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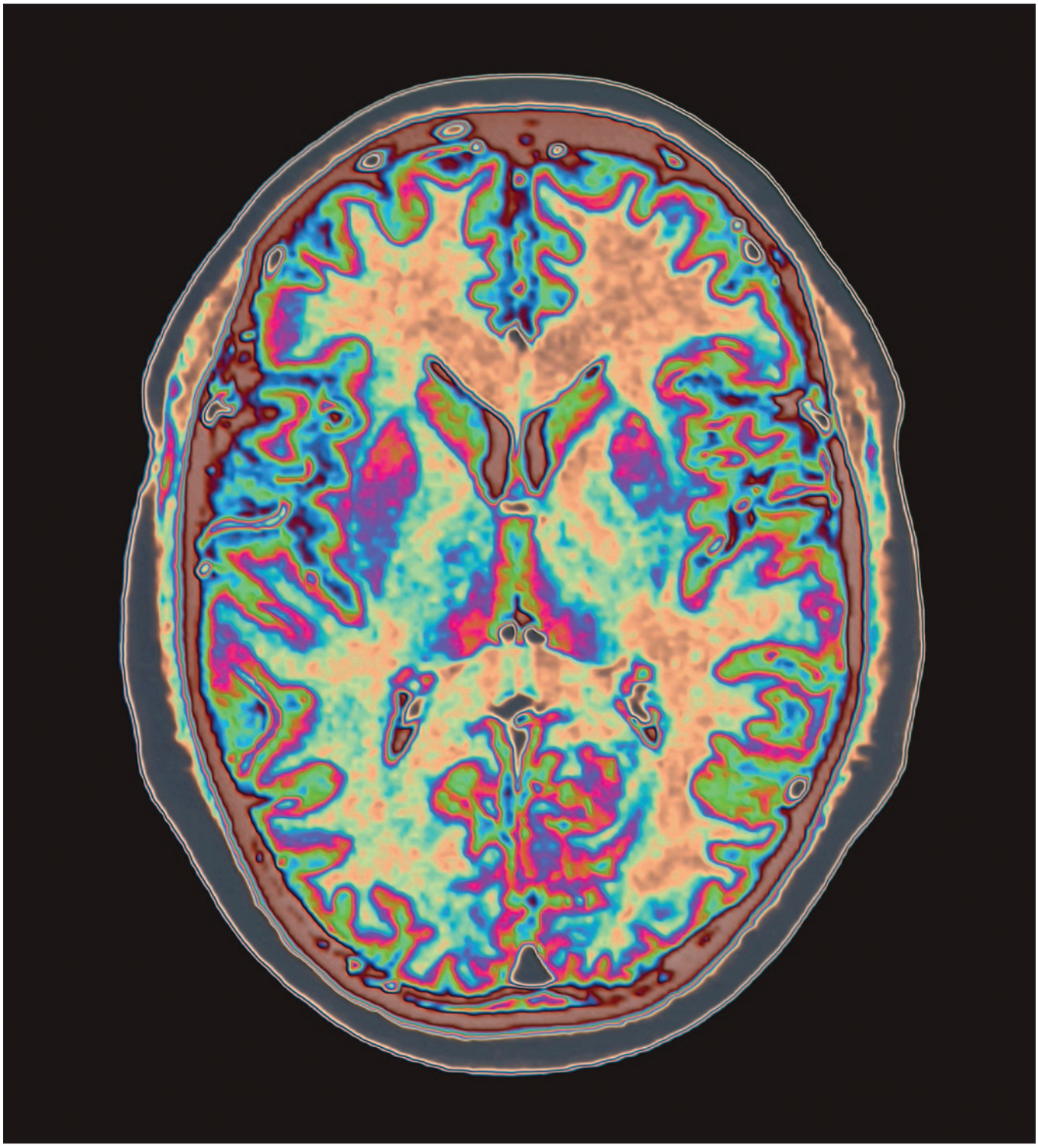
TRIAL TALK

December/January 2020 Volume 69 Issue 1



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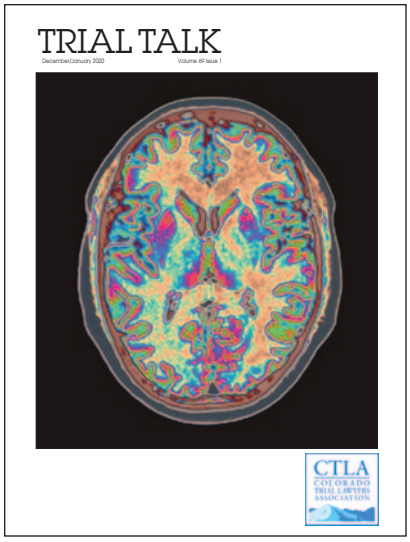

TRIAL TALK

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TRIAL TALK® (ISSN 0747-1378) is published bimonthly by the Colorado Trial Lawyers Association at 303 E. 17th Ave., Suite 320, Denver, CO 80203-1255, for $24 per year included in the dues paid by members of the Association.

Subscriptions for nonmembers are $75 per year. Periodical postage paid at Denver, CO., and additional mailing offices. For address corrections, telephone (303) 831-1192.

POSTMASTER: Send address changes to TRIAL TALK, 303 E. 17th Ave., Suite 320, Denver CO 80203-1255.

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Building on Our Success

By Julie Whitacre

One of the things I enjoy most about my job is the endless flow of suggestions from members to improve our current programs or recommendations to start new ones. From offering more CLE's to talking to law students, there is never a shortage of fresh ideas to consider. I am proud to report that in the last two years CTLA staff and leaders have worked together to strengthen our public relations efforts, increase our bipartisan legislative outreach, offer more CLE, start a boot camp for our legal staff, and start student chapters at DU and CU.

For the first time that anyone can remember, we have hired a public relations consultant who is helping us develop and implement an earned and paid media strategy. Since she came on board, we have had an op-ed place in *The Colorado Sun* and a video produced that is being shared on social media highlighting the important work trial lawyers do to make our state safer.

As we move into the legislative session, she will help us develop additional videos and work with reporters to advance proactive legislation to hold insurance companies and large corporations accountable. Throughout all of this we will be collecting names and emails to build a coalition of advocates to help us achieve our legislative goals this year and in the future.

Expanding our success at the Capitol is always important. In addition to increasing our public relations efforts, we are also working on growing bipartisan outreach. Over the last few years, we have set money aside to work on messaging and outreach to Republicans. The work we do has become very partisan, although it should not be. Rule breakers should be held accountable and that is a message the resonates across party lines. We want to work with people on both sides of the aisle to prevent the rich and powerful from writing and playing by their own rules.

In addition to our legislative work, I know that continuing legal education is an important benefit CTLA offers its members. Another first for us is that we have a staff person whose entire focus is coordinating CLE's and special events. In addition to Blockbuster and Convention, we are consistently offering programs throughout the year. In 2020, the seminar committee has five day-long CLE's planned, including one on insurance bad faith in April. Additionally, there are special programs for new lawyers and members of the Women's Trial Lawyer Network. I am also excited to announce that we are conducting a unique eight-week course for paralegals to gain the foundational knowledge and skills needed to prepare for a civil trial.

Something that should come as no surprise to any of us is that fewer people are entering the profession and our membership is getting older. By our estimates, nearly 25 percent of CTLA members are expected to retire in the next decade. That means we must make a concerted effort to expose young lawyers to civil plaintiffs' work early in their careers and demonstrate the benefits of becoming a member. To that end, last year we helped start a formal student group at the University of Denver Sturm College of Law. Later this spring, we have plans to have a group up and running at the University of Colorado Law School. We are also attending campus job fairs and having get-togethers with diverse student groups.

These additions are just the tip of the iceberg. At the same time, we are increasing our attention to diversity and inclusiveness, streamlining our membership process, increasing the number of members giving to EAGLE, adding additional CLE courses to our online store, and improving our technology to move our association further into the digital age.

While growing programs, CTLA has worked to become more effective with the money we bring in through membership dues and EAGLE contributions. When the CTLA Board of Directors approved the 2020 budget, they focused on being efficient with the money we have while continuing to offer the services our members have come to expect. This year's budget includes money to keep the new programs going while decreasing our operating expenses by over 12 percent.

CTLA has long relied on the generosity of EAGLE contributions to fulfill many of the goals of our organization. Fortunately, EAGLE pledges have remained a reliable source of income, but the timing of payments is inconsistent which makes it challenging to use them to create a budget with ongoing programs. Membership dues, on the other hand, are a much more predictable source of revenue. Therefore, as part of the budget, the Board also approved a modernized dues structure that will go into effect on March 1, 2020.

The inspiration for the modernized dues structure came from the American Association for Justice. They recognize that an attorney in practice for 20 years likely has a higher income potential than one that has been practicing 10 years. The old CTLA dues structure treated everyone with 10 or more years' experience the same. The modernized structure adds three new categories: 11-15 years, 16-20 years, and 21+ years.

CTLA Modernized Dues Structure
effective 3/1/20

CATEGORY	DUES
0-2 years in practice	$130
3-5 years in practice	$350
6-10 years in practice	$470
11-15 years in practice	$530
16-20 years in practice	$560
21+ years in practice	$590
Legal Staff	$90
Retired	$100
Honorary	$0
Student	$0

Deciding to change our dues structure was not a decision the board came to lightly, but one they think is necessary to give CTLA a more stable source of revenue so we can continue to grow the programs and benefits we offer our members. I am excited about what's possible in the years ahead and it cannot be done without you. I am grateful for the continued support and look forward to strengthening the positive impact CTLA has for you, your practice and your clients. ▲▲▲

Introduction: New Year, New(er) Lawyers

By Nicole M. Quintana

The New Year often brings fresh starts, new or renewed habits, and ambitious resolutions. But it is also a time for reflection. We're coming off a year of issues that addressed old and new law in our primary areas of practice; looked at trends in the law around the United States; and delved into areas that we touch on less frequently. Our publication reached trial lawyers associations all over the United States, judges from numerous jurisdictions, not to mention the hundreds of lawyers who read and learned from the lessons about which our membership wrote. We, as an organization, have an incredible opportunity to profoundly impact the legal profession, legislation, and perhaps most importantly, our clients and consumers at large. Our hope is to renew and continue that habit through *Trial Talk*.

However, we must also consider resolutions and new habits. We hope this New Year to provide issues reflecting diverse viewpoints, both in authorship and subject matter. In that vein, we look to our new(er) lawyers in this issue to bring fresh perspectives on the practice of law—from brain injury to insurance to employment to property damage to the impact of new legislation. As always, we're thankful for the contributions and insights.

As I said last year, we are better lawyers through sharing our stories and passing on the lessons we have learned. If you have an idea for a future article, please submit it to Nicole Quintana, Editor-in-Chief, nicole.quintana@omtrial.com, or Holly Bennett, Managing Editor, hollyb@ctlanet.org. Here's to a year of successes (however you may define them), losses from which we learn, and a bit more personal solace and serenity. ▲▲▲

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When Work Isn't Working: An Intersection of Personal Injury, FMLA, and the ADA

By Emily R. Fiscus

As attorneys practicing in plaintiff-side personal injury or employment law, many of us grow accustomed to hearing heartbreaking stories of how our clients' worlds have been turned upside down. Some clients discuss terrifying car accidents which have left them with broken bones. Other clients tell us nightmares about hitting their heads, and then not being able to perform as they once could at work. Most clients just want to feel like themselves again.

Our legal systems are complex, the number of providers can be endless, and the number of policies at play that often do not align, all create vertical and insular components that our clients must attempt to weave together to address their whole person. We are fortunate enough to act as a horizontal thread to tie systems together. Becoming injured and losing physical autonomy or mental efficacy serves as a blow to a major pillar of our clients' foundations. An unfortunate ripple effect of injury may often lead to loss of employment, another devastating blow to the pillar of our clients' foundations. Not only do our clients' jobs provide for income and health benefits, but a person's job often plays an integral role in how a person identifies in the world. If poor performance is not adequately addressed and identified at work, your client could be terminated, without much recourse. To prevent a catastrophic result like the loss of employment with rippling effects, it is incumbent that we front-end potential issues to ensure protection of our client, as a whole person.

Many clients are fully aware of the results of their injuries and may transparently discuss these issues with you. However, some clients may not even be aware of how they are changing. As you meet with your client, you may observe that the client has become much more agitated and irritable since you met them years ago, or you may observe a trend that they seem to not recall what they told you only moments before. For both subsects of clients, but especially those who may not even realize how their behaviors are manifesting in a potentially problematic way in the workforce, it becomes all the more important for you to take an active role in advising your client (or seeking help from an employment attorney).

If you or your client has concerns that her injuries, symptoms, or disabilities are causing issues at work, one of the first steps to take is placing the employer's HR department on notice. While the employer certainly may have noticed a spike in attendance issues, an increase of calling in sick, a decrease in productivity, or an undesirable change in demeanor, the employer may not know the reason why. If left in the dark, the employer may attribute your clients' issues to personality differences and may terminate your client with relative ease in an "at-will" employment state. However, bringing the employer into the light may be essential. Clients will often **not** report the serious health condition or qualified disability to their employer: maybe they are afraid that reporting may actually cause them to be terminated; maybe not recognizing their changed state; or maybe trying the "fake it 'til you make it" method while trying power through. Ironically, reporting the serious health condition or qualified disability may be the single best thing your client can do to protect her job, long-term employment, and health benefits.

This article addresses how these serious health conditions and/or disabilities may trigger employment protections for your client under the Family Medical Leave Act ("FMLA") or the Americans with Disabilities Act and the Americans with Disabilities Amendments Act of 2008 (referred to collectively as "ADA"). A general overview of FMLA and ADA will be discussed here, as well as the interaction between the two, with best practice tips for how we can issue spot and protect our clients in a variety of legal sectors.

FMLA

After becoming injured, your client may need to consider taking FMLA leave sooner than later. Doing so may allow your client to take advantage of 12 full weeks away from work, or may allow for intermittent or reduced leave to be taken in separate blocks of time from an hour to several

weeks.[1] Whether your client simply cannot work at all, needs intermittent time off (one day a week, a few hours a day), or there is concern that your client's work performance falls below reasonable expectations, securing FMLA leave may act in the interest of preserving your client's job in the long run. "FMLA is intended to allow employees to balance their work and family life by taking reasonable unpaid leave for medical reasons. . . ."[2] "The Act is intended to balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, and to promote the national interests in preserving family integrity."[3] Congress recognizes that giving an employee time away from work to care for her serious health condition benefits both employers and employees, as a "direct correlation exists between stability in [personal] life and productivity in the workplace."[4] The strong upside to FMLA is that it guarantees eligible clients time away from work to focus on recovery without the worry of being terminated for taking time away, while also preserving access to health insurance benefits.

Eligibility

FMLA is not guaranteed to every employee at every job. To be eligible, at the time the leave is requested, the employee must have been employed by the employer for at least 12 months, and must have worked 1,250 hours in that 12 month period.[5] Additionally, the employee must be employed at a worksite with 50 or more employees employed by the employer within 75 miles, or must be a governmental employer of any size.[6] There are some exceptions and nuances to these eligibility requirements that are worth exploring if your client does not appear to qualify at first blush.[7] Additionally, where an employer may be too small and not be required to provide FMLA, some employers, may still choose to do so as defined in their employee handbook or internal policies.[8] You should be sure that all internal policies regarding leave, FMLA, and the employee handbook are requested from your client's employer.

As discussed above, giving the employer adequate notice is not only advisable, it may be mandatory under the FMLA when the serious health condition is foreseeable.[9] For example, if your client was in a car accident and as a result, has been planning a related surgery for 3 months down the road, that later surgery is foreseeable, and therefore your client should be sure to notify her employer with at least 30 days before the requested leave is to begin.[10] Conversely, if after the initial car accident, your client was immediately hospitalized for two days, that leave was not foreseeable prior to its occurrence. In that instance, FMLA requires your client to notify her employer of the need for leave "as soon as practicable."[11]

Additionally, you should inform your client that her employer may require a certification from her medical provider to document her serious health condition, the appropriate medical facts to support the need for leave, a statement that she cannot perform the essential functions of her job, and the nature of work restrictions and limitations.[12] As you may already be in possession of medical records, or may have spoken with your client's ongoing treating physicians, you can help facilitate this process. There are also templates promulgated by the Department of Labor available online.[13] The burden lies with your client's employer to determine if FMLA leave is appropriate, and to notify your client within five days of such decision, while also providing your client an opportunity to address any deficiencies within the certification form within seven days.[14]

To take advantage of FMLA, in the context of this article, your client must be experiencing a serious health condition.[15] A "serious health condition" is defined as "an illness, injury, impairment or physical or mental condition that involves inpatient care . . . or continuing treatment by a health care provider . . . ."[16] FMLA recognizes "incapacity" as, among other things, the "inability to work."[17] The interrelation between personal injury and employment is imperative to not only monitor and inquire about injury as it relates to damages, but as a proactive and protective step to ensure continued employment.

Finances and Benefits

While a major benefit of FMLA is that it provides for peace of mind of job security for your client, despite time needed away from work, a downfall of FMLA leave is that typically, leave is unpaid.[18] That being said, you should be sure your client has reviewed her employer's internal policies, as some employers may provide for paid FMLA leave. Another way to address a gap in income during leave, is for your client to substitute accrued paid leave for unpaid leave, effectively running vacation or paid-time-off hours concurrently to the 12 weeks of FMLA. Depending on the employer's policy, an employer can actually mandate the substitution of accrued paid leave for unpaid FMLA leave.[19] Additionally, during her FMLA leave, your client may wish to replace her income with secondary employment. The employer's policy will typically address this, and a uniform provision that is applied uniformly that precludes secondary employment while on FMLA may be enforceable.[20] If no policy exists, however, the employer may not deny benefits to its employee, unless the FMLA leave was fraudulently obtained.[21]

Short-term disability ("STD") and long-term disability ("LTD") policies in effect may also be a source of income during unpaid FMLA leave. You can help your client immensely by guiding them to contact their insurance carrier, obtain all policies, making requests for payment of benefits, and preparing your client to be prepared to appeal denials. If your client does not have STD or LTD policies, they may need to turn to begin applying for SSDI or SSI to prevent an injury from wreaking havoc on income.

The other significant benefit to taking time away from work pursuant to FMLA, is that your client's employer must continue to maintain full health benefits on behalf of your client.[22] Especially during a time in which insurance coverage is essential to minimize your client's out-of-pocket spending or having to rely on liens, or worse, consider foregoing necessary treatment due to costs, being able to stay employed with health insurance benefits remains paramount. Other benefits, such as accrual of holiday pay, are to be determined by the employer's policy.

Reinstatement

FMLA acts as a great safety net for your client living with a serious health condition to take time off work to focus on her recovery and wellness, while resting assured that she will continue to be employed after taking a leave of absence. "On return from FMLA leave, an employee is entitled to be returned to the same position the employee held when leave commenced, or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment. An employee is entitled to such reinstatement even if the employee has been replaced or his or her position has been restructured to accommodate the employee's absence."[23] "An equivalent position is one that is virtually identical to the employee's former position in terms of pay, benefits and working conditions, including privileges, perquisites and status. It must involve the same or substantially similar duties and responsibilities, which must entail substantially equivalent skill, effort, responsibility, and authority."[24] However, exceptions exist for de minimus, intangible, or unmeasurable aspects of the job, which do not require equivalent reinstatement.[25]

It is noteworthy to discuss "equivalent reinstatement" with your client. For the most part, your client may return to her exact same job, or a job that operates very similarly. However, "equivalent" does not mean "exact," and there can certainly be upset and adjustment around a change in position. You can support and encourage your client to talk with her employer, to indicate her desires around her position, and to maintain frequent contact with her employer about her anticipated return date if maintaining her same position is a top priority. There are exceptions around reinstatement if your client is a "key employee," which involves a deeper conversation and notification prior to granting a leave request. [26] A potential "fitness for duty" evaluation near the conclusion of leave can also impact reinstatement.[27]

As your client lives through the highs and lows of her condition and recovery, she may, at times, feel defeated. There may be days when your client feels like giving up, and she states her intent to never return to work. You should be clear with your client that she should use her words wisely when speaking with her employer. Your client will no longer be entitled to reinstatement, if, she gives her employer unequivocal notice of her intent to not return.[28] This is not the same, however, as your client indicating uncertainty about her condition, or even that she may not be medically able to return, so long as she clearly expresses her intent or desire to be able to return.[29] Absent unequivocal statements about intent to not return, or considerations related to being a key employee, your client is otherwise protected and afforded the opportunity to reinstatement.

To ensure smooth reinstatement, FMLA prohibits an employer from interfering with its employee's rights or attempting to restrain or deny the exercise of such rights. Your client's employer may not penalize your client for taking leave, nor can the employer use the leave as negative factor in employment actions like hiring, promotions, or disciplinary action.[30]

ADA

The ADA exists to recognize the contributions individuals with disabilities make to society, including within the realm of employment, and stands to prohibit discrimination on the basis of disability.[31] Our "[n]ation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals" with disabilities.[32] A failure of an employer to work collaboratively and openly with employees results in more than just a frustration of our nation's goals; the result, is often, unlawful discrimination. The ADA provides that "[n]o covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.[33]

Unlike FMLA, all employees and even applicants for employment are eligible for protection under the ADA immediately, without regard to the amount of time the individual has

been employed.[34] The ADA applies to all employers that employ at least 15 employees.[35] Colorado's Anti-Discrimination Act ("CADA") prohibits disability-based discrimination in the workplace, and applies to all employers, not just those employing 15 or more employees.[36]

Definitions

"If an employee is a **qualified individual** with a **disability** within the meaning of the ADA, the employer must make **reasonable accommodations** . . . barring **undue hardship**, in accordance with the ADA."[37] Your client is "qualified" if he satisfied the required skill, experience, education or other job-related requirements for the position, and could perform the essential functions of the position, with or without reasonable accommodations.[38]

There are three elements to consider when evaluating whether your client has a "disability" pursuant to the ADA: 1) impairment; 2) one or more major life activities; and 3) a showing that the impairment substantially limits one or more major life activities.[39]

First, whether or not your client's condition constitutes an "impairment" is a question of law for the court to decide.[40] Your client may have a "disability" if he has a physical or mental impairment that substantially limits one or more major life activities;[41] having a record of such impairment;[42] or even simply being regarded as having such an impairment.[43] Some impairments are more visible than others; however, the ADA addresses a full range of impairments that may exist only internally or to the knowledge of the employee. If your client struggles with mental health, PTSD, a traumatic brain injury, or other impairments that are more difficult to spot, it is all the more important for your client to raise the issue of this impairment to his employer.

Second, the ADA does not exclusively list all potential "major life activities," but includes, *inter alia*, activities such as working, concentrating, thinking, communicating, sleeping, walking, bending, performing manual tasks, and operation of major bodily functions.[44] You should also be mindful of making the connection between major life activities, especially when your client cannot/does not. Keeping an employment law claim at the forefront of your mind, if your client reports to you major disruption in his sleep, you can help connect the impact on sleep as a major life function, and begin to ask your client how the lack of sleep may also be impacting his ability to perform at work, another major life function. However, the ADA does not require multiple major life functions to be impacted by the impairment. Understanding that working and employment are daily life activities that are important and necessary not only for your client but also are major life activities recognized by the courts, should continue to remind employers of their obligation to "make working work" for those with disabilities. The determination as to whether your client's assertion of the related major life activity in question, is also ultimately a matter of law for the court to decide.[45]

Third, unlike the first two elements discussed above, the third element, "substantial limitation" of one or more major life activities, is a question of fact for the jury to determine.[46] This means that it remains incumbent on your client to put forth facts that demonstrate why the impairment is more than an annoyance or inconvenience at work, but meets the threshold of "substantial limitation." In making such a determination, the jury should consider the condition, the manner, and the duration of time it takes your client to perform the major life activity of working. "In the case of the major life activity of working, the term substantially limits means significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities."[47] It is also important to note that the term "'substantially limits' shall be construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA. 'Substantially limits' is not meant to be a demanding standard."[48]

Even if the impairment is episodic or in remission, if it would substantially limit even one major life activity when active, the impairment also constitutes a disability.[49] Further, while an individual may mitigate the effects of his or her impairment through the use of medication, health devices, assistive technologies, and through other methods, the determination as to whether the impairment substantially limits the

individual's major life activities must be made without regard to the mitigating measures.[50]

Reasonable Accommodation and Undue Hardship

When you are aware that your client may have a disability that is potentially placing his job at risk due to poor performance or other issues stemming from substantial limitation, you should talk early and often with your client about the importance of your him self-identifying his disability to his employer. While some disabilities may be clearly identifiable, others may not be; and unless the employer is placed on notice of a disability, the employer may not have a duty to act. Once your client informs her employer of her disability, then must begin an interactive process to discuss reasonable accommodations that should ultimately be put in place. Some examples of reasonable accommodations may be a shorter workday, a shorter workweek, or light duty assignment. Extended time off from work may, in limited circumstances, be considered a reasonable accommodation as well.[51]

During the interactive process, your client's employer may claim that your client's requests for accommodations are not reasonable or place an "undue hardship" on the employer. The ADA does not require employers to make accommodations that would truly pose an undue hardship on an employer; however, there is no bright-line test as to what is "undue" versus what is merely a minor expense or inconvenience. Instead, "the term 'undue hardship' means an action requiring significant difficulty or expense. . . ." when considered with the following factors: the nature and cost of the accommodation; the overall financial resources of the employer; the number of persons employed by the employer; and the impact of the requested accommodation upon the operations of the employer."[52] You should guide your client to be resilient and remain engaged in the interactive process. If his first request for an accommodation was not accepted, he should continue to press the employer to come up with an accommodation that they won't assert is unduly burdensome. Your client should be aware that the burden lies on the employer, too, to take all reasonable steps to create an accommodation. Therefore, obstructionist employers should not easily deter a client who wants to make working work.

Interaction of FMLA to ADA

FMLA and ADA may afford your client many similar protections in the realm of employment, but foundation and analyses are different.[53] The leave provision of FMLA is wholly distinct from the reasonable accommodation provision of ADA.[54] The interaction between the two, is to expand coverage and provide for the greatest right of the employee.[55] Similarly, FMLA's "serious health condition" and ADA's "disability" are distinct concepts that must be analyzed separately.[56] "FMLA entitles eligible employees up to 12 weeks of leave in any 12-month period due to their own serious health condition, whereas the ADA allows an indeterminate amount of leave, barring undue hardship, as a reasonable accommodation."[57] "FMLA requires employers to maintain employees' group health plan coverage during FMLA leave on the same conditions as coverage would have been provided if the employee had been continuously employed during the leave period, whereas ADA does not require maintenance of health insurance unless other employees receive health insurance during leave under the same circumstances."[58] In some aspects, FMLA may provide more favorable protections for your client (continued health insurance), while ADA may provide more favorable protections in other scenarios (ongoing, indeterminate accommodation). In this article, FMLA and ADA are compared for purposes of taking leave from work, although the ADA stands for providing reasonable accommodations of all types.

To explore the interaction of FMLA and ADA, 29 C.F.R. § 807 works through tiered approaches and coverages pursuant to the Acts. Mirroring that example here, consider your client who was just in a car accident. Your client was taken to the hospital and was diagnosed with a concussion, with concern about an ongoing brain injury. The next day, your client returned to work, but quickly realized that she was struggling with light sensitivity, tiredness, fogginess, and inability to focus. After meeting with her health care providers, she decided she needed to take 10 weeks off work. The initial question may be whether your client wishes to ask for time off of work as a reasonable accommodation under the ADA, or whether she wishes to ask for time off of work as a reasonable accommodation under the ADA, or whether she wishes to ask for time off work due to a serious health condition under the ADA, or whether the leave would be considered **both** a reasonable accommodation and count as 10 of her 12 weeks of allotted FMLA leave.[59] If your client and employer agreed to the designation of both an ADA accommodation and FMLA leave, your client would receive the great advantage of being reinstated into her same job, as required by the ADA, rather than an equivalent position under FMLA.[60] Your client would also receive the greater benefit, in that her employer would be required to maintain health benefits per FMLA, whereas health benefits may be removed if the absence of 10 weeks resulted in a reduced-schedule or part-time employee designation under the ADA.[61]

Then, after 10 weeks off, your client returns to work, but per her doctor's instruction, is restricted to working part-time. Per her FMLA leave, she would remain entitled to health insurance benefits for the remainder of the two-week equivalent of FMLA leave.[62] Your client would be entitled to ADA reasonable accommodations to ensure satisfactory performance of the essential functions of that part-time position,[63] further protecting her job security. Additionally, she would return, even under a part-time schedule, to her same job, not a temporary assignment or alternative position.[64]

Once your client exhausted all of her remaining FMLA leave, she should ask her employer for additional FMLA leave to accommodate full weeks of leave at a time, or a continued part-time schedule. If your client has a medical reason, with a defined duration, and positive prognosis if additional time is granted, she should absolutely communicate all such supporting information and documentation to her employer. While her employer is not obligated to grant her request, there exists no harm in asking for additional FMLA leave. If the employer remains unwilling to grant additional FMLA leave, your client can continue to ask for reasonable accommodations per the ADA, to include weeks off of work, or a part-time schedule.[65] "Workers who have used up FMLA leave can still have rights under the ADA if they meet the ADA definition of a person with a disability. Accommodation is one such right. Additional leave (beyond the worker's FMLA leave) could be an accommodation that must be provided under the ADA."[66] Her employer is required to engage in an interactive process to propose and discuss reasonable accommodations, and barring undue hardship, must make such accommodations.[67] At this point, if her employer does not provide health benefits for part-time employees, your client may lose her health benefit coverage through her employer.[68]

However, by this point, your client has hopefully begun to make a recovery from her brain injury. Rather than continuing to work below her typical standard, by informing her employer as to her serious health condition and disability, she ensured legal protections to preserve her employment and benefits. During her 10 weeks of leave from work, she hopefully devoted time to treatment and rest, and was able to come back with much more productivity, thus effectuating the dual purpose of FMLA to benefit employees and employers. By coming back part time—and stretching her final two weeks of FMLA leave out longer than two consecutive calendar weeks—your client was able to maintain health benefits longer than if she had taken 12 consecutive weeks at once. The interplay between FMLA and ADA, providing for leave, and whatever equation of accommodation to provide the greater benefit, worked in your client's favor.

Make Working Work

As a personal injury attorney, understanding the framework of employment protections does nothing but support your client in a time filled with ambiguity. And, as an employment attorney, understanding the warning signs of traumatic brain injury, trauma, and mental health diagnoses that may be more than ailments, but cognizable serious health conditions or disabilities, does nothing but support your client across systems. After sustaining injury, enduring trauma, or just trying to stay on top of the countless health appointments and tasks, it is certainly understandable why clients' ability to work suffers. By taking FMLA leave or requesting reasonable accommodations, your client can be best situated to make working work. ▲▲▲

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Endnotes:

[1] 29 C.F.R. § 2612(b); 29 C.F.R. § 825.202.

[2] 29 C.F.R. § 825.101(a).

[3] *Id.*

[4] *Id.* at (c).

[5] 29 C.F.R. § 825.110 (a)(1), (2).

[6] *Id.* at (3).

[7] *See, e.g.,* 29 C.F.R. § 825.110.

[8] *See, e.g., Valdez v. McGill*, 462 Fed. Appx. 814 (10th Cir. 2012).

[9] *See* 29 C.F.R. § 825.302(a).

[10] 29 C.F.R. § 825.302(a).

[11] *Id.*

[12] 29 C.F.R. § 825.305.

[13] https://www.dol.gov/whd/forms/WH-380-E.pdf (accessed Jan. 4, 2020).

[14] 29 C.F.R. § 825.305.

[15] FMLA leave is not limited to the employee's own serious health conditions only; leave may also be permitted for the care of family members for a variety of other reasons, not discussed in this article.

[16] 29 C.F.R. § 825.113(a).

[17] *Id.* at (b).

[18] 29 C.F.R. § 825.207.

[19] *Id.*

[20] 29 C.F.R. § 825.216.

[21] *Id.*

[22] 29 C.F.R. § 825.209.

[23] 29 C.F.R. § 825.214.

[24] *Id.*

[25] *Id.*

[26] 29 C.F.R. § 825.217; 29 C.F.R. § 825.300.

[27] *Id.*

[28] 29 C.F.R. § 825.204.

[29] *Id.*

[30] 29 C.F.R. § 825.220(b).

[31] *See* 42 U.S.C. § 12101(a)(1), (3).

[32] 42 U.S.C. § 12101(a)(7).

[33] 42 U.S.C. § 12112(a).

[34] *See* 42 U.S.C. § 12101 (thus, applying not only to already-working employees, but potential applicants, as well).

[35] 42 U.S.C. § 12111(5)(A).

[36] C.R.S. § 24-34-402.

[37] 29 C.F.R. 825.702(b).

[38] 42 U.S.C. § 12111(8).

[39] *Doebele v. Sprint/United Mgmt. Co.*, 342 F.3d 1117, 1129 (10th Cir. 2003).

[40] *Id.*

[41] 42 U.S.C. § 12101(1)(a).

[42] *Id*. at (1)(b).

[43] *Id.*at (1)(c).

[44] 42 U.S.C. § 12102(2).

[45] *Doebele*, 342 F.3d at 1129.

[46] *Id.*

[47] *See e.g., Rakity v. Dillon Cos., Inc.*, 302 F.3d 1152, 1158 (10th Cir. 2002) (internal quotation omitted).

[48] 29 C.F.R. § 1630.2(j)(1)(i).

[49] 42 U.S.C. § 12101(4)(d).

[50] *Id.* at (4)(E)(i). However, note that the use of eyeglasses or contact lenses *shall* be considered as mitigating, and therefore may preclude a finding of substantial limitation of one or more major life activities. *Id*. at (4)(E)(ii).

[51] *See, e.g., Valdez v. McGill*, 462 Fed. Appx. 814 (10th Cir. 2012) (citing *Hudson v MCI Telecomms. Corp.*, 87 F.3d 1167, 1168-69 (10th Cir. 1996); *see also* https://adata.org/factsheet/work-leave (accessed Jan. 4, 2020).

[52] 42 U.S.C. § 12111(10).

[53] 29 C.F.R. § 825.702.

[54] 29 C.F.R. § 825.702(a).

[55] *Id.*

[56] *Id.*

[57] *Id.* at (b).

[58] *Id.* at (b).

[59] *See* 29 C.F.R. § 825.702(c)(1).

[60] *See id.*

[61] *See id.*

[62] *See id.* (3).

[63] *See id.*

[64] *See id.*

[65] *Id.*

[66] https://adata.org/factsheet/work-leave (accessed January 4, 2020).

[67] *Id.*

[68] *See id.*

History of SLAPP Suits

By Kylie Schmidt

Strategic Lawsuits Against Public Participation ("SLAPP") have become a common tool for intimidating and silencing critics from exercising their First Amendment rights. The goal of a SLAPP suit is not to win on the merits, but rather to discourage a person's right to free speech through the prospect of expensive litigation.

The acronym SLAPP was coined in the 1980s by University of Denver professors Penelope Canan and George W. Pring.[1] The professors originally defined the term as "a lawsuit involving communications made to influence a governmental action or outcome, which resulted in a civil complaint or counterclaim filed against nongovernment individuals or organizations on a substantive issue of some public interest or social significance."[2] This definition morphed as time went on, and includes all suits about speech on any public issue in the most broad interpretations.

Colorado's judicial approach to SLAPP lawsuits originated from a zoning dispute in Evergreen, Colorado.[3] The environmental group Protect Our Mountain Environment ("POME") to a real estate developer's approved application to rezone 507 acres of land in Evergreen, CO.[4] The district court ruled against POME on May 9, 1980.[5] Shortly before the ruling was entered, the real estate developer responded to the POME's challenge by filing a lawsuit against the group and its counsel.[6] The suit claimed abuse of the legal process and civil conspiracy with counsel to bring a groundless lawsuit, among other claims, and sought $10,000,000 in compensatory damages and $30,000,000 in exemplary damages.[7]

POME filed a motion to dismiss, arguing that its previous action against the developer was a lawful exercise of its First Amendment right to petition the government for redress of grievances.[8] The case ultimately went to the Colorado Supreme Court which, in an effort to balance constitutional free speech rights with the deterrence of baseless litigation, established an anti-SLAPP framework that made it easier for defendants to obtain dismissal of SLAPP suits.[9] The *POME* court promulgated a new rule for cases concerning alleged misuse or abuse of the administrative or judicial processes of government:

> That standard requires that when, as here, a plaintiff sues another for alleged misuse or abuse of the administrative or judicial processes of government, and the defendant files a motion to dismiss by reason of the constitutional right to petition, the plaintiff must make a sufficient showing to permit the court to reasonably conclude that the defendant's petitioning activities were not immunized from liability under the First Amendment because: (1) the defendant's administrative or judicial claims were devoid of reasonable factual support, or, if so supportable, lacked any cognizable basis in law for their assertion; and (2) the primary purpose of the defendant's petitioning activity was to harass the plaintiff or to effectuate some other improper objective; and (3) the defendant's petitioning activity had the capacity to adversely affect a legal interest of the plaintiff.[10]

Notably, the scope of this rule was limited only to circumstances where an administrative or judicial process is abused. A defendant that successfully challenged a SLAPP suit under POME would not be entitled to reasonable attorneys' fees.[11] Although the 1984 opinion didn't use the term SLAPP, it still established the methods by which Colorado courts have addressed SLAPP lawsuits for several decades.

Judicial and legislative responses following POME strongly favored protecting citizens from the harmful effects of SLAPP suits. New York Supreme Court Judge J. Nicholas Colabella said in reference to SLAPPs: "Short of a gun to the head, a greater threat to First Amendment expression can scarcely be imagined."[12] California became the first state in the country to enact a law protecting individuals and

businesses against SLAPPs, which are now known as anti-SLAPP laws. Last legislative session, Colorado became the 31st state to enact an anti-SLAPP law.

Colorado's Anti-SLAPP Statute

Near the end of the 2018-2019 legislative term, Senator Mike Foote, Representative Lisa Cutter, and Representative Shannon Bird introduced HB 19-1324.[13] HB-1324 ("Anti-SLAPP Statute") passed; it applied to cases filed on or after July 1, 2019.[14] The general assembly determined it was in the public interest to "encourage continued participation in matters of public significance and that this participation should not be chilled through abuse of the judicial process."[15] The general assembly further found the purpose of the law was to encourage and safeguard a person's constitutional rights to petition, speak freely, and associate freely, while at the same time protect the right to file meritorious lawsuits for demonstrable injury.[16]

As compared to POME, Colorado's Anti-SLAPP Statute significantly expanded the acts afforded protection that an individual may undertake in furtherance of one's right of petition or free speech.[17] In addition to protecting defendants of SLAPP suits related to written or oral statements made before a legislative, executive, or judicial proceeding, the law covers such statements made **in connection** with issues under consideration in those same proceedings.[18] Further, written or oral statements and other conduct or communication on issues of public interest are covered by the new statutory scheme.[19]

When a suit concerns an act in furtherance of the person's right of petition or free speech in connection with a public issue, it is subject to a special motion to dismiss unless the plaintiff establishes there is a reasonable likelihood the plaintiff will prevail.[20] The special motion must be filed within 63 days after the complaint is served and scheduled for a hearing not more than 28 days after service of the motion.[21] The court has discretion to extend the deadline for the special motion to dismiss, and may also schedule hearings beyond the time frame imposed by the statute due to the court's docket.[22] The court must consider pleadings and affidavits from the parties that state the facts upon which the liability or defense is based.[23] If the court determines the plaintiff has established a reasonable likelihood that the plaintiff will prevail on the claim, neither the ruling or of the fact of the determination is admissible in evidence at any later stage; the burden of proof for the original claim remains unaffected.[24]

Discovery is stayed upon filing of a notice of the special motion until entry of the order ruling on the motion, unless the court orders specific discovery take place.[25] Defendants that prevail on the special motion to dismiss are entitled to attorneys' fees and costs unless the court determines such a motion is frivolous or filed only to cause unnecessary delay.[26]

The procedure with the special motion to dismiss does not apply to actions brought by or on behalf of the state enforcing a law or protecting against an imminent threat to health or public safety.[27] Also excluded are actions brought solely in the public interest or on behalf of the general public where certain conditions are met.[28] Suits brought against individuals engaged in the business of leasing goods or services arising from any statement of conduct by that person are not subject to these procedures when particular factors are met.[29] To ensure the protections apply to news and press sources, the statute specifically excludes those employed by newspapers, radio or television stations, or similar entities where information is communicated to the public.[30]

Orders granting or denying a special motion to dismiss can be addressed via an immediate interlocutory appeal.[31] This allows a defendant to pause the lawsuit and directly appeal to a higher state court before discovery in the lawsuit can begin, which helps prevent the costly discovery process.

Prediction: California Law will Guide the Interpretation and Use of Colorado's Anti-SLAPP Statute

Colorado's Anti-SLAPP Statute tracks, almost verbatim, Cal. Civ. Code § 425.16 ("California's Anti-SLAPP Act") which was first enacted in 1992.[32] However, Colorado's Anti-SLAPP statute lacks a "SLAPPback" provision. SLAPPback provisions like California's

enables the defendant in a SLAPP suit to file one in return after successfully obtaining dismissal of the original SLAPP suit.[33] The SLAPPback behaves similarly to a malicious prosecution lawsuit. Besides this one notable variation between the laws, it is likely that Colorado courts will look to California case law interpreting the anti-SLAPP language to guide the application of Colorado's Anti-SLAPP Statute.

The California cases addressed in this section delineate several rulings that may offer insight into outcomes where Colorado's Anti-SLAPP Statute is used.

a. Definition of "Public Interest"

The California Supreme Court broadly construes the term "public interest" within its anti-SLAPP statute.[34] A plaintiff can't avoid application of the law by "attempting, through artifices of pleading, to characterize an action as a garden variety breach of contract [or] fraud claim, when in fact the liability claim is based on protected speech or conduct."[35]

b. Use of Anti-SLAPP Motions to Refute an Employee's Claims of Discrimination and Retaliation

In states with strong anti-SLAPP laws, courts have found that certain adverse employment actions that concern constitutional rights fall within the purview of the anti-SLAPP statute. California Courts of Appeal were split for several years on whether California's anti-SLAPP statute applied to an employee's claims of discrimination and retaliation.[36] At the forefront of the debate was whether the employer's alleged motive to discriminate or retaliate eliminates any anti-SLAPP protection that might otherwise attach to the employer's employment practices.[37]

Some panels held that the anti-SLAPP statute does not apply to claims of discrimination or retaliation by an employer, because such claims did not arise out of any protected speech or petitioning activity by the employer, even if the alleged adverse action implicated protected speech or petitioning activity. Rather, such actions arose out of the employer's improper motivation in proceeding with the allegedly improper contact.

Other panels held that the anti-SLAPP statue does apply to discrimination and retaliation claims against employers. For example, in *Symmonds v. Mahoney*, Defendant Edward Mahoney terminated Plaintiff Glenn Symmonds, a drummer who performed with him.[38] Symmonds filed suit and asserted claims of age, disability, and medical condition under state law.[39] Mahoney relied on the California anti-SLAPP statute, arguing that he had the constitutional right to select whomever he wished to perform music with him and that Symmonds' claim arose in connection with an issue of public interest (given the media's and the public's interest in Mahoney and his music).[40] The appellate court emphasized that Mahoney's burden in applying the anti-SLAPP statute "was not an onerous one" and required only a "prima facie showing that the plaintiff's claims arise from the defendant's constitutionally protected free speech or petition rights" in connection with a public issue or an issue of public interest.[41] The court further reasoned that it "must generally presume the validity of the claimed constitutional right in the first step of the anti-SLAPP analysis."[42] Ultimately, the Court held the decision to terminate Symmonds was considered protected conduct under the California's anti-SLAPP statute.[43]

The division among California Courts of Appeal resolved this year in *Wilson v. Cable News Network, Inc.*[44] The case evolved from television producer Stanley Wilson's allegations of discrimination, retaliation, wrongful termination, and defamation against CNN, his former employer.[45] Wilson was terminated following an audit of his work involving suspected plagiarism.[46] Defendants filed a special motion to strike all causes of action pursuant to California's anti-SLAPP statute.[47] The motion argued all of CNN's staffing decisions were acts in furtherance of its right of free speech and were in connection with the public interest.[48] The trial court granted the motion and dismissed the lawsuit, concluding that Wilson failed to show any of his claims had minimal merit.[49] A divided Court of Appeal reversed, rejecting the characterization of defendants' allegedly discriminatory and retaliatory conduct because it does not qualify as protected activity.[50]

The California Supreme Court reversed in part and affirmed in part the Court of Appeal, holding that "the plaintiff's allegations about the defendant's invidious motives will not shield the claim from the same preliminary [anti-SLAPP] screening for minimal merit that would apply to any other claim arising from protected activity."[51] However, the Supreme Court further held that "CNN has the burden of showing Wilson's role bore such a relationship to its exercise of editorial control as to warrant protection under the anti-SLAPP statute" and that "CNN has failed to make that showing."[52] The Supreme Court remanded the question of whether Wilson's termination claims could be stricken under the anti-SLAPP statute.[53]

As to Wilson's claims of discrimination and retaliation involving CNN's alleged actions that preceded his termination, the Supreme Court held that they would survive regardless because CNN was unaware of any potential plagiarism by Wilson until a few weeks before his termination.[54]

Wilson made clear that California's anti-SLAPP statute may be used in

employment cases where the employer's alleged discrimination and retaliation implicates protected speech or petitioning activity where there are issues of public concern involved. However, the application is made only where the employment operations implicate issues of public concern.[55]

c. Use of Anti-SLAPP Motions to Combat Defamation Claims

The *Wilson* court undertook a separate analysis in relation to Wilson's defamation claim.[56] The Court determined the defamation claim was based on CNN's speech rather than any tangible action.[57] Although the anti-SLAPP statute refers to "conduct", courts have assumed the term also includes oral or written statements.[58] The Court found that Wilson's defamation claim—arising from statements CNN made about the reasons for Wilson's termination—did not arise from speech on "a public issues or issue of public interest"[59] that contributed to the public discussion of that issue.[60] In summary, a defamation claim based upon alleged privately made statements is not subject to the anti-SLAPP statute where an employee is not a public figure and the statements at issue do not address a public controversy.

Anti-SLAPP Statutes in Federal Court

It is well established that a federal court sitting in diversity applies state substantive law and federal procedural rules.[61] Courts continue to struggle with whether state anti-SLAPP statutes can be applied in federal court. The answer, in dealing with the *Erie* doctrine, depends on whether the statute is construed as procedural or substantive. For many years federal courts routinely held state anti-SLAPP statutes could be used in federal court cases.[62]

Part of the reason why federal courts apply state anti-SLAPP statutes in federal court is to avoid forum shopping. These courts reasoned the state statutes provided substantive legal defenses, and applying them in federal court furthered important, substantive state interests.[63] As the *Godin* court explained, refusing to apply a state anti-SLAPP statute in federal court "would thus result in an inequitable administration of justice between a defense asserted in state court and the same defense asserted in federal court. . . . [T]he incentives for forum shopping would be strong: electing to bring state-law claims in federal as opposed to state court would allow a plaintiff to avoid [the anti-SLAPP statute's] burden-shifting framework, rely upon the common law's per se damages rule, and circumvent any liability for a defendant's attorney's fees or costs."[64] This reasoning echoed the earlier *Newsham* court which reasoned that, "if the anti-SLAPP provisions are held not to apply in federal court, a litigant interested in bringing meritless SLAPP claims would have a significant incentive to shop for a federal forum. Conversely, a litigant otherwise entitled to the protections of the Anti-SLAPP statute would find considerable disadvantage in a federal proceeding."[65]

A significant circuit split on application of state anti-SLAPP law in federal court existed about a year ago, but recent opinions have revealed a change in the landscape. More circuits now disfavor application of state anti-SLAPP laws due to the conflict with the Federal Rules of Civil Procedure 12 and 56. Four circuits (District of Columbia, Fifth, Tenth, and Eleventh) have refused to apply state anti-SLAPP laws in federal court.[66] Another has held that the denial of an anti-SLAPP motion is not immediately appealable.[67]

Although the Ninth Circuit has upheld the application of state anti-SLAPP laws in federal court, judges began to question whether state anti-SLAPP statutes could apply in a federal court diversity case years ago.[68] Most recently, the Ninth Circuit clarified the standards applicable to anti-SLAPP motions in federal in *Planned Parenthood Federation of America v. Center for Medical Progress.*[69] In *Planned Parenthood*, the plaintiff alleged that the defendants fraudulently entered the plaintiff's conferences and obtained meetings with the organization's staff to create false and misleading videos.[70] The defendants filed two motions to dismiss the claims: one under Federal Rule of Civil Procedure 12(b)(6) and one under California's Anti-SLAPP Statute.[71] The district court denied both motions.[72]

Because the defendants' arguments under Rule 12 were identical to those in the anti-SLAPP motion, the district court concluded that it need only assess the sufficiency of the plaintiff's complaint.[73] When the defendants raised factual defenses, the district court held questions of fact precluded dismissal.[74]

The Ninth Circuit affirmed the district court's decision, and clarified the standards applicable to anti-SLAPP motions in federal courts.[75] Adopting the holding from a previously unpublished decision, the court held that if the anti-SLAPP motion attacks the legal sufficiency of the plaintiff's complaint, a court evaluates the motion using the standard under Rule 12 and Rule 8.[76] If, on the other hand, a defendant's motion attacks the **factual sufficiency** of the claim, "then the motion must be treated as though it were a motion for summary judgment and discovery must be permitted."[77]

The panel emphasized the apparent inconsistencies between California's Anti-SLAPP Statute and the Federal Rules of Civil Procedure, holding that

a contrary reading "would lead to the stark collision of the state rules of procedure with the governing Federal Rules…."[78] It also rejected the defendants' argument that a plaintiff is **required** to present evidence, holding that "if the defendants have urged only insufficiency of pleadings, then the plaintiff can properly respond merely by showing sufficiency of pleadings, and there's no requirement for a plaintiff to submit evidence to oppose contrary evidence that was never presented by the defendants."[79]

Judge Gould, joined by Judge Marguia, issued a concurrence inviting the court to revisit its decision to hear anti-SLAPP appeals immediately.[80] The concurring opinion urged the Ninth Circuit to revisit its practice of immediately reviewing the denial of anti-SLAPP motions under the collateral order doctrine.[81] In their view, denial of an anti-SLAPP motion does not qualify as a collateral order because "it [] requires the court to directly assess the merits of Plaintiffs' complaint" instead of resolving claims separate from the merits.[82] The judges stopped short of encouraging the Ninth Circuit to reconsider its decision to apply anti-SLAPP statutes in federal court, but noted that "one of the primary drivers for allowing this practice to continue—prevention of a circuit split—has occurred despite our best efforts."[83]

The Tenth Circuit has already declined to apply specific anti-SLAPP statutes in federal court in *Los Lobos Renewable Power, LLC v. Americulture, Inc.*[84] In *Lobos*, a dispute arose over contractual rights and obligation of two businesses related to 2,500 acres of land leased by the United States Bureau of Land Management.[85] The complaint included paragraphs alleging the Defendants made material misrepresentations concerning the Plaintiffs to numerous state agencies and other public bodies.[86] Defendants responded to these allegations by filing a "special motion to dismiss" authorized by New Mexico's anti-SLAPP statute[87], claiming the state law's protections were substantive in nature.[88] The district court determined that New Mexico's anti-SLAPP statute is a "procedural provision" that does not apply in federal court.[89] The *Lobos* panel affirmed the district court's decision, concluding that the plain language of the New Mexico anti-SLAPP statute reveals the law is a procedural mechanism not designed in impact the outcome of the case but only the timing of the outcome.[90] The court noted, though, that the statute was unlike many other states' anti-SLAPP statutes[91], which shift substantive burdens of proof or alter substantive standards.[92]

Conclusion

Colorado's early case law protecting the first amendment rights of its citizens has greatly expanded with the passing of the anti-SLAPP statute. Given the nearly identical language in Colorado's Anti-SLAPP Statute as compared to California's, it is likely Colorado courts will use rulings in California as persuasive authority to assist in creating a new body of law in our state. Employment attorneys may begin to see special motions to dismiss filed as tactics to defeat claims of discrimination and retaliation in state court. Because specific language used in Colorado's Anti-SLAPP Statute implicates substantive measures, federal courts in Colorado have room to distinguish from the Tenth Circuit's decision in *Lobos* and permit special motions to dismiss in diversity cases. ▲▲▲

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Endnotes:

1 George W. Pring & Penelope Canan, SLAPPs: Getting Sued for Speaking Out (1996).

2 *Id*.

3 *Protect Our Mountain Env't, Inc. v. Dist. Court of Cnty. of Jefferson*, 677 P.2d 1361 (Colo. 1984).

4 *Id*. at 1362-1363.

5 *Id*. at 1364.

6 *Id*.

7 *Id*.

8 *Id*. at 1362.

9 *Id*. at 1368-1369.

10 *Id*.

11 C.R.S. 13-17-201.

12 *Gordon v. Morrone*, 590 N.Y.S.2d 649, 656 (N.Y. Sup. Ct. March 31, 1992).

13 Strategic Lawsuits Against Public Participation, H.R. 1324, 72nd General Assembly (Colo. 2019).

14 *Id*.

15 C.R.S. 13-20-1101(1)(a).

16 C.R.S. 13-20-1101(1)(b).

17 C.R.S. 13-20-1101(2)(a).

18 C.R.S. 13-20-1101(2)(a)(I)-(II).

19 C.R.S. 13-20-1101(2)(a)(III)-(IV).

20 C.R.S. 13-20-1101(3)(a).

21 C.R.S. 13-20-1101(5).

22 *Id*.

23 C.R.S. 13-20-1101(3)(b).

24 C.R.S. 13-20-1101(3)(c).

25 C.R.S. 13-20-1101(6).

26 C.R.S. 13-20-1101(4)(a).

27 C.R.S. 13-20-1101(8)(a)(I).

28 C.R.S. 13-20-1101(8)(a)(II).

29 C.R.S. 13-20-1101(8)(a)(III).

30 C.R.S. 13-20-1101(8)(b)(I)-(II).

31 C.R.S. 13-4-102.2; C.R.S. 13-20-1101(7).

32 C.R.S. 13-20-1101; Cal. Civ. Code § 425.16.

33 Cal. Civ. Code § 425.18.

34 *Equilon Enterprises v. Consumer Cause, Inc.*, 52 P.3d 685, 67 (Cal. 2002).

[35] *Martinez v. Metabolife Internat., Inc*., 113 Cal. App. 4th 181, 187 (Cal. Ct. App. 2003).

[36] *Wilson v. Cable News Network, Inc.*, 444 P.3d 706, 712 (Cal. 2019).

[37] *Id*.

[38] *Symmonds v. Mahoney*, 31 Cal. App. 5th 1096, 1100 (Cal. Ct. App. 2019).

[39] *Id*.

[40] *Id*. at 1099.

[41] *Id*. at 1103.

[42] *Id*.

[43] *Id*. at 1105.

[44] *Wilson v. Cable News Network, Inc.,* 444 P.3d 706 (Cal. 2019).

[45] *Id*. at 711-712.

[46] *Id*. at 711.

[47] *Id*. at 712.

[48] *Id*.

[49] *Id*.

[50] *Id*.

[51] *Id*. at 710.

[52] *Id*. at 721.

[53] *Id*. at 723.

[54] *Id*.

[55] *Id*. at 722.

[56] *Id*. at 723.

[57] *Id*.

[58] *Id*.

[59] Cal. Civ. Code § 425.16(e)(4).

[60] *Wilson*, 444 P.3d 706, 724; *See also Jeffra v. California State Lottery*, 39 Cal. App. 5th 471 (Cal. Ct. App. 2019) (although employer's investigation of possible misconduct by employee was protected activity within the meaning of the anti-SLAPP statute, plaintiff established a probability of prevailing on the merits of his claim, so employer's motion was properly denied).

[61] *Erie Railroad Co. v. Tompkins*, 304 U.S. 64 (1938).

[62] *See, e.g., Godin v. Schencks*, 629 F.3d 79 (1st Cir. 2010); *Henry v. Lake Charles American Press, L.L.C.*, 566 F.3d 164 (5th Cir. 2009); *United States ex rel. Newsham v. Lockheed Missiles & Space Co.*, 190 F.3d 963 (9th Cir. 1999).

[63] *Godin*, 629 F.3d 79; *Newsham*, 190 F.3d 963.

[64] *Godin,* 629 F.3d 79 at 92.

[65] *Newsham*, 190 F.3d 963 at 973.

[66] *Abbas v. Foreign Policy Grp., LLC*, 783 F.3d 1328, 1333-37 (D.C. Cir. 2015); *L. Lobos Renewable Power, LLC v. Ameri-Culture, Inc.*, 885 F.3d 659 (10th Cir. 2018); *Carbone v. CNN, Inc.*, 910 F.3d 1345 (11th Cir. 2018); *Klocke v. Watson*, 936 F.3d 240 (5th Cir. 2019).

[67] *Ernst v. Carrigan*, 814 F.3d 116, 119 (2d Cir. 2016).

[68] *See, e.g., Makaeff v. Trump Univ., LLC*, 715 F.3d 254, 275 (9th Cir. 2013) (Kozinski, J., concurring) ("Federal courts have no business applying exotic state procedural rules which, of necessity, disrupt the comprehensive scheme embodied in the Federal Rules"); *Makaeff v. Trump Univ., LLC*, 736 F.3d 1180, 1188 (9th Cir. 2013) (Watford, J., dissenting from denial of rehearing *en banc*) (Rules 12 and 56 "establish the exclusive criteria for testing the legal and factual sufficiency of a claim in federal court.").

[69] *Planned Parenthood Fed'n of Am. v. Ctr. for Med. Progress,* 890 F.3d 828 (9th Cir. 2018).

[70] *Id*. at 831.

[71] *Id*.

[72] *Id*.

[73] *Id*. at 832.

[74] *Id*.

[75] *Id*. at 833-834.

[76] *Id*.

[77] *Id.* at 833.

[78] *Id.* at 834.

[79] *Id*.

[80] *Id*. at 835-838.

[81] *Id*. at 835-837.

[82] *Id.* at 836.

[83] *Id.* at 836.

[84] *Los Lobos Renewable Power, LLC v. Americulture, Inc.,* 885 F.3d 659, 673 (10th Cir. 2018).

[85] *Id.* at 661.

[86] *Id.* at 662.

[87] N.M. Stat. Ann. §§ 38-2-9.1 & 38-2-9.2.

[88] *Lobos*, 885 F.3d 659 at 662.

[89] *Id*.

[90] *Id*. at 668.

[91] *Cf., e.g., Makaeff v. Trump Univ., LLC*, 715 F.3d 254 (9th Cir. 2013) (addressing a California anti-SLAPP statute that shifted substantive burdens and altered substantive standards).

[92] *Lobos*, 885 F.3d 659 at 666.


Short-Term Healthcare Insurance and the Institutionalization of Post-Claims Underwriting

By Jessica L. Derakhshanian and Shane C. Fulton

I. Introduction

Millions of Americans seeking alternatives to the Affordable Care Act's comprehensive health care coverage may be drawn towards short-term health insurance plans, enticed by the plans' availability or price. Because these plans operate outside of the ACA and are not governed by its rules, many times, insureds are surprised to discover that the coverage provided by these plans is not inclusive and often, can be rescinded if the insurer later determines that the insured did not correctly answers policy application questions, even when the supposed incorrect answer has nothing to do with the need for the health care at issue. All too often, the policy is rescinded after a claim has been made—thereby leaving the insured in a vulnerable position and without coverage.

The purpose of this article is to (1) provide a review of short-term health insurance regulation over the last decade, (2) analyze the ways in which the changing regulatory landscape has fostered the institutionalization of post-claim underwriting, and (3) suggest means by which regulators and legal practitioners may address inequities in the current health insurance market.

II. Chronology

A. Pre-Affordable Care Act

Prior to the implementation of the Affordable Care Act (ACA) in 2014, health insurance sold in the individual market was medically underwritten. That is, insurers evaluated the health status, medical history, and other risk factors of applicants to determine whether to issue coverage, and if so, on what terms. Applications for individual market policies included lengthy questionnaires seeking disclosure of information concerning past medical care, pregnancy, medications, lab results, past treatment, diagnosis, and a variety of other issues. Also, applications typically included an authorization that allowed the insurer to obtain and review all of the applicant's medical records.

In this regard, the standard in the health insurance industry was for the insurer to complete a comprehensive investigation prior to agreeing to insure an applicant.[1] The ostensible purpose of medical underwriting is and was to allow the insurer to issue policies to healthier, less-risky applicants and avoid adverse selection. As a result, people with a current or past diagnosis of a "declinable medical condition"—including a variety of mental health disorders, obesity, heart disease, dementia, arthritis, and many, many other conditions—were often denied coverage.[2] It is estimated that approximately 27% of Americans under the age of 65 have health conditions that would likely leave them uninsurable.[3]

B. The Affordable Care Act

In 2014, Congress enacted the Affordable Care Act, which remedied some of the exclusionary effects of medical underwriting. In particular, the ACA required certain plans to include essential health benefits and also mandated that health insurers could not exclude from coverage or charge higher premiums to people with preexisting conditions. Many of the most important protections of the ACA apply to individual and small group plans.

Short-term health insurance, however, is specifically exempted from the ACA's purview. The ACA adopted existing definitions of insurance terms found in the Public Health Service Act. To this end, 42 U.S. Code § 300gg–91 defines "individual health insurance coverage" as "health insurance coverage offered to individuals in the individual market, but [which] does not include short-term limited duration insurance." Neither HIPAA nor the ACA expressly defined exactly how short "short-term" is, but regulations that antedated the ACA required the term of coverage to be less than 12 months.[4]

C. Short-term Health Insurance

Despite the limitations, short-term health insurance policies remain attractive to a percentage of the population because these plans are generally cheaper than ACA-compliant plans and thus appeal to younger, healthier consumers.

Cheaper premiums, however, do not translate to lost profits for insurers. Short-term policies are highly profitable for insurers, as they have significantly lower loss ratios than

ACA-compliant plans. Data from the National Association of Insurance Commissioners (NAIC) shows that short-term plans had an average loss ratio of about 65 percent in 2017 (compared to 80 percent for ACA-compliant individual market policies).[5] The three largest insurers offering short-term coverage had even lower loss ratios of about 44 percent, 34 percent, and 52 percent. The increased profits may fairly be attributed to the fact that short term policies generally offer skimpier coverage and insurers' frequent post-claim recissions result from post-claim underwriting..

As the ACA's major reforms went into effect, some insurers began selling short-term policies that lasted for 364 days. By offering coverage that extends just one day shy of 12 months, insurers could sell non-ACA compliant policies that met the definition of short-term, limited-duration insurance under federal law and, thus, avoid having to bring these policies into compliance with the ACA.

In 2016, federal regulators concluded that short-term coverage was being sold as primary coverage and was adversely impacting the risk pool for ACA-compliant coverage. It was estimated that enrollment in short-term coverage would reach 1.9 million people by 2022. To combat the move towards short-term policies, the IRS, HHS, and Employee Benefits Security Administration issued a regulation limiting short-term coverage to a period of less than three months, including renewals—the time period that individuals may remain without coverage without having to pay the ACA's individual responsibility penalty.[6]

D. Executive Order 13813 and the New Rules

In October 2017, President Trump signed an executive order directing federal agencies to draft regulations aimed at unraveling the ACA.[7] As related to short term limited duration health insurance, this Order directed the Secretaries of the Treasury, Labor and Health and Human Services to "consider proposing regulations or revising guidance, consistent with law, to expand the availability of" short-term medical plans. This Order urged the Secretaries to "consider allowing such insurance to cover longer periods and be renewed by the consumer."[8]

In response to this Order, the Departments of Health and Human Services, Labor, and Treasury released a proposal in February 2018 that extended the availability of short-term health insurance plans. This proposal, which was finalized in August 2018, changed the maximum duration a consumer could purchase such coverage. Prior to 2018, federal regulations limited the duration of short-term health plans to 90 days. Now, individual plan buyers who are unable or unwilling to by ACA-compliant plans may have the option to purchase a short-term insurance plan for an initial term of up to 364 days, with potential for renewals up to 36 months.[9]

To justify this change, HHS pointed to the coverage's name: "short-term limited duration." HHS reasoned that "short-term" and "limited duration" must mean different things or the name would be redundant. "Short-term", HHS argues, refers to initial term, but "limited duration," allows for multiple renewals.

In the final rule, HHS noted that nothing in the federal statute would prevent a person from enrolling in a new short-term plan after the expiration of the 36-month period. "Nothing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months." As written, a person could purchase multiple short-term plans, potentially linking together short-term coverages for an indefinite period of time.

E. Challenges to the New rule

In September 2018, a group of seven plaintiffs made up of health insurers, physicians, and consumer advocacy organizations, sued the United States Department of Treasury along with multiple other defendants, in the United States District Court for the District of Columbia, challenging the HHS rules. In *Association for Community Affiliated Plans, et. al v. United States Department of Treasury, et. al*,[10] the plaintiffs argued that the new rule violated the plain-English meaning of "short-term" and "limited duration," that it arbitrarily reversed previous limits on these plans to create an alternative to ACA-compliant plans that Congress did not authorize, and that it violated the ACA by effectively undercutting ACA plans, making them increasingly unaffordable and unsustainable for consumers.

In July 2019, however, U.S. District Court Judge Richard J. Leon rejected these claims, finding that Congress had intentionally left the definition of "short-term limited duration insurance" up to HSS and that the Trump Administration had not violated the ACA with the 2018 regulations. Judge Leon found that "any potential negative impact" from the rule would be "minimal," and "its benefits are undeniable."[11]

Nevertheless, HHS made it clear in the final regulations that states may continue to implement more restrictive rules.[12]

III. Post-Claims Underwriting

The proliferation of short-term medical policies has coincided with the institutionalization of a controversial practice known as post-claim underwriting. Post-claim underwriting is an inversion of the established sequence

of underwriting. In other words, the insurer "wait[s] until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued."[13]

This practice, which was largely used by health insurers prior to the adoption of the ACA, has been the subject of multiple Congressional investigations. In a June 16, 2009 hearing, Henry Waxman, Democratic Representative from California, stated:

> They scour the policyholder's original insurance application and the person's medical records to find any discrepancy, any omission or any misstatement that could allow them to cancel the policy. They try to find something, anything so they can say that this individual was not truthful in that original application. It doesn't have to even relate to the medical care the person is seeking and often doesn't.

For its part, the Mississippi Supreme Court has strongly admonished insurers that engage in post-claims underwriting.

> It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn *after* he submits a claim that he is *not* insured, and, therefore, cannot obtain any other policy to cover the loss…[14]

An insurer engaged in post claim underwriting does not attempt to reduce risk or adverse selection. Instead, the insurer performs no underwriting and endeavors to generate the greatest amount of premium revenue possible. The result is that the insurer will have issued at least some policies to individuals that would not have been able to secure coverage had underwriting been performed. Yet, the insurer has reduced costs across the board by disposing with underwriting. Further, to the extent that a traditionally uninsurable individual never makes a claim during the short pendency of the policy, the insurer still recognizes a profit that would not have been recognized had underwriting been performed. Finally, to the extent that the traditionally uninsurable individual *does* make a claim, an insurer engaging in post-claim underwriting then takes the opportunity to conduct an exhaustive underwriting process in an attempt to deny claims based upon application misrepresentations or pre-existing condition exclusions.

Examples of the real-world consequences of these "junk" plans, which were cited in the *Association for Community Affiliated Plans, et al. v. United States Department of Treasury, et al.*,[15] complaint include:

- A woman in Illinois went to the hospital with heavy vaginal bleeding resulting in a five-day hospital stay and a hysterectomy, only to be denied coverage under her short-term plan on the ground that her menstrual cycle constituted a pre-existing condition.
- A man in Washington, D.C., purchased a short-term plan with a stated maximum payout of $750,000; when he sought coverage for a $211,000 bill resulting from a hospitalization, however, he was paid only $11,780, in part due to a denial of coverage based on his *father's* medical history.

Post-claim underwriting allows carriers to transform an uncertain event—the loss— into an event that is certain. "This manipulation of the odds is possible only because of the postponement in performance occasioned by the sequential character of the insurance contract."[16] The insurance industry argues that post-claims underwriting and rescission are necessary to defend against fraud and keep insurance affordable. "In some cases, an applicant may have an incentive to conceal information about her health or risk status from an insurer in order to obtain coverage or terms of coverage that might otherwise not be issued. At the same time, an applicant might inadvertently fail to disclose information—for example, about health history in the distant past or concerning seemingly minor and unimportant health conditions or symptoms."[17]

For their part, consumer advocates argue that insurers have a strong financial incentive to rescind coverage for individuals with high-value claims. This is evidenced by the lower amount paid out by short-term carriers.[18] Additionally, information discovered during the investigation process may or may not be related to the claim that triggered the investigation.[19] Critics also argue that the industry uses vague questions in applications that are difficult for applicants to answer accurately and completely, thereby leaving the door open for future rescission.

Finally, in the event that an insured's policy is rescinded after a post-claim investigation, the insured does not merely lose the benefits of their short-term policy—they are without the ability to purchase a new or different policy that would cover their pending claim. To combat the risk of this outcome, certain states, including Connecticut in Connecticut General Statute Sec. 38a-477b, require pre-approval of coverage cancellation or rescission.

IV. Colorado's Regulation on Short-Term Policies

The Colorado Division of Insurance (DOI), which is part of the Department

of Regulatory Agencies (DORA), amended the regulations governing short-term limited duration health benefit plans to require these plans provide many of the protections afforded by ACA qualified plans. As provided by amended regulation 4-2-59, short-term health plans must comply with multiple rules:

- Because short-term plans meet the state definition of health benefit plans, they must cover essential health benefits mandated by Colorado law, such as preventive services, prescription drugs, hospitalization and maternity and newborn care.
- Premiums for such plans can vary only due to the same factors as ACA-qualified plans: family (individual vs. family plan), geographic rating area, age (with premiums for the oldest to be no more than three times the cost of the youngest, a 3:1 ratio), tobacco use and the benefits of the plans themselves.
- The health status of enrollees, and their claims history, cannot be used to calculate or vary premiums.
- Policies are guaranteed-issue, meaning that anyone who applies must be accepted. Pre-existing conditions may be excluded from coverage.
- Short-term plans must spend at least $0.80 of every dollar collected in premiums on health care claims. This is known as a medical loss ratio (MLR) of 80%.

Since the implementation of this regulation, insurers no longer offer short-term medical plans in Colorado.

V. Other States' Approaches

Other states have also joined Colorado in restricting the sale of short-term plans:

- **California** enacted SB910 in 2018 that prohibits the sale of short-term plans in the state as of January 1, 2019.[20]
- **Hawaii** passed HB1520, which was signed it into law in July 2018. The legislation prohibits the sale of a short-term plan to anyone who was eligible to purchase a plan in the exchange during the previous calendar year, either during open enrollment or during a special enrollment period. The only people who aren't eligible to purchase coverage in the exchange are undocumented immigrants, incarcerated individuals, and people who are eligible for premium-free Medicare Part A.[21]
- **Maryland** enacted HB1782 in 2018, which limits short-term plans to three months and prohibits renewal.
- **Vermont** also enacted H.892 to limit short-term plans to three months and prohibit renewal. Currently, no short-term plans are for sale in Vermont.
- Lawmakers in **Illinois** approved HB2624, which limits short-term plans to durations of less than 181 days, prohibits renewals, and prevents an enrollee from purchasing a new short-term plan from the same issuer within 60 days of the termination of a previous short-term plan. Governor Rauner vetoed HB2624, but lawmakers overrode his veto in November 2018 and the bill became law.
- **Washington** has limited short-term plans to three months, prevents renewals, and prohibits insurers from selling short-term coverage in the prior 12 months. The new rule also prohibits the sale of short-term plans during open enrollment, if the short-term coverage is to take effect in the coming year.
- **Delaware** and **New Mexico** have both implemented regulations that limit short-term plans to three-month durations and prohibit renewals.[22]
- **Maine** enacted legislation, LD1260, that requires short-term plans to terminate no later than December 31st of the year in which the plan was issued. The new law also imposes various other requirements, including a ban on the sale of short-term plans during the ACA's open enrollment period (unless the plan is slated to start and end prior to the start of the new year) and a requirement that the applicant be informed about the availability and cost of ACA-compliant options.
- **South Carolina**: In *Mitchell Jr. v. Fortis Insurance*, the defendant insurer argued that "as a general matter, post-claim underwriting is 'perfectly lawful' in South Carolina." The Supreme Court of South Carolina, however, held "Fortis's post-claim underwriting practices played a pivotal role in the harm inflicted upon Mitchell in South Carolina. This evidence was probative of Fortis's bad faith conduct, and was properly submitted to the jury.[23]

Other states have worked to **expand** access to short-term plans, including:

- **Indiana** enacted legislation HB1631 that allows short-term plan durations to conform with the new federal rules for plans issued on or after July 1, 2019. The legislation also added a new requirement that short-term plans have benefit maximums of at least $2 million, and took effect in July 2019.[24]

- **Oklahoma** enacted legislation SB993 that allows short-term plans to mirror the same maximum durations as the federal rules.[25]
- **Arizona** enacted legislation SB1109 that allows short-term plans to mirror the same maximum durations as the federal rules.[26]
- **Missouri** lawmakers considered HB165 (it passed the House in 2018, but not the Senate), which would have defined short-term coverage as a policy with a duration of less than one year.[27] The House passed the bill, but it didn't reach a full vote on the Senate floor.
- In **Minnesota**, current rules restrict short-term plans to no more than 185 days in duration, and residents are limited to having short-term insurance for no more than 365 days out of a 555-day period. But HF3138 would have redefined a short-term plan as being less than a year in duration and eliminated the 365 out of 555 days cap.[28] The bill passed the House, but did not advance to a vote on the Senate floor.
- In **Virginia**, lawmakers passed SB844 in 2018, to allow short-term plans to have a term of up to 364 days, however, Governor Northam vetoed this bill in May 2018.[29]

While many states have led the charge to combat the abuses of post-claim underwriting, Congress continues to fight as well. A 2009 Congressional Investigation led by the House of Representatives Committee On Energy and Commerce determined that, "Over the past 5 years almost 20,000 individual insurance policyholders have had their policies rescinded by three insurance companies who will testify today: Assurant, United Health Group and WellPoint."[30]

Although this 2009 investigation did not specifically pertain to short-term health insurance policies because short-term policies operate outside of the ACA, the same problems have arose again.

In a March 13, 2019 letter to National General CEO Barry Karfunkel, the Committee states,

> The Committee's initial examination of these plans has yielded disturbing information about how insurance companies that sell STLDI discriminate against individuals with pre-existing conditions and put consumers at significant financial risk. Additionally, we are troubled that consumers who sign up for these plans are being misled about the nature of the coverage they are purchasing.

VI. Conclusion

Based on the recent federal court ruling upholding the 2018 HHS regulations directed by the Trump Administration, for the time being it seems that any broadside attack on the rules face an uphill battle. However, state regulators remain generally resistant to short-term coverage that misleads consumers and institutionalizes of post-claim underwriting. Insurers are already unwilling to write short-term coverage in a number of states, and this is a trend that may well continue.

Nevertheless, many consumers have already fallen victim to post-claim underwriting. Fortunately, Colorado insurance law provides multiple avenues through which consumers can seek recourse. Colorado's Unfair and Deceptive Trade Practices Act, C.R.S. § 10-3-1104(1)(h), sets forth certain standards, the violation of which can be used as evidence of bad faith conduct. Where an insurer has engaged in post-claims underwriting, its actions could result in numerous violations of this Act, including but not limited to the following:

- Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; and
- Compelling an insured to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by an insured.

In addition, if the insurer delays payment or denies a claim for medical benefits owed, the insured may also have a claim against the insurer under C.R.S. § 10-3-1115 as well as Colorado's Prompt Pay Statute, C.R.S. §10-16-106.5. Colorado's Prompt Pay Statute mandates payment or denial of all claims within 90 days after receipt; the only exception to this 90-day rule is if the insured engaged in fraud. Notably, depending on the facts of each case, additional remedies may be available. ▲▲▲

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Endnotes:

[1] Thomas C. Cady & Georgia L. Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. (2000), *available at* https://researchrepository.wvu.edu/wvlr/vol102/iss4/5.

[2] Garu Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, The Henry J. Kaiser Family Foundation (Dec. 2016), http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA

[3] *See id.*

[4] 26 CFR 54.9801-2.

[5] https://www.naic.org/prod_serv/AHP-LR-18.pdf

[6] 26 CFR 54.9801-2.

[7] Executive Order 13813, Executive Order Promoting Healthcare Choice and Competition Across the United States, 82 F.R. 48385 (October 12, 2017), *available at* https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/.

[8] *Id*. at sec. 3.

[9] Short-Term, Limited Duration Insurance, 83 F.R. 38212, *available at* https://www.govinfo.gov/content/pkg/FR-2018-08-03/pdf/2018-16568.pdf.

[10] *Ass'n for Cmty. Affiliated Plans, et al. v. U.S. Dep't of Treasury*, Case No. 18-2133 (RJL) (D.D.C. Jul. 19, 2015).

[11] *Id.*

[12] Short-Term, Limited Duration Insurance, 83 F.R. 38212, 38232 "This final rule has no federalism implications to the extent that current state law requirements for short-term, limited-duration insurance are the same as or more restrictive than the Federal standard in this final rule."

[13] *Lewis v. Equity Nat. Life Ins. Co.*, 637 So.2d 183 (Miss. 1994).

[14] *Id*. at 188-89 (emphasis added).

[15] *Ass'n for Community Affiliated Plans*, Case No. 18-2133.

[16] *See* Cady & Gates, *supra* note 1, at 819.

[17] Peter Harbage & Hilary Haycock, Primer on Post-Claims Underwriting (Robert Wood Johnson Foundation 2016), available at https://harbageconsulting.com/wp-content/uploads/2016/08/Primer-on-Post-Claims-Underwriting.pdf.

[18] According to the National Association of Insurance Commissioners' 2018 *Accident and Health Policy Experience Report*, the average loss ratio of the top five short-term plan insurers by total premiums was 39.2% in 2018 (compared to 80% from ACA-compliant policies). In other words, these short-term carriers only paid 39 cents out of every dollar collected in premium on medical care.

[19] While many states do not require the condition investigated be related to the conditions requiring medical treatment, there are exceptions to the rule. *See* Tenn. Code Ann. 56-7-103: "No written or oral misrepresentation or warranty made in the negotiations of a contract or policy of insurance, or in the application for contract or policy of insurance, by the insured or in the insured's behalf, shall be deemed material or defeat or void the policy or prevent its attaching, unless the misrepresentation or warranty is made with actual intent to deceive, or unless the matter represented increases the risk of loss."

[20] *See* CA Ins. Code Section 10123.61 ("Commencing January 1, 2019, a health insurer shall not issue, amend, sell, renew, or offer a policy of short-term limited duration health insurance in this state.").

[21] *See* HB1520, Relating to Insurance, "No insurer shall issue, renew, or re-enroll an individual in a short-term, limited-duration health insurance policy or contract if the individual was eligible to purchase health insurance through the federal health insurance marketplace during an open enrollment period…" *available at* https://www.capitol.hawaii.gov/session2018/bills/HB1520_CD1_.htm.

[22] *See* HB285, Section 2.I., *available at* https://www.nmlegis.gov/Sessions/19%20Regular/final/HB0285.pdf (limiting short-term plans to three months.).

[23] *Mitchell v. Fortis Ins. Co.*, 385 S.C. 570, 595, 686 S.E.2d 176, 189 (2009).

[24] HB1631 (2019), *available at* http://iga.in.gov/legislative/2019/bills/house/1631/#document-2a4d294a.

[25] SB993 (2019), *available at* http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENR/SB/SB993%20ENR.PDF.

[26] SB1109 (2019), *available at* https://legiscan.com/AZ/text/SB1109/id/1962211/Arizona-2019-SB1109-Chaptered.html.

[27] HB1685 (2018), *available at* https://www.house.mo.gov/billtracking/bills181/hlrbillspdf/5383H.02P.pdf.

[28] HF3138 (2018), *available at* https://www.revisor.mn.gov/bills/text.php?number=HF3138&type=bill&version=3&session=ls90&session_year=2018&session_number=0&format=pdf.

[29] SB844, An Act relating to individual health insurance coverage; short-term policies (2018), *available at* http://lis.virginia.gov/cgi-bin/legp604.exe?181+ful+SB844ER+pdf.

[30] Statement of Congressman Bart Stupak, Hearing Before Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, June 16, 2009.

Total Loss Property Damage Claims: Practical Tips You Can Use Today

By Lisandra Matos

When a crash occurs, our clients do not know about the chronic back pain that may follow them for the rest of their lives, the tear in their shoulder, or how gruesome this whole process will be for them and their family. However, they immediately know one thing: their car is destroyed, and their lives are put upside down because of this.

That is why many Plaintiffs focus on the property damage claim at the beginning of their case instead of their health. As personal injury attorneys, we are concerned about the personal injury case. However, the reality is that until we deal with the property damage questions, our clients will not focus on what matters the most, their health. Living in Denver and not having a car can paralyze you more than any physical pain.

In our law firm, we help our clients with their property damage claim so that they can focus on their health and the personal injury case. In this article, I will discuss the tools we use to help our clients when their vehicle is declared a total loss.

How to Negotiate the Vehicle's Fair Market Value?

The insurance companies typically use companies such as CCC, Mitchell, or AutoSource to determine the fair market value of the lost vehicle. These companies exclusively work with insurance companies, and not surprisingly, the reports created by them are not always in our clients' favor. As personal injury attorneys, we do not have similar companies who will work with us, so challenging these reports can seem daunting. Adjusters may say that "this report is final," but we know that everything is negotiable.

The Colorado insurance regulations require the following in total loss claims:

1. The insurer shall develop and maintain written procedures that will be consistently used when determining the value of a vehicle declared a total loss.
2. Claims files shall include the credible source used for valuation by vendor name and the methodology for determining the amount of the loss. Claims files shall document that the valuation considered unique characteristics of a total loss vehicle, such as classic status, unique finishes, mileage and/or, special accessories.[1]

Therefore, the first step should be to request the insurance company's valuation report and make sure that your client has a chance to review it. The insurance company may evaluate the vehicle as a different trim level or fail to include features that the lost car had. The car owner will know more about those details than the attorney. Also, ask your client to send you any maintenance receipts that he may have.

The second step is to review the valuation report and make sure that the comparables used by the insurance company are located in the Denver area. If the comparable vehicles are not in the Denver area, is that vehicle representative of the fair market value of your client's car? It is very unlikely that your client will go out of state to buy a replacement vehicle, and such a long-distance purchase also comes with additional expenses not accounted for in the insurance company's valuation report.

Use websites such as nada.com, Edmunds.com, and kbb.com to obtain your own comparable vehicles in the Denver area. Do not focus on the estimated value listed on these websites. Instead, look for vehicles similar to your client's car that are being sold in the Denver area. Most likely, you will find that if your client wanted to buy a similar car, they would need to come up with more money than what the insurance company is trying to offer.

Demand a re-evaluation of the fair market value of the vehicle in which the insurance company takes into account the comparable vehicles that you found and the maintenance receipts provided by your client. Also, make sure to point out any vehicle characteristics that might have been missed by the appraiser and any other issues in the valuation report.

This approach has helped me obtain significantly better offers for our client's total loss property damage claims.

Loss of Use Damages

Most likely, the insurance company will not advise your client that if they are deprived of the use of their vehicle, they can recover for the loss of use of their vehicle.

According to the Colorado Jury Instructions for Civil Trials:

> If you find in favor of the plaintiff, you shall also award an amount which will reasonably compensate the plaintiff for any loss of use of (his) (her) *(insert description of property)*during the time reasonably required to make the necessary repairs. These damages must be proven by a preponderance of the evidence. The measure of these damages is the *(the reasonable rental value of the [insert description]) (the reasonable cost of renting or replacing a similar [insert description] for use) (lost profits)* while repairs are being made.[2]

Moreover, the Colorado Division of Insurance Regulations states:

> Payments for third-party coverage for a replacement motor vehicle, of a comparable class, shall not be discontinued until:
>
> a. Three days after payment for the total loss of the motor vehicle was mailed, via US Postal Service, to the last-known address of the claimant or after a reasonable settlement offer has been made in compliance with § 10-3-1104 (1) (h), C.R.S.; or
>
> b. One day after payment for the total loss of the motor vehicle was transmitted via overnight delivery to the last-known address of the claimant or directly to the financial account of the claimant; or
>
> c. Payment is made directly to the entity repairing the motor vehicle of the claimant and the repaired vehicle is returned to the claimant or claimant has a reasonable opportunity to take possession of the vehicle from the repair facility.[3]

Calculate the number of days your client should have had a rental vehicle as required by Colorado law and look for the rental value of a car similar to your client's vehicle. This information can be easily obtained in car rental companies' websites.

Send a demand enclosing proof of the rental value of a similar vehicle, the Colorado Jury Instructions for loss of use damages, and the relevant Colorado insurance regulations. This is a very simple process that can make a huge difference for a client who is trying to purchase a new car because it will allow your client to have extra cash that can be used towards their new car.

Using loss of use claims to avoid insurance company's liability investigation delays

In some cases, the insurance can take a long time to determine liability. In the meantime, your client may be waiting for a liability determination to get a rental, or to have their car repaired if they do not have these coverages with their own insurance company. This can be extremely stressful for someone who lost their car and was injured at no fault of their own.

The longer the third-party insurance company takes to accept liability, the more days that we can include in the loss of use demand. We have found that this approach encourages the adjusters to finalize their liability investigation faster.

When the Bank Owns the Car

Client's Car Payments Due Before the Total Loss Claim is Resolved

The insurance companies may not pay the bank before the client's next monthly car payment is due, which can affect your client's credit history. You can advise your client to call their bank and explain that the car was declared a total loss and request an extension for payment while the insurance company evaluates the claim. It is important that your client continues to communicate with their bank so that their credit score is not affected by late payments.

Gap Insurance

It is crazy that you can be involved in a car crash through no fault of your own, your car is completely destroyed, you are injured, **and then**, you also end up owing money to the bank because the at-fault driver's insurance company is only obligated to pay the fair market value of the car instead of what you owe on your loan. In these cases, gap insurance may be the answer. Claims with gap insurance companies are not very challenging, but they require a lot of documents that may not even be in your client's possession. If you anticipate that gap insurance will have to be involved, it is important to advise the client to start gathering these documents to avoid additional delays caused by a gap insurance claim. It is also important that your client continues to communicate with the bank so that their credit score is protected.

When Your Client Gets a Rental Car

It is important to advise your client to make sure that damages to their rental vehicle are covered under their

own insurance. It is possible that your client can be involved in another accident while in the rental, and it is important to know who will be responsible if something happens. If your client's insurance does not cover damages to the rental car, the other insurance company should pay for the rental vehicle's insurance. The Division of Insurance Regulations outline this process as follows:

1. An insurer shall provide payment to a third-party claimant for a collision damage waiver required by a motor vehicle rental company when the claimant does not have collision coverage, or coverage does not extend to a rental vehicle through his or her own motor vehicle insurance and the insurer may request the following:

a. Verification that the claimant did not have collision coverage on the damaged vehicle, at the time of loss, or that the collision coverage on his/her automobile policy does not extend to rental vehicles; and

b. Verification that the Collision Damage Waiver was signed, by the claimant, indicating collision coverage was secured. [4]

Conclusion

The main argument against getting involved in the property damage claim is that it is time-consuming. I agree. Sometimes, a lot of different issues come up and our office spends more time than planned on these claims. However, the benefit outweighs the cost. Being involved in the property damage claim helps us get our client's trust early in the process as we show them that we are ready to fight for them and do what they hired us to do. Also, the quicker the property damage claim gets resolved, the stronger the injury cases will be because your clients will be able to shift their focus to their health and their personal injury case. ▲▲▲

Lisandra Matos is a bilingual personal injury attorney in Lakewood, CO. She focuses her practice on helping the Latino community in Colorado. Her background as an immigrant allows her to understand the collateral challenges that her clients experience after being involved in a car crash. Lisandra has devoted her legal career to being a voice for the underrepresented.

Endnotes:

[1] Division of Insurance Regulation 5-2-15, Section 5(A).

[2] C.J.I.-CIV. 6:13 (2014).

[3] Division of Insurance Regulation 5-2-15, Section 5(B)(1).

[4] Division of Insurance Regulation 5-2-15, Section 5(B)(1).

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Critical Considerations for Proving Brain Injury Cases

By Amanda R. Pfeil Hood and Amy N. Rogers

Brain injury cases are very different from any other type of personal injury case. Unlike a broken bone where you can physically view the injury itself, a brain injury is an invisible injury. Insurance companies do not usually understand the intricacies of a brain injury and how they affect the brain injured plaintiff. Because a person suffering from a brain injury may not look or sound injured, it is important to know how to prove this type of injury to be successful for your client. This article endeavors to educate regarding what a brain injury is and helpful tips to prove it.

What is a Mild Traumatic Brain Injury?

Before deciding to represent a person with an acquired mild brain injury, it is imperative to understand what a mild traumatic brain injury (mTBI) is. The American Congress of Rehabilitation Medicine defines a mild traumatic brain injury as:

A traumatically induced physiologic disruption of brain function, as manifested by one of the following:

- Any period of loss of consciousness;
- Any loss of memory for events immediately before or after the accident;
- Any alteration in mental state at the time of the accident; or
- Focal neurological deficits, which may or may not be transient.[1]

It is important to note that this definition does not require the physical impact of the head onto another object to meet the definition of a mild traumatic brain injury. Rather, it can be from a flexion extension or rotational forces of the head and neck without any physical contact that can result in a mTBI. The main focus to diagnose a mTBI is on the alteration of the patient's mental state and physical manifestation of symptoms.

The manifestation of certain physical, cognitive, emotional, and sleep-related symptoms can be key to recognize early that a person sustained a brain injury. **Physical** signs and symptoms of a brain injury include headache, nausea, vomiting, balance problems, dizziness, visual problems, fatigue, photophobia (light sensitivity), photophobia (noise sensitivity), numbness/tingling, feeling dazed, or feeling stunned. **Cognitive** signs and symptoms of brain injury include feeling mentally "foggy" or slowed down, difficulty concentrating or remembering, forgetfulness, memory loss, confusion, slow responses to questions, or repeating questions. Common **emotional** signs and symptoms include irritability, sadness, anxiety, depression, increased emotional lability (rapid mood changes), and nervousness. Other **sleep-related** signs and symptoms, such as drowsiness, difficulty falling asleep, or sleeping more or less than usual.[2]

It is not unusual for certain symptoms to get overlooked or incorrectly attributed to other things rather than realizing they are due to a brain injury, for example, dizziness, headaches, or emotional or personality changes. Thus, it is important for you to understand the constellation of symptoms to best be able to explain what and why your client is having these symptoms and how to correlate that to a mTBI.

Know Who Your Client Is, Both Before and After the Brain Injury.

When proving a brain injury case, it is vitally important to obtain as much information possible to show the clients preinjury status. Gather information to show your client's capabilities prior to sustaining a brain injury and objectively quantify their prior level of function.

Medical History and Records: Sit down with your client and work with them to recall as much history as you can get from birth to present. Help your client to create a detailed

history of every medical provider that he or she has seen in their lifetime. This includes not only primary care records, but also records from eye doctors, therapists, dentists, etc. Then order your client's medical records for as far back as is possible. Don't forget to ask regarding any prior loss of consciousness or other concussions. The medical literature informs that repeated mild traumatic brain injuries cause cumulative damage to the brain, which can cause memory loss and learning dysfunction. The medical history can additionally help you to prove that your client did not have the symptoms that they are now complaining about post incident. Additionally, gathering the complete medical history provides also ensures that you will not be surprised by anything that unexpected shows up in their records. It is better to know what is in their history than be surprised latter down the road in litigation.

Employment and Educational Records: Order your client's education records, including test scores, and for as far back as possible. Order your client's employment records, not only the wage loss but reviews and production documents. Scour these documents to learn out who your client was before suffering a brain injury and if there is any black and white documentation on how well they were doing at school or work before the collision versus any changes after the collision.

Only after you gather objective evidence of your client's pre-brain injury capability and function can you compare that to the level of function after the brain injury and persuasively argue how the brain injury impacted your client's life. Additionally, these documents are important to be able to provide to your medical and vocational experts who will be able to look at this information to be able to provide valid and strong opinions on causation.

Know Your Client's Support System.

In order to effectively prove a brain injury, you should get to know your client's support system, before and after the incident. As stated above, it is critical to know who your client was and how they functioned before the collision versus afterward. In order to learn this information, you must take time to get to know your client and his or her family members, friends, and coworkers who spent significant time with your client before and after the brain injury. It is typical that persons close to your client may have a better understanding than even your client does of the changes the client went through due to the brain injury and how it affected their life, their personality, and their behavior. Friends or family members may report that their loved one is far more irritable after suffering a brain injury and even small noises, such as the ticking sound of a turn signal in a vehicle, can trigger them.

Gather stories from friends and family members regarding specific examples of your client's past and how that has changed after words. The more examples and stories that you obtain about your client prior to versus post injury will assist in painting a picture for the jury on who this client was and can invest them in your client's challenges since the brain injury. For example, say your client before the injury was very active in his or her community and regularly gave back in the way of volunteering or would never say no to help out a neighbor, and yet after the injury they were not capable of doing those things any longer. This shows that the brain injury affected not only your client but also affected those in the community whom he or she would regularly give a helping hand. This endears a jury to your client. The smallest details or examples of how the person changed due to the brain injury may end up being the most convincing facts and testimony to prove that the brain injury occurred.

Not only are friends and family invaluable in telling your client's story, often times with the brain injured client, he or she struggles to communicate or fully understand what you are saying. Friends and family can sometimes help you understand how to better communicate with your client and can help with any communication barriers that may result from a brain injury.

Know the Medicine and the Best Providers.

Failure to develop a rich understanding of the injury itself and the best providers available to assist your client with his or her symptoms does a disservice to the representation of the brain injured client. The types of medical professionals who may be involved in your brain injured client's care include neurologists, neuro psychologists, physical medicine and rehabilitation specialists, otolaryngologists (ENT), neuro-optometrists and neuro-ophthalmologists, cognitive therapists, speech therapists, vision therapists, vestibular therapists, psychologists, and endocrinologists.[3] It is important to understand each of these specialties and how each one can assist your brain injured client. Not all clients will require every specialty, but you should be armed with knowing not only what kind of specialty may assist your client and who specifically in those communities are fully capable of understanding brain injuries and how best to affectively assist your client in healing.

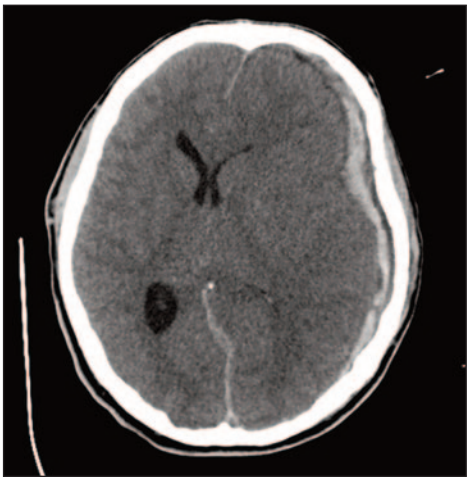
Not only should you understand what these specialties involve, but you should work with your key providers

to ensure that they are providing you the necessary opinions on diagnosis, causation, apportionment, and prognosis. The key providers should be given documents outside of their records to assist them in understanding your client and to arm them with the tools and information to be able to provide expert opinions. For example, make sure that your key providers have a copy of the police report, relevant prior medical records, relevant records post-collision, and other documents specific to their specialty and their opinions.

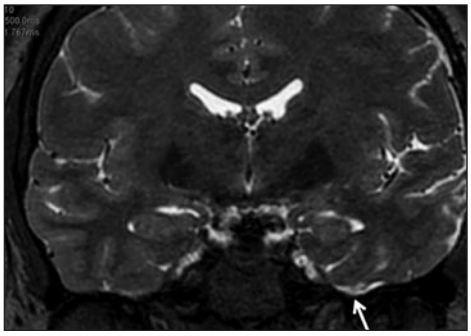
Neuroradiology and Clinical Correlation.

A picture is worth a thousand words. Thus, you should be aware of what different neuroradiology images are available, what they mean, and how/when to use them.[4]

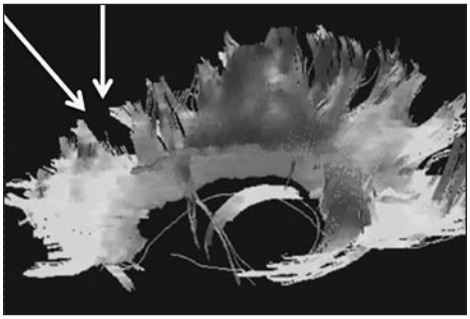
CT Scan: A CT Scan does not show a mTBI or concussion. A CT Scan is useful for more moderate to severe forms of brain injury. It can show bleeds; fractures; ventricle displacement, loss, and enlargement; or midline shift, etc. For example, below is a CT Scan image for a young man who sustained Second Impact Syndrome in a high school football game after being prematurely returned to play. Here you can see a subdural hematoma, a midline shift, and ventricle displacement, loss, and enlargement.

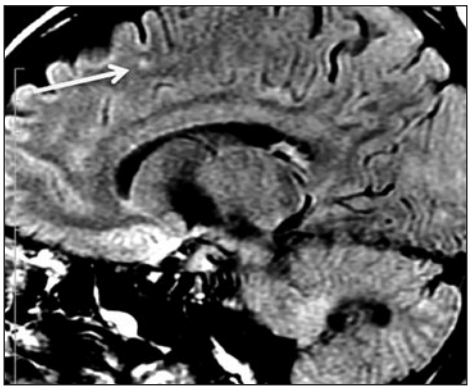


MRI Scans: With MRI's there are different weights, such as 1.5T, 2T, and 3T. These weights are the strengths of the magnets and the thinness or thickness of the slices, the higher the weight and the thinner the slice, the more likely it is that findings will appear on the MRI. The 3T MRI is optimal with higher resolution and thinner slices. This allows the neuroradiologist to find contusions and shearing that can be present in an mTBI due to the enhanced detection capabilities. For example, below is a 3T MRI with thinner slices where the neuroradiologist was able to detect a subtle interior temporal contusion.



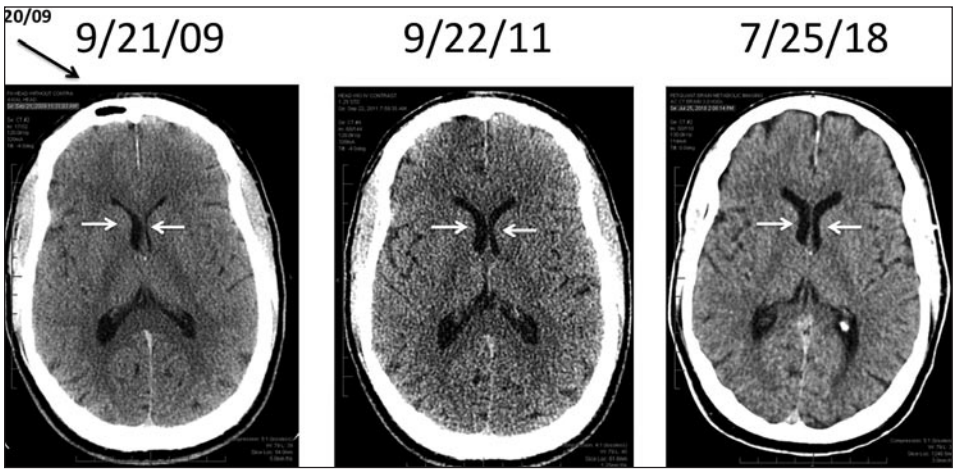
Diffusion Tensor Imaging (DTI): DTI is an MRI based neuro-imaging technique that enables measurement of the restricted diffusion of water flow along axon in the brain tissues and compares the diffusion to the axons in a white matter fiber tract. Axons can be thought of as the "telephone wires" of the brain. DTI provides a unique insight into the brain to measure the neural tract in comparison to a normative database to determine injured areas of your client's brain. This comparison yields a numerical value regarding the health of the axons. Low values are indicative of axonal injury. In addition, the DTI findings can be matched to the area of injury shown on other imaging, such as MRI. Physical findings that are consistent on more than one type of imaging is objective proof of brain injury. Below is an example where the DTI Imaging matched sheering as seen on an MRI.





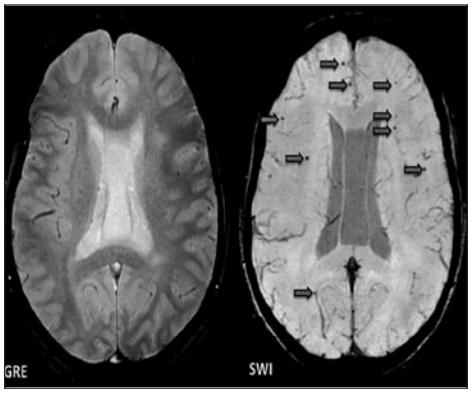
"Despite significant variability in sample characteristics, technical aspects of imaging, and analysis approaches, **the consensus is that DTI effectively differentiates patients with TBI and controls**, regardless of the severity and timeframe following injury. Furthermore, many have **established relationship between DTI measures and TBI outcomes**."[5]

NeuroQuant: NeuroQuant measures the volume of structures of the brain and compares that information to normative databases to assist with diagnosis of neurological conditions, including traumatic brain injury.[6] This can be done early on after an injury and compared to a later point in time to measure the differences for brain atrophy, *i.e.*, brain damage and death. In particular, NeuroQuant can be a very effective tool to show traumatic brain injury resulting from carbon monoxide exposure. Carbon monoxide exposure causes diffuse brain injury, meaning multiple lobes throughout the brain lose volume (injury) as opposed to a focal injury in a specific location, such as when the front and back portions of the brain are injured



during a whiplash-type mechanism of injury. Measured loss of volume in the lobes diffusely throughout the brain can objectively prove that your client suffered a brain injury as a result of carbon monoxide exposure. Below are photographs showing global atrophy in the form of abnormal ventricular volume.

Susceptibility Weighted Imaging (SWI) and Gradient Echo (GRE): SWI and GRE are two additional tools for objectively showing brain injury. These tools allow the neuroradiologist to detect very tiny bleeds in the brain, known as microhemorrhages and calcifications. SWI uses a slightly different sequence and is 4-6 times more likely to find hemorrhages than its GRE counterpart, see the below comparison:



Neuroradiology must be Clinically Correlated: In consideration of all the various types of imaging that can be used to prove a brain injury, the findings that are most likely related to trauma include atrophy of the brain (global, hippocampal, cortical); white matter shearing and hyper intensities; bleeding, sudden swelling, and structural damage; and positive DTI findings. However, these findings mean nothing unless there is clinical correlation. This means that the positive finding on imaging needs to be clinically correlated by a medical professional both to the mechanism of injury as well as the clinical presentation of symptoms. Factors to consider as part of the clinical correlation include age, the mechanism of injury, any history of trauma or clinical suspicion, positive additional findings on imaging scans, exclusion of other risk factors, and the size and number of deviations from normal.

Common Defenses to Brain Injury Cases.

- Certain defenses are commonly attempted to argue against the existence of the brain injury itself and whether the client experienced and continues to experience symptoms from the brain injury.
- "The person did not hit his or her head in the collision or incident." It is well known amongst the medical community that a person does not have to actually hit their head in order to sustain a brain injury. It is the mechanism of injury itself that results in the injury. For example, when a person is in a motor vehicle collision and experiences a whiplash type of mechanism of injury, their head can move forward and backward without ever hitting anything. It is this forward and backward motion that can jostle the brain inside the skull, resulting in damage to typically the front and/or back portions of the brain. The movement of the head itself and the rotational forces are sufficient to cause injury.
- "The person did not have a loss of consciousness or posttraumatic amnesia." Just as a person does not need to hit their head to sustain a brain injury, nor do they have to experience a loss of consciousness. Also, there are times that the brain injured client does not realize that they lost consciousness. So, you should dig deeper instead of taking that information at face value. Walk your client through the accident and everything that they remember. For example, the client will say I remember getting hit and then the next thing I remember is someone knocking at my window. That is a loss of consciousness or post traumatic amnesia.
- "The CT scan was without abnormal findings and is definitive proof that a person did not suffer a brain injury." First, CT Scans do not show concussions or mTBIs. Second, not all mTBIs will show up on the other types of imaging above-described. Third, medical providers treat symptoms, not imaging, make sure you get your medical providers to diffuse the lack of findings on imaging.
- "The ER did not indicate a concussion or head injury." ER providers are often looking for the acute emergency problem that may need urgent care and treatment and do not

always look for concussions or head injuries. Thus, look at the records for the symptoms, was your client complaining of any of the symptoms described above? In addition, it is also possible that symptoms do not immediately develop.

- Probably the most common theory by the defense to refute a brain injury is the minor impact or light impact collision argument. Defense counsel loves to tout photos of vehicles showing little visible damage as definitive proof that a person could not possibly have sustained a brain injury in a collision. Just because a collision was a "light impact," meaning the crash occurred at low speeds or did not result in a significant amount of visible damage to the vehicle does not mean that these collisions cannot cause a serious bodily injury or a brain injury. Unfortunately, whether or not the "light impact" argument is true, juries believe it. In this situation, it is critical to search for any facts or evidence to show why the light impact doesn't matter. For example, it may make sense to have the frame of the vehicle measured to see if there was any damage to it that was missed in the damage estimate or vehicle repair. Was your client a particularly fragile egg? If so, it may not take as much force for he or she to get injured in a collision. Consult with an accident reconstructionist to decide whether it makes sense to hire an expert to opine as to how this collision caused injury to your client. If you take a "light impact" case, you will need to fight twice as hard and search for any little detail to beef up your case to prove how the forces generated in this collision were more than sufficient to cause injury.
- Finally, the arguments that the worst brain injury symptoms appear first and the argument that all brain injuries get better, so prolonged symptoms must be attributed to something else are commonly raised. It is true that most concussions resolve within six months. Those brain injuries that do not resolve within that amount of time place the individual at risk for suffering with long-term deficits. Symptoms certainly can get better or worse as the individual works through treatment. However, the "worst first" theory has been debunked in the medical literature, so if you are facing that, be aware that there is literature that you can use for cross-examination on that issue.

Inadmissible Defense Comments on the Plaintiff's Credibility.

Defense counsel commonly attempts, whether directly or indirectly, to argue or submit testimony by medical professionals that a plaintiff is malingering, exaggerating, or feigning his symptoms, and that he is motivated to do so as a result of the litigation or secondary gain. Any such argument or attempt to submit evidence regarding same is an improper attempt to admit inadmissible evidence. A medical provider is not appreciably more qualified than a lay juror to form an opinion regarding whether the plaintiff is truthful about his injuries based on the medical evidence. These types of credibility determinations are solely within the province of the jury. Expert opinion testimony on malingering, exaggerating symptoms, and secondary gain is not helpful to a jury. Helpfulness to the jury hinges on whether the testimony is relevant to the case per C.R.E. 401. Defense expert opinions that a plaintiff is malingering or exaggerating is not relevant in that it is not helpful to the jury in determining whether a person suffered an actual brain injury as a result of a collision or other incident. The jury can make its own determination of credibility, and the jury should be permitted to arrive at its own conclusion without a defense medical expert inserting his or her prejudicial opinion. Any probative value of testimony or evidence regarding malingering, exaggerating, feigning symptoms, or motivation as a result of litigation is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury. Such evidence creates a serious danger of confusion of the issues or misleading the jury, as the jury may substitute the expert's credibility assessment of the plaintiff for the jury's own commonsense determination. It is improper to usurp the critical function of the jury with defense medical testimony regarding the plaintiff's credibility. Any such evidence is inadmissible. Thus, if you are facing this issue in one of your cases, fight the opinion and move to strike it.

Know When to Hold 'Em and Know When to Fold 'Em.

In any brain injury case, it is critically important to know when to push and know when to fold. Because of the difficulty in proving an invisible disability such as a brain injury, the right time to push for the full value of the case is when all the facts and evidence you gathered support doing so: demonstrated high prior level of function; good documentation of medical providers showing no prior history of the same or similar symptoms; strong evidence of liability and damages; and good support network of the injured person to build of the story of who your client was before the brain injury and how the brain injury affected his or her life that ability to function.

Of course, when the facts and evidence do not add up, you may be taking

a risk if you are pushing for too much for a brain injured client. It is also important to know when to fold. Be aware of this risk when liability is in question. Defense counsel will fight like hell against a brain injury case when the collision itself is a "light impact." Be vigilant when there are questions surrounding client telling the truth as client credibility is essential to proving a brain injury. Having clean clear medical history is critical, so if there are issues with the medical history, this may create and issue with proving the brain injury. For example, the lack of symptoms or diagnosis in the ER or at the first medical visit may create issues for proving when the brain injury occurred. The more of these trouble areas that exist, the more difficult it will be to prove your brain injury case. Be aware of the costs financially and emotionally, as there can be a significant psychological component for your clients to put them through litigation and ultimately not be successful.

Every Brain Injury is Different Because Every Brain is Uniquely Different.

Remember that because every brain is unique, the recovery for each person will be different.[7] Struggling with the brain injury is particularly difficult for very high functioning individuals, as he or she is used to operating at a certain level. When a brain injury diminishes his or her ability to live and work as they did before, this creates intense frustrations due to the inability to function. Because each brain injured client is different, their specific needs will differ, which will alter how you should interact with them and assist them through their case. It is important to remind yourself as well as the client to be patient with their progress.

Know Your Available Resources.

Failing to take the time necessary to truly understand the medicine, the available treatments, the types of brain injury, and the client and their support system does a disservice to your client's case. If you feel that you are in over your head handling a brain injury case, consult with a knowledgeable attorney and consider a co-counsel agreement. It is better to ask for help and be successful then to leave a struggling client in an unwinnable situation. Moreover, there are many available resources available through the Brain Injury Alliance of Colorado (BIAC).[8] Reach out to BIAC to find out what resources your client may qualify for, it could make a world of difference. ▲▲▲

Amanda Pfeil Hood has been practicing for over 9 years. She focuses her practice on personal injury and medical malpractice. Amanda primarily works with clients who have sustained catastrophic injuries as a result of the fault of another. The vast majority of her clients have sustained traumatic brain injuries and/or permanent orthopedic injuries.

Amy N. Rogers is an associate attorney at Ogborn Mihm LLP. Her practice focuses on personal injury matters, with a specialty in assisting clients with traumatic brain injuries or other traumatic spinal cord injuries. She has dedicated her career to advocating for and serving the individual.

Endnotes:

[1] https://acrm.org/wp-content/uploads/pdf/TBIDef_English_10-10.pdf.

[2] https://www.nichd.nih.gov/health/topics/tbi/conditioninfo/symptoms.

[3] http://www.tbiguide.com/whoprofessionals.html.

[4] Christopher A. Mutch, et al., *Imaging Evaluation of Acute Traumatic Brain Injury*, 27 NEUROSURG. CLIN. OF N. AM. 409-39 (2016), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5027071/.

[5] M.B. Hulkower, et al., *A decade of DTI in traumatic brain injury: 10 years and 100 articles later*, 34 AM. J. NEURORADIOL. 2064-2074 (2013), available at http://www.ajnr.org/content/34/11/2064.

[6] Eric R. Braverman, et al., *Evoked Potentials and Memory/Cognition Tests Validate Brain Atrophy as Measured by 3T MRI (NeuroQuant) in Cognitively Impaired Patients*, 10 PLOS ONE 8 0133609 (Aug. 5, 2015) available at 10.1371/journal.pone.0133609.

[7] https://biau.org/types-and-levels-of-brain-injury/.

[8] https://biacolorado.org/.

Lessons Learned from Listening to Real People

By Jeffrey Boyd

I have been a trial lawyer for 37 years. In addition, since 1998, I have been involved in a wide range of trial consulting —helping other plaintiff's lawyers improve their cases. I have conducted hundreds and hundreds of interactive focus groups in 60+ jurisdictions across the county: rich, poor, rural, urban, conservative (and ultra-conservative) and liberal. I have learned that if you have the courage to expose your case to real people and are willing to listen to what they say, you can gather the information you need to create a presentation at trial that meets the needs of the jury and provides the foundation for a great result. The following are some of the most important things I have learned by spending thousands of hours talking to real people, a/k/a jurors.

1. Jurors don't think like lawyers. They think like people.

You, as a lawyer, with your legal education and constant immersion in the profession, are on one side of a bridge that crosses the river of justice. Jurors are on the other side. Don't expect them to come to your side; you need to go where they are. Jurors have a magnificent ability to make wise and fair decisions when they are given the information they need to make decisions in a case. But we, as trial lawyers, must ask ourselves: are we willing to put aside **our** prejudices, and deal with jurors as they are, not as we think they should be?

Jurors don't stay in the box that is defined by admitted evidence and jury instructions. They often attach great importance to facts that lawyers don't feel are relevant. They have their own ideas about "the law." They see your trial through their personal experiences. You have to accept this and work with it. You won't get very far

driving the square peg of how you think jurors ought to be into the round hole of reality. At the end of the day, real people fill out the verdict forms, not lawyers or judges.

Focus groups can be used to evaluate a case; to find out if the existing case, as presented, is a winner. However, the **far better** use is to learn:

- How a jury fits the facts of your case into the mental boxes we call "liability" and "damages;"
- What people need to know that you didn't know they needed to know, including "legally insignificant facts";
- What problems your case has from their perspective, and how to fix those problems;
- How they feel about your witnesses and exhibits.

You can take that knowledge and improve your presentation to get a great verdict. I tell the lawyers I work with that "I can make you feel good or I can help you to find out how to get a better result, but I can't do both." You have to be willing to look the ugly in the eye and lose the case at the focus group to find out how to win at trial.

2. Simple = Strong. Repeat. Simple = Strong.

The biggest mistake plaintiff's lawyers make is that they allow their case to become too complicated. We drown in the endless parade of facts and experts that has become the modern negligence case. Complexity favors the defense. Time and time again in focus groups I see defendants win cases because the plaintiff doesn't clearly and simply make the case for why they should win.

Don't over-try your case. **There are only a few things in any case that matter**. Use focus groups to find out what those are and stick to those issues. Also, don't underestimate the fact that jurors don't "get it" if they hear "it" only one time. Repeat, repeat, repeat. If it is important, bring it up again and again, in voir dire, in opening, with every relevant witness, in closing, and in rebuttal.

3. Ask "Why" not "What."

Lawyers are great at talking about **what** happened: the defendant went left of center into the oncoming car, the company didn't follow its own maintenance rules, the drug manufacturer sold a drug that killed people.

What is easy. As lawyers, we are taught (with limited exceptions) that **what** is the thing that matters. The

defendant went left of center into an oncoming car. There are three witnesses and a video that prove it. Summary judgment/directed verdict, right! Who cares why? We are done here.

"Yeah, I hear you, but **why** did this happen?" ask the jurors. "**Why** did that nice lady sitting in the courtroom go left of center?" Was she on her way to the hospital with her sick son? Was she texting? Drunk? Was there snow on the road? What may look like summary judgment facts to lawyers may look like a forgivable act of God to jurors. It matters because jurors value the case accordingly; damages awards are built on the strength of the **liability** evidence.

Jurors judge cases, and make compensatory damages awards, based on their perception of the **relative moral fault** of the parties. To do that, they need to know **why** something happened. And regardless of whether there is a line on the verdict form for the fault of the plaintiff, the plaintiff's conduct goes on the scales, too.

4. The "Big 4" Questions.

Make these questions the core of your case. I can't tell you how many times I have talked to good lawyers who are months or years into their case and yet they struggle to give clear and simple answers to these questions. Jurors are only going to give you so much mental energy. The "shotgun" approach to presenting your case is a formula for frustration and loss. Build your case around these questions:

1. What did the defendant do (that the plaintiff thinks was wrong)?
2. Why was it wrong/who says it was wrong?
3. What was the alternative—what should the defendant have done?
4. What difference did the defendant's conduct make?

You can have more than one "set" of these (e.g. negligent training, and speeding, as your theories in a trucking case), but you have to answer all four for each set.

5. Which Verdict Is Better for Me?

In this world, a juror's self-interest is a huge factor and, I believe, a prime driver behind verdicts. Jurors can't help but see the results of the case as having an effect on their lives; they are filtering the case through the question **"will it be better for me if the plaintiff wins or will it be better for me if the defendant wins?"** This is most easily seen in medical negligence cases, where jurors are weighing concerns that a plaintiff's verdict will raise **their** medical bills, or make it harder for **them** to access medical care versus the principal that holding bad doctors accountable will increase the quality of **their** care. This weighing of personal interests is in the background in every case.

Make it clear that what's at stake is the jurors' world: safer products, the moral comfort of enforcing Rules of the Road on a bad actor, the idea that they have a voice in how the world works. The juror has to decide that if they don't vote against the defendant, the conduct will happen again, and that they or someone they love will be harmed.

6. Jurors Don't Know What Their Job Is.

When prospective jurors walk in the door, there are two questions on their minds: "What am I supposed to do?" and "How am I supposed to do it?" Jurors often don't know, don't understand, and don't accept the differences between a civil case and a criminal case. At least 90% of their "experience" with the law—books, movies, the television programs that endlessly loop on late-night TV—is criminal law. Then we come in and start talking about "preponderance" and "standard of care" and "compensatory non-economic damages." Put another way, most prospective civil jurors do not know what their job will be – that they will be asked to decide fault, causation, and damages based upon the civil standards for those issues.

Think about this—my experience is that many, if not most, prospective jurors are surprised to find that they will be asked to decide damage issues. Many are downright perplexed to find that "pain and suffering" is compensable, let alone that **they** have to "put a value" on it. Don't assume. Teach, starting very early in voir dire. Introduce and educate about the job of a civil juror. They will be grateful. The worst thing you can do at trial is to make a juror feel stupid.

7. Ask About Personal Experiences

Jurors see and judge everything that happens in the courtroom through the filter of their personal experiences. Few real facts override what they think they know. In voir dire, ask about jurors' personal experiences with the key issues in your case. Do they ride a motorcycle (or refuse to ride one)? Have they ever worked on a construction site? Have they or someone close to them had the kind of surgery, taken the kind of drug, or experienced the kind of procedures in the hospital that are going to come up in your trial? If so, you need to know what that was like for them. Let them tell you their stories. Listen.

Be very wary of jurors with strong emotional connections to their stories. Strong or emotionally involved jurors have an enormous influence in the jury room. Beware, especially, of the "expert witness" juror; a juror who has some familiarity with key concepts in your case that the other members don't

have. They will "testify" in deliberations and you will have no idea which way they will spin the story.

8. Use Facts, Not Emotions.

Tailor your case presentation toward jurors who are interested in facts, not emotions. Trial lawyers tend to be emotional people, driven by important causes. The jurors that end up on a panel after voir dire are usually people who are quiet, steady, and conscientious. Why? Since they are less assertive and talk less during voir dire, they are less likely to be kicked off. These people are sympathetic and cooperative; helpful people who like working behind the scenes, performing in predictable and consistent ways, being good listeners, and avoiding conflict. Their priorities are cooperation, stability, quality, and analysis. They want data, not drama. They are turned off by harsh trial tactics and emotional appeals.

9. Liability Drives Damages.

The most important thing you will learn in focus groups is that jurors never stop talking about liability. Unlike lawyers, real people don't think of fault as a "yes" or "no" decision, but as a long sliding scale of the relative moral fault of anyone involved. Those factors include the evidence and the jury instructions, but in the decision-making continuum, those sacred pillars are often secondary to the jurors' personal life experiences and moral values. What happened to Uncle Joe or what they learned in Sabbath School will carry more weight than the instructions that Judge Smith reads to them at the end of the case.

Jurors evaluate damages **only** through the context of liability. Gruesome X-rays and million-dollar life care plans mean nothing if the jury thinks the injuries were caused by an "accident." Juries spend 80% of their time discussing liability and 20% of their time discussing damages, even in so-called stipulated liability cases.

If lawyers explain their case in the language of the juror's moral beliefs about liability issues, they will get greater damage awards. In fact, you should **constantly** talk about what the defendant did wrong, even in cases where liability is admitted or seems obvious.

Any juror will tell you that they want to award a "fair" amount for damages. The problem is that they don't really decide what an **injury** is worth, they decide what the defendant's **fault** is worth.

10. Anchor Your Damages.

The vast majority of jurors have no idea what a case is "worth." As lawyers, we take it for granted that cases have "value," and we like to think that we know what factors affect that value. However, we don't pay enough attention to the fact that most jurors have no idea what a case is "worth."

The key here is to give the jurors an "anchor. In the old days, we used to think it was rude or presumptuous to ask the jury for a specific number or a range. Modern juries will actually punish you if you don't. Over and over in focus groups I see this: we run the case with no guidance as to the value or what the plaintiff is seeking, which results in a crazy patchwork of values all over the map. We then run the case and tell the jurors how the parties value the case. Almost every time, this results in the numbers being higher than with no anchor, and closer together—a much better base for deliberations and consensus.

A juror in a wrongful death focus group once told me that she decided the life of a long-married man with children was worth $10,000 "because that's what a really nice dog would cost." That was her anchor. You can do better than that. Jurors need an anchor, starting early in the case. I favor giving a range in voir dire ("I want you to know that I will be asking you for several hundred thousand dollars in this case. . .") rather than a hard number—but do give a hard number in closing.

11. Speak About "Choice" Versus Failure."

I often hear negligence expressed as a series of "failures": the defendant failed to train, failed to adjust their speed for the weather, failed to test the design. However, jurors tell me that "failures can be forgiven," that "everyone fails" or that you "learn by failing." That's not what you want them to be thinking.

It is my experience that bad **choices** are the stronger frames: the defendant **chose** to put untrained workers in the field, **chose** to keep driving at the speed limit even as the snow fell, **chose** to put an untested design on the market. You want to present what happened as the (inevitable) result of a series of the defendants' bad choices. Choices are intentional; failures are an accident. You want intentional.

12. Blame the System, Not the Individual (Where You Can).

Define your negligence as the result of a **systemic** problem. Jurors are reluctant to judge the behavior of individuals—it feels too personal, "there but for the grace of God go I," etc. However, bad **choices** made by a company, an organization, or a group are easier to assign blame to. Systemic problems (or the lack of systems that would avoid problems) are also more threatening to the jurors (see Section 5 above): "If it happened once, it could happen again – to me." Dig deep—and back up the negligence in time so that

your presentation is based on the months or years of a system that was doomed to fail instead of what happened in the minutes or seconds just before the harm. Think about the difference between the negligence that allows a commercial driver to be put behind the wheel without a background check versus a driver "who did everything he could do" to avoid a wreck at the last minute. The system failure is harder to defend.

13. Why Aren't We Talking About Insurance?

Ask for a preliminary jury instruction about insurance. Insurance is relevant to jurors, period. They expect to hear about the defendants' liability insurance, and about whether the plaintiff had medical (or life) insurance. When they don't hear about that at trial, it creates a blank spot in the trial narrative that they fill in with guesses that are almost always wrong, and which mostly favor the defendant ("The doctor must not have insurance or we would have heard about it," or, "The insurance company must have already paid but the plaintiff wants more"). Because most courts will not allow you to address this directly, you should ask for a strong preliminary jury instruction that says, in essence, "insurance isn't relevant so don't consider it." This instruction doesn't take insurance out of the conversation in deliberations, but it does explain why the parties aren't talking about it and gives jurors who follow the law ammunition to fight back against jurors who keep bringing it up.

14. There May Be Difficulty Understanding or Accepting Non-Economic Damages.

Lawyers accept that damages are a way to compensate for a loss. Many jurors are fixated on the idea that "no amount of money will bring back the deceased plaintiff," and the idea that it is wrong to "profit" from a loss. You have to educate them as to the morality, purpose, and validity of non-economic damages, and you have to "anchor" their evaluations with your credible valuation of the case.

15. Be Visual.

Use visuals at trial for all important facts and concepts. Cognitive research has shown that people process information in this order: 1) color; 2) pictures; 3) shape and symbol; 4) printed word; 5) spoken word. But what do lawyers use most often? Number 5. Nowhere in a juror's life are they asked to absorb important information based on lectures (opening and closing) and question-and-answer sessions (direct and cross) without extensive visual support. Give it to them. **Simple** timelines. Pictures and diagrams. Even just an outline of who the key witnesses are and what they are going to talk about, with a headshot picture to introduce/remind the jurors who these people are. You can never have too many visuals.

Conclusion.

Trials are not won over fights about the 28th page of the 14th deposition. Today's jurors want a clear, short statement of what's right and wrong and what they should do about it. Put aside what **you** think about a case and get in touch with what matters to the real people who will decide it. ▲▲▲

Throughout the course of his career, Jeff has tried over 100 civil jury trials to verdict, an impressive accomplishment that is rare even among experienced trial lawyers. Jeff has represented hundreds of people who were injured as a result of motor vehicle collisions, motorcycle collisions, unfair treatment by insurance companies, wrongful death, and legal malpractice. Jeff is also president of Boyd Trial Consulting and has worked as a trial consultant throughout the United States since 1998. He is also on the board of the Washington State Association for Justice.

Comparative Negligence in Medical Malpractice Cases

By Anthony Viorst

In medical malpractice cases, the defendant, a doctor or other medical provider, will occasionally allege that the plaintiff-patient was comparatively negligent in creating the condition that required the allegedly negligent medical treatment. For instance, it has been alleged that the plaintiff's intoxication, suicide attempt, or unnecessarily dangerous conduct, which created the occasion for the medical care which later is the subject of a medical malpractice claim, should be considered an act of comparative negligence in relation to the malpractice of the treating medical provider. As shown below, Colorado state and federal courts have almost uniformly rejected this contention.

In *Blackman v. Rifkin*,[1] a case more than 30 years old, the patient was intoxicated and presented for care for a scalp laceration from a head injury. At the hospital, the patient was unable to provide the medical staff with an adequate history to aid in its diagnostic efforts, and the patient also engaged in combative and obstructive behavior which interfered with those efforts. At trial, both parties introduced evidence concerning the degree of plaintiff's intoxication on the night in question, as well as evidence of the standards that should be followed in diagnosing and treating intoxicated persons. At the close of evidence, the trial court rejected the plaintiff's proposed instruction that her act of becoming intoxicated could not be considered a cause of her brain damage. Affirming this ruling, the Colorado Court of Appeals stated that "the evidence of plaintiff's intoxication here was neither remote nor distinct from the issues of malpractice.[2]"

No Colorado appellate case issued since *Blackman* has authorized a medical provider accused of malpractice to assert a comparative negligence defense against the plaintiff-patient. On the contrary, only two cases have mentioned the *Blackman* comparative-negligence holding, and both have found it distinguishable.

In *Spence v. Aspen Skiing Co.*,[3] a Colorado medical malpractice case filed in federal Court, Judge Edward Nottingham distinguished *Blackman*, because in *Blackman* the patient "was unable to provide an adequate history and . . . her obstreperous behavior interfered with diagnosis and treatment.[4]" In *Spence,* Judge Nottingham cited myriad cases, from across the country, supporting the proposition that a jury in a medical malpractice case should not be permitted to consider the alleged negligence of the plaintiff-patient. Judge Nottingham concluded that these cases were consistent with Colorado law, stating as follows:

> . . . Persons providing medical treatment—whether they be hospitals, , nurses, or EMT's—should expect to treat not only patients who fall ill doctors or are injured through no fault of their own, but also those whose own neglect or intentional conduct has placed them in the precarious position of requiring medical treatment. Indeed, the latter category of patients is probably as numerous as the former category. All patients, regardless of how they sustain an illness or injury, may reasonably expect competent treatment from those into whose hands they have placed themselves. (Citation omitted). It would be inconsistent with the reasonable and normal expectations of both parties for the court to excuse or reduce the provider's liability simply because it was the patient's own fault that she required care in the first place.[5]

Thereafter, in *Kildahl v. Tagge*,[6] the Colorado Court of Appeals concluded that *Blackman* was limited to situations in which the patient hinders the defendant-doctor in the performance of his or her professional duties. In *Kildahl*, there was "no evidence suggesting that decedent failed to provide an adequate medical history or that she failed to cooperate in the context of the proposed treatment by defendants.[7]" Because the decedent's conduct did not "prevent[] defendants from properly diagnosing and treating her condition,[8]" the Court of Appeals held that the trial court erred in allowing the jury to consider the defense of comparative negligence. Since the issuance of the *Kildahl* decision, Colorado appellate courts have adopted its interpretation of *Blackman*, and have found that *Blackman* is limited to situations in which the plaintiff-patient fails to provide an

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adequate medical history or fails to cooperate with treating medical providers. And, absent such misconduct by the plaintiff-patient, a medical provider accused of malpractice is legally prohibited from interposing a comparative negligence defense against a patient.

In *Fried v. Leong*,[9] the Court of Appeals cited *Kildahl* for the proposition that it was "error to submit [a] comparative negligence instruction in [a] malpractice case when plaintiff's conduct created only the occasion for malpractice.[10]" Based upon the precedent set by *Kildahl*, the *Fried* Court stated further that "when a plaintiff seeks damages for the aggravation of a pre-existing condition, conduct that merely created the condition cannot be prorated.[11]"

In *P.W. v. Children's Hosp. Colo.*,[12] the Colorado Supreme Court held that a known suicidal patient admitted to a secure mental health unit of a hospital and placed under high suicide-risk precautions could not be subject to a comparative negligence defense when the patient attempted suicide while in the hospital's custody. In reaching this conclusion, the *P.W.* Court stated that:

> . . . [W]hen a defendant assumes a duty to a plaintiff, "what counts as contributory negligence is determined largely by the scope of the defendant's duty." Dan B. Dobbs, The Law of Torts § 200, at 500 (2000). If the defendant's duty to protect the plaintiff contemplates, encompasses, and thereby subsumes the plaintiff's duty not to act in a certain way, then the plaintiff cannot be faulted for acting in that way.[13]

In *P.W., supra*, the Colorado Supreme Court also addressed the argument that prohibiting a comparative negligence defense would "create a rule that no patient can be comparatively negligent in a medical malpractice case.[14]" The Court stated that no such blanket rule existed, because under *Kildahl* "a plaintiff's failure to provide an adequate medical history or cooperate in treatment can provide a basis for comparative negligence.[15]"

In *Blatchley v. Cunningham*,[16] a Colorado case filed in federal court, Judge Wiley Daniel granted summary judgment in favor of plaintiffs with regard to the defendant's affirmative defense of comparative negligence. In *Blatchley,* the plaintiff fell and sustained a leg fracture while snowboarding in Colorado. As a result of the substandard medical care that he received at the hospital, he subsequently developed compartment syndrome, resulting in permanent tissue and muscle death in that leg. The defendant hospital raised an affirmative defense of comparative negligence, asserting that the plaintiff's compartment syndrome was caused by him engaging in a dangerous snowboarding maneuver. In granting summary judgment as to this defense, Judge Daniel stated as follows:

> The defense of contributory negligence in a medical malpractice action is inapplicable when a patient's conduct provides the occasion for medical attention, care, or treatment which later is the subject of a medical malpractice claim. *Spence v. Aspen Skiing Co.*, 820 F. Supp. 542, 544 (D. Colo. 1993). Following the rationale in *Spence*, I am persuaded that a jury should not be instructed on contributory negligence or allowed to consider contributory negligence in a case against a hospital and, or in addition to, a doctor, where a plaintiff has alleged that the defendants were negligent in providing care and treatment. *Id.* at 543. I find this to be the case even where a plaintiff has done something negligent to place himself in the situation where hospitalization and medical care are required. *See id.* As the Court in *Spence* reasoned, "[p]ersons providing medical treatment—whether they be hospitals, doctors, nurses, or EMT's—should expect to treat not only patients who fall ill or are injured through no fault of their own, but also those whose own neglect or intentional conduct has placed them in the precarious position of requiring medical treatment." *Id.* at 544. Further, "[a]ll patients, regardless of how they sustain an illness or injury, may reasonably expect competent treatment from those into whose hands they have placed themselves." *Id.* (Citations omitted). "It would be inconsistent with the reasonable and normal expectations of both parties for the court to excuse or reduce the provider's liability simply because it was the patient's own fault that she required care in the first place." *Id.*[17]

Recently, in *Panczner v. Fraser*,[18] a Colorado federal diversity case, the plaintiff-patient alleged that the defendant-doctor failed to properly treat his frostbite, and the defendant-doctor asserted a defense that the plaintiff was comparatively negligent in contracting the frostbite in the first place. After examining the *Kildahl, Spence, P.W.,* and *Blatchley* cases cited above, Judge William Martinez granted the plaintiff's motion for summary judgment as to the defendant's comparative negligence defense. In granting this motion, Judge Martinez stated:

> . . . To hold otherwise would be a sea change in the very notion of the medical standard of care. It would endorse the idea that medical professionals may lawfully give

> otherwise substandard care to those who "deserve it" because they cause their own injuries. The Court is aware of no jurisdiction that would allow its medical professionals to implement such a draconian standard, much less a jurisdiction where the highest court would endorse such a standard for purposes of tort liability.[19]

The cases cited above follow the universal rule regarding comparative negligence in medical practice cases, which is set forth in Restatement (Third) of Torts: Apportionment of Liability §7 comment M (June 2018). Comment M states that "in a case involving negligent rendition of a service, including medical services, a factfinder does not consider plaintiff's conduct that created the condition the service was employed to remedy." As examples of this principle, the *Restatement* presents several pertinent examples:

> 8. A negligently injures himself in an automobile accident. A seeks medical treatment from B, who negligently aggravates A's injury. In a suit in which A seeks to recover from B for the part of A's injuries caused by B's medical malpractice, the factfinder does not consider A's negligence in causing the accident. A's negligence produced the very condition B undertook to treat.
>
> 9. A is injured in an automobile accident but negligently delays seeking medical treatment from B, making that treatment riskier. B aggravates A's injuries by negligently providing medical treatment. In a suit in which A seeks to recover from B for the part of A's injuries caused by B's medical malpractice, the factfinder does not consider A's negligence in delaying seeking medical treatment. A's negligence produced the very condition that B undertook to treat.
>
> 10. A seeks medical treatment from B. B aggravates A's condition because B negligently fails to properly diagnose A's problem. B's failure to diagnose A's condition was due in part to A's negligent failure to provide accurate answers to B's questions. In a suit in which A seeks to recover from B the part of A's injuries caused by B's negligence, the factfinder does consider A's negligence in failing to accurately answer B's questions. That conduct was not a cause of the condition B undertook to treat.
>
> 11. A seeks medical treatment from B. B negligently provides medical treatment and injures A. A's injuries are aggravated by A's negligent failure to follow B's instructions about taking medicine. A seeks to recover damages caused by B's medical negligence. The factfinder does take into account A's negligent failure to follow B's directions with respect to taking the medicine. That conduct was not a cause of the condition B undertook to treat.

As set forth above, the Restatement only permits a medical-malpractice jury to consider the plaintiff-patient's comparative negligence in situations in which the plaintiff-patient fails to provide an adequate medical history (Illustration 10) or fails to cooperate in treatment (Illustration 11).

In addition to all of the legal authorities cited above, well-settled Colorado case law states that a tortfeasor takes his victim as he finds him.[20] This doctrine makes a tortfeasor liable for damages to the extent the tortious conduct "has

increased the severity of a pre-existing . . . condition of the plaintiff.[21]"

The above-referenced authorities clearly weigh against the presentation of a comparative negligence defense in a Colorado medical malpractice case. A practitioner faced with a comparative negligence defense in a medical malpractice case should consider moving for summary judgment. ▲▲▲

Anthony Viorst, shareholder at The Viorst Law Offices, P.C., specializes in the fields of personal injury, medical and legal malpractice, and police brutality. He has written numerous articles on these topics for *Trial Talk* and *The Colorado Lawyer*, and has been recognized as a Colorado Super Lawyer since 2005. He also speaks broken Spanish.

Endnotes:

[1] *Blackman v. Rifkin*, 759 P.2d 54, 56- 57 (Colo. 1988).

[2] *Id.* at 56.

[3] *Spence v. Aspen Skiing Co.*, 820 F. Supp. 542, 544 (D. Colo. 1993).

[4] *Id.* at 544.

[5] *Id.* at 544.

[6] *Kildahl v. Tagge*, 942 P.2d 1283 (Colo. App. 1996).

[7] *Id.* at 1286.

[8] *Id.* at 1285-1286.

[9] *Fried v. Leong*, 946 P.2d 487 (Colo. App. 1997).

[10] *Id.* at 489.

[11] *Id.*

[12] *P.W. v. Children's Hosp. Colo.*, 364 P.3d 891 (Colo. 2016).

[13] *Id.* at 897.

[14] *Id.* at 897, n.6.

[15] *Id.* at 897, n.6.

[16] *Blatchley v. Cunningham*, 15-cv-00460-WYD-NYW, 2017 WL 4333993 (D. Colo. 2017).

[17] *Id.* at 2.

[18] *Panczner v. Fraser*, 374 F. Supp. 3d 1063 (D. Colo. 2019). The author represented the plaintiff in the *Panczner* case.

[19] *Id.* at 1074.

[20] *See Fischer v. Moore*, 183 Colo. 392, 517 P.2d 458, 459 (1973); *McLauphlin v. BNSF Railway Co.*, 300 P.3d 925, 935 (Colo. App. 2012).

[21] *McLauphlin,* 300 P.3d at 935 (citing 2 STUART M. SPEISER, ET AL., THE AMERICAN LAW OF TORTS § 8.13 at 572 (2003)).

What to Do After 50 Years of Trials?

By James C. Bull

An article in the October/November 2019 *Trial Talk*® entitled *Forty Lessons Learned from the First Forty Year Years in Practice*, by Alvin Wolff, which is full of lots of good ideas, got me to thinking about the "End Game" in this business of helping people. *Trial Talk*® does a great job with trial practice substance and tactics, but the "Human Side" of what happens to an Old Trial Lawyer, once in a while gets lost in the mix. So here goes.

Query: After you've tried cases for almost 50 years, what's your encore? Options many adopt are: Nothing-Keep up with your practice as long as you breath; charitable and pro bono work; find a position as a mediator, teacher, consultant or "of counsel"; travel to spiritual venues; or tend your garden. I'm sure there are a myriad of other choices. I have met very few middle 70's trial lawyers, still trying cases. Maybe, it's too much stress or lost sleep. Maybe you just can't stand getting beat by an upstart! However, I figured my time was approaching for decision time when a judge in a county court trial asked me for my response to defense counsel's objection and I had to have the judge repeat the words of the objection. To continue the trench warfare beyond age 73, I would have had to invest in expensive hearing equipment. I was no candidate, emotionally, for a transistor stuck into my ear, which everyone could see. We all have some fatal flaw (arguendo). Mine might be "EGO!"

So, I decided to finish all my courtroom work and not accept anything that I could not finish in a couple years. I tried or settled my last few cases in various district courts and the court of appeals, then closed the office in Littleton for all new litigation and focused on a practice, where, I could see and read to do my work. At that stage I had practiced almost 49 years. I tried my first case, solo, in 1969, after having second chaired as a law clerk in a Glenwood Spring trial in Spring, 1968. Luckily, I still had my assistant of 36 years, Wendy, who helped me more than I can ever say.

What went through my mind? First, I figured no one would hand me a gold watch. I never expected it and it didn't happen. But, what I did not expect was a bit of whining by long-time clients. They seemed oblivious to my physical changes. Those who were, by habit, litigious, I referred to several good litigation counsel in the Denver area. Those who still had estate planning, real estate matters, or contract issues, I continued to assist unless the client had serious tax planning. I referred those clients to specialized tax counsel. Emotionally, I was not quite "done" as in "full stop." For several years, I still commuted three or four days a week from Frisco in the mountains to Littleton. If I had a trial, I stayed at a Hampton Inn. After we moved down to Taos in mid-2016, my practice income didn't just **whither**, it took a dive not even seen in the stock market during the worst October crash. But, I still maintained insurance and active status.

In retrospect, I really didn't care about the declining practice income because I was still with my original spouse of almost 50 years, had three great kids with families. Two of them had their own successful law practices, and they would call me occasionally for advice—which helped my fragile ego. We had owned our home in Taos, New Mexico, for almost 25 years, and it was paid for—no mortgage. That was a huge "key."

So, I have concluded that Old Trial Lawyer Rules Numbers 1 and 2 are:

Do your best to keep your First Betrothed, and

Do your Best to Pay off the Bank.

I know that both may be tough in some cases, but, as Goals, they seem good ideas.

I notice a few of my classmates from CU Class of 1968, have continued their practices as "mediators." I think that route is fantastic. However, I was never much of a mediator, as a few defense types in Colorado know. That role didn't appeal to me much, if at all. "Advocacy" and "mediation" require two different philosophical approaches to problem solving. So, know your mental bent. My Rule was to try not to push a square peg into a round hole. It will take some whittling of your persona to make it work. I also believed that "the shortest distance between A and B is a straight line." Someone smart invented that idea; it wasn't me.

Some of my classmates established national law firms of great standing and were able to hire lots of staff and partners. My hat is off to those guys who can't leave because their name is on the door and they are "Rainmakers." My pride for my class and classmates is unending!

Quite a few of my classmates became judges; some retired after decades wearing black robes. Another hat comes off my head! They get to sub in as senior judges a few months a year if they want to or hire on with a mediation firm for part time work.

What did I do that made some sense?

1. I kept my active status with the Colorado Supreme Court and made it clear on my card that I was only licensed in Colorado.
2. I sought out a well-reputed active trial lawyer in Taos to hook up with if I had a local pro bono matter—or to refer matters that came to me in N.M.
3. I limited my Colorado practice to long-time clients and accepted no new clients or litigation matters.
4. I took up gardening and tried to grow—to date, unsuccessfully —various local crops.
5. I put the skis down after 60 years, due to questionable knee structure.
6. I did a lot of writing and editing of friends' writing, which kept my brain somewhat active. Some of my writing was never published. I have a whole novel in my computer about a crazy U.S. President who ran as an evangelical preacher. I figured no one would ever believe it!

At the outset of this essay, I asked what does a long-term practitioner do when she or he meets up with reality of nature? I suggest one come up with a "plan" some place along the line so that the "age" issue doesn't just jump out of nowhere. We did. We bought our home in Taos two decades ago just for this contingency. With little practice income, we rely on Social Security and investment earnings. My plan? Don't leave anything to luck. Invest conservatively and wisely, with an eye to investment earnings and dividends. Not pie in the sky. Most who know us here in Taos, would acknowledge that we are weathering the winding down fairly well. Now if I could just get that corn to grow to my knees by the 4th of July, I would agree!!! ▲▲▲

James C. Bull was a partner of Bucholtz & Bull, PC until 2016. He retired from litigation after 200 civil and criminal trials and many more settlements. He's currently a solo practitioner—no litigation—when he is not napping or boating. Jim was president of CTLA from 1983-1984.

To Draw Traffic, Legal Marketers Need to Provide Enough to E-A-T

By Rafi Arbel

To bring hungry readers to your law firm's blog or other online content, you need to provide enough to E-A-T.

That's the new acronym for Expertise, Authoritativeness, and Trustworthiness, which Google now measures and incorporates into its search algorithm for certain types of sites. Google is placing greater value on high-quality content that is produced with journalistic professionalism, is accurate, explained well and is based on "established editorial policies and robust review processes."

Google makes it clear that a high level of E-A-T is considered a primary characteristic of a high- quality page, along with a descriptive or helpful title, satisfying information about who has produced it, and a creator with an overall positive reputation.

Fight Against Disinformation

Google is not looking to evaluate the truthfulness each piece of content. Instead, it seeks to reward sites with a proven track record of E-A-T. In a whitepaper published by Google, "How Google Fights Disinformation,"[1] it explains how the company is working to eliminate disinformation in its search results. The company acknowledges that neither technology nor humans can always determine the trustworthiness of information. "Our ranking system does not identify the intent or factual accuracy of any given piece of content," the whitepaper says. Instead of attempting to evaluate the veracity of each piece of content, Google's algorithm attempts to "give lower quality ratings to informational pages that contain demonstrably inaccurate content." Further, "[Google's Ranking System] is specifically designed to identify sites with high indicia of expertise, authority and trustworthiness."

For Lawyers, It's Your Money or Your Life

Only certain types of websites are subject to Google's higher level of scrutiny. Those that deal with legal, financial, medical and other sensitive areas are subject to this review. These types of sites are known as *Your Money or Your Life* (YMYL) sites. Law firm websites squarely fall in this category. Pages on these sites are held to a higher "page quality" standard. The E-A-T guidelines attempt to "improve the trustworthiness of [Google's] results for contexts and topics that [their] users expect [them] to handle with particular care."

How to Improve Your E-A-T Score

If having a high E-A-T score is desirable, what choices can you make to improve your score? In short, if you're a law firm that wants to rank well on Google, make sure your content is substantive and helpful and that you have a strong online reputation.

Creating Great Content

Ideally, lawyers should be great writers and author all content their sites. In our experience, the time demands of a busy practice greatly limit their ability to write marketing copy directed at prospective clients on the web. Yet, a site devoid of any attorney involvement is exactly what the E-A-T analysis hopes to demote in the search results. Perhaps the best solution is a hybrid model where the lawyer creates the structure and main points of an article, leaving the writing to outside legal writers.

Reputation Matters

Long before there was an E-A-T score, I advised clients just how important active participation in their professional and personal communities is to growing their practices. It has the potential to demonstrate thought leadership and is the best way for colleagues, referring attorneys, and prospective clients to understand whom the lawyer is and the value

he or she brings. **Those lawyers who give CLE's, who volunteer and take leadership roles in their professional and personal communities, and who actively and visibly demonstrate a commitment to their craft, may realize an unanticipated online benefit**.

Going forward, I predict that Google's sharper focus on expertise, authoritativeness, and trustworthiness will further extend the benefits of doing well by doing good to the Internet. Not only that, I've discovered that those firms who actively give back are often those who are the most conscientious and provide the best client service. In the end, that translates into positive online reviews, which can only help your E-A-T score. ▲▲▲

Rafi Arbel founded Market JD, a 30-person digital agency that helps injury and workers' compensation law firms grow their practices online. A licensed attorney in Illinois, he earned his MBA, with honors, from the University of Chicago Booth School of Business.

Endnote:

[1] https://kstatic.googleusercontent.com/files/388aa7d18189665e5f5579aef18e181c2d4283fb7b0d4691689dfd1bf92f7ac2ea6816e09c02eb98d5501b8e5705ead65af653cdf94071c47361821e362da55b.

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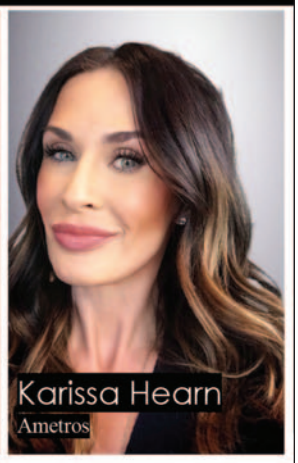
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