MATTHIESEN, WICKERT & LEHRER, S.C.

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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER DECEMBER 2011

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 Jamie Breen at **jbreen@mwl-law.com**. We appreciate your friendship and your business.*

IN THIS ISSUE....

HEALTH INSURANCE SUBROGATION

6th CIRCUIT REJECTS APPLICATION OF COMPARATIVE FAULT PRINCIPLES TO MEDICARE REIMBURSEMENT RIGHTS UNLESS FAULT IS DETERMINED AT TRIAL

Hadden v. U.S., 2011 WL 5828931 (6th Cir. 2011)

By Gary L. Wickert

On November 21, 2011, the 6th Circuit Court of Appeals issued a significant decision which has eliminated at least some of the long-standing confusion, although none of the difficulties, of settling tort claims in the face of the Medicare Secondary Payer (MSP) Statute. This long-anticipated decision is only the second – although the most enlightening – federal appellate court interpretation of the MSP Statute and the seeming conflict between Medicare's broad right of reimbursement and its effect on the already-difficult realities faced by injured persons trying to settle pending tort suits involving comparative fault when Medicare has or will make conditional payments for medical expenses.

In *Hadden v. United States*, 2009 WL 2423114 (W.D. Ky. 2009), the U.S. District Court for the Western District of Kentucky dismissed a suit brought by Vernon Hadden, in which Hadden was appealing

administrative decisions by Medicare which denied a request to waive or compromise its conditional payment reimbursement rights. In August 2004, Hadden was standing near a traffic circle in Kentucky when he was struck by a vehicle owned by Pennyrile Rural Electric Cooperative Corporation. His medical bills totaled $82,036.17. Medicare paid his bills in full, because Hadden is a Medicare beneficiary. Hadden sued Pennyrile and later settled for $125,000.

Pursuant to 42 U.S.C. § 1395y (b)(2)(B)(i), if a no-fault or liability insurer will not pay "promptly," providers may submit claims to Medicare, and Medicare may make a conditional payment. However, when the proceeds from the no-fault or liability settlement become available – as from the settlement of a tort claim - Medicare has a priority right of recovery. Medicare assessed Hadden's conditional payments in the amount of $62,338.07 and sought recovery against him after his tort settlement. Hadden requested that Medicare waive its conditional payment rights based upon the argument of comparative fault. Hadden claimed that the Pennyrile vehicle was only 10% at fault (accounting for the relatively small settlement amount) and that Medicare should, therefore, recover no more than 10% of the conditional payment amount. The Center for Medicare and Medicaid Services (CMS) denied the request for reduction of conditional payments, and Hadden paid the $62,338.07 (plus some interest) under protest.

Hadden exhausted his administrative remedies, but an Administrative Law Judge took a dim view of this theory, finding that the plain language of the Medicare Statute required Hadden to reimburse Medicare the full amount that Medicare had demanded, and Hadden brought this suit against Medicare (U.S.) in Federal Court. The federal trial judge dismissed Hadden's suit against Medicare and gave the following reasoning:

> *"[t]he primary payer in this case is the insurer who paid [the settlement amount] between Plaintiff and [Defendant]. More importantly, the underlying claim in this case was not adjudicated on the merits; it was settled. In other words, had Plaintiff wanted equitable allocation and subrogation principles to apply in this case, then he should have proceeded to trial on the merits of his tort claim in state court… As [the Medicare Appeals Council] explained… any allocation of liability proposed by Plaintiff would be purely speculative."*

The federal trial judge declared that under current law, adjudication on the merits is required for equity in situations where Medicare is asked to compromise or waive its reimbursement rights, which is very costly. The relevant section of the Medicare Statute provides:

> *(2) Medicare secondary payer*
> *(B) Repayment required*
> *(ii) Primary plans. A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.... 42 U.S.C. Â§ 1395y(b)(2)(B)(ii).*

Pennyrile is the "primary plan" referenced in the MSP Statute. Hadden is the "entity that receives payment from a primary plan." Medicare paid $82,036.17 in medical expenses, so under the above statute, Hadden must reimburse Medicare to the same extent that Pennyrile "had a responsibility to make payment" with respect to those services.

The 6th Circuit noted that the key term here is "responsibility" since Hadden's obligation to reimburse Medicare for its payment of his medical expenses is coextensive with Pennyrile's responsibility to pay them. Hadden's argument, of course, is that (according to him) Pennyrile "had a responsibility to make payment for only 10% of his medical expenses" (*i.e.,* only $8,000) and that his reimbursement obligation is thus limited to the same extent.

The deck was stacked against Hadden from the beginning. Congress has directly spoken on this issue in a way highly unfavorable to Hadden. In 2003, Congress amended § 1395y(b)(2)(B)(ii) to add the underlined language below:

> *A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.*

In addition, the 9th Circuit had encountered an identical argument back in 1995 and concluded that § 1395y(b)(2)(B) was silent as to whether the argument was correct. *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995). There, the 9th Circuit Court turned to Medicare's interpretation of the statute, under which Medicare was *"entitled to full reimbursement of conditional Medicare payments when a beneficiary receives a discounted settlement from a third party."* The Court easily found this interpretation to be reasonable, and thus deferred to it.

In his argument to the 6th Circuit, Hadden made the following points:

(1) His obligation to reimburse Medicare should be limited to a pro-rata share of his settlement that represents medical expenses.

(2) Medicare reimbursement should be handled according to other statutes, such as the Medical Care Recovery Act, 42 U.S.C. § 2651(a) and the Medicaid statute.

(3) Medicare's right to reimbursement can only be enforced when an action is specifically brought by them.

(4) Medicare should waive or reduce its lien because his recovery was against equity and good conscience.

The 6th Circuit rejected all of Hadden's arguments and affirmed the Federal Trial Court's decision. The most significant clarification by the 6th Circuit was the affirmation that Medicare's reimbursement rights includes the "responsibility" to reimburse Medicare of the beneficiary (Hadden) and a primary plan (Pennyrile), keeping the pressure on third-party liability insurers to insist on MSA compliance when settling tort suits. The 6th Circuit found that when a beneficiary like Hadden demands medical expenses from a primary plan, like Pennyrile, to their full extent, he cannot argue that Medicare should receive only 10% of the total. In short, the Court determined that the scope of the responsibility to reimburse Medicare is determined by what has been requested of the third party.

The *Hadden* decision keeps the pressure on all parties to tort lawsuits to comply with Medicare's requirements for reimbursing or protecting its interests and conditional payment reimbursement rights. However, the decision opens up the possibility that, if properly handled, Medicare may be convinced or forced to accept a compromised amount of its lien. Careful pleading in the tort case as well as the possible use of "friendly suits" to determine percentages of fault following or in conjunction with a tort settlement are possible options open for the astute, cost-conscious insurer.

If you have any questions regarding this article or subrogation in general, please contact Gary Wickert at **gwickert@mwl-law.com**.

PROVING MEDICAL EXPENSES IN TEXAS SUBROGATION CASES

As first reported in our August newsletter, on July 1, 2011 the Texas Supreme Court finally settled the long-standing issue of whether an injured plaintiff may recover the amount of medical expenses charged by doctors or the amount actually paid or incurred. Trial lawyers have long argued that plaintiffs should be entitled to recover the amount charged to them by doctors and hospitals, which is usually significantly more than the discounted amounts paid by subrogated insurers or compensation carriers. Defendants have, of course, argued just the opposite. This new standard for proving medical expenses is having the effect of bringing plaintiffs' counsel and subrogated carriers together, because we have something the trial lawyers want and need.

In *Haygood v. De Escabedo*, 2011 WL 2601363 (Tex. 2011), Haygood sued Escabedo for damages, including medical expenses, following an automobile accident. At trial, Escabedo moved to limit the evidence to the amount of medical expenses actually billed rather than the amount charged - a difference of $95,000. This amount represented the discount that Haygood's health insurer had negotiated with the hospital for the services performed. Haygood's attorney introduced into evidence the amount charged his client, even though § 41.0105 of the Texas Practice & Remedies Code, since 2003, has restricted the amount that could be *recovered* to the amount actually *paid.* Section 41.0105 states:

> *In addition to any other limitation under law, recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.*

The trial court in *Haygood* allowed *evidence* of the amount charged, but the Court of Appeals held that § 41.0105 restricts not only *recoverable damages* but also *relevant evidence* to prove damages. In affirming, the Texas Supreme Court held that § 41.0105 limits a claimant's recovery of medical expenses to those expenses that have been or must be paid by or for the claimant and limits evidence only to recoverable medical expenses. It declared that since a claimant is not entitled to recover medical charges that a medical provider is not entitled to be paid (usually due to health insurance discounts) unless evidence of such charges is irrelevant to the issue of damages. Trial lawyers have long introduced the larger amount representing the medical expenses *charged* the injured plaintiff, because larger medical expenses lead juries to awarding larger verdicts.

To recover damages for past medical expenses, a Texas plaintiff has the burden of proof and must present evidence that the medical expenses incurred were both reasonable and necessary. Proof of "reasonable and necessary" can be made by expert (doctor) testimony or by submitting affidavits from the medical provider in compliance with § 18.001 of the Texas Civil Practice and Remedies Code. Under § 18.001, an affidavit stating the amount a person charged for a service was reasonable at the time and place that the service was provided and that the service was necessary is sufficient evidence that the amount charged was reasonable or that the service was necessary, unless a controverting affidavit is filed.

Saddled with the burden of proving medical expenses, trial lawyers must now seek out and enlist the assistance of subrogated carriers in order to draft and file their medical affidavits. Previously, they would routinely ignore subrogated carriers because there was nothing needed from them until they made their demand to reduce or waive the subrogated interest. However, that has all changed. Now, trial lawyers in Texas must obtain detailed records of amounts of medical expenses actually paid by subrogated carriers in order to complete their affidavits. Subrogated carriers should use this sudden popularity to cooperate,

assist, and work together with trial lawyers in order to produce a large recovery for both of them. But this might also be a nice time to approach plaintiff's counsel with a request for an advantageous stipulation as to the lien, or even an agreed amount to be reimbursed to the carrier, saving it both time and money.

As a result of the change in law, we will be seeing plaintiff's counsel in cases wanting our payment ledgers earlier and more often in cases, in order to cross check the payment amounts to meet their evidentiary burden. Even subpoenaing records from the health care provider might not always produce the desired information. Successful subrogation requires innovative and cost-effective action on the part of subrogation counsel. The new *Escabedo* decision provides an entirely new level of opportunity to negotiate with plaintiff's counsel in cases where the carrier has a subrogation interest or lien.

If you should have any questions regarding this article or subrogation in general, please contact Gary Wickert at **gwickert@mwl-law.com**.

PROPERTY SUBROGATION

ILLINOIS MAKES IT HARDER TO SUBROGATE AGAINST TENANT

Auto Owners Ins. Co. a/s/o John Ellis v. Thomas Callaghan, 952 N.E.2d 119 (Ill. App. 2011)

The rule of subrogation known as the "*Sutton Rule"* states that a tenant and landlord are automatically considered "co-insureds" under a fire insurance policy as a matter of law and, therefore, the insurer of the landlord who pays for the fire damage caused by the negligence of a tenant may not sue the tenant in subrogation because it would be tantamount to suing its own insured. The "*Sutton Rule"* is derived from an Oklahoma Court of Appeals decision styled *Sutton v. Jondahl*, 532 P.2d 478 (Okla. App. 1975) and is the benchmark against which the landlord/tenant subrogation laws of most states is measured.

Illinois has until recently avoided *per se* rules with regard to the "*Sutton Rule."* and taken a more flexible case-by-case approach, holding that a tenant's liability to the landlord's insurer for negligently causing a fire (or other damage) depends on the intent and reasonable expectations of the parties to the lease as ascertained from the lease as a whole. *Dix Mutual Ins. Co. v. LaFramboise*, 597 N.E.2d 622, 625 (Ill. 1992). Although a tenant is generally liable for fire damage caused to the leased premises by his negligence, if the parties intended to exculpate the tenant who negligently caused fire damage, their intent as expressed in the lease agreement will be enforced. Illinois courts historically had ruled that in order to make this determination about intent, the lease must be interpreted as a whole so as to give effect to the intent of the parties. *Stein v. Yarnall -Todd Chevrolet, Inc.*, 241 N.E.2d 439 (Ill. 1968).

In *Dix*, the lease did not contain a provision expressly apportioning fault in the case of a negligently caused fire, so the Court construed the lease "as a whole" and concluded that it did not reflect any intent that the tenant would be responsible for fire damage. Absent any such intent, the tenant is considered a co-insured with the landlord and an insurer may not sue its own insured for subrogation. The same outcome results from an oral lease which contains only basic terms such as rent and duration of the lease. *Cincinnati Ins. Co. v. DuPlessis*, 848 N.E.2d 220 (Ill. App. 2006). The rule, therefore, appeared for years to be that a tenant would be an implied co-insured and could not be sued by the landlord's subrogee for fire or other damage unless a contrary intent could be gleaned from the four corners of the lease itself.

In 2011, however, the Illinois Court of Appeals decided the case of *Auto Owners Ins. Co. a/s/o John Ellis v. Thomas Callaghan.* This unfortunate decision distorts the holding in *Dix.* Auto Owners leased space to its tenant, Thomas Callaghan. The Auto Owners lease had no provision regarding insurance, but did require that the tenant's security deposit would cover any damages and that the tenant's liability for damage was not limited to the security deposit. Despite this language, the Court moved closer to the

"Sutton Rule" by declaring that simply by paying rent, the tenant becomes an “implied co-insured” and may not be sued by the landlord or the landlord’s subrogated property carrier for damage the tenant causes. Instead of applying the *Dix* rule that the tenant is liable, *unless* the lease demonstrates the intent to exculpate the tenant, the new decision seems to shift the burden and hold that the tenant cannot be sued unless the lease affirmatively places liability on the tenant.

If you have any questions regarding this article or subrogation in general, please contact Gary Wickert at **gwickert@mwl-law.com**.

MED PAY/PIP SUBROGATION

ON THE CHOPPING BLOCK

FLORIDA NO-FAULT ON THE CHOPPING BLOCK

Personal Injury Protection (PIP) coverage pays benefits for medical expenses and lost wages incurred by the insured and his/her passengers injured in an accident, including funeral costs. PIP is normally associated with no-fault insurance and is required in Delaware, Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Oregon, Pennsylvania, and Utah. In some states, like Texas, it is mandated, but the insured can choose to opt out. PIP may or may not be recoverable in subrogation depending on the state. It should also be remembered that some states may offer Med Pay but not PIP, and vice-versa.

PIP coverage is not health insurance, and it is not designed to pay for your medical bills as they are incurred. It is designed for a one-time settlement or payment for all of your damages. Depending on the state, it may cover all reasonable expenses for necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. Each state has its own minimum PIP limits. For example, the personal injury insurance minimum required by law in Florida is $10,000 for bodily injury or death of one person in any one accident.

In Florida, there is a legislative battle brewing over the PIP insurance system with the state’s governor and chief financial officer leading the charge. In a joint statement, Governor Rick Scott and CFO Jeff Atwater outlined four steps to reform the no-fault law, first enacted in the early 1970s, which requires drivers to have PIP that provides $10,000 in coverage per person for medical bills, regardless of fault in an accident. Despite the good intentions of the Florida Legislature, no-fault insurance has created the problem of PIP insurance fraud throughout the state. The Legislature intended no-fault insurance to lower premiums, but state officials report that Florida drivers are paying much more per family because of PIP insurance fraud.

With Governor Rick Scott throwing his political weight behind it, a move to revamp Florida’s no-fault auto insurance program will be pushed to the forefront of the 2012 Legislature. However, with a similar bill failing in 2011, there are no guarantees that proponents of changing the PIP landscape will be any more successful next year as it will pit the governor, insurance companies and top lawmakers against an equally powerful coalition including trial lawyers, doctors and other health-care providers.

The current no-fault system amounts to nothing more than a $900 million tax on Florida consumers. Accidents are down, but costs are way up. Part of the reason Florida is in the midst of an auto insurance fraud crisis is due to timid, superficial changes which have simply pushed the problem off for decades.

A report on the no-fault law in Florida published by the National Association of Mutual Insurance Companies (NAMIC) says the state’s lawmakers have “always seemed a step behind trying to combat the latest healthcare tactics,” resulting in “runaway” increases in PIP costs. Proponents of the change claim that the no-fault system in Florida has been taken over by fraud clinics, lawyer referral services and organized crime.

Ridding itself of its current no-fault system would return a viable source of automobile insurance subrogation to the country. PIP subrogation in Florida is currently prohibited unless the insured's vehicle is a "commercial vehicle", the insured is a pedestrian struck by a "commercial vehicle", or the tortfeasor is uninsured.

In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan which took effect January 1, 1972. The no-fault plan came complete with plenty of promises and positive projections as a replacement for the traditional tort reparations system, with the purpose of serving as a means to quickly and efficiently compensate injured parties in auto accidents regardless of fault. The proponents of no-fault insurance promoted it as a more efficient and fair means of providing redress to automobile accident victims. They believed that this system provides compensation in a swifter fashion than the tort system, and that no-fault would lower the cost of insurance, with both benefits being primarily produced by reducing litigation. The principle underlying no-fault automobile insurance laws is a trade-off of one benefit for another, by assuring payment of medical, disability (wage loss) and death benefits, regardless of fault, in return for a limitation on the right to sue for non-economic damages (pain and suffering).

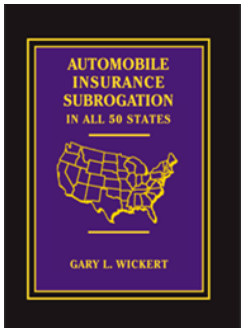
The objectives of the no-fault law were enumerated by the Florida Supreme Court in 1974 in *Lasky v. State Farm Ins. Co*., 296 So.2d 9 (Fla. Sup. Ct. 1974). The Court opined that the no-fault law was intended to:

- assure that persons injured in vehicular accidents would be directly compensated by their own insurer, even if the injured party was at fault, thus avoiding dire financial circumstances with the "possibility of swelling the public relief rolls;"
- lessen court congestion and delays in court calendars by limiting the number of law suits;
- lower automobile insurance premiums; and
- end the inequities of recovery under the traditional tort system.

In the ensuing 40 years, the Legislature has periodically revised the no-fault law, courts have interpreted its key provisions, and various constituent groups have analyzed its impact upon Florida motorists. More recently, in Special Session A of the 2003 Legislative Session, a sunset provision was passed that, effective October 1, 2007, repealed the Motor Vehicle No-Fault Law unless the Legislature re-enacted the law prior to such date. While the sunset provision actually did take effect on October 1, 2007, the Legislature re-enacted the no-fault law, effective January 1, 2008. Three short years later it could once again be headed for the recycling bin.

If you have any questions regarding this article or subrogation in general, please contact Gary Wickert **gwickert@mwl-law.com**.

UPCOMING EVENTS



December 2011 - MWL's *Automobile Insurance Subrogation: In All 50 States* will soon be released. It is the last and most anticipated of the subrogation trilogy, and a book which will serve as the "Bible" for any insurance company writing personal lines or commercial automobile insurance. There is no other book, resource, or authority like it - anywhere. It is a complete treatment - A to Z - of virtually every issue which the insurance claims or subrogation professional will face in the area of automobile insurance. The myriad of subrogation topics addressed in this treatise were carefully selected by the author as the most frequently-asked-about areas of automobile

insurance subrogation. MWL is very proud of the work which went into this book and looks forward to the feedback and symbiosis with the claims/recovery industry which has helped make its other subrogation resources the leaders in the industry. You can pre-order the book or learn more about it from our publisher, Juris Publishing, or by clicking **HERE**. The publisher is offering a 20% pre-publishing discount for the book if it is pre-ordered by December 15, 2011.

February 8, 2012 – Gary Wickert will be presenting a live webinar entitled *"Automobile Subrogation In All 50 States*" from 10:00 - 12:00 p.m. (CST). This webinar is approved for 2.0 Texas CE credits and is free to clients and friends of MWL. A registration link will soon be on our website homepage, but you can register now by clicking on the "Register Now" button to the right.

May 9-12, 2012 - MWL will be exhibiting at the *7th Annual Claims Education Conference* in Napa Valley, California. Jamie Breen will be at Exhibit Booth 12 so stop by our booth if you plan on attending this conference and introduce yourself. For more information on this conference, please go to **www.claimseducationconference.com**.

INDUSTRY NEWS

ZURICH REACHES AGREEMENT WITH PATRIOT NATIONAL TO UNDERWRITE WORKERS' COMPENSATION INSURANCE

Zurich Financial Services Group recently announced that through its wholly-owned subsidiary, Zurich American Insurance Co., it plans to aggressively expand its share of Florida's captive insurance market by using Patriot National Insurance Group's agency force. Zurich is a leading provider of property and casualty insurance in North America and globally, while Patriot is a leading provider of workers' compensation insurance.

Zurich was looking for ways to further assert themselves as a captive solutions provider and the deal allows that, according to Zurich. Under the program, the Fort Lauderdale, Florida-based Patriot Preferred Agency Captives will act as program administrators responsible for all underwriting and claims services. Acting as a captive program, instead of just marketing the risk to an insurer, the agency can reinsure the risk through an affiliated company. They can also act as risk managers, staff their own claims departments, and negotiate deductibles or reinsurance as need be. Patriot National introduced its agency-owned captive platform in 2009 and in two years surpassed $100 million in annual workers' compensation premiums. Patriot National's current captive business is run through two subsidiaries: (1) Fort Lauderdale, Florida-based Guarantee Insurance Co. which specializes in large deductible policies, segregated cell portfolio captives, and agency-owned captives; and (2) Washington, D.C.-based Ullico Casualty Insurance Co.

ACE, LTD. PURCHASES AGRIBUSINESS INSURER PENN MILLERS

ACE Ltd. has completed a $107 million cash buy of Penn Millers Holding Corp. The purchase provides ACE, Ltd. with an established, specialty niche business and offers them the opportunity to expand their substantial agricultural market capabilities offered through their rain and hail crop insurance and ACE Westchester excess and surplus lines business. Wilkes-Barre, Pennsylvania-based Penn Millers operates in 34 states and provides insurance to companies that manufacture, process and distribute agricultural products. Penn Millers will survive as a wholly-owned subsidiary of ACE.

SEDGWICK WINS BUSINESS INSURANCE BUYERS CHOICE AWARDS

Third-party administrator and claims management specialist Sedgwick Claims Management Services, Inc. recently received top honors as the best overall third-party claims administrator (TPA) at the 2011 Business Insurance Buyers Choice Awards. Sedgwick swept the recognition category for third-party claims administrators, winning six distinct awards: Mid-Market Service Award, Large Account Service Award, Mid-Market Expertise Award (tied), Large Account Expertise Award, Mid-Market Best Overall TPA, and Large Account Best Overall TPA. Sedgwick accepted the awards at an awards banquet in Chicago on November 29.

MERRY CHRISTMAS AND HAPPY NEW YEAR!

Matthiesen, Wickert & Lehrer, S.C. would like to thank all of our clients for a wonderful year and we wish you all a Merry Christmas, Happy Hanukkah, and a blessed Holiday Season. Regardless of what Christmas means to you, we hope your Christmas is full of holiday cheer shared with family and friends. For us at Matthiesen, Wickert & Lehrer, S.C., Christmas is just the beginning – a simple, yet wonderful reminder of Christ's humble beginning as a human child in this world. It's only a beginning because His birth merely set the stage for the power, glory, and salvation that would be revealed in His life, death, and resurrection come Easter morning.

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