19 OCHDL LAWYERS SELECTED AS 2022 BEST LAWYERS®; ANOTHER 5 NAMED BEST LAWYERS: ONES TO WATCH

We are pleased to announce 19 of our lawyers have been included in the 2022 Edition of *The Best Lawyers in America,* and an additional five have been selected as 2022 *Best Lawyers: Ones to Watch*.

The following are the O'Neil, Cannon, Hollman, DeJong and Laing lawyers named to the 2022 lists:

Best Lawyers in America

- Douglas P. Dehler – Litigation – Insurance
- James G. DeJong – Corporate Law, Mergers and Acquisitions Law, and Securities / Capital Markets Law
- Seth E. Dizard – Bankruptcy and Creditor Debtor Rights / Insolvency and Reorganization Law and Litigation – Bankruptcy
- Peter J. Faust – Corporate Law and Mergers and Acquisitions Law
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- Jason R. Scoby – Corporate Law
- Steven J. Slawinski – Construction Law

Best Lawyers: Ones to Watch

- Trevor C. Lippman – Litigation – Trusts and Estates
- Erica N. Reib – Labor and Employment Law – Management and Litigation – Labor and Employment
- Kelly M. Spott – Trusts and Estates
- Christa D. Wittenberg – Commercial Litigation

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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.

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20 OCHDL LAWYERS SELECTED AS 2021 BEST LAWYERS®; ANOTHER 5 NAMED BEST LAWYERS: ONES TO WATCH

We are pleased to announce 20 of our lawyers have been included in the 2021 Edition of *The Best Lawyers in America,* and an additional five have been selected as 2021 *Best Lawyers: Ones to Watch*.

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- Seth E. Dizard – Bankruptcy and Creditor Debtor Rights / Insolvency and Reorganization Law and Litigation – Bankruptcy
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- Thomas A. Merkle – Family Law
- Joseph D. Newbold – Commercial Litigation
- Chad J. Richter – Business Organizations (including LLCs and Partnerships) and Corporate Law
- John R. Schreiber – Bankruptcy and Creditor Debtor Rights / Insolvency and Reorganization Law and Litigation – Bankruptcy
- Jason R. Scoby – Corporate Law
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OCHDL CREATES NEW HEALTH CARE LAW BLOG

Welcome to the first edition of the O'Neil, Cannon, Hollman, DeJong and Laing Health Care Law Advisor. We have created this blog as an informational and educational resource for our clients and contacts. The health care industry changes often and quickly, and we seek to help keep you apprised of important legal developments in the health care field.

Over the past few months, we have spent significant time advising clients on issues relating to the COVID-19 pandemic. We include in this inaugural blog post links to some of our recent writings regarding COVID-19 issues, including links of two cover stories in *The Wisconsin Lawyer* magazine. *The Wisconsin Lawyer* is the monthly publication of the State Bar of Wisconsin and addresses issues of interest throughout the state and country.

Christa Wittenberg and Grant Killoran authored the cover article in the April, 2020 edition of *The Wisconsin Lawyer* entitled "Due Process in the Time of the Coronavirus." Their article analyzes legal concepts governing the measures utilized by public health officials to combat an outbreak of contagious disease, focusing on COVID-19. Their article can be found here.

Grant Killoran, Joe Newbold and Erica Reib authored the cover article in the June, 2020 edition of *The Wisconsin Lawyer* magazine entitled "The New Wave of Litigation: An Early Report on COVID-19 Claims." Their article analyzes the types of claims being made related to the COVID-19 pandemic. Their article can be found here.

We also include a link to a recent article on our firm's Employment LawScene blog related to the COVID-19 pandemic entitled IRS Says Reduced-Cost or Free COVID-19 Testing or Treatment Won't Prevent Individuals from Making or Receiving HSA Contributions.

Lastly, in conjunction with last week's start of the Major League Baseball season, we include

a link to an article recently posted in our newsroom by Attorney Pete Faust entitled COVID-19 Raises Privacy Issues for Major-League Baseball. The article discusses not only the current state of privacy policy in the baseball world, but also reviews the obligations of other businesses under the ADA, FMLA, CARES Act, GINA, and HIPAA.

We hope you enjoy this blog. If you have any questions about any of the articles or issues discussed in it, please feel free to contact the authors.

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

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EIGHTEEN OCHDL ATTORNEYS NAMED 2020 BEST LAWYERS IN AMERICA®

O'Neil Cannon is pleased to announce that eighteen lawyers have been named to the 2020 Edition of *Best Lawyers*, the oldest and most respected peer-review publication in the legal profession.

Best Lawyers has published their list for over three decades, earning the respect of the profession, the media, and the public as the most reliable, unbiased source of legal referrals. Its first international list was published in 2006 and since then has grown to provide lists in over 75 countries.

“For more than a third of the century,” says CEO Steven Naifeh, “Best Lawyers has been the gold standard of excellence in the legal profession.” President Phil Greer adds, “We are extremely proud of that record and equally proud to acknowledge the accomplishments of these exceptional legal professionals.”

Lawyers on *The Best Lawyers in America* list are divided by geographic region and practice areas. They are reviewed by their peers on the basis of professional expertise, and undergo an authentication process to make sure they are in current practice and in good standing.

We would like to congratulate the following attorneys named to the 2020 *Best Lawyers in America* list:

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- Peter J. Faust – Corporate Law, Mergers and Acquisitions Law
- John G. Gehringer – Commercial Litigation, Construction Law, Corporate Law, Real Estate Law
- Joseph E. Gumina – Litigation – Labor and Employment
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- Dean P. Laing – Commercial Litigation, Personal Injury Litigation – Plaintiffs, Product Liability Litigation – Defendants
- Gregory W. Lyons – Commercial Litigation, Litigation – Insurance
- Patrick G. McBride – Commercial Litigation
- Thomas A. Merkle – Family Law
- Chad J. Richter – Business Organizations (including LLCs and Partnerships)
- John Schreiber – Bankruptcy and Creditor Debtor Rights / Insolvency and Reorganization Law, Litigation – Bankruptcy
- Steven J. Slawinski – Construction Law

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- Peter J. Faust – Mergers and Acquisitions Law, Corporate Law
- Robert R. Gagan – Municipal Law
- John G. Gehringer – Real Estate Law, Construction Law, Commercial Litigation, Corporate Law
- Joseph E. Gumina – Litigation – Labor and Employment
- Dennis W. Hollman – Trusts and Estates, Corporate Law
- Grant C. Killoran – Litigation – Health Care
- Dean P. Laing – Commercial Litigation, Personal Injury Litigation – Plaintiffs, Product Liability Litigation – Defendants

- Gregory W. Lyons – Commercial Litigation, Litigation – Insurance
- Gregory S Mager – Family Law
- Patrick G. McBride – Commercial Litigation
- Thomas A. Merkle – Family Law
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- Steven J. Slawinski – Construction Law
- John Schreiber – Bankruptcy and Creditor Debtor Rights/Insolvency and Reorganization Law, Litigation – Bankruptcy

Additionally, Attorney Dean P. Laing has been named the 2019 Milwaukee Lawyer of the Year in Product Liability Litigation–Defendants.

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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.

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