

## Chapter J

### Health Care and Health Insurance

The state's involvement in health care and health insurance issues is primarily through four agencies:

- The **Department of Health Services** (DHS), whose involvement comes through its six divisions: (1) the Division of Public Health; (2) the Division of Health Care Access and Accountability; (3) the Division of Mental Health and Substance Abuse Services; (4) the Division of Quality Assurance; (5) the Division of Long Term Care; and (6) the Division of Enterprise Services. An organization chart for DHS is available at [http://dhs.wisconsin.gov/organization/435\\_DHS/CoverPage.pdf](http://dhs.wisconsin.gov/organization/435_DHS/CoverPage.pdf).
- The **Department of Regulation and Licensing** (DRL), through various examining boards and affiliated credentialing boards, regulates health care professionals.
- The **Office of the Commissioner of Insurance** (OCI) is responsible for regulation of group and individual health insurance plans.
- The **Department of Employee Trust Funds** (DETF) provides health insurance coverage for state employees and administers a health insurance pool for local governmental units that choose to participate in it.

Issues that were discussed in the 2009-10 Legislative Session and that are likely to be considered in the 2011-12 Legislative Session include reimbursement for health care providers under state programs; credentialing and the scope of practice of various health care professionals; access to health care coverage by uninsured persons and cost containment in those state programs that provide access; general health care cost increases; transparency of health care cost and quality data; and implementation of federal health reform.

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## Major Coverage Programs

Described below are four major programs with state government involvement that provide health care coverage to eligible persons. With the exception of the Health Insurance Risk-Sharing Plan (HIRSP), the programs are administered by DHS, with claims processing done by private contractors. HIRSP is administered by the HIRSP Authority. Medicaid, BadgerCare Plus, and SeniorCare all have income eligibility criteria, while Medicaid also has asset eligibility requirements. HIRSP has no such requirements, but is primarily for persons who have difficulty obtaining health insurance in the market because of a health condition.

In addition to the programs described in this chapter, DHS also administers programs that provide assistance to persons with certain chronic diseases (chronic renal disease, cystic fibrosis, and hemophilia) and acquired immunodeficiency syndrome (AIDS).

*Detailed information about Medicare is included in a federal publication, Medicare & You, which is available at:*  
<http://www.medicare.gov>.

Also, the federal **Medicare** program is a major source of payment for health care for elderly and disabled persons. Medicare Part A covers inpatient hospital care and Medicare Part B covers physicians' services and other health care services. Medicare Part C (also called Medicare + Choice or Medicare Advantage) involves provision of Medicare services through private sector health plans.

The Medicare Part D outpatient prescription drug benefit began in January 2006. Generally, persons who are eligible for both Medicare and Medicaid (dual eligibles) receive prescription drug coverage under Medicare Part D. However, states are required to pay the federal government a portion (90% in 2006, phased down to 75% in 2015 and later years) of what they save by not having Medicaid pay for prescription drug coverage for these dual eligibles (referred to as the "clawback" provision).

### Medicaid (Medical Assistance)

*Important Information About Your Enrollment and Benefits:*  
<http://dhs.wisconsin.gov/em/impubs/pubs/p-00079.pdf>.

Medicaid is a program that generally provides health care services to persons who are elderly, blind, or disabled.

While Medicaid has income and asset eligibility requirements, it does provide spousal impoverishment protections when one spouse enters a nursing home and the other spouse remains outside of the nursing home. In that situation, the law allows the spouse outside the nursing home to retain greater assets and income than would otherwise be allowed in order for the spouse in the nursing home to be eligible for Medicaid. Medicaid laws also limit divestment of property in order to bring the applicant's assets below the level allowed for Medicaid eligibility.

Medicaid covers a wide array of health care services. Unlike the federal Medicare program, Medicaid is a major payer for long-term care services, including nursing home services. Included in the services covered are physician services, hospitals, rural health clinics, medical supplies and equipment, transportation to receive services, and a wide variety of other health care services.

Medicaid is funded jointly by the federal government and the State of Wisconsin. In general, services are reimbursed approximately 58% by the federal government and 42% by the state government.

**BadgerCare Plus**

BadgerCare Plus is a program that expanded on the former BadgerCare program and that provides an array of health care services for children, parents, and childless adults. Generally, children and their parents and caretaker relatives with family income at or below 200% of the federal poverty level are eligible for the Standard Plan, which covers the same services as Medicaid covers. Persons who are eligible for the Benchmark Plan include children and their parents and caretaker relatives with family income between 200% and 300% of the family poverty level. Children with family income over 300% of the federal poverty level may purchase coverage in the Benchmark Plan at the full cost of coverage. The Benchmark Plan covers a set of health care services specified in the statutes, which are different than those covered by Medicaid.

*BadgerCare Plus information:*  
1-800-362-3002;  
<http://dhs.wisconsin.gov/badgercareplus/>.

The program also includes the Core Plan, which provides services to childless adults who are under age 65 and who have family income at or below 200% of the federal poverty level. In addition, it includes the Basic Plan, which was created in the 2009-10 Legislative Session, and provides services to persons who are eligible for and on the waiting list for the Core Plan.

BadgerCare Plus participants are required to pay a premium that is based on family income.

BadgerCare Plus is funded by federal funds available under Medicaid and under the State Children’s Health Insurance Program (SCHIP), state general purpose revenue (GPR) funds, and premiums paid by some participants.

**SeniorCare**

SeniorCare is a program that provides prescription drug coverage to eligible elderly persons. To be eligible, a person must be a state resident who is at least 65 years of age, not receive Medicaid benefits, have an annual household income at or below 240% of the federal poverty level, and pay a \$30 annual enrollment fee. The term “household income” is defined by DHS by rule. Federal poverty levels are calculated annually and the income eligibility limits for SeniorCare may be found at the DHS website at <http://www.dhs.wisconsin.gov/seniorCare/factsheets/phc10078.htm>.

*SeniorCare information:*  
1-800-657-2038;  
<http://dhs.wisconsin.gov/seniorCare/index.htm>.

To qualify for coverage under SeniorCare, a participant must meet an \$850 annual deductible for prescription drugs (\$500 for persons with a household income between 160% and 200% of the federal poverty level). After meeting the deductible, the participant is charged a copayment for drug purchases at the rate of \$5 for a generic drug and \$15 for a brand name drug. The deductible does not apply to persons with annual incomes of less than 160% of the federal poverty level. In addition, drug coverage is available under SeniorCare for persons whose household income exceeds 240% of the federal poverty level if they spend greater than the amount by which their income exceeds 240% of the federal poverty level on prescription drugs.

SeniorCare is funded by state GPR, federal Medicaid dollars, and enrollment fees.

**HIRSP**

HIRSP is a program that provides health care coverage to eligible persons who have difficulty obtaining health insurance in the market because of a health condition. There are no income or asset eligibility requirements under HIRSP. However, in order to be eligible, a person must: (1) be eligible for Medicare because of a disability; (2) have tested positive for human immunodeficiency virus (HIV); or (3) within nine months prior to applying for HIRSP, have received a notice of cancellation of coverage or a notice of rejection from an insurer; a notice of reduction or limitation of coverage that substantially reduces coverage when compared with coverage available to persons considered to be a standard risk; a notice of increase in premiums exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer’s policies; or a notice of pre-

*HIRSP:*  
<http://www.hirsp.org>.

mium for a policy not yet in effect from two or more insurers that exceeds the premium applicable to a person considered to be a standard risk by 50% or more. The notices must be based wholly or partially on medical underwriting considerations. In addition, certain persons who have lost employer-sponsored group health insurance may qualify for HIRSP, without having to satisfy any exclusion period for preexisting conditions.

HIRSP is funded by insurer assessments, health care provider discounts, and premiums paid by participants.

## Federal Health Care Reform

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (P.L. 111-148), into law. The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), which made several significant changes to P.L. 111-148, was signed by the President on March 30, 2010.

Some major features of the legislation are as follows:

- **Individual coverage requirement and subsidies.** Requires most individuals to have health insurance beginning in 2014. Penalties, phased in over several years, will be assessed against those who do not have qualifying coverage. Penalties will not be assessed against persons below certain income levels, those for whom premiums for the lowest-cost plan exceeds 8% of an individual's income, and certain others. Provides cost-sharing subsidies and premium credits to individuals based on income level and cost of coverage.
- **Employer requirements and tax credits.** Requires employers with 50 or more employees to provide health insurance to employees beginning in 2014, and will impose assessments for noncompliance. Offers tax credits to small businesses (i.e., fewer than 50 employees) to make employee coverage more affordable.
- **Health exchanges.** Provides funding to states to establish state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges, administered by a governmental agency or nonprofit agency. Individuals and small businesses may purchase qualifying coverage through the exchanges. If a state fails to set up an exchange by January 1, 2014, the federal Department of Health and Human Services (DHHS) will establish and operate an exchange in the state, either directly or through an agreement with a nonprofit entity.
- **Private insurance.** Establishes new requirements for private insurance companies, including requiring dependent coverage for children up to age 26 for all individual and group policies, prohibiting pre-existing condition exclusions for children, prohibiting lifetime caps on coverage and requiring new private plans to cover preventive services with no copayments or deductibles. Requires insurance plans to spend 80% or 85% of premium dollars on medical services. Insurers that do not meet these thresholds must provide rebates to policyholders.
- **Medicaid expansion; Medicare.** Provides Medicaid coverage to all individuals under age 65 with incomes up to 133% of the federal poverty level. Increases certain Medicaid payments to primary care providers, adjusts payments to states, and makes numerous other changes to Medicaid and Medicare.

- **Prevention and wellness.** Requires development of a national strategy to improve the nation's health and creates a Prevention and Public Health Fund. Expands coverage requirements for prevention services under private and government programs. Requires chain restaurants to disclose nutritional content of foods.
- **Health care workforce.** Creates various programs to improve the health care workforce quality and increase supply, including training programs, scholarships, loans, grants, and loan repayment programs.

Changes to Wisconsin law will be required by the new federal law, and the Legislature may wish to pursue other changes which may make the state eligible for additional benefits.

The two state agencies primarily responsible for implementing health care reform in Wisconsin are DHS and OCI. Governor Doyle established the Office of Health Care Reform by Executive Order on April 7, 2010. The office is led by the Secretary of DHS and the Commissioner of Insurance, and was directed to maintain a website to provide information about health care reform, the phases of implementation, and how changes may benefit them. The website is located at:  
[www.healthcarereform.wisconsin.gov](http://www.healthcarereform.wisconsin.gov).

The Joint Legislative Council appointed a Special Committee on Health Care Reform Implementation on May 20, 2010 and directed it to study and make recommendations on what changes should be made to Wisconsin's statutes and administrative rules in response to recently enacted federal health care reform legislation. The committee is directed to study all aspects of the federal legislation that affect Wisconsin including insurance market reforms, coverage for uninsured persons, preventive care, taxation, quality improvement, and health workforce issues. The membership and work of the committee can be viewed at:  
<http://www.legis.state.wi.us/lc/committees/study/2010/REFORM/index.html>.

The National Conference of State Legislatures (NCSL) has prepared numerous fact sheets and informational publications containing information about the state's role in the implementation of the federal health care legislation, including the *State Legislators' Check List for Health Reform Implementation-FY 2010*. These publications are available at: [http://www.ncsl.org/default.aspx?tabid=17639#ncsl\\_info](http://www.ncsl.org/default.aspx?tabid=17639#ncsl_info).

The Kaiser Family Foundation website is widely cited as an excellent resource for information on the federal health care legislation:  
<http://www.kff.org/healthreform/8061.cfm>.

The U.S. DHHS maintains a website for consumers which provides resources for selecting health care coverage, with information on both private and public options. The site also offers information about the implementation of the federal legislation. The site is: [www.healthfinder.gov](http://www.healthfinder.gov).

## Health Insurance Regulation

Health insurance is regulated by OCI, both with respect to financial stability and consumer protection. Types of health insurance regulated by OCI include plans in which an insured person may select from any health care providers to provide covered services (generally referred to as an "indemnity plan") or plans in which an insured person is limited to or is given an incentive for obtaining covered services from health care providers selected by the plan (generally referred to as a "defined network plan" or "managed care plan"). Types of defined network plans include

health maintenance organizations (HMOs) and preferred provider plans (PPPs; also referred to as “preferred provider organizations” or “PPOs”).

**Insurance mandates.** Included in the insurance laws are various types of mandates that must be met by insurance plans. These health insurance mandates generally fall into the following categories: (1) requiring coverage of a particular type of health care provider (e.g., a chiropractor or an optometrist); (2) requiring coverage for the treatment of a particular disease or condition (e.g., temporomandibular disorders or breast reconstruction); (3) requiring coverage of a particular type of health care treatment, service, or equipment (e.g., mammograms or lead poisoning screening); and (4) requiring coverage for particular persons because of their relation to the insured person (e.g., newborn infants or adopted children).

**ERISA preemption.** Because of federal preemption, OCI does not regulate self-insured employee benefit plans. The federal Employee Retirement Income Security Act (ERISA) provides that it supersedes all state laws that relate to employee benefit plans. Therefore, the state’s insurance laws, including health insurance mandates, do not apply to such plans. However, ERISA’s preemption does not apply to governmental self-insured plans, such as municipal or school district self-insured plans, and the state’s insurance laws may be applied to those plans.

## General Patients’ Rights

In 1998, the Legislature enacted a law that created a range of consumer rights for persons insured under defined network plans. The law sets forth duties of health plans and patients’ rights in the following areas: (1) access standards; (2) continuity of care; (3) provider disclosures; (4) quality assurance; (5) use of a physician as a medical director; (6) data systems and confidentiality; and (7) OCI oversight. Included in the statutes are requirements that defined network plans include a sufficient number, and types, of providers to meet anticipated needs; requirements regarding referrals to specialists, including referrals to obtain obstetric or gynecologic benefits; continuity of care after a provider is no longer included as a selected provider in a defined network plan; prohibitions on penalizing participating providers who discuss all treatment options with insured persons (generally called “gag clauses”); and a requirement for developing a process for selecting participating providers and reevaluating them. The rights and duties relating to defined network plans are generally set forth in ch. 609, Stats., and subch. III of ch. Ins 9, Wis. Adm. Code.

In addition to the above provisions that apply to defined network plans, the statutes also provide protections for insured persons relating to coverage of emergency care and experimental treatment. Those provisions apply to all health benefit plans, not just to defined network plans. The statute relating to emergency care requires that if a health care plan provides coverage of any emergency medical services, it must provide coverage of emergency medical services that are provided in a hospital emergency facility and that are needed to evaluate or stabilize an emergency medical condition. The term “emergency medical condition” is defined in the statutes using a “prudent layperson” definition.

The statutes also require a health care plan that limits coverage of experimental treatment to define the limitation and disclose the limits in any policy. The disclosure must state who is authorized to make a determination on the limitation and the criteria the plan uses to determine whether a treatment, procedure, drug, or device is experimental. Time deadlines for making a determination and the right of appeal are also included in the statute.

**Continuation Rights**

*Both federal law and Wisconsin law provide for the ability of a person who would otherwise terminate coverage under a group plan to continue to be covered under the group plan for a specified period of time.*

Both federal law and Wisconsin law provide for the ability of a person who would otherwise terminate coverage under a group plan to continue to be covered under the group plan for a specified period of time. In addition, Wisconsin law provides for conversion from group plan coverage to individual policy coverage. The federal law is often referred to as "COBRA," since it was created by the Consolidated Omnibus Budget Reconciliation Act of 1985.

Under the federal COBRA law, employees who terminate employment for any reason other than gross misconduct, persons whose hours are reduced, and dependents of those persons, may continue group coverage for up to 18 months. Dependents may continue coverage for up to 36 months if they lose coverage because of death of the employee, divorce from the employee, the dependent has reached the maximum age under the policy, or the employee becomes eligible for Medicare. Disabled employees may continue coverage for up to 29 months.

Under the Wisconsin law, continuation rights are available for: (1) the former spouse of a group member who otherwise would terminate coverage because of divorce or annulment; (2) a group member who would otherwise terminate eligibility for coverage except in cases of discharge due to misconduct; and (3) the spouse or dependent of a group member if the group member dies while covered by the group policy and the spouse or dependent was also covered. Generally, the person electing continuation coverage in the group plan may continue such coverage for 18 months. Wisconsin law also permits a terminated insured to choose conversion coverage, without having to show evidence of insurability, under individual coverage that is reasonably similar to the coverage under the group policy.

Persons electing continuation coverage under Wisconsin law may be required to pay the full premium for such coverage. Under federal law, they may be required to pay up to 102% of the premium.

Wisconsin law on continuation rights covers groups of all sizes, whereas federal law covers only groups of 20 or more employees. However, federal law is more expansive in that it covers persons under self-insured employee benefit plans, whereas Wisconsin law may not cover these plans because of ERISA preemption.

**Grievances and Independent Review**

**Grievances.** Wisconsin statutes require that all health benefit plans, as defined in the law, must establish and use an internal grievance procedure. The procedure must include the opportunity for an insured person to submit a written grievance in any form; establishment of a grievance panel for investigation of each grievance; prompt investigation of grievances; notification to each grievant of the disposition of the grievance and any corrective action taken; and retention of records for at least three years. The grievance panel must include at least one person authorized to take corrective action on the grievance and at least one insured person other than the person filing the grievance.

**Independent review.** The statutes also require health benefit plans to establish an independent review procedure under which an insured person may request and obtain an independent review of an adverse determination or an experimental treatment determination by a health benefit plan. An adverse determination is a reduction or denial of payment for treatment based on the treatment not meeting the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. An experimental treatment determination is a determination by a plan to deny payment for treatment based on the treatment being experimental under the terms of the plan. Independent review is available only if the

cost or expected cost of the treatment will exceed \$250, adjusted for inflation (\$292 in 2010; updated information is available at <http://oci.wi.gov/iro/adjamt.htm>).

Whenever an adverse determination or an experimental treatment determination is made, the insurer must provide notice to the insured person of the right to obtain an independent review, including a current listing of independent review organizations (IROs) that are certified. The insured person selects the IRO to conduct the review. The insured person must pay a \$25 fee to the IRO, but the fee is refunded if he or she prevails in whole or in part. Also, the insurer must pay a fee to an IRO for each independent review in which it is involved. The statutes provide a timetable for independent reviews, certification requirements for IROs, conflict of interest standards, qualifications of clinical peer reviewers, and immunity provisions.

The statutes require that the decision of an IRO regarding an adverse determination must be consistent with the terms of the health benefit plan. An IRO decision regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental, based on medically and scientifically accepted evidence.

In June 2002, the U.S. Supreme Court upheld state independent review statutes over a challenge based on ERISA grounds.<sup>1</sup>

## Portability

Health insurers may provide a limited period of time after enrollment during which a person's preexisting condition is not covered by the plan. Under Wisconsin law, a group health benefit plan may not exclude a preexisting condition for more than 12 months (or 18 months for a person who enrolls in the plan after his or her first opportunity to enroll).

"Portability" refers to the ability of a person to change health insurance plans and have the new insurer reduce the period for excluding a preexisting condition by the amount of time that the person was covered under a previous plan (referred to as "creditable coverage"). For example, if a person has seven months of coverage under a health benefit plan and then changes plans, the new plan may exclude coverage for the preexisting condition for only five months. However, previous creditable coverage is not included if it is followed by a period of at least 63 days during which the person was not covered under any creditable coverage.

## Mental Health Parity

In the 2009-10 Legislative Session, the Wisconsin Legislature enacted legislation requiring parity in insurance coverage of nervous and mental disorders, alcoholism, and other drug abuse problems. 2009 Wisconsin Act 218 specifies that a group health benefit plan, a governmental self-insured plan, and an individual plan that provides coverage for those conditions, must provide that various treatment limitations (e.g., exclusions and limitations, deductibles, copayments) may be no more restrictive for those conditions than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. Certain exceptions are provided for employers with fewer than 10 employees and plans that elect to be exempt and that show that their costs have increased by more than a specified amount.

The state statute is very similar to a 2008 federal law on parity--the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008.

Additional details about both the federal and state laws on this topic are available in a Wisconsin Legislative Council memorandum describing 2009 Wisconsin Act 218 (<http://www.legis.state.wi.us/lc>; click on Publications and then on Act Memos).

# Health Facilities and Residential Programs

## Licensing

The state licenses and certifies a number of health facilities and caregiving residential programs. Residential programs that provide services to minors and that are licensed by the Department of Children and Families (DCF) include foster homes, treatment foster homes, group homes, and residential care centers for children and youth. The statutes also allow a foster home or treatment foster home to be licensed by a county human services or social services department or by a licensed child welfare agency.

Information about facilities regulated by DHS is available at: [http://dhs.wisconsin.gov/rl\\_DSL/index.htm](http://dhs.wisconsin.gov/rl_DSL/index.htm).

In addition, DHS licenses adult family homes, community-based residential facilities (CBRFs), and residential care apartment complexes (RCACs) for adults, as well as hospitals and nursing homes. CBRFs are facilities that serve five or more adults who do not require care above intermediate level nursing care and who receive no more than three hours of nursing care per week. RCACs (also sometimes referred to as assisted living facilities) are places where five or more adults reside and that consist of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, an individual bathroom, sleeping and living areas, and that provide to residents not more than 28 hours per week of services that are supportive, personal, and nursing services.

## Zoning

The statutes provide that, under specified circumstances, certain residential caregiving programs, including CBRFs for adults and group homes and residential care centers for children, may locate in areas that are locally zoned for residences of families. These programs, which are referred to generally as community living arrangements in the statutes, may locate in specified residential areas depending on their capacity. In addition, the statutes provide that no community living arrangement may be established within 2,500 feet, or a lesser distance established by ordinance, of any other community living arrangement. However, a federal district court in Wisconsin has held that the distance requirement in the law is preempted by the federal Fair Housing Amendments Act and the federal Americans with Disabilities Act.<sup>2</sup> Additional information about these statutes is provided in a Wisconsin Legislative Council publication, *Establishment of Group Homes and Similar Facilities in Residential Neighborhoods* (<http://www.legis.state.wi.us/lc>; click on Publications by subject and the Information Memorandum is under Human Services and Aging).

Also, information about these facilities and programs is included in Chapter L (Human Services and Aging) of the Wisconsin Legislator Briefing Book.

# Health Professionals

## Licensing and Certification

Examining boards and affiliated credentialing boards in DRL license and certify a number of health care professionals, including nurses, chiropractors, dentists and dental hygienists, physicians, physician assistants, respiratory care practitioners, podiatrists, dietitians, athletic trainers, occupational therapists and occupational therapy assistants, optometrists, pharmacists, acupuncturists, psychologists, social workers, marriage and family therapists, professional counselors, hearing instrument specialists, speech-language pathologists, and audiologists. DHS licenses emergency personnel, including first responders and various categories of emergency medical technicians (EMTs).

An examining board is a part-time body that: sets standards of professional competence and conduct for the profession under its supervision; prepares, conducts, and grades examinations; grants licenses; and examines complaints. An affiliated credentialing board generally has the same authority as an examining board, but is

attached to an examining board and must submit its proposed rules to the examining board to which it is attached for comment.

In addition to providing for a basic credential, such as a license or certificate, the statutes also allow certain health care providers who satisfy additional requirements to engage in a higher level of practice than that provided under the basic credential. For example, a nurse who satisfies additional requirements established by the Board of Nursing is authorized to issue prescription orders; such a nurse is referred to as an advanced practice nurse prescriber.

### Caregiver Background Checks

Under Wisconsin law, certain entities regulated by DHS or DCF or county departments of human services or social services are required to conduct a background check on employees with direct client contact at the time of employment and every four years after that. The background check involves a criminal history search from records maintained by the Department of Justice, information maintained by DHS concerning abuse, and other specified information. The entities covered by the law include nursing homes, CBRFs, hospitals, home health agencies, child welfare agencies, and group homes. In addition to applying to these entities, the law also applies to regulatory agencies, such as DHS, DCF, and county departments with respect to licenses and certificates for those entities.

Under the caregiver background law, the regulated entities may not hire or contract with a caregiver if the person has engaged in certain misconduct or been convicted of a “serious crime,” as defined by statute. The statutory definition of that term includes a number of serious crimes and includes additional crimes that are considered serious if the entity is one that serves children. However, the law provides a process by which a person who has engaged in certain misconduct or been convicted of a serious crime may demonstrate that he or she has been rehabilitated.

More information about the caregiver background check law is available at <http://www.dhs.wisconsin.gov/caregiver/index.htm>.

## Public and Preventive Health

### Description of Public Health System

*At the state level, the public health system is primarily administered by DHS, through its Division of Public Health. At the local level, public health services are rendered by local public health departments and tribal health centers.*

At the state level, the public health system is primarily administered by DHS, through its Division of Public Health. The division is further divided into bureaus: (1) the Bureau of Communicable Disease and Emergency Response (communicable diseases, sexually transmitted disease programs, AIDS programs, immunization, public health preparedness, and emergency medical services); (2) the Bureau of Community Health Promotion (nutrition and physical activity, family health, and chronic disease prevention and cancer control); and (3) the Bureau of Environmental and Occupational Health (food safety, health hazard evaluation, radiation protection, and asbestos and lead). The division also includes an Office of Health Informatics (eHealth initiative, population health, vital records, and health care information).

At the local level, public health services are rendered by local public health departments and tribal health centers. In most counties, the local health department is a county agency. However, in a handful of counties, local health departments may be any of the following: (1) a joint city-county health department; (2) a municipal or multiple municipal health department; or (3) a combination of a county health department and municipal health departments. A number of local health departments have also been granted agent status by DHS for the purposes of performing environmental health activities such as issuing permits to and making investigations of hotels, restaurants, campgrounds, swimming pools, and similar types of entities. In addition, several American Indian tribes operate tribal health centers.

## Tobacco Control

A recurring issue for the Legislature has been the issue of tobacco control, including access by minors to tobacco products and regulation of smoking in public places. In the 2009-10 Legislative Session, the Wisconsin Legislature enacted a statewide ban on smoking in specified places, including taverns, restaurants, retail establishments, and lodging establishments, as well as other enclosed places that are places of employment or public places. The smoking ban took effect on July 5, 2010. Certain exceptions are provided in the law, including private residences, and retail tobacco stores or tobacco bars, as defined in the statute, that were “grandfathered-in” as of June 3, 2009.

Additional details about the statewide smoking ban are available in a Wisconsin Legislative Council publication, *Smoking Ban* (<http://www.legis.state.wi.us/lc>; click on Publications by subject and the Information Memorandum is under Health).

## Medical Malpractice

Wisconsin law requires specified health care providers (including physicians, nurse anesthetists, and hospitals) to carry insurance or self-insure for liability up to statutorily specified levels. The level is \$1,000,000 per occurrence and \$3,000,000 for all claims in a year. The law also requires those health care providers to pay annual assessments into the Injured Patients and Families Compensation Fund (formerly called the Patients Compensation Fund), which then provides coverage for medical malpractice claims in excess of those amounts.

## Advance Directives

A living will and a power of attorney for health care are documents that are referred to generally as advance directives. They are designed to specify the advance wishes of a competent person with regard to health care to be rendered when the person is no longer capable of making health care decisions. A living will is a directive to physicians not to use life-sustaining procedures or feeding tubes when the person is in a terminal condition or persistent vegetative state. A power of attorney for health care is a document that authorizes another individual, known as a “health care agent,” to make health care decisions for the person when the person is incapacitated. While use of a living will is limited to persons who are in a terminal condition or persistent vegetative state, a power of attorney for health care may be used at any time that the person is incapacitated, regardless of whether or not the person is in a terminal condition. Therefore, the power of attorney for health care is not limited to end-of-life decision-making.

Forms for living wills and powers of attorney for health care (or a power of attorney for finance and property) may be obtained by sending a self-addressed, stamped, business-sized envelope to DHS, at the following address: Living Will/Power of Attorney, Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

The living will, power of attorney for health care, power of attorney for finance and property, and authorization for final disposition are also available from the DHS website at <http://dhs.wisconsin.gov/forms/advdirectives/ADFormsPOA.htm>.

## Additional References

1. At the beginning of each legislative session, the **Legislative Fiscal Bureau** prepares Informational Papers that describe various state programs. These Informational Papers, which include descriptions of Medical Assistance and BadgerCare, may be found at <http://www.legis.state.wi.us/lfb/index.html> (click on Publications).
2. **OCI** has prepared a number of publications that provide assistance to persons purchasing health insurance and other types of insurance. Those publications may be found at [http://oci.wi.gov/pub\\_list.htm](http://oci.wi.gov/pub_list.htm). Included in the list of OCI publications are the following:
  - Guide to Long-Term Care ([http://oci.wi.gov/pub\\_list/pi-047.htm](http://oci.wi.gov/pub_list/pi-047.htm)).
  - Wisconsin Guide to Health Insurance for People With Medicare ([http://oci.wi.gov/pub\\_list/pi-002.htm](http://oci.wi.gov/pub_list/pi-002.htm)).
  - Fact Sheet on Managed Care Consumer Protections in Wisconsin ([http://oci.wi.gov/pub\\_list/pi-102.htm](http://oci.wi.gov/pub_list/pi-102.htm)).
3. **DHS** has prepared a number of consumer publications and websites that describe programs and services under the jurisdiction of the department. These may be found at <http://www.dhs.wisconsin.gov/programs/consumer.htm>. Some of the specific information prepared by DHS are as follows:
  - Consumer Guide to Health Care (<http://dhs.wisconsin.gov/guide/index.htm>).
  - Choosing Wisconsin Residential Options (<http://dhs.wisconsin.gov/bqaconsumer/ResidOpts/seek.htm>).
4. The **Board on Aging and Long Term Care** operates a Medigap help line, with a toll-free number of 1-800-242-1060. The help line is designed to answer questions about health insurance, primarily Medicare supplemental policies, long-term care insurance, and other health care plans available to Medicare beneficiaries.

<p>Medigap Help Line: 1-800-242-1060.</p>
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The Board on Aging and Long Term Care also operates an ombudsman program that serves as an advocate for long-term care consumers who reside in nursing homes or group homes or are participating in the Community Options Program. The toll-free number for the ombudsman program is 1-800-815-0015.

In addition to the toll-free number, persons may contact the Medigap help line or the ombudsman program at [BOALTC@lhc.state.wi.us](mailto:BOALTC@lhc.state.wi.us) or by writing to the Board on Aging and Long Term Care at 1402 Pankratz Street, Suite 111, Madison, WI 53704-4001.

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<sup>1</sup> *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002).

<sup>2</sup> *Oconomowoc Residential Programs v. Greenfield*, 24 F. Supp. 2d 941 (E.D. Wis. 1998).

## Glossary of Terms and Abbreviations

**APNP** – Advanced practice nurse prescriber. A nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, or clinical nurse specialist who meets specified requirements and is granted a certificate to prescribe drugs by the Board of Nursing.

**CBRF** – Community-based residential facility. A place in which five or more adults live and receive care, treatment, or services, but only limited nursing services.

**CMS** – Federal Centers for Medicare and Medicaid Services. Part of DHHS.

**COBRA** – Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law includes provisions for continuation of group health care coverage after a person would otherwise leave the group.

**Defined network plan** – A health care plan in which an enrollee's choice of health care providers is generally limited to those selected by the plan, although under some of the plans, enrollees may choose other providers and pay a larger share of the cost. Types of defined network plans include health maintenance organizations (HMOs) and preferred provider plans (PPPs).

**DHS** – State Department of Health Services.

**DHHS** – Federal Department of Health and Human Services.

**ERISA** – Employee Retirement Income Security Act. This federal law preempts states from applying their insurance laws to nongovernmental self-insured plans.

**OCI** – Office of the Commissioner of Insurance.

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