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CONTROLLING HOSPITAL COSTS

The continuing escalation of health care costs prompted the Wisconsin Legislature to debate restrictions on hospital construction and limitations on medical service costs during deliberations on the 2001-03 state budget adjustment bill. The lawmakers considered a variety of options including: 1) a moratorium or restrictions on new construction, renovation, or expansion of health care facilities, 2) a moratorium on acquisition of major medical equipment, and 3) price controls on hospital rate increases. Although none of these proposals was included in the 2001-03 budget, the Assembly Health Committee plans to hold hearings across the state this summer to address citizen concerns about these issues. In addition, beginning June 24 in Milwaukee, Governor Scott McCallum has initiated a series of five "health care listening sessions" to receive testimony from health care providers, employers, unions, and the general public.

COSTS OF HEALTH CARE SURGING

Recent research illustrates the severity of the problems facing Wisconsin. The 16th annual Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, released March 1, 2002, reported that the cost of health care in southeastern Wisconsin is 55% higher than other metropolitan areas in the Midwest. On the insurers' side of the equation, a survey of 200 businesses by the Wauwatosa insurance brokerage Frank F. Haack & Associates predicted that area businesses expect 25% increases in premium rates for health insurance in the coming year. If true, this would be the third year in a row that increases in the southeastern part of the state have climbed 20% or more. The trends identified in both of these Wisconsin reports parallel a national survey released June 2002 by the international consulting firm Hewitt Associates, which concludes health maintenance organization (HMO) premiums will rise an average of 22% nationally in 2003, on top of the 15.3% increase HMOs experienced in 2002. (Overall, Hewitt reports, health care premiums for 2002 rose about 15.6% nationally, following a 10.2% jump in 2001.)

Among the factors contributing to these double-digit jumps in health care costs and medical insurance premiums are the increased use and escalating cost of prescription drugs; the increased reliance on expensive advanced medical technology; an aging population that will require additional medical care; excess hospital capacity and duplication of services; and inadequate federal Medicare reimbursement rates that do not cover actual costs, which result in cost shifting to other payers.

WISCONSIN ATTEMPTS TO CONTROL COSTS

Over the past three decades, Wisconsin has tried to contain hospital and health facility costs, both through private efforts within the health industry and by means of legislated regulation of rates and capital expenditures.

Hospital Rate-Setting Regulations

Hospital Rate Review Program. Wisconsin's initial effort at hospital cost containment in 1972 was a private undertaking of the Wisconsin Hospital Association (WHA) and Blue Cross/Blue Shield of Wisconsin, in which providers and insurers voluntarily attempted to control rising hospital rates through the Wisconsin Hospital Rate Review Program. The legislature officially recognized the program four years later in Chapter 224, Laws of 1975, (Section 146.60, 1975-76 Wisconsin Statutes) when it authorized the Department of Health and Social Services (DHSS), predecessor to the current Department of Health and Family Services, to contract with the WHA and "associated hospital services" to prospectively set hospital rates. The process was still voluntary and, by statute, open to all hospitals in the state. In September 1976, the contract created the Wisconsin Rate Review Council. Following public hearings, rate review standards were developed, and participating hospitals were limited to one rate increase each year, unless an emergency arose. There were no enforcement mechanisms associated with the contract.

The Legislative Audit Bureau evaluated the rate review program in 1980 and reported that voluntary agreements were not controlling costs. The legislature responded by enacting Chapter 323, Laws of 1981, which required that future contracts should include both sanctions and incentives to control costs. The objective of the program was to review a hospital's total expenditures and revenues, approve its annual budget based on what appeared to be necessary financial requirements, and set the maximum rates for the coming year. The aim was to set the rates charged private payers (typically insurers) at a level that, when supplemented by payments received from governmental programs, would cover the hospital's approved level of expenditures. This program was replaced in 1983.

Hospital Rate-Setting Commission. By 1983 the legislature had decided that an effective cost control program would require a government-managed mandatory rate-setting system that covered all hospitals within Wisconsin. In the biennial budget (1983 Wisconsin Act 27), it created a Hospital Rate Setting Program (Chapter 54, 1983-84 Wisconsin Statutes), which provided for a Hospital Rate-Setting Commission of three full-time commissioners to serve as an independent state agency replacing the voluntary quasi-public Hospital Rate Review program. Act 27 also established a separate advisory Hospital Rate-Setting Council designed to assist the commission and composed of 11 members representing "a balance of economic, provider, scientific, government and consumer viewpoints." The legislature stated its purpose was "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."

Beginning July 2, 1983, and for the remainder of the transitional period, all hospitals in the state were limited by the maximum rates that had been established by the voluntary program. The maximums set by the commission took effect on February 1, 1985.

The commission was authorized to establish and enforce, on a prospective basis, the maximum rates that Wisconsin's 168 existing hospitals could charge their private-pay patients. Each hospital could request rate changes annually. In responding to the requests, the commission was to evaluate the hospital's proposed financial requirements and apply a variety of standards, including comparisons with prudently administered hospitals that were of a similar size or provided similar services, the special circumstances of rural hospitals and teaching

hospitals, and the past budget and rate experience of the particular hospital. In addition to setting maximum rates, the commission could disallow elements of a hospital's proposed financial requirements. Certain hospitals with gross annual patient revenues of less than \$50 million (a figure that would be adjusted annually to reflect changes in the consumer price index and the hospital market basket index) were eligible to receive automatic approval of their rate requests, provided that they met specified criteria.

In cases where a hospital increased its rates without authorization, the commission could challenge the rates in circuit court. If the hospital was found to have intentionally exceeded the approved level of increase, the court could impose a forfeiture of up to \$5,000 for each week in which the hospital failed to comply with the commission's order. In addition, the hospital could be required to forfeit 50% of the amount overcharged and to implement a rate increase which the court found more consistent with the commission's order.

Originally, the commission's operations were financed on a one-third/two-thirds division derived respectively from state general purpose revenue and program revenue generated primarily from assessments levied on individual hospitals according to their gross private-pay revenues. 1985 Wisconsin Act 120 converted the commission's funding entirely to program revenue, effective FY 1986-87.

The law that created the Hospital Rate-Setting Commission also scheduled its sunset on July 1, 1989. 1985 Wisconsin Act 29 accelerated that sunset to July 1, 1987, and the entire rate-setting program was repealed by the next biennial budget (1987 Wisconsin Act 27), effective August 1, 1987.

Hospital Construction Regulations

Certificate of Need. Chapter 29, Laws of 1977, required persons planning the lease, construction, or purchase of a health care facility, a substantial change in service at an existing health care facility, or purchase of expensive clinical equipment to obtain a Certificate of Need (CON) from DHSS prior to the proposed action. The review process included public hearings, taking of written testimony, regional consultations, and study of feasibility and need. CON requirements were repealed by 1983 Wisconsin Act 27. (Chapter 150, 1977-78 Wisconsin Statutes)

Capital Expenditure Review Program. 1983 Wisconsin Act 27 created the Capital Expenditure Review Program for preapproval of the construction of nursing homes and hospitals and certain other projects. This replacement for the CON program redefined the range of projects subject to review and approval, strengthened the review procedures, and imposed a statewide limit on the number of beds in nursing homes and those facilities that primarily served the developmentally disabled. Projects regulated under the program included the purchase of a hospital, increases in a hospital's approved-bed capacity, and construction or operation of ambulatory surgery centers or home health agencies. (1983 Wisconsin Act 85 exempted development of innovative medical technology from capital expenditure review.)

The Hospital Rate-Setting Commission, in conjunction with DHSS, was responsible for determining the effects of hospital capital expenditures on private payer hospital rates. The commission had to analyze the effects of proposed projects within 45 days after a completed application was received from a hospital. Based on its assessment of the financial feasibility of the proposed project, it then recommended approval, approval with modifications, disap-

proval, or issued no recommendation. DHSS made the final decision as to whether a project could proceed.

1985 Wisconsin Act 29 increased the expenditure limits of proposed hospital projects that were subject to capital expenditure review. It also expanded the review process to include psychiatric or chemical dependency beds, neonatal intensive care and cardiac services, the initiation of organ transplant programs, and the implementation of burn centers and air transport services. Although Act 29 placed a July 1, 1989, sunset on the Capital Expenditure Review Program, 1987 Wisconsin Act 27 accelerated the termination date to August 1, 1987.

Cost Containment Commission. 1991 Wisconsin Act 250 phased in a new attempt at cost containment. In the interim between September 30, 1992, and July 1, 1993, the act required that a project analysis be conducted and a public hearing be held prior to: 1) obligating more than \$1 million for a capital expenditure at a hospital; 2) implementing a new hospital service or acquiring clinical medical equipment that exceeded \$500,000 in cost; 3) purchasing or otherwise acquiring a hospital; or 4) constructing or operating an ambulatory surgery center or home health agency. After June 30, 1993, hospitals and other health care providers had to obtain approval from the Cost Containment Commission, created by the act, before undertaking any of these projects. The act limited the number of approved hospital beds in the state to 22,516 and created a general moratorium that extended to July 1, 1996, on obligations for capital expenditures or implementing services to increase a hospital's bed capacity or increase the number of psychiatric or chemical dependency beds of a hospital. Act 250 also created a Cost Containment Council to advise the commission and report on various issues, including recommendations for a state health services plan to be adopted by the commission. 1995 Wisconsin Act 27 eliminated both the commission and the council.

Keeping the Public Informed

Notifying the Public About Hospital Rate Increases. After elimination of the rate-setting program, 1987 Wisconsin Act 399 required hospitals to publish a newspaper notice 10 days before instituting a rate increase. 1991 Wisconsin Act 250 added the requirement that hospitals which were proposing to increase rates by a percentage that exceeded the percentage increase in the consumer price index for the previous year would have to hold a local public hearing and submit a report of the hearing to the appropriate state agency. The hearing was to focus on specific information: the expected impact of the proposed rate change on health care costs; the expected improvement, if any, in the local health care delivery system; and any other issues related to the proposed rate change. 1997 Wisconsin Act 231 repealed the requirement for hearings but maintained the public notice mandate in cases where the rate increases exceeded inflation.

As amended by 1997 Act 231, Section 153.08, Wisconsin Statutes, currently continues the 10-day advanced published notice for any rate increase. It also imposes more stringent publication requirements on a hospital that proposes a percentage increase in its rates that exceeds percentage of increase in the consumer price index for the preceding year. In that case, it is necessary to publish a Class I notice describing the proposed rate change in a newspaper likely to give notice in the area where the hospital is located no sooner than 45 days and no later than 30 days before the proposed rate change is to take effect.

Information for Health Care Consumers. In addition to requiring public notice of hospital rate increases, 1987 Wisconsin Act 399 also established the Office of Health Care Informa-

tion (OHCI) and the Board on Health Care Information in DHSS to collect, analyze, and disseminate “in language that is understandable to lay persons” certain financial and patient-related health care information on hospitals, ambulatory surgery centers, and, beginning April 1, 1992, other health care providers. Under the program, which was funded primarily through assessments on hospitals proportionate to their gross private-pay patient revenues, health care providers and state agencies had to submit required information to the office, and 1989 Wisconsin Act 18 provided that monetary forfeitures could be levied against hospitals and ambulatory surgery centers that failed to provide necessary information. 1991 Wisconsin Act 250 required the office to establish, by January 1, 1993, a uniform hospital accounting system, which must be used by each hospital beginning with the hospital’s first fiscal year which begins after June 30, 1993. (This date was delayed to March 31, 1994, by 1993 Wisconsin Act 4.)

OHCI and the hospital data systems unit of the Center for Health Statistics were transferred from DHSS to the Office of the Commissioner of Insurance by 1993 Wisconsin Act 16. Later, 1997 Wisconsin Act 27 abolished OHCI and transferred its functions to the Department of Health and Family Services (DHFS). As required by 1997 Wisconsin Act 231, DHFS currently uses the information it gathers to prepare a guide that assists consumers in selecting health care providers and health care plans. [Section 153.05, Wisconsin Statutes]