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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER **DECEMBER 2008**

TO CLIENTS AND FRIENDS OF MATTHIESEN, WICKERT & LEHRER, S.C.:

This monthly electronic subrogation newsletter is a service provided exclusively to clients and friends of Matthiesen, Wickert & Lehrer, S.C. The vagaries and complexity of nationwide subrogation have, for many lawyers and insurance professionals, made keeping current with changing subrogation law in all fifty states an arduous and laborious task. It is the goal of Matthiesen, Wickert & Lehrer, S.C. and this electronic subrogation newsletter, to assist in the dissemination of new developments in subrogation law and the continuing education of recovery professionals. If anyone has co-workers or associates who wish to be placed on or removed from our e-mail mailing list, please provide their e-mail addresses to Rose Thomson at rthomson@mwl-law.com. We appreciate your friendship and your business.

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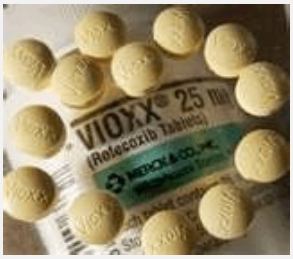

ERISA SUBROGATION RIGHTS SNUBBED IN *VIOXX* DECISION:

Avmed, Inc. v. BrownGreer, PLC, 2008 WL 4909535 (5th Cir. 2008)

The 5th Circuit Court of Appeals in New Orleans has given health insurance subrogation the ultimate snub. The court recognized the likelihood that many ERISA health plans have legitimate rights of subrogation and reimbursement resulting from medical expenses they paid to plan participants who suffered health problems and cardiovascular thrombotic events after taking Vioxx, a drug intended to relieve pain and inflammation. However, the court also questioned whether settlement funds belonged, in good conscience, to the subrogated plans, and indicated that "technical" problems inherent in mass tort multi-district litigation makes it difficult for subrogated plans to perfect their rights of subrogation.

The court in *Avmed* heard the appeal of the district court's denial of two motions for preliminary injunctive relief filed by a group of self-funded ERISA plans arising out of the Vioxx multi-district litigation. The subrogated plans sought to enjoin distribution of interim payments from the settlement of the Vioxx multi-district litigation until such time as they are able to assert equitable rights against any of their plan beneficiaries who are involved in the settlement negotiation process and for whom they have paid Vioxx-related medical expenses. The appellants requested preliminary injunctive relief pursuant to ERISA, (1) mandating the

disclosures of the identities of the Vioxx claimants participating in the settlement, and (2) enjoining distribution of interim settlement funds until such time as the appellants are able to assert reimbursement rights against those claimants for whom they have paid medical expenses related to Vioxx.

This multi-district products liability litigation involves the prescription drug Vioxx. Merck, a New Jersey corporation, researched, designed, manufactured, marketed, and distributed Vioxx to relieve pain and inflammation resulting from osteoarthritis, rheumatoid arthritis, menstrual pain, and migraine headaches. On May 20, 1999, the Food and Drug Administration (FDA) approved Vioxx for sale in the United States. On September 30, 2004, Merck withdrew Vioxx from the market after data from a clinical trial indicated that the use of Vioxx increased the risk of cardiovascular thrombotic events. Soon, thousands of suits and numerous class actions were filed against Merck in state and federal courts throughout the country alleging various products liability, tort, fraud, and warranty claims.

It is estimated that 105 million prescriptions for Vioxx were written in the United States between May 20, 1999 and September 30, 2004, and that approximately 20 million patients have taken Vioxx in the United States. On February 16, 2005, the Judicial Panel on multi-district litigation conferred multi-district litigation status on Vioxx lawsuits filed in federal court and transferred all such cases to the United States District Court for the Eastern District of Louisiana. On November 9, 2007, after extensive litigation, Merck formally announced that it had reached a Settlement Agreement with the plaintiffs representing the injured Vioxx patients. The private Settlement Agreement establishes a pre-funded program for resolving pending or tolled state and federal Vioxx claims against Merck as of the date of the settlement, involving claims of heart attack, ischemic stroke, and sudden cardiac death, for an overall amount of $4.85 billion.

In order to determine eligibility and valuation of individual claims submitted for enrollment, the Settlement Agreement provides that an independent Claims Administrator will review claims and calculate the total number of points awarded to each claimant during the claims valuation process. An Escrow Agent will hold and disburse the funds as claims adjudication proceeds. Pursuant to the terms of the Settlement Agreement, BrownGreer, PLC, was appointed as the Claims Administrator and U.S. Bancorp, Inc., the other named defendant herein, was appointed the Escrow Agent.

In reviewing whether a claim is eligible for enrollment in the Vioxx Settlement Program, the Claims Administrator must decide whether the claim satisfies certain criteria set forth by each of the three “gates”: (1) evidence of a qualifying injury, (2) duration of use, and (3) proximity of injury to usage. Each claimant is initially awarded a number of points based on such individual factors as: age, injury, duration of usage, consistency of use, the date of the relevant usage, whether the claimant used Vioxx pre-or post-label adjustment, and the claimant’s general health and medical history. Factors in the claimant’s medical history that might affect the points award include smoking, cholesterol levels, and whether the claimant or the claimant’s family has a history of heart attacks or ischemic strokes.

The Settlement Agreement provides for the disbursement of interim settlement payments to eligible claimants. In order to qualify for interim payments, claimants must fulfill certain registration and filing obligations according to the terms set forth in the Agreement. Pursuant to the Agreement terms, claimants who timely fulfill all of their filing obligations may qualify to receive interim settlement payments beginning on August, 1, 2008, or the date on which the Claims Administrator has determined pre-review points awards for a specific number of claimants, whichever is later, conditioned on Merck’s waiver of its walk away privileges. On July 17, 2008, Merck began funding the Settlement Program with an initial deposit of $500 million for interim disbursements.

A group of self-funded ERISA plans filed suit against BrownGreer, PLC, the Claims Administrator, and U.S. Bancorp, Inc., the Escrow Agent, with regard to the settlement. This is precisely the procedure which previous U.S. Supreme Court and federal appellate decisions have indicated is necessary in order for ERISA plans to successfully seek reimbursement out of third-party settlements such as this one. In *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferer, Poirot, & Wansbrough*, 354 F.3d 348 (5th Cir. 2003), the court determined that the subrogated funds must (1) be specifically identifiable, (2) belong in good conscience to the plans, and (3) be within the possession and control of the defendant beneficiary.

The court in *Avmed* noted that the Claims Administrator in the Vioxx settlement has not yet finished determining which claimants are eligible for funds. It said that the court has no reliable way of determining which claimants will ever receive funds, much less the amount they will receive. They also pointed out that none of the ERISA plans suing for equitable relief had language which designated an unallocated settlement fund like the one in the Vioxx settlement as an "identifiable" fund from which the plan could recover.

The usual complicated issues accompanying ERISA health insurance subrogation – such as the plans at issue are really ERISA-covered, differences in plan language, and the medical causation issues which may arise – combined with complicated and cumbersome problems accompanying complex mass tort litigation, convinced the court that allowing the injunctive relief sought by the plans would be opening Pandora's box. The court seemed to be throwing up its hands and saying, "It's just too much of a pain to satisfy some measly subrogation interests." Although many of the plans' language may have been sufficient and could have proven the expenses they paid related to the Vioxx health issues, because all the subrogated claims were in one big heap and somebody was going to have to sort it all out, the court punted.

It isn't surprising to subrogation professionals to see the courts relegate subrogation claims to that of the red-haired step-child and shy away from allowing the interjection of a whole slew of new claims and issues into an already complicated case. The plans do have recourse. They will need to refine the claims and provide the court with greater specificity of facts, and perhaps even proceed with individual claims for relief. Until then, however, plan underwriters and scribes should quickly take a hint from this 5th Circuit decision and include language in their plans which designate an unallocated settlement fund like the one in the Vioxx settlement as an "identifiable" fund from which the plan may collect.

INSURANCE SUBROGATION

MWL RELEASES NEW 50 STATE SUMMARY OF MADE WHOLE DOCTRINE

Matthiesen, Wickert & Lehrer has just completed a 50-state summary of the treatment and application of the made whole doctrine in all 50 states. The chart is available on our website at www.mwl-law.com and can be found on the left-hand side of the home page by all of the other subrogation resources, including:

- ★ Statutes of Limitations In All 50 States
- ★ Deductible Reimbursement Laws In All 50 States
- ★ Contributory Negligence/Comparative Fault Laws
- ★ Med Pay/PIP Subrogation In All 50 States
- ★ Economic Loss Doctrine In All 50 States
- ★ Employee Leasing Subrogation Laws In All 50 States
- ★ First Party Diminution In Value Cases In All 50 States
- ★ Landlord/Tenant Subrogation In All 50 States
- ★ Workers' Compensation Subrogation In All 50 States
- ★ Spoliation Laws In All 50 States

The made whole doctrine is an equitable defense to the subrogation or reimbursement rights of a subrogated insurance carrier or other party, requiring that before subrogation and/or reimbursement will be allowed, the insured must be made whole for all of its damages. Precisely what being “made whole” means varies from state to state, and some states apply the made whole doctrine, others don't. Some allow a policy to contract around the necessity of the insured being made whole, and others don't. In fact, some states hold that unless the policy specifically requires the insured be made whole before you can subrogate, there is no such requirement. Other states apply the doctrine automatically. Even in states in which the doctrine applies, the manner in which the doctrine is applied, the burden of proof, and what is considered a recovery by the insured in order to determine if it is made whole, all vary from state to state. Now, for the first time, you can access a resource which instantly brings the made whole doctrine across all 50 jurisdictions to your fingertips, allowing you to respond instantly to trial lawyers misquoting or misunderstanding the application of subrogation's greatest rivalry - the made whole doctrine.

Please call us with any questions, or if you see any changes or additions which need to be made to the list. MWL continues to serve as the premier subrogation law firm in the country, providing access to cutting edge subrogation law and assisting you in maximizing subrogation recoveries - large and small. If you haven't yet utilized our firm in handling your subrogation files, please consider giving us the opportunity to prove ourselves and our aggressive, cost-effective subrogation program to you and your recovery team.

INSURANCE SUBROGATION

SEEKING REIMBURSEMENT FROM A CARRIER THAT COVERED YOUR LOSS

By Michael R. Sinnen

Equitable contribution among co-insurers of a single loss is subrogation’s first cousin. Do you often face a situation in which another insurance company provides co-insurance for your insured’s loss, but will not reimburse you for their fair share after you have paid the claim in full? Our clients often inquire about the circumstances under which they may pursue a co-insurer for the additional coverage the other insurance companies provide for a given loss. Cases between co-insurers have become hotly litigated in courts throughout the United States. A basic understanding of the causes of action you have against potential co-insurers will assist you in your initial evaluation of these cases, and MWL is ready to pursue those carriers who stubbornly refuse to pay, despite providing coverage.

Two causes of action that an insurer may have against another insurer in these coverage cases are equitable subrogation and equitable contribution. Judges and lawyers alike become confused on the difference between these two claims. One of the differences between these causes of action pertains to situations in which they apply. Indeed, while equitable subrogation applies when an excess insurer is pursuing a case against a primary insurer, or when a primary insurer is pursuing a case against another primary insurer that covers a different risk, equitable contribution applies when carriers cover the same loss, and provide the same type of coverage (*i.e.,* primary carrier vs. primary carrier or excess carrier vs. excess carrier). Additionally, the remedies provided by these causes of action differ. In equitable subrogation actions, a carrier is pursuing full reimbursement for its loss, while equitable contribution actions consist of shifting a portion of a loss to another carrier.

Therefore, carriers seeking reimbursement against other carriers must look to the language of their own policy, as well as the adverse carrier’s policy, to determine whether the same risk is insured. If the same risk is insured, and the same type of coverage is provided, then the paying carrier will have an equitable contribution cause of action against the co-insurer. The amount that the paying insurer is entitled to pursue will be based on the language of the two policies, and the paying insurer should consult the “other insurance”

provisions of the policies, as well as other applicable provisions, to determine the amount they may be entitled to pursue. Meanwhile, if a carrier pays a loss and then realizes that they do not cover the risk, or that they are only an excess carrier and a primary carrier exists, that carrier may have a claim for equitable subrogation, and may be able to be reimbursed for the entire amount paid on a claim.

MWL has dealt extensively with claims for both equitable subrogation and equitable contribution and is ready to assist you with either type of case. Whether it is analyzing insurance policies to determine the type of action you may have, or representing your interests in a declaratory judgment action against another insurer, MWL is prepared to help you collect monies that other insurers rightfully owe your company. If you have any questions regarding equitable subrogation or equitable contribution, please contact Mike Sinnen at msinnen@mwl-law.com.

PROPERTY SUBROGATION

SOUTH DAKOTA FINALLY TAKES POSITION ON LANDLORD/TENANT SUBROGATION AND *SUTTON* RULE

American Family Mut. Ins. Co. v. Auto-Owners Ins. Co., 2008 WL 4816666 (S.D. 2008)

For those of you who handle property subrogation and utilize our Landlord/Tenant Subrogation Chart on our website, you may have noticed that South Dakota remained one of the last states which is undecided with regard to the application of the "*Sutton* Rule" when it comes to a landlord's property insurer subrogating against one of the landlord's tenants for property damage (*e.g.,* fire or water damage) to the landlord's property. That has changed. On November 5, 2008, the South Dakota Supreme Court officially rejected the blanket application of the "*Sutton* Rule" and adopted a "case-by-case" approach which looks at the terms of the applicable lease under which subrogation may be denied if the lease expressly requires the landlord to maintain fire insurance or the lease exonerates a tenant from losses caused by a fire.

In *American Family Mut. Ins. Co. v. Auto-Owners Ins. Co.*, Donald Babinski owned a rental duplex located in Sioux Falls, South Dakota. Babinski purchased a business owner's policy of insurance from American Family to provide coverage for property damage to the rental dwelling. Under the insurance policy, American Family was granted the right of subrogation in order to recover any amounts paid under the policy from those responsible for causing the loss. On January 28, 2005, the tenants signed a lease agreement to rent one unit of the duplex owned by Babinski. The lease agreement contained the following provisions:

> *(2) MAINTENANCE, REPAIRS, AND ALTERATIONS. Resident agrees: ... (b) to be responsible for, at Resident's own cost, any and all breakage or damage done to any part of the premises, including damages or theft by Resident's guests to the apartment and common areas of the building ...*
> ** * **
> *(H) LIABILITY OF RESIDENT AND MANAGEMENT.*
> *(1) NON-LIABILITY OF LESSOR.... Resident is required to maintain liability and personal property insurance during the term of the lease or any subsequent leases. Proof of insurance is required at the time the lease is signed.*
> *(3) RESIDENT SHALL REIMBURSE MANAGEMENT FOR (a) any loss, property damage, or cost of repair or service (including plumbing problems and freezer punctures) cause[d] by negligence or improper use by Resident, his/her agents, family or guests ...*

The lease did not contain any provision reserving a right of subrogation in favor of the landlord's insurer, American Family, nor did it specifically address damage to the dwelling caused by fire. In accordance with

the lease, the tenants purchased a homeowners' insurance policy from Auto-Owners for the rental duplex. The term of the policy provided coverage from February 28, 2005 to February 28, 2006. All three tenants were covered under the policy.

On March 1, 2005, an accidental fire occurred when one of the tenants, Ashley Deiss, took ashes from the fireplace and moved them to a cardboard box inside a closet in the residence. As a result of the fire, American Family paid insurance proceeds to Babinski in the amount of $96,959.42 for the damage caused by the fire. American Family then sought subrogation in this amount against Auto-Owners on the tenants' homeowners' insurance policy. Auto-Owners denied American Family's subrogation claim. American Family subsequently filed a declaratory judgment action seeking a determination of whether it had a subrogated interest against the Auto-Owners policy held by the tenants.

The circuit court issued a memorandum decision concluding that the South Dakota Supreme Court would adopt the rule first pronounced in *Sutton v. Jondahl,* 532 P.2d 478 (Okla. App. 1975). The *Sutton* rule precludes a landlord's insurer from asserting a subrogation claim against a tenant absent an express agreement to the contrary. The circuit court found that public policy reasons supported the *Sutton* approach including the legal certainty provided by the rule and the fact that it avoids gamesmanship over the manner in which landlords craft lease provisions. The circuit court held that even if it adopted the alternative case-by-case approach, American Family did not have a subrogation right. This was because the tenants could not reasonably anticipate that the landlord's insurer could assert a subrogation claim against them if the rental property was destroyed by a fire caused by their negligence.

On appeal, the Supreme Court was asked to decide a matter of first impression for this state. The issue was whether, for subrogation purposes, a tenant is co-insured under his or her landlord's insurance policy absent an express provision in the parties' lease to the contrary. If the Court decides that the tenant is co-insured under the landlord's policy, an insurer could not bring a subrogation action against a tenant who caused damage to the landlords' insured premises because the right of subrogation cannot arise in favor of an insurer against its own insured. The court noted that other states applying the *Sutton* rule have found that the rule protects the reasonable expectations of the tenant. They also noted that although some treatises acknowledge *Sutton* as a modern trend, at least one criticizes the holding and the trend:

> *Sutton, the leading modern case denying subrogation of lessees, cites no cases for the proposition that the lessee is a co-insured of the lessor, comparable to a permissive user under an auto insurance policy. Contrary to the court's statement, the fact both parties had insurable interests does not make them co-insureds. The insurer has a right to choose whom it will insure and did not choose to insure the lessees, and under this holding the lessee could have sued the insurer for loss due to damage to the realty, e.g., loss of use if policy provides such coverage.* 6A, J.A. Appleman, Insurance Law and Practice § 4055 at 78 (2005).

Several jurisdictions have rejected *Sutton's* categorical rule and instead have applied a flexible case-by-case approach. Under the case-by-case approach, the court avoids "making assumptions and adopting fictions that are largely conjectural, if not patently illogical, and instead applies basic contract principles and gives proper credence to the equitable underpinning of the whole doctrine of subrogation."

The case-by-case approach was attractive to the South Dakota Supreme Court because it was consistent with the public policy of South Dakota. Section 20-9-1 of the South Dakota Statutes provides for the general proposition that "[e]very person is responsible for injury to the person, property, or rights of another caused by his willful acts or caused by his want of ordinary care or skill, subject in the latter cases to the defense of contributory negligence." Also, § 43-32-10 specifically addresses damages caused by a lessee's negligence in the context of a lease:

In every hiring of residential premises, whether in writing or parol, the lessee shall preserve the premises, appliances, appurtenances, and other leased personality in good condition, and repair all deteriorations or damage thereto occasioned by his negligent, willful or malicious conduct or such conduct of persons acting under his direction or control.

The Supreme Court concluded that the case-by-case approach is the best approach to employ in the landlord-tenant context because it applies basic contract principles. Subrogation may be denied under the case-by-case approach if the lease expressly requires the landlord to maintain fire insurance or the lease exonerates a tenant from losses caused by a fire. They rejected the notion that a tenant is implied to be a co-insured under a landlord's insurance policy. Therefore, they officially adopted the case-by-case approach as a better reasoned rule that recognizes the intent of the parties under contract law and the equitable underpinning of subrogation.

This significant and well-reasoned decision leaves West Virginia as the only state left which has not committed itself to a particular approach to handling landlord/tenant subrogation claims. For information on how each state approaches this area of subrogation law, please see our Landlord/Tenant Subrogation Chart at http://www.mwl-law.com/CM/Resources/Landlord-Tenant-Subrogation-070308.pdf.

INSURANCE SUBROGATION

SUBROGATION AND UNPUBLISHED OPINIONS

On October 14, 2008, the Wisconsin Supreme Court considered a fourth request to permit citation of unpublished Wisconsin appellate opinions as persuasive authority. The courtroom was full of judges arguing both pro and con. Currently, § 809.23(3) restricts citation of Wisconsin Court of Appeals decisions to published decisions only. Likewise, the laws of many states prohibit lawyers from referring to or citing unpublished opinions in their briefs and motions. Matthiesen, Wickert & Lehrer took a stand in favor of allowing citation of these unpublished opinions because we felt it to be a position most favorable to the subrogation industry. Here's why.

In most states, when the Court of Appeals issues a decision, that opinion usually gets printed and included in an official reporter which can then be accessed by lawyers who subscribe to the official reporter. Hundreds of decisions a day are decided by courts of appeal across the country, and in order to prevent the reporters from becoming stuffed with obtuse and often irrelevant case law, the courts make a decision with each case as to whether or not the decision they have just rendered should be published in the official reporter. Usually, they look at the issue in the case and determine if the issue or issues addressed are merely duplicative of other cases which have handled those issues, adding nothing new to the body of jurisprudence in that state. If they do not, the case is not ordered to be published. The law in most states is that such "unpublished" opinions cannot be cited as authority in briefs or motions. One of the compelling reasons for this rule is that the unpublished opinions were not easily available to lawyers and practitioners, and therefore some would be at a disadvantage because they wouldn't have easy access to the cited yet unpublished opinions.

Today, however, these unpublished opinions are easily available electronically to anybody, including non-lawyers. In addition, the growing trend in other jurisdictions is to cite such opinions. The Federal Rules abolished the proscription of citing unpublished opinions, judgments, orders and dispositions as of January 1, 2007. Other states seem to be moving in that same direction. Wisconsin has resisted, but the Supreme Court has given proponents of allowing citation to unpublished opinions a fourth bite at the apple.

It never ceases to amaze us as to the large number of significant and frequently first impression cases which the Court of Appeals arbitrarily does not order published. This is especially true in the area of subrogation, which many jurists perhaps consider to be somewhat arcane and on the fringe of "legitimate" legal issues. MWL has made it a practice to regularly cite to unpublished opinions extensively in our subrogation books, simply noting that such opinions are unpublished and might not be citeable as legal precedent in some states. However, if the law continues to change in this regard, these books will be full of additional case law which may be relevant in understanding and advocating a particular issue or position.

INSURANCE SUBROGATION

DON'T WRITE OFF YOUR CHOICE-OF-LAW PROVISION MERELY BECAUSE WISCONSIN IS THE FORUM

By Ryan L. Woody

It is undisputed that the Wisconsin Supreme Court is no friend to the insurance industry. That explains why the Wisconsin Supreme Court has continually frowned upon standard choice-of-law provisions contained within form insurance policies. However, you should not abandon your choice-of-law argument so quickly. If your CGL or Professional Consult Policy contains a choice-of-law provision, a review of the underlying facts will be important in determining whether a Wisconsin court will enforce the foreign choice-of-law.

Many CGL or Professional Consult Policies contain a choice-of-law provision that states:

> *xx. Choice of Law. This policy and all additions to, endorsement to, or modifications of the policy shall be interpreted under the laws of the State of _____.*

Wisconsin courts recognize that parties are free to contract with regard to a choice-of-law, unless that choice violates the public policy of the State. *Bush v. National School Studios*, *Inc.*, 139 Wis.2d 635, 407 N.W.2d 883 (1987); Restatement (Second) of Conflict of Laws § 187. That Section of the Restatement reads:

> *(1) The law of the state chosen by the parties to govern their contractual rights and duties will be applied if the particular issue is one which the parties could have resolved by an explicit provision in their agreement directed to that issue.*
> *(2) The law of the state chosen by the parties to govern their contractual rights and duties will be applied, even if the particular issue is one which the parties could not have resolved by an explicit provision in their agreement directed to that issue, unless either (a) the chosen state has no substantial relationship to the parties or the transaction there is no other reasonable basis for the parties' choice, or (b) application of the law of the chosen state would be contrary to a fundamental policy of a state which has materially greater interest than the chosen state in the determination of the particular issues and which, under the rule of § 188, would be the state of the applicable law in the absence of an effective choice of law by the parties.*
> *(3) In the absence of a contrary indication of intention, the reference is to the local law of the state of the chosen law.*

In Wisconsin, a court will uphold a valid choice-of-law provision where the non-forum contacts are of greater significance. *State Farm Mut. Auto. Ins. Co. v. Gillette*, 2002 WI 31, 251 Wis.2d 561, 541 N.W.2d 662. Therefore, if the contract was formed outside of Wisconsin, but the operations or service was performed in Wisconsin, a choice-of-law provision will be upheld in Wisconsin. Similarly, if a Wisconsin insured obtained an insurance policy for operations contemplated outside of Wisconsin, a choice-of-law provision should also be upheld.

However, the practitioner should recognize that Wisconsin courts will not blindly apply a choice-of-law provision where significant Wisconsin contacts exist. In *Appleton Papers, Inc. v. Home Indemnity Co.*, 2000 WI App. 104, 235 Wis.2d 39, 612 N.W.2d 760, a large Wisconsin corporation sued its liability insurer for breach of its duty to defend. The insurer sought to enforce a New York choice-of-law provision within its insuring agreement. The *Appleton Papers* court restated the general rule governing choice-of-law provision as:

> *A provision that a contract of insurance shall be governed by the law of a given state is void where such express provision violates a statute of the state of the contract or would, if given force, evade statutory provisions declaring a rule of public policy with reference to contracts made within the jurisdiction, or where the contract stipulation would violate the interests of the public policy of the state, since these cannot be changed by the contract of the parties.* Citing, 2 Couch On Insurance 2d 24.23 at 24-39 to 40.

After reviewing that rule, the court found that the insurance contract was formed in Wisconsin to cover Appleton Papers, a Wisconsin Corporation. Because the insurance contract was formed in Wisconsin, the insurer's attempt to apply a foreign arbitration provision failed. As such, the court easily denied the New York insurer's attempt to enforce its New York choice-of-law and arbitration provision.

Thus, if you are handling a case in Wisconsin involving non-Wisconsin parties and a non-Wisconsin insurance contract, the court will enforce the parties' choice-of-law agreement. This is because a choice-of-law provision can destroy certain negative Wisconsin laws that greatly favor insureds, such as Wis. Stat. § 631.81, which provides for a one-year notice of claim requirement. This section is commonly used by insureds to extend coverage under a policy for a year after the policy has lapsed. A valid choice-of-law provision can avoid application of such negative laws. Should you have any choice-of-law issues or coverage questions, please feel free to contact me at rwoody@mwl-law.com.

MERRY CHRISTMAS AND HAPPY NEW YEAR!

Matthiesen, Wickert & Lehrer, S.C. would like to thank the many local counsel members of our national recovery program who sent gifts and cards over the holiday season. Your generosity and thoughtfulness are appreciated and serve as a constant reminder of the great subrogation team we make on behalf of our many clients. We wish you and yours a Merry Christmas and a joyful Holiday Season.

The best part of the holiday season is remembering those who make the holidays meaningful. Matthiesen, Wickert & Lehrer, S.C. would like to wish you and your families all the happiness and prosperity this season can bring and may it follow you throughout the coming year!

This electronic newsletter is intended for the clients and friends of Matthiesen, Wickert & Lehrer, S.C. It is designed to keep our clients generally informed about developments in the law relating to this firm's areas of practice and should not be construed as legal advice concerning any factual situation. Representation of insurance companies and/or individuals by Matthiesen, Wickert & Lehrer, S.C. is based only on specific facts disclosed within the attorney/client relationship. This electronic newsletter is not to be used in lieu thereof in any way.