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A DEFENSE LAWYER'S PRIMER TO THE "NEW" DUTY AND CAUSATION ANALYSIS IN IOWA

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The Iowa Supreme Court recently adopted significant portions of the *Restatement (Third) of Torts: Liability for Physical and Emotional Harm* (2005) in *Thompson v. Kaczinski*, 774 N.W.2d 829 (Iowa 2009). The American Association for Justice's (AAJ) flagship publication, *Trial* magazine, has featured an article on the new *Restatement*, touting its potential advantages to the plaintiff's trial bar.[2] Amanda Wachuta's article[3] in the last issue of *Defense Update* aptly introduced and discussed *Thompson*, so that analysis will not be repeated here. Instead, we will introduce the application of *Thompson* in recent Iowa cases, and present various strategic considerations for defense counsel going forward.

In *Thompson* the Court adopted Section 7 of the *Restatement (Third), Liability for Physical and Emotional Harm*:

> Section 7. Duty
>
> (a) An actor ordinarily has a duty to exercise reasonable care when the actor's conduct creates a risk of physical harm.
>
> (b) In exceptional cases, when an articulated countervailing principle or policy warrants denying or limiting liability in a particular class of cases, a court may decide that the defendant has no duty or that the ordinary duty of reasonable care requires modification.

The *Thompson* Court also adopted Sections 6, 26 and 29 of the *Restatement* (*Third*):

> Section 6. Liability for Negligence Causing Physical Harm
>
> An actor whose negligence is a factual cause of physical harm is subject to liability for any such harm within the scope of liability, unless the court determines that the ordinary duty of reasonable care is inapplicable.
>
> Section 26. Factual Cause
>
> Tortious conduct must be a factual cause of harm for liability to be imposed. Conduct is a factual cause of harm when the harm would not have occurred absent the conduct. Tortious conduct may also be a factual cause of harm under Section 27.
>
> Section 29. Limitations on Liability for Tortious Conduct
>
> An actor's liability is limited to those harms that result from the risks that made the actor's conduct tortious.

Thompson significantly changed the "duty" and "causation"

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2 "The New Restatement's Top Ten Tort Tools," Trial, pp. 44-48 (April 2010).

3 *See* Iowa Supreme Court Adopts Restatement (Third) Rules on Duty and Causation, Makes Summary Judgment More of a Long Shot: A Note on *Thompson v. Kaczinski*, 774 N.W.2d 829 (Iowa 2009), *Defense Update*, Spring 2010, pp. 7-8.

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analysis in every tort case in Iowa. *Thompson* broadened the scope of duty by creating a presumption of a generalized duty to exercise reasonable care. This duty will be present except in an "exceptional case" where there is an "articulated countervailing principle or policy" which warrants limiting the presumption. *Id*. at 834-835. Additionally, *Thompson* redefined the causation analysis by using two elements: 1) factual cause and 2) scope of liability. *Id*. at 837. Now gone from the Iowa legal landscape are the terms "proximate cause" and "substantial factor." "Scope of liability" is used instead of proximate or legal cause to provide a limit to an actor's liability *solely* to those risks created by the actor's tortious conduct.

The Iowa Supreme Court has applied *Thompson* in two reported cases. *Van Fossen v. MidAmerican Energy Co.*, 777 N.W.2d 689 (Iowa 2009) was filed the same day as *Thompson*; it represents an example of a case where the Court actually found *no duty* using the new analysis. *Van Fossen* provides insight into what the Court will consider when determining whether an exception to the "duty presumption" exits. In *Van Fossen*, the question presented was whether the owners of a power plant should have tort liability for the wrongful death of the spouse of an employee of an independent contractor. The plaintiff alleged that he routinely encountered asbestos in the course of his employment and asserted that his late wife contracted mesothelioma as a consequence of her regular exposure to asbestos dust while laundering his work clothes. The Court in *Van Fossen* concluded that this scenario "presents an instance in which the general duty to exercise reasonable care is appropriately modified." *Id.* at 696. In reaching this determination, the Court found that the prevailing case law in other jurisdiction supported this result, as well as the public policy concept that employers of independent contractors have little, if any, control over the employees of a subcontractor, let alone their family members at home.

Royal Indemnity Co. v. Factory Mutual Insurance Co., 2010 Iowa Sup. LEXIS 55 (June 11, 2010) also cited and discussed the *Thompson* formula at length. It should be considered as a "failure of proof" case. *Royal Indemnity* arose out of a warehouse fire that destroyed property (basically new product inventory awaiting shipment) stored by Deere & Company. Plaintiff claimed that Factory Mutual's (FM) negligent inspection of the premises either resulted in a subsequent fire, or allowed the water pressure in the building's extinguishing system to be so low as to be incapable of putting out or limiting the fire. In *Royal Indemnity*, there were two contexts in which the "scope of liability" inquiry could have been applied. First, the Court noted that "[u]nder the Restatement (Third) analysis, to impose liability, something FM did or did not do must have increased the risk to Deere's product." *Id*. at *30. Second, the Court analyzed ". . . whether merely moving in [Deere claimed that had it known the true facts, it would not have moved its product into the building at the outset] increased the risk or created the harm that destroyed Deere's product." *Id*. at *31. In both contexts, the plaintiff's case failed because there was no evidence to demonstrate that FM *caused* the damages suffered by Deere. The ultimate result was that a very large ($39.5 million) verdict and judgment for plaintiff was reversed on appeal, and the case dismissed.

Thompson was also cited and discussed in an unpublished Iowa Court of Appeals decision, *Rossiter v. Evans*, 2009 Iowa App. LEXIS 1720 (Dec. 30, 2009), and a federal district court decision, *Nationwide Agribusiness v. Structural Restoration, Inc.,* 2010 U.S. Dist. LEXIS 36305 at *36 (S.D. Iowa 2010) (recognizes and applies *Thompson* to a claim based on negligent misrepresentation; collapse of a tank found to be "among the range of harms that [defendant] risked" when it sent an inspection report to plaintiff).

Thompson's holding is clear; what is less clear is what the impact of this change will be, and how defense practitioners will take advantage of the opportunities occasioned by this development. Do these changes "favor" plaintiffs or defendants? Will it be more difficult for defendants to obtain summary dismissals based on "no duty" arguments, or the lack of causation? How does this development impact strategic or procedural considerations in defending tort cases in Iowa? How will new jury instructions on the causation element be changed? These are just a few of the questions that the authors will attempt to address.

1. Was *Thompson* a substantive change, or merely a clarification of existing law?

Thompson's analysis of duty and causation had as its genesis the *Restatement Third of Torts, Liability for Physical and Emotional Harm* (2005). This development should probably be considered a clarification of existing law, rather than a wholesale change or reversal from existing doctrines. There is no "sea change" here. *Accord A.W. v. Lancaster County Sch. Dist. 0001*, 280 Neb. 205, 2010 Neb. LEXIS 88 at * 23 (July 16, 2010)(Nebraska adopts Section 7 of the *Restatement (Third)* and notes "the disposition of this appeal would have been the same regardless"); *Behrendt v. Gulf Underwriters Ins. Co.*, 768 N.W.2d 568 (Wis. 2009)(foreseeability not relevant to "no duty" determination); *Gipson v. Kasey*, 150 P.3d 228 (Ariz. 2007) (incorporating "foreseeability" into the duty analysis expands the judge's function at the expense of the jury's). To claim that the law has significantly changed is to assume that the prior law was clear, well known and understood, which is a dubious proposition.

The prior law of "duty" in Iowa (as well as most other

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jurisdictions) has been, at best, disorganized and unpredictable. Trying to forecast when a court would find a legal duty, and when it would not, depended (perhaps) more on who the particular judge hearing the dispositive motion was, as opposed to any clear body of legal doctrine. Except in the clearest of cases, when a court would find that some result was "unforeseeable as a matter of law," one could not help but think that a *factual* determination, better reserved for the *jury's* determination, was being made. The "test" of foreseeability itself was of limited assistance as well, except in its most simple applications. The law was somewhat consistent that if a particular result from conduct was not reasonably foreseeable, then "duty" (and thus, legal liability) would not follow. But knowing this did not make it any easier to predict at what point a court would find that some eventuality is, in fact, not reasonably foreseeable, or "unforeseeable." Also, there is no commonly accepted definition of "foreseeable" amongst plaintiff or defense attorneys, and no Iowa jury instruction has ever defined that term. Plaintiffs argue that if something is possible, then it is foreseeable. They also like to point out that if something has happened before, then it is foreseeable. Defense lawyers take a more restrictive view, and argue that an event should be reasonably *predictable* in order for it to be foreseeable. Even with the *Restatement (Third),* the most infamous "F" word in the law, "foreseeability," remains essentially undefined. At least under the *Restatement* and *Thompson,* foreseeability has been removed from the duty analysis.

The law of proximate cause in Iowa was no less confusing and muddled. "Proximate cause" had different meanings, depending upon the context and usage. Proximate cause was both a *prima facie* element of every tort case, and also a sub-part of the proximate cause element itself. Defining "legal cause" in terms of a "substantial factor without which the injury or damage would not have occurred" mixed factual (i.e., "but for") causation concepts with the policy considerations at the core of legal cause. If use of the new terms "factual cause" and "scope of liability" helps to eliminate confusion from the sloppy use of the term "proximate cause," and serves to further define the correct analysis, then these changes should be welcome.

Most defense lawyers would have an (almost) visceral reaction to the Court's pronouncement in *Thompson* that there is some sort of undefined, "generalized" duty on the part of every person to exercise reasonable care. To impose a general duty seemingly without limits is problematic. The argument of "no legal duty" was always an effective weapon in every defense lawyer's toolkit. This was one strategy that could be used to avoid the plaintiff's argument that "questions of negligence and proximate cause are normally reserved for the jury's determination." "Duty" was always a *legal* issue for the court, which meant it could be decided on a motion to dismiss or motion for summary judgment. Now it appears as though the "no duty" strategy has been eroded. From Torts 101 and our first year in law school, "duty" was always a *prima facie* element of every tort action. It was just as much a *sine qua non* as "breach of duty," "proximate cause" and "damages." At first blush it seems as though the *Restatement (Third)* eviscerated one element (or fully 25%) of the burden of proof of every plaintiff in every tort case.

A further concern is that duty was formerly an element *where the plaintiff always had the burden of proof*. This made sense. However, under the *Restatement* and *Thompson*, duty is now *presumed* and will stand as being established in the case *unless the defendant (in a so-called "exceptional case") can rebut and overcome the presumption*. This 180 degree shift in the burden of proof should be of serious concern to all defense counsel and their clients.

2. Does the new analysis "favor" plaintiffs or defendants?

This question is always of interest, but it is nearly impossible to answer. You never try the same case to the same jury (or submit a motion to the same judge) twice, first under the "old" law, and second, under the "new" law, which is what you would have to do in order to isolate the true effect of the change. Yet, a couple of observations can be made.

In *Thompson*, a summary judgment in favor of defendant was granted in the trial court and this was affirmed by the Iowa Court of Appeals. On further review to the Iowa Supreme Court, the Court reversed the summary dismissal and remanded the case to the district court for trial. In *Thompson* it seems clear that the "new" analysis favored the plaintiff. Under the old law, the case was dismissed for two reasons: 1) there was no "duty;" and 2) nothing the defendants did or did not do was a "proximate cause" of plaintiff's injury.[4]

Yet, two subsequent cases, *Van Fossen* and *Royal Indemnity,* actually found in favor of defendants by using the *Third Restatement's* analysis. In *Royal Indemnity* a $39.5 million verdict for plaintiffs at trial was reversed on appeal. In another case applying *Thompson* that is unpublished, *Rossiter*, 2009 Iowa App. LEXIS 1720, the Iowa Court of Appeals affirmed a plaintiff's verdict of $1.5 million ($800,000 of which was for punitive damages).[5] Yet, in *Rossiter* one could argue that even under the old law the plaintiff's verdict would have been upheld, since the

4 Interestingly, in *Thompson* the trial court *sua sponte* found there to be "no proximate cause" between the defendant's actions and the plaintiff's harm. It did this even though the defendant's motion was limited to a "no duty" argument.

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defendant there knew or should have known of a risk, which in turn was "foreseeable" and therefore gave rise to a duty to warn the plaintiff. In *Royal Indemnity* it could also be argued that even under the old analysis, a reversal of the plaintiff's verdict was justified. This is because the plaintiff failed to carry its burden of proof to show what caused the fire, or what caused the building's extinguishing system to fail, once the fire had started.

The legal presumption in favor of a duty to exercise reasonable care probably means that prior cases that were dismissed because the court found, as a matter of law, that no duty existed, will now occur less frequently. This result will favor plaintiffs, as will the shift in the burden of proof. Fewer motions to dismiss will be made and granted, and there will be few (if any) motions for summary judgment granted on "no duty" grounds. With fewer cases being dismissed on motion, more cases will proceed to mediation, and absent resolution will proceed to trial, in an already overburdened and fiscally-overstretched state court judicial system.

Another view is that cases that would not have survived under the old law will also not survive application of the new analysis, albeit for different reasons. For example, instead of arguing there is "no duty" based on lack of foreseeability, the focus of the movant will change to what "articulated, countervailing principles or policies" can be identified in favor of legal immunity, under the facts. Typically a trial court will not dismiss a case as a matter of law based on the argument that there was *no breach of duty*, unless the facts are undisputed and no rational fact finder could come to a different conclusion; this is a very rare situation, indeed. In the vast majority of cases the "no breach" argument will be a jury issue incapable of decision by the court. If the dispositive motion is denied, even under the new regime it can always be argued to the jury that no failure to exercise reasonable care occurred, and thus no "breach" of duty occurred, since the ultimate result in the particular case was not reasonably foreseeable.

3. Does *Thompson*'s analysis apply to breach of contract or other actions not based in tort?

This issue is not answered in *Thompson* but was discussed briefly in *Royal Indemnity*. In *Royal Indemnity*, plaintiff pled its claims under alternative tort and contract theories based on the same underlying facts. Plaintiff argued that defendant was liable for a negligent inspection, and also argued that the defendant breached its contract to do an inspection of the premises. Under Iowa law, "proximate cause" is not an element of a breach of contract action, but rather, plaintiff must show "the damages resulted from FM's breach and were in the contemplation of the parties." *Royal Indemnity*, 2010 Iowa Sup. LEXIS 55 at *17 (emphasis added); *see also Kuehl v. Freeman Bros. Agency, Inc.*, 521 N.W.2d 714, 718 (Iowa 1994). The contract claim was ultimately dismissed in favor of defendant since "it was not in the contemplation of the parties that FM would be called upon to answer for any conceivable fire loss." *Id.* At *21. Although plaintiff in *Royal Indemnity* "cross-pollinated" the tort theory with the contract theory of recovery, the *Restatement (Third)* and *Thompson* only govern "duty" and "causation" in the context of a tort case. Also, the *Restatement (Third)*, by its very title, pertains only to "torts." For this reason breach of contract actions should remain unaffected by this change.

4. Does *Thompson*'s analysis apply to tort claims for purely economic damage or reputational harm?

This question may be in play because the *Restatement (Third),* by virtue of its title, applies to tort claims for "physical and emotional harm." Although *Thompson* was a negligence case and its holding could be argued to be limited to such cases, only, its analysis would appear to apply to all tort actions and does not contain any language that would purport to limit its application. *Royal Indemnity*, (slip op. at p 20) cites to *Spreitzer v. Hawkeye State Bank,* 779 N.W.2d 726 (Iowa 2009), a fraud case, where the Iowa Supreme Court essentially applied a scope of liability analysis in order to limit the damages recoverable in a fraud action for economic losses. *Royal Indemnity* (slip op. at 21-22), in applying the scope of liability analysis to the negligence claims, also relies on *Movitz v. First National Bank of Chicago*, 148 F.3d 760 (7th Cir. 1998), which rejected a recovery for a failed investment in a hotel property (i.e., purely economic losses). No language in *Thompson* or *Royal Indemnity* provides that the analysis is limited *only* to cases involving physical or emotional harm.[6]

Finally, it should be noted that the "economic loss doctrine" bars many tort claims for purely economic or monetary losses, as recently discussed in *Van Sickle Construction Co. v. Wachovia Commercial Mortgage, Inc.*, 2010 Iowa Sup. LEXIS 60 (June 25, 2010)(allowing recovery of economic losses in negligent misrepresentation claims).

5 *Rossiter* presented such egregious facts that it most likely would have been decided the same way under the "old" law. That case had a very unsympathetic defendant (defendant gave plaintiff an STD when he knew that he had an STD, but he lied to her and told her otherwise).

6 On this question the *Restatement (Third)* itself states that it "does not address protection of reputation or privacy, economic loss, or domestic relations." *Restatement (Third) of Torts, Liability for Physical and Emotional Harm*, Introduction, p. 2 (2005). Even so, it is difficult to imagine that other tort claims would have a *different* definition of causation, or one that would not include the basic elements of cause-in-fact and scope of liability.

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5. What will the new jury instructions on causation look like?

The Iowa State Bar Association's Jury Instruction Committee met on June 25, 2010.[7] One item on its agenda was to create new uniform causation jury instructions for use in Iowa tort cases. One thing is for certain: since *Thompson,* the former Iowa jury instructions defining "proximate cause" (No. 700.3 et.seq.) are no longer correct or valid. Although the Committee's draft instructions await final approval by the ISBA's Board of Governors, they are set forth below:

700.3 Cause – Defined.

The conduct of a party is a cause of damage when the damage would not have happened except for the conduct.

700.3A Scope of Liability – Defined.

You must decide whether the claimed harm to plaintiff is within the scope of defendant's liability. The plaintiff's claimed harm is within the scope of a defendant's liability if that harm arises from the same general types of danger that the defendant should have taken reasonable steps [or other tort obligation] to avoid.

Consider whether repetition of the defendant's conduct makes it more likely harm of the type plaintiff claims to have suffered would happen to another. If not, the harm is not within the scope of liability.

Explanatory notes and authorities are also provided with each instruction.

The changes from the prior uniform jury instruction on proximate cause (No. 700.3) are self-evident. The term "proximate cause" has been eliminated.[8] Two different instructions are now used (if applicable); one for "factual cause" and the other for "scope of liability." Finally, the "substantial factor" language has been eliminated.

6. How can defense attorneys use *Thompson* and the *Restatement (Third)* to their best advantage?

As previously discussed, two cases cite and discuss *Thompson'*s analysis with approval, and adopt the proximate cause methodology. *Royal Indemnity. Co. v. Factory Mutual Insurance,*, 2010 Iowa Sup. LEXIS 55; *Van Fossen v. Mid America Energy Co.,* 777 N.W.2d 689 (Iowa 2009). Two other cases based on Iowa law have adopted *Thompson'*s and the *Restatement (Third)'*s approach as well. *See Nationwide Agribusiness*, 2010 U.S. Dist. LEXIS 36305; *Rossiter v. Evans*, 2009 Iowa App. LEXIS 1720.

Here are some "practice pointers" for defense lawyers to keep in mind when confronting these issues in future cases.

A. Use the proper terminology and learn the new analysis.

"Duty" remains an element of every tort case and is a question of law for the court to decide. A general duty to exercise reasonable care exists in every situation as a "default," unless there is an "articulated countervailing rule or policy." If defendant can identify an appropriate countervailing policy (e.g., the Iowa statute of repose), then it is possible to get a case dismissed on a "no duty" basis. "Foreseeability" is no longer a consideration in the "duty" inquiry, although it is relevant to the "scope of liability" determination of causation. Although foreseeability no longer determines whether a duty exists, it is a proper consideration in determining whether the defendant has *breached* the generalized duty to exercise reasonable care.

"Proximate cause" in tort cases is replaced by the term "causation" which consists of two elements: 1) factual cause; and 2) scope of liability. The "substantial factor" test is discarded.

B. Do not argue that "no duty" exists because an injury or result is not foreseeable.

Prior "no duty" motions to dismiss or for summary judgment should be reframed to initially presume that a duty exists, and then to identify "articulated countervailing principles or policies" to override that duty. This is the only remaining circumstance under which the court can conclude, as a matter of law, that "no duty" exists. Alternative strategies that defense counsel might employ to achieve the same result include: 1) arguing that factual causation is absent, discussed in more detail *infra*; or 2) arguing that causation is absent under the "scope of liability" element, since the result was not reasonably foreseeable.

C. Do not forget the "lack of factual cause" defense.

It is easy to assume that the "but for" element of causation is present in every case, but defense

7 Many thanks to Jury Instructions Committee (and IDCA) member Tom Waterman for providing us an advanced copy of the new, proposed jury instructions on factual causation and scope of liability.

8 The term "proximate" has also been deleted from the verdict forms and marshalling instructions in the Committee's submission to the Board of Governors.

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counsel should not fall into this trap. For many cases and claims this defense may be case dispositive. Take for example a common situation: a product liability case, where plaintiff has sued defendant for failure to warn. Assume further that the evidence shows that the plaintiff did not read or look at the warning signs or instructions (e.g., in an operator's manual) that were provided with the product. Plaintiff's expert gives opinion testimony critical of the warnings and instructions in the manual. Since the plaintiff did not read what was provided, there is no proof that any *different or additional* warning or instruction in the manual would have been read (let alone heeded). As a result, the failure to warn claim fails for lack of factual causation. The "but-for" test is not met as a matter of law. *See, e.g., Alfano v. BRP Inc.,* 2010 U.S. Dist. LEXIS 64182 (E.D. Cal. 2010) (plaintiff did not read warning that was provided, thus, there could be no proximate cause); *Henry v. General Motors Corp.,* 60 F.3d 1545 (11th Cir. 1995)(plaintiff's failure to read a warning negated the causation element of plaintiff's failure to warn claim). Failure to warn is not a proximate cause of injury when it is clear that warning would have made no difference. *Kauffman v. Manchester Tank & Equip. Co.,* 1999 U.S. App. LEXIS 32173 at *10 (9th Cir. 1999)(citing *Anderson v. Weslo, Inc.,* 906 P.2d 336, 341 (Wash. Ct. App. 1995)(failure to warn did not cause injury where plaintiff "paid so little attention to the warnings that were given, [that] it is unlikely that he would have changed his behavior in response to even more detailed warnings").

A recent Iowa example is *Royal Indemnity*[9], previously discussed. *See* 2010 Iowa Sup. LEXIS 55. In *Royal Indemnity* a very large plaintiff's verdict was reversed on appeal because the plaintiff did not prove at trial what the cause of a warehouse fire was. *See id*. Since the cause was undetermined, there was no way of knowing whether defendant's allegedly negligent inspection was a *factual cause* of the damages. *See id*.

D. Search for and create "articulated, countervailing principles or policies."

The generalized duty on the part of everyone to exercise reasonable care is not boundless. *Thompson* noted that "an actionable claim of negligence requires the existence of a duty to conform to a standard of conduct to protect others, a failure to conform to that standard, proximate cause, and damages. Whether a duty arises out of a given relationship is a matter of law for a court's determination." 774 N.W.2d, at 834. Therefore, "duty" remains a *prima facie* element of every tort case. The *Thompson* Court also acknowledged that a duty may not exist where an "articulated, countervailing principle or policy warrants denying or limiting liability in a particular class of cases." *Id.* at 835. In such a case a trial court can order a dismissal based on lack of "duty."

Van Fossen v. Mid-American Energy Co., 777 N.W.2d at 689 (Iowa 2009) is a good example of this analysis. In *Van Fossen*, the Court concluded that no duty existed, because a "countervailing policy or principle" existed, i.e., that employers have limited control over the work performed by subcontractors.[10] The Court also seemed persuaded that other jurisdictions had considered this precise scenario (a family member of a worker getting asbestosis by virtue of doing the worker's laundry), and the majority had concluded that "no duty" existed. *Id.* at 697.

Most likely there are other potential examples of "countervailing principles or policies," and this is a place where defense counsel can use their creativity. We can think of a couple: 1) statutes that provide for immunity from liability (*e.g.* the work comp exclusive remedy bar, Iowa Code Section 85.20;[11] because of this an injured worker cannot argue that an employer has a "generalized duty" to exercise reasonable care; and 2) common-law doctrines entrenched in the law (e.g., the "good Samaritan" rule).

In *Thompson* Justice Cady provided another

9 This is true even though the Court chose to analyze this issue under the "scope of liability" element.
10 In *Van Fossen* the spouse of an employee of a subcontractor developed asbestosis allegedly as a result of exposure to her husband's workclothes.
11 Interestingly, the Supreme Court missed a chance to do this in *Royal Indemnity*, where a provision of the Iowa Code (Section 517.5) provides legal immunity for insurance companies that do inspections of their insured's premises. If the Court had chosen to do so, it could have avoided the more complicated "scope of liability" analysis it undertook, and simply decided the case on this statutory basis, finding at the outset that no legal duty existed. If no duty exists, then there is no need to analyze the presence or absence of causation.

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example in his concurring opinion, where he opined that the result in that case might well have been different, had a recycling container (left on the end of the driveway near the road for pickup on garbage day), instead of a dismantled trampoline, blew into the road and caused an accident. 774 N.W.2d at 840. In this example it could be argued that since the practice of recycling is to be fostered, the court might well choose to limit or deny liability in such a situation.

In spite of the foregoing discussion, predicting exactly when a court might find an "articulated countervailing principle or policy" that will vitiate a duty to exercise reasonable care which would otherwise exist, may prove to be difficult in particular cases.

E. The general "duty" is to merely exercise *ordinary* or *reasonable* care, not "extraordinary" care.

Defense counsel should work on enhancing their advocacy skills and techniques with lay-person juries in arguing what type of conduct constitutes negligence. Negligence is nothing more than the absence of *ordinary* or *reasonable* care. This is a relatively low and minimal standard of conduct. It may be effective to discuss a couple of real-life, factual situations to help flesh out these terms in a manner that is helpful to the defense. For example, a driver's failure to inspect a vehicle before driving it is not an act of negligence, unless there is some good reason to believe that something is wrong with the vehicle, and would be found by a reasonable inspection. On the other hand, if the car is making loud noises and operating in a strange manner, a decision to continue driving it until an accident occurs might very well be negligent. The law merely requires *reasonable* or *ordinary* care, not *extraordinary* care. Since the *Restatement (Third)* and *Thompson* now impose a general duty of reasonable care in most situations, defense counsel should invest some time and effort in developing effective advocacy techniques for presentation to the jury in arguing whether or not this "duty" was breached in the particular circumstances.

F. Study the new causation jury instructions and develop techniques to argue those instructions to the jury.

Both the "factual cause" and "scope of liability" elements of causation under *Thompson* present opportunities to persuasively argue the defense case. As previously noted, factual cause can be a fighting issue in many cases. Especially in products liability, failure-to-warn cases, defense counsel cannot merely assume that plaintiff would have read, understood, and *heeded* the warning or instruction that allegedly would have prevented the accident. This is especially true when all of the other warnings and instructions were obviously disregarded, or the plaintiff generally engages in "risky" behaviors.

With regard to "scope of liability," this may be an issue in a particular case as well. The *Royal Indemnity* case, which resulted in the notable reversal of an eight-figure verdict for plaintiff at trial, was decided on this element. This element can be at issue in those accidents with bizarre facts, or that have convoluted fact patterns, have an attenuated, unclear or unproven chain of circumstances, or where the results of conduct were not predictable or foreseeable pre-accident from an objective point of view. Bear in mind that the second paragraph of proposed Iowa Uniform Jury Instruction 700.3A, *supra*, recognizes that harm is not within the scope of liability if repetition of defendant's conduct does not increase the risk of that harm. The language of the second paragraph can be of assistance where the allegedly negligent act or omission and the plaintiff's injury are merely coincidental and unrelated.

Conclusion.

Even though one may disagree with certain aspects of *Thompson v. Kaczinski* and its genesis, the *Restatement (Third) of Torts: Liability for Physical and Emotional Harm,* this law is most likely here to stay. The Iowa Supreme Court has used the new analysis to decide two significant cases since *Thompson* was decided in late 2009. The duty and causation inquiry which underpins every tort case has significantly changed. There will be new uniform jury instructions on causation for tort cases. Any defense trial lawyer handling tort cases as a part of their practice should learn the new calculus, and develop techniques to effectively present these concepts to the court and jury.

MESSAGE FROM THE PRESIDENT

James A. Pugh

How quickly a year goes by - - - especially when you are my age. In September, I will pass the President's gavel to Steve Powell. It has been an honor, a privilege and a challenge to serve as your President during the last year. Before leaving this position, I would like to use this last stand at the pulpit to express my suggestions for the future course of this organization.

It was General MacArthur who stated, "Defensive strategy never has produced ultimate victory." While the name of our organization includes the word "defense", I believe our future success will depend on our going on the offensive. The Plaintiffs' Bar is constantly, and aggressively on the offense with respect to matters of legislative and judicial policy. Playing defense is no longer an option. I would suggest three areas of concentration.

First, we, as a group and as individual defense attorneys, need to focus on the appellate courts as a means, not to just win an individual case, but to fashion a body of civil common law which is equitable to our clients. One good example of this is the evolution of the tort of first-party bad faith. The Plaintiffs' Bar fought for a number of years to gain recognition of this tort in Iowa. Finally, in 1988, the Supreme Court acceded to these efforts. In response, a number of defense attorneys began a concentrated endeavor to limit the effect of this tort. By 2005, after a series of appellate cases championed by those defense attorneys, the tort of first party bad faith has been relegated to those few egregious cases which truly warrant tort protection. This type of effort needs to be replicated in the future to help develop common law favorable to civil defendants.

Second, we need to encourage and promote defense attorneys to judicial positions. The most elemental step in this process centers on the respective judicial nominating commissions. Our organization should establish a standing committee to monitor the election/appointment of commission members and work to insure defense representation on those bodies.

Finally, our organization and members must get more actively involved in the election of state legislators. This year's activities at the legislature make it abundantly clear that we can no longer play defense. Concededly, we do not have the resources to match the significant monetary contributions put forward by the Plaintiffs' Bar. Consequently, we have to concentrate on a more "grass roots" effort. Every one of our members should contact the legislative candidates within their own districts and inquire as to their positions regarding issues of importance to civil defendants. Such a discussion can also be used as a pre-emptive tool to educate future legislators regarding the defense side of important issues. We need to make our position known before they get to Des Moines.

There, I've said my piece (peace?). Now, as General MacArthur said, I can "just fade away."

MEDICARE'S INTEREST IN YOUR SETTLEMENT

By Donald G. Fernstrom and Aaron P. Frederickson, Arthur, Chapman, Kettering, Smetak & Pikala, P.A., Minneapolis, MN

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I. INTRODUCTION

The increasing cost of health care and limitations on the availability of private employer sponsored health care insurance has resulted in the federal government assuming an ever-increasing financial burden in paying for medical services to aging and disabled individuals. On December 5, 1980, Congress enacted §1862(b) of the Social Security Act, commonly known as the Medicare Secondary Payer Act. [42 U.S.C. 1395y]. The provisions enacted affect group health plans, worker's compensation plans, automobile liability, general liability and no fault plans (including self insurers).[1]

The Office of the Chief Actuary of the Social Security Administration has estimated that the Medicare Trust Fund will be depleted as soon as 2017, unless something is done to relieve the financial pressure on Medicare. There are three options available to prevent Medicare from being unable to meet its obligations. 1) Raise taxes, 2) reduce benefits or 3) recoup medical expenses from the entities which are primary payers. Those entities include group health carriers, workers' compensation carriers or plans, general liability, auto liability and no fault carriers or plans and self insurers. Thus far Congress has chosen to protect the fiscal integrity of the Medicare program by increased enforcement of the MSP Act.

The MSP Act was largely unenforced until the early 1990s. Since that time, the federal government, through the Centers for Medicare and Medicaid Services ("CMS"), has taken an active role in enforcing its mandate to recover from the primary sources involved in cases in which Medicare would otherwise be liable to pay. Under the MSP Act, CMS has the right to recoup benefits that they have paid from claimants, medical providers, employers, insurers, third-party administrators and even from attorneys. CMS has the right to recoup benefits that they have paid from any entity or person that has benefited financially from shifting the burden of medical expenses to Medicare. In addition to recovery of the benefits paid by the federal government pending determination of the primary payer, CMS has the ability to hold the entities accountable for the payment of medical care benefits in the *future,* which are related to a claimed accident or injury.

Medicare currently covers more than 40 million Americans. That number will increase to 76 million as the baby boomers enter the Medicare system or nearly 25% of the population. Based on this surge in Medicare eligibility, CMS has begun to expand its enforcement of the MSP Act beyond its current enforcement in workers' compensation cases to automobile and general liability cases.

1 42 U.S.C. § 1395y (b)(2)(A)(ii).

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Congress has enacted additional legislation to assist CMS in recouping Medicare payments. Under the SCHIP Extension Act of 2007, mandatory insurer reporting requirements were enacted, which will require all insurers and self insurers to report those claimants who are receiving Medicare benefits at the time any payment is made on a claim. It is very likely that counsel for the Department of Health and Human Services is looking for a test case on Medicare to use in its enforcement of the Medicare Secondary Payer Act in liability cases.

All parties must adequately consider and protect Medicare's interest, in past and future medical expense payments, when settling a general liability, automobile or workers' compensation claim. If these interests are not reasonably considered, the parties and their attorneys could face litigation brought by the federal government to recover those interests.

II. HOW TO PROTECT MEDICARE'S INTEREST

In order to protect Medicare's interest, the parties must resolve those conditional payments made by Medicare pending determination of the primary payer. They must also protect Medicare's interest in the payment of future medical expenses related to the claim. Protection of Medicare's future interests may include consideration of a Medicare Set-Aside ("MSA").

A. Settlement of Conditional Payments

Conditional payments are those payments made by Medicare in which a claim has been denied by an insurance carrier or pending the determination of the primary payer responsible, where the Medicare beneficiary decided to pursue treatment utilizing their Medicare benefits. Once Medicare has made payment for medical care and treatment, if that medical expense should have been paid by another entity, a direct cause of action is created for CMS to recover under the MSP Act.

Interested parties have the responsibility to place Medicare on notice of their interest in conditional payments made in a liability, auto, no-fault or workers' compensation claim. Notice must be given in writing to the Coordination of Benefits Contractor ("COBC") at the following address:

CMS-Medicare COBC
MSP Claims Investigation Project
PO Box 33847
Detroit, MI 48232
Phone: (800) 999-1118

At the time of contact, COBC will require the following information:

- CMS Consent to Release Form
- The claimant's name
- The claimant's Medicare Health Insurance Claim Number ("HICN")
- The date of alleged illness/injury
- Illness/injury (ICD-9 codes optional)
- Name and address of the insurance carrier
- Name and address of the legal representatives
- Name and address of the insured
- The policy/claim number2

Once the COBC has been placed on notice, it is advisable to make a follow-up telephone call to verify that the information was received. Once the COBC has received and processed the information, it will forward a common working file to the Medicare Secondary Payer Recovery Contractor ("MSPRC") for retrieval of conditional payment information. The MSPRC is the Medicare contractor responsible for determining payments made by Medicare on behalf of the claimant and updating Medicare's claim as the case proceeds. All settlement inquiries should be directed to the MSPRC.

The MSPRC to be contacted depends on the type of claim being processed:

Workers' Compensation
MSPRC – WC
P.O. Box 33831
Detroit, MI 48232-3831
Phone: (866) 677-7220

Auto/Liability
MSPRC – Auto/liability
P.O. Box 33828
Detroit, MI 48232-3828
Phone: (866) 677-7220

Group Health Plans
MSPRC – GHP
P.O. Box 33829
Detroit, MI 48232-3829
Phone: (866) 677-7220

2 http://www.msprc.info/

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When requesting conditional payment information from the MSPRC, a valid Notice of Representation or CMS Consent to Release form must be provided. The MSPRC will not release conditional payment to a party without proper authorization. Further information about the MSPRC and its operations can be found at http://www.msprc.info/.

Conditional payment information will take approximately 65 days to process. The MSPRC must also receive a written notice requesting a "final" conditional payment letter upon settlement of a claim. This may take an additional 90 days. All requests for "compromise" or "waiver" of conditional payments are made through the MSPRC.

B. Protecting Medicare's Future Interests

An MSA is an effective tool that can be used to adequately consider the future interests of Medicare and protect the parties from government action and recoupment or non-recognition of a settlement.[3] By obtaining approval from CMS *prior* to settlement, workers' compensation insurers and self-insurers are able to obtain "safe harbor" protection from future government action or non-recognition of a settlement agreement or release.[4] Unfortunately, this procedure is not yet available to auto or general liability insurers or self-insurers. Although some Medicare Regional Offices will review auto or general liability settlements, dependent upon their workload, even if it is reviewed and approved by CMS there is no "safe harbor" protection afforded.

An MSA submission is not required in all workers' compensation settlements. If, at the time of the settlement: a) the claimant is not a Medicare beneficiary, b) does not have a reasonable expectation of becoming eligible for Medicare benefits or c) the settlement does not close out future medical care and treatment, then Medicare does not require prior approval.

If the claimant is not a Medicare beneficiary at the time of settlement, but has a reasonable expectation of becoming eligible for Medicare benefits within 30 months of the settlement date and the settlement closes out future medical care and treatment for the injury, a more exacting review of the facts of the case must be undertaken to protect your client.

CMS has implemented review thresholds, which trigger the requirement of prior approval of an MSA submission in workers' compensation cases, if "safe harbor" treatment is sought. Under these guidelines CMS review of a proposed settlement is **required** when:

- The individual is a Medicare beneficiary at the time of settlement and the total settlement is greater than $25,000 **or**[5]
- The individual is **not** a Medicare beneficiary at the time of settlement, but the total settlement is over $250,000 **and** there is a reasonable expectation of Medicare entitlement within 30 months of the settlement date.[6]

1. What Must Be Included in Determining the Total Settlement Amount?

The "total settlement" amount must take into consideration all benefits that have been paid to or on behalf of the claimant in the past for the same injury *and* the total sum of the current settlement amount paid to the claimant.[7] This includes payments to all medical providers, group health insurers, and government agencies, for medical care and treatment provided for the injury, as well as future medical expenses and attorney's fees paid in conjunction with the proposed settlement. Where the parties are using an annuity to fund the settlement, the cost of the annuity's seed money and total payout over the course of the annuity must be included. Careful review of these threshold levels should take place, when an injured claimant will likely need medical care and treatment in the foreseeable future.

2. What Constitutes a Reasonable Expectation of Medicare Benefits?

The MSP Act does not define what constitutes a "reasonable expectation" of Medicare benefits. However, the

3 42 C.F.R. § 411.46.

4 See generally Memorandum from Parashar B. Patel, Centers for Medicare and Medicaid Services, July 23, 2001; Memorandum from the Centers for Medicare and Medicaid Services, April 22, 2003.

5 Memorandum from the Centers for Medicare and Medicaid Services, April 25, 2006.

6 Memorandum from Parashar B. Patel, Centers for Medicare and Medicaid Services, July 23, 2001, pp. 5-6.

7 Memorandum from Parashar B. Patel, Centers for Medicare and Medicaid Services, July 23, 2001, pp. 5-6; Memoranda from the Centers for Medicare and Medicaid Services, July 11, 2005; April 25, 2006; See also July 23, 2001. The October 27, 2008 CMS "Operating Rules" have suggested that the "total settlement" amount does not include prior wage loss benefits paid to the employee. Similar "operating rules" released on April 22, 2010 make the same suggestion.

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April 22, 2003 policy memorandum from CMS has provided some guidance. According to this memorandum, those situations in which an individual has a "reasonable expectation" of Medicare eligibility include those where:

1. The individual has applied for Social Security Disability Benefits;
2. The individual has been denied Social Security Disability Benefits, but anticipates appealing that adverse decision;
3. The individual is in the process of appealing or refiling for Social Security Disability Benefits;
4. The individual is age 62 years and 6 months old and will become eligible for Medicare benefits within the next 30 months; or
5. The individual has End Stage Renal Disease ("ESRD"), but does not yet qualify for Medicare based on ESRD.

CAVEAT:
Based on the above CMS review thresholds, the parties are left in a situation in which prior approval of an MSA submission **may not be required**, but they still must "adequately consider" and protect Medicare's future interests.[8] CMS has provided very little guidance on how to proceed in those situations. The parties may be able to exercise some creativity in their settlements, depending on their tolerance for risk.

III. INTERPRETING THE MEDICARE SECONDARY PAYER ACT

There are a number of tools that can be utilized when confronting issues involving the enforcement of the MSP Act. Some of these tools are useful, but some raise more questions than they answer.

A. Federal Regulations Interpreting the MSP

Federal regulations regarding the MSP are located in the Code of Federal Regulations ("CFR") and are intended to help people better understand the interest Medicare has in settlements and the possible ramifications for not protecting those interests.[9] At this time, these regulations only discuss workers' compensation settlements, and do not directly deal with auto or general liability matters. It is important to consult these regulations before entering into settlements involving the resolution of past and future Medicare interests.

B. CMS Policy Memorandums and the MSP

CMS has also prepared numerous policy memoranda interpreting the MSP.[10] The first such policy memorandum was issued on July 23, 2001, specifically directed toward workers' compensation. This memorandum set the foundation for MSAs and put people on notice of CMS's **intention to vigorously enforce** the MSP Act. According to this memorandum:

> [I]t is in Medicare's best interest to learn the existence of WC (workers' compensation) situations as soon as possible in order to avoid making mistaken payments. The use of administrative mechanisms sometimes referred to by attorneys as Medicare Set-Aside Trusts in WC commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

This memorandum outlined the scope of CMS's review of MSAs and further defined what cases must be submitted for review.

CMS published its next policy memorandum on April 22, 2003. In this memorandum, CMS gave further guidance as to when a claimant has a "reasonable expectation" of becoming eligible for Medicare benefits. This memorandum also reassured the public that once CMS agrees to an MSA, the individual can be certain that Medicare's interests have been adequately considered. Unfortunately, this "safe harbor" provision does not apply to auto or general liability litigants.

On May 23, 2003, CMS issued a memorandum, which provided additional clarification on the CMS review thresholds. It also noted that CMS would not issue verification letters to parties wanting a determination of when an MSA is required.

In 2004, CMS issued two additional policy memoranda. The first such memorandum on May 7, 2004 defined what payments were to be included in CMS's review thresholds. On October 15, 2004, CMS clarified issues surrounding the payment of medical charges in an MSA, MSA administration requirements and the reporting duties for MSA administrators.

On April 25, 2006, CMS issued one of its more significant memoranda. This memorandum established a **workload** review threshold of $25,000. According to these memoranda,

8 42 C.F.R. § 411.46; Memorandum from Parashar B. Patel, Centers for Medicare and Medicaid Services, July 23, 2001, p. 5.
9 42 C.F.R. § 411.20 et. seq.
10 CMS's policy memoranda can be found at: http://www.cms.hhs.gov/.

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low-dollar settlements are settlements in which the settling insurance carrier or third-party administrator has paid less than $25,000 in benefits on behalf of the claimant. Prior to these memoranda, an MSA submission would be required regardless of the settlement amount. Under these revised guidelines, CMS will no longer review workers' compensation Medicare Set-Aside proposals for Medicare beneficiaries, where the total settlement amount is less than $25,000.[11] The memorandum further noted that the review thresholds are not substantive or "safe harbor" thresholds. They are only **workload** thresholds for the benefit of CMS. The settling parties must always consider Medicare's interest in workers' compensation cases, regardless of the amount of the settlement, to ensure that Medicare is secondary to the insurance carrier or other primary payer in such cases.

On December 30, 2005, CMS issued a policy memorandum dealing with the Medicare Prescription Drug Improvement and Modernization Act, which established prescription drug benefits under Medicare Part D.[12] All MSA proposals on or after January 1, 2006 need to take into consideration the claimant's future use of prescription medications. If the MSA does not consider this, CMS will reject the MSA proposal as not reasonably considering Medicare's interests.

The memorandum did provide some guidance in considering the prescription drug benefit, but there are additional pitfalls not covered in the memorandum. One noticeable ambiguity concerns the method of calculating the price for future medications under the MSA allocation, whether to use the average wholesale price, the workers' compensation reimbursement rate (if applicable) or the actual amount billed for the drug. CMS did not provide clarification as to when the different calculation methods should be used. Another ambiguity deals with the use of generic versus brand name medications. CMS did not provide guidance as to the amount that should be used when preparing the MSA allocation. Further clarification on these issues should be anticipated.

To add to the confusion, not all prescription medications are covered under Medicare and, therefore, not covered by the CMS guidelines. Drugs in the following categories should not be considered as part of an MSA allocation or submission:

- Drugs used for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or hair growth;
- Drugs used for the symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride prescriptions;
- Non-prescription drugs;
- Inpatient drugs;
- Barbiturates; and
- Benzodiazepines.[13]

Notwithstanding the ambiguities in the CMS memoranda, reasonable judgment must be used when preparing the MSA allocation, so that it includes an adequate allocation for prescription drugs. It is also important to use a method of calculation that is justifiable and cost effective.[14] Prior medical records of a claimant should be obtained and reviewed in order to determine what medications a claimant has used in the past and what will most likely be used in the future.

On July 24, 2006, CMS issued another policy memorandum. This memorandum was an attempt to further clarify the consideration of prescription drugs and their calculation in an MSA allocation. CMS now requires separate allocations for medical services and prescription drugs. The MSA funds are to be used for all medical services and prescription medications covered by Medicare, but Medicare will not require that the funds paid from an MSA be spent in the identical corresponding percentages. For example, if $10,000 is placed in an MSA with $4,000 designated for medical services and $6,000 for prescription medications, CMS will not discontinue payments if $7,000 is paid for medical services and only $3,000 for prescription medications. If the full $10,000 in the MSA is properly exhausted, Medicare will resume payment for any additional medical expenses and prescription drugs. The memorandum also noted that: "the claimant and all other parties to the WC settlement can rely on CMS's written opinion regarding whether the WC settlement adequately protects Medicare's interest."

Based upon the content of the July 24, 2006 memorandum, prescription drug cost will certainly continue to be an issue in determining the amount of a Medicare Set-Aside. CMS has given close scrutiny to the amount allocated for future prescription drug use. Not infrequently, the amount allocated for prescription drug expense exceeds the amount allocated for future medical treatment.

11 Memorandum from the Centers for Medicare and Medicaid Services, April 25, 2006.
12 Memorandum from the Centers for Medicare and Medicaid Services, December 30, 2005.
13 Patty Meifert and Robert T. Lewis, Calculation of Prescription Drug Costs in MSA Allocations, NAMSAP News, January 2006, at 3.
14 Id.

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On May 20, 2008 another policy memorandum was issued by CMS. It deals exclusively with the technical requirement that, when determining life expectancy for use in WCMSA proposals, the only table recognized will be CDC Table 1, "Life Table for the Total Population."

On August 25, 2008, CMS issued another memorandum. This memorandum provided guidance regarding the use of rated ages in MSA submissions, and also noted that the claimant's actual age would be used for calculation purposes if a rated-age was not submitted. The memorandum also provided details on the pricing of various implantable devices and further clarified the method used for termination of an MSA account.

CMS continues to issue policy memoranda regarding compliance with the MSP Act. On April 3, 2009 CMS resolved the ambiguity in drug pricing for use in an MSA. According to the April 3, 2009 memorandum, the pricing of prescription medication would be subject to the "average wholesale price."

Further direction from CMS, in a subsequent undated memorandum, noted that the RED BOOK® should be used to evaluate the sufficiency of the prescription drug component. CMS also provides guidance regarding the use of drug tapering, the expiration of patents, off-label medication use, drug utilization review findings, brand name or generic drugs usage and information concerning the multiple manufacturers of a particular drug.

On May 14, 2010, CMS issued its most recent policy memorandum regarding MSP compliance. This memorandum was limited to issues related to Medicare Part D and the use of rated ages in determining the MSA. This memorandum indicated, that in order for a medication to be includable in an MSA, the medication must be prescribed for "outpatient use" according to the Federal Food, Drug, and Cosmetic Act,[15] or approved other uses under applicable Federal law.[16] The effective date for these changes was June 1, 2009.[17]

The May 14, 2010 policy memorandum also provided guidance regarding the use of rated ages in the MSA allocation and approval process. According to the new guidelines from CMS, MSA submissions are now required to provide CMS with all rated ages obtained during a claimant's lifetime and also must "certify" the accuracy of the rated age information as follows: "Our organization certifies that all rated ages obtained on the claimant, at any time during that individual claimant's lifetime, have been included as part of this submission to the Centers for Medicare & Medicaid Services."[18]

Lest we give short shrift to the policy memoranda of a regulatory agency in the interpretation of a federal statute, one must bear in mind the decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), which set forth the basic doctrine of administrative law known as *Chevron* deference. The principle stated in *Chevron* is, that when a statute is ambiguous, the federal agency's official interpretation of the statute, if reasonable, is the last word on the subject.

C. Case Law Interpretation of the Medicare Secondary Payer Act

Case law interpretation of the MSP has been slow to develop since the Act's inception in 1980. Several important cases demonstrate the federal government's ability to recoup medical care and treatment paid for by Medicare under the enforcement provisions of the MSP.

In *United States v. Baxter International*, 345 F.3d 866 (11th Cir. 2003), the United States filed a Complaint-in-Intervention in a class action lawsuit against the manufacturer of silicon breast implants and sought to escrow the settlement funds from the products liability settlement with Baxter. The government's intervention complaint was premised on the MSP Act and recognized Medicare's ability to recoup medical expenses it paid, directly from the beneficiaries who received the settlement proceeds in the class action lawsuit.[19] According to the government's complaint, of the nearly 400,000 claimants in the lawsuit, roughly 81,000 had received some of the $41 million in settlement proceeds.[20] In addressing the power of the federal government to recover Medicare benefits, the Eleventh Circuit Court of Appeals stated:

> In carrying out its principal purpose of shifting the burden of paying for health care from Medicare to private insurers, the MSP creates as a practical matter a need for insurers to determine, before paying a

15 21 U.S.C. § 301 et seq.
16 42 U.S.C. §1396r-8 and (g)(1)(B)(I)
17 Memorandum from the Centers for Medicare and Medicaid Services, p. 1
18 Id.
19 Baxter, 345 F.3d at 867.
20 Id. at 873-874.

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> disputed liability claim (involving among its alleged damages medical expenses likely to have been paid by Medicare), whether the Government has made a conditional payment, ***885** upon peril of being forced to pay the same claim twice. As the second payer, such insurer is in a position to determine which claim has been, or is at risk of being, paid twice, while Medicare, as the first payer, is not. Because the statute is built on the recognition that Medicare frequently will not know which of its payments has been subsequently duplicated by an insurer, it would--in this unique setting of a class action involving thousands of claimants--defeat the purpose of the statute to require that the Government identify each patient, procedure, and payment amount at the pleading stage without benefit of discovery.[21]

The Court then allowed the government's claim to proceed, which ultimately resulted in a recovery by the federal government of $11.3 million.[22]

In *Brown v. Thompson*, 374 F.3d 253 (4th Cir. 2004), the Fourth Circuit Court of Appeals allowed the federal government to recover under the MSP Act, where the payment of benefits was made as part of the settlement of a medical malpractice action.

This precedent later allowed for recovery by the federal government under the MSP Act in a slip and fall accident.[23] In *Pollo Operations v. Tripp*, the plaintiff was involved in a slip and fall accident, which resulted in a mediated settlement of $55,000.[24] As a part of this claim, a total of $37,000 in medical bills associated with the accident were conditionally paid by Medicare.[25] The executed settlement agreement noted that all subrogation claims were to be resolved by the plaintiff, who would satisfy all medical and related liens from the settlement funds. Settlement funds included any claim by the claimant for medical payments coverage.[26] The settlement agreement also noted that the plaintiff will execute appropriate indemnity and hold harmless agreements consistent with protecting the defendant from any claim of medical lien.[27]

Following the settlement, an action was commenced to determine the resolution of Medicare's lien. In reviewing the matter, the District Court of Appeals of Florida, Third District, stated that the MSP Act applied to all matters involving cases where a liability insurer paid a Medicare beneficiary based upon a tortfeasor's legal liability.[28] The Court was troubled by the plaintiff's attempt to retain an undeserved and unnecessary windfall, by keeping all of the settlement proceeds and not properly taking care of Medicare's interest.[29] The Court was also troubled by ethical considerations. It required that the parties notify Medicare of the underlying settlement so that Medicare could recover its share of the settlement proceeds.[30]

In *Arkansas Department of Health and Human Services, et al., v. Ahlborn*, 126 S. Ct. 1752 (2006), a case involving Medicaid, not Medicare, the United States Supreme Court set a precedent by unanimous decision, that will impact the future of Medicaid and its interest in lawsuits involving Medicaid beneficiaries. The Court examined a matter involving a 19-year-old college student, who suffered permanent brain damage as a result of a car accident. Medicaid is a federal medical reimbursement program that is administered by the states on behalf of the federal government. The Arkansas Department of Health and Human Services ("ADHS") sought to recover $215,645.30 in Medicaid benefits that it had paid on behalf of the claimant, when it was determined that she did not have sufficient assets available to pay her own medical expenses. ADHS was not a party to the lawsuit to recover benefits from the third party, although the plaintiff's attorney did keep them informed of details concerning insurance coverage. ADHS did intervene in the suit to assert a lien on the proceeds of any third-party recovery. They requested that plaintiff's counsel advise them of any hearing in the case, but did not actively participate in settlement negotiations.

The case was settled without a hearing for $550,000. There was no allocation of the settlement between pain and suffering, lost

21 Id. at 884-885.
22 NAMSAP Symposium, Robert T. Lewis, Conditional Payments (2005).
23 Pollo Operations v. Tripp, 906 So. 2d at 1101 (Fla. 3d Dist. App. 2005).
24 Id. at 1102.
25 Id.
26 Id.
27 Id.
28 Id. at 1103.
29 Id.
30 Id. at 1105-1106.

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wages, or past and future medical expenses. ADHS asserted its lien against the entire settlement proceeds. The plaintiff then filed suit in U. S. District Court for the Eastern District of Arkansas to obtain a declaration that the Arkansas lien violated federal Medicaid laws, in that satisfaction of their interest would require invasion of her compensation for pain and suffering, loss of income, and future earning capacity. The District Court obtained a stipulation from the parties that the entire claim was worth $3,040,708.18 in order to assist in its resolution of the legal issues. The settlement amount was approximately one-sixth of the value of the entire claim. Plaintiff argued that ADHS should only recover one-sixth of their total lien based on that allocation. The District Court held that the plaintiff had assigned her entire right of recovery to ADHS, in exchange for their conditional payment of her medical expenses, and awarded ADHS its entire lien in the amount of $215,645.30. The Eighth Circuit reversed and held that ADHS was only entitled to its pro rata share of the settlement and allowed recovery of only one-sixth of the conditional medical payments made by Medicaid.

The U.S. Supreme Court agreed to hear the case due to a conflict between the Circuits. The *Ahlborn* Court affirmed the decision of the Eighth Circuit, limiting the recovery of ADHS to its pro rata share of the medical expenses, a total of $35,581.47 or one-sixth of the total medical expenses it paid. This decision is of great interest, in that it limited the ability of Medicaid to recover the entire amount of medical expenses it paid, preventing the invasion of the other compensation awarded to the plaintiff (e.g., pain and suffering, lost wages, and loss of earning capacity). Although the case involves third-party liability and is limited to Medicaid, it may signal the intention of the U.S. Supreme Court to decide medical expense reimbursement matters on equitable grounds and not to allow full recovery of government liens to the detriment of the plaintiff's ability to recover general damages. Although it only applies to Medicaid cases, it can be argued by analogy that the same principal should apply to Medicare. We will have to wait for the appropriate Medicare case to come before the U. S. Supreme Court before we will know the answer.

Following the holding in *Ahlborn*, the federal courts continued to discuss the principles of equity when resolving issues concerning conditional payments. In *Mathis v. Leavitt*, 554 F.3d 731 (8th Cir. App. 2009), the court analyzed the rights of Medicare to recover in a wrongful death action. While this case did not directly state a formula or percentage, that Medicare should be allowed to recover, they did suggest that Medicare's right to recover "might well be subject to a rule of equitable apportionment that would reduce the amount that Medicare could recover." 554 F.3d at 733-34, *citing Sinman v. Shalala*, F.3d 841, 844-45 (9th Cir. 1995).

Notwithstanding the *dicta* in *Mathis* and the decision in *Ahlborn*, recent litigation in the district courts concerning the Medicare Secondary Payer Act has tended to favor the federal government's right to recovery. That trend has also suggested an underlying concern toward maintaining the solvency of the Medicare program.

In *Hadden v. U.S.,* 2009 U.S. Dist. LEXIS 69383 (W. Ken. 2009), the Plaintiff, who was a Medicare beneficiary, settled a claim following a motor vehicle accident. Prior to the settlement, Medicare made conditional payments on behalf of the plaintiff exceeding $64,000. At the time of the settlement, the Plaintiff sought a "waiver" of conditional payments based on comparative fault principles. Applying comparative fault, the plaintiff argued that Medicare could recover only ten percent of the total settlement proceeds on its Medicare lien. CMS denied the waiver request. The plaintiff pursued an administrative appeal through the US Department of Health and Human Services. When that was unsuccessful, the plaintiff commenced a lawsuit in federal court. When the case reached federal district court, CMS brought a summary judgment motion, which was granted. CMS was awarded full reimbursement of its conditional payments, without any reduction on equitable grounds as allowed in *Ahlborn*.

The district court judge specifically rejected the "equitable apportionment" principles that were the cornerstone of the *Alhborn* decision. In doing so, the judge distinguished Medicaid, which is a federally funded program administered by the states, from Medicare, which is solely a creature of federal law. Based on this distinction, it was held by the court that *Alborn* was not controlling on Medicare related issues.

It is important to note that *Hadden* did not discuss the obligation of the parties in considering Medicare's future interests. Given the rejection of equitable principles in *Hadden*, it is clear that employers, insurers, and self-insurers may need to look to Congress and not to the courts, for relief from the heavy hand of CMS, when seeking reduction of the allocation required by Medicare for future medical expenses.

In *U.S. v. Harris*, U.S.D.C. for the N. D. of West Virginia, the U.S. filed a complaint against the attorney for the Medicare beneficiary for conditional payments due CMS as part of a settlement in a liability suit. CMS paid $22,549.67 in medical services. The total settlement amount in the underlying suit was $25,000.00. Mr. Harris, the plaintiff's attorney informed CMS of the settlement terms and forwarded his attorney's fee

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MEDICARE'S INTEREST IN YOUR SETTLEMENT ... *CONTINUED FROM PAGE 16*

and costs documentation to CMS. CMS determined that they were entitled to $10,253.59 out of the total settlement and informed Mr. Harris of the applicable administrative appeal rights. Neither the plaintiff nor Mr. Harris pursued an administrative appeal. When CMS did not receive the requested sum of $10,253.59 within the 60 day statutory period for payment, they commenced the action to recover the payment plus interest. The Court awarded CMS the full amount of their demand plus interest on summary judgment. It's not just the defense bar that needs to be concerned about the MSP Act.

U.S. v. Stricker was filed in U.S.D.C. for the E.D. N.D. Alabama in 2009. This appears to be the first case in which the government seeks to recover directly from the insurance carriers funds paid as part of settlement proceeds in a mass tort class action settlement. The U.S. Attorney alleged that the defendant insurers, Travelers and AIG, made payment of the settlement proceeds without ascertaining whether any of the plaintiffs were Medicare beneficiaries at the time of settlement or whether Medicare had made any conditional payments on behalf of Medicare beneficiaries pending the settlement. Under 42 C.F.R. 411.24 Medicare is allowed to recover payment from the liability insurance carrier, regardless of whether payment has already been made to the Medicare beneficiary. The government is seeking summary judgment, while the defendants have moved for dismissal. It will be interesting to see how this case comes out and whether or not the decision is appealed.

IV. PREPARING AN EFFECTIVE MEDICARE SET-ASIDE ALLOCATION

A. The Medicare Set-Aside

The MSA allocation is a vital part of any submission to CMS. The information provided in the allocation allows CMS to analyze and determine the reasonableness of the proposed set-aside amount. Depending on the type of injury and the size of the settlement, it can be as simple as submitting a statement from the claimant's treating physician or as complex as the inclusion of a life care plan.

In order to properly consider Medicare's interest, the MSA allocation in a workers' compensation case must consider all benefits paid to or on behalf of the injured claimant for the same accident. This includes past payments to providers and group health insurers, conditional payments made by Medicare pending resolution of liability issues and expected future medical expenses, including prescription drug costs.

Future medical expenses are determined on a case-by-case basis and carry a standard of reasonableness for review. This requires collection of the medical expenses paid, followed by a detailed analysis of the claimant's injuries and medical records. Each MSA allocation will have a unique medical expense projection. CMS will compare the amount being allocated for future expenses with past medical expenses to determine the reasonableness of the proposed allocation.

B. Review and Analysis of Medical Records

Future related care and treatment should be divided into two categories: those services covered by Medicare and those that are not. This division requires the careful review and analysis of the reason behind each proposed medical device, service or expense. In workers' compensation cases, these proposed costs are subject to any applicable workers' compensation fee schedule. In liability cases, they are based on what a treating provider would receive under "usual and customary" charges.

Preparing a proper and effective MSA allocation requires extensive medical experience and training in determining the usual and customary cost of treatment. This involves a thorough review, analysis and summarization of the claimant's past and current medical information. The records must be organized chronologically and pre-existing conditions, surgical and diagnostic procedures identified.

The medical history should be thoroughly analyzed for causal relationship to the claimant's injury. Diagnostic codes should be reviewed for accuracy and to determine how and whether treatments and services provided correspond to the injuries sustained in the accident. A review of the diagnostic codes will also assist in the evaluation as to the appropriateness of the treatment. All unrelated diagnoses and diagnostic codes should be excluded.

It is extremely important that the medical records reviewed include all treatment and services rendered for the same body part, before and after the claimant's injury. This is where the advocate will scrutinize the records for pre-existing conditions and find support for an argument that the pre-existing condition should lead to a lower set-aside amount, because the current treatment relates, at least in part, to the pre-existing condition.

It is imperative that the medical records continue to be supplemented throughout the settlement process. It is important for the MSA allocation to evaluate and eliminate any inconsistencies in treatment based on established standards and protocols, including any applicable workers' compensation treatment parameters. After the medical records have been reviewed, the reasonableness and necessity of continued treatment, the

Continued on page 18

accuracy of the current diagnosis and the potential duration of the treatment is analyzed.

C. Prescription Drug Calculations

As of January 1, 2006, CMS has mandated that to fully consider and protect Medicare's interest, prescription drug expenses must be considered and included as part of the MSA allocation.[31] This inclusion will dramatically increase the amount of the proposed MSA allocation as the cost of prescription drugs is quickly becoming one of the largest cost categories within future medical expenses.[32]

An MSA allocation containing a proposed amount for future prescription drug treatment must also include a letter explaining how that amount was calculated.[33] If CMS finds that treatment records indicate a need for future prescription drugs and there is no amount proposed in the MSA allocation, they will take the position that Medicare's interest has not been adequately considered.[34] This can lead to significant exposure and risk for all parties involved in the settlement.[35]

Determining an amount related to the projected future prescription drug treatment requires knowledge and understanding of the various Medicare Part D coverage plans, in addition to the core formulary lists for each plan. It is also necessary to have an understanding of the drugs that Medicare specifically excluded from Part D plans.

Finally, the allocator must have the knowledge to be able to consider all other methods whereby the projected amount for prescription drug treatment can be reduced. Some of these methods include utilizing a rated age to reduce the life expectancy of a claimant, encouraging physicians to prescribe generic equivalents versus brand name drugs, and obtaining an opinion from the treating physician regarding the anticipated time claimant will be utilizing a particular drug.[36]

A successful MSA allocation requires intense and critical evaluation, analysis, and planning. Medical records must be scrutinized carefully and diagnostic codes evaluated and reconciled with treatment services provided for the injury. Non-accident related treatment and codes should be excluded. Having a proper and thorough understanding of the diagnostic codes, the treatment provided, the prescription drug costs, the Medicare Part D plans and rehabilitation processes, ensures that the MSA allocation submitted will adequately consider Medicare's interests and will likely lead to CMS's approval of the submission.

V. CONSIDERATIONS IN LIABILITY ACTIONS

As noted above, the MSP Act applies to all general liability, automobile, and workers' compensation actions. However, unlike in workers' compensation claims, **CMS does not have a formalized process for dealing with liability actions.** The parties are left to their own devices as to how best to comply with the MSP Act. What steps are required to reasonably consider Medicare's interests?

There is nothing that prevents a party to a liability action from using procedures similar to those set forth for workers' compensation claims and submitting a settlement with a proposed MSA to CMS. However, in contrast to workers' compensation claims, **liability claims will not be afforded "safe harbor" status.** The value of an MSA submission in a liability case is to demonstrate that the parties have taken reasonable steps to protect Medicare's interest, in order to avoid legal action by Medicare to recover its payments.

Based on these factors, both plaintiff and defense counsel should review their liability settlements, in order to determine whether Medicare's past and future interests have been "adequately considered," before finalizing a settlement. Conditional payments must be resolved by the procedures outlined above.

Consideration should always be given to protecting Medicare's future interests in any liability claim, where the claimant is a Medicare beneficiary at the time of settlement. Counsel should also proceed with caution when the claimant meets any of the following conditions:

- A claimant is 62 years and 6 months old at the time of settlement;
- A claimant is currently receiving SSDI benefits;
- A claimant has applied for or is appealing a denial of SSDI benefits; and
- A claimant has End Stage Renal Disease (ESRD), even if not yet eligible for Medicare.

There are other factors which should be considered, that make it more likely that CMS will take legal action to recoup medical

31 Memorandum from the Centers for Medicare and Medicaid Services, December 30, 2005.
32 Patty Meifert and Robert T. Lewis, Calculation of Prescription Drug Costs in MSA Allocations, NAMSAP News, January 2006, at 3.
33 Memorandum from the Centers for Medicare and Medicaid Services, December 30, 2005.
34 Id.
35 Patty Meifert and Robert T. Lewis, Calculation of Prescription Drug Costs in MSA Allocations, NAMSAP News, January 2006, at 3.
36 Id.

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MEDICARE'S INTEREST IN YOUR SETTLEMENT ... *CONTINUED FROM PAGE 18*

expenses paid by Medicare, even after the case has settled. The dreaded *claw back* provision. This would include the following fact situations:

Liability cases that include a life care plan as a part of the settlement agreement—this is a tip-off that future medical expenses are being considered in the settlement;

Any claim where both workers' compensation and liability claims are involved, future medical expenses are likely being considered in any global settlement;

Catastrophic injury cases, such as traumatic brain injuries, spinal chord injuries, amputations or cases involving severe psychological components. Long-term medical care and treatment will be presumed by CMS as necessary in these cases;

Structured settlements: Medicare generally takes notice of these settlements, it is often presumed that long-term care may be part of the settlement agreement; and

Any case in which the injured person will require future medical care and treatment for the injury.

VI. ENFORCEMENT ACTIONS UNDER THE MSP

Under the MSP, the primary plan has the responsibility to reimburse the Social Security Trust Fund for any payment made by Medicare with respect to any item or service where it can be demonstrated that the primary plan had a responsibility to make payment. The primary plan's responsibility may be demonstrated by a judgment or a payment conditioned upon the recipient's compromise, waiver, or release of liability (whether or not there is a determination or admission of liability). [37]

There are two primary means of enforcement under the MSP with applicability to both liability and workers' compensation claims.

A. Direct Action by the United States

The United States can bring a direct action to recover payment for any item or service against any or all entities that are or were required to make payment under a primary plan. A primary plan includes any insurer, self-insurer, third-party administrator or employer, if that employer sponsors or contributes to a group health plan.

An uninsured entity is considered self-insured under the MSP Act, since the Medicare Modernization Act of 2003. If the federal government is successful in its action, the responsible party pays double damages to Medicare for the amount paid.

The United States may also recover from any entity that has benefited from the receipt of payment from a primary plan or from the proceeds of a primary plan's payment to any entity (this includes plaintiffs, plaintiff's attorneys and health care providers).

B. Private Cause of Action

In case the above provisions are not enough to cause concern, the statute provides for double damages for a private cause of action against a primary plan which fails to provide primary payment. These actions may be started by any entity under the authority of the MSP Act. Examples of litigation thus far include *United States v. Baxter International,* 345 F.3d 866 (11th Cir. 2003) and *United Seniors Association, Inc. v. Philip Morris USA, et. al.,* U.S.D.C., District of Massachusetts (filed August 4, 2005).

The federal government is clearly intent on obtaining reimbursement for conditional payments made by Medicare. Employers and insurers must be aware that language that requires the plaintiff to satisfy any outstanding medical liens or hold harmless and indemnify the tortfeasor and his insurer from any unsatisfied liens may be unreliable in avoiding liability for reimbursement of Medicare. Recognizing that many plaintiffs will have limited means, or will have already spent the settlement proceeds, the federal government may prefer to exercise their enforcement measures against the deep pockets of the employers, insurers and even the Medicare beneficiary's attorney.

Preventive measures can be taken to limit potential liability through direct action by the federal government or private causes of action. While these measures will not provide a "safe harbor" in liability cases, it is far better to take reasonable measures to protect Medicare's interest than to run afoul of the MSP Act and jeopardize the validity of a settlement.

All parties should confirm that appropriate inquiries are made of the claimant during the intake process and in the discovery process through interrogatories. Defense counsel should include a request for admissions to confirm the plaintiff's representation with respect to Medicare. If the claimant is a Medicare beneficiary at the time of settlement, obtain a copy of their Medicare HICN card.

42 C.F.R. 411.23 requires that the Medicare beneficiary cooperate in any action by CMS to recover its conditional pay-

37 42 U.S.C. §1862.

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ments. If CMS is unsuccessful in recovering its conditional payments, due to lack of cooperation of the beneficiary, CMS may recover directly from the beneficiary.

Parties should always obtain a signed authorization from the claimant and Consent for Release of Information, so that direct inquiry can be made to Medicare concerning conditional payments made. This authorization will be required by the COBC before accessing Medicare payment records.

Often defendants will issue the settlement check in the name of the claimant and their attorney. Although this is thought to provide an additional layer of protection to the defendant and their insurer, it may not be a practical solution to the problem. CMS has stated that they do not want checks from any party until the final conditional payment has been determined. Before Medicare will endorse any draft, they will require all other parties to have endorsed it and that a signed copy of the final settlement agreement accompany the draft. Medicare will then deposit the proceeds in the Medicare Trust Fund before disbursing any surplus settlement proceeds to the plaintiff. It is unlikely that plaintiff's counsel will tolerate such delays. If they do go along with such a plan, they could provide Medicare with another potential source of recovery, namely the fees of the plaintiff's attorney.

VII. MANDATORY INSURER REPORTING REQUIREMENTS

Under the Medicare, Medicaid, and SCHIP Extension Act of 2007,[38] Congress enacted legislation designed to assist CMS in its enforcement of the provisions of the Medicare Secondary Payer Act. It requires all group health plans, liability insurers, self-insurers, no-fault insurers and workers' compensation plans to report to CMS when a claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability). The Federal Government intends to gather this information to increase enforcement of its lien rights under the MSP Act.

This legislation has already taken effect for group health plans as of January 1, 2009. It will become effective for liability insurers, self-insurers, no-fault insurers, and workers' compensation plans on January 1, 2011. Workers' compensation plans include claims under FELA, the Long Shore and Harbor Workers' Act and the Jones Act.

Reporting requirements will be completed by electronic format in a form and manner, including frequency, specified by the Secretary of the Department of Health and Human Services. Responsible Reporting Entities (RRE's) will have been required to comply with the Electronic Data Interface (EDI) that CMS will be utilizing to monitor the settlements, well before they actually are required to start submitting data.

This legislation includes an allocation of $35,000,000.00 for enforcement of these Mandatory Insurer Reporting Requirements. The penalty for non-compliance is $1,000 per claim per day. The burden is now on the insurer or self-insurer to identify a Medicare beneficiary whose illness, injury, incident, or accident was at issue on January 1, 2011.

VIII. PRACTICE POINTERS WHEN DEALING WITH CMS

- CMS is currently overwhelmed by the volume of paper required to process claims for Medicare benefits. To help this process run as smoothly as possible, it is suggested that you follow a few protocols:
- Obtain a properly executed CMS Consent to Release from the claimant at the start of litigation. Include the plaintiff and defense attorney or law firms' name on the authorization to allow you to communicate directly with Medicare.
- When completing the initial file investigation, determine whether Social Security and Medicare have paid any benefits on behalf of the employee or if the employee has applied or intends to apply for social security disability benefits. It is ideal to obtain this information during the intake interview and again at the time of the claimant's deposition.
- Consider the desired settlement well in advance of the anticipated settlement date. It will take time for CMS to process your submission and the more lead time you provide, the less likely it is that CMS will delay the settlement.
- Monitor the CMS website for changes to the MSA approval process and comply with the requested submission procedures located there.

IX. CONCLUSION

The parties to any liability claim, no-fault, medical payment or workers' compensation claim involving claimants who fall within the purview of Medicare will be impacted by the MSP Act and the new Mandatory Insurer Reporting Requirements. It is clear that the federal government will continue to increase its efforts to vigorously enforce the MSP and it will take action to obtain recovery

38 This action is commonly referred to as "Section 111," or the "MMSEA of 2007."

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MEDICARE'S INTEREST IN YOUR SETTLEMENT ... *CONTINUED FROM PAGE 20*

when its interests are not being protected. This is particularly true in an era of spiraling medical costs and in view of the demographics of an aging workforce.

Social security and Medicare are at the forefront of the balancing act between social justice and economic reality. Personal injury litigants, insurers, third-party administrators, self-insurers, risk managers and their attorneys will all be involved in the process of resolving these competing interests for the foreseeable future. Each of these interests will be subject to the **preemptive authority** of the federal government.

If we are going to be successful in meeting these challenges, familiarity with these societal trends, knowledge of the changes in legislation as they occur and changes in the enforcement of existing laws by the executive branch will be required. The application of that knowledge in forming creative solutions to these issues, without exposing our clients to adverse consequences, should be the goal of all in the legal community. We can react to these changes or we can be proactive in developing workable solutions.

IDCA WELCOMES NEW MEMBERS

Laura R. Miller (Student)
3021 Boulder Drive
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laura.pettengill@drake.edu

Timothy M. Morrison
Locher Pavelka Dostal Braddy & Hammes, LLC
2002 Douglas Street
Omaha, NE 68102
(402) 898-7000
tmorrison@lpdbhlaw

IDCA SCHEDULE OF EVENTS

September 14, 2010
IDCA Board Meeting & Dinner
3:45 p.m. Executive Committee
4:00 p.m. – 8:00 p.m. Full Board Meeting/Dinner
West Des Moines Marriott, 1250 Jordan Creek Pkwy.,
West Des Moines, IA

September 15–16, 2010
46th Annual Meeting & Seminar
8:00 a.m. – 5:00 p.m. both days
West Des Moines Marriott, 1250 Jordan Creek Pkwy.,
West Des Moines, IA

April 1, 2011
IDCA Spring Seminar
8:00 a.m. – 5:00 p.m.
Coralville Marriott Hotel and Conference Center,
Coralville, IA

IOWA DEFENSE COUNSEL ASSOCIATION

2010 IOWA LEGISLATIVE REPORT

By Robert M. Kreamer

Robert M. Kreamer

The Iowa Democrat party in 2010 again had total control of the Iowa legislative process. The Senate was controlled by a margin of 32-18 and the House of Representatives by a 56-44 margin. These political margins, coupled with Governor Chet Culver serving his final year of a four-year term, gave the Democrat party their strongest control of the legislative process since 1965.

With this strengthened control, most of the prior legislative priorities of the Iowa Defense Counsel Association were doomed from the beginning since they had historically been opposed by organized labor and by the Iowa Trial Lawyers Association (currently operating under the name of Iowa Association for Justice), two key support groups of the Iowa Democrat party. Because of this strong history, the IDCA Board of Directors elected to abandon almost all of their prior legislative priorities and instead concentrate on defending against anticipated legislative proposals that would be initiated by organized labor and the Iowa Association for Justice. During the course of the 2009 legislative session, there were numerous bills introduced and supported by these two groups that were of grave concern and interest to your IDCA Board, including the following:

1. House File 795 – This legislation would allow an injured employee the right to select their own doctor and health care in Worker's Compensation cases. This legislation was strongly promoted by organized labor and the Iowa Association for Justice. This legislation was approved by the House Labor Committee and placed on the House Debate Calendar. There was no further action taken by the Iowa House and House File 795 was happily killed for the session by IDCA and its allies on this issue.

   We were successful again in 2010 in opposing HF 795. Because HF 795 is one of those issues that never seems to go away, it is my expectation that we will again have to face this "choice of doctor" legislation in 2011.

2. House File 758 – This bill was introduced in 2009 and provided under Iowa's wrongful-death statute, Code Section 633.336, that damages recoverable may include damages for decedent's loss of enjoyment of life, measured separate and apart from the economic productive value the decedent would have had if the decedent had lived. This legislation was the number one priority of the Iowa Association for Justice later in the 2009 session and had passed the Iowa House on a vote of 58-41 and was still under consideration by Senate leadership until the very final hours of the last session day. Because House File 758 failed to pass the Iowa Senate, it was abundantly clear that the 2010 legislative session was going to be subject to intense lobbying throughout.

   Presently only five states – Alabama, Arkansas, Georgia, Hawaii and North Carolina – allowed an estate to recover these damages for a decedent's loss of enjoyment of life. Interestingly, these five states, in a study commissioned by the United States Chamber of Commerce to evaluate the overall quality and treatment of tort and contract litigation in the 50 states, ranked Alabama 20, Arkansas 34, Georgia 28, Hawaii 45, North Carolina 21, and Iowa 7. These five states are hardly the states Iowa should want to model in adopting new tort law.

   Throughout the past two years, "Legislative Alerts" have been sent to IDCA members urging opposition to HF 758 for the following reasons:

   1. Loss of enjoyment of life is too speculative in a death case to be awarded.

   2. Loss of enjoyment of life will necessarily be based on emotion, sentiment and sympathy.

   3. HF 758 creates and entirely new category of damages never recognized nor awarded in Iowa wrongful-death cases.

      During the 2010 legislative session, "Legislative Alerts" were sent to our IDCA members to contact members of the Senate thought to be weak in their support of HF 758. These seven or eight Senators had been brought down to the Governor's private office and subjected to much pressure but, fortunately for IDCA and the people of Iowa, this tactic failed and HF 758 failed to have the necessary 26 votes.

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2010 IOWA LEGISLATIVE REPORT ...

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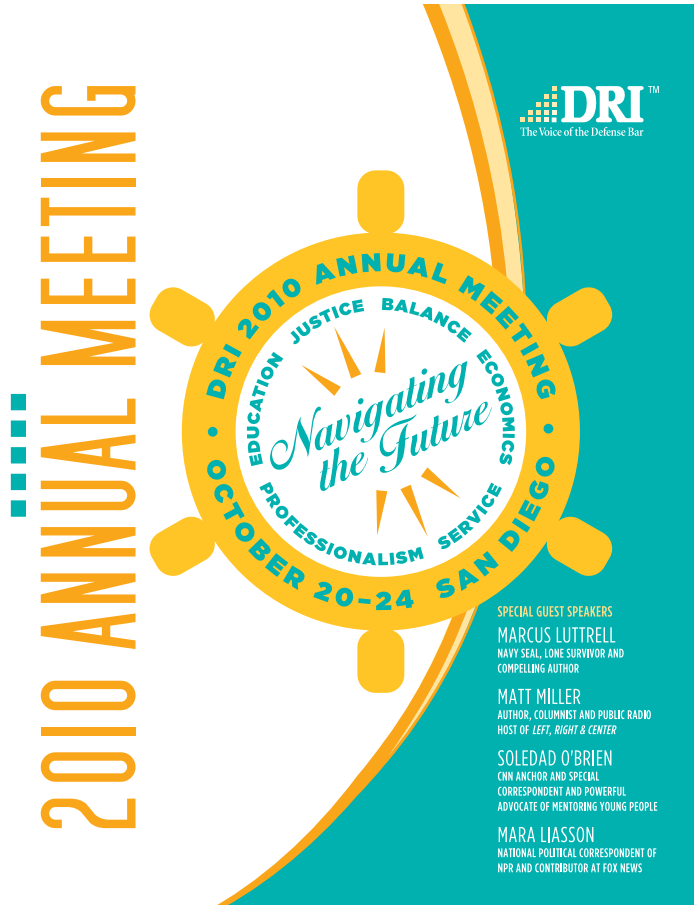
3. Senate File 321 – This legislation was initiated by the Iowa Association for Justice and they referred to it as the "Car Insurance Consumer Fairness Act of 2009". This legislation was strongly opposed by IDCA, the insurance industry and business interests. One reason for opposition was that it would require insurance companies selling UM/UIM coverage to cover injuries caused by "physical contact with or reasonable avoidance of physical contact with" another vehicle. A second reason for opposition to this legislation was that it would require those selling UM/UIM coverage to offer polices with UM/UIM limits at least equal to those of the liability (the "bodily injury or death") portion of the policy. Finally, this legislation would have allowed an injured person who paid premiums for UM/UIM coverage to sue UM/UIM insurance companies who unreasonably refuse to pay claims for benefits in good faith. The problem, however, with this legislation is that the insurer would have the burden of proving that it acted in good faith. This legislation was approved on a party-line vote by the Senate Judiciary Committee in the 2009 session but received no further attention during the balance of the 2009 session. It remained alive, however, for the 2010 session but received no further attention in 2010.

In conclusion, while the 2010 legislative session was extremely difficult, it was also highly successful. A large reason for this success was the willingness of IDCA leadership to come to the Capitol to provide expert testimony as to why the above-mentioned legislative bills were unnecessary and would make bad law for the State of Iowa. Additionally, a big thank you goes out to you, the IDCA membership, for promptly responding to the IDCA Legislative Alerts in contacting your legislator and voicing your concern over the identified legislation. Legislators generally respond favorably to constituent contacts and in 2010 your contacts helped make the difference – thank you!

Finally, a big thank you to Jim Pugh, President, and to Greg Witke, IDCA Legislative Chair, for their leadership and support throughout this past session and to you, the IDCA membership, for allowing me the opportunity to represent you on Capitol Hill – THANKS!

DEFENSE RESEARCH INSTITUTE 2010 ANNUAL MEETING



San Diego Marriott Hotel & Marina
333 West Harbor Drive San Diego, CA 92010

Wednesday, October 20, 2010 - Sunday, October 24, 2010

DOWNLOAD BROCHURE at http://www.dri.org/open/AnnualMeeting.aspx

DRI's 2010 Annual Meeting, October 20-24, in San Diego promises to be an exciting event! Featured blockbuster speakers include Marcus Luttrell, navy seal, lone survivor and compelling author; Soledad O'Brien, CNN special correspondent and powerful advocate of mentoring young people; Matt Miller, author, columnist and public radio host of Left, Right & Center; and Mara Liasson, political correspondent for NPR and contributor at Fox News Channel. Save $200 off the regular registration fees of $895 member / $995 non-member when you register by September 22. Registration Rates

Corporate Members	695.00 USD
Member	695.00 USD
Non Member	795.00 USD

Iowa Defense Counsel Association

Tuesday, September 14, 2010

4:00 – 8:00 p.m. **IDCA Board Meeting & Dinner**

8:00 – 11:00 p.m. **IDCA Hospitality Room Open**

Wednesday, September 15, 2010

7:00 a.m. – 5:00 p.m. **Registration Open**

7:00 – 7:45 a.m. **Exhibitor Set-Up**

7:00 – 8:00 a.m. **Continental Breakfast**

7:45 a.m. – 6:00 p.m. **Exhibits Open**

8:00 – 8:15 a.m. **Welcome and Opening Remarks**
James Pugh, IDCA President, and Stephen Powell, Annual Meeting & Seminar Chair

8:15 – 9:00 a.m. **Case Law Update I – Employment, Commercial, Contract, Constitutional Law, Damages, Government**
Benjamin M. Weston, Lederer Weston Craig PLC, Cedar Rapids, IA

9:00 – 10:00 a.m. **Pants on Fire: False Statements and Testimony [1.0 Ethics hours]**
Doug Richmond, Aon Global Professions Practice, Chicago, IL

10:00 – 10:15 a.m. **Legislative Update**
Robert M. Kreamer, IDCA Executive Director, Kreamer Law Office, Des Moines, IA

10:15 – 10:30 a.m. **Break & Exhibits Open**

10:30 – 10:45 a.m. **DRI Update**
Michael W. Thrall, Nyemaster, Goode, West, Hansell & O'Brien, P.C., Des Moines, IA; Harold Peterson, Mid-Region Representative

10:45 – 11:30 a.m. **Medicare Update**
Stephanie Stacy, Baylor, Evans, Curtiss, Grimit, & Witt, LLP, Lincoln , NE

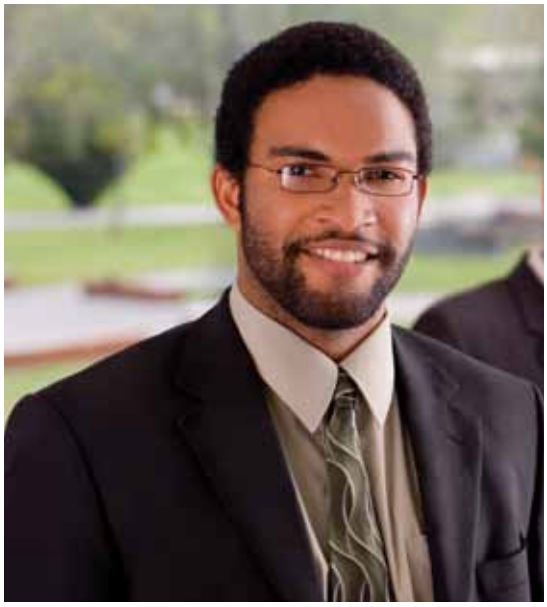
11:30 a.m. – 12:00 p.m. **Iowa Supreme Court Update**
The Honorable Marsha K. Ternus, Iowa Supreme Court, Des Moines, IA

12:00 – 1:00 p.m. **Luncheon & Awards**
Exhibits Open

1:00 – 3:00 p.m. **Making Your Case at Trial with a Better Memory**
Paul Mellor, Success Links, Richmond, VA

3:00 – 3:15 p.m. **Break & Exhibits Open**

3:15 – 5:00 p.m. **Making Your Case at Trial with a Better Memory, continued**



Keynote Speaker: Paul Mellor

Paul Mellor is President of Success Links, a memory training company dedicated to helping people improve their lives by improving their memory power.

A finalist in the 2008 USA Memory Championship, Paul offers valuable systems and solutions on how to strengthen memory.

He has presented his popular seminars to car dealers and court reporters; sheriffs and salespeople; furniture reps and fitness instructors; hospital staffs and home builders; politicians and postal workers; lawyers and lay people.

Paul's skills have benefited business professionals, senior citizens and school children. Paul has written extensively on memory improvement, conducts seminars throughout the nation and believes that everyone can build their brain power.

Deadline to Register: September 3, 2010

46th Annual Meeting & Seminar

5:00 – 6:00 p.m. **IDCA Reception with Exhibitors**
Network with exhibitors and colleagues during the IDCA Reception. This reception is open to all registered attendees at no additional cost.
(West Des Moines Marriott)

5:30 – 7:30 p.m. **IDCA Action Stations and Networking**
Continue networking and enjoy dinner during this ticketed function.
(West Des Moines Marriott)

7:30 p.m. **IDCA Hospitality Room Open**

Thursday, September 16, 2010

7:00 a.m. – 5:00 p.m. **Registration Open**

7:00 a.m. – 3:15 p.m. **Exhibits Open**

7:00 – 8:00 a.m. **Continental Breakfast**

8:00 – 8:45 a.m. **Case Law Update II - Negligence and Torts**
Tony James, Bradshaw Law Firm,
Des Moines, IA

8:45 – 10:00 a.m. **Capturing the Facts, Preservation of Facts and Evidence for Investigations**
Tom Long, Packer Engineering, Naperville, IL

10:00 – 10:15 a.m. **Break & Exhibits Open**

10:15 – 11:00 a.m. **Jury Selection**
Jennifer Rinden, Shuttleworth & Ingersoll, P.L.C.,
Cedar Rapids, IA

11:00 a.m. – 12:00 p.m. **A View from the Iowa Court of Appeals**
The Honorable Larry Eisenhauer,
Iowa Court of Appeals, Des Moines, IA

12:15 – 1:30 p.m. **Luncheon & Annual Meeting**
Exhibits Open

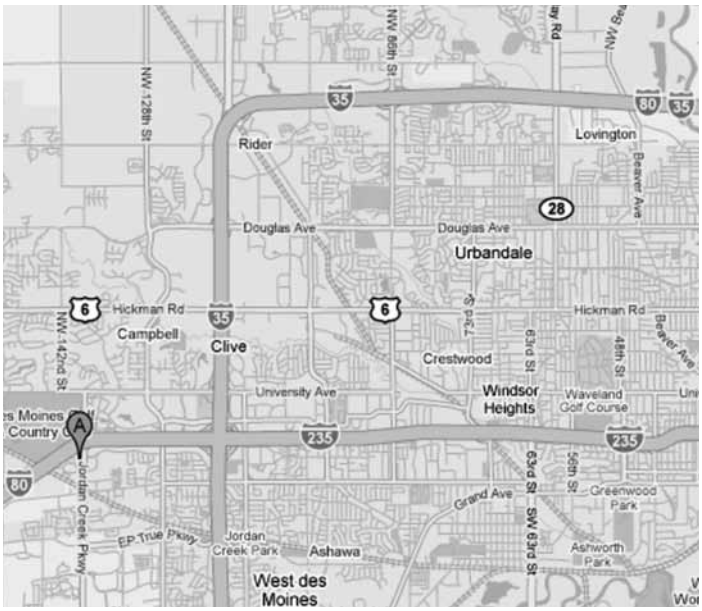
1:30 – 3:00 p.m. **An Insider's View of Witness Preparation**
LaVerne Morris, MPS, TrialGraphix, Chicago, IL,

3:00 – 3:15 p.m. **Break & Exhibits Open**

3:15 – 4:00 p.m. **What the Mediator Knows that You Should Know**
Peter Gartelos, Gartelos Wagner & Ament,
Waterloo, IA

4:15 – 5:00 p.m. **Case Law Update III – Civil Procedure, Juries & Trial, Insurance, Judgment & Limitation of Actions**
Kami Holmes, Swisher & Cohrt, P.L.C.,
Waterloo, IA

5:00 p.m. **Adjourn**



Hotel Information:

West Des Moines Marriott
1250 Jordan Creek Parkway
West Des Moines, Iowa
Phone: (515) 267-1500
Toll-Free: (800) 228-9290

Reservations:

A block of rooms has been reserved for September 14 – 15, 2010. Please call the West Des Moines Marriott hotel directly to book your reservations. Be sure to mention the Iowa Defense Counsel Association when you make your reservation to receive the group room rate.

To be guaranteed the IDCA room block rate, please make your reservations by August 31, 2010. Reservations made after August 31 cannot be guaranteed the room block rate.

http://www.marriott.com/hotels/travel/dsmwd-west-des-moines-marriott/

Room Rate:

$109.00 plus tax (Single/Double/Triple/Quad)
Check In: 3:00 p.m.
Check Out: 12:00 p.m.

Parking:

Parking at the hotel is complimentary.

Registering for the Annual Meeting & Seminar:

Registrations may be faxed to IDCA at (515) 243-2049 or mailed to: IDCA, 100 East Grand Ave., Suite 330, Des Moines, Iowa 50309. Call IDCA Headquarters at (515) 244-2847 or email to staff@iowadefensecounsel.org for more information.

Speaker outlines will be provided on CD only. Outlines will be emailed as a PDF file the week prior to the Annual Meeting & Seminar. Attendees may print and bring outlines to the Annual Meeting & Seminar. Printed materials will not be available.

Annual Meeting & Seminar Cancellation/Refund Policy:

- If written cancellation is received by September 3, 2010, a full refund will be received.
- No refunds for cancellations after September 3, 2010. Seminar materials will be mailed to registrant.
- No refund for No-Shows. Seminar materials will be mailed to registrant.

Approved for 12.0 Federal CLE File# 10-158 • Approved for 13.5 State Credit Hours CLE State ID# 70816 (Includes 1.0 Ethics Hours)

Iowa Defense Counsel Association 46th Annual Meeting & Seminar

ATTENDEE REGISTRATION West Des Moines Marriott • 1250 Jordan Creek Parkway • West Des Moines, IA

September 15–16, 2010

Name: _____

Badge Name: _____

Company/Firm: _____

Mailing Address: _____

City, State Zip: _____

Telephone: _____

Fax: _____

Email: _____

Spouse/Guest Badge Name (Wednesday Reception/Dinner Only): _____

_____

Special Needs Requests (vegetarian meals, wheel chair access, etc.): _____

_____

Please select the pricing option to assist us with an accurate count.

Registration Fees: (Circle one)

Includes Meals*:	IDCA Member $375	Non-Member $475	_____
No Meals:	IDCA Member $275	Non-Member $375	_____

Young Lawyer Rate (Admitted to practice less than 2 years)

Includes Meals*:	IDCA Member $275	Non-Member $375	_____
No Meals:	IDCA Member $175	Non-Member $275	_____

Seminar Materials Only

	IDCA Member $75	Non-Member $125 _____

TOTAL $ _____

***Meals include:** *Wednesday Continental Breakfast, Wednesday Noon Luncheon, Wednesday Night Dinner, Thursday Continental Breakfast, Thursday Noon Luncheon, and all morning/afternoon breaks on both days. All registrations include the Wednesday night reception with exhibitors.*

Payment Information: (Deadline to Register: September 3, 2010)

❑ Enclosed please find a check made out to Iowa Defense Counsel Association (IDCA) for $_____

❑ Credit card payment: ❍ MasterCard ❍ Visa

Account #: _____ Exp. Date: _____ CVV Code: _____ Billing Zip Code _____

Name on Card: _____ Signature: _____

Approved for 12.0 Federal CLE File# 10-158
Approved for 13.5 State Credit Hours CLE State ID# 70816
(Includes 1.0 Ethics Hours)

IOWA DEFENSE COUNSEL ASSOCIATION

Return to:

Iowa Defense Counsel Association
100 East Grand Avenue, Suite 330
Des Moines, IA 50309
Phone: (515) 244-2847 • Fax: (515) 243-2049
E-mail: staff@iowadefensecounsel.org
Website: www.iowadefensecounsel.org

Deadline to Register: September 3, 2010