LRB–2561/1
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2001 ASSEMBLY BILL 925

March 14, 2002 – Introduced by Representatives JOHNSRUD, COGGS, BERCEAU, J. LEHMAN, MILLER, BIES, URBAN and HINES, cosponsored by Senator MOEN. Referred to Committee on Health.

AN ACT ***to repeal*** 153.08, 153.75 (1) (g) and 165.40; ***to amend*** 50.35, 50.36 (1), 146.37 (1g) and 632.75 (5); and ***to create*** 15.105 (27), 15.107 (18), 20.438, 49.45 (3) (e) 11., subchapter III of chapter 150 [precedes 150.61] and 230.08 (2) (mp) of the statutes; **relating to:** establishing a hospital rate–setting commission and hospital rate–setting council; setting hospital rates; creating a program to review hospital capital expenditures and other activities of hospitals; granting rule–making authority; making appropriations; and providing penalties.

Analysis by the Legislative Reference Bureau

HOSPITAL RATE–SETTING

This bill creates a hospital rate–setting commission (commission) attached to the department of administration (DOA). The bill requires the commission to set maximum rates that a hospital may charge for services. Under the bill, a hospital may request rate changes according to a schedule created by the commission. As part of the rate–change review procedure, the hospital must publish a notice of review stating the process by which interested persons may become parties to the review. The hospital must also submit to the commission its proposed financial requirements. The financial requirements include all of the following:

1. Necessary operating expenses.
2. Interest expenses on debt incurred for capital or operating costs.

3. Costs of medical education.

4. Costs of services, facilities, and supplies that organizations related to the hospital by common ownership or control supply.

5. Unrecovered costs from private parties who fail to pay the full charge for services provided.

6. Fees assessed by the commission or other regulatory agency.

7. Capital requirements.

The bill specifies standards for the commission's decision making including:

1. The need to reduce the rate of hospital cost increases while preserving the quality of health care.

2. Cost–related trend factors based on nationally recognized economic models.

3. Special circumstances of rural and teaching hospitals.

The commission is authorized under this bill to disallow certain costs and revenues in determining its rate recommendation.

Under the bill, if the hospital does not accept the commission's recommendations, the hospital must request a settlement conference between its representatives and the commission staff. If the hospital is dissatisfied with the results of the settlement conference, the hospital may request an informal hearing before the commission. The commission may conduct a formal hearing instead of an informal hearing. If a formal hearing is held, the commission must issue at the end of the hearing its order establishing maximum rates for the hospital's year under review. If an informal hearing is held, the commission must issue its order within 50 days after the date on which the hospital requested the hearing.

This bill authorizes hospitals to increase rates selectively if the aggregate increase in its rates does not exceed the amount authorized by the commission. The hospital must, prior to increasing rates, explain to the commission its method in applying the increase and allow the commission five working days to determine if the aggregate increase exceeds the authorized amount. If the commission disapproves the hospital's method in applying the increase, and the hospital fails to modify its method as recommended by the commission, the commission may challenge the method in circuit court.

Except under certain circumstances, this bill prohibits the commission from reducing rates prior to the date of the scheduled succeeding review or during the succeeding review. The bill also prohibits the commission from directly interfering with the patient–physician decision–making relationship, directly controlling the volume or intensity of hospital utilization, or directly restricting the freedom of a hospital to exercise management decisions in complying with rates established by the commission.

The bill also creates a hospital rate–setting council in DOA. The council consists of 11 members each appointed for staggered four–year terms. The bill specifies that the members shall include all of the following:

1. Three individuals nominated by the Wisconsin Health and Hospital Association.

2. One physician nominated by the State Medical Society of Wisconsin.

3. One individual nominated by the largest service insurance corporations.

4. One individual nominated by the Wisconsin division of the Health Insurance Association of America.

5. One individual who is a registered nurse and nominated by the Wisconsin Nurses Association.

CAPITAL EXPENDITURE REVIEW PROGRAM

Under current law, no person may lease or acquire an ownership or controlling interest in a hospital or system of hospitals that is owned by a nonprofit corporation, a city, a county, the state, or the University of Wisconsin Hospitals and Clinics Authority without first receiving approval of the attorney general, office of the commissioner of insurance, and the department of health and family services (DHFS), if the lease or acquisition results in one person owning or controlling more than 49% of the hospital or hospital system or results in at least a 20% change in ownership or control of the hospital or hospital system.

The bill eliminates this requirement and, instead, requires a person to receive approval from DHFS before doing any of the following:

1. Obligating by or on behalf of a hospital a capital expenditure in excess of $1,000,000 or, if the purpose of the capital expenditure is to convert a hospital to a new use or to renovate all of part of a hospital, in excess of $1,500,000.

2. Implementing an organ transplant program, burn center, neonatal intensive care program, cardiac program, or air transport services or adding psychiatric or chemical dependency beds.

3. Purchasing or otherwise acquiring a hospital.

4. Constructing or operating an ambulatory surgery center or a home health agency.

The bill creates an exemption from the approval requirements for the following activities:

1. Any project that has been agreed upon in a legally enforceable contract prior to the effective date of the bill.

2. Any obligation by or on behalf of a hospital for heating, air conditioning, electrical systems, telecommunications, computer systems, or nonsurgical outpatient services that is not a component of another project that requires DHFS approval if the obligation is not more than 20% of the hospital's gross annual patient revenue for its last fiscal year.

3. Any project that DHFS determines is for the research, development, and evaluation of innovative medical technology, the development of clinical applications of the technology, or the research, development, and evaluation of a major enhancement to existing medical technology.

The bill requires a person who intends to undertake a project or activity that is subject to DHFS approval to publish a notice describing the project or activity and to conduct a public hearing on the proposed project or activity. The bill also requires DHFS to publish a notice or receipt of an application for review of the project or activity. DHFS must also conduct a public meeting upon the request of an affected party to review projects or activities for which an application for approval has been filed. If an applicant is adversely affected by a decision of DHFS, the applicant may petition for judicial review of the decision. An approval issued under the bill is valid

for one year from the date of issuance. DHFS may grant one extension of up to six months for each approval.

Finally, the bill requires DHFS to adopt a state medical facilities plan at least once every three years. The plan must include a description of the state hospital system and identify any needed or surplus hospital beds.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 15.105 (27) of the statutes is created to read:

15.105 **(27)** HOSPITAL RATE–SETTING COMMISSION. There is created a hospital rate–setting commission, which is attached to the department of administration under s. 15.03. No member of the council may have a financial interest in a hospital, as defined in s. 50.33 (2). Any member of the commission who voluntarily assumes a financial interest in a hospital shall vacate the office. Any member of the commission who involuntarily assumes a financial interest in a hospital shall divest himself or herself of the office within a reasonable time or shall vacate the office.

SECTION 2. 15.107 (18) of the statutes is created to read:

15.107 **(18)** HOSPITAL RATE–SETTING COUNCIL. There is created in the department of administration a hospital rate–setting council. The council shall consist of 11 members appointed for staggered 4–year terms, who shall represent a balance of economic, provider, scientific, government, and consumer viewpoints. No more than 3 members may be state employees. The council shall include all of the following:

(a) Three members nominated by the Wisconsin Hospital Association.

(b) One member who is a physician and nominated by the State Medical Society of Wisconsin.

(c) One member nominated by the largest service insurance corporations licensed under ch. 613. The size of a service insurance corporation shall be based on

premium volume as reported in the most recent Wisconsin insurance commissioner's report on business.

(d) One member nominated by the Wisconsin division of the Health Insurance Association of America.

(e) One member who is a registered nurse and nominated by the Wisconsin Nurses Association.

SECTION 3. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

				2001–02	**2002–03**
20.438 Hospital rate–setting commission					
(1) HOSPITAL RATE SETTING					
(a) General program operations	GPR	A		–0–	–0–
(g) Assessments	PR	A		–0–	–0–

SECTION 4. 20.438 of the statutes is created to read:

20.438 Hospital rate–setting commission. There is appropriated to the hospital rate–setting commission for the following programs:

(1) HOSPITAL RATE SETTING. (a) *General program operations.* The amounts in the schedule for hospital rate–setting activities under subch. III of ch. 150.

(g) *Assessments.* The amounts in the schedule for hospital rate–setting activities under subch. III of ch. 150. All moneys received under s. 150.67 and 2001 Wisconsin Act .... (this act), section (4), shall be credited to this appropriation.

SECTION 5. 49.45 (3) (e) 11. of the statutes is created to read:

49.45 **(3)** (e) 11. Notwithstanding subds. 1. to 10., the department may authorize the hospital rate–setting commission to determine the rate of

reimbursement for services provided under the medical assistance program in the manner specified under subch. III of ch. 150.

SECTION 6. 50.35 of the statutes is amended to read:

50.35 Application and approval. Application for approval to maintain a hospital shall be made to the department on forms provided by the department. On receipt of an application, the department shall, except as provided in s. 50.498, issue a certificate of approval if the applicant and hospital facilities meet the requirements established by the department. Except as provided in s. 50.498, this approval shall be in effect until, for just cause and in the manner herein prescribed, it is suspended or revoked. The certificate of approval may be issued only for the premises and persons or governmental unit named in the application and is not transferable or assignable. ~~The department shall withhold, suspend or revoke approval for a failure to comply with s. 165.40 (6) (a) 1. or 2., but, except~~ Except as provided in s. 50.498, ~~otherwise~~ the department may not withhold, suspend or revoke approval unless for a substantial failure to comply with ss. 50.32 to 50.39 or the rules and standards adopted by the department after giving a reasonable notice, a fair hearing and a reasonable opportunity to comply. Failure by a hospital to comply with s. 50.36 (3m) shall be considered to be a substantial failure to comply under this section.

SECTION 7. 50.36 (1) of the statutes is amended to read:

50.36 **(1)** The department shall promulgate, adopt, amend, and enforce such rules and standards for hospitals for the construction, maintenance, and operation of the hospitals deemed necessary to provide safe and adequate care and treatment of the patients in the hospitals and to protect the health and safety of the patients and employees; and nothing contained herein shall pertain to a person licensed to practice medicine and surgery or dentistry. The building codes and construction

standards of the department of commerce shall apply to all hospitals and the department may adopt additional construction codes and standards for hospitals, provided they are not lower than the requirements of the department of commerce. Except for the construction codes and standards of the department of commerce and except as provided in ~~s.~~ ss. 50.39 (3) and 150.61 to 150.68, the department shall be the sole agency to adopt and enforce rules and standards pertaining to hospitals.

SECTION 8. 146.37 (1g) of the statutes is amended to read:

146.37 **(1g)** Except as provided in s. 153.85, no person acting in good faith who participates in the review or evaluation of the services of health care providers or facilities or the charges for such services conducted in connection with any program organized and operated to help improve the quality of health care, to avoid improper utilization of the services of health care providers or facilities or to determine the reasonable charges for such services, or who participates in the obtaining of health care information under ch. 153 or in hospital rate–setting activities under subch. III of ch. 150, is liable for any civil damages as a result of any act or omission by such person in the course of such review or evaluation. Acts and omissions to which this subsection applies include, but are not limited to, acts or omissions by peer review committees or hospital governing bodies in censuring, reprimanding, limiting or revoking hospital staff privileges or notifying the medical examining board or podiatrists affiliated credentialing board under s. 50.36 or taking any other disciplinary action against a health care provider or facility and acts or omissions by a medical director, as defined in s. 146.50 (1) (j), in reviewing the performance of emergency medical technicians or ambulance service providers.

SECTION 9. Subchapter III of chapter 150 [precedes 150.61] of the statutes is created to read:

CHAPTER 150

SUBCHAPTER III

HOSPITAL RATE SETTING AND CAPITAL

EXPENDITURE REVIEW

150.61 Definitions. In this subchapter:

(1) "Commission" means the hospital rate–setting commission.

(2) "Consumer price index" has the meaning given in s. 16.004 (8) (e) 1.

(3) Notwithstanding s. 150.01 (12), "hospital" has the meaning given in s. 50.33 (2), except that "hospital" does not include a center for the developmentally disabled, as defined in s. 51.01 (3).

(4) "Rates" means individual charges of a hospital for the services that it provides or, if authorized under s. 150.64 (3), the aggregate charges based on case mix measurements.

150.612 Prospective rate setting. (1) Beginning on July 1, 2003, the commission shall prescribe maximum hospital rates on a prospective basis. The commission may revise these rates as provided in this subchapter. The commission shall publish biennial reports that contain the proceedings and any information necessary to describe the rate of hospital cost increases and the financial condition of hospitals.

(2) No hospital may charge rates that exceed the rates established by the commission under this subchapter.

150.615 Rule making. The commission shall promulgate rules to implement this subchapter.

150.62 Requests for rate changes. (1) (a) The commission shall create a schedule allowing each hospital to request rate changes annually. Beginning on July

1, 2002, the schedule shall permit a hospital to request a rate change on or after the date the hospital receives its audited financial statements for the most recent fiscal year. Beginning on July 1, 2002, the commission may schedule a review of the hospital's rates and revise the rates on its own initiative or at the request of any person who has good cause for requesting review.

(b) A hospital may submit a rate request on or after the date scheduled by the commission.

(2) (a) No later than 10 days after a hospital submits a rate request under sub. (1) (a), the hospital shall publish a class 1 notice under ch. 985. If the commission schedules a review under sub. (1), the commission shall publish a class 1 notice under ch. 985 no later than 10 days after the date scheduled for the review.

(b) A notice under par. (a) shall contain a summary of the rate–change request and a description of the process by which an interested person may become a party to the review.

(c) A person may become a party to the review only by notifying the commission in writing no later than 30 days after the date the notice is published.

(3) At the time a hospital requests a rate change, the hospital shall submit to the commission the proposed financial requirements specified under s. 150.625 and, except as provided in s. 150.64 (4) (g), any information that the commission determines is necessary to set and monitor rates. Corporate affiliates of the hospital and other organizations that generate financial requirements of the hospital shall also provide to the commission financial or other statistical information related to the financial requirements that the commission determines is necessary to set and monitor rates.

(4) The commission may require hospitals to conform with a uniform reporting system.

(5) The commission shall regularly publish a list of the 25 most used charge elements for hospitals.

150.625 Financial requirements. (1) The financial requirements that a hospital must submit under s. 150.62 (3) shall include all of the following:

(a) Necessary operating expenses, including wages, employee fringe benefits, purchased services, professional fees, repairs and maintenance, dietary and medical supplies, pharmaceuticals, utilities, insurance, standby costs, and applicable taxes. A hospital may include as necessary operating expenses any amount paid to members of a religious order or other organized religious group if the amounts were actually paid to the members and are equivalent to the amounts paid to hospital employees for similar work. The commission may not use previously accumulated depreciation of capitalized assets to offset operating expenses.

(b) Interest expenses on debt incurred for capital or operating costs. Interest payments on debts incurred for capital costs shall be offset by income earned on investments unless the income is assigned by the donor. After the sale of a hospital, financial requirements shall include the interest expense on debt incurred for capital costs only if the debt does not exceed the revalued price of the hospital, as specified in sub. (4).

(c) Direct and indirect costs of medical education, allied education, and research programs that are approved by the commission as reasonable and necessary to maintain the quality of the programs less any tuition, scholarships, endowments, gifts, grants, and similar sources of revenue that are received by the hospital.

(d) Costs of services, facilities, and supplies that organizations related to the hospital by common ownership or control furnish to the hospital. These costs shall be calculated as the charge of the furnishing organization, but may not exceed a reasonable amount in relation to the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(e) Unrecovered costs from private parties who fail to pay the full charge for care provided, unless the hospital fails to maintain sound credit and collection policies to minimize the costs.

(f) Fees assessed by the commission or other regulatory agencies.

(g) Operating fund working capital requirements. In this paragraph, "working capital requirements" means capital in use to operate the hospital at a level sufficient to avoid unnecessary borrowing, including cash, accounts receivable, inventory, and prepaid expenses less accounts payable and accrued interest. Working capital requirements shall be calculated independently of available funds, as defined in par. (i) 1. and be based on the net change in the estimated year–end balance of the hospital's year under review, compared to the year–end balance of the hospital's prior fiscal year, for the following accounts:

1. Cash.

2. Accounts receivable.

3. Inventories.

4. Prepaid expenses.

5. Trade accounts payable.

6. Accrued interest payable.

(h) An amount necessary to establish and maintain a contingency fund in cash and investments equal to 2% of the budgeted gross revenue for the hospital's year

under review. The hospital shall use cash and investments to establish and maintain its contingency fund and shall use the fund to pay any unexpected expenses. The commission may review any expenditure of contingency funds in a prior year that requires restoration in the hospital's year under review for reasonableness, consistent with the nature of the unexpected expense.

(i) Capital requirements, calculated as the greater of historical, straight–line depreciation of plant and equipment or the cost of proposed capital purchases as offset by available funds, plus debt retirement expenses, prospective accumulation, and capitalized interest. In this paragraph:

1. "Available funds" includes cash and investments that are not assigned by the donor and are available to meet capital needs and does not include operating fund working capital requirements, prospective accumulations that are authorized by the commission, donor–restricted or creditor–restricted funds, grants, commitments for capital requirements, debt retirement expenses, or the amounts disallowed under s. 150.63 (2) (b). The commission may authorize prospective accumulations if a project that must be appeared under s. 150.71 (1), has lending requirements that necessitate such an accumulation or if the interest costs for the project may be lowered by borrowing, or if financial needs of a hospital occur because of balloon payments. The commission may also authorize prospective accumulations to finance a project that must be approved under s. 150.71 (1), if the cost of the project equals or exceeds 25% of the hospital's gross patient revenue for the current fiscal year, the hospital has submitted a 3–year capital expenditure plan to the commission, and the department indicates that the project is consistent with the projected needs of the community.

2. "Capital purchases" includes minor remodeling and the purchase of equipment, land, land improvements, and leasehold improvements.

3. "Depreciation" means the rational allocation of the historical cost of capitalized assets throughout the useful lives of those assets.

4. "Prospective accumulation" does not include funds that exceed the cost of the capital project for which the funds are accumulated.

(j) The amount by which estimated relief payments and medical assistance payments under ch. 49 and medicare payments under 42 USC 1395 to 1395ccc, as determined under s. 150.64 (1) (a), exceed actual payments.

(k) Any financial incentives that are authorized by the commission for efficiently operated hospitals.

(2) Hospitals may collect revenue from sources other than patients, including gifts and grants, investment income, or income from activities that are incidental to patient care. Revenues from endowment funds or donor–restricted gifts to provide services for designated patients shall offset the cost of those services. No revenue from general endowment funds or unrestricted gifts may be used to offset operating expenses except that revenue from these funds or gifts may be used to offset interest expenses. Revenues received to finance special projects or wages paid to special project employees shall offset the cost of patient services. Revenues from meals sold to visitors or employees, from pharmaceuticals sold to persons who are not patients, from the operation of gift shops or parking lots, or from the provision of televisions, radios, or telephones to patients shall offset the cost of these services, to the extent that the amount of revenue offset from any of these services may not exceed the cost of the service.

(3) Purchase discounts, the amount by which actual payments by government payers exceed estimated payments under s. 150.64 (1) (a), and allowances and refunds of expenses shall be subtracted from the calculation of financial

requirements under this section. Revenues from invested funds shall also be subtracted from the calculation of financial requirements but may not offset an amount that exceeds the hospital's interest expenses. Any costs of a project that must be approved under s. 150.71 (1) and that does not receive the approval may not be included in the calculation of a hospital's financial requirements.

(4) After the sale of a hospital, the commission may calculate depreciation under sub. (1) based on a revaluation of the hospital's plant and equipment to determine its reasonable value. The revaluation shall be based on appraisals conducted by 2 independent appraisers, one of whom shall be selected by the hospital and one of whom shall be selected by the commission. The hospital shall pay the cost of both appraisals.

150.63 Initial determinations. (1) The commission and commission staff shall review and evaluate each hospital's proposed financial requirements and rate–change request. In reviewing and evaluating the financial requirements and rate–change request, the commission shall consider all of the following:

(a) The need to reduce the rate of hospital cost increases while preserving the quality of health care in all parts of the state and taking into account the financial viability of economically and efficiently operated hospitals.

(b) Comparisons with prudently administered hospitals of similar size or providing similar services that offer quality health care with sufficient staff. In classifying hospitals according to size and services, the commission shall consider volume, intensity, and educational programs and special services provided by hospitals.

(c) A variety of cost–related trend factors based on nationally or regionally recognized economic models.

(d) Special circumstances of rural hospitals and teaching hospitals.

(e) Past budget and rate experiences of the hospital.

(f) Findings of the utilization review program under s. 150.66 (3) concerning the hospital that submits the rate request.

(2) After reviewing a hospital's proposed financial requirements, the commission may disallow any of the following:

(a) Costs associated with medical services that a utilization review program under s. 150.66 determines are medically unnecessary or inappropriate.

(b) 1. Except as provided in subd. 2., 40% of the amount by which patient revenue generated by the hospital during its previous fiscal year exceeds 104% of the hospital's budgeted patient revenue for that year, if the hospital's annual gross patient revenue, as adjusted under s. 150.68, is less than $5,000,000, or exceeds 102% of the hospital's budgeted patient revenue for that year, if the hospital's annual gross patient revenue, as adjusted under s. 150.68, equals or exceeds $5,000,000.

2. The commission shall promulgate rules to specify a procedure under which hospitals whose variable costs exceed 65% are subject to a lesser disallowance under subd. 1.

(c) Rate overcharges of the hospital that occurred in a prior year and for which payers have not been reimbursed.

(d) The amount by which incremental expenses that are associated with the cost of a project that must be approved under s. 150.71 (1) exceed 105% of the expenses projected in the hospital's application for approval of the project. This paragraph does not apply if any of the following applies:

1. The hospital demonstrates to the satisfaction of the commission that the excess was due to conditions beyond its control.

2. The excess occurs more than 3 years after completion of the project.

(e) Costs that the commission determines are unreasonable.

(f) Excessive wages. In determining whether wages are excessive under this paragraph, the commission shall consider the wage levels of hospitals located in a relevant geographic area surrounding the hospital that submitted the rate request as well as wage levels of hospitals that are similar in size or that provide similar services. In addition, the commission shall consider the hospital's ability to attract adequate staff and the wage trends in nonregulated, related sectors of the state economy.

(g) Amounts paid for services regulated under s. 111.18 (2) (a) 1.

(3) (a) After reviewing the hospital's financial requirements and rate request, the commission staff shall suggest to the commission any disallowances authorized under sub. (2) and shall submit a rate recommendation to the hospital and commission. If the rate recommended by the commission staff differs from the rate request submitted by the hospital, the commission staff shall provide an explanation for the difference.

(b) 1. Except as provided in subd. 2., the commission staff shall submit its recommendations under par. (a) no later than 60 days after the date that review commences under s. 150.62 (1), even if the commission staff determines that the data provided by the hospital for a scheduled review are incomplete. The commission staff may, however, recommend a disallowance or an alternate rate, including no rate increase, on the grounds of insufficient data.

2. a. The commission staff may extend the deadline specified in subd. 1. by 15 days if it determines that the rate request submitted involves particularly complex issues of fact.

b. The deadline specified in subd. 1. may be extended with the consent of the hospital and the commission staff.

150.635 Review of rate recommendations. (1) A hospital that disputes any part of a recommendation of the commission staff under s. 150.63 shall, no later than 10 days after the recommendations are submitted under s. 150.63 (3), request a settlement conference with the commission staff for the purpose of resolving the differences in the hospital's rate request and the commission staff's recommendation. The chairperson of the commission, or a commissioner designated by the chairperson, shall preside over the settlement conference. No later than 20 days after the hospital requests a settlement conference, the settlement conference shall be completed.

(2) No later than 10 days after completion of the settlement conference under sub. (1), the hospital may request a hearing before the commission under sub. (3). Upon receipt of a request, the commission shall grant a hearing to the hospital. The hospital may present testimony based on any standard for decision making specified in s. 150.63 (1). All questions of fact shall be determined without ascribing greater weight to evidence presented by commission staff than to evidence presented by any other party solely due to its presentation by the staff.

(3) (a) Informal hearings shall be conducted before at least 2 commissioners. Sworn testimony is required only if the presiding commissioners so specify. The commissioners may establish time limits for cross–examination of witnesses and rebuttal arguments and may limit the number of persons who may appear at the hearing. Rules of evidence, except the rule that evidence be relevant to the issues presented, do not apply to informal hearings.

(b) A hospital that requests an informal hearing shall present the reasons supporting its proposed rate increase and financial requirements. Commission staff shall respond by explaining the alternate recommendations. Within the time limits established under par. (a), the hospital, parties to the review, and commission staff may cross–examine witnesses and rebut arguments presented. The hospital, parties to the review, and the commission staff may employ experts to present their position. The presiding commissioners may impose an overall time limit on the length of the hearing.

(c) The commission may conduct a class 1 contested case proceeding under ch. 227 in place of an informal hearing under pars. (a) and (b).

(4) The commission shall keep a complete written record of all hearings and investigations conducted under sub. (3). The commission shall provide a transcribed, certified copy of all or any part of the record at the request of any person who is a party to the hearing or investigation. The commission may charge a fee to cover the costs of providing copies of the record.

(5) (a) Any person may request a hearing under s. 227.44, regardless of whether any other hearing is authorized by law or is authorized at the discretion of the commission or whether any other proceeding is authorized by rule of the commission, except that no person may receive more than one contested case hearing concerning a particular act or failure to act by the commission.

(b) Notwithstanding par. (a), no person may request a hearing under s. 227.44 pertaining to the subject matter of a hearing under sub. (3).

(c) The right to a hearing under s. 227.44, as specified in this subsection, applies only to subject matter pertaining to this subchapter.

150.64 Commission orders. (1) (a) The commission shall determine allowable financial requirements and disallowances under s. 150.63 (1) and (2) for the hospital. From the difference between these amounts, the commission shall subtract the hospital's estimated relief payments and medical assistance payments under ch. 49 and medicare payments under 42 USC 1395 to 1395ccc, unless the commission determines that the hospital's estimates are incorrect, in which case the commission shall subtract its own estimates of the hospital's relief, medical assistance, and medicare payments. The commission shall, by order, establish maximum rates that allow the hospital to generate revenue sufficient to provide this remainder. The commission shall, by rule, establish acceptable methods for hospitals to use in estimating payments by relief, medical assistance, and medicare under this paragraph. Each hospital shall choose one of the methods and use it consistently unless the commission authorizes the hospital to change the method.

(b) Unless the hospital requests a hearing under s. 150.635 (2), the commission shall issue an order under par. (a) no later than 15 days after the commission staff submits its recommendations under s. 150.63 (3) (b) or, if the hospital requests a settlement conference under s. 150.635 (1), no later than 15 days after the commission determines that the hospital will not seek a hearing following the conclusion of the settlement conference. If the hospital disputes only part of the recommendations of the commission staff, the commission may establish maximum rates under par. (a) concerning the recommendations that the hospital agrees with prior to the conclusion of the hearing under s. 150.635 (3).

(c) If the commission conducts a hearing under s. 150.635 (3) (c), the commission shall establish by order maximum rates for the hospital's year under review at the conclusion of the hearing. If the commission conducts an informal

hearing under s. 150.635 (3) (a) and (b), the commission shall issue its order no later than 50 days after the date on which the hospital requested the hearing.

(d) Each order that the commission issues concerning financial requirements and rates shall state findings of fact and the reasons supporting the order. If the commission denies any part of a rate request, the order shall also specify any financial requirements that were disallowed.

(e) A hospital may apply an increase in its rates selectively, if the aggregate increase in its rates does not exceed the amount authorized by the commission. No hospital may change a method of applying its rate increase that has received the commission's approval without submitting the changes to the commission for its approval under this paragraph. Prior to increasing rates or changing a method of applying a rate increase, the hospital shall explain to the commission the method of applying the rate increase. If, after 5 working days, as defined in s. 227.01 (14), the commission does not notify the hospital that it has not approved the hospital's rate increase, the hospital may increase its rates as proposed and the commission may not challenge the method prior to the date of a succeeding review under s. 150.62 (1) except as provided in sub. (4) (a). If the commission does not approve the hospital's method of applying the rate increase, the commission shall recommend an alternate method. If the hospital does not modify its method of applying the rate increase, the commission may challenge the method in circuit court. If the hospital's method generates an aggregate increase in the hospital's rates that is inconsistent with the amount authorized by the commission, the hospital is subject to a forfeiture equal to 50% of the amount overcharged and shall comply with the alternate method recommended by the commission or with any other method ordered by the court that the court finds more consistent with the commission's order.

(f) A hospital that receives approval of a rate increase that may commence only between the 2nd and 7th months of its fiscal year may make an adjustment to the rate increase for that fiscal year only to generate an amount of revenue equal to the amount that would have been generated if the hospital could have commenced the rate increase beginning with the first month of its fiscal year.

(g) Except as provided in s. 150.65, if a party seeks judicial review of a commission order, the affected hospital may continue to bill payers at the rates established by the commission. No hospital that bills payers under this paragraph adversely affects its right to contest the rates established by the commission.

(2) Notwithstanding sub. (1) and ss. 150.62, 150.63, and 150.635, at the request of a hospital the commission may waive the procedures for review of a rate request and issue an interim order if the commission determines that an emergency exists.

(3) The commission may promulgate rules to establish a system that defines rates as aggregate charges based on case mix measurements if the commission submits its proposed system to the joint committee on finance for review and if the committee approves the system. The system shall be consistent with the standards specified under s. 150.63 (1).

(4) The commission may not do any of the following:

(a) Reduce rates established prior to the date the commission schedules a review under s. 150.62 (1), unless the hospital misstated a material fact at a prior rate–setting proceeding. Projections on the volume of hospital services utilized do not constitute material facts under this paragraph.

(b) Reduce rates established in a previous review under s. 150.62 (1) unless any of the following apply:

1. The hospital implements an unauthorized rate increase in its approved rates, unless the increase is trivial.

2. The hospital uses moneys that it has prospectively accumulated for an authorized capital project for purposes other than the authorized project.

3. The hospital's actual total revenue for its fiscal year exceeds its actual total financial requirements by more than 10%.

(c) Interfere directly in the personal or decision–making relationships between a patient and the patient's physician, except as provided in s. 150.66.

(d) Control directly the volume or intensity of hospital utilization, except as provided in s. 150.66.

(e) Restrict the freedom of patients to receive care at a hospital consistent with their religious preferences or request a hospital that is affiliated with a religious group to act in a manner contrary to the mission and philosophy of the religious group.

(f) Restrict directly the freedom of a hospital to exercise management decisions in complying with the rates established by the commission, unless the hospital agrees to a condition attached to the establishment of the rates.

(g) Require the submission of unrelated financial data from religious groups affiliated with a hospital.

150.65 Injunctions of commission orders. No injunction may be issued to suspend or stay enforcement of an order of the commission unless all of the following occur:

(1) All parties to the review under s. 150.62 (1) (b) from which the commission's order was issued are notified of the petition seeking an injunction, are given an

opportunity to appear at a hearing prior to the issuance of the injunction, and are made parties to the proceeding in circuit court.

(2) If the party seeking the injunction is not the hospital that was a party to the proceeding from which the commission's order was issued, the party enters into an undertaking by at least 2 sureties at a level that the circuit court finds sufficient to guarantee the payment of all damages that the hospital may sustain by delaying the effect of the commission's order.

150.655 Expedited review, expedited cases and exempt hospitals. (1) Notwithstanding s. 150.635, the commission may promulgate rules under which hospitals meeting specific criteria receive expedited review of rate requests under this subchapter.

(2) (a) Notwithstanding s. 150.62, a hospital that has gross annual patient revenue of less than $10,000,000, adjusted as provided in s. 150.67, for the hospital's last fiscal year is eligible to receive automatic approval of its rate request if all of the following criteria are met:

1. The commission has conducted a complete review of the hospital's rates and has set the hospital's rates in a preceding year.

2. The hospital requests a rate increase that is less than an inflationary index consisting of the average of the consumer price index and the hospital market basket index.

(b) A hospital that is eligible for automatic approval of its rate–increase request under this subsection shall, prior to implementing the increase, publish a class 1 notice under ch. 985, in one or more newspapers likely to give notice to its patients and payers, a list of the price adjustments it is making to 100 of its charge elements as specified by the commission.

(c) The commission may, by rule, extend automatic approval status under this subsection to other hospitals.

(3) Notwithstanding s. 150.62 (1), the commission may grant hospitals whose gross annual patient revenue is less than $10,000,000, adjusted as provided in s. 150.67, a rate increase that takes effect over a 2–year period with an automatic escalation clause taking effect at the end of the first year. A hospital that receives a 2–year rate increase is not required to request a rate increase at the end of the first year.

150.66 Utilization review program. (1) The commission shall approve and evaluate all–patient utilization review programs for each hospital.

(2) The commission shall contract with one or more independent utilization review programs to develop review standards, and the commission may contract with any person to monitor implementation of these programs by hospitals and to perform peer review functions for hospitals that fail to meet the performance standards adopted by the commission. The commission may not contract with state agencies, other than the University of Wisconsin System, under this subsection.

(3) Each utilization review program the commission approves shall include a general summary of utilization within the hospital. The programs shall meet minimum standards established by the commission and do all of the following:

(a) Evaluate the medical necessity or appropriateness of care relative to admissions, lengths of stay, and ancillary services.

(b) Report to the commission, in conjunction with each hospital's submission of proposed financial requirements, any unnecessary or inappropriate medical care utilization and associated costs.

(4) No hospital or physician may be paid for a service that a utilization review program under this section determines is medically unnecessary or inappropriate. If the hospital or physician has already been paid, the hospital or physician shall reimburse the payer within 30 days. The commission may commence an action to enforce this subsection in the circuit court for the county in which the hospital is located.

150.665 Enforcement and penalties. (1) (a) Until the commission establishes different rates under this subchapter, no hospital may charge any payer an amount exceeding the rates in effect as of the effective date of this paragraph .... [revisor inserts date].

(b) The attorney general may petition a court to enforce compliance with par. (a) and s. 150.612 (2) if the attorney general first notifies the hospital and provides the hospital a reasonable time to correct the violation. The commission may petition a court to enforce compliance with any statutory requirement or with any rule or order of the commission if it first notifies the hospital and provides the hospital a reasonable time to correct the violation. The commission shall commence any action under this paragraph in the circuit court for the county in which the hospital is located.

(c) A hospital that intentionally violates s. 150.612 (2) may be subject to a forfeiture of up to $5,000. Each week that a hospital intentionally violates s. 150.612 (2) is a separate violation.

(2) Any person who intentionally violates an order of a hearing examiner issued under s. 227.46 (7) to protect trade secrets in a contested case brought under this subchapter shall be subject to a forfeiture of $5,000.

150.67 Annual adjustments. The commission shall adjust annually the limits on gross annual patient revenue in ss. 150.63 (2) (b) and 150.65 (2) (a) and (3) to reflect annual changes in the average of the consumer price index and the hospital market basket index.

150.68 Assessments. Beginning July 1, 2002, the commission shall, within 90 days after the beginning of each fiscal year, estimate the total amount of revenue required for administration by the commission of this subchapter during that fiscal year and assess that estimated total amount to hospitals in proportion to each hospital's respective gross private–pay patient revenues during the hospital's most recently concluded fiscal year. The commission shall promulgate rules to establish the rate of the assessments under this section. Each hospital shall pay the assessment by December 1 of the year in which the assessment is made. The assessments shall be credited to the appropriation account under s. 20.438 (1) (g).

150.71 Approval required. (1) Beginning on the effective date of this subsection .... [revisor inserts date], no person may do any of the following unless the person applies for and receives the department's approval as specified under this subchapter:

(a) Except as provided in s. 150.713 and subject to sub. (2), by or on behalf of a hospital, obligate for a capital expenditure more than $1,000,0000, unless the capital expenditure is to convert a hospital to a new use or to renovate part or all of a hospital.

(b) Except as provided in s. 150.713 and subject to sub. (2), by or on behalf of a hospital, obligate for a capital expenditure more than $1,500,000 to convert a hospital to a new use or to renovate part or all of a hospital.

(c) Implement an organ transplant program, a burn center, a neonatal intensive care program, a cardiac program, or air transport services or add psychiatric or chemical dependency beds.

(d) Purchase or otherwise acquire a hospital.

(e) Construct or operate an ambulatory surgery center or a home health agency.

(2) The cost of studies, surveys, plans, and other activities essential to a proposed capital expenditure specified under sub. (1) (a) or (b) shall be included in determining the value of the capital expenditure. A capital expenditure includes any donation of equipment or facilities that, if acquired directly, would be subject to review under this subchapter and any transfer of equipment or facilities for less than fair market value that, if transferred at fair market value, would be subject to review under this subchapter.

150.713 Exceptions. (1) A person who has, prior to the effective date of this subsection .... [revisor inserts date], entered into a legally enforceable contract, promise, or agreement to do any of the activities specified in s. 150.71 (1), is not required to apply for or receive the department's approval under this subchapter to do any of the activities agreed to in the contract, promise, or agreement.

(2) A person may obligate for a capital expenditure, by or on behalf of a hospital, without first obtaining the department's approval under this subchapter, not more than 20% of the hospital's gross annual patient revenue for its last fiscal year if the expenditure is for heating, air conditioning, ventilation, electrical systems, energy conservation, telecommunications, computer systems, or nonsurgical outpatient services and is not a component of another project specified in s. 150.71 (1).

(3) A person who receives an exemption from the department under s. 150.715 is not required to apply for or receive the department's approval to obligate a capital

expenditure on behalf of a hospital or to make a substantial change in a health service as specified in the exemption.

150.715 Innovative medical technology exemption. (1) In this section:

(a) "Clinical trial" means clinical research conducted under approved protocols in compliance with federal requirements that are applicable to investigations involving human subjects, including the requirements for an informed consent advising the patient clearly of the risks associated with participating in the clinical research.

(b) "Innovative medical technology" means equipment or procedures that are potentially useful for diagnostic or therapeutic purposes and that introduce new technology in the diagnosis and treatment of an illness.

(2) The department may grant any person who intends to undertake a capital expenditure of more than $500,000, or who intends to make a substantial change in a health service, an exemption from the requirements of s. 150.71 if the person meets all of the following requirements:

(a) The capital expenditure or substantial change in a health service is for the research, development, and evaluation of innovative medical technology, the development of clinical applications of the technology, or the research, development, and evaluation of a major enhancement to existing medical technology.

(b) The person submits an application for an exemption to the department.

(c) The person demonstrates that, prior to applying for an exemption, preliminary animal studies or preliminary clinical investigations establish that the innovative medical technology or major enhancement to existing medical technology has a reasonable probability of advancing clinical diagnosis or therapy.

(d) In developing and evaluating the clinical applications of the technology or research, the person uses scientifically sound studies to determine clinical efficacy, safety, cost–effectiveness, and appropriate utilization levels in a clinical setting.

(e) The person conducts the clinical trials, evaluation, or research according to scientifically sound protocols that are subject to peer review and approval and meets the requirements that are applicable to investigations and clinical evaluation involving human subjects.

(f) The innovative medical technology will be used to conduct necessary research, development, and evaluation.

(g) The person does not include any recovery of capital expenses that are incurred as part of the capital expenditure or substantial change in a health service exempted under this section in the expense and revenue budget for purposes of rate setting under ss. 150.61 to 150.68 until after the person receives the approval of the federal food and drug administration and the department for general medical use of the innovative medical technology or major enhancement to existing medical technology. The person may recover operating expenses only after the federal food and drug administration approves the expenses for safety and efficacy and a third party agrees to pay for the expenses.

(3) No more than 2 exemptions may be granted under this section for each type of innovative medical technology and major enhancement to existing medical technology.

150.717 Notification requirement. A person who intends to undertake an activity specified in s. 150.71 (1) shall notify the department in writing at least 30 days prior to submitting an application for review. An application expires one year

from the date the applicant notifies the department under this section unless the department declares the application complete as provided under s. 150.719 (1).

150.719 Review requirements. (1) The department's review of an application begins on the date that a completed application is received. On or before the 20th day of the month that immediately follows the receipt of a completed application, the department shall send a notice of receipt of the completed application to the applicant and shall publish a class 2 notice under ch. 985 in a daily newspaper with general circulation in the area where the proposed activity will be located. No application for review that is received from a hospital is complete until the commission receives a proposed capital budget under s. 150.73.

(2) The department may group applications for the same or similar types of facilities or services or for activities that are proposed within the same health planning area, as defined by the department under s. 150.33 (1), for concurrent review. The department shall base its review under this subsection on a comparative analysis of the applications, using the criteria specified in s. 150.72 and a ranking of priorities determined by the department. In reviewing an application, the department shall first consider cost containment in applying the criteria under s. 150.72 (1) and shall also consider the comments of any affected parties. The department shall promulgate rules specifying the requirements for review under this subsection.

150.72 Review criteria. (1) No application for an activity specified in s. 150.71 (1) (a) to (e) may be approved by the department unless the applicant proves by a preponderance of the evidence that each of the following criteria has been met or does not apply to the activity:

(a) The activity is consistent with the state medical facilities plan adopted under s. 150.733.

(b) A need for the activity, as determined by current and projected utilization, exists.

(c) The activity will efficiently and economically use resources, including financing for capital investment and operating expenses, when measured against alternative use of resources.

(d) The applicant has sufficient cash reserves and cash flow to pay operating and capital costs.

(e) Increases in operating and capital costs that will result from the activity are reasonable, including the direct charge to the consumer, the applicant's projected request for rate increases under ss. 150.61 to 150.67, and the charges to be paid by medical assistance and disability insurers. In considering whether the increases are reasonable, the department shall consider the analysis provided by the commission under sub. (2).

(f) Financing for the activity is available at market rates.

(g) Health care personnel needed to provide the proposed services are available and will be effectively used.

(h) Proposed construction costs are consistent with industry averages.

(i) Any proposed expansion and construction or renovation alternatives are cost–effective.

(j) The activity is consistent with efficiency standards and criteria.

(k) The applicant is participating in a utilization review program that is applicable to a statistical sampling of all hospital patients regardless of payment source, that requires public disclosure of all review data in a form useful to the

department but protects the identities of individual patients and health care professionals, and that is conducted by persons who are free of any substantial conflict of interest.

(L) The applicant has prepared a plan to provide health care to low–income individuals, and the department has approved the plan.

(2) The commission shall determine the effect of any rate change the applicant has requested on the applicant's activity and provide a report to the department no later than 45 days after the department receives a completed application.

150.723 Review process. (1) Upon the request of an affected party, the department shall hold a public meeting to review activities for which an application for review has been received. All affected parties may present testimony at the public meeting. The department shall keep minutes or other record of testimony presented at the public meeting.

(2) (a) The department shall issue an initial finding to approve or reject the application no later than 75 days after the date on which the notice under s. 150.719 (1) is published unless the applicant consents to an extension of this period. The department may not require substantial modifications of any project as a condition of approval without the applicant's consent. The department shall submit the initial finding to the applicant. Unless the applicant makes a timely request for a hearing under sub. (3), an initial finding issued under this subsection shall be considered a final action.

(b) Notwithstanding par. (a), the department may extend the review period of all projects being reviewed concurrently for 60 days if the department finds that completing the review within the 75–day time period under par. (a) is not practical due to the number of applications under review.

(3) (a) If an applicant's application is rejected, the applicant may request a public hearing to review the department's initial finding if the applicant submits a request for the hearing in writing no later than 10 days after the department issues the initial finding or the applicant may initiate a hearing under s. 227.42. The department shall commence the hearing no later than 30 days after the date on which a timely request for the hearing is received unless all parties consent to an extension of the period.

(b) Except as provided in s. 227.42, ss. 227.43 to 227.50 do not apply to hearings under this subsection. The department shall promulgate rules specifying all of the following:

1. Procedures for scheduling hearings under this subsection.

2. Procedures for conducting hearings under this subsection, including methods of presenting arguments, cross–examination of witnesses, and submission of exhibits.

3. Procedures following the completion of a hearing under this subsection, including the establishment of time limits for issuance of a decision.

4. Standards relating to ex parte communication in hearings under this subsection.

5. Procedures for reconsideration and rehearing.

(c) The department shall issue all decisions in writing.

(d) Each applicant has the burden of proving, by clear and convincing evidence, that the department's initial finding was arbitrary and capricious, contrary to law, or contrary to the weight of the evidence on the record when considered as a whole.

150.725 Judicial review. An applicant adversely affected by a decision of the department under s. 150.723 (3) may petition for judicial review of the decision under

s. 227.52. The scope of judicial review shall be as provided in s. 227.57, and the record before the reviewing court shall consist of all of the following:

(1) The application and all supporting material received prior to the department's initial finding issued under s. 150.723 (2)

(2) The record of the public meeting held under s. 150.723 (1).

(3) The department's analysis of the activity and the activity's compliance with the criteria specified in s. 150.72 (1).

(4) The record of the hearing held under s. 150.723 (3).

(5) The department's decisions and analysis issued under s. 150.723 (2) or (3).

150.727 Validity and contents of an approval. (1) An approval is valid for one year from the date of issuance. The department may grant one extension of up to 6 months for each approval.

(2) Each approval shall specify the maximum capital expenditure that may be obligated for an activity.

(3) Each approval shall include the proposed timetable for implementing and completing the project and, for the 3–year period following completion of the activity, the activity's depreciation and interest schedule, any required staff, the proposed per diem rate needed to pay capital costs, and the proposed per diem rate needed to pay operating costs.

150.73 Capital budget reporting. Beginning January 1, 2003, each hospital shall annually, by January 1, submit to the department a proposed capital budget for the 5–year period that begins on July 1 of the year in which the proposed budget is submitted. The budget shall specify all anticipated capital expenditures for activities specified in s. 150.71 (1) (a) to (c) and (e) and all anticipated application dates.

150.733 State medical facilities plan. (1) The department shall adopt a state medical facilities plan at least once every 3 years that includes a description of the state hospital system and identifies any needed or surplus hospital beds. Each plan, except the initial plan adopted under this subsection, shall also include a description of needed and surplus health services and any other comments the department determines are useful.

(2) The department may not approve an application for any activity that requires the addition of hospital beds that would exceed the number of beds authorized by the state medical facilities plan for the acute care service area where the project would be located. The department shall promulgate rules to define an acute care service.

SECTION 10. 153.08 of the statutes is repealed.

SECTION 11. 153.75 (1) (g) of the statutes is repealed.

SECTION 12. 165.40 of the statutes is repealed.

SECTION 13. 230.08 (2) (mp) of the statutes is created to read:

230.08 **(2)** (mp) One staff director of the hospital rate–setting commission, created under s. 15.105 (27).

SECTION 14. 632.75 (5) of the statutes is amended to read:

632.75 **(5)** PAYMENTS FOR HOSPITAL SERVICES. No insurer may reimburse a hospital for patient health care costs at a rate exceeding the rate established under ~~ch. 54, 1985 stats., or s. 146.60, 1983 stats., for care provided prior to July 1, 1987~~ ss. 150.61 to 150.67.

SECTION 15. Nonstatutory provisions.

(1) INITIAL APPOINTMENT OF MEMBERS OF THE HOSPITAL RATE–SETTING COMMISSION. Notwithstanding the length of terms specified for the members of the hospital

rate–setting commission under section 15.105 (27) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

(a) One member for a term expiring on March 1, 2005.

(b) One member for a term expiring on March 1, 2007.

(c) One member for a term expiring on March 1, 2009.

(2) INITIAL APPOINTMENT OF MEMBERS OF THE HOSPITAL RATE–SETTING COUNCIL. Notwithstanding the length of terms specified for the members of the hospital rate–setting council under section 15.107 (18) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

(a) The members specified under section 15.107 (18) (a) of the statutes, as created by this act, for terms expiring on July 1, 2003.

(b) The members specified under section 15.107 (18) (b) and (d) of the statutes, as created by this act, and the members not specified in section 15.107 (18) (a) to (e) of the statutes, as created by this act, for terms expiring on July 1, 2005.

(c) The members specified under section 15.107 (18) (c) and (e) of the statutes, as created by this act, for terms expiring on July 1, 2007.

(3) REQUEST TO SUPPLEMENT APPROPRIATION. By April 1, 2002, the hospital rate–setting commission shall submit to the secretary of administration a request to supplement the appropriation under section 20.438 (1) (g) of the statutes, as created by this act, as specified under section 16.515 of the statutes. The request shall include a proposed budget for activities of the hospital rate–setting commission under subchapter III of chapter 150 of the statutes, as created by this act.

(4) HOSPITAL RATE–SETTING COMMISSION RULES.

(a) The hospital rate–setting commission shall submit proposed rules required under section 150.615 of the statutes, as created by this act, to the legislative council

staff for review under section 227.15 (1) of the statutes no later than May 1, 2002. These rules may not take effect before July 1, 2002.

(b) Using the procedure under section 227.24 of the statutes, the hospital rate–setting commission shall promulgate rules required under section 150.68 of the statutes, as created by this act, for the period prior to the effective date of the rules submitted under paragraph (a), but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a) and (2) (b) of the statutes, the hospital rate–setting commission need not provide evidence of the necessity of preservation of the public peace, health, safety, or welfare in promulgating the rules under this subsection.

SECTION 16. Effective date.

(1) This act takes effect on January 1, 2003, or on the day after publication, whichever is later.

(END)