defense UPDATE

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MEDICARE'S NEW RULES FOR 2010

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The federal government is currently in the process of implementing a new system designed to ensure that its Medicare program is not paying for medical treatment that should be covered by private parties. The new program is targeting insurers (group health, liability, no-fault, and workers compensation) by requiring a reporting of claims handled and resolved when the claim involves a Medicare beneficiary. The consequences of failing to comply with the new program are severe, including a doubling of damages and $1,000 per day penalties. This article provides an overview of information civil litigators must be familiar with when handling claims involving medical treatment.

Medicare's New Program Rollout

An implementation timeline has been issued setting the periods during which insurers must take action to comply with Medicare's new program. There are separate timelines for group health versus liability/no-fault/workers compensation insurers. As for liability/no-fault/workers compensation insurers, the subject of this article, electronic registration for the new program was to be completed by September 30, 2009.

A testing period for the submission of insurers' "claim input files" to Medicare began January 1, 2010 and will continue through March 31, 2010. On April 1, 2010, some insurers will begin submitting "claim input files" to meet their reporting obligations. The program will be rolled out by Medicare on a predetermined schedule with all liability, no-fault, and workers compensation reporters submitting "claim input files" by July 1, 2010. Defense counsel handling claims involving medical expenses will need to be aware of Medicare's new rules in order to properly advise their insurer clients.

Background on Medicare

Medicare is a widely-known federal program that provides health care payments covering (1) persons over 65 years of age, (2) persons under 65 years of age with a qualifying disability, and (3) persons with end stage renal disease. *Medicare General Information, Eligibility, and Entitlement Manual*, Ch.1, § 10. At its inception in 1965, Medicare was created to be the "primary payer" of medical expenses for beneficiaries, meaning it paid before other potentially responsible parties. *Id.* The notable exception was workers' compensation cases where Medicare was a "secondary payer". *Id.* As such, Medicare would typically be responsible for beneficiaries' medical expenses, unless the benefits are owed due to a workplace injury in which case the employer or its insurance carrier would be primarily responsible for payment. This arrangement, while virtually guaranteeing beneficiaries' medical expenses would be paid in most situations, has left Medicare paying expenses that may have been the responsibility of other parties such as tortfeasors and their insurance plans.

Medicare's responsibilities were amended by Congress and President Jimmy Carter in 1980. Changes came in the form of the "*Omnibus Reconciliation Act*". Pub. L. No. 96-499. Specifically, Section 953 expanded the situations where Medicare was deemed a "secondary payer" beyond simply workers' compensation cases. *Id.* From that point forward Medicare was also a "secondary payer" to other insurance plans including automobile, liability, and no-fault plans. *Id.* Since 1980, additional refinements have been made to provide fur-

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ther means by which Medicare can avoid or recoup financial commitments. Since the inception of Medicare federal law has been expanded to make Medicare a "secondary payer" to essentially all potentially responsible private payment sources. Indeed, a conscious effort has been made to shift costs from the Medicare program to private sources of payment. *Medicare Secondary Payer Manual*, § 10.

Need for change

Efforts to curtail Medicare's fiscal responsibilities have been thought necessary to maintain its ongoing viability. Medical expenses have seen dramatic annual increases, and the population of potential Medicare beneficiaries has grown. These trends, individually and collectively, foretell substantial difficulties for Medicare in adequately funding its legal obligations to beneficiaries. The Social Security and Medicare Board of Trustees has publicly indicated that Medicare's fiscal status is challenging. *www.ssa.gov/OACT/TRSUM/index.html*. The Board has stated that long term program costs are not sustainable under current program parameters. *Id*. The Medicare trust fund has already begun using trust assets to cover liabilities, and projects growing annual deficits that will exhaust reserves by 2017. *Id*. It is, therefore, not surprising that Medicare, in evaluating its options, would look to its well-established "secondary payer" legal status as a means to narrow this ever-widening gap between its funding and financial commitments.

New legislation

Recent legislation and regulatory guidance provide Medicare with tools to recoup funds from settlements or monetary awards made within the context of civil litigation. Of course, the law has long held Medicare a "secondary payer" which should allow it to avoid the payment of expenses rightfully charged to others. However, in practice, Medicare has often lacked the information necessary to identify circumstances where its "secondary payer" status may efficiently be invoked. Instead, Medicare would often end up paying medical expenses without knowing of a private insurance plan's potential liability or the plan's eventual settlement or monetary award payment(s) to a Medicare beneficiary.

On December 29, 2007, the *Medicare, Medicaid and State Children's Health Insurance Program Extension Act of 2007* (MMSEA) was signed by President George W. Bush. Pub. L. No. 110-173 (codified at 42 U.S.C. 1395y(b)(7) - (8)(2008). The MMSEA amended the Medicare Secondary Payer Act to include mandatory provisions for the reporting of claims and settlements involving Medicare beneficiaries. Under MMSEA, civil litigants will now be statutorily required to affirmatively notify Medicare of settlement agreements and commitments to provide medical treatment when involving Medicare beneficiaries. The purpose is to provide Medicare with the tools to enforce its rights as a "secondary payer" in recouping monies previously spent and providing Medicare with protection against future medical expenses.

Who is affected?

Medicare is a "secondary payer" to employer-based group health insurance plans as well as liability insurance (including self-insurance), no-fault insurance, and workers compensation insurance plans. This article focuses upon Medicare's interaction with liability and no-fault insurance plans.

What insurance plans are covered by the Medicare "Secondary Payer Act"? The federal government defines "liability insurance" as:

> Insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

42 C.F.R. § Part 411.50.

> No-fault insurance has been defined as:
>
> Insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage", "personal injury protection", or "medical expense coverage".

Id.

If you represent, or are involved in litigation with any of these entities, then you will need to be conscious of potential Medicare issues as they must be considered before and during settlement negotiations, at the payment of a monetary award or settlement, or at the time that any commitments are made to pay medical expenses. Parties refusing, or otherwise failing to properly consider Medicare's interests when handling claims, run the risk that Medicare later seeks recoupment or protection for or against past and future Medicare-covered medical expenses.

The consequences for failing to account for Medicare's interests could be severe. When Medicare is required to pursue its interests it may become entitled to a doubling of damages and the imposition of significant penalties and interest. 42 U.S.C. § 1395y(b)(2)(B)(iii). In short, there are compelling reasons to be proactive in assessing potential Medicare interests.

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How to determine whether a person is a Medicare beneficiary?

Insurers handling claims will first need to determine if the claimant/plaintiff making the claim is a Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) beneficiary. This article addresses only Medicare beneficiary claims. Medicare beneficiaries can be identified on a preliminary basis by looking at their age (over 65 years old), whether they have been approved for Social Security Disability benefits, or whether they have been off work for an extended time. Claim handlers would be wise to review the Medicare status of claimants / plaintiffs at the outset and periodically while handling claims with an eye towards these factors. When in litigation, as a matter of practice, legal counsel will want to propound discovery, and require timely supplementation, directed towards ascertaining a claimant's current and anticipated Medicare status.

The Centers for Medicare and Medicaid Services ("CMS") has developed a "Query System" which allows insurance carriers to perform a search that will show whether a person is a Medicare beneficiary. *MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers Compensation User Guide ("User Guide")*, § 13. To perform the search, the insurer will want to obtain the following information from the claimant/plaintiff: Health Insurance Claim Number (HICN), Social Security Number (SSN), first and last name, date of birth, and gender. *Id.*

It is important to remember that while insurers will want to determine whether a claimant / plaintiff is a Medicare beneficiary at the outset of the claim the insurer has an ongoing responsibility to remain cognizant of Medicare issues as the case progresses. As such, insurers should continue to monitor the person's status until the claim is finally resolved and not simply rely upon a preliminary search at the outset of the case. In this regard, it would be wise to enter periodic reminders at the case outset to re-check a claimant's status as a matter of course. Under certain circumstances, the insurer will need to continue assessing and re-assessing a claimant's status even after resolution when there is an ongoing responsibility for medical expense.

When must a claim be reported?

Once it has been determined that a person is a Medicare beneficiary, the question becomes when the insurer must affirmatively report the required information to Medicare. The answer is once "the claim is resolved through a settlement, judgment, award, or other payment." 42 U.S.C. 1395y(b)(8)(C). It does not matter whether or not the parties have entered into any stipulations or agreements regarding disputed liability issues. *Id.* The controlling statute is concerned only with whether or not a payment has been made. *Id.*

Typically, in the liability context, the event which initiates the required report to Medicare will be issuance of a single settlement or award payment. Once done, a report must be made. Claims are reported electronically. *User Guide*, § 3. Insurers electronically report claims on a quarterly basis. As a result, claims are reported within 90 days after the triggering event. *User Guide*, § 8.2. Generally, if a claim proceeds to trial with the claimant/plaintiff receiving an award that is appealed, then the insurer does not need to report the claim to Medicare until resolution of appeals provided the insurer does not otherwise make voluntary payment or accept responsibility for medical expenses during the pendency of the appeal. *User Guide*, § 11.10.2.

Medicare reporting is also required when a party assumes ongoing responsibility for medical payments. *User Guide*, § 11.8. "The trigger for reporting ORM (ongoing responsibility for medical) is the assumption of ORM by the RRE [responsible reporting entity] – when the RRE has made a determination to assume responsibility for ORM, or is otherwise required to assume ORM, – not when or after the first payment for medicals under ORM has actually been made. Medical payments do not actually have to be paid on the claim for ORM reporting to be required." *Id.* Reporting is required both when the ongoing responsibility for medical payments is assumed as well as when it is terminated. *Id.* This circumstance will likely be most prevalent in workers' compensation or no-fault claims. It is important to recognize that payment of medical expenses, even while investigating a claim, will require that an insurer report the claim to Medicare. *Id.*

What needs to be reported?

Should the insurer determine the claimant/plaintiff is a covered beneficiary and the time has come to report the claim to Medicare, then the insurer will need to gather certain information regarding the individual. By statute, the information which must be reported to Medicare includes "the identity of the claimant" and other information necessary to make "an appropriate determination concerning coordination of benefits, including any applicable recovery claim." 42 U.S.C. 1395y(b)(8)(B)(i)-(ii). The agency has been given authority to specify the particular types of information called for under the statute.

CMS has issued User Guides applicable to group health and non-group health (e.g., liability and no-fault insurance) plan reporters that provide additional detail as to the types of information that must be provided to Medicare. The User Guides are available on the CMS website. Generally, the reported information will need to include such subjects as: The claimant/plaintiff's name, address, date of birth, SSN, HICN; the insurer's name, address, policy type, tax identification number, policy number; the insured's name; the date,

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nature, and cause of injury or incident; and the settlement date and amount. *User Guide*, § 11.2.2.

What is the penalty for failure to report?

Congress has given Medicare a significant tool in seeking compliance with the MMSEA reporting rules. Section 111 requires that parties affirmatively provide Medicare with information that will allow it to determine whether its "secondary payer" status is applicable. Parties will also need to indicate what types and amounts of payment obligations are being assumed. Should parties fail in their duty to properly report, there is a severe statutory penalty. Insurers that fail to comply will be "subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant". 42 U.S.C. § 1395y(b)(8)(E). This penalty provision applies separate from other potential consequences of delayed payment, such as the doubling of damages and interest.

Insurers cannot afford to let claims fall through the cracks as the statutory penalties will quickly accrue into sizable amounts. The effects may become compounded by delayed reporting given the limited opportunity to report only on a quarterly basis. Indeed, the 90-day delay of a single claim would accrue a $90,000 penalty. It remains to be seen how aggressively Medicare may pursue penalties against insurers thought to be less than fully compliant.

What can Medicare recover?

Medicare's legal obligation is to pay certain medical expenses on behalf of beneficiaries. In a typical insurance claim involving a person's physical or mental injury, a claimant/plaintiff has incurred medical expenses and/or may be anticipating future medical expenses. Under these circumstances, Medicare would be interested in recouping monies spent for past medical expenses and protecting itself against paying future medical expenses that may be incurred.

Medicare's interests in past medical expenses involve recouping amounts spent on behalf of beneficiaries that were the responsibility of another party, the "primary payer". While Medicare is statutorily prohibited from paying expenses that are the responsibility of a "primary payer," it may make "conditional payments" when payment is not expected to be made by the "primary payer" in a timely manner. 42 U.S.C. § 1395y(b)(2)(B)(i). Medicare then has a "right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment". 42 C.F.R. § 411.24(g). Medicare's ability to seek and obtain judgment against plaintiff's counsel, directly, for reimbursement of funds, has been recognized by at least one federal district court. *See*, *United States v. Harris*, 2009 WL 891931 (N.D. W. Va. March 26, 2009). Even if the insurer has already reimbursed the beneficiary or another party for the Medicare-covered expense, Medicare may still pursue its claim for reimbursement from the insurer when Medicare has not received its reimbursement. 42 U.S.C. § 1395y(b)(2)(B)(ii)-(iii); 42 C.F.R. § 411.24(i)(1). If Medicare is required to bring suit to recover amounts paid as "conditional payments," and is successful, Medicare is entitled to recover double damages plus interest. 42 U.S.C. § 1395y(b)(2)(B)(ii)-(iii). It should also be noted that beneficiaries have a private right of action and therefore may bring their own claims against a "primary payer," which likewise carry the potential for a doubling of the recovery. 42 U.S.C. § 1395y(b)(3)(A).

Medicare is also interested in ensuring that it does not become responsible for future medical expenses that should be covered by a "primary payer." The federal government has not yet explained how it would prefer private parties account for Medicare's interest in protecting against future medical expenses. This interest has, however, been addressed in the workers' compensation setting. In workers' compensation, Medicare has established a program whereby private litigants may enter into Medicare set-aside agreements ("MSA"). The MSA expressly sets aside funds to be used in providing for the beneficiary's future medical care needs relating to the alleged workplace injury. Under circumstances specified within a series of internal memorandums issued and distributed by CMS, the parties will submit a proposed MSA to Medicare for its approval. Submissions are made before or after the parties have agreed to a settlement (hopefully with an agreement as to which party bears the risk of a rejected submission). Medicare may respond to requests by approving the requested MSA or denying the request and indicating the MSA changes that need be made (often involving increased funding of the MSA) to adequately account for Medicare's interests. There is much that goes into properly preparing an MSA for Medicare approval.

Medicare has not yet proposed a system for the handling of future medical expense issues in non-workers' compensation claims. So, while the workers' compensation program is informative, it remains to be seen how Medicare would like parties to account for Medicare's interest in protecting against future medical expenses. In the meantime, parties and their counsel will need to consider the options and attendant risks in considering Medicare's interests in future medical expenses.

Practice Pointers for Defense Counsel

- Upon receipt of claims involving medical expenses gather information to determine whether the claimant is a Medicare beneficiary.
- Use Medicare's "query system" to determine whether a claimant is a Medicare beneficiary.
- Propound and pursue discovery addressed at determining claimants' Medicare status.

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- Docket internal reminders to periodically re-check Medicare status of claimants.
- To prepare for settlement discussions, including any commitments to assume the responsibility for any past or future medical expenses, request a list of "conditional payments" from Medicare.
- Consider how to resolve any Medicare "conditional payments" during settlement negotiations including addressing medical causation issues, settlement structure, settlement check payees, indemnification agreements, etc.
- during settlement negotiations and within settlement documents.
- Consider the need for a Medicare Set-Aside, and its contemplated funding and administration, during settlement negotiations as a way to account for Medicare's interests.

IDCA SCHEDULE OF EVENTS

April 9, 2010
IDCA Board Meeting & Lunch

12:00 p.m.

Marriott Coralville Hotel & Conference Center

300 East 9th Street, Coralville, IA

April 9, 2010
IDCA Spring CLE Seminar

8:30 a.m. – 4:30 p.m.

Marriott Coralville Hotel & Conference Center

300 East 9th Street, Coralville, IA

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

IMPORTANT IOWA CASE ON SUBSEQUENT REMEDIAL MEASURES

by Kevin M. Reynolds, Whitfield & Eddy, PLC, Des Moines, IA

Kevin M. Reynolds

On October 23, 2009, the Iowa Supreme Court decided an important case with respect to the inadmissibility of subsequent remedial measures under Iowa Rule of Evidence 5.407. *Scott v. Dutton-Lainson Company,* 774 N.W.2d 501 (Iowa 2009). In *Scott*, the Court made an important clarification regarding Rule 5.407 in light of *Wright v. Brooke Group Ltd.*, 652 N.W.2d 159 (Iowa 2002), which had done away with the "strict liability" nomenclature. Iowa R. Evid. 5.407 uses the terms "strict liability" and there was a question about how that rule should be applied after *Wright*. *Scott* is important to products liability cases, but also has ramifications outside of the products liability context. *Scott's* rule applies to virtually any tort case where negligence is one of the theories of recovery, and the alleged tortfeasor has taken actions after the event which could have made the accident less likely to occur.

In *Scott*, plaintiff suffered an injury to his foot when the jack on a boat trailer collapsed. Scott sued the manufacturer of the jack, Dutton-Lainson Company, based on "defects in [the jack's] design and manufacturing and the negligence of the defendant." Slip opin. p. 2. After the accident, the manufacturer modified the tooling for the jack pin, which allowed the pin to move into the pin hole further. This would prevent the pin from coming out and allowing the jack to collapse. In addition, one of the manufacturer's employees admitted in deposition that the manufacturer had modified the design of the jack pin as a result of Scott's accident.

Before trial, the manufacturer filed a motion *in limine* seeking to exclude evidence of these subsequent remedial measures under Iowa Rule of Evidence 5.407. The trial court sustained the motion and excluded the evidence. The case was submitted to the jury on theories of design defect and failure to warn. The jury returned a defense verdict. Scott appealed, arguing that the trial court had erred in excluding evidence of subsequent remedial measures. The case was initially transferred to the court of appeals, which held that the evidence was admissible and reversed the district court. On further review, the Iowa Supreme Court reversed, reinstated the trial court's ruling, and the jury's defense verdict was affirmed.

The Court initially noted that the case presented a "mixed" standard of review. On the one hand, "claims of errors in admission of evidence is for an abuse of discretion," *see State v. Stone*, 764 N.W.2d 545, 548 (Iowa 2009), but to the extent an evidentiary ruling "implicates the interpretation of a rule of evidence, our review is for errors at law." *State v. Jordan*, 663 N.W.2d 877, 879 (Iowa 2003). Practice pointer: if you are an appellee and seeking affirmance of the trial court, couch the applicable standard of review as "an abuse of discretion." A trial court has broad discretion, especially with regard to evidentiary questions. On the other hand, if you are the appellant and seeking a reversal, posit the standard of review as "review for errors at law," or argue that an abuse of discretion occurred through the application of an erroneous legal standard.

The issue in *Scott* arose because the terms "strict liability" had been abandoned in *Wright*, yet Iowa Rule of Evidence 5.407 continued to use those terms:

> Rule 5.407. Subsequent remedial measures
>
> When, after an event, measures are taken which, if taken previously, would have made the event less likely to occur, evidence of the subsequent measures is not admissible to prove negligence or culpable conduct in connection with the event. This rule does not require the exclusion of evidence of subsequent measures when offered in connection with a claim based on *strict liability in tort* or breach of warranty or for another purpose, such as proving ownership, control, or feasibility of precautionary measures, if controverted, or impeachment.
>
> (emphasis added).

How could *Wright's* holding be squared with the language of Rule 5.407 in a "strict liability" case involving the evidentiary admissibility of subsequent remedial measures?

In a well reasoned opinion, Justice Streit determined this issue based on the nature of the underlying claims being made. In *Scott*, plaintiff was suing for defective design and defective failure to warn. *Wright* delineates the "tests" for each of these claims, which are set forth in "black letter law" fashion in the Restatement (Third) of Torts, Sections 2(b) and 2(c), respectively. "Defective design" is defined as follows:

> [A product] is defective in design when the foreseeable risks of harm posed by the product could have been reduced or avoided by the adoption of a reasonably alternative design by the seller or other distributor, or a predecessor in the commercial chain of distribution, and the omission of the alternative design renders the product not reasonably safe.

Restatement (Third) of Torts, Products Liability, § 2(b), at 14.

In adopting this test, the Court in *Wright* noted that "negligence principles are more suitable" for design defect and failure to warn claims." 652 N.W.2d at 168. Since subsequent remedial measures are not admissible in an action based on negligence, Justice Streit

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reasoned that such evidence should not be admissible in a product liability case stating claims for design defect or failure to warn.

With regard to a failure to warn or instruct claim, after *Wright*, Section 2(c) of the Restatement (Third) provides the relevant test:

> [A product] is defective because of inadequate instructions or warnings when the foreseeable risks of harm posed by the product could have been reduced or avoided by the provision of reasonable instructions or warnings by the seller or other distributor, or predecessor in the commercial chain of distribution, and the omission of the instructions or warnings renders the product not reasonably safe.

In further support of its analysis, the Court in *Scott* also noted that in a decision handed down several years before *Wright,* it had held that failure to warn claims in Iowa cannot be brought under a theory of strict liability, and are based on a negligence standard, only. *Olson v. Prosoco, Inc.*, 522 N.W.2d 284, 289 (Iowa 1994). Again, since the test of liability for failure to warn is, in essence, a "reasonableness" test akin to a negligence claim, any products liability case asserting a claim based on failure to warn should not admit evidence of subsequent remedial measures.

Scott did not directly involve a products claim based on manufacturing defect. However, the Court in Scott provided litigants with guidance on this type of claim as well. In *Wright* the Court adopted Section 1 of the Restatement (Third), which sets forth the test governing claims of manufacturing defect: [A product is defective when it] contains a manufacturing defect when the product departs from its intended design even though all possible care was exercised in the preparation and marketing of the product. *Wright,* 652 N.W.2d at 168.

In *Scott* the Court noted that it had previously recognized that "strict liability is appropriate in manufacturing defect cases, but negligence principles are more suitable for other defective product cases." *Wright,* 652 N.W.2d at 168. To conclude, after *Scott*, the reference to "strict liability" in Iowa R. Evid. 5.407 is applicable to a manufacturing defect claim, only.

Iowa R. Evid. 5.407 also contains an exception for breach of implied warranty of merchantability claims. How should this be interpreted? Although *Scott* did not involve such a claim, the Court offers guidance on this question as well:

> Rule 5.407 refers to breach of warranty claims as it does strict liability claims and therefore does not require exclusion of evidence of subsequent remedial measures. *Wright* held, however, that a claim for breach of implied warranty under Iowa Code section 554.2314(2)(c) "requires proof of a product defect as defined in Products Restatement section 2." *Wright*, 652 N.W.2d at 181-82. Therefore, a breach of warranty claim will require proof of the standard for either a manufacturing defect, a design defect, or a failure to warn. Application of rule 5.407 to breach of warranty claims must be determined based on which of the three tests the plaintiff chooses to proceed under.

774 N.W.2d at 505, fn. 2.

As a result, if the claim underlying the breach of implied warranty is for manufacturing defect, then Rule 5.407 will not apply to exclude evidence of a subsequent remedial measure. If, on the other hand, the claims underlying the asserted breach of warranty are for defective design or failure to warn, subsequent remedial measures would be excludable under Rule 5.407.

On pages 505 and 506 of the opinion the Court chronicles the history of both state and federal evidentiary rules regarding subsequent remedial measures. *Scott* 774 N.W.2d at 505, 506. The Iowa rule, first adopted in 1983, has always included an exception for "claims based on strict liability or breach of implied warranty." In federal courts initially there was a split of authority in the circuits, as to whether the inadmissibility of subsequent remedial measures applied to a products liability claim. *See Grenada Steel Indus., Inc. v. Alabama Oxygen Co.,* 695 F.2d 883, 886-88 (5th Cir. 1983)(citing cases). With mass-produced products in the field, some courts felt that the policy basis underlying the rule (*i.e.*, that a defendant would resist making changes after an accident, for fear that it would come back to "haunt" them as an "admission of fault" in the particular lawsuit) would not apply where, if changes were not made, a defendant-manufacturer could be subject to massive liability in subsequent actions. Notably, in 1997 Federal Rule of Evidence 407 was amended to prevent the admissibility of subsequent remedial measures in all products liability cases, including those based on strict liability. The Iowa rule (which was originally modeled after the federal rule) has not been amended to remain consistent with the language of the federal rule. Currently, subsequent remedial measures are inadmissible in any product liability case in federal court, including those which use a "strict liability" test (*i.e.*, for manufacturing defect), unless an exception applies[1]. After *Scott*, it is clear that Iowa Rule of Evidence 5.407 only permits evidence of subsequent remedial measures in a products liability case involving a manufacturing defect. This type of claim is believed to be relatively rare, as most products cases seem to pursue defective design or failure to warn or instruct claims.

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[1] This difference could be a reason for a defendant to remove a products case to federal court, if federal court jurisdiction (typically under diversity of citizenship) is available.

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CLAIM (whether based on strict liability or breach of implied warranty)	TEST	ARE SUBSEQUENT REMEDIAL MEASURES ADMISSIBLE?
Defective manufacture	"strict liability"[2]	Yes
Defective design	negligence[3]	No
Failure to warn or instruct	negligence[4]	No

After *Scott*, the following rules apply:

The outmoded "strict liability" terminology appears elsewhere in Iowa's jurisprudence. For example, Iowa Code § 613.18 provides as follows:

> 613.18. Limitation on products liability of non-manufacturers.
>
> 1. A person who is not the assembler, designer, or manufacturer, and who wholesales, retails, distributes, or otherwise sells a product is:
>
> a. Immune from suit based upon *strict liability in tort* or breach of implied warranty of merchantability which arises solely from an alleged defect in the original design or manufacture of the product.
>
> b. Not liable for damages based upon *strict liability in Tort* or breach of warranty of merchantability for the product upon proof that the manufacturer is subject to the jurisdiction of the courts of this state and has not been judicially declared insolvent.
>
> 2. A person who is a retailer of a product and who assembles a product, such assembly having no causal relationship to the injury from which the claim arises, is not liable for damages based upon *strict liability in tort* or breach of implied warranty of merchantability which arises from an alleged defect in the original design or manufacture of the product upon proof that the manufacturer is subject to the jurisdiction of the courts of this state and has not been judicially declared insolvent.
>
> (emphasis added)

How should Section 613.18 be applied after *Wright*? Although not directly on point, *Scott* provides some guidance as to how the Court might decide the issue in an appropriate case.

After *Scott* a principled argument could be made that any reference to "strict liability" in Iowa law should be interpreted to mean a claim for manufacturing defect, only. This is because the test for a manufacturing defect under the Restatement (Third), § 2(a), as adopted by *Wright*, is akin to true "strict liability." In a manufacturing defect case, a manufacturer's due care is not relevant, nor is it a defense to the action. This aspect is the basis for the phrase "liability without fault" that can oftentimes be misleading, especially when applied to design defect or failure to warn claims. Yet, this approach does not completely fit with the language of Section 613.18 Code of Iowa (2009). That statute refers to a claim "based upon strict liability in tort or breach of implied warranty of merchantability which arises solely from an alleged defect in the original *design or manufacture* of the product." Clearly, § 613.18 refers to both *strict liability in tort* and *design* as if they are inseparable. But after *Wright*, there is no such thing as "strict liability design defect." Instead, there is one claim for defective design, that claim is governed by Section 2(b) of the Restatement (Third) of Torts, Products Liability, and the test utilized is, in essence, a negligence or "reasonableness" test.

Instead, one should look at the public policy basis underlying the statute in order to determine how it should be applied. §613.18 was designed to immunize a retailer, wholesaler, or distributor from liability based on mere *vicarious liability* for *either* a *design or manufacturing* defect, unless an exception applies. The exception is that the court cannot obtain jurisdiction over the manufacturer, or the manufacturer has been judicially declared insolvent. The same interpretation could be used for § 1(b) of 613.18. On the other hand, if a retailer, wholesaler or distributor is *negligent* in some manner, independent of any action of the manufacturer, and that negligence is a proximate cause of an accident or injury, then § 613.18 would *not* provide immunity for those actions.

§ 613.18 is clearly aimed at negating mere vicarious liability for defective design or manufacture on the part of pass-through sellers in products liability cases. This interpretation preserves the protec-

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[2] Restatement (Third) of Torts, Products Liability, Section 2(a).
[3] Restatement (Third) of Torts, Products Liability, Section 2(b).
[4] Restatement (Third) of Torts, Products Liability, Section 2(c).

IMPORTANT IOWA CASE ON SUBSEQUENT REMEDIAL MEASURES ... *CONTINUED FROM PAGE 8*

tions available to non-manufacturers in products liability cases. It is also consistent with Iowa's comparative fault scheme, in that parties whose actual conduct causes an accident should be held liable in proportion to the degree of *their* fault.

Subsection 2 of 613.18 could be applied in the same way. This section is designed to eliminate mere *vicarious liability* on the part of a product seller who is also an *assembler* (but not a manufacturer), so long as the manufacturer is before the court and is solvent, *and so long as the assembler's actions or conduct did not cause the accident*. Of course, if the seller (*e.g.*, a retailer, such as K-Mart) is an assembler, and puts together a bicycle, does so in a negligent fashion, and this "negligent assembly" is a proximate cause of an accident where the bicycle falls apart and injures a consumer, then the product seller (in this instance, K-Mart) *is* liable and the statute provides no defense. But in this case the retailer is not merely "vicariously" liable for the product liability tort of the manufacturer.

The other aspect of Iowa law where the terms "strict liability" appear is in the Comparative Fault Act. Section 668.1(1) provides as follows:

> 668.1 Fault defined.
>
> 1. As used in this chapter, "fault" means one or more acts or omissions that are in any measure negligent or reckless toward the person or property of the actor or others, *or that subject a person to strict tort liability*. The term also includes breach of warranty, unreasonable assumption of risk not constituting an enforceable express consent, misuse of a product for which the defendant otherwise would be liable, and unreasonable failure to avoid an injury or to mitigate damages.
>
> (emphasis added)

Applying *Scott's* holding to Section 668.1(1) would appear to create no problem. This portion of the comparative fault act means simply that all product liability theories are to be considered subject to the Act, and to constitute "fault." This is so even though some courts referred to earlier iterations of "strict liability" as so-called "liability without fault." This portion of the comparative fault act is designed to make it clear that a plaintiff's negligence is a defense to a products liability claim. In some states, that is not the case.

To conclude, *Scott* did a good job of reconciling *Wright* and its abandonment of the "strict liability" terminology with Iowa Rule of Evidence 5.407. There is now more clarity on how the rule restricting the admissibility of subsequent remedial measures should be applied in a products liability case. Action by the Iowa Legislature to "clean up" Iowa law and render it more consistent with *Wright v. Brooke Group Ltd.* with respect to other references in Iowa law to "strict liability" is not likely. Although *Scott* is helpful, we must await further guidance from the Iowa Supreme Court in order to see how the other references to the outmoded terms "strict liability" in Iowa law will be interpreted. Hopefully this article has suggested how the Court might strike that balance.

IOWA DEFENSE COUNSEL ASSOCIATION

MESSAGE FROM THE PRESIDENT

James A. Pugh

LETS STOP HOUSE BILL HF758

In the last Defense Update issue, I outlined my primary goal as your President; increase membership to 400 during 2010. This was a goal I voluntarily established to increase the strength of our organization. At our December board meeting, I announced my second goal. This goal was not voluntarily established, but was thrust upon our group by events in last year's legislature. I refer to the absolute necessity of defeating House Bill HF758 in the Iowa Legislature.

HF758 amends §633.336 to provide that wrongful death damages "may include damages for the decedent's loss of enjoyment of life . . . ". This bill was put forward as part of the trial lawyers' agenda last year and effectively stayed below the radar until late in the session. It was passed by the House and had also been approved by the Senate Judiciary Committee. But for a flurry of activity at the end of the session, this bill would have been passed with little opposition. As the new session begins, we have a small window of opportunity to inform our legislators of the unnecessary and flawed nature of this bill.

Procedurally, the bill will go back to the Senate Judiciary Committee, but will remain in its approved status with the House. Our concentration, therefore, should be centered on the Senate Committee, at least initially. I have listed the committee members below and ask that all our members contact these Senators and express opposition to the bill. Mike Thrall has put together a "talking points" memo which can be used to fashion your communication. You can contact either Mike or myself if you would like a copy. I would suggest three additional arguments in opposition.

First, in this time of budgetary and judicial crisis, should we be initiating further causes of action and damages into a system that doesn't have the resources to handle its present work loads?

Second, Iowa generally has some of the lowest auto insurance rates in the country, and hence one of the highest rates of insured autos. If this law leads to higher insurance premiums, and a consequential decrease in the percentage of insured autos, is the public really served.

Finally, and philosophically, is there really any moral obligation or duty that warrants payout to a survivor of damages related to the decedent's loss of enjoyment of life. Our wrongful death damages have always been directed at compensating the survivors for their economic loss. We need to keep it that way.

PROOF STANDARDS UNDER THE IOWA CIVIL RIGHTS ACT: A GROSS OVERSIGHT?

by Frank Harty and Debra Hulett, Nyemaster Goode P.C., Des Moines, IA

Frank Harty

Debra Hulett

In the wake of the Iowa Supreme Court's decision in *DeBoom v. Raining Rose, Inc.*[1], some practitioners have speculated that the Iowa Supreme Court broke tradition by rejecting the United States Supreme Court's holding in *Gross v. FBL Financial Services, Inc.*[2] with regard to the way age discrimination cases are analyzed. In fact, a close analysis of *DeBoom* and a review of the chronology of the case demonstrate that in *DeBoom*, the Iowa Supreme Court did not intend to address *Gross* and did not make any sweeping change in the way it analyzes discrimination claims. The eighth circuit court of appeals recently recognized as much in *Gross v. FBL Financial Services, Inc.*, 588 F.3d 614 (8th Cir. 2009) (on remand). This article discusses the likely development of age discrimination proof standards under the Iowa Civil Rights Act ("ICRA").

THE *GROSS* DECISION

In *Gross*, the United States Supreme Court held that the burden of persuasion never shifts to the party defending an age discrimination claim brought under the Age Discrimination in Employment Act ("ADEA"). *Gross v. FBL Financial Services, Inc.*, 129 S.Ct. 2343, 2348 (2009). The *Gross* decision resolved a split among the federal courts of appeals and firmly established a proof standard consistent with the plain language of the ADEA.

THE *DEBOOM* DECISION

In *DeBoom v. Raining Rose, Inc.*, 772 N.W.2d 1 (Iowa 2009), the Supreme Court of Iowa held in part that the causation standard applicable to Iowa's common law retaliatory discharge tort does not apply to a sex and pregnancy discrimination claim under the ICRA. The plaintiff in *DeBoom* alleged that she was terminated because of her sex and pregnancy. At trial, however, the district court used jury instructions that were derived in part from the elements of Iowa's common law retaliatory discharge tort and in part from the ICRA. *Id.* at 13.

Consistent with the ICRA, the instructions directed the jury that the plaintiff in a sex and pregnancy discrimination case must prove that her protected status "was a determining factor" in the employer's adverse employment decision. *DeBoom*, *Id* at 12. The district court also instructed the jury that "Plaintiff's pregnancy was a 'determining factor' if that factor *played a part* in the Defendant's later actions towards Plaintiff. However, Plaintiff's pregnancy need not have been the only reason for Defendant's actions." *Id.* at 13 (emphasis in original). This portion of the instructions was the same as the eighth circuit court of appeals model jury instruction for sex and pregnancy discrimination under Title VII. The Supreme Court of Iowa held that these instructions—taken from federal law prohibiting sex and pregnancy discrimination—were appropriate. *Id.* at 12-13. Although DeBoom suggested that it would be less confusing if trial courts use the term "motivating" factor rather than "determining" factor, the court held that substitution of the term "determining" for "motivating" was not error. *Id.* at 13-14

The district court, drawing from the elements of Iowa's retaliatory discharge tort, also instructed the jury that "[a] determining factor need not be the main reason behind the decision. It need only be the reason which *tips the scales decisively* one way or the other." *Id.* at 13 (emphasis in original). *DeBoom* held that this portion of the instructions misstated the plaintiff's burden of proof by imposing a "higher burden of proof than is required in discrimination cases." *Id.* Moreover, the court concluded that the retaliatory discharge portion of the instructions was inconsistent with the portion of the instructions based on the ICRA, so the jury was likely confused about what the plaintiff had to prove to prevail on her claim. *Id.* at 14. Based on this instructional error, the Supreme Court of Iowa reversed the judgment and ordered a new trial. *Id.*

In the wake of *DeBoom*, some members of the plaintiff's bar have argued that the Iowa Supreme Court rejected the U.S. Supreme Court's analysis in *Gross*. Indeed, at least one federal judge has taken that position. *Schott v. Care Initiatives*, 2009 WL 3297290, at *4 (N.D. Iowa Oct. 15, 2009). Shortly after *DeBoom* was decided, the Eighth Circuit Court of Appeals weighed in on the matter and concluded that *DeBoom* did not reject, or even consider, Gross. *See Gross v. FBL Financial Services, Inc.*, 588 F.3d at 618-20.

THE IOWA SUPREME COURT FOLLOWING FEDERAL LAW

The Iowa Supreme Court has repeatedly interpreted the ICRA in a manner consistent with companion federal anti-discrimination statutes, bringing uniformity and predictability to the employers and employees that must navigate the complementary regimes. A long line of Iowa Supreme Court opinions reflects that Court's consistent practice of adopting and drawing from the companion federal analytical frameworks when interpreting the ICRA. A sampling of those cases includes:

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1 772 N.W.2d 1 (Iowa 2009).
2 129 S.Ct. 2343 (2009).

PROOF STANDARDS UNDER THE IOWA CIVIL RIGHTS ACT: A GROSS OVERSIGHT? ... *CONTINUED FROM PAGE 11*

- ADEA analytical framework regarding voluntary early retirement incentive plans, *Weddum v. Davenport Cmty. Sch.* Dist., 750 N.W.2d 114 (Iowa 2008);
- the *Morgan*[3] statute of limitations analysis, *Farmland Foods, Inc. v. Dubuque Human Rights Comm'n*, 672 N.W.2d 733 (Iowa 2003);
- the *Faragher-Ellerth*[4] affirmative defense, *Farmland Foods*, 672 N.W.2d at 744;
- the *Reeves*[5] analytical framework, *Farmland Foods*, 672 N.W.2d at 741 n.3;
- the *St. Mary's v. Hicks*[6] analytical framework, *Board of Supervisors of Buchanan County v. Iowa Civil Rights Comm'n*, 584 N.W.2d 252, 256 (Iowa 1998);
- the *McKennon*[7] after-acquired evidence doctrine, *Walters v. U.S. Gypsum Co.*, 537 N.W.2d 708, 708-09 (Iowa 1995);
- the *Price Waterhouse*[8] mixed motive analytical framework, *Landals v. George A. Rolfes Co.*, 454 N.W.2d 891, 893-94 (Iowa 1990);
- the *Burdine*[9] analytical framework, *Hamilton v. First Baptist Elderly Housing Found.*, 436 N.W.2d 336, 338-39 (Iowa 1989);
- the federal analytical framework and religious accommodation requirement, *King v. Iowa Civil Rights Comm'n*, 334 N.W.2d 598, 601-02 (Iowa 1983); and
- the *McDonnell Douglas v. Green*[10] analytical framework, *Linn Coop Oil Co. v. Quigley*, 305 N.W.2d 729, 733 (Iowa 1981).

DeBoom is no exception. In fact, *DeBoom* reiterates the Iowa Supreme Court's intention to follow, rather than deviate from, companion federal analytical frameworks when analyzing the ICRA. Rather than distinguishing the ICRA from federal law, in *DeBoom*, the Iowa Supreme Court adopted in part the eighth circuit's Title VII model jury instructions for discrimination "because of" sex and pregnancy. 772 N.W.2d at 11-14. Additionally, the Iowa Supreme Court interpreted the ICRA in a manner that followed the federal Pregnancy Discrimination Act's expansive definition of pregnancy.[11] *Id*. at 7-8.

When clear textual differences in statutory language exist, the Iowa Supreme Court has recognized distinctions between the ICRA and federal law.[12] That is likely the reason why, in *DeBoom*, the Supreme Court of Iowa did not adopt the Title VII standard for sex and pregnancy discrimination in its entirety. Title VII, in contrast to the ICRA, goes beyond a prohibition on discrimination "because of" sex or pregnancy. The federal Civil Rights Act of 1991 amended Title VII by adding a provision to impose liability on an employer when an employee "demonstrates" that an impermissible consideration "was a motivating factor for any employment practice, even though other factors also motivated the practice." Pub. L. No. 102-166, § 107 (now contained in 42 U.S.C. § 2000e-2(m)). Under that provision of Title VII, once a plaintiff establishes that a prohibited characteristic motivated an employer's decision, the employer is liable for engaging in a prohibited employment practice. Title VII does provide the employer with an opportunity to limit the damages a plaintiff may obtain under this avenue. Once liability is established, the burden of persuasion shifts to the employer to establish it would have made the same decision regardless of the prohibited characteristic. In *Desert Palace v. Costa*[13], the Supreme Court interpreted 42 U.S.C. § 2000e-2(m). To date, the Supreme Court of Iowa has declined to decide whether *Desert Palace* is applicable to the ICRA.[14] Given the patent differences between the Title VII provisions that *Desert Palace* interpreted and the ICRA, however, the Court does not need to address it.

Where the ICRA is similar to federal law, however, the Iowa Supreme Court has opted for uniformity and clarity. For this reason, it seems likely the Iowa Supreme Court will embrace the *Gross* decision. The ICRA—like the ADEA—imposes the burden of persuasion on the plaintiff at all times. *See Landals*, 454 N.W.2d at 893-94; *Trobaugh v. Hy-Vee Food Stores, Inc.*, 392 N.W.2d 154, 156-57 (Iowa 1986); *Peoples Mem. Hosp. v. Iowa Civil Rights Comm'n*, 322 N.W.2d 87, 92-93 n.5 (Iowa 1982); *Linn Coop Oil Co.*, 305 N.W.2d at 733. In addition, the ICRA—like the ADEA—prohibits discrimination in employment "because of" an individual's age. Iowa Code § 216.6(1); 29 U.S.C. § 623(a)(1). Finally, the Iowa Supreme Court has consid-

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3 *Nat'l R.R. Passenger Corp. v. Morgan*, 536 U.S. 101 (2002).
4 *Faragher v. City of Boca Raton,* 524 U.S. 775 (1998); *Burlington Indus., Inc. v. Ellerth,* 524 U.S. 742 (1998).
5 *Reeves v. Sanderson Plumbing Prods., Inc.,* 530 U.S. 133 (2000).
6 *St. Mary's Honor Ctr. v. Hicks,* 509 U.S. 502 (1993).
7 *McKennon v. Nashville Banner Publ'g Co.,* 513 U.S. 352 (1995).
8 *Price Waterhouse v. Hopkins,* 490 U.S. 228 (1989).
9 *Texas Dep't of Cmty. Affairs v. Burdine,* 450 U.S. 248 (1981).
10 *McDonnell Douglas Corp. v. Green,* 411 U.S. 792 (1973).
11 *See* 42 U.S.C. § 2000e(k).
12 *See, e.g., Vivian v. Madison,* 601 N.W.2d 872, 878 (Iowa 1999) (in contrast to Title VII, supervisory employee may be held liable for unfair employment practices under the ICRA); *Hulme v. Barrett*, 449 N.W.2d 629, 631-32 (Iowa 1989) (in contrast to the ADEA, ICRA is "age-neutral" in that the class protected from age discrimination is not limited to individuals age 40 or older); *Chauffeurs, Teamsters & Helpers, Local Union No. 238 v. Iowa Civil Rights Comm'n*, 394 N.W.2d 375, 384 (Iowa 1986) (in contrast to Title VII, punitive damages are not available under the ICRA).
13 539 U.S. 90 (2003).
14 *See Smidt v. Porter*, 695 N.W.2d 9, 14 (Iowa 2005).

PROOF STANDARDS UNDER THE IOWA CIVIL RIGHTS ACT: A GROSS OVERSIGHT? ... *CONTINUED FROM PAGE 12*

ered the ADEA's analytical framework when interpreting the ICRA's prohibition on age discrimination. *See Weddum*, 750 N.W.2d at 118; *Ritz v. Wapello County Bd. of Supervisors*, 595 N.W.2d 786, 793 (Iowa 1999). Like the Iowa Supreme Court, federal courts recognize the symmetry between the ICRA and the ADEA.[15]

DeBoom presented the Iowa Supreme Court with an interpretive issue that the federal courts did not face in analyzing Gross's age discrimination claim. The Iowa Supreme Court interpreted *two* subsections of Iowa Code § 216.6 in *DeBoom*: Iowa Code § 216.6(1) and Iowa Code § 216.6(2). Iowa Code § 216.6(1)(a) provides that an employer may not take adverse action against a person because of sex or disability (including pregnancy). Iowa Code § 216.6(2) contains comprehensive provisions addressing pregnancy discrimination. One part of that subsection, at issue in *DeBoom*, provides: "[a] n employer shall not terminate the employment of a person disabled by pregnancy because of the employee's pregnancy."[16] There are no counterparts to these provisions in the ADEA.

Furthermore, age discrimination is inherently different than sex and pregnancy discrimination. In enacting the ADEA, for example, Congress recognized distinctions between the more pernicious types of discrimination protected by Title VII and the type of prejudices and biases that drive age discrimination; therefore, federal law provides a different level of protection for age discrimination. A report of the Secretary of Labor, prepared at Congress's request, noted that "there was little discrimination arising from dislike or intolerance of older people, but that 'arbitrary' discrimination did result from certain age limits." *Smith v. City of Jackson*, 544 U.S. 228, 232 (2005). Consequently, the ADEA was designed to prevent employers from discriminating against older workers based on groundless perceptions and assumptions. *Hazen Paper Co. v. Biggins*, 507 U.S. 604, 610 (1993). And, in the federal context, the statutory objectives of the ADEA were "to promote employment of older persons based on their ability rather than age; to prohibit the arbitrary age discrimination in employment; [and] to help employers and workers find ways of meeting problems arising from the impact of age on employment." *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 589-90 (2004). As discussed above, the legislative history of the ICRA reflects comparable distinctions. Therefore, the ICRA treats age discrimination differently than sex and pregnancy discrimination.

Perhaps the best evidence that the *DeBoom* court did not reject *Gross* is the fact that the *DeBoom* opinion did not cite *Gross*. A review of the *DeBoom* briefing and oral argument makes clear that neither party asked the court to reject *Gross*. Indeed, this would have been impossible given the fact that the briefs in *DeBoom* were submitted nearly two years before *Gross* was decided. Oral argument in *DeBoom* preceded *Gross* by more than one year. Thus, it would have been impossible for the litigants in *DeBoom* to anticipate what the Supreme Court would do in *Gross*.

THE CLOSER ANALYSIS

Although both *Gross* and *DeBoom* addressed the propriety of jury instructions in discrimination cases, the cases presented entirely different issues. In *Gross*, the plaintiff characterized his age discrimination claim as a "mixed motive" claim. Relying on *Price Waterhouse*, *Gross* argued that once he established his age was a factor in the adverse employment decision, the burden of persuasion should shift to the employer to show the absence of causation. *DeBoom* did not present a mixed motive case; instead, she presented a classic pretext claim.

The Iowa Supreme Court has applied the *Price Waterhouse* burden-shifting framework as an alternative to the *McDonnell Douglas* pretext framework for ICRA claims that involve direct evidence of discrimination. *Landals*, 454 N.W.2d at 893-94; *Civil Serv. Comm'n v. Iowa Civil Rights Comm'n*, 522 N.W.2d 82, 90 (Iowa 1994). The Iowa Supreme Court applies *Price Waterhouse* to the ICRA and has held that Justice O'Connor's concurring opinion is controlling. *Landals*, 454 N.W.2d at 893-94; *Casey's Gen. Stores, Inc. v. Blackford*, 661 N.W.2d 515, 520 n.3 (Iowa 2003). Therefore, under the ICRA, to receive a burden-shifting instruction, a "plaintiff must show by direct evidence that an illegitimate criterion was a substantial factor in the decision." *Price Waterhouse*, 490 U.S. at 276. Direct evidence is evidence that relates directly to the challenged decision. *Id.* at 277 (employee must satisfy evidentiary threshold by showing "*direct evidence* that decisionmakers placed substantial negative reliance on an illegitimate criterion in reaching their decision") (emphasis added). *See also Casey's Gen. Stores, Inc.*, 661 N.W.2d at 520 n.3.

The *DeBoom* case neither addressed nor undermined the Iowa Supreme Court's precedent adopting the *Price Waterhouse* burden-shifting framework. When the Iowa Supreme Court intends to overrule its precedent, it clearly expresses its intention to do so.[17] The Iowa

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[15] *See, e.g., King v. U.S.*, 553 F.3d 1156, 1160 n.3 (8th Cir. 2009) ("Because the same analysis applies to age discrimination claims under the ADEA and the ICRA, we do not separately discuss King's claim under the ICRA"); *Christensen v. Titan Distrib., Inc.*, 481 F.3d 1085, 1095 n.4 (8th Cir. 2007) ("The same analysis applies for age discrimination claims brought under Iowa law"); *Fisher v. Pharmacia & Upjohn*, 225 F.3d 915, 919 n.2 (8th Cir. 2000) ("The ICRA is interpreted to mirror federal law, including the ADEA"); *Montgomery v. John Deere & Co.*, 169 F.3d 556, 558 n.3 (8th Cir. 1999) ("The discrimination claims alleged under the Iowa Civil Rights Act are analyzed in the same manner as their federal law counterparts").

[16] Iowa Code § 216.6(2)(d).

[17] *See, e.g., Bontrager Auto Serv. v. Iowa City Bd. of Adjustment,* 748 N.W.2d 483, 495 (Iowa 2008); McElroy v. State, 703 N.W.2d 385, 395 (Iowa 2005); *Kiesau v. Bantz*, 686 N.W.2d 164, 173 (Iowa 2004); *State v. Liddell*, 672 N.W.2d 805, 811-12 (Iowa 2003); *State v. Robinson,* 618 N.W.2d 306, 312-13 (Iowa 2000); *Miller v. Westfield Ins. Co.*, 606 N.W.2d 301, 304-05 (Iowa 2000).

PROOF STANDARDS UNDER THE IOWA CIVIL RIGHTS ACT: A GROSS OVERSIGHT? ...
CONTINUED FROM PAGE 13

Supreme Court expressed no intent to overrule precedent in *DeBoom*. Instead, the Iowa Supreme Court approved the eighth circuit model jury instruction for a claim of discrimination "because of" sex and pregnancy under Title VII. *DeBoom*, 772 N.W.2d at 13. The parties in *DeBoom* did not raise the issue of burden-shifting. The Iowa Supreme Court did not address the issue of burden-shifting. Thus, the Iowa Supreme Court's interpretation of *Price Waterhouse*—using the direct evidence standard set forth in Justice O'Connor's concurring opinion—governs analysis of the mixed motive jury instructions that the district court used at trial.

CONCLUSION: LOOKING FORWARD

The eighth circuit dismissed the argument that *DeBoom* rejected *Gross*. Thus, in Iowa's federal courts, *Gross* dictates that pendent claims under Iowa Code Chapter 216 be analyzed using the *Price Waterhouse* analysis adopted by the Iowa Supreme Court in *Vaughan v. Must, Inc.*, 542 N.W.2d 533, 538-39 (Iowa 1996).

Indeed, given the thorough and well reasoned analysis of the eighth circuit in *Gross*, it is likely that Iowa trial courts will likewise apply the *Price Waterhouse* standard or the *Gross* standard in age claims brought under the Iowa Civil Rights Act. Although the matter won't be settled until the Iowa Supreme Court weighs in, it seems likely that the *Gross* decision may have a longer life under Iowa law than federal law. This is true because federal legislation has been proposed that would overturn Gross.

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IDCA SPRING SEMINAR

April 9, 2010

Coralville Marriot Hotel & Conference Center • 300 East 9th Street • Coralville, Iowa 52241

Current Developments in Employment Law

AGENDA - Friday, April 9, 2010

8:00 – 8:15 a.m.	**Welcome and Announcements** Gregory Barntsen, Program Chair, Smith Peterson Law Firm, Council Bluffs, IA
8:15 – 8:55 a.m.	**New Developments under the Family and Medical Leave Act** Iris Muchmore, Simmons Perrine Moyer Bergmon PLC, Cedar Rapids, IA
8:55 – 9:35 a.m.	**Current Developments in Federal Employment Litigation** Kevin Visser, Simmons Perrine Moyer Bergmon PLC, Cedar Rapids, IA
9:35 – 10:15 a.m.	**The Employee Free Choice Act** Jim Gilliam, BrownWinick, Des Moines, IA
10:15 – 10:25 a.m.	**Networking Break**
10:25 – 11:05 a.m.	**Fair Labor Standards Act: Compliance and Litigation** Hugh Cain, Hopkins & Huebner, P.C., Des Moines, IA
11:05 – 11:45 a.m.	**Where Will Employment Discrimination Cases be Litigated:** **How Gross DeBoom and the ADAAA Influence the Choice of State and Federal Court** Patrick Smith, Bradshaw Fowler Proctor & Fairgrave PC, Des Moines, IA
11:45 a.m. – 1:00 p.m.	**Lunch**
1:00 – 1:45 p.m.	**New Employment Claims under State and Federal Law** Frank Harty, Nyemaster, Goode, West, Hansell & O'Brien, P.C., Des Moines, IA
1:45 – 2:30 p.m.	**Practical Considerations for the Expansion of Individual's Rights Based on Sexual** **Orientation and Gender Identity** Ann Holden Kendell, Dickinson Law, Des Moines, IA
2:30 – 2:45 p.m.	**Networking Break**
2:45 – 3:30 p.m.	**Social Media in the Workplace** Megan Erickson, Dickinson Law, Des Moines, IA
3:30 – 4:15 p.m.	**ADAAA Employment Changes** Terri C. Davis, Shuttleworth & Ingersoll PLC, Cedar Rapids, IA

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IOWA DEFENSE COUNSEL ASSOCIATION

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April 9, 2010

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Current Developments in Employment Law

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