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.

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, or any of the other attorneys at OCHDL.

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.

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 extension 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.

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 at 414-276-5000 or Steve.Slawinski@wilaw.com.

LETTERS OF INTENT NOT IMPORTANT? BE CAREFUL.

When buying or selling a business, it is critical to take the negotiation and preparation of the letter of intent seriously. All too often, I hear the phrase, "letters of intent are not binding, so we don't need to spend time negotiating them." Other times, a new client will have already signed a letter of intent before engaging our firm or other advisors. Letters of intent contain many key terms, and while it is true that signing a letter of intent will not typically bind a party to close the transaction, it is important for all parties in a transaction to understand that if the transaction does close, it will likely close on the terms contained in the letter of intent. Accordingly, when negotiating a letter of intent in the sale of business context, the parties should invest the time and energy necessary to fully understand the impact the letter of intent's terms will have on the transaction.

A letter of intent (also sometimes referred to as a term sheet or an LOI) is usually prepared by the buyer and presented to the seller, and it describes the key terms of the buyer's proposal to purchase the seller's business. Among other things, the LOI will describe what the buyer is buying (typically, either the assets of the business or the shares in the business), the purchase price, and how the purchase price will be paid (all cash, seller note, earn-out, etc.). It may also contain additional concepts relating to non-competition, post-closing employment for the seller's owner, assumption of liabilities, indemnification, and terms relating to the buyer's lease or purchase of the real estate used by the seller's business. An LOI also typically contains certain provisions that are actually binding on the parties, including provisions that require the seller to deal exclusively with the buyer for a period of time, dictate which state's law will apply when interpreting the LOI, obligate the parties to maintain confidentiality, and state that each party will be responsible for its own transaction expenses. Finally, because buyers and sellers have varying degrees of leverage as a transaction progresses, buyers and sellers may take different approaches when selecting the terms to include and the terms to omit in an LOI.

Given the importance that an LOI will have on the transaction, the parties must understand the terms in the LOI and recognize that the agreed-upon terms in the LOI will form the basis for the terms that will be contained in the definitive purchase agreement and related documents. A party that attempts to change the agreed-upon terms in an LOI, because it did not fully understand the LOI's terms, will face challenges. That party will likely be accused of

“re-trading” or “moving the goalposts,” and, as a result, the party taking this approach will often lose a tremendous amount of negotiating capital; capital that could be well spent on other commonly negotiated terms in the definitive purchase documents. This practice often results in a longer transaction process, increased transaction expenses for both parties, and a lower likelihood of the transaction actually closing.

In conclusion, while an LOI is not technically binding on the parties in most cases, the LOI will have a significant impact on the overall transaction. It is critical for the parties to recognize this.

For more information on LOIs and this topic you can contact Jason Scoby at 414-291-4714 and jason.scoby@wilaw.com

Jason Scoby is a member of the firm’s Business Practice Group and Banking and Creditors’ Rights Practice Group. He advises and represents individuals, businesses, and banks on a variety of corporate, banking, and business-related issues, including mergers and acquisitions, commercial loan transactions, corporate issues, contract negotiation and preparation, and business entity selection and formation.

QSEHRAS ALLOW SMALL EMPLOYERS TO REIMBURSE EMPLOYEES’ PERSONAL HEALTH COSTS

Although the Affordable Care Act’s (ACA’s) market reforms eliminated the ability of employers to permissibly reimburse employees for individually-incurred health insurance or medical costs, recent legislation now affords certain small employers with an alternate reimbursement option. The 21st Century Cures Act amended the Internal Revenue Code to authorize the creation of a new stand-alone HRA vehicle known as a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

An employer may elect to implement a QSEHRA if the business offers *no* group health plan *and* is exempt from the ACA’s Employer Shared Responsibility provisions by virtue of having had fewer than 50 full-time (including full-time equivalent) employees in the prior year. The 50-employee limit applies to the aggregate number of employees across all commonly-controlled or affiliated businesses.

A QSEHRA is not a “health plan” within the meaning of the ACA, but may be used to pay for

or reimburse the costs of medical care and health insurance premiums incurred on behalf of an eligible employee or the employee's family members. The employee must provide proof of the expenses or coverage costs and the IRS may later request written substantiation. Reimbursements in a calendar year may range up to $4,950 (for payments relating to only the employee) or up to $10,000 (for family coverage costs). These amounts will be adjusted for inflation, and must be prorated for partial years.

Only an employer may fund a QSEHRA. Funds paid into the QSEHRA must be in addition to salary and not paid as a salary substitute. Accordingly, salary reduction contributions by employees are not permitted. With some exceptions, the reimbursement must be made available "on the same terms to all eligible employees" of the employer. Employees who have been employed by the QSEHRA sponsor for less than 90 days, or who work part time, are part of a collective bargaining unit, or are under age 25 may be excluded from participation.

The rules require an employer to furnish a written notice to its QSEHRA-eligible employees at least 90 days before the beginning of a year for which the QSEHRA is provided. In the case of an employee who is hired mid-year, the notice must be provided no later than the date on which the employee begins participation in the QSEHRA.

The notice must include the amount of the eligible employee's permitted benefit under the QSEHRA and advise the employee to inform any health care Exchange of such benefit amount if the employee is applying for advance payment of the premium assistance tax credit.

Under an initial transition rule, the first-applicable QSEHRA notice deadline was March 13, 2017. In Notice 2017-20, however, the Treasury Department and IRS suspended the notice deadline and waived any penalties that could have been imposed on employers for failure to provide the first written notice. Future guidance will specify a revised notice deadline, and will provide at least 90-days' additional time for employers to prepare and provide the notice.

While QSEHRA benefits must be reported (but not treated as taxable) on the employee's W-2 and Form 1095-B, its benefits are exempt from COBRA, or similar, continuation coverage requirements.

Ultimately, whether or not implementation of a QSEHRA makes sense for a small employer will depend on the business's specific personnel-related objectives and goals. For some employers, the cost and administrative requirements may outweigh the potential advantages, while for others a QSEHRA will present the best possible avenue to provide employees with assistance toward paying for health care.

WOMAN WITH DEMENTIA LOSES HOME AFTER ALLEGEDLY UNKNOWINGLY SIGNING OVER DEED: RESOURCES TO PROTECT YOUR LOVED ONES FROM ELDER FINANCIAL ABUSE

In March 2017, Milwaukee WISN 12 reported a heart-wrenching story about a criminal investigation alleging two neighbors defrauded a 92-year-old woman suffering from dementia.

According to the allegations, they acquired her home as a gift through a deed and gained control of her nearly $2 million in assets through the execution of a durable power of attorney document. The neighbors then boxed the woman's belongings up, moved her out of the home she grew up in, and used her funds to remodel the house. You can read the full story here.

Unfortunately, this is an all-too-common story in the world of inheritance litigation. I regularly receive calls from previously unsuspecting individuals who have just realized that a loved one was financially abused during the victim's most helpless moments. Sometimes we are fortunate enough to suspect this while the victim is still alive so we can try to do something about it. More often than not, nobody recognizes this until after the victim has died. The shock usually comes when this person receives the victim's purported estate planning documents—whether a will or a trust, or their amendments—that dramatically change the expected inheritance of some or all of the victim's family members.

This type of situation happens more than many expect. As we become more aware of this problem through stories such as this and learn more about the effects of dementia and other diseases, it is important that we as a society are mindful of this issue. Of course every person, including our oldest population, has the right to do with their property as they wish. It needs to be as a result of his or her free will, however, and not at the hands of an individual with ulterior motives.

In the right circumstances, civil litigation may be the best way to position yourself to thoroughly investigate these matters. This is particularly so if you did not have reason to suspect the abuse until after the victim has died. Unlike the example above, criminal prosecutors are often limited in their ability to conduct a thorough investigation into matters involving a person's rightful estate. The obligation is often on the aggrieved person to protect his or her own rights.

I encourage you to look at the various resources referenced in the article and in your community if you fear a loved one or you are potential victims of financial abuse.

If you would like more information on this topic you can contact Trevor Lippman at 414-276-5000 or trevor.lippman@wilaw.com

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SECURED CREDITORS MUST FILE BANKRUPTCY PROOFS OF CLAIM IN THE SEVENTH CIRCUIT

In a reversal of a decision of the U.S. Bankruptcy Court for the Northern District of Illinois, the United States Seventh Circuit Court of Appeals in *In re Pajian* rejected a common bankruptcy court practice of not requiring secured creditors to file proofs of claim in order to receive distributions toward pre-petition secured arrearages as part of a debtor's chapter 13 plan of reorganization.

Pajian involved a chapter 13 bankruptcy debtor indebted to Lisle Savings Bank, a secured creditor. Lisle filed a late proof of its secured claim and the debtor objected to the claim based upon its untimeliness. Formerly, courts would allow a secured creditor such as Lisle Savings Bank to abstain from filing a proof of claim and, instead, wait to object to a proposed plan of reorganization that failed to include payments toward the creditor's secured pre-petition arrearage claim.

In opining that Rule 3002(c) of the bankruptcy code requires all (not only unsecured) creditors to file proofs of claim within 90 days of a Section 341 meeting of creditors, the Court of Appeals effectively barred Lisle Savings Bank from receiving distributions on its pre-petition secured arrearage claim as part of the debtor's plan of reorganization. While the Court of Appeals acknowledged that a secured creditor's lien (and right to foreclose the same) remains unaffected by its failure to timely file a proof of claim, the court's decision means that a debtor need not make plan payments to its tardy secured lender during its plan of reorganization (presumably 5 years), but is only required to make loan payments to its lender coming due during the plan in order to avoid a foreclosure of the bank's lien.

As a result, the debtor in *Pajian* was not required to make plan payments of loan arrearages during the course of its entire plan of reorganization. Because Lisle's lien was not avoided, however, the bank remained entitled to realize upon its pre-petition secured arrearage to the extent of the value of its security, but only after completion of the debtor's plan of reorganization or default under the terms thereof.

Many deadlines are very short under the bankruptcy rules. If you are a creditor, whether secured or unsecured, it is of utmost importance to contact bankruptcy counsel immediately upon receiving a notice of bankruptcy. Failure to comply with bankruptcy deadlines, including the filing of a timely proof of claim, may prejudice the rights of a secured creditor as displayed by *Pajian*.

For further information, please contact John Schreiber or any of the attorneys in OCHD&L's Banking and Creditors' Rights Practice Group.

SETH E. DIZARD APPOINTED TO THE NATIONAL BOARD OF DIRECTORS FOR THE RUFFED GROUSE SOCIETY

Attorney Seth E. Dizard has recently been appointed to the National Board of Directors for the Ruffed Grouse Society. Established in 1961, the Ruffed Grouse Society (RGS) is North America's foremost conservation organization dedicated to preserving our sporting traditions by creating healthy forest habitat for ruffed grouse, American woodcock, and other wildlife. RGS works with landowners and government agencies to develop critical habitat utilizing scientific management practices.

Seth is a longtime member of the David Uihlein (Milwaukee) Chapter of RGS. O'Neil Cannon has been a regular corporate sponsor of RGS since Seth joined the firm. As an avid hunter and conservationist, the honor means a great deal to Seth and he looks forward to serving on the National Board. The firm is proud of Seth, as well as its longstanding tradition of giving back, in addition to supporting those causes which are important to its lawyers and staff.

RGS is mainly comprised of grouse and woodcock hunters who support national scientific conservation and management efforts to ensure the future of the species. The organization employs a team of wildlife biologists to work with private landowners, and government, including local, state and federal, land managers who are interested in improving their land for ruffed grouse, American woodcock and the other songbirds and wildlife that have similar requirements.

To read more about the Ruffed Grouse Society and their efforts click here.