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The prestigious Chambers USA Directory has included O'Neil, Cannon, Hollman, DeJong and Laing S.C. as one of the notable firms in the category of Corporate/M&A. Additionally, Chambers has included Jim DeJong and Pete Faust among their Recognised Practitioners.

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## DON'T SELL YOURSELF SHORT: EARLY TAX PLANNING TO MAXIMIZE THE SALE OF YOUR BUSINESS

What part of selling a business is most important to sellers? Most would respond that receiving the highest purchase price is most important. At first blush, this makes sense. However, sellers often focus on the number of zeros in the purchase price and ignore the fact that paying a large amount of income taxes will effectively reduce the purchase price. *Really*, sellers hope to walk away with the most cash in their pockets, i.e. the most after-tax proceeds. Sellers can maximize their after-tax proceeds by engaging in tax planning early. Too often, sellers lose out on tax savings by not considering the tax consequences of a sale sooner.

Prior to engaging with a buyer, sellers can identify tax opportunities and risks that affect the purchase price through sell-side due diligence. Generally, buyers prefer to purchase assets (as opposed to stock) and will pay a premium to do so. Sellers prefer stock sales to take advantage of favorable capital gains rates. However, a seller could identify early on that its net operating losses (NOLs) create an opportunity that allows the seller to negotiate a higher purchase price in an asset sale with peace of mind that it can offset its gains with NOLs. Alternatively, if a seller can pass on its NOLs to a buyer through a stock sale, the seller could demand a higher purchase price as the NOLs create value to the buyer by reducing the buyer's future tax liabilities.

Sellers should also pinpoint tax risks that may drive down the purchase price. For example, a seller may discover any of the following in due diligence: failure to file all required income and sales and use tax returns in all required jurisdictions; use of improper accounting methods; poorly designed compensation plans; and failure to comply with local tax laws and transfer pricing methodologies. Ideally, a seller will identify these issues before a buyer does and correct them before the buyer can knock down the purchase price.

Sellers should negotiate certain “minor” aspects of a transaction earlier. Generally, sellers lose leverage and buyers gain leverage as a transaction proceeds. Sellers would often benefit from negotiating certain terms as early as the letter-of-intent stage of a deal, because these “minor” terms have meaningful tax consequences to the seller. For example, parties usually negotiate purchase price allocation at the very end of a transaction when the seller has much less bargaining power even though the purchase price allocation will directly impact the seller’s bottom line. Also, if not negotiated early on, the seller may have difficulty renegotiating the form(s) of consideration used even though the range of possible forms of consideration – cash, debt, rollover equity, escrows, earn outs, etc. – creates a range of tax consequences to the seller.

Overwhelmed yet? Most business owners know that differing overall structures create differing tax consequences when selling a business; however, most do not think about the less obvious aspects of a transaction that could have a meaningful impact on the seller’s bottom line. By the time many of these tax planning opportunities and risks are identified, the seller has lost the leverage to make meaningful changes. Sellers should engage early in tax planning and sell-side due diligence if they plan to sell a business. Not doing so could leave the seller with a much smaller effective purchase price than expected.

For more information on this topic contact Samantha Amore at 414.276.5000 or [samantha.amore@wilaw.com](mailto:samantha.amore@wilaw.com).

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## **THE RUFFED GROUSE SOCIETY MOVES FORWARD**

Attorney Seth Dizard was mentioned in the Milwaukee Journal Sentinel for his involvement with the [Ruffed Grouse Society](#) and its recent developments to continue moving the organization forward. The society signed a memorandum of understanding with the U.S. Forest Service, and the Society hired its first habitat biologist, a Hales Corners native named Dan Dessecker.

Seth was elected earlier this year to serve on the organization's national board of directors.

[Click here to read the full story.](#)

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## **JIM DEJONG SPEAKS TO 2017 CARROLL GRADUATES**

Jim DeJong, chairman of the Milwaukee law firm of O'Neil Cannon, provided the keynote address at Carroll University's Commencement Sunday, May 14.

Carroll alumnus DeJong '73 told 2017 graduates that a lot had changed since his days here but one thing is the same, "Carroll is truly a special place." And, of course, Gert is still here. That spurred some giggles among graduates, warming up the crowd before Jim shared his key message: Be present in the moment. "While we can connect with people in various ways electronically, we can only build true relationships with intentional focus and effort," he said.

DeJong has been involved with Carroll University since 1958 and both he and his father the Rev. Lloyd DeJong have served terms on the Carroll University Board of Trustees. Most recently DeJong, the immediate past chair of the board, served as co-chair with Campaign Carroll, working to raise \$52.7 million.

More than 670 Pioneers celebrated their Commencement in a ceremony on Main Lawn, where thousands of friends and family gathered for the special occasion.

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## **EEOC WELLNESS LAWSUIT AGAINST WISCONSIN EMPLOYER ENDS IN \$100,000 SETTLEMENT**

A Wisconsin employer's settlement last month with the EEOC ended the final round of litigation initiated against it by the EEOC over its workplace wellness plan.

In 2009, Manitowoc-based Orion Energy Systems (Orion) implemented a wellness program that included a health assessment. The health assessment consisted of a personal health questionnaire, a biometric screening, and a blood draw. An Orion employee refused to participate and, as a result, was required to pay her full health premium costs of more than \$400 per month. (Meanwhile, for employees who participated in the health assessment, the

employer paid 100% of the premium cost). The employee openly questioned the purpose of the health assessment, the confidentiality of its results, and the CEO's response to her questions. Approximately three weeks after declining to participate in the health assessment, her employment was terminated. She then filed a complaint with the EEOC, which in turn sued Orion in August 2014, alleging that the company's wellness program violated the ADA as "involuntary" and that the company had retaliated against her in violation of the ADA.

The ADA generally prohibits employers with 15 or more employees from requiring medical examinations or making disability-related inquiries of an employee, unless the examination or inquiry is job-related and consistent with business necessity. The law includes an exception for "voluntary" wellness programs, but the EEOC had not finalized its definition of a "voluntary" wellness program until May 2016, nearly seven years after the events at issue in this case.

In a mixed September 2016 decision, the court for the Eastern District of Wisconsin ruled against the EEOC by finding that the wellness plan was voluntary. The court determined that the health assessment incentive (the premium cost) was permitted within the framework of a "voluntary" plan, and therefore was *not* prohibited under the general ADA medical examination and inquiry rules. While shifting even 100% of the premium cost to the employee was a strong incentive, it was still not an involuntary "compulsion," the court reasoned, because employees could still choose between completing the health assessment or paying the full premium.

While the court's ruling essentially approved the design of the wellness plan, it declined to dismiss the employee's ADA retaliation and interference claims. In other words, it was only the termination (allegedly in response to the employee's refusal to participate in the wellness plan) that the court found troubling.

To resolve these remaining issues, Orion agreed to pay the former employee \$100,000. Orion also agreed:

- Not to maintain any wellness program in the future with disability-related inquiries or medical examinations that do not meet the criteria for "voluntary" wellness plans as defined under the May 2016 final EEOC regulations;
- Not to engage in any form of retaliation, including interference or threats, against any employee for raising objections or concerns as to whether the wellness program complies with the ADA;
- To tell its employees that any concerns about its wellness program should be sent to its human resources department;
- To train its management and employees on the law against retaliation and interference under the ADA; and
- To conduct an additional training meeting with its chief executive officer, its chief operating officer, its chief financial officer, its HR director, and all employees responsible for negotiating or obtaining health coverage or selecting a wellness

program. This training is to include an explanation of the settlement terms and the ADA's requirements regarding wellness programs.

While Orion, in the consent decree, "continues to deny the EEOC allegations," the settlement serves as a reminder to employers not to base any employment decisions on participation or non-participation in a workplace benefit program. Wellness programs must comply not only with multiple provisions of the ADA, but also with HIPAA, the Genetic Information Nondiscrimination Act (GINA), the Affordable Care Act, and other laws. As these rules, and relevant case law, continue to evolve, it is important that employers maintaining, implementing, or considering updating a wellness plan proceed with an awareness of the potential costs of noncompliance.

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## **OCHD&L'S CLAUDE KRAWCZYK JOINS THE PROFESSIONAL RECOGNITION SOCIETY**

Attorney Claude Krawczyk has been named to the Greater Milwaukee Foundation's Herbert J. Mueller Society.

The recognition society acknowledges the efforts of professional advisers who are committed to their clients, philanthropy and the community. Krawczyk is one of 12 new members this year to the society, which now includes more than 300 professional advisers.

The society is named in memory of Herbert Mueller, a local estate planning attorney who, through his quiet efforts, helped shape the Foundation into the strong, stable and successful organization it is today. By the time of his death in 2001 at age 91, Mueller had worked with his clients to start more than a dozen Foundation funds with gifts totaling nearly \$50 million.

For more than a century, the [Greater Milwaukee Foundation](#) has helped individuals, families and organizations realize their philanthropic goals and make a difference in the community, during their lifetimes and for future generations. The Foundation consists of more than 1,200 individual charitable funds, each created by donors to serve the charitable causes of their choice. The Foundation deploys both human and financial resources to address the most critical needs of the community and ensure the vitality of the region. Established in 1915, the Foundation was one of the first community foundations in the world and is now among the largest.

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# RETHINKING YOUR DOCUMENT RETENTION HABITS WHILE SPRING CLEANING?

Springtime can be a good excuse to “clean house.” If you are evaluating your document retention practices this season, consider these points as you determine what to keep and what to toss:

- If you are involved in litigation or reasonably anticipate litigation, you are required to keep all documents related to the case by implementing what is referred to as a “litigation hold.” This includes suspending automatic deletion features on servers or email systems. Courts can issue monetary sanctions or even enter an adverse judgment for failure to take reasonable steps to preserve documents related to litigation.
- Know and comply with all regulatory document-keeping requirements that may apply to you or your business. As just one example, lenders are currently subject to record retention requirements under federal lending laws that include keeping closing disclosures for five years. See 12 C.F.R. § 1026.25. If you are unsure of the governing requirements, consult an attorney.
- Weigh the costs and benefits of keeping documents. On one hand, it can be valuable to be able to dig out old documents when an unexpected problem or opportunity arises. Quickly finding key correspondence to defeat a threatened lawsuit can save money and headaches. On the other hand, storing documents—whether paper or electronic—has real costs. Paper documents take up space that may be used for more productive purposes. The storage of electronic documents and emails has costs, as well, including hardware, software, maintenance, and tech support. A good document retention policy aims to balance these competing interests.
- Documents are only useful if you know where and how to find them. Just like a storage room full of unlabeled paper files, electronic records that are haphazardly stored, poorly named, or unsearchable are of limited value.
- Consistency is key. A formal document retention policy that is reliably implemented is best. In the event of a future lawsuit or dispute, a document retention policy that was consistently followed could minimize discovery disputes over destroyed documents.

If you are unsure of the legal implications of keeping or disposing of certain documents, contact an attorney. For more information, contact [Christa Wittenberg](#) at 414-276-5000, [Christa.Wittenberg@wilaw.com](mailto:Christa.Wittenberg@wilaw.com), or any of the other attorneys at OCHDL.

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# DON'T OVERLOOK LIFE-INSURANCE CONVERSION NOTICE OBLIGATIONS

## Employer, Not Insurer, Found Liable for Payment of Life Insurance Benefit

A court ruling earlier this month highlights the importance for employers of reviewing internal policies and procedures regarding the communication of post-employment life insurance rights. In *Erwood v. WellStar Health Systems*, a federal judge in Pennsylvania ruled that an employer owes more than \$750,000 to the widow of a deceased former employee.

In this case, an employee terminated employment at the end of his FMLA period and died of a terminal illness just over nine months later. Although the former employee and his spouse believed he would continue to be covered under a life insurance policy following the end of his employment, the group policy coverage lapsed and was not continued because the company's benefits representative did not properly explain the post-employment individual policy conversion right.

Although the availability of a conversion right was mentioned in a summary plan description, the court found that the employer did not satisfy its disclosure obligations to the employee because no specific form, deadline, or other essential information about the conversion right was ever mentioned or provided, even when the employee and his spouse had reached out with questions and attended an in-person meeting. Instead, the representative simply provided multiple assurances during the employee's FMLA leave period that all benefit coverages would "remain the same."

The court held that the failure to provide the employee with specific conversion right election information amounted to a breach of the fiduciary obligation imposed by ERISA to convey complete and accurate information material to the beneficiary's circumstances. The court also found that an ERISA fiduciary may not, in the performance of its duties, materially mislead those to whom the duties of loyalty and prudence are owed. That duty not only includes the affirmative duty to inform, but also the duty to inform when the fiduciary knows that silence might be harmful to the beneficiary. The court found that the employer had breached these fiduciary obligations in its failure to provide the required conversion notice, and, as a result, found that such breaches amounted to a material misrepresentation by the employer resulting in harm to the spouse as beneficiary.

Unfortunately, the company's benefit representative was unaware of the company's communication and fiduciary obligations to provide notice to the employee of the conversion right and wrongly assumed that such notice would be provided by the life insurance carrier itself. Because the deceased employee and his spouse had relied on the company's communications to their detriment, the judge used the equitable remedy provisions of ERISA

to award the widow the full amount of the life insurance benefit, \$750,000 (plus interest), she would have received under the policy, had the life insurance benefit continued from the date on which employment ended.

### Compare and Contrast with COBRA

Most employers are quite familiar with the obligation to provide a notice of COBRA or state continuation coverage to group health plan participants who cease to be eligible for the workplace group health insurance plan. The process of providing continuation coverage notices has become routine, and indeed, is often handled by the plan's group health insurance carrier.

However, the opposite is true of group life insurance policies. Not only are some employers less aware that group life insurance coverage applies only to active employees, the contractual language of group policies typically requires the employer (rather than the insurer) to provide the conversion right notices when employment ends.

The court's decision in *Erwood* highlights the importance of periodically reviewing internal post-employment benefits right notice obligations and of understanding who exactly has those obligations. This is particularly important in light of the fact that employers may change carriers over time, and that the details of conversion notice requirements may vary from carrier to carrier.

When the same insurer provides both long-term disability and life insurance, it may be that the insurer will be aware of an employee terminating employment on account of disability. In such case, it is possible that an insurer will be willing to assist in making sure that an employee receives a life-insurance conversion notice. It is more common, however, that the onus for providing notice of conversion rights rests solely on the employer, and not the carrier. The *Erwood* decision makes that reality clear for employers.

Because beneficiaries often become aware that eligibility or conversion information was inaccurate or incomplete (or that premiums have lapsed) only after the plan participant has passed away, life insurance errors of this kind are prime candidates for the application of an (often expensive) equitable remedy under ERISA that makes the beneficiary whole.

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## **DON'T FORGET ABOUT DOL'S NEW OVERTIME RULES JUST YET**

In November, a federal court in Texas issued a nationwide injunction blocking the U.S. Department of Labor (DOL) from implementing its updated overtime regulations, which would have required, among other things, that exempt employees be paid a minimum salary of \$913 per week. Because of the injunction, the new overtime regulations did not go into effect on December 1, 2016, as planned. However, they have also not completely gone away, and their fate is still uncertain.

The Obama administration immediately appealed the injunction to the Fifth Circuit Court of Appeals and asked for an expedited proceeding, which was granted. The DOL filed its initial brief on December 15, 2016, and the twenty-one states, which had opposed the implementation of the new overtime regulations and were granted the injunction, filed their brief on January 17, 2017. DOL's final reply brief was originally due January 31, 2017. However, since President Trump was inaugurated on January 20, 2017, the Trump administration has asked for three extensions to file its reply brief, all of which have been granted. The first two extensions were requested so that the new administration could consider its position on the new regulations and whether it would continue to defend them. Most recently, on Wednesday, April 19, 2017, the Fifth Circuit granted the DOL another two months, until June 30, 2017, to file its brief due to the fact that Alexander Acosta, the nominee for Labor Secretary, has not yet been confirmed.

It is not yet clear what stance the Trump administration will take on the overtime regulations, as there has been no official position taken by the President and nominee Acosta did not take a definitive position during his confirmation hearings. However, even if the administration decides not to pursue the appeal, others may. For example, the AFL-CIO's Texas branch has petitioned to join the litigation as a defendant due to its concerns that the current administration will not adequately defend the prior administration's regulations, and the national AFL-CIO has threatened to sue the DOL if it tries to scale back the regulations in any way. Additionally, the lower court, which issued the initial temporary injunction, could still issue a permanent injunction or rule on a pending motion for summary judgment, as it declined to halt proceedings while the Fifth Circuit reviewed the injunction. Therefore, these overtime regulations should still be on employers' radar, and we will keep you updated on further developments.

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## **THE FOUR CORNERS RULE AND INSURERS' DUTY TO DEFEND IN WISCONSIN**

One of the central purposes of liability insurance is to protect the insured by providing a defense in the event of a lawsuit. But what defines the limits of an insurer's duty to defend its

insured under Wisconsin law? How is the insurer to decide whether or not to defend an insured in a given case? Has an insurer breached its duty if it refuses to do so? These are critical questions. If an insurer breaches its duty to defend, the insurer may face severe consequences under Wisconsin law, including potential bad faith liability, loss of coverage defenses, and liability beyond policy limits.

With so much at stake, how should an insurer determine its duty to defend? That question is not always easy to answer. Unfortunately, Courts in Wisconsin have made answering that question more difficult with a confusing series of inconsistent decisions over the decades.

## The Four Corners Rule

To determine the insurers' obligation to defend a policyholder, states including Wisconsin have typically applied what's known as the "four corners rule"—review is limited to what's within the "four corners" of the documents' pages. No more, no less. In this case, that means that an insurer must decide whether or not to defend by comparing the language of the insurance policy to allegations made in the complaint. All other sources of information are deemed irrelevant.

As originally conceived, the rule was intended to protect the insured. It was to preclude insurers from denying a defense based upon the litigation's actual merits, and to prevent insurers from using facts they have learned to deny a defense.

In recent years, courts throughout the country have wrestled with the application of the four corners rule. The majority of states have carved out exceptions to it, while Wisconsin courts have struggled with these exceptions.

## Amorphous Rulings For Amorphous Exceptions

In *Grieb v. Citizens Cas. Co.*, 33 Wis.2d 552, 558 (1967), the Wisconsin Supreme Court found that an insurer was not required to defend a policyholder. The Court saw no need to go beyond the four corners of the complaint and the insurance policy in that case. But in dicta the Court appeared to recognize at least four situations in which it could be appropriate to look beyond the four corners of the documents:

1. Where there was a conflict between allegations made in the complaint and the known facts;
2. Where the allegations are ambiguous or incomplete;
3. Where the relevant facts fall both within and outside the policy coverage; or
4. Where the complaint states conclusions rather than facts.

The Wisconsin Supreme Court neither applied nor expressly adopted any of these exceptions in *Grieb*. Nevertheless, since then, both State and Federal courts in Wisconsin have used

these exceptions.

For example, in *American Motorists Ins. Co. v. Trane Co.*, 544 F.Supp. 669 (W.D. Wis. 1982), a Federal District Court read *Grieb* to mean that an insurer could look at “known or readily ascertainable facts,” but only if there was a conflict between the allegations and the facts or an ambiguity in the allegations.

In 1987, the Wisconsin Court of Appeals (District III) also looked to facts not included in the complaint, in *Berg v. Fall*, 138 Wis.2d 115 (Ct. App. 1987).

In *Berg v. Fall*, plaintiff Robin Berg alleged that he’d been punched by defendant James Fall. The Plaintiff’s complaint alleged only intentional conduct, not negligence. Fall’s insurer refused to defend Fall in the lawsuit, because its policy expressly excluded coverage for any intentional injury to another party. But Fall claimed that he had acted in self-defense, and therefore the policy’s exclusion should not apply. The trial court decided that Fall had committed an intentional act (i.e., to strike Berg), and his reason for doing so was irrelevant. It granted summary judgment in favor of his insurer.

The Court of Appeals considered the same extrinsic facts but reversed, holding that the insurer had a duty to defend Fall. The policy was intended to exclude intentional torts. Citing *Grieb*, enough of the facts were there, accessible in the record, to support Fall’s position, and, if proven, these facts would be a complete defense to the assault and battery claim. The appellate court also said that it wasn’t surprising that Berg had omitted from his complaint facts that supported Fall’s defense, and that Berg’s omission should not determine Fall’s insurance coverage.

However, a year later, the Court of Appeals (District IV) took the opposite view. In *Professional Office Bldgs. v. Royal Indem. Co.*, 145 Wis.2d 573, (Ct. App. 1988), the trial court considered extrinsic facts known to the insurer but not included in the complaint, and concluded the insurer had no duty to defend. But the Court of Appeals reversed, stating that the Federal Court’s decision in *American Motorist* was persuasive, but ultimately, it did not control in Wisconsin state courts. *Grieb* required the duty to defend to be determined solely by the allegations of the complaint, it held, without regard to extrinsic facts (contained in deposition testimony and so forth).

Later cases only further muddied the issue. In *Doyle v. Engleke*, 217 Wis. 2d 277 (1998), and in *Smith v. Katz*, 226 Wis. 2d 298 (1999), the Wisconsin Supreme Court signaled that under Wisconsin law an insurer’s duty to defend is to be determined under the four corners rule, looking solely to the insurance policy and the allegations of the complaint. In both cases, the high court criticized the Court of Appeals’ decision in *Berg* as being contrary to a long line of Wisconsin cases, yet did not overrule *Berg*.

Then, some twenty years after *Berg, Estate of Sustache v. Amer. Fam. Mut. Ins. Co.*, 2007 WI App 144, 303 Wis.2d 714 (2007), came before the Wisconsin Court of Appeals.

Like *Berg, Sustache* involved a fistfight, and, once again, the complaint alleged only intentional battery, but the insured claimed he had acted in self-defense. The trial court based its decision solely upon the complaint and found no duty to defend. The Court of Appeals affirmed, citing *Doyle and Smith*, concluding that Wisconsin law “knows no exceptions” to the four corners rule. Yet, in dicta the Court noted that where the “true facts” call for coverage but the complaint fails to reveal those facts, the insured should be entitled to a defense. The Wisconsin Supreme Court had declined to hear the case on certification by the Court of Appeals. Hence, the Court of Appeals noted that “We think the issue warrants Supreme Court comment at some point in the future.”

Given the mixed precedent, consideration of extrinsic facts by trial courts had become commonplace and inconsistent. Insurers had little clear guidance to help them resolve questions involving the duty to defend. And neither party could rely on trial courts to produce predictable results. In practice, cases often boiled down to insurers relying on extrinsic facts when denying a defense, while insured defendants asserted extrinsic facts as grounds for demanding a defense.

## A New Clarity in the Duty to Defend?

To resolve the ongoing tension, in 2016, the Wisconsin Supreme Court decided a pair of companion cases: *Water Well Solutions Service Group Inc. v. Consolidated Ins. Co.* and *Marks v. Houston Cas. Co.* These two cases reestablished the supremacy of the strict application of the “four-corners” rule in Wisconsin.

In *Water Well Solutions Serv., Inc. v. Consolidated Ins. Co.*, 2016 WI 54 (2016), Water Well Solutions Services, Inc. (“Water Well”) had been hired by the Waukesha Water Utility in 2009 to replace a pump in an existing well. Two years later, Water Well’s pump failed, and Waukesha sued for negligence. Water Well turned to its insurer, Consolidated Insurance Company (“Consolidated”), for defense against the suit, under its Commercial General Liability Policy. Consolidated refused either to defend or to indemnify Water Well. Consolidated argued that it was not required to do so, because the complaint only alleged physical injury to Water Well’s product, and the policy specifically excluded such claims.

Water Well hired its own counsel, and, eventually, it reached an out of court settlement with the Utility. Then, Water Well filed suit against Consolidated, alleging bad faith and breach of the duty to defend. The circuit court granted summary judgment in Consolidated’s favor, finding no duty to defend, and the Wisconsin Court of Appeals affirmed.

Water Well appealed to the Wisconsin Supreme Court, arguing that the complaint did not

include all of the physical damage at issue, claiming that other property besides the well had been damaged. If that was the case, Water Well continued, Consolidated would have been required to represent the firm. Therefore, Water Well argued that it should be allowed to present evidence establishing that additional damage. The insured urged the Court to adopt an exception to the four corners rule where an insurer refused to defend based upon a policy exclusion without seeking a coverage ruling and the complaint is factually incomplete or ambiguous.

The Court declined the invitation, instead clarifying adherence to the strict application of the four corners rule.

“We now unequivocally hold that there is no exception to the four-corners rule in duty to defend cases in Wisconsin,” the Court wrote in *Water Well*. “We overrule any language in *Berg* suggesting that evidence may be considered beyond the four corners of the complaint in determining an insurer’s duty to defend.”

The Court did, though, address concerns about insurers who make a unilateral decision not to defend. While the Court did not require insurers to always seek a coverage determination, it “strongly encourage[d]” them to do so. Without one, insurers were acting “at [their] own peril” and opening themselves “up to a myriad of adverse consequences.”

On that same day, the Court also issued its decision in a companion case, *Marks v. Houston Cas. Co.*, 2016 WI 53 (2016).

Marks, the insured, was the trustee of two trusts that owned a corporation, Titan Global Holdings, Inc. (“Titan”). Marks was an officer of Titan. Between 2007 and 2009, Marks and Titan became defendants in several lawsuits. Marks tendered his defense to Houston Cas. Co., with whom he had a policy for his work as trustee.

The lawsuits Marks faced, however, alleged only that Marks had committed misconduct as an officer of Titan, not as trustee. As a result, Houston refused to defend, because the policy contained an exclusion for Marks’s activities as an officer for any entities other than the trusts. Houston did not seek a coverage ruling when making this decision. At trial, the court found Houston had no duty to defend, and the appeals court affirmed.

The Supreme Court affirmed that, not just an initial grant of coverage, but the *entire* policy, including exclusions, must be considered when determining whether a duty to defend exists. The insurer may only be barred from asserting exclusions if it has *breached* the duty to defend. Because Houston’s decision not to defend was correct, the Court explained, no breach occurred, and the exclusions were properly applied.

In *Marks*, the Court stated that the application of the exclusion could be determined from the allegations alone. The Court did note though, that it may not always be clear if an exclusion

applies from the complaint, and often, extrinsic facts may be necessary for that determination. In such cases, the insurer would have a duty to defend.

## What Now? Determining Duty to Defend in a *Post-Water Well and Marks World*

The *Water Well* Court couldn't have been more emphatic: the four corners rule applies, with no exceptions.

Accordingly, insurers should defend whenever the complaint alleges an arguably covered claim, even if the insurer knows certain facts that might negate coverage. Insurers cannot rely on policy exceptions or exclusions for protection, unless the complaint's allegations specifically trigger one of these clauses.

What if allegations in the complaint are arguably covered by the policy, but the insurer knows relevant extrinsic facts that negate coverage? *Newhouse v. Citizens Sec. Mut. Ins. Co.*, 176 Wis.2d 824 (1993) outlines the required procedure:

- Provide a defense under reservation of rights;
- Intervene and seek bifurcation and a stay of the underlying action;
- Seek a coverage determination while the underlying action is stayed or pending;
- Continue to provide defense as needed, pending a final ruling on coverage; and
- Withdraw defense only after a final ruling determines no coverage exists.

Although *Water Well* and *Marks* allow insurers to refuse to defend without first seeking a coverage ruling, the Court warned that doing so is risky. Skipping the process is best reserved for small-dollar cases or cases where the facts are clear and simple.

Must an insurer defend where known facts support coverage, but the complaint does not allege a covered claim? According to both *Water Well and Marks*, the answer is no. Extrinsic facts *cannot* be considered to create the duty to defend. And whether those facts would work to invoke coverage or to deny it is irrelevant.

But it is worth noting that neither *Water Well* nor *Marks* involved extrinsic facts known to the insurer that supported coverage (as did *Berg*).

There may be other business or strategic reasons to defend an insured, in such cases, even though no defense may be required under the four corners rule. As an example, if it is likely that an insurer may end up having to provide a defense down the road, it may wish to control the defense from the start, shaping litigation strategy. And if coverage will be litigated at some point, defending the insured may foster goodwill with a court that considers the coverage question.

## Putting the Four-Corners Rule and Duty to Defend to Work

As stated at the beginning, if an insurer makes an incorrect decision regarding the duty to defend, there can be severe consequences. Thus, even with this newly clarified four corners rule, there are still issues insurers must consider, moving forward.

For instance, even if extrinsic evidence is no longer relevant to determine the duty to defend, it *is* admissible regarding the insurer's duty to *indemnify*. Therefore, insurers must still investigate facts relating to indemnification, and *Water Well* does nothing to change that.

We need to see how the Court handles other fact-patterns. And depending on those subsequent cases, there's always a possibility of legislative enactments in response to those rulings.

And insurers must be aware that Wisconsin's "no exceptions" rule puts it in the minority. In neighboring Illinois, extrinsic facts are relevant, and an insurer is responsible for investigating those facts. A strategy prevailing in Madison may be disaster in Chicago.

It will take time to figure out just how bright this bright-line rule truly is. Until then, insurers should proceed carefully.

For more information on this topic contact [Steve Slawinski](mailto:Steve.Slawinski@wilaw.com) at 414-276-5000 or [Steve.Slawinski@wilaw.com](mailto:Steve.Slawinski@wilaw.com).