mediation of a claim naming only one doctor did not toll the statute of limitations applicable to claims against doctors not named in the mediation request. Dipple v. Wisconsin Patients Compensation Fund, 161 Wis. 2d 854, 468 N.W.2d 789 (Ct. App. 1991).

When a care provider was deceased, it was sufficient to name the deceased provider in the mediation request rather than a legal entity, such as the estate or the provider's insurer. In that case, the tolling of the statute of limitations under sub. (4) was effective against an insurer and the Wisconsin Patients Compensation Fund. Failure to name the fund as a party to an action brought against the insurer within the 30-day period under sub. (4) barred the claim against the fund. Geiger v. Wisconsin Health Care Liability Insurance Plan, 196 Wis. 2d 474, 538 N.W.2d 830 (Ct. App. 1995), 95-0692.

The limitation periods under s. 893.55 (1) (a) and (b) [now s. 893.55 (1m) (a) and (b)] are both tolled by the filing of a request for mediation under sub. (4). Landis v. Physicians Insurance Co. of Wisconsin, 2001 WI 86, 245 Wis. 2d 1, 628 N.W.2d 893, 00-0330.

Sub. (5) does not mandate dismissal for filing an action before the expiration of the statutory mediation period. When a plaintiff fails to comply with sub. (5), the circuit court retains discretion to determine the appropriate sanction. Ocasio v. Froedtert Memorial Lutheran Hospital, 2002 WI 89, 254 Wis. 2d 367, 646 N.W.2d 381, 00-3056.

Nothing in the language of either this section or s. 655.445 precluded the application of this section to a mediation request filed under s. 655.445 when an action was filed but became a nullity due to failure to complete service. Young v. Aurora Medical Center of Washington County, Inc., 2004 WI App 71, 272 Wis. 2d 300, 679 N.W.2d 549, 03-0224.

Delivery of a mediation request by regular mail is not determinative of the validity of the request. Geisel v. Odulio, 807 F. Supp. 500 (1992).

Failure to name the Wisconsin Patients Compensation Fund in a mediation request did not exempt the fund from the tolling of the statute of limitations under sub. (4). Geisel v. Odulio, 807 F. Supp. 500 (1992).

655.445 Request for mediation in conjunction with court action. (1) COMMENCING ACTION, REQUEST AND FEE.

Beginning September 1, 1986, 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 shall, within 15 days after the date of filing an action in court, file a request for mediation. The request shall be prepared and delivered in person or sent by registered mail to the director of state courts, in the form and manner required under s. 655.44 (2) and (3), together with a notice that a court action has been commenced and the fee under s. 655.54 shall be paid.

(2) SCHEDULING. All time periods under s. 802.10 (3) are tolled on the date of filing the court action. The time periods remain tolled until the expiration of the mediation period under s. 655.465 (7).

(3) NO COURT PROCEEDINGS BEFORE MEDIATION. For actions filed under sub. (1), no discovery may be made and no trial, pretrial conference or scheduling conference may be held until the expiration of the mediation period under s. 655.465 (7).

History: 1985 a. 340; 1989 a. 187 s. 28; Sup. Ct. Order No. 95-04, 191 Wis. 2d xxi (1995).

The 15-day time limit for filing a request for mediation after commencement of court action is directory rather than mandatory. Eby v. Kozarek, 153 Wis. 2d 75, 450 N.W.2d 249 (1990).

Mailing is not the equivalent of filing. Mailing is to send postal matter. Filing entails delivery to the intended recipient. Hoffman v. Rankin, 2002 WI App 189, 256 Wis. 2d 678, 649 N.W.2d 350, 01-3202.

Nothing in the language of either this section or s. 655.44 precluded the application of s. 655.44 to a mediation request filed under this section when an action was filed but became a nullity due to failure to complete service. Young v. Aurora Medical Center of Washington County, Inc., 2004 WI App 71, 272 Wis. 2d 300, 679 N.W.2d 549, 03-0224.

655.45 Reports to licensing bodies. (1) For the quarter beginning on July 1, 1986, and for each quarter thereafter, the director of state courts shall file reports complying with sub. (2) with the medical examining board, the physical therapy examining board, the podiatry affiliated credentialing board, the board of nursing and the department, respectively, regarding health care providers licensed by the respective bodies.

(1m) For the quarter beginning on July 1, 1995, and for each quarter thereafter, the director of state courts shall file reports complying with sub. (2) with the dietitians affiliated credentialing board regarding health care providers certified by the dietitians affiliated credentialing board.

(2) The reports under subs. (1) and (1m) shall set forth all of the following:

(a) The names of all health care providers who are named as defendants in court actions of which the director of state courts receives notice under s. 655.44 (6) or 655.445 (1) during the quarter.

(b) Whether any court action of which the director of state courts received notice under s. 655.44 (6) or 655.445 (1) was disposed of by settlement, compromise, stipulation agreement, dismissal default or judgment during the quarter and the amount of the settlement or award to the claimant, if any, to the extent the director of state courts has any of the information under this paragraph.

History: 1985 a. 340; 1989 a. 187 s. 28; 1993 a. 107, 443; 1997 a. 75, 175; 2009 a. 113, 149; 2011 a. 258.

655.455 Notice to health care providers and fund. The director of state courts shall serve notice of a request for mediation upon all health care providers named in the request, at the respective addresses provided in the request, and upon the fund, by registered mail within 7 days after the director of state courts receives the request if delivered in person or within 10 days after the date of mailing of the request to the director of state courts if sent by registered mail.

History: 1985 a. 340; 1989 a. 187 s. 28; 2001 a. 65.

655.465 Mediation panels; mediation period. (1) MEDIATION PANEL FOR DISPUTE. The director of state courts shall appoint the members of a mediation panel under sub. (2) and send notice to the claimant and all respondents by registered mail. The notice shall inform the claimant and all respondents of the names of the persons appointed to the mediation panel and the date, time and place of the mediation session. The director of state courts may change the date, time or place of the mediation session as necessary to accommodate the parties, subject to the requirement that the mediation session be held before the expiration of the mediation period under sub. (7).

(2) APPOINTMENT OF MEDIATORS. Each mediation panel shall consist of the following members appointed by the director of state courts:

(a) One public member who is neither an attorney nor a health care provider and who is selected from a list of public member mediators prepared every 2 years, or more frequently upon request of the director of state courts, by the governor or, if any person resigns or is unable to serve as a public member mediator, from a list of alternates prepared by the director of state courts.

(b) One attorney who is licensed to practice law in this state.

(c) One health care provider as follows:

1. Except as provided in subds. 4. and 5., if all respondents named in the request for mediation are physicians, a physician who is licensed to practice in this state and who is selected from a list prepared by a statewide organization of physicians designated by the director of state courts.

2. Except as provided in subds. 4. and 5., if none of the respondents named in the request for mediation is a physician, a health care provider who is licensed to practice in this state in the same health care field as the respondent and who is selected from a list prepared by the department or the examining board or affiliated credentialing board that regulates health care providers in that health care field.

3. Except as provided in subds. 4. and 5., if more than one respondent is named in the request for mediation at least one of whom is a physician and at least one of whom is not, a health care provider who is licensed to practice in this state and who is selected from the list under subd. 1. or 2., as determined by the director of state courts.

4. If the director of state courts determines that a list under subd. 1. or 2. is inadequate to permit the selection of an appropriate health care provider, a health care provider who is licensed to practice in this state and who is selected from an additional list prepared by the director of state courts.

5. If the director of state courts determines that lists under subds. 1. or 2. and 4. are inadequate to permit the selection of an appropriate health care provider for a particular dispute, a health care provider who is licensed to practice in this state and who is selected by the director of state courts.

(3) FILLING VACANCIES. If a person appointed to a mediation panel under sub. (1) resigns from or is unable to serve on the mediation panel, the director of state courts shall appoint a replacement selected in the same manner as the predecessor appointee.

(4) CONFLICT OF INTEREST. No person may serve on a mediation panel if the person has a professional or personal interest in the dispute.

(5) COMPENSATION. Each mediator shall be compensated $150 plus actual and necessary expenses for each day of mediation conducted. Compensation and expenses shall be paid out of the appropriation under s. 20.680 (2) (qm) upon such authorizations as the director of state courts may prescribe.

(6) IMMUNITY AND PRESUMPTION OF GOOD FAITH. (a) A mediator is immune from civil liability for any good faith act or

omission within the scope of the mediator's performance of his or her powers and duties under this subchapter.

(b) It is presumed that every act or omission under par. (a) is a good faith act or omission. This presumption may be overcome only by clear and convincing evidence.

(7) MEDIATION PERIOD. The period for mediation shall expire 90 days after the director of state courts receives a request for mediation if delivered in person or within 93 days after the date of mailing of the request to the director of state courts if sent by registered mail, or within a longer period agreed to by the claimant and all respondents and specified by them in writing for purposes of applying ss. 655.44 (4) and (5) and 655.445 (3).

History: 1985 a. 340; 1989 a. 187 s. 28; 1989 a. 359; 1993 a. 107.

A claimant's failure to participate in mediation within the 90-day period under sub. (7) does not require dismissal. The court may determine an appropriate sanction. Schulz v. Nienhuis, 152 Wis. 2d 434, 448 N.W.2d 655 (1989).

If a party wishes to reschedule a mediation session for a time outside the 90-day statutory period, the party must obtain a written agreement to do so. If a respondent requests a rescheduling without providing a mutually agreed upon date within the 90 days and no written agreement is obtained, the mediation period does not terminate until the rescheduled mediation session is completed. Seaquist v. Physicians Insurance Co. of Wisconsin, 192 Wis. 2d 530, 531 N.W.2d 437 (Ct. App. 1995).

Completion of mediation within the period under sub. (7) is not a jurisdictional prerequisite for maintenance of a medical malpractice suit. Bertorello v. St. Joseph's Hospital of Marshfield, Inc., 685 F. Supp. 192 (1988).

655.54 Filing fee. Requests for mediation filed with the director of state courts are subject to a filing fee of $11. The filing fee shall be paid into the mediation fund under s. 655.68.

History: 1985 a. 340; 1989 a. 187 s. 28.

655.58 Mediation procedure. (1) NO RECORD. Mediation shall be conducted without a stenographic record or any other transcript.

(2) NO EXAMS, SUBPOENAS, OATHS. No physical examinations or production of records may be ordered, no witnesses may be subpoenaed and no oaths may be administered in mediation, whether by a mediation panel or member thereof or as a result of application to a court by any person.

(3) NO EXPERT WITNESSES; PANEL CONSULTANTS PERMITTED. (a) Except as provided in par. (b), no expert witnesses, opinions or reports may be submitted or otherwise used in mediation.

(b) The mediation panel or any member thereof may consult with any expert, and upon authorization of the director of state courts may compensate the expert from the appropriation under s. 20.680 (2) (qm).

(4) PATIENT RECORDS CONFIDENTIAL EXCEPT TO PARTIES. All patient health care records in the possession of a mediation panel shall be kept confidential by all members of the mediation panel and all other persons participating in mediation. Every person participating in mediation shall make available to one another and all members of the mediation panel all patient health care records of the patient named in the request for mediation that are in the person's possession.

(5) COUNSEL PERMITTED. Any person participating in mediation may be represented by counsel authorized to act for his or her respective client.

History: 1985 a. 340; 1989 a. 187 s. 28.

655.61 Funding. (1) The mediation fund created under s. 655.68 shall be financed from fees charged to health care providers. The director of state courts shall, by February 1 annually, determine the revenues needed for the operation of the mediation system during the succeeding fiscal year and inform the board of governors of that amount. The director of state courts shall also inform the board of governors of the number of requests for mediation involving each type of health care provider set out in s. 655.002 for the most recent fiscal year for which statistics are available. The board of governors shall set fees to charge health care providers at a level sufficient to provide the necessary revenue.

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

(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 mediation fund created under s. 655.68.

(3) If the fees under sub. (1) for any particular fiscal year are not established by the board of governors or approved by the joint committee on finance under s. 655.27 (3) (bt) before June 2 of that fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the fees for that fiscal year are subsequently established by the board of governors or approved by the joint committee on finance under s. 655.27 (3) (bt), the balance for the fiscal year shall be collected or refunded, except that the commissioner may elect not to collect or refund minimal amounts.

History: 1985 a. 340; 1989 a. 187; 1991 a. 214; 2015 a. 90.

Cross-reference: See also s. Ins 17.01, Wis. adm. code.

SUBCHAPTER VII

MEDIATION FUND

655.68 Mediation fund. (1) CREATION. There is created a mediation fund to pay the administrative expenses of the mediation system created under subch. VI.

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

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

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

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

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

History: 1985 a. 340; 1987 a. 186; 1989 a. 187 s. 28; 1991 a. 214.