HEALTH CARE LAW ADVISOR ALERT: DON'T BE CAUGHT OFF GUARD BY FEDERAL "SURPRISE BILLING" LEGISLATION

The federal No Surprises Act was signed into law in December 2020 and becomes effective on January 1, 2022. Although similar state laws exist elsewhere, Wisconsin does not currently have a "surprise billing" law. As a result, many Wisconsin health care providers will need to take steps to ensure they are complying with the requirements of this new federal law, which will impact their billing and revenue cycle practices.

The Act's primary goal is to protect patients from surprise medical bills, including unexpected charges for out-of-network services. The Act protects patients in two important ways that providers should understand.

First, for emergency services, the law prohibits out-of-network providers from balance billing for amounts beyond what the patient would have been required to pay if the services had been delivered in-network.

Second, for certain non-emergency services, the law similarly prohibits out-of-network providers from balance billing beyond the patient's in-network obligations, but with an exception that allows some providers to balance bill if they give the patient written notice at least 72 hours before services are provided and obtain the patient's consent.

The 72-hour notice must comply with specific requirements. For example, it must disclose to the patient that the provider is out-of-network, give the patient a good-faith estimate of the out-of-network charges that will be incurred, and identify alternative providers who are available to the patient. But this 72-hour notice exception does not apply for certain types of out-of-network services provided at in-network facilities, including ancillary services (such as anesthesia), diagnostic services (such as radiology and lab), or any other services that the Secretary of Health and Human Services (HHS) may identify. Providers who violate the law's balance billing prohibitions face penalties from HHS of up to $10,000 per violation.

Beyond protecting patients, the Act also provides a framework for resolving certain billing disputes between out-of-network providers and health plans. Under the new federal law, within 30 days of being billed, private health plans that cover emergency services must pay at least a portion of an out-of-network provider's charges for covered emergency services, regardless of whether prior authorization was obtained. The same is true for out-of-network charges for covered non-emergency services rendered at in-network hospitals and facilities. The specific amounts that health plans must pay to out-of-network providers within this 30-day period will generally be determined based on the health plan's median in-network

payment for the same or similar services. If the health plan's language excludes or otherwise does not cover the services being provided, then rather than make this partial payment, the health plan may issue a benefit denial within 30 days of being billed for the services.

Upon receiving the health plan's partial payment or denial letter, an out-of-network provider and health plan have 30 days to try to negotiate a resolution of any dispute. If the dispute is not resolved within this timeframe, the provider then has a tight window—four calendar days from the end of the 30-day negotiation period—to initiate an appeal using an Independent Dispute Resolution (IDR) process established under the new federal law.

The IDR process creates an independent review and expedited arbitration process. Within three days of initiating the IDR process, the parties must select a certified IDR entity to decide their dispute. Then, within 10 days of selecting the IDR entity, both the provider and the health plan must submit "final offers" to the IDR entity, together with any supporting materials that the IDR entity requires and any other information either party believes is pertinent to their dispute. The IDR entity will then select one of the two offers. The party whose offer is not selected must pay the costs of the IDR, which are expected to range from approximately $500 to $2,000 in most cases. Once an IDR entity makes its decision, the balance due must be paid within 30 days.

When deciding which "final offer" to accept, the IDR entity must consider a benchmark known as the "qualifying payment amount" (QPA) for the services at issue. As of January 1, 2022, the QPAs for various services are expected to be set at amounts that represent the median of the contracted (in-network) rates that the health plan paid for such services in the relevant market as of January 31, 2019, with an upward adjustment based on the consumer price index for urban consumers (CPIU). For 2023 and subsequent years, the QPAs for existing health plans will continue to be adjusted upward based on the CPIU. For new health plans formed after January 31, 2019, the QPAs may be calculated based on a different methodology approved by HHS, or pursuant to a database that HHS may set up in accordance with the Act.

The law mandates that an IDR entity consider the QPA when evaluating and deciding which of the competing "final offers" to approve. But there are other factors that IDR entities are also directed to consider, including the provider's training, experience and outcome measurements; the complexity of the case; the provider's teaching status; and any contracting rate history between the parties over the prior four years.

Finally, the Act requires that, effective January 1, 2022, providers must have processes in place to ensure they are regularly supplying updated provider information to health plans for use in directories that are made available to help patients identify in-network providers.

For additional information about the requirements of the federal No Surprises Act, please

contact Doug Dehler by phone at (414) 276-5000 or by email at doug.dehler@wilaw.com.

HEALTH CARE LAW ADVISOR ALERT: WELL-DRAFTED ASSIGNMENT OF BENEFIT FORMS ARE CRITICAL WHEN FIGHTING ERISA CLAIM DENIALS

Most private health insurance coverage in the United States is employer-sponsored and governed by a federal law known as the Employment Retirement Income Security Act of 1974 (ERISA). Navigating an appeal of a benefit denial issued by an ERISA-governed health plan can be confusing. A quick review of federal regulations governing ERISA benefit denials, which can be found **here**, suggests how challenging it may be for health care providers to navigate the ERISA claims landscape successfully.

ERISA benefit denials are frequently written by a health insurer or third-party administrator (TPA) that is not the legal entity truly providing the health benefits to the patient. The legal entity providing the benefits—the health insurer**,** so to speak—is known as an "ERISA plan." When a health care provider obtains an assignment of its patient's benefits, those rights are against the ERISA plan, not necessarily the health insurer or TPA that may have written a benefit denial letter.

Health care providers can improve their chances of successfully recovering benefits from ERISA plans by ensuring that their Assignment of Benefit (AOB) forms are properly worded. AOB forms should fully authorize a provider to pursue all of its patient's appeal rights under ERISA. In addition, AOB forms should allow a health care provider to obtain full information about the ERISA plan's benefits, so that the provider can properly assess what benefits are available for various medical procedures. Absent appropriate AOB language, a provider's billing administrators may find themselves stymied when attempting to obtain the health benefits that both the provider and patient deserve. A review of AOB form language may be warranted to ensure that a health care provider has the best possible chance of recovering benefits from ERISA plans successfully.

Doug Dehler is a shareholder and a member of the firm's Litigation group. Doug's practice includes advising clients on insurance coverage and health benefit issues.

INSURANCE COVERAGE FOR BUSINESS SHUTDOWNS RELATED TO COVID-19

Some business insurance policies may provide coverage for a “business interruption” resulting from recent government orders requiring the suspension of business operations. On March 24, 2020, Governor Tony Evers and the Wisconsin Department of Health Services issued Emergency Order #12, Safer At Home Order, a copy of which can be found here. The Order is effective March 25, 2020. As a result of this Order, many local businesses are being forced to suspend operations. Most property insurance policies contain “business interruption” coverage triggered by covered losses that cause property damage. For example, if a business is forced to shut down due to a fire, there is often coverage not only for the cost of repairing the fire damage, but also for lost business income. In some cases, these business insurance policies may also provide limited coverage for business shutdowns resulting from communicable diseases like coronavirus (COVID-19). The insurance policy language providing this coverage varies significantly between insurance policies. Our firm’s experienced insurance coverage attorneys are available to review business insurance policies to determine whether there may be coverage for business shutdowns resulting from the recent government orders. To arrange for a review of your insurance policies, please contact Attorney Doug Dehler or Attorney Patrick McBride at O’Neil Cannon

SEVENTH CIRCUIT COURT OF APPEALS REJECTS “WORTHLESS” SUBWAY CLASS ACTION SETTLEMENT

On August 25, 2017, the Seventh Circuit Court of Appeals rejected a settlement of a class action lawsuit that alleged Subway’s “footlong” sandwiches failed to measure up. *In re Subway Footlong Sandwich Marketing and Sales Practices Litig.*, 869 F.3d 551 (7th Cir. 2017). The settlement offered “zero benefits for the class” and only served to enrich class counsel, according to the Court of Appeals. Thus, the class action settlement was rejected and the case was remanded to the district court.

The Subway footlong litigation was ill-advised from the start. It was filed after Subway customers posted pictures on social media allegedly showing that some “footlong” sandwiches measured closer to 11 inches. Several class action law firms jumped on board

and quickly filed lawsuits alleging violations of state consumer-protection statutes. But the facts didn't support the claims. Subway used the same size "raw dough sticks" at all its stores, and that raw dough always weighed exactly the same. Although baking variations caused some of the raw dough sticks to bake up a bit short of 12 inches, those customers who bought slightly smaller sandwiches received no less bread, by volume, than any other. And, the quantity of meat and cheese was the same on each sandwich. Customers also could add a wide range of other toppings to their sandwiches. So, in the end, there was no evidence that any customer was short-changed any food.

The settlement of the Subway lawsuit, which was approved by the district court, required Subway to take certain steps over a period of four years to reduce the likelihood that there would be "short" footlong sandwiches in the future. Although the district court and the parties found value in Subway taking these additional steps, the Seventh Circuit Court of Appeals disagreed. Specifically, the Court of Appeals focused on language in the parties' settlement agreement stating that, even after these steps were taken, it was still possible that Subway's footlong sandwiches would be slightly shorter than 12 inches because of baking variations. In the Court of Appeals' view, the settlement accomplished nothing that would benefit the consumers who made up the class.

Upon concluding that the Subway class action settlement offered "zero benefits" to the class, the Court of Appeals vacated the district court's order approving the settlement. The case was recently remanded to the district court, where it currently awaits further action.

For more information about the benefits and drawbacks of class action litigation generally, you may contact Doug Dehler at 414-276-5000 or doug.dehler@wilaw.com.

FEDERAL JUDGE RULES IN FAVOR OF E-RATE PROGRAM WHISTLEBLOWER

On January 20, a Wisconsin federal judge ruled in favor of a private telecommunications auditor, Todd Heath, who filed a lawsuit claiming that Wisconsin Bell defrauded the federal E-Rate program by overcharging schools and libraries. The lawsuit was brought under the False Claims Act (FCA), a federal law encouraging whistleblowers to come forward when they discover "false claims" or fraud committed on the federal government.

The E-Rate program was established by the Telecommunications Act of 1996 to provide schools and libraries with subsidies needed to upgrade their telecommunications equipment and improve access to the Internet and related services. Here's how Propublica described

why the E-Rate program matters: “E-Rate was set up… at the dawn of the Internet era to avert a digital divide between rich and poor students by subsidizing telecommunications services to schools and libraries… [The program] requires providers to set rates for schools and libraries at the lowest prices offered to comparable customers… [to] help schools in less-wealthy areas provide their students with access to the Web.”

E-Rate is funded by “Universal Service” charges, which federal law authorizes Wisconsin Bell and other telecommunications companies to include on business and consumer telephone bills nationwide. The funds collected are administered by the Universal Services Administrative Company (USAC) under the direction of the FCC.

Wisconsin Bell argued that the E-Rate Program did not involve any “federal funds” and, therefore, Wisconsin Bell could not be liable under the FCA for the overcharges being alleged. United States District Court Judge Lynn Adelman rejected these arguments, pointing out that the E-Rate program was established by the federal government and that E-Rate funding would not exist if not for the government’s actions. He also rejected Wisconsin Bell’s argument that it had no liability under the FCA because USAC was not acting as a government “agent” when administering E-Rate. He noted: “It seems difficult to dispute that USAC was acting on the FCC’s behalf and subject to its control while administering the subsidy fund.”

Wisconsin Bell asked to appeal Judge Adelman’s decision to the Seventh Circuit Court Appeals immediately, which would have put the trial court case on hold indefinitely, but Judge Adelman rejected this request in his January 20 court order, meaning that the lawsuit can continue toward trial.

The law firm of O’Neil Cannon Hollman DeJong and Laing SC represents the whistleblower in this case. If you believe you have information that an individual or company is defrauding the federal government, contact Doug Dehler at OCHD&L for a confidential consultation about your rights and options at (414) 276-5000.

WILL MY ADULT CHILD WITH AUTISM LIVE INDEPENDENTLY? ESTATE PLANNING FOR FAMILIES OF ADULTS WITH AUTISM SPECTRUM DISORDERS

According to the Centers for Disease Control, the prevalence of autism has increased by 6%

to 15% annually since 2002, making autism the fastest-growing developmental disability in the United States.

While this trend may be alarming to young couples having children today, there are also families in our country right now dealing with the confusing prospect of providing for adult children with autism spectrum disorders. More than 3.5 million Americans currently live with autism and 35% of young adults (ages 19–23) with autism have not held a job or received any postgraduate education.

Doug, co-author of this article, is the father of an adult son (19 years old) with autism. Together, he and Megan wrote this article to help families understand that there are ways to provide for their autistic adult children without disqualifying those children from available government programs.

That is the heart of the issue: How can you help your child achieve a level of independence appropriate for him or her while also assuring that you keep all government assistance options available?

Your Help vs. Government Benefits

If you are a parent of an adult child with autism, you are likely looking for ways to help him or her today, and you also want to provide for your child after your death. However, there is a dilemma. If not carefully planned, gifts or inheritances from family members or friends can disqualify your child from eligibility for certain potential government benefits. Those benefits, though often modest in amount, may make the difference between your child living independently in adulthood, or remaining at home or possibly being institutionalized after your death.

For example, an adult child with autism often may meet the legal definition of “disabled” such that he or she could be entitled to Supplemental Security Income (SSI) benefits. The purpose of SSI is to provide income for food and shelter. It was designed to provide recipients with approximately 75% of the threshold amount for the federal poverty cut-off. As of January 1, 2015, the maximum federal SSI monthly payment for an individual is $733. Many states provide a supplemental SSI benefit, which ranges from about $20 to $100 per month, depending on the state. In Wisconsin, the maximum supplemental SSI benefit is currently $84 per month, which makes the total maximum SSI benefit $817 per month for Wisconsin residents.

Some SSI recipients may be eligible for an additional SSI benefit if they have exceptional needs. These benefits are called SSI-E benefits. Exceptional needs generally means 40 hours per week of attendant care, including custodial care. In Wisconsin, for those who qualify, the maximum SSI-E monthly payment is currently $95.99.

While not exorbitant, these payments can help your adult child have some level of financial independence. But, here's the important part for parents to remember: There are strict limits on how much your child can earn and own and still be eligible for SSI. For example, the amount of your child's SSI benefit is reduced dollar-for-dollar by "countable income." This includes gifts or financial contributions (other than SSI) used by your child to pay for food or shelter. There is also a strict limit of how much your child can own and remain eligible for SSI. The asset limit is generally $2,000, with certain important (but limited) exceptions for necessary items such as a car, home, and certain other assets.

Unfortunately, this means that a well-intended gift or inheritance from a family member (such as you, or a grandparent) could result in your child being disqualified from receiving future SSI benefits. However, this dilemma can be avoided with proper estate planning, through which you can develop a comprehensive plan for your child's financial future. Many times, this estate planning involves creating a special needs trust, through which certain financial assistance can be provided without impacting your child's SSI eligibility.

Special Needs Trusts May Help You Achieve Your Goals

Special needs trusts (also called "supplemental needs trusts") (SNTs) have specific provisions pertaining to the needs of disabled beneficiaries. The purpose of an SNT is to preserve the beneficiary's eligibility to receive public benefits while supplementing his or her lifestyle with private funds in order to enrich his or her life. Usually, parents will set up an SNT during their lifetimes to benefit their disabled child after the parents pass away in order to ensure there are adequate funds available for the child's benefit, without worrying that such funds will disqualify the child from receiving public benefits.

Why Use an SNT?

An SNT may be used to retain and expend funds to supplement (not supplant) government benefits without rendering the beneficiary ineligible to receive them. Here are a few examples of expenses that a properly created SNT generally may cover for the benefit of your disabled child:

- Purchase of a residence.
- More sophisticated or advanced medical, dental, psychiatric, or psychological treatment, cosmetic surgery, rehabilitation, and educational or vocational services.
- Paying the differential cost for shelter between a shared or private room in a group home or nursing home.
- Providing entertainment, such as admission to museums and movie theaters, tuition for art courses, restaurant meals while away from his or her residence, cable television service, a computer with games and other software installed, a stereo or CD or DVD player, and tapes or disks.
- Paying for travel for recreation purposes.

- Paying for any services needed by the beneficiary to permit him or her to reside in his or her own home.
- Providing household furniture and furnishings.
- Paying for preparation of income tax returns and paying any income tax liabilities.
- Paying the expenses of a hobby.
- Paying for legal services to obtain, maintain, or regain eligibility for governmental or private agency benefits, to pay for any legal advice and consultation needed by the trustee to administer the SNT properly and to maintain public benefits eligibility.
- Paying for hair grooming and nail care services.
- Paying for writing supplies and postage.
- Purchasing and paying the costs of maintaining pets.
- Purchasing an automobile, including any modifications or special accommodations needed due to his or her disabilities, whether the motor vehicle is operated by the beneficiary or someone else for his or her benefit.
- Paying the costs of making the beneficiary's living environment more amenable in light of his or her disabilities, whether or not the home in which he or she resides is owned by him or her or by someone else, or is a residence purchased by the SNT, or is a nursing home, or health care center, or community based residential facility.
- Prepaying for funeral and burial pre-arrangements for the beneficiary.

SNTs provide a very powerful financial vehicle to help you provide for your child. But, SNTs are just one estate planning tool you might consider.

If you have a child with autism or other disabilities, you must think strategically about how you might help provide for your child in a way that ensures he or she will be adequately cared for, especially after your death, without taking any actions that might disqualify him or her from receiving government assistance.

If you would like additional information, you may contact either Doug Dehler or Megan Harried at (414) 276-5000.

VICTORY FOR WHISTLEBLOWERS AND TAXPAYERS: USE OF PUBLICLY AVAILABLE INFORMATION DOES NOT BAR CASES INVOLVING GOVERNMENT FRAUD

Under a federal statute known as the False Claims Act, whistleblowers with knowledge of overcharges or other fraudulent activity directed at the federal government may be entitled to substantial monetary rewards through lawsuits known as *qui tam* cases. The monetary

rewards authorized by the False Claims Act provide those who have valuable information about government fraud a strong incentive to come forward and report it. Companies alleged to have engaged in such fraud often fight back by arguing that a whistleblower's *qui tam* case should be dismissed because it is improperly based on "publicly available" information, citing the False Claims Act's "public disclosure bar."

In a victory for whistleblowers and taxpayers, a federal appellate court based in Chicago recently rejected a broad reading of the public disclosure bar. In *U.S. ex rel. Heath v. Wisconsin Bell, Inc.*, the Seventh Circuit Court of Appeals ruled that the public disclosure bar did not apply where a whistleblower's *qui tam* claim cited a contract that was available for public review on a government website. The Court of Appeals decided that the whistleblower's claim against Wisconsin Bell could proceed because it was not "based upon" the publicly available contract, but instead was based on "genuinely new and material information" that the whistleblower obtained through "his own investigation and initiative."

The whistleblower who filed the case, Todd Heath, is a telecommunications consultant based in Waupun, Wisconsin. Heath is retained by school districts and private businesses to identify overcharges contained in their telephone bills. Those bills and supporting materials are often complex and can be confusing even to sophisticated consumers. Heath, who has been auditing phone bills for more than 20 years, has the training and experience necessary to interpret such materials. Relying on information obtained through his own investigation and professional experience, Health filed a *qui tam* case alleging that Wisconsin school districts were overcharged for telecommunications services.

The Wisconsin school districts were not the only victims of the alleged overcharging, according to Heath, because the federal government subsidizes and pays a substantial portion of the schools' telecommunications bills under a federal program known as the E-Rate program. Before he filed his *qui tam* case, Heath notified the federal government of his findings, as required by the False Claims Act.

The public disclosure bar relied upon by Wisconsin Bell as a defense is intended to prevent whistleblowers from filing "parasitic" or "opportunistic" *qui tam* lawsuits based on information obtained through government reports or other public documents of the type specifically listed in the federal law. The Court of Appeals concluded that the public disclosure bar did not apply to Heath's lawsuit, however, explaining that his case was not "based upon" the contract that Wisconsin Bell cited to support its defense. After ruling in Heath's favor on this issue, the Court of Appeals decided not to consider other arguments made by Heath concerning the public disclosure bar.

Heath is represented in this case by Doug Dehler of O'Neil, Cannon, Hollman, DeJong and Laing, S.C. in Milwaukee, Wisconsin. It is expected that, within several weeks, the Seventh Circuit Court of Appeals will send the case back to a federal court in Wisconsin for additional

proceedings.

If you have questions regarding this case or any other potential whistleblower case under the False Claims Act, please contact Attorney Doug Dehler at 414-291-4719 or doug.dehler@wilaw.com.