INTERNATIONAL ASSOCIATION OF CLAIM PROFESSIONALS

DECLARATIONS

2020 - 2021
Year in Review

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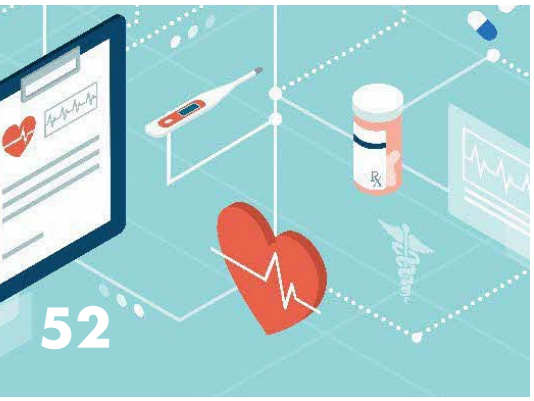

FEATURES

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Teresa Ku

LETTER FROM THE EDITOR

Dear Members and Supporters of the IACP:

My Editors Message comes to you after another year of challenging times. We are excited to bring the 2020-2021 issue of Declarations to align with 2021 Annual Conference. This will be our first in person conference since the beginning of the Covid-19 pandemic and since we were all together for the 50th Anniversary conference in Laguna Beach, California.

During 2021, the IACP continued to bring its members a series of webinars on compelling topics. Please check the IACP website for recordings of any that you may have missed.

Declarations has always brought added value to our membership. To all the contributors, thank you for submitting such relevant and topical articles. The world is quickly changing these days and these articles only begin to highlight some of the challenges our industry faces.

Stay safe, and we look forward to seeing some of you in-person in 2021.

—Jessica

JESSICA ROGIN

Director

Vice President Specialty Claims, US Casualty

Liberty Mutual Insurance

ALEX M. SARDINIA

President

CPCU, AIC, ARE Senior Vice President Claims

Holborn

LETTER FROM THE PRESIDENT

Welcome the IACP's 2021 edition of Declarations

Thank you for attending the 2021 IACP Annual Conference. As special as our 50th Anniversary celebration was in Laguna Nigel, this conference will be equally special for obvious reasons. We are thrilled to welcome you to the fabulous Phoenician for our first in-person association gathering in two years.

The global impact of the pandemic – physically, emotionally, and financially has touched many of us, our families, friends, colleagues, and businesses. Despite all that you may have endured, we are grateful that you decided to be here – with all of us. Notwithstanding the many headwinds, obstacles, and challenges that we faced, the IACP is positioned to deliver its usual a high quality, pertinent and topical program. A special thanks to all the speakers who have also graciously agreed to participate and share their time and talent.

Navigating our way through uncharted waters in 2020 was quite an accomplishment. While 2021 presented similar but some different challenges, fortunately or unfortunately, we had experience being a "virtual" association and were we able to work through our challenges much more efficiently.

- The European Conference and New York Conferences were rescheduled again without financial consequence to the association.

- The IACP hosted three additional webinars – updating Covid litigation, presenting an interesting leadership overview, and a Cyber liability focused presentation.
- Membership and Diamond Sponsorship increased.
- The Young Claim Professional Award was re-established for 2021 after a pandemic pause.
- We explored the potential utility and benefits of a dedicated social networking platform. We were met with some challenges that prevented a larger roll-out but continue to explore various possibilities.
- RFPs for future European and Annual Conference venues are underway
- Association By-laws were reviewed and refreshed, and membership categories and opportunities have been updated.

Despite all that was accomplished, the reality is that we simply would not be in the position we are in, the ability to host an annual conference, if not for the continued support of the membership and our sponsors. We know that it wasn't easy supporting a virtual organization but your continued support for the IACP has helped us get here today. Thank you for all that you do and all that you have done.

Thank you also to the entire IACP board, which agreed to continue to serve for 2 consecutive years. Due to the pandemic, the directors took active rolls in the various webinars, the annual conference committee, membership, and sponsorship. It was truly an "all hands-on deck" approach and I want to acknowledge everyone who participated on the many, many zoom meetings and conference calls that were held.

Thank you once again to Jessica Rogin and Fred Gindraux for their hard work, diligence, and patience, by delivering yet again another exceptional collection of industry updates for the IACP's latest edition of Declarations.

I would like to thank and acknowledge the IACP's Executive Director – Catherine Kalaydjian for her tireless work on all things IACP. Most of you know that Cathy is a Past President of the association and a Vince Donohue award winner. Her dedication and commitment to the association never ceases to amaze me and is nothing short of remarkable. Cathy and her team have been instrumental in everything we have done and been able to accomplish. Thank you Cathy. You passion for the IACP is truly inspiring.

This has been a two-year journey to get here. Although the road continues to be bumpy, I am hopeful that every attendee will see a little more light at the end of the of the tunnel.

So please enjoy. Enjoy the program, the property, the food, the drink, and most of all, enjoy being with one another once again.

—Alex

2021 VINCE DONOHUE AWARD

Written by Clemens Reidel, IACP Board of Director

A couple of years ago, a member of Swiss Re's senior management asked during an internal meeting what the acronym APH means. Instead of giving the most obvious answer, 'Asbestos, Pollution, Health Hazard', someone replied: 'It stands for Fred Gindraux.'

That is one of many such anecdotes which amply illustrates the exceptional reputation and influence of this year's Vince Donahue Award recipient. Frederic Gindraux -- affectionately known to all but his wife, Joan, as "Fred" -- is a standard-bearer of all attributes this award was established to reflect: Significant contributions to the industry and to the IACP through exemplary professionalism in claims management, leadership and broader business endeavors, bringing respect and recognition to the critical role of claims professionals in our industry. It is an honor and privilege for me to introduce the Vince Donohue recipient and most of all to call him a friend.

Fred and I have worked together for more than ten years – first divided by an ocean and then by the wall between our offices at Swiss Re in Armonk, NY. I can't count the number of times I walked over to Fred's office to seek advice or just to catch up. My reasons? Fred knows everything about this business; he invariably exerts himself to offer a helpful response to every question; and, like so many in the industry, I trust him. In short, Fred is the living embodiment of 'institutional knowledge'. At the same time, I know Fred to be one of the most modest and patient people I have ever met. Even in the context of disagreement or conflict, Fred is unfailingly respectful to those holding differing views and is always willing to consider them with a truly open mind. At the same time, Fred is a man of professional conviction, who has stood by his commercial values for decades. Finally, all of us have benefited immensely from Fred's ability to look past a difficult situation once resolved – he never holds a grudge, and he never seeks to blame others. In Fred's idiom, the phrase, 'We talked about this', means that a positive outcome is in the offing and relationships remain intact, if not stronger moving forward.

The stories of those who have worked with Fred over many decades tell me that Fred's career has been marked by an unusual combination of technical proficiency, market knowledge, integrity and personal warmth. Fred has solved a wide array of thorny coverage and business problems over the years by marshaling his technical understanding and often convincing counter-parties – who,

FRED GINDRAUX

President 2017-2018

Fred and David Attisani, IACP Cup Match 2019

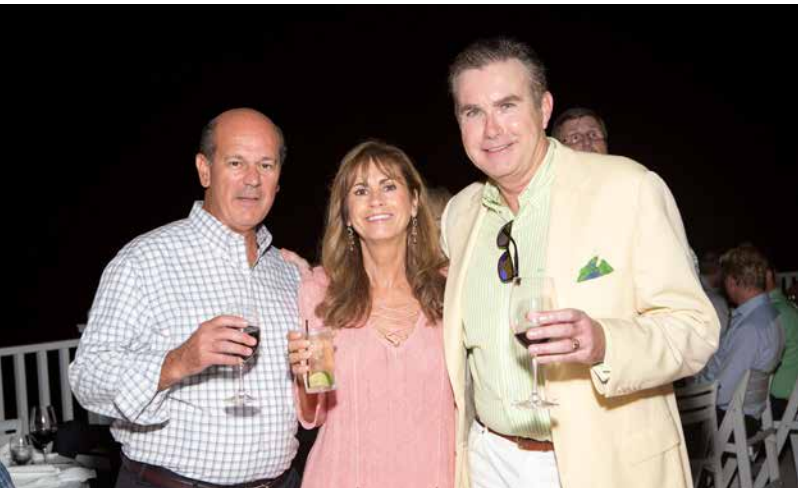
having observed Fred for decades, trust him implicitly – to compromise. In the process, Fred has built an impressive network of business partners, many of whom became friends beyond their active years as a result of Fred's loyalty and dedication to personal relationships.

Beyond his professional excellence, Fred is an accomplished leader. When you talk with professionals who work or formerly worked for Fred, you will hear the same attributes over and over again -- loyalty, trust and respect. The long tenures of Fred's team members attest to his laudable skills as a leader and colleague.

The IACP has special cause to honor Fred who served as President during a challenging time. The forementioned wall between Fred's and my office was, I'm happy to say permeable, and I witnessed the many hours, days and weeks of his personal time Fred devoted to IACP's financial stability and governance. To Fred, IACP is not just an industry association – it is a circle of trust and friendship. Fred's impact and contribution to the association as President and Past President has been and continues to be significant, and he deserves our deepest gratitude and respect for his dedication and thoughtful leadership.

All of Fred's accomplishments and recognitions are built on his increasingly rare experience in re/insurance claims. Fred's career began at Liberty Mutual Insurance Company where he handled property and liability claims. As a road adjuster he completed field investigations and disposition of workers compensation, products, general and auto liability claims. He moved on to excess insurance claims at American International Group as Home Office Claims Examiner, Products Liability Claims.

He ventured into reinsurance at American Re-Insurance Company (now Munich Re) as a Regional Claims Consultant, Special Products Litigation Unit. At Cigna Reinsurance Fred served as Chief Claims Officer. Following the sale of Cigna Re, he joined North American Re in 1995,



which is now Swiss Re America, where Fred has been at the forefront of managing APH claims with great skill and efficiency for more than 25 years.

Fred is known and respected as a specialist in managing complex loss exposures and home office claims operations with specific emphasis in the handling of products and mass tort liability claims for leading insurance and reinsurance companies. He is a frequent guest lecturer on emerging risks, asbestos, environmental and run-off claim issues on behalf of the Reinsurance Association of America, the International Association of Claims Professionals (IACP), Federation of Defense and Corporate Counsel (FDCC), Mealey's, the American Academy of Actuaries, Glasser Legalworks, and the American Conference Institute. Fred is a Member of the Society of CPCU, New York Chapter and served as Chair of the Reinsurance Association of America Claims Committee and member of the APIW.

Finally, no description of Fred's achievements would be complete without reference to his care for younger colleagues, stewardship of their careers, and genuine interest in the quality of their personal lives. In Fred's own words, the attention to the new generation of claims professionals is driven by the simple fact that he was a Millennial, too. Just a couple of years ago.

In that connection, Fred continues to grow young with his family, and he takes understandable and immense pride in his exceptionally close and thriving family—including and especially his wife Joan, "Joanie" to Fred —who have supported Fred's career and, in some cases, formed close personal relationships with Fred's industry friends and business associates.

Congratulations to Fred for receiving this more than well-deserved award!

Fred, Joan Gindraux and Ed Quinn Jr., Bermuda 2017

IACP ANNUAL ASSOCIATION DIAMOND SPONSORS

IACP OFFICERS AND DIRECTORS

Alex Sardinia, CPCU, AIC, ARe

President

Alex Sardinia joined HOLBORN in August of 2017 as Senior Vice President, Claims and is responsible for providing the highest levels of Claims service to HOLBORN's customers and enhancing the value-added proposition of Claims.

Alex has extensive experience in Insurance and Reinsurance claims handling and has held numerous Senior Claims Management positions throughout his career.

Prior to joining HOLBORN, Alex served as Markel Corporation's Executive Claims Officer with responsibility for Property and Casualty Claims in North America and Bermuda. In 2008, Alex was appointed Markel's first Senior Claims officer and served as Managing Director of North America Claims where he led the creation of

Markel's Shared Service Claims Division. He joined Markel in 2004 as Vice President, Claims Manager for Markel Underwriting Managers.

Alex began his insurance career as a Claims Adjuster with Liberty Mutual in 1984. His reinsurance career includes various claim handling and management roles at M&G Re/TOA Re, Chatham Re, and Gerling Global Reinsurance Company/Constitution Re.

Alex holds an undergraduate degree in Business Management from Ithaca College and has earned the CPCU, AIC, and ARe designations.

Scott Kellers

Vice President

Scott Kellers is Head of Claims for Liberty Syndicates and Deputy Head of Claims for Liberty Specialty Markets. Scott works closely with the CCO to continually deliver the market leading claims service Liberty is renowned for. The LSM claims team consists of approximately 200 claims professionals, spread across the globe involved in managing in excess of 60 different insurance and reinsurance classes of business.

Scott has worked in the London Market in excess of 20 years. During his career Scott has had direct involvement managing numerous significant complex catastrophic claims on behalf of the market an example of which is involvement as the Lloyd's reinsurance market representative handling the Chile and New Zealand earthquake losses which involved significant interaction with both the New Zealand and Chilean governments as well as international and domestic reinsurers and brokers.

Scott is ACII qualified and has served and continues to serve on a number of senior Market Committees (LMACC and IUA NMCC) and Associations (IACP). Scott won the Insurance Insider future industry leader award and last year was awarded the 2019 Claims Professional of the Year.

Scott enjoys reading and running, when he can find the time, and at one point had aspirations to play football professionally – that was before seeing the light and realising what a fantastic career in insurance could bring!

Dhara Patel

Treasurer

Dhara Patel is the President of American Claims Management and oversees several companies within the Brown & Brown Claims Services Division, including, ICA, United Self Insured Services, Preferred Governmental Claim Solutions, Investigation Solutions and National Claims Connections.

Partnering with insurance companies and self-insured entities, Brown & Brown's Services Division is composed of claims advocacy businesses, claims adjusting, and claims processing for property, auto, general liability, professional liability and workers' compensation clients. In addition, she oversees multi-line claims systems development team, business analysts, database administrators and the national compliance team.

During her 20-year insurance career, Dhara has handled complex claims for general liability, property, professional liability, E&O, D&O and construction defects. Prior to joining ACM in 2001, Dhara was a litigation and securities paralegal at Gibson, Dunn & Crutcher. She

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has a Bachelor of Science in Accounting with a minor in Information Technology, plus a graduate degree in Accounting. Dhara is a frequent claims expert source for Insurance Journal.

James Parker

Secretary

James was appointed Chief Claims Officer for AXIS Re in May 2016 and has overall responsibility for all Reinsurance Claims globally.

Prior to joining AXIS, he worked in a variety of complex claims roles, working for Insurance as well as Loss Adjusting firms in both the UK and London market, as well as in Zurich, where he resides today.

Prior to joining the industry, James graduated with a BA (Hons) degree in History from Kent University, Canterbury and then qualified in Law from Leicester University. He has been involved in the Insurance / Reinsurance claims industry for over 20 years, joining AXIS Re in 2005 when he was engaged as Claims Manager for AXIS Re Europe to establish their European Reinsurance claims operation.

Thomas Joyce

Immediate Past President

Tom Joyce is the President of Nautilus Insurance Group, a member of the WR Berkley Insurance Group. Previously he held the position of Chief Claims Officer, Executive Vice President and Chief Underwriting Officer.

Prior to joining Nautilus, Tom worked for St. Paul Fire & Marine Insurance Company in various technical and leadership roles and then spent the past twenty years with the Scottsdale Group, most recently the Vice President of Claim Operations. Tom earned a Bachelor of Science Degree from Northern Arizona University, and holds a number of professional designations, including an Associate in Surplus Lines Insurance and Associate in Claim Law. Tom is a member of the Professional Liability Underwriting Society (PLUS).

Tom is a native of Arizona and has served as Board Member and Board President to the Tumbleweed Center for Youth Development, a community-based organization helping troubled, homeless and neglected youth and currently serves as Chair of United Blood Services of Arizona Community Leadership Council. Tom lives with his wife and three children in Scottsdale, Arizona.

DIRECTORS (TERM EXPIRATION)

Steven Clark

Director (2021)

Steve is the Managing Director of Client Services and Head of Claims UK - Reinsurance Solutions / Aon

Steve joined Aon in 2002 as the Team Leader of Americas claims working closely with the US offices.

Prior to joining Aon Steve worked for Guy Carpenter in a similar capacity covering most aspects of US and International claims. Steve's principle role was as claims negotiator with London and European markets and has been responsible for the resolution of high profile and contentious claims including those emanating from WTC and Katrina. In Steve's current role as Managing Director, he is responsible for setting the strategic direction of all global claims placed via the London office. Steve has been integral in the overall management, broker and market response to the recent worldwide catastrophes and has been instrumental in harnessing client and reinsurer relationships to ensure the optimization of a prompt and efficient claims settlement process.

Steve is part of the Aon UK Executive team and is Aon's representative for the LIIBA steering group.

IACP OFFICERS AND DIRECTORS

Neil Dalton RD

Director (2021)

Neil Dalton is Ascot Group's Director of Claims responsible for Ascot's claims operations in London and Bermuda. He joined Ascot in 2007.

After training as a lawyer Neil began his insurance career in the Lloyd's market in 1990 where he was appointed the claims manager of Syndicate 329 in the Octavian Group (subsequently Markel International Syndicate 3000). During his career Neil also worked for Lloyd's Franchise Performance Directorate as a Senior Claims Manager. Neil is a Director of Ascot Underwriting Asia in Singapore. He is also a member of the LMA Claims Committee.

Neil served in the Royal Navy, reaching the rank of Lieutenant Commander.

Corinne R. Kruse, J.D.

Director (2021)

Corinne Kruse just recently joined Guy Carpenter as Global Claims Consultant. Previously she was the Vice President and Head of Reinsurance Claims and Recoveries at Zurich American Insurance Company.

She has worked at Zurich since 2006 in various reinsurance management functions. She manages a team of lawyers, claims and accounting professionals, supervises reinsurance recoveries for Zurich globally, s assists with reinsurance placements and is a Six Sigma/ Lean Black Belt facilitating operational improvements within the organization.

Prior to Zurich, Corinne held senior leadership roles at Lumberman's Mutual Casualty Company, CNA Financial Company, Broker's Risk Placement Service and ISBA Mutual Insurance Co. ranging from legal counsel, claims counsel and claims executive. Corinne obtained her law degree at The John Marshall Law School in Chicago, Illinois and her B.S. in Economics and International Relations at Bradley University in Peoria, Illinois.

Charles Kroh

Director (2021)

Charles Kroh is Head of Core Specialty, Property and Casualty Claims for Munich Reinsurance America, Inc. operating out of the Philadelphia, PA office. He currently manages the claims staff responsible for claims in the Munich Re Specialty Insurance Division; including general liability, professional liability, public officials liability, trucking and commercial auto liability, school board liability, workers compensation and hospital professional liability. His claims consulting experience includes Claims Operational Reviews, Third Party Administrator Reviews, litigation management and expense control, case reserve analysis, and mergers and acquisitions due diligence.

Prior to joining Munich Re in 2001, Chuck was with General Accident/CGU for 16 years. At CGU, he was the Claims Manager of the National Accounts Department managing a staff of analysts facilitating claims handling for large accounts.

Chuck Kroh holds a Bachelor of Arts degree in political science from Catawba College in Salisbury, North Carolina. He has earned the designation Senior Claims Law Associate from the American Educational Institute.

Melissa Hill

Director (2021)

Melissa Hill is Vice President, Enterprise Claims Operations for American Family Insurance Company. In this role Melissa will oversee the strategic direction and financial performance results for Enterprise Claims through reimagining data driven decision making. She is based in Atlanta and is reporting to Chris Conti, Enterprise Chief Claims Officer. Her move to American Family was an obvious match and partnership. Melissa has over 25 years of insurance experience and understands the value of claims data to the overall organizational profitability. Immediately prior to this, Melissa was the Head of Claims at Hiscox USA.

Previously Melissa spent several years as SVP, Chief

IACP OFFICERS AND DIRECTORS

Claims Officer at Blackboard Insurance Company (fka, Hamilton USA) where she further developed her passion for the use of data and analytics to support not only data driven business decisions but create a data driven claims journey for the customer.

Melissa joined AIG in 2005 as a Complex Claim Director responsible for wide range of casualty liability claims. From there, Melissa continued to advance her career and responsibility in various claims management roles in Liability, Workers Compensation and Operations. Melissa has been successful in leading multiple claim operations domestically and internationally. Throughout her career, she has always partnered with underwriting, compliance, customer relations and reinsurance to ensure claims was aligned with the overall customer experience.

Dr. Eberhard Witthoff

Director (2021)

Dr. Eberhard Witthoff has been Head of Claims Munich Re since 2016 for the Global Clients and the region Asia-Pacific. He has the worldwide responsibility for Cyber claims, Casualty, Credit risk and Agro.

Eberhard began his career as an insurance and contract lawyer in a law firm in Munich serving clients nation-wide and joined Munich Re as a primary (fire/industrial) insurance specialist in 1997. From 2001 to 2005, he was Senior Claims Lawyer for the German market. In 2005 he became Head of Claims for Central Eastern Europe. From 2007 to 2016 he held the position of Head of Claims for the Germany, Asia-Pacific, and Africa Division.

Jessica Rogin

Director (2022)

Jessica Rogin is the Vice President, Specialty Claims for Liberty Mutual's Global Risk Solutions, US Casualty Claims organization. In Specialty Claims, Jessica oversees a department of claims professionals that support the National Insurance Specialty business including all Construction, which includes Construction Defect, Energy, Public Entity, Healthcare, Programs, Unsupported Excess and Environmental. Her department also manages all the Coverage related claims, as well as Emerging Risks. Before her current position, Jessica worked for Liberty International Underwriters, the Global Specialty Lines division of Liberty Mutual Group, as Chief Claim Officer - US.

Prior to joining LIU, Jessica was the Vice President of Casualty Claims for Crum & Forster, where she worked for fifteen years. During her tenure at Crum & Forster, Jessica also worked for several years in the Corporate Legal department where she supported the claim department in coverage analysis and monitored the extra-contractual claims for the company. She obtained her B.A. from the University of Rochester and her J.D. from Benjamin N. Cardozo School of Law. Jessica is a licensed attorney, admitted to practice law in New York and New Jersey.

Clemens Reidel

Director (2022)

Clemens Reidel is the Chief Insurance Officer Movinx. This follows his assignment to lead the implementation of Swiss Re's Casualty Underwriting Strategy for the US market. Prior to this he was the Head of US Property & Casualty Claims and is based in Swiss Re America's Armonk office. In this function he leads the reinsurance claims management activities for all main lines of business within the United States. Very recently he was assigned to lead the implementation of Swiss Re's Casualty Underwriting Strategy for the US market.

Until 2016 Clemens led the property and casualty claims management unit for Germany, Austria, Nordic and Baltic countries at Swiss Re Europe. In addition, he served as member of the German Insurance Association's Motor Insurance Committee and representative of the insurance industry on national and European level.

IACP OFFICERS AND DIRECTORS

He joined Swiss Re after the acquisition of GE Insurance Solutions in 2007 where he had worked as Senior Claims Counsel for large general and motor liability claims for several years. Prior to that Clemens started his professional career in corporate investment banking.

Clemens Reidel graduated from law school at Ludwig-Maximilan University in Munich, Germany and is admitted as attorney to the Munich Bar Association.

ASSOCIATE BOARD MEMBERS

Nicholas A. Kimpton

Nick recently retired after a 35 year career in the reinsurance claims industry including over 15 in the London Market.

Nicholas's most recent position was as a Director in Client Services of Aon Reinsurance Solutions. In this position Nick managed a team responsible for the administration, coverage determination, dispute resolution, reporting, billing and collection of claims and collateral funding for numerous Aon clients. He also played an active role in the departmental policy making and system development efforts.

Prior to joining Aon Reinsurance Solutions, Nick held the position of Assistant Vice President at Aon Technical Services Inc. from 1984 to 1988, where he managed professional liability programs, at both a primary and reinsurance level.

Nick began his career in the London Market where he held the position of Associate Director and established and managed the Claim Department for Ballantyne, McKean and Sullivan Ltd. While in London, Nick played an active role in numerous Market committees and their efforts to streamline the Lloyds and London Company systems and procedures.

Nick is an active member in the Aon Reinsurance Solutions practice groups and currently chairs the regional Americas Claim Practice Group. He also chairs the Global Property Claim Practice Group. Nick is also a member of the Brokers Medical Malpractice and Structured Solutions groups.

Robert Riccobono, CPCU

Robert, recently promoted to the position of Senior Vice President, North American Claims Group, Allied World Insurance Co. His previous position was as the Global Head of TPA Operations for Allied World Assurance Co., where he oversaw Allied World's North American Programs and TPA Operations for Global Markets.

Prior to this Robert spent 8 eight years in supervisory and management roles with Rockville Risk Management where he focused on complex New York Construction claims, managing claims and litigation for numerous domestic and international clients. Prior to this he worked for Zurich Specialty Insurance Co. for several years handling FELA Short-Line Railroad claims. He earned a CPCU designation and served as Chairperson of the Long Island Chapter of the CPCU Society from 2010-2011.

Robert began his career in the insurance industry after graduating from Hofstra University. First as a liability field investigator for First Central Insurance Co. and then worked for various Third-Party Administrators in roles of increasing responsibility.

IACP OFFICERS AND DIRECTORS

GENERAL COUNSEL

David Abbott

David is the Head of London Markets for DWF. DWF has operations on 4 continents servicing more than 27 key locations with over 3100 employees globally.

DWF has one of the largest specialist insurance practices in the UK and continues to make considerable investments in growing its London presence.

Prior to his current position David was the co-head of Clyde & Co's global reinsurance practice and a lead member of the specialty insurance practice, including the political risk, trade credit and product recall teams. David also specialises in energy and industrial risks. David practises across a number of classes of business.

David regularly advises insurers in relation to political and trade credit risks and has acted for the London market in a number of recent large losses. He undertakes both coverage work and subrogation actions. David also advises the market on product recall matters, most recently in relation to food and pharmaceutical products.

David also advises London and international markets on energy matters. He has acted on coverage and subrogation on large cases in a number of different jurisdictions.

He acts for London, international and legacy reinsurance markets and often deals with high value, prominent and ground breaking issues. He advises on both dispute and non-contentious work.

David is co-author of Reinsurance Practice and the Law and Tolleys Insurance Handbook and is English counsel to the Lloyd's Reinsurance Claims Group. David speaks regularly at conferences on insurance and reinsurance issues and assists market bodies such as the IUA, LMA and CILA.

David also undertakes general commercial litigation in a variety of industries.

EXECUTIVE DIRECTOR

Catherine Kaladjian

Catherine is currently the Executive Director of the IACP, a position that was began in late 2017. She is a Past President of the IACP (2007) and she was awarded the prestigious Vince Donohue Award by the association in 2013. A longtime active supporter of the organization, she joined the then XSLCA in 1992.

Catherine has enjoyed a very successful career in the insurance industry culminating most recently in the position of COO & Chief Claim Officer of Endurance Specialty Holdings Ltd. in Bermuda (2003 - 2014). There Catherine was a standing member of the Executive Team reporting directly to the CEO and Chairman. Over time various direct reports included Claims, IT, HR, Marketing, Facilities and Corporate Real Estate and Underwriting Operations. She has held successor claims leadership positions with QBE the Americas where she headed the US/South/Latin Americas claims operations for both insurance and reinsurance claims exposures and MGA Business, Resolute Reinsurance Corporation for 10 years and Integrity Insurance Company. She started in the business as a Claims Adjustor for GAB Business Services.

In addition to dedicating her time to the IACP, Catherine has also been a supporter of women in leadership positions in the industry. She was the President of the Association of Professional Insurance Women (APIW), sitting on their Board for over 10 years and in 2014 was named by Reactions Magazine as one of the top 50 women in insurance/reinsurance. Catherine is a cum laude graduate of Siena College, Loudonville, New York with a BA in Management & Marketing.

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Past Presidents

2020 - 2021 Board of Directors

Vince Donohue Honoree

2021 Young Claims Professional Award

INTERNATIONAL ASSOCIATION OF CLAIM PROFESSIONALS

2021 ANNUAL CONFERENCE

September 26-29, 2021
The Phoenician, Scottdale, AZ

PROGRAM SCHEDULE

Sept 26

Camelback Ballroom Registration Desk	12:00pm – 5:00pm
Welcome Reception and Dinner **Location: The Jokake Inn** **Vince Donohue Presentation / Young Professional Award** **Music: The Western Fushion Band**	6:00pm – 10:00pm

Sept 27

Hot Breakfast **Location: The Camelback Plaza** **Open to All Registrants**	7:00am - 8:30am
Welcoming Remarks: Alex Sardinia, IACP President **Location: Camelback Ballroom K&L**	8:00am – 8:15am
Keynote Speaker: **Frank Harrison**, *Chairman of the Board and CEO, Holborn Corp.*	8:15am – 9:00am
Session Topic: Executive Industry Roundtable **Ann Haugh**, *President Global Property, AXIS RE* **Kimberly Holmes**, *Executive Vice President, Chief Actuary and Strategic Analytics Officer, Kemper Corp.* **Mike Miller**, *CEO, Ategrity*	9:00am – 10:00am
Break	10:00am – 10:15am

Conference Attire: Business Sessions are Business Casual (shorts permitted). Evening Receptions are Resort Casual (shorts permitted)

Hotel and CDC COVID guidelines will be followed and encouraged for everyone's safety.

Sept 27

Achieving "ESG" When You Are Far from the Risk (Environmental, Social, Governance) **Tom Johansmeyer**, *Assistant Vice President, ISO Claims Analytics*	10:15am – 11:00am
Social Inflation: Actions, Strategies and Intelligence for the Defense **Dana Franzatti**, *Head of Reinsurance Claims US, Swiss Re* **Jane Mandigo**, *SVP Claims, Swiss Re*	11:00am – 11:45am
Special Guest Speaker **Dave Bing**, *Former Mayor of Detroit, Professional NBA Hall of Fame Basketball Player, Businessman*	11:45am – 12:30pm
Golf Outing – Off Property - Camelback Golf Club **Buses Depart at 12:45pm** **Boxed Lunches on the Cart**	1:30pm Starting Tee Time
Cocktails and Dinner **Location: Camelback Plaza** **Music: Sahnas Brothers**	6:30pm – 10:00pm

Sept 28

Hot Breakfast **Open to All Registrants**	7:00am – 8:30am
Police Liability/Municipality Insurability **Margaret Zechlin**, *Lead Underwriter of Allied Public Risk* **Doug Hayden**, *President of Wright Public Entity (a MGA)* **Eric Homer**, *President of Clear Risk Solutions (a MGA)*	8:00am - 9:00am
Ransomware: Threat Update and Lessons Learned **Jena Valdetero**, *Shareholder, Greenburg Taurig*	9:00am - 9:45am
Break	9:45am - 10:00am
SUEZ Canal & Supply Chain **Walter Crawford**, *Commercial Proactive Response Lead, Booze Allen Hamilton* **Charles McCammon**, *Vice President Risk Consulting, Willis Towers Watson*	10:00am - 11:00am
Extreme Weather and Texas Energy Grid **Lawrence T. Bowman**, *Director Kane Russell Coleman Logan* **Dr. Gavin Dillingham**, *HARC: Houston Advanced Research Center*	11:00am - 12:00pm

Conference Attire: Business Sessions are Business Casual (shorts permitted). Evening Receptions are Resort Casual (shorts permitted)
Hotel and CDC COVID guidelines will be followed and encouraged for everyone's safety.

Sept 28

Annual Member Business Luncheon Meeting **Location: Camelback Ballroom K&L**	12:15pm – 1:00pm
Cocktails & Arizona Street Fair **Location: East Lawn**	6:30pm - 10:30pm
President Remarks **Alex Sardinia**	
Incoming President **Scott Kellers**	

Sept 29

Continental Breakfast **Location: Camelback Ballroom Foyer**	8:00am – 9:30am
Human Performance Optimization for Remote Teams - How to Measure Impact **JD Dolan**, *Co-Founder / Partner, LDR Growth Partners*	9:00am – 9:45am
Civil & Structural Engineering Risk – The Surfside Condominium Collapse **Jason Ball, P.E.** *Senior Civil/Geotechnical Engineer, SEA, Ltd.*	9:45am – 10:30am
Break	10:30am – 10:45am
Can Insurance Solve the Big Tech Culture Wars? **Matthew Feeney**, *CATO Institute*	10:45am – 11:30am
Advanced Technologies and the Future of Claims **Mark Breading**, *Strategic Meets Action, a ResourcePro Company*	11:30am – 12:15pm
Closing Remarks **Alex Sardinia**, *President*	12:15pm - 12:30pm
Farewell Luncheon BBQ **Location: The Orchid Lawn**	12:30pm – 2:00pm

Conference Attire: Business Sessions are Business Casual (shorts permitted). Evening Receptions are Resort Casual (shorts permitted)
Hotel and CDC COVID guidelines will be followed and encouraged for everyone's safety.

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Speakers

IACP 2021 Annual Conference

Frank T. Harrison

Chairman of the Board, and Chief Executive Officer

Frank Harrison serves as Chairman of the Board, and Chief Executive Officer of Holborn.
He joined the firm in 1989 as an Assistant Vice President, and progressed steadily through successive appointments as Senior Vice President (1996), Chief Operating Officer (1999), Executive Vice President (2001) and President (2004). He was named Chairman in 2012.
Frank began his career at Sten-Re in 1983, where he started in the Reinsurance Accounting Department. He worked for two years at Sten-Re and then for four years at Cole, Booth, Potter after the merger of the two reinsurance broker firms. In 1985, he transferred to the broking staff and rose to the position of Assistant Vice President.
Frank received his B.S. in Economics with a concentration in Strategic Management from the Wharton School at the University of Pennsylvania.
A former world class decathlete and competitor in the Olympic Decathlon trials, Frank now serves on the board of the U.S. Athletic Trust, a non-profit organization that raises money for aspiring Olympic athletes.

Ann Haugh

President Global Property, AXIS Re

Ann Haugh is currently President of Global Property at AXIS Re.

Ann began her career in the U.S. market over 28 years ago as a Management Liability Underwriter and has subsequently held numerous senior executive positions spanning underwriting, distribution, operations and strategy at Zurich Insurance, Arch Insurance, Aspen Insurance and Thomas Miller in the US, London and Zurich.

Throughout her career Ann has been passionate about developing the next generation of talent by building underwriter training programmes and leading sponsorship and mentoring initiatives. She is equally committed to supporting company and industry D&I initiatives and has recently become an Advisory Board member of Insider Progress. She was a past recipient of the Business Insurance Woman to Watch award and is a member of the APIW (Association of Professional Insurance Women), the ISC (Insurance Supper Club) and the CII.

Kimberly Holmes

EVP, Chief Actuary and Strategic Analytics Officer

Kim is EVP, Chief Actuary and Strategic Analytics Officer for Kemper. Since joining in early 2019, she leads actuarial, data science and data functions. Most recently, Kim founded and led XL Catlin's global Strategic Analytics team, the enterprise center of excellence for advanced analytics, developing and implementing of leading-edge analytical decision tools across XL Catlin. Prior to joining XL Catlin in 2010, Kim was the Chief Actuary of Endurance Risk Solutions, the large account insurance business for Endurance Specialty Insurance where she created innovative analytics to improve decision making, developed casualty risk management tools and focused on ways to use analytics to drive strategy. Kim's career also includes serving as Chief Actuary of Enterprise Reinsurance Ltd, a finite reinsurance company and working at General Reinsurance where she held various actuarial and underwriting roles. Her early career was spent in actuarial consulting. In 2018 Kim was named one of Digital Insurance's Women in Insurance Leadership and Corinium's Top 50 Data and Analytics Professionals in the USA and Canada. Kim has a BS in mathematics from William Smith College and an MS in Data Science from Northwestern University. She is an Associate of the Casualty Actuarial Society, a member of the American Academy of Actuaries, and a Certified Specialist in Predictive Analytics.

Speakers

IACP 2021 Annual Conference

Mike Miller

CEO, Ategrity

Mr. Miller is the CEO of Ategrity Specialty Holdings LLC, an independently owned holding company that owns Ategrity Specialty Insurance Company and Sequentis Reinsurance Company Limited. Mr. Miller and a group of industry veterans started this group of companies in 2018. Prior to starting Ategrity, Mr. Miller was President of Nationwide Ventures – an operation he started for Nationwide, with the goal of investing in early stage startup companies that were innovating in the insurance industry. From 2005 to 2015, Mr. Miller was President and COO of Scottsdale Insurance Company where he profitably grew the company from $1.9bn to $3.0bn in direct written premium. To facilitate the strategic growth of Scottsdale Insurance Company, he implemented product diversification strategies and added new lines of business, orchestrated the successful acquisition of Veterinary Pet Insurance Co., started Freedom Specialty Insurance Company, Crestbrook Insurance Company, and maintained strong relationships with wholesale producers and reinsurance brokers nationwide. Prior to his tenure of President and COO at Scottsdale Insurance Company, Mr. Miller was CFO of the Nationwide P&C Insurance Companies (2000-2004) and was CFO of Scottsdale Insurance Group of Companies. He began his insurance career at Celina Group in 1977 and joined Nationwide in 1985, holding increasingly responsible positions within the finance organization of Nationwide prior to becoming CFO of Scottsdale Insurance Group.

Tom Johansmeyer

Assistant Vice President, ISO Claims Analytics

Tom Johansmeyer is Assistant Vice President – PCS Strategy and Development at ISO Claims Analytics, a division of Verisk – insurance solutions. He leads all client- and market-facing activities at PCS, including new market entry, new solution development, and reinsurance/ILS activity. Currently, Tom is spearheading initiatives in global terror, global energy and marine, and regional property-catastrophe loss aggregation. Previously, Tom held insurance industry roles at Guy Carpenter (where he launched the first corporate blog in the reinsurance sector) and Deloitte. He's a veteran of the US Army, where he proudly pushed paper in a personnel position in the late 1990s.

Dana Franzatti

Head of Reinsurance Claims US, Swiss Re

Dana serves as the Americas regional head of Property & Casualty Business Management for Swiss Re. She is a member of the cross-functional team advising on the impact of social inflation and has presented broadly on the topic. Prior to joining Swiss Re, Dana spent the first part of her career as an insurance defense attorney in New York City and ten years within Professional Liability Claims at a global insurer. She is a member of the New York, New Jersey and Illinois Bars and graduated from Hamline University School of Law. Dana holds a B.A. from University of Minnesota and an M.A. in English from Northern Illinois University.

Jane Mandigo

SVP Claims, Swiss Re

Jane is a Senior Vice President, Casualty Expert with the Swiss Re P&C Business Management Americas Claims division. In her role, she consults on issues relating to reinsurance coverage and assesses emerging risk trends for a variety of subject matters including: Opioids, Social Inflation, Professional Lines, Sexual Harassment and Climate Change.

Prior to her Senior Claims Expert position, Jane was Chief Product Underwriter for primary professional liability lines of business. She also handled complex professional liability claims across various lines for many years.

Before joining Swiss Re, Jane practiced with the insurance defense group at the Kansas City law firm of Shughart, Thomson & Kilroy. Jane served a two-year term as a federal judicial clerk in the United States District Court for the Western District of Missouri, Southern Division, for the Honorable Russell G. Clark.

She is a member of the Missouri Bar and graduated from the University of Missouri, Columbia School of Law where she held positions on the Missouri Law Review and Order of the Coif. Jane graduated Summa Cum Laude from Drury College with a degree in English.

Dave Bing,

Former Mayor of Detroit, Professional NBA Hall of Fame Basketball player, Businessman

Dave Bing has uniquely claimed success in three distinct arenas: professional sports, business and politics. Dave Bing was elected the 62nd Mayor of the City of Detroit in May 2009. A native of Washington, D.C., Bing is a graduate of Syracuse University where he earned his Bachelor of Arts in Economics, and was later bestowed an honorary Doctorate of Laws in 2006. He was also a standout basketball player in both high school and college.

Dave Bing came to Detroit in 1966 when he was drafted by the Detroit Pistons as their #1 pick. Voted one of the top 50 basketball players of all time, Bing was inducted into the Michigan Hall of Fame in 1984, and into the Naismith Hall of Fame in 1990.

Bing turned his winning strategies from the basketball court to the boardroom as the founder of an automotive supply corporation, The Bing Group in 1980, where he served as President and Chairman until April 2009. Within a decade, The Bing Group was recognized as one of the nation's top Minority-Owned Companies by Black Enterprise.

Answering yet another call to serve, Bing decided to run for Mayor to help rebuild a city that he has loved and been a part of for more than 40 years. Proving that the basics of good performance, integrity and business can be applied to any area or industry, Bing has brought a renewed sense of trust and hope to the City of Detroit.

Bing's latest challenge is establishing the Bing Youth Institute whose mission is to create a meaningful mentoring experience to help unleash the unlimited potential in young men of color.

Margaret Zechlin

Lead Underwriter of Allied Public Risk

Based in San Francisco, CA, Margaret has been in the insurance industry since 1980. During that time, she has held various Underwriting, Sales and Management positions with both national insurers and reinsurers. For the past eight years, she has focused exclusively on the Public Entity market segment. In her current capacity, she is focused on developing a geographically diverse book of business with retailers and wholesalers dedicated to the Public Entity sector. Margaret has a B.A. in Political Science from Mississippi State University.

Doug Hayden

President of Wright Public Entity (a MGA)

Douglas J. Hayden is President of Wright Public Entity with over 200 employees on Long Island and Albany, NY which consists of the New York Schools Insurance Reciprocal and the New York Municipal Insurance Reciprocal. These public/private joint ventures

carry Best's A and Best's A- ratings respectfully. In addition, the New York State Municipal Worker's Compensation Alliance, various state-wide Worker's Compensation Cooperatives and self-insured clients make up Wright Public Entity. Wright Public Entity is a subsidiary of Brown & Brown. In January 2014, Brown & Brown acquired the Wright Insurance Group. Brown & Brown is the 6th largest insurance intermediary in the world. Prior to becoming President of Wright Public Entity, Mr. Hayden was Executive Vice President of the Wright Insurance Group. Mr. Hayden is currently an active member of Brown & Brown's Leadership Council.

Prior to joining The Wright Insurance Group in 2006, Mr. Hayden served as General Attorney/Chief Legal Officer and also served as interim Executive Director/Chief Executive Officer of the New York State Insurance Fund (NYSIF), then the 6th largest Worker's Compensation carrier in the United States. In addition, Mr. Hayden was NYSIF's Chief Ethics Officer. Mr. Hayden is a graduate of Hofstra University School of Law. He began his legal career as an Assistant District Attorney in Nassau County where he tried numerous cases to verdict as well as working with numerous law enforcement branches in the prosecution of organized crime. He is also admitted to practice law in the Eastern and Southern District of New York.

Mr. Hayden is the past Chairman (2005) and now sits on the executive committee of the New York State Bar Association Torts, Insurance and Compensation Law Section and is co-chair of the Ethics Committee. Mr. Hayden sits on the Board of Directors and is Past Chairman of the American Society of Worker's Compensation Professionals; Insurance Federation of New York; Defense Association of New York; the Emerald Society of Long Island; CYO Nassau Suffolk; Catholic Cemeteries of Rockville Center and Parents' Leadership Council at Providence College.

In 2012, Mr. Hayden was the recipient of the New York State Bar Association Torts Insurance & Compensation Law Section John L Leach Memorial award in recognition of outstanding service and distinguished contributions to the legal profession. Also, in 2012 he was the New York Claims Association honoree in recognition of outstanding contributions to the legal and claim profession in New York State. In 2016, Mr. Hayden was the recipient of the Neal Levin award for his service in the insurance industry at the Israel Bonds Association Insurance Division luncheon and was inducted into his Alma Mater, the Holy Cross High School Hall of Fame in November of 2016. Mr. Hayden was also the recipient of the Executive with Vision award by the Institute of Jewish Humanities in December of 2016.

Mr. Hayden also serves as the Village Justice of Floral Park. He was first elected in 1999. He served as President of the Nassau County Magistrates' Association (2015-2016) and has served on the Board of Directors of the Magistrates Association since 2000. He is also active in the New York State Bar Associations Judicial Section and is the Judge Advocate of the Floral Park Knights of Columbus.

In addition to being active in his community, Mr. Hayden is active in his Parish, Our Lady of Victory. He has been a long time CYO basketball coach for over 25 years. Mr. Hayden was also the recipient in 2007 of the National Catholic Educators Association Distinguished Alumni award and was co-chair of the Our Lady of Victory Church Capital Campaign Fund and Restoration Committee in 2009. He is a member of the American Legion-Sons of Legion; Board Member of the Hance Family Foundation; Floral Park Little League Coach and Floral Park Indians soccer and basketball coach.

Mr. Hayden resides in Floral Park, New York with his wife, Una, and their four children, Conor, Ryan, Shannon, and Sean.

Speakers

IACP 2021 Annual Conference

Eric Homer

President of Clear Risk Solutions (a MGA)

Eric began his employment with Clear Risk Solutions (formerly known as Canfield and Associates) in 1994, and has worked in various aspects of our industry, leading to him becoming President.

Eric has been directly involved in all aspects of Clear Risk Solutions' operations. He now oversees programs, pools, and team operations on several Brown & Brown public entity offices. Eric currently oversees two other national programs for Arrowhead General Insurance, owned by Brown & Brown; Arrowhead Tribal, and Arrowhead Manufactured Housing programs. All of which includes services, carrier relationship management, marketing, board relationship management, growth strategy, and financial planning. This requires continual monitoring of the insurance product for effectiveness and competitiveness in the market space, and searching for new markets that can provide the necessary coverages, providing availability and stability in the markets.

Eric was a driving force in the establishment of many of the current loss control services. Services include loss control, risk management, claims, underwriting, and marketing. He developed and implemented the Personnel Issues Program with the USIP board in 1996. This program, now called the Pre Litigation Program, continues to be a vital and successful loss control component for all programs Clear Risk Solutions administers. He continually pursues ongoing development of risk management services for members, in order to positively affect claims activity and program performance. Eric has worked closely with six program formation boards to evaluate and create feasibility studies, prior to starting member-owned, joint self-insurance programs.

Eric works closely with self-insurance program boards to maintain healthy relationships. He helped establish and maintain the distribution plan for self-insurance. He has worked with the self-insurance program boards to establish and implement policies related to membership design and has helped modify and develop interlocal agreements and bylaws. Eric has also worked with Board legislative agendas and state regulatory agencies. Eric's experience and expertise is critical to the development, management, and success of all programs. He has overseen all aspects of placement for property and casualty insurance from 1994 to 2019.

Eric directly contributed to the substantial growth of all Clear Risk Solutions programs, and in 2004, successfully worked to change pooling legislation to allow the formation of the Non Profit Insurance Program (NPIP). NPIP, which started with only 36 members, and has since grown to over 850. Eric has successfully negotiated insurance renewals for these programs with overall in force, ground up premiums of approximately eighty million dollars.

In addition, Eric served on Traveler's Public Entity Advisory Council from 1998-2008 and served on the Ephrata School District Board of Directors from 1998-2002.

Outside of the office, Eric is a family-focused father and husband. He enjoys fly fishing, golf, and the outdoors.

Jena Valdetero

Shareholder, Greenburg Taurig

Jena M. Valdetero serves as Co-Chair of the firm's U.S. Data, Privacy and Cybersecurity Practice where she advises clients on complex data privacy and security issues. She has led more than 1,000 data breach investigations. A litigator by background, Jena defends companies against privacy and data breach litigation, with an emphasis on class action lawsuits. She has designed and

conducted dozens of data breach tabletop exercises to empower clients to respond effectively to a data security incident. She also counsels companies on data privacy and security compliance programs and advises on cyber risks associated with mergers and transactions. Jena also advises a diverse array of clients on compliance with existing and emerging privacy laws, including the General Data Protection Regulation (GDPR), the California Consumer Privacy Act (CCPA), the Gramm Leach Bliley Act (GLBA), and the Health Insurance Portability and Accountability Act (HIPAA). She is a certified privacy professional through the International Association of Privacy Professionals (CIPP/US), for which she is a former KnowledgeNet Co-Chair.

Walter Crawford

Commercial Proactive Response Lead, Booze Allen Hamilton

Mr. Walter Crawford is a Senior Associate where he leads Booz Allen Hamilton's Commercial Proactive Incident Response and Resiliency business. Mr. Crawford has 7 years of government and commercial consulting experience delivering groundbreaking solutions to a wide range of enterprise challenges. During this time, he has functioned as the chief architect for the design and build of numerous cyber incident response programs for major multinational organizations especially clients in the OT, Biopharmaceuticals, Healthcare, Hi-Tech, Retail, and Financial Services industries. In addition, he has lead resiliency implementations for numerous enterprises, especially those with major supply chain operations. Also, he was the author of Booz Allen's proprietary T.E.A.M. Breach Readiness Assessment framework. This framework has been instrumental in enabling clients to assess overall detection and response preparedness to manage large scale cyber incidents. Mr. Crawford holds a B.B.A. in Banking and Finance from the University of Georgia and a CompTIA Security+ certification.

Charles McCammon

Vice President Risk Consulting, Willis Towers Watson

Charlie joined Willis in October 2013 to lead a growing commitment to risk consulting in the North American marine and logistics spaces. With over thirty years of experience in the transportation industry he has an extensive operational, legal, risk and business background. After graduating from SUNY Maritime College in 1987, he went to sea aboard a variety of vessel types from tankers to roll/on roll/off vessels upgrading his license from Third Mate to Master. He came ashore in 1993 and worked as a marine surveyor while also attending Loyola University (New Orleans) Law School.

After receiving his J.D. in 1997, he served as General Counsel, Risk Manager and Assistant VP of Operations for one of the largest marine transportation companies in the US. Prior to joining WTW, he practiced transportation law for fifteen years focusing his litigation practice on representing a variety of transportation clients and their insurers. He also advised clients on a wide range of corporate and commercial issues from asset acquisitions and sales to company formation, insurance requirements, regulatory filings and commercial contracts.

Charlie retired as a Captain from the US Navy Reserves after serving 32 years in a variety of marine transportation and logistics focused billets. In September of 2010 he was recalled to active duty and forward deployed to Iraq during Operation New Dawn. During this year long assignment, he was embedded with US Forces Iraq's logistics team to coordinate the drawdown of forces and equipment from Iraq. Before retiring he served for eight years as a Navy Emergency Preparedness Liaison Officer to FEMA Region I, FEMA Region II and the State of New Jersey.

Charlie's expertise includes risk consulting, complex

claims advocacy, contractual review, emergency preparedness, strategic planning, loss control, operational risk analysis and litigation strategy and oversight.

Lawrence T. Bowman

Director Kane Russell Coleman Logan

For more than three decades trial lawyer Lawrence "Larry" Bowman has represented clients in complex commercial litigation, including construction, energy, contractual, tort, product liability, intellectual property, antitrust, and securities matters. He counsels a broad spectrum of individual corporate and insurance company clients in the courtroom during trials and around the negotiation table in the settlement of significant cases.

Larry enjoys representing people and organizations involved in building things and adding value to their communities. He frequently advises contractors and subcontractors and other construction-related companies dealing with disasters such as fires, crane failures, and structural collapses. The process of large-scale commercial construction comes fraught with many kinds of risks, and Larry's clients rely on him to guide them through the aftermath of accidents, injuries, construction defects, and other challenging situations.

With many years of experience and an in-depth insight into the legal landscape, Larry quickly reads and understands the relationships among the parties involved in conflicts stemming from project incidents. He adeptly synthesizes information—including physical evidence, eyewitness testimonies, and personal observations—to create coherent and influential accounts that explain why and how something happened, who is responsible, who may not be responsible.

When clients hire Larry he takes the time to discuss their issues empathetically and thoroughly, see things from their perspective, and gain a keen understanding of their problems in all their dimensions. He then draws on his broad and deep knowledge to create sensible strategies that contain and manage problems while helping clients attain their goals. If courtroom litigation is the best path forward, Larry brings skilled and passionate advocacy to maximize outcomes.

Away from the Office:

In his free time, Larry is an avid reader of many types of prose and frequently attends movies and theater performances. In addition to swimming, hiking, and playing golf, he travels often for both work and pleasure and enjoys spending time with his wife Julia, their three children, and five grandchildren.

Dr. Gavin Dillingham

HARC: Houston Advanced Research Center

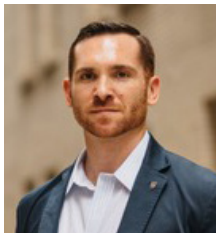
Dr. Gavin Dillingham is Director for Clean Energy Policy and Director of the US Department of Energy's (DOE) Southcentral and Upper West Combined Heat and Power TAP. Dr. Dillingham joined HARC in 2012 where he leads multi-stakeholder efforts focusing on policy and programs to improve the climate resilience of power infrastructure and built environment and to help usher in the energy transition via a variety of clean energy initiatives.

He builds and leads strong, well-balanced teams of experts to successfully implement large, multi-year clean energy projects. His current projects include being the principal investor for the DOEs Solar Energy Technology Office (SETO) grant on rapid deployment of solar+storage in low-income neighborhoods and the DOE's Advance Manufacturing Office (AMO) grant to develop a micro-grid feasibility analytics tool. Recently, he led the effort to build out and launch the Texas Clean Energy Hub. The Hub includes a variety of tools, resources, webinars, as well as HARC's Energy Crossroads Podcast, to help spur along the clean

energy transition in Texas.

Dr. Dillingham is also leading efforts to commercialize HARC's research. With the HARC team, University of Houston and Lehigh University, he led the start-up of Pythias Analytics, Inc. Pythias Analytics is a start-up company focused on providing climate analytics and scenario planning for the energy sector.

Dr. Dillingham received a Bachelor's degree from Texas Tech University and his PhD from Rice University in 2008. He holds the Climate Change Professional (CCP) certification from the Association of Climate Change Officers (ACCO) and the Sustainability Associate (SA) from the Institute for Sustainable Professionals.



JD Dolan

Co-Founder / Partner, LDR Growth Partners

John "JD" F. Dolan II is a Co founder and Partner at LDR Growth Partners, where he describes his purpose as, "Building and leading high performing teams (*Teams for the Arena*), cultivating human performance (*data focused health*), and forging long-term partnerships". At LDR, his focus surrounds negotiating complex strategic partnerships, both domestically and internationally. Most recently, JD successfully sourced and led LDR's invested partnership with one of the world's most well-respected value investing firms, Fairfax Financial Holdings Limited (Toronto, CA), spearheaded the establishment of a global innovation infrastructure and CVC arm (*Corporate Venture Capital*), developed and facilitated a multi-national leadership and performance curriculum, and researched & developed (through execution) a data-focused corporate wellness and human performance optimization pilot.

Prior to LDR, JD served as an Army Infantry officer and later US Special Operations Commander, deploying four times in support of US combat operations in Iraq and Afghanistan, where he led one of the most significant battles in the War on Terror (*in terms of effects on the enemy*). JD earned a BA from Dickinson College, an MBA from Columbia University Business School, and after leaving Special Operations Command, served as the Assistant Professor of Military Science at St John's University in New York City. A published author (*The Soldier's Financial Leadership Guide*) and featured by publications including: Entrepreneur, Success, Business and American Express, JD often speaks on topics ranging from leadership and performance coaching to health & corporate wellness. His favorite topic is, "Building a morning routine" (*Ritual, Routine, and the Power of Habit*).

His personal interests include family, fitness, and all things outdoor... and of course his goldendoodle Darby (*named after William O. Darby – of Darby's Rangers*). JD also serves as a director and advisor for two US Special Operations and Veteran focused non-profit organizations, as well as an award winning for profit "HealthWear" company.

Jason Ball

P.E Senior Civil/Geotechnical Engineer, SEA, Ltd.

Jason performs forensic investigations of soils, site construction, building envelopes, and construction materials to determine the extent or cause of the distress and/or damage. He provides investigation and consultation for a variety of construction-related projects including earthwork, foundation settlement, retaining walls and earthen slopes, concrete, asphalt, masonry, floor slabs and pavements, vibration and blasting, and Special Inspections. Performs investigations related to premises liability, building codes, potentially defective construction and design,

storm water runoff, or other civil engineering issues. Jason provides expert witness testimony in state and federal courts of law.

Matthew Feeney

CATO Institute

Matthew Feeney is the director of Cato's Project on Emerging Technologies, where he works on issues concerning the intersection of new technologies and civil liberties. Before coming to Cato, Feeney worked at *Reasonmagazine* as assistant editor of Reason.com.

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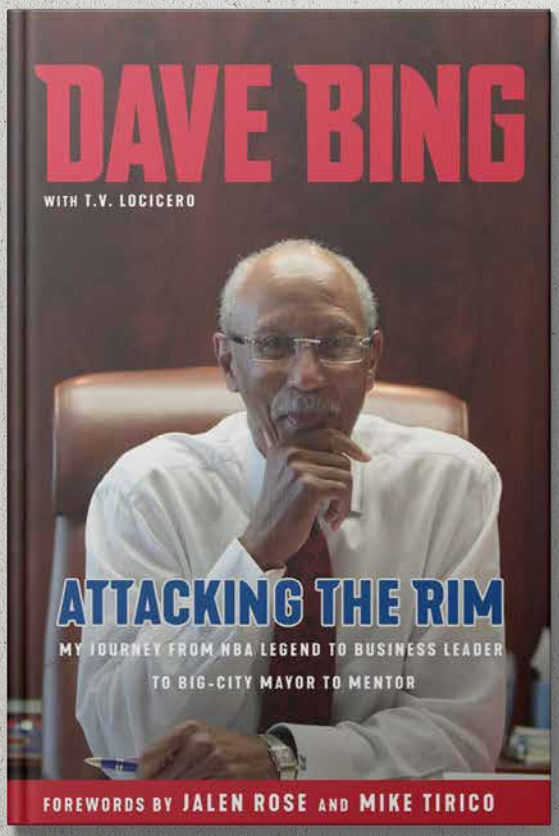
SPECIAL GUEST SPEAKER

DAVE BING

AUTHOR OF

"Attacking the Rim: My Journey from NBA Legend to Business Leader to Big-City Mayor to Mentor"



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PFAS: AN EMERGING RISK

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An emerging risk...

The environmental and health impacts associated with PFAS chemicals are a true emerging risk issue being seen across the globe. With in-depth studies and pending federal regulations, there is an increased focus on these so called "forever chemicals"

What are PFAS?

PFAS, short for Perfluoroalkyl and Polyfluoroalkyl Substances, refer to a group of at least 4,700 man-made chemicals that have been used in a range of industrial and everyday consumer products globally since the 1940s due to its qualities, namely, that many are heat, water, grease and oil resistant. The most common PFAS are PFOA, PFOS, and GenXi.

These synthetic chemicals are commonly referred to as forever chemicals since they don't break down and can potentially bio-accumulate over time. This means that humans being at the top of the food chain, will likely have higher concentrations of PFAS in their system through exposure, than animals and plants lower down the chain.

Because they possess a durable makeup, the chemicals persist in the environment and in the human body for decades. It is asserted that they can dispersed through air and water and have been found as far as the Arctic and open ocean waters. PFAS have also been found in fish, shellfish, vegetables and others grown in contaminated soil or water.

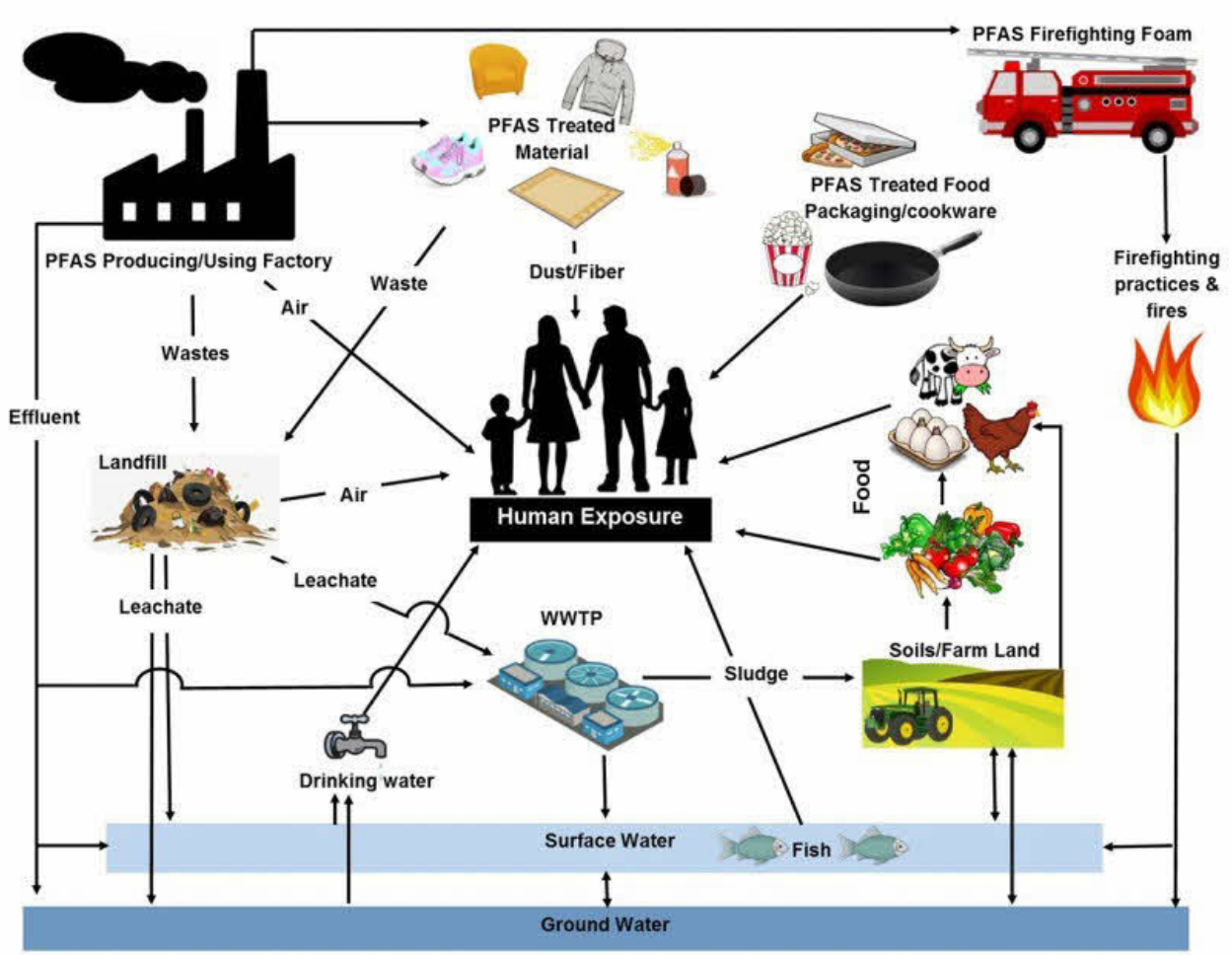
The most studied and pervasive chemical forms are per- fluorooctanoic acid (PFOA also known as C8) and perfluorooctane sulfonate (PFOS). PFOA has been used in the production of the chemical polytetrafluoroethylene (PTFE). PFOS has been used in pesticides, surface coatings for carpets, furniture, waterproof apparel and paper goods.

PFAS have also been used in the production of both commercial products such as firefighting foams and fire retardants and also commonly used domestic products such as non-stick cookware, pizza boxes and take-out containers, food packaging, rubbers and plastics, electronics, cosmetic products and some dental floss.

The Centers for Disease Control and Prevention (CDC) found PFOA in the blood of 98% of Americans, as well as in breast milk and umbilical cord blood. The persistent nature of the chemicals means that even sites which have no record of using PFAS themselves, may be contaminated by adjacent or other local sites.

According to a report by the Environmental Working Group (EWG), published in July 2018, "there are 172 known PFAS contamination sites in 40 states." Additionally, "an EWG analysis of unreleased data estimated that more than 1,500 drinking water systems, serving up to 110 million Americans, may be contaminated with PFOA, PFOS and similar fluorinated chemicals[iii]."

How are humans exposed?



Human Exposure and sources of PFAS
Image: DWP, adapted from oliaei et al. 2013.

Exposure is typically through contaminated ground water and soil, and is limited to a specific geographic area, for example, near an industrial facility where PFAS were produced or used to manufacture other products. Another source of these chemicals in the environment arises from disposed products in landfills as they settle and breakdown and dissolve into ground water. In all these cases, PFAS can enter the food chain, for example, crops grown in contaminated soils or using water from a contaminated source. To a lesser extent, PFAS can also migrate, or transfer, into food from certain food contact materials such as, grease proofing agents in paper and paper board packaging. Working in certain occupational settings may impose a greater risk and higher level of exposure than others as directly in contact with the substance[iv].

PFAS are also a component of many of the firefighting foams used by the military, airport authorities, oil refineries and local fire and rescue agencies. It is these foams that are most often implicated when PFAS is found in groundwater or in the environment. In 2016, a study of groundwater across the USA found these chemicals in drinking water in 27 states, impacting 6 million Americans. Many of these communities were near military bases, airports, and industrial sites[v].

Health and financial impact of PFAS exposure

This propensity for PFAS to be stored in the body, increases concerns about the possible effects of these compounds on human health. They have been associated with negative consequences for human health, such as pregnancy complications, thyroid disease, high cholesterol, and cancer, although these are not fully established[vi]. Although there is no scientific consensus on the effects of exposure to high levels of certain PFAS compounds, studies have linked high levels of exposure to certain PFAS compounds in humans to a variety of negative health effects. All outcomes have linked the chemical to symptoms & health issues based on 'probability' and 'likelihood.'

Both the Environmental Protection Agency (EPA) and the International Agency for Research on Cancer (IARC), a division of the World Health Organization, has classified PFOA as "possibly carcinogenic to human,"

based on limited evidence in humans that it can cause testicular and kidney cancer, and limited evidence in lab animals.[vii]

Further, peer-reviewed studies of the effects of PFASs on laboratory animals and epidemiological studies of human populations that have been exposed to PFASs have indicated that exposure to PFOA and PFOS over certain levels may result in adverse health effects, including[viii]:

- Low infant birth weights
- Liver damage
- Immune systems effects (e.g. depressed antibody production in response to vaccination)

It is not known how much PFAS exposure is safe for humans or whether there are important differences in toxicity between different PFAS compounds.

These gaps in understanding of PFAS make it difficult to set regulatory limits for PFAS exposure or provide advice for people living in areas where PFASs have been detected.[ix]

Based on what is known so far about health impacts, the EPA, in 2016, set a lifetime health advisory levels for PFOS and PFOA, two of the most prevalent PFAS chemicals, at just 70 parts per trillion. In other words,

for every trillion water molecules in a sample, there can be only 70 molecules of PFOS or PFOA (individually or combined). This was revised down from a 400 ppt standard set in 2009.

The EPA's Lifetime Health Advisory limits do not represent definitive cut-offs between safe and unsafe conditions. Rather, they reflect the Agency's determination of an adequate margin of protection for individuals throughout their lives from possible adverse health effects.

Existing drinking water advisory levels in many other countries are dramatically different from those of the U.S. EPA and individual states. For instance, Canada advises levels at 600 ppt and 200 ppt for PFOS and PFOA, respectively. Australia's levels are 70 ppt and 560 ppt, and the United Kingdom recommends 300 ppt and 1,000 ppt for PFOS and PFOA[x].

While the risk assessments conducted by EPA give significant weight to PFAS exposure and human health associations, the causal relationship between PFAS toxicity and adverse human health effects remains unclear.

A report commissioned by the Nordic Council of Ministers to consider the potential impact of PFAS on human health in the European Economic Area (EEA) considered the financial impact of inaction / better risk management but concluded more research was necessary to determine the actual harmful nature of the chemical.[xi]

The health-related cost estimates were constructed using scientific evidence concerning the chosen adverse health endpoints, under the following scenarios:

- exposure level in workers at chemical production or manufacturing sites (subject to high exposure);
- people living near chemical plants (subject to medium exposure); and
- the general population (subject to low exposure).

Potential impact of PFAS on human health in the European Economic Area (EEA)

Exposure level	'Exposed' population and source	Health endpoint	EEA population at risk	EEA annual costs
Occupational (high)	Workers at chemical production plants or manufacturing sites	Kidney cancer	84,000-273,000	€12.7-41.4m
Occupational (high)	Communities near chemical plants, etc with PFAS in drinking water	All-cause mortality Low birth weight Infection	12.5m 156,344 births 785,000 children	€41-49bn1 3,354 births of low weight 1.5m additional days of fever
Background (low)	Adults in general population (exposed via consumer products, background levels)	Hypertension	207.8m	€10.7-35bn
Total				**€52-84bn**

* Estimates of annual health-related costs from PFAS exposure in the EEA. Source: The cost of inaction – a socioeconomic analysis of environmental and health impacts linked to exposure to PFAS. Report commissioned by the Nordic Council of Ministers 2019

Landmark Litigation

This lack of clarity has led some experts, like the 2018 Australian Expert Health Panel for PFAS, to conclude that there is no current evidence demonstrating a large impact on an individual's health or overall cancer risk from PFAS exposure. The Australian panel concluded that, while there are observed health effects associated with PFAS exposure, the level of health effect reported in people with the highest exposure is still within the normal ranges for the general population. The panel also cautioned that the hundreds of epidemiological studies addressing the association between PFAS and health outcomes are based on only a few populations and the observed effects may be explained by confounding variables, such as age, smoking, or socio-economic status[xii].

However, Australia saw its largest class action in its history. Up to 40,000 people who live and work on land contaminated by the chemical compound PFAS sued the Australian Government, arguing their property values have plummeted. PFAS chemicals were present in firefighting foam used by the Department of Defence in training facilities across Australia since the 1970's. The chemicals contaminated local environments; negatively impacting residents, their land and their livelihood. The firm representing these plaintiffs enlisted the support of American activist Erin Brockovich and filed an action over Christmas 2019. This was settled in February 2020 by the federal government who are currently finalising the confidential terms of a settlement.[xiii] This will now set a precedent for thousands more Australians exposed to PFAS contamination across Australia.

Insurance Exposure

Although issues of causation remain in flux, litigation continues to ensue with complainants asserting claims for relief based on common law torts, including negligence, property torts (trespass), nuisance (public and private), intentional torts (battery), and product liability (defective product failure to warn and design defects).

Employers Liability and Worker's Compensation

It is evident that PFAS has commonly been applied in a variety of industrial uses, be that at manufacturing level or end usage by firefighters. As such, claims arising out of PFAS exposure in the course of employment, where illness is alleged, remains a direct risk for employers, especially in the UK, where liability is strict. Currently several cases by firefighters are focused on lawsuits against the manufacturers but could still seek legal redress against their employers. Further, and not unlike asbestos, employees working in these manufacturing companies and are exposed directly to the substance will have long tail exposure and future claims.

Similarly, worker's compensation insurers should be aware of the potential for PFAS to contribute to workplace illness claims.

Product liability claims

Manufacturers, producers and distributers of products containing PFAS may be subject to product liability claims for the hazards potentially posed by PFAS.

Where manufacturers have caused offsite migration, for example spread of PFAS from a manufacturing facility into groundwater or adjacent land or waters, have seen lawsuits by third party seeking restitution of costs incurred in dealing with the contamination or compensation of any alleged illness. In the cases seeking costs in dealing with the contamination of waterways, plaintiffs are relying on the EPA 70ppt recommendation being exceeded. Whilst the EPA recommendation is not enforceable it is proving persuasive. Consequently, numerous governmental entities, water utilities and private property owners have commenced lawsuits against the polluting manufacturers to seek cleanup and remediation costs.

Where injury is claimed, litigants would need to demonstrate that exposure to PFAS contamination has caused them harm. While there are studies that support a positive association, it may prove difficult to tie incidence of PFAS exposure to a specific disease or illness.

Exposure of agriculture and aquaculture industries to risk

Given the capacity for PFAS to migrate into adjoining land and waters through storm water or groundwater, there is potential for farming or fishing operations near contaminated land to potentially be exposed to PFAS

contamination. This carries broader potential for claims.

There are broader exposure pathways for consumers to ingest PFAS, leading to claims by consumers for any health consequences and Claims made by farmers or fishers for any economic loss or devaluation of their business caused by PFAS contamination.

This accordingly has implications for insurers of those industries, who for example, may be exposed to claims for business interruption caused by being unable to continue fishing operations while decontamination works are carried out or exclusion areas are applied.

Other risks for insurers

In another case, the plaintiff alleged continuing contamination of the Tennessee River and associated public drinking water supplies with PFAS that the plaintiff claims originated from a local manufacturing facility and two local landfills.

Among several arguments that the claims should be dismissed, the owners of the landfills argued that the claims were a collateral attack on existing, valid permits including a solid waste permit that authorized disposal in the landfill of the material at issue. The court denied the motion to dismiss stating that the permits only authorize disposal of non-hazardous waste, and there is a dispute over whether the PFAS-containing material is a hazardous waste. The owner of the manufacturing facility also made several arguments that the claims should be dismissed, including mootness due to an existing enforcement by the state agency in the form of a Remedial Action Agreement. The court denied this motion on the basis that Riverkeeper is seeking additional remedies not provided in that agreement, such as an injunction banning additional disposal of PFAS-containing materials absent demonstration of an appropriate, functioning liner.

Insurers may find themselves exposed to claims, where environmental insurance policies cover remediation claims by the insured for their own land, claims by third parties relating to offsite migration from the Insured's land, or remediation orders made by regulators concerning the Insured's land.

Pollution Policy

Expenses related to PFAS claims can potentially be covered by a pollution policy unless there is a specific exclusion.

Because pollution programs cover multiple years, if there is a regulatory change during the policy period that classifies something as a contaminant that was not considered one before, the policy will still respond to claims triggered by that new contaminant.

Looking ahead...

Much is still unknown about these emerging contaminants, including the severity of the chemicals' impact on health and the extent of litigation exposure borne by manufacturers, product distributors, waste disposal and any party in the PFAS supply chain. The equivocal evidence that PFAS exposure causes illness remains open for interpretation. Because these chemicals were used for so long and are so persistent in the environment, there will be likely be a great deal of legacy exposure.

The mere fact that you have a chemical concentration above an EPA advisory level that is associated with bodily injury is enough to pursue toxic tort litigation in the US. However, it does not guarantee a successful outcome due to defendants now seeking appeals on decisions. No such lawsuits have emerged in the UK as yet, but it's not to say the trend won't be too far behind.

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TELEMEDICINE, ONE STEP CLOSER TO A NATIONAL STANDARD OF CARE

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"To our patients: For insurance reasons, the doctor will be treating you anonymously via teleconference from an undisclosed location."

—Sign seen on doctor's office wall

While the practice of telemedicine had already been growing steadily, recently released medical claim submission data demonstrates that the transition to telemedicine has accelerated exponentially throughout the COVID-19 pandemic which began in January of 2020. For example, FAIR Health, the nation's largest repository of private medical reimbursement claims data, reported telehealth claim submission in the Northeast region grew 15,503% in March 2020 compared to March 2019 (0.07% to 11.07% of total medical claims submitted).

The growth in nationwide telehealth claim submission was also staggering with an increase from March 2019 to March 2020 of 4,3467% (0.17% to 7.52% of total medical claim lines). Just as many have found the benefits of work-from-home can outweigh the challenges, so too will many patients avail themselves of the opportunity to remotely consult with health care practitioners.

Novel legal issues will continue to surface as the practice of telemedicine proliferates. Cross-jurisdictional practice garners significant attention since conflicting federal and state laws, rules and regulations, and voluntary protocols have all struggled to keep up with demand and increasing risk and quality issues. Licensing, standard of care, parity of reimbursement, availability of insurance in cross-state practice, cyber and privacy concerns and other issues all have the potential to spawn litigation.

The following is an overview of the present and prospective risks and benefits of telemedicine. For purposes of this article, the terms telemedicine and telehealth will be used interchangeably to describe the delivery of health-related care, services, education, and information via telecommunications technology, which includes videoconferencing, remote monitoring, electronic consults, and wireless communications.

The confluence of wearable monitoring and at-home diagnostic devices, improvements in the speed and quality of image transmission, the increased availability online of the right specialists and the maturation of AI has begun and will continue to reshape the medical profession and all industries involved directly and indirectly in the health care sector.

This undeniable revolution in the field of medicine logically requires a corresponding evolution of the metrics used to assess performance both in terms of value of the service and outcomes. To be clear, the applicable fundamental legal principles remain sound. It is the underlying circumstances which have changed. To put it another way, the game is changing, and the rules certainly require some reinterpretation and adjustment. Inflexible application of pre-existing, static rules and standards to new and emerging technologies and practice models is counterintuitive. Accordingly, for example, allowance should be made for the modification of the in-person standard of care to account for care that is not, in fact, delivered "in person." Refusal to acknowledge and accommodate such changes can only serve to hinder further development and implementation.

The benefits of telemedicine, along with the corresponding risks, have been well documented in and through an array of trusted sources including the federal government, private industry and innumerable medical, legal and insurance societies.

The widely acknowledged benefits of telemedicine include the following:

- Access to specialists possessing skills or offering services that might otherwise be out of reach;
- Reduced errors and improved outcomes owing to algorithm-assisted diagnosis based on patient data collection and analytics;
- Continuity of care facilitated by the ability of providers in different locations to access and communicate through a centralized medical record;
- Delivery of state-of-the-art health care to previously under-served regions nationally and worldwide;
- Faster access to health professionals;
- Increased convenience and time savings for patients;
- Ability of patients, even amidst a pandemic, to continue chronic care at home through remote monitoring and oversight for an ever-widening category of medical conditions;
- Full-scale implementation of shared care whereby patients, primary care physicians and specialists enjoy easier and more frequent "direct" communication between providers and their patients;
- Interaction of health care providers with one another and their patients from ICUs, EDs, ORs, temporary triage and care facilities, or while in transit;

- Alternatives to overburdened emergency departments or urgent care centers;
- Reduced risk, and anxiety or perceived risk, of transmission of contagious disease; and,
- Encouraging patients who might be averse to in-person care for any number of reasons including mobility, privacy, or other concerns. For example, telepsychiatry has been a boon to those who could not or would not leave their homes to appear in a therapist's office.

At the same time, the practice of telemedicine presents commonly associated risks. As a practical matter, here are some examples of the limitations of the technology itself:

- Potential for limitations or glitches in technology to result in miscommunication or interruption in treatment;
- Limitations of verbal communication, even when coupled with video, without a physical examination;
- Limited familiarity on the part of the health care provider with local resources in an unlimited number of remote locations where the patient may need in-person or urgent care;
- Likelihood that certain patients, particularly children or adolescents, may end a session by closing the laptop more readily than they would actually walk out of a therapist's office;
- The possibility of undisclosed recording of the visit by a patient, with a chilling effect on candor for both participants; and
- Limitations in the ability to secure the communication of protected health information in accordance with applicable HIPAA and HITECH privacy and security rules.

These limitations present new categories of allegations of professional malpractice, such as the following:

- Potential failure to recognize circumstances requiring prompt termination of a telehealth visit in favor of an in-person exam or emergency treatment;
- Failure to ensure that the patient being examined and obtaining prescriptions is the actual patient, for instance increasing the risk of inappropriate prescription of controlled substances;
- Licensing issues exposing the practitioner to claims of unauthorized practice of medicine in another jurisdiction unless they participate in a shared-credentialing program such as hub-and-spoke hospital network;
- Failure to obtain and/or properly document informed consent to the very nature of telehealth treatment;
- Failure to properly train and update staff on ever changing policies, practices, and protocols applicable to telehealth; and
- Untimely review of patient data shared through a remote device and the expectation that health care practitioners obtain and review all of the available information.

Many of the risks of telemedicine result in higher costs to operate as well as increased costs and complexity in defense of potential personal injury claims from several factors:

- Cybersecurity and shifting the risk of data breach from the technology vendor to the health care providers;
- Increased costs associated with defense counsel organizing and maintaining large data sets derived from multiple sources and devices, storing a variety of file formats (video, audio, text, digital images, film, etc.), and the costs associated with large scale discovery exchange of electronically stored information, and the need for forensic authentication of the data for evidentiary use; and
- Exposure to liability under laws of the state where the patient is located at the time of the telemedicine visit which may have different procedural and substantive rules, and markedly different jury verdict potential, compared to the jurisdiction where the practitioner is trained and licensed.

DISCUSSION

The Deceptively Limited Number of Reported Malpractice Claims Involving Telemedicine

To date, there have been comparatively few claims related to telemedicine. According to the Center for Connected Health Policy, "Claims of malpractice liability involving telemedicine have been few and most existing cases have been settled out of court with the final settlements sealed." In fact, a 2019 research letter published by JAMA noted that at that time its investigation revealed no "involved claims of medical malpractice against DTC [direct to consumer] telemedicine services or their health care professionals."[2]

While these findings pre-date the explosive expansion of telemedicine occasioned by the recent coronavirus pandemic, they are nevertheless encouraging. That said, claims have a lag time, and the broader use of telemedicine is a comparatively new phenomenon, so it is reasonable to predict an uptick. Indeed, one health insurance provider reported that 60% of outpatient mental health visits are currently virtual, a proportion that remains even after the easing of the social-distancing lockdown.[3]

Misdiagnosis

The telemedicine malpractice claims which have been identified tend to involve allegations of misdiagnosis and/or improper prescription of medications across state lines. As always, clinicians should be guided by their best judgment and promptly inform patients in the event it is determined that adequate evaluation requires an in-person rather than telehealth visit. Terminating a telemedicine visit by promptly and clearly explaining why it is necessary to seek in-person care may prevent a dangerous delay in care which could otherwise lead to a claim.[4]

Prescription Writing Exposures

Along with misdiagnosis, prescribing medication across state lines without conducting in-office patient exams commonly presents issues leading to malpractice and even criminal exposures.[5] Several states have local databases requiring a practitioner to make sure another doctor has not already prescribed the same controlled substance, and as a practical matter pharmacies may refuse to honor out-of-state prescriptions for fear of liability.[6]

It can even be said that prescribing controlled substances to a patient known only online is one of the likeliest scenarios to result in legal action against the physician.[7]

For example, the Florida Medical board concluded that physician review of patient questionnaires submitted over the internet was insufficient to prescribe medication absent physical examinations verifying patients' health.[8] The same medical board held that the pharmacy violated Arizona state law when it dispensed medication pursuant to such prescription orders.

According to the US Department of Justice, pursuant to the Controlled Substances Act ("CSA")[9], a prescription for a controlled substance issued by means of the internet (including telemedicine) must generally be predicated on an in-person medical evaluation. The CSA contains certain exceptions to the requirement of an in-person visit. One such exception was triggered by the COVID-19 Pandemic in January of 2020, when the U.S. Secretary of Health and Human Services declared a public health emergency under 42 U.S.C. 247d.[10] Going forward, the status of the decision to loosen those restrictions remains uncertain.

Utilization of telehealth visits has enabled providers to deliver uninterrupted care to patients in legitimate need of prescribed medications throughout the coronavirus pandemic. The experience, mainly positive, has helped highlight for public policy purposes the vast potential for more efficient delivery of services to a broader population including those previously underserved.

Fraud

Not surprisingly, the rapidly changing landscape has also presented ample opportunity for abuse.

Telehealth is on the radar of the Medicare Fraud Strike Force. In September of 2020, the Department of Health and Human Services Office of Inspector General, along with state and federal law enforcement partners, exposed a massive health care fraud ring engaged in, among other things, the prescription and distribution of controlled substances. More than 345 defendants in 51 judicial districts were charged with participating in health care fraud schemes involving more than $6 billion in alleged losses to federal health care programs. As part of the "telefraud" scam involving aggressive marketing of telehealth services, defendant telemedicine executives allegedly paid doctors and nurse practitioners to order unnecessary durable medical equipment, genetic and other diagnostic testing and pain medications, either without any patient interaction or with only a brief telephonic conversation with patients they had never met or seen.[xi]

Adequate Record Keeping and the Advisability of Recording the Visit

The practice of telemedicine has created many unique information management issues for both practitioner and staff. Health information management requires organizing and maintaining large data sets derived from multiple sources and devices such as

remote monitoring and mobile health products, i.e., "wearables." The data must be stored in a variety of file formats (video, audio, text, digital images, film); necessitating protocols for the safe transmission and access by providers and patients alike.

The additional burdens placed upon physician and staff can be daunting; the consequences of a misstep, devastating. As with traditional in-person visits, accurate documentation of all aspects of a telehealth visit is critical. The nature of the telemedicine visit, itself, generates additional items that require specific documentation. For example: whether the service was provided via technology with synchronous audio/video or by audio alone; the patients physical location; the location of the provider; the identity and location of any other providers in the event of a team meeting; the recommendations of any such additional providers; the fact that the visit was conducted virtually; explanation of the risks associated with telehealth visits; that informed consent specific to telemedicine was obtained; the patient's history; the physical exam; recommendations; and, the amount of time spent providing services. Even before the visit occurs many practitioners have found a need for dedicated staff whose job it is to make sure that the patient is able to connect virtually.

The practitioner must also document any connectivity issues which, in the provider's opinion, might have affected the quality of the communication. A patient must be advised of the limits of confidentiality when communicating via an electronic medium and, just as importantly, that it may be determined that telemedicine is not appropriate for the diagnosis and treatment of their condition.

The range of a responsibilities attendant to a Telehealth visit from the providing team's perspective is, therefore, incredibly broad. The event is no less complicated from the perspective of the patient. Thus, even more-so than in the in the case of claims arising from in-person care, a laborious and costly search for the truth of what transpired during a telehealth visit will likely be at the epicenter of virtually every telemedical malpractice claim.

Were the relevant risks adequately explained to the patient? Was informed consent achieved? Were all necessary instructions clearly and adequately conveyed? Does the record created by the provider accurately reflect the visit? An exhaustive list of potential issues is unnecessary. Suffice to say that the economic cost associated with probing such issues accounts for a significant percentage of any defense litigation budget.

The stakes are at least equally high for the patient. The costs associated with the misinterpretation of instructions, or inability to firmly grasp or recall recommendations can be both financially and physically devastating. The potential for error is often compounded by the issues associated with patients own unique profile including the patients living arrangements, age, education, cognition and memory issues, vision and/or hearing loss, anxiety and stress occasioned by the visit, adequacy of available technology and ability to operate it. Unlike the physician, there is likely no team of assistants surrounding the patient in this potentially new and intimidating virtual setting - likely unfolding in a time of need - to help ensure all essential information is accurately memorialized for future use by the patient, dissemination to family or support system and to other providers, etc. The trend toward shortening hospital stays and in favor of patient driven outpatient care enhances the need of patients and their families for specific, memorialized information. Our experience has shown that the amount of information correctly recalled by patients absent memorialization can be strikingly limited.

Some health systems have concluded that these concerns may be mitigated by recording all telehealth visits. However, recordings in certain settings such as mental health care are generally thought to be counterproductive, but are otherwise recommended. We are mindful that recordings have the potential to violate patient privacy and interfere with patient care. In addition, recordings may be edited and otherwise manipulated to suit the needs of a particular party. Accordingly, recordings should only be undertaken, stored, used, and/or disclosed in compliance with

state and federal law. As with the need to ease restrictions on cross-border practice, variations among the applicable state and federal laws regarding the creation, maintenance, use and dissemination of recordings pose a significant barrier to implementation.

Specifically, under federal law recording is permitted so long as one party to the conversation consents. This federal rule is also the law in only 38 states. The remaining states require consent on the part of all participants for the recording to be permitted.

While the efficacy of such recordings from the patient's perspective may subject to a litany of patient specific variables, the benefit of having the recording at trial should greatly assist the defense of malpractice claims. Nevertheless, support for recordings is far from universal among health practitioners. Certainly, the fear of how such recording may be used in litigation is relevant. Whether that concern is justified and/or outweighs the potential benefits is the question. Absent a recording, a patient may convincingly claim that the examination proceeded in a different manner than described by the physician, and/or that the plaintiff or physician said or did not say something notwithstanding the provider's written record. Accordingly, there is no basis to forecast a greater risk of litigation where a visit is recorded. Rather, recordings have the potential to greatly reduce the incidence of conflicting claims and the attendant time consuming and costly credibility battle. The recording, meanwhile, can help reinforce the impression that the doctor was indeed thorough and responsive, in order to counter most claimant's story that the doctor gave curt or nonexistent responses to the patient's concerns. Infinitely fallible recollections and or intentional misstatements on both sides would be resolved by the recording. Knowing that what transpired is "of record", and not wholly open for debate, should theoretically result in fewer claims.

To the extent that a recording of the visit may enhance the patient's ability to better pursue the recommended course of action, outcomes will undoubtedly improve. Improved outcomes result in fewer "legitimate" claims of malpractice. Recorded interactions should also provide a meaningful hedge against frivolous or fabricated claims. There even may be a clinical benefit if a patient can play back the doctor's instructions during a course of therapy, although we are unaware of any patient portals that presently offer this tool.

Standard of Care

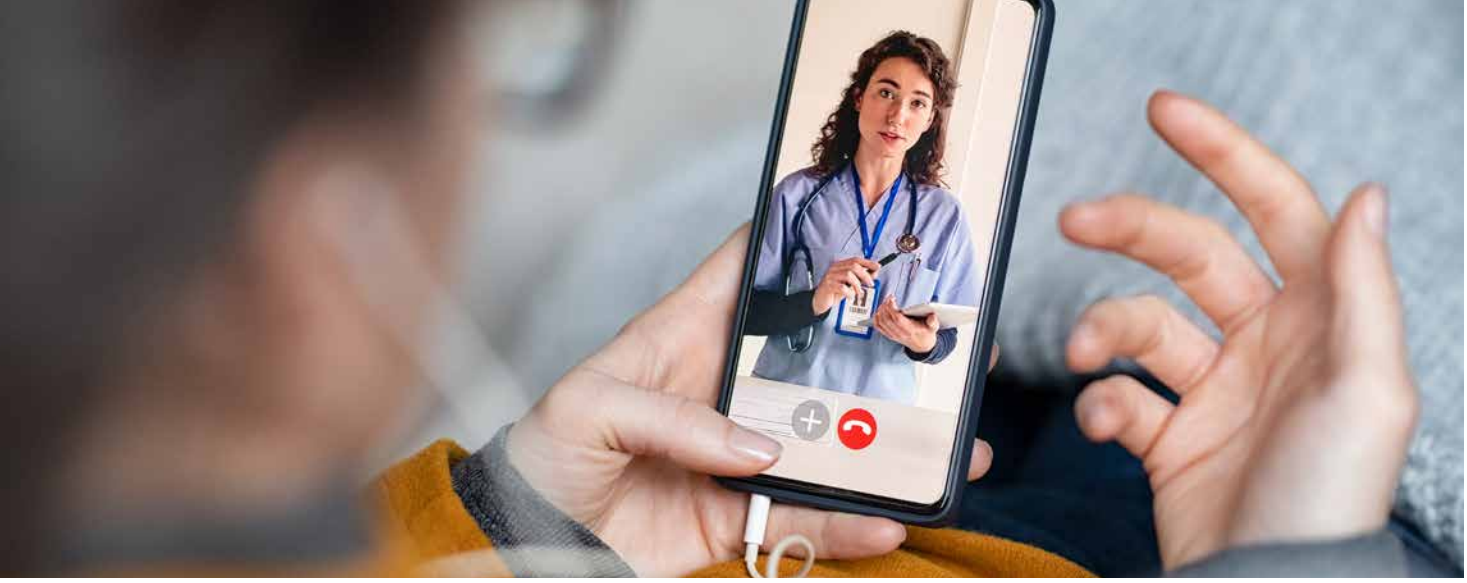
The standard of care varies in certain telemedicine situations. For asynchronous "store and forward" type communications, it might not matter that the radiologist is situated remotely from the hospital or health care facility where the imaging was produced. The standard of care is no different whether the doctor is in the basement of the hospital or in a home office. The duties do not change with respect to reviewing the imaging study, and communicating the results if urgent.

On the other hand, for a virtual visit the standard of care may be altered to reflect what can and cannot be done in that context. For instance, the doctor would be adhering to the standard of care by determining that a hands-on physical examination is needed. The doctor's duty is discharged by referring the patient for follow up at a clinic, urgent care facility or emergency department. In a hospital-to-hospital ("hub and spoke" telemedicine) scenario, there may be mid-level practitioners with the patient who can provide not only vital signs but also varying degrees of physical examination, not much different than a physician on-site supervising a physician assistant or collaborating with a nurse practitioner.

The time has come to modify the in-person standard of care now applicable in telehealth settings to account for care that is not, in fact, delivered "in person." Expert witnesses who have experience with telemedicine and knowledge of the geographic area will have to explain to a jury just what can, and cannot, be done in the telemedicine setting.

Privacy Concerns and Cybersecurity

Privacy concerns are not completely abated by use of HIPAA and HITECH compliant platforms during telemedicine visits. Privacy breaches in and of themselves have given rise to personal injury claims. Often a breach can result from a combination of



human error, or misconduct, in order to exploit a weakness in the security protocols. This gives rise to the prospect of negligent hiring and supervision claims, as well as allegations of the failure to have sufficient security protocols in place.

Since telehealth firms typically partner with multiple vendors to deliver products and services, the prospect of shifting risk should be explored or else it is borne by the doctor or facility in the first instance. Health care providers may or may not have the negotiating power to demand that a vendor's contract provides for indemnification, or potentially for additional insurance coverage, to the health care provider. Cybersecurity insurance also can provide parallel coverage to some degree, along with professional malpractice insurance, for such claims.

It is not uncommon for a privacy breach to have been caused by a vulnerability in a device the patient has introduced into the equation no matter how secure the health care provider's platform may be. Some mobile health devices and wearables, by their nature, create a distinct privacy challenge. They live, at least in part, outside the highly regulated realm of the traditional doctor-patient relationship. The number, complexity and functionality of such devices changes on an almost daily basis. Thus far, the Federal Government has adopted a comparatively passive approach, seeking to regulate wearables only if they are classified as a "medical device." In general, digital health technology is classified as a medical device if a digital health technology is used to diagnose a disease or condition, or in the cure, mitigation, treatment, or prevention of disease.[12] The divide becomes increasingly vague as such "gadgets" evolve into something more. That said, a more heavy-handed approach by the FDA at this stage might have the undesirable effect of curbing industry growth and delaying or negating potential health benefits. Along the way, clarity in terms of the applicability of privacy and cyber laws with respect to such devices may likely be the subject of litigation.

"Doctors [Still] With Borders"

Originally inspired by concerns of public safety and economic protectionism, states have been regulating the practice of medicine by examining and licensing practitioners since the formation of the United States.[13] Notwithstanding the wisdom originally giving rise to this practice, its present effect is to unnecessarily restrain practice across borders notwithstanding compelling the need and a recent history of the undeniable benefits derived from even a temporary waiver of such restrictions. Unanimous agreement on the part of the states to permanently simplify and expedite the licensing process permitting cross-border practice would foster the necessary maturation and improvement of the entire telehealth infrastructure.

In traditional health care, the patient and the provider are generally in the same state. With telemedicine, this is often not the case. Accordingly, the laws and licensing requirements of multiple states may be relevant since telemedicine services are mainly deemed rendered where the patient, not the provider, is located. When engaging in the practice of telemedicine, a physician must consider whether such "out of state" practice exceeds the scope of his/her medical licenses. Although federal standards govern medical training and testing, each state has its own licensing board, and doctors must procure a license for every state in which they practice

medicine. A physician who violates these regulations can run the risk of exposure to criminal charges in addition to other professional and/or civil penalties.

In response to the recent pandemic, many states elected, at least temporarily, to reel in licensing requirements so that providers with equivalent licenses in other states were able to practice via telehealth. The loosening of such restrictions was facilitated through The Interstate Medical Licensure Compact (IMLC), "an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. Thus, the IMLC is a critical component of the movement to improve access to care for patients and ready access to licensure for qualifying physicians. The IMLC was officially implemented in 2017. While membership growth has increased markedly throughout the pandemic, approximately 20 states have yet to join the pact.[14]

Notwithstanding the positive impact of the IMLC, significant differences in approach among states and the federal government, and inconsistent messaging from regulators, continue to create licensing issues for those seeking to provide care to patients across state lines without fear of penalty. These challenges will become more acute as states may permit certain state-level emergency declarations to expire. This remaining uncertainty may have a chilling effect on the continued growth of telemedicine since providers will likely seek to avoid non-compliance with an ever changing morass of rules, regulations, and legislation.

The waiver and/or streamlining of state licensing requirements is fundamental to the delivery of desperately needed care to areas where the health care community has been stretched to the point of breaking by the coronavirus pandemic. Given the public policy goal and proven ability of telemedicine to expeditiously deliver care and expertise where and when it is needed, notwithstanding physical proximity, any rules tending to unduly restrict the interstate practice of telemedicine warrant immediate review and clarification.

Over the past two decades, the medical professional liability insurance marketplace has been hardening in response to higher paid claims. The evolving market is putting upward pressure on premiums and downward pressure on insurance industry capacity. This is particularly true for specialists who treat high-risk patients. No doubt, the generally challenging environment has contributed to the shortage of doctors and other health care providers. In fact, according to data published in 2020 by the AAMC (Association of American Medical Colleges), the United States is projected to face an estimated shortage of between 54,100 and 139,000 physicians, including shortfalls in both primary and specialty care, by 2033.[15]

By implication, an inadequate number of providers will increasingly overburden those that remain, and generate a corresponding rise in potential malpractice. Likewise, the increasing dissatisfaction within the underserved patient population translates into ill will directed against the medical community. Parenthetically, this same population will comprise the pool of jurors which will ultimately decide those malpractice suits. Moreover, patient expectation of a suboptimal experience and/or the fundamental lack of reasonably available care has the effect of discouraging the pursuit of timely care, or any care at all. As a result, otherwise treatable conditions worsen, requiring the type of preventable critical and/or chronic care emblematic of those in underserved communities. If we agree that preventative care is essential to better health, then it must follow that the lack of access to preventative care is responsible for otherwise avoidable consequences including chronic conditions which are far more costly to contend with.

As an industry, we justifiably bemoan "social inflation" and the proliferation of "nuclear verdicts." We bear part of the cost and dedicate tremendous resources hoping to identify the causes and craft potential solutions. While no panacea is on the horizon, there are incremental steps worthy of serious consideration. To begin, expand the partnership with organized medicine to support the nationwide trend toward easing restrictions, including as regards coverage, on cross-border practice. This will have the effect of multiplying the number of providers potentially available, in a crisis and otherwise, and improving the overall condition of underserved communities which, would otherwise be the wellspring of higher verdicts.

Telepsychiatry and Choice of Law Considerations

While the advent of the COVID-19 pandemic has facilitated a significant use of telemedicine in other specialties, telepsychiatry has long been considered the most active application of telemedicine in the United States. The specialty tends to be more interview based and less procedure based than most other specialties making it well suited to remote engagement through telemedicine. Moreover, "Research has indicated that telepsychiatry is comparable to face-to-face services in terms of reliability of clinical assessments and treatment outcome."[16]

As with any specialty, the practice of telepsychiatry is deemed to occur in the state where the patient is located. Physicians and patients are often located in states with different liability laws, statutes of limitations, standards of care or damage caps, etc. Liability claims between parties residing in different states often generate complex choice of law issues. Where more than one jurisdiction's laws could potentially apply to the issues presented, a conflict exists between the jurisdictions' laws and a choice of law determination must be made. The task of deciding that issue can be costly and time consuming. Moreover, outcomes are not readily predictable and, where divergent damages laws are involved, exposures may be significantly increased. Likewise, conflicting coverage rulings also continue to hamper the ability of insurance carriers to forecast outcomes and assess risk.

Physicians may face liability exposure in different venues as patients may choose or be required to file any malpractice lawsuits in their own states, where the treating physician may not be licensed. This poses unique issues as to licensing, differing standards of care and malpractice insurance.

For example, if a provider's New York patient receives therapy while skiing in New Hampshire, which law will apply? The general understanding is that a patient who is temporarily out-of-state but maintains his legal residence in New York may be treated by the New York physician, even if the physician does not have a license to practice in New Hampshire. Even prior to the COVID-19 pandemic, physicians generally would be permitted to treat for a limited time on that basis.

Let's assume that this New York psychiatrist's malpractice insurance policy describes the coverage territory as "anywhere within the State of New York." Would a telepsychiatry visit with that same New York patient skiing in New Hampshire be covered?

Fortunately, several medical malpractice carriers have recently begun to expand coverage territory. In that regard, the company that insures the greatest number of psychiatrists in the US has amended its policy to cover named insured psychiatrists anywhere in the United States. The policy language for this sets forth as follows:

"This policy applies to Medical Incidents anywhere in the world provided the original Claim for covered Damages is brought within the United States of America, its territories or possessions, Puerto Rico or Canada."

On the other hand, standard policy language in a typical New York malpractice policy as to the coverage territory might read as follows:

Territory means: (1) the State of New York and any adjoining state; and (2) anywhere in the world where you provide Professional Services in an emergency situation requiring immediate intervention.

Thus, a typical policy would not likely extend coverage beyond New York unless the patient is in an adjoining state at the time services are rendered. Still other policies cover only the State in which the doctor is practicing.

For many reasons made abundantly clear by recent events, as well as in order to remain competitive, serious consideration should be given to crafting endorsements extending such coverage. For instance, Florida has instituted in statute 456.47(4) a streamlined procedure for out-of-state physicians to become licensed in that state for telehealth purposes only. Included in the requirements is a provision that:

(e) A provider registered under this subsection shall maintain professional liability coverage or financial responsibility, that includes coverage or financial responsibility for telehealth services provided to patients not located in the provider's home state, in an amount equal to or greater than the requirements for a licensed practitioner under s. 456.048, s. 458.320, or s. 459.0085, as

applicable (emphasis supplied).

Predictably, insureds have increasingly begun to request this extended coverage. The trend is certainly in that direction.

The Impact of Artificial Intelligence

No doubt the confluence of wearable technologies, home monitoring and diagnostic devices, speed and quality of image transmission, increased availability online of the right specialists and the maturation of artificial intelligence ("AI") is transforming health care.

The advance of technology and the pace of its integration into the practice of medicine should be embraced not only for its potential to enhance the scope and quality of care delivered but also as a tool to dramatically mitigate the risk of malpractice. Simply put, AI will lead to better care outcomes and improve the productivity and efficiency of care delivery. Like it or not, AI is already incorporated in subtle ways into our electronic medical record systems with things as simple as choosing a template or a set of drop-down menus for a particular type of patient encounter. Better outcomes necessarily entail reduced incidents of malpractice.

That said, the march of technology brings with it a host of new issues impacting the insurance and defense industries. Just as the topic of virtual or telemedicine is almost certain to arise in any discussion of health care risk management, the issue of artificial intelligence is central to the issues around technological platforms.

In a diagnostic claim scenario, plaintiff may allege that the standard of care required the physician to utilize all available tools, including artificial intelligence where it has been implemented in that practice setting. The claimant may allege that the doctor should have, but failed to, run the clinical picture through AI. Or, in a case where the doctor did involve AI, plaintiff may allege that different information should have been elicited or considered. As we have seen historically in medical malpractice cases, the advance of technology inevitably gives rise to additional potential theories of malpractice.

Artificial intelligence, by definition, is a "black box" that not only obscures the underlying logic, but also continually changes by virtue of machine learning. Consequently, the answer you get in 2021 may be different than the one the same system will evolve to provide at some point in the future. This functional anomaly may compromise any meaningful retrospective review performed at the time the case goes to trial in the year 2024. Should the diagnosis of an impending diabetic crisis have been made if only, at the time of treatment, the patient had complained of certain symptoms such as thirst or headache? Neither side will have the ability, in 2024, to examine the "what if's" for

treatment rendered in 2021. Judges and jurors tend to have a "digital hoarding" mentality, expecting that anything that can be saved should or would be available at a later date. The suspicion arises, and is sometimes encouraged by a judge's instructions to the jury, that the missing data was nefariously deleted or hidden.

We are unaware of any electronic medical record system with the capability to simulate or recreate the AI system as it operated at a prior point in time, in other words to work back from the time of trial to the time of treatment.[17] Without that capability, there will be gaps in the proof put forth by both the plaintiff and the defense when the case comes to trial.

The lone certainty is that additional expertise will be required to present medical opinion evidence at trial. This will likely entail production of a witnesses with credentials that include experience with the technology platforms involved and/or additional expert consultants. Either way, the costs associated with the undertaking are likely to be significant.

Artificial intelligence necessarily relies upon the scope of available data, and the nature of the increasing sources of that data may result in questionable statistical analysis factoring into the diagnostic guidance of the AI algorithm. While the enormous potential of wearables continues to reveal itself, so too does corresponding concern about its accuracy and the risks and costs associated with the management of, and responsibility for, the data produced. While devices like the Apple Watch may initially have been viewed as glorified exercise and fitness trackers, they can now do things like monitor blood oxygen saturation levels, (helpful in diagnosing COVID-19) as well as blood glucose, blood pressure, and electrocardiograms to detect atrial fibrillation. More specialized devices, both implantable and wearable, are of course in use with the associated issues as to the shifting of risk from the monitoring service to the doctor.

A thorough analysis of the breadth of these transformative technologies is well beyond the scope of this article. Suffice to say that whether from an at home BP monitor, Fitbit or Apple Watch, useful information is increasingly flowing between and among patients and providers for review and incorporation into a treatment plan. In short, it is becoming increasingly clear that the future care of any one patient will involve a mix of physical, digital and asynchronous/AI-based care. The potential impact of AI in terms of speed alone cannot be overstated. There are few sectors in which speed is more important than health care. The minutes shaved off the time required to administer treatment by deploying AI's deep learning algorithms has the potential to preserve organ function, save brain cells and to save lives.

Notwithstanding the practical challenges posed by the exponential growth of patient and provider generated data, as the use of AI to interpret such data increasingly aligns with the applicable standard of care, failure to facilitate that review and follow the ensuing advice, when otherwise appropriate, may lead to exposures. Still, the medical, legal and insurance industries remain wary of the scenario whereby the decision to rely on AI tools does not end well. How will juries react to a physician finger pointed toward a computer?

Notably, according to a recent article in the Journal of Nuclear Medicine, potential jurors are growing more comfortable with the concept of providers' acceptance of AI generated medical recommendations.[18] Consequently, clinicians may be less liable for using AI than commonly believed, particularly when following both the standard care in conjunction with AI generated recommendations.

These preliminary findings should help mitigate concerns that a decision to rely upon AI might increase exposure. Indeed, juries and medical experts alike may begin to expect a doctor to use every available tool in formulating a treatment plan.

CONCLUSION

The advance of technology, and the pace of its integration into the practice of medicine should be embraced not only for its potential to enhance the scope, equitable distribution and quality of care delivered, but also as a tool to dramatically mitigate the risk of malpractice and associated liabilities.

Telemedicine provides greater, and more equitable, access to health services, cost-effectiveness, enhanced educational opportunities, improved health outcomes, enhanced quality of care, quality of life and social support. Coupled with artificial intelligence, the use of new technology is changing what patients can expect from their health care providers. We are seeing the erosion of a "local" standard of care and should soon be holding practitioners across the nation to the same standard of practice. At the same time, new challenges have presented that may shift the way we assess risk, and certainly will add to the expense of defending professional malpractice claims.

1 Article contributed by Lou Tassan, Esq., Robert F. Elliott, Esq., Brian E. Lee, Esq., and Robert G. Vizza, Esq., of Bartlett LLP.
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Mr. Tassan serves as the managing partner of bartlett llp, and practices in all areas of insurance defense with particular emphasis on high exposures matters involving attorneys professional liability, construction general liability, construction delay/defect, entertainment, excess/monitoring/trial, general liability (auto, premises, hospitality), healthcare, insurance coverage/regulatory, products, recreational and transportation.

Previously, mr. Tassan was responsible for growth and management of the general liability practice of a multi-state insurance defense firm headquartered in new york; was founding partner of a new york litigation boutique having a client base ranging from individuals to emerging companies and global institutions; and, began his career at one of nation's largest law firms where he was chief associate to the firm's senior trial/managing partner involved in the litigation and trial of complex construction, product liability/toxic tort claims, age discrimination, civil rights, voting rights, insurance bad faith claims, estate matters, commercial real estate disputes, fraud and civil rico actions.

Mr. Tassan received a bachelor of arts degree, magna cum laude, from Fordham College and his juris doctorate from Fordham University School of Law.

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Mr. Elliott is perennially recognized as a "top lawyer" by the New York Times as well as a "super lawyer" in Thompson Reuters super lawyer magazine. He was recently made a lifetime member of Swarthmore's who's who – worldwide and is a founding member of the New York State Academy of trial lawyers and proudly serves as its 10th judicial district director.

Over the last 30 plus years mr. Elliott has amassed nearly 100 defense verdicts in high exposure, complex jury trials ranging from medical malpractice to municipal, motor vehicle, transportation liability, premises liability and construction accidents in a wide variety of jurisdictions. He regularly represents licensees before various professional discipline boards. He handles an array of compliance matters for hospitals, long term care facilities and residential care providers. He is a recognized authority in mental health law and litigation. Mr. Elliott is also involved in the defense of high severity transportation, construction and other general liability claims.

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Robert g. Vizza heads the firm's Appellate Practice Area, dealing with far-reaching legal issues ranging from professional malpractice litigation to premises, construction and workplace liability and civil rights cases.

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While at Dartmouth cCllege, mr. Vizza was the president of the Nathan Smith Society for Pre-health Professionals. Mr. Vizza later served as the editor in chief of Res Gestae while at St. John's university School of Law.

Mr. Vizza actively counsels the firm's institutional clients on how to update policies and procedures in keeping with evolving case law. Most recently, mr. Vizza gave a series of talks on the court of appeals decision which defined, for the first time, a duty on the part of physicians to warn patients not to drive after receiving narcotic pain medication. Having argued that case in the state's highest court, Mr. Vizza was successful in limiting the proposed potential liability to just this limited circumstance, and in convincing the court not to impose any duty on the hospital's part to prevent the patient from driving. The case will also stand as precedent for the types of cases that fall under the procedural and substantive protections afforded to doctors and hospitals facing medical malpractice claims as opposed to actions for ordinary negligence.

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Mr. Lee handles appeals and has extensive experience in the defense of medical malpractice, federal civil rights, products liability, and complex general negligence actions.

He regularly lectures to psychiatrists on a variety of risk management topics, has lectured the association of hospital risk managers on the subject of structured settlements and was a beta tester for the New York State unified court system e-courts system.

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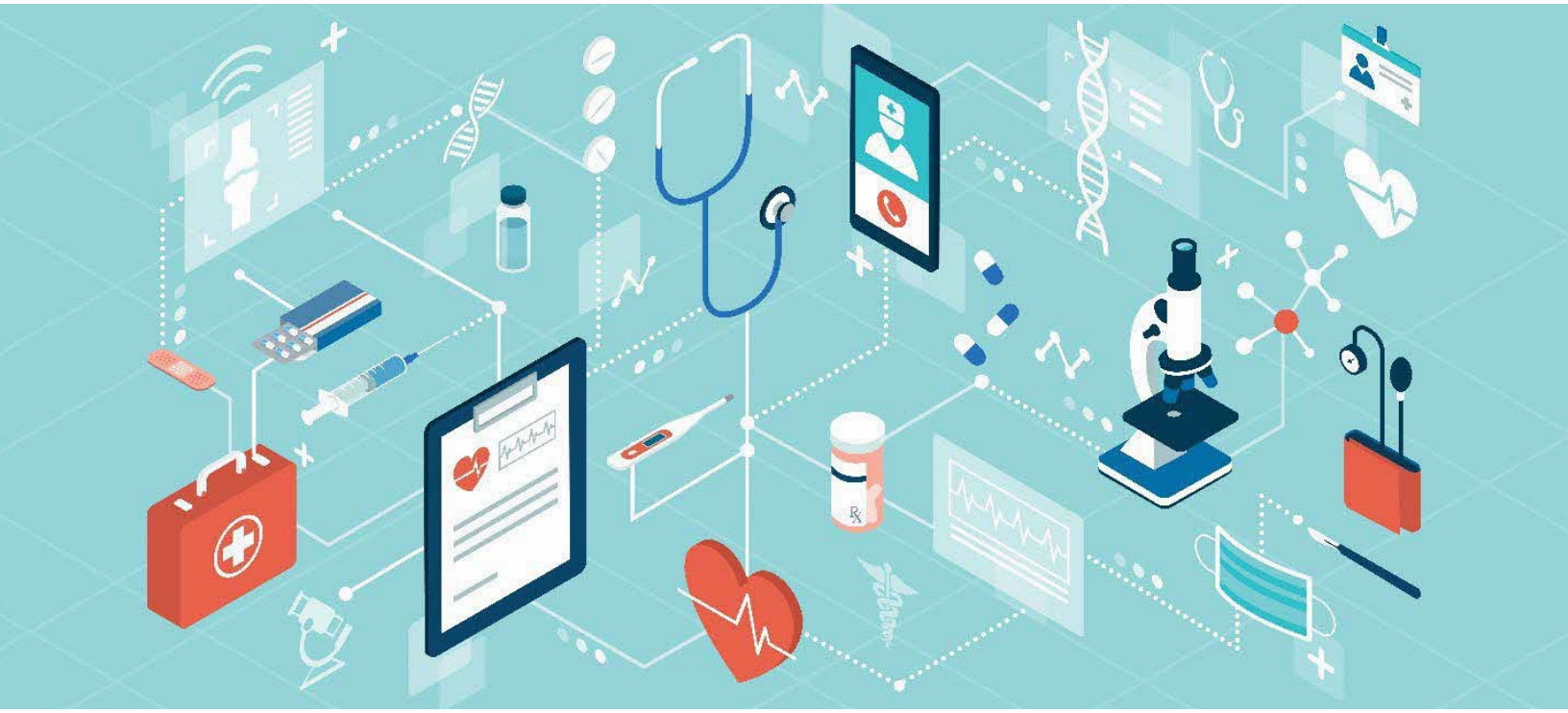
THE INCREASING IMPACT OF MEDICARE COMPLIANCE ON CLAIMS OPERATIONS



By Barbara Fairchild, CEO, NuQuest & Bridge Pointe

In addition to a near complete shutdown of much of the country due to the COVID-19 pandemic, the Medicare Secondary Payer (MSP) compliance space has experienced several major developments over the past 18 months. While it has been nearly a decade since either Congress or the Centers for Medicare and Medicaid Services (CMS) have made significant changes to the MSP program, the effects of congressional and CMS' actions last year are sure to have lasting impacts on claims operations, financial outlays, and the ability to resolve claims that have Medicare and MSP components. Following is a review of the two programmatic changes to the Medicare program and how these changes and COVID may impact claims operations.

Medicare Refresher

As a refresher, Medicare is essentially a health insurance program for people age 65 and older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (ESRD – permanent kidney failure requiring dialysis or a kidney transplant). There are four main parts to the Medicare program, Part A – Part D. Each part of Medicare covers different beneficiaries, services, and costs.

- **Part A -** Hospital Insurance provides coverage for inpatient care in hospitals and skilled nursing facilities (but not custodial or long-term care). It also helps cover hospice care and some home health care.
- **Part B -** Medical Insurance (Supplemental Medical Insurance) provides coverage for physician and other supplier items and services as well as hospital outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and additional home healthcare.
- **Part C -** Medicare Advantage Plan provides expanded coverage that are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare program and are sometimes called Medicare Advantage Organizations (MAOs). These plans are an alternative to the fee-for-service Part A and Part B coverage, and they provide extra coverage for services such as vision or dental care.
- **Part D -** Prescription Drug Coverage provides prescription drug coverage to Medicare beneficiaries opting into Part D. Private companies provide the coverage. Beneficiaries choose the drug plan they wish to enroll in, and most will require payment of a monthly premium. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was enacted establishing Medicare Part D. The law extracted prescription coverage under Medicare Part C and established a separate program.

The Medicare Secondary Payer Act

The Medicare Secondary Payer Act (MSP) was enacted into law in 1980 to preserve Medicare for future generations. To reduce the amount of payments Medicare makes, the law prohibits Medicare from making payments of medical benefits when there is an identifiable primary payer available, such as a Group Health Plan (GHPs) or workers' compensation, property or casualty insurance plan and self-insured entity plans (NGHPs) with medical payment responsibility. For purposes of this article, the discussion will focus on NGHPs only.

The MSP generally provides that Medicare may not make a payment for medical services where payment has been made or can reasonably be expected to be made under a workers' compensation plan or under an automobile or liability insurance policy (including a self-insured plan) or under no fault insurance, all of which are considered primary to Medicare, i.e. primary plans. In the event Medicare makes a payment where an identifiable primary payer is available, the MSP provides Medicare with a direct right of action against the primary payer, a subrogation right against settlement funds and the possibility of obtaining penalties, interest, and double damages.

Nevertheless, Medicare has the authority to make conditional payments when a primary payer has not made or cannot reasonably be expected to make payment with respect to an item or service otherwise covered by Medicare. Any such payment is conditioned upon reimbursement to the Medicare trust fund. Generally, a conditional payment is made where the primary payer either is disputing the treatment and has not paid for it or the medical provider directly bills Medicare who is yet to be put on notice of the primary payer's claim.

Reimbursement for conditional payments is required by a primary plan or entity that receives payment from a primary plan where it is demonstrated that the primary plan has or had a responsibility for the item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan, or the primary plan's insured or by other means. Medicare may file suit directly against any or all entities that are

or were required or responsible to make payment with respect to conditional payments made by Medicare and collect double damages.

Medicare may also choose to recover its conditional payments from entities that have received payment or proceeds from a primary plan. Medicare also has subrogation rights for conditional payments, allowing Medicare to stand in the shoes of the Medicare beneficiary in actions to recover its payments. However, the MSP limits recovery by CMS to a statute of limitations of three years from when Medicare received notice of the settlement, judgment, award, or other payment made in accordance with the MSP. Medicare is further restricted from obtaining recovery for dates of services within three years from which the item or service was furnished to the beneficiary.

Finally, the MSP act requires primary payers to report claims that involve Medicare beneficiaries on a quarterly basis. A primary payer is required to determine whether a claimant is entitled to Medicare (on any basis) and if the claimant is a Medicare beneficiary, submit the identity of the claimant and any other information as specified by the Secretary of Health and Human Services to decide regarding coordinating benefits, including recovery. If an applicable plan fails to comply with reporting requirements, CMS may seek civil penalties.

Civil Money Penalties

One of the hottest topics of 2020 was the publication of a proposed rule by CMS regarding the imposition of civil money penalties when group health plan GHP and non-group health plan NGHP responsible reporting entities (RREs) fail to meet their MSP reporting obligations under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). The MMSEA revised the MSP to include mandatory insurer reporting requirements with respect to Medicare beneficiaries who have coverage through GHP plan as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation NGHP or NGHP insurance. RREs must determine whether a claimant (including an individual whose claim is unresolved) is entitled to Medicare benefits (known as a "query") and submit

certain claim information to CMS. In addition, the MMSEA provides that failure of an RRE to comply with the reporting requirements could result in civil money penalties of up to $1,000 for each day of noncompliance with respect to each claimant.

While most RREs quickly began querying claims to identify Medicare beneficiaries and developed means to report such claims to CMS, the civil money enforcement provision was never utilized or even put into effect despite the mandatory nature of the fine. One of the main criticisms of the MMSEA was the seemingly onerous penalty, especially since it was hard lined and did not allow for innocent errors or provide safe harbors. In 2013, the MSP was revised to include a small change to the civil money penalty provision. Rather than being mandatory, the penalty was made discretionary, which laid the burden on CMS to develop rules by which the civil penalties would be administered. Again, however, the threat waned and there was no action by CMS to impose penalties. After more than a decade from the enactment of the MMSEA, CMS finally gave the industry its view for how and when it would calculate and impose civil money penalties.

In February 2020 CMS published a proposed rule that would modify the Medicare program to specify how and when it would calculate and impose civil money penalties.

Generally, the proposed rule provides three circumstances in which civil money penalties will be imposed:

- When an RRE fails to register and report as required by the MSP reporting requirements for a claimant within one year of a settlement, judgement, award or other payment (known as a Total Payment Obligation to Claimant, or TPOC) to such claimant
- When an RRE contradicts the information, they have previously reported to CMS in response to attempts to recover conditional payments from the RRE
- When an RRE's reporting practices exceed error tolerance thresholds in four out of eight consecutive quarters

In each instance where a civil money penalty is imposed, the penalty would be up to $1,000 per calendar day of noncompliance for each individual for a maximum annual penalty of $365,000. Of course, these penalties are adjusted for inflation, which could result in an annual penalty of more than $500,000 per claim per year.

After publishing the proposed rule, there was a 90-day public comment period, which ended in April 2020. Since that period has passed, the industry is waiting to see what is next. Options for CMS include republishing the proposed rule for additional comments, withdrawing the proposed rule altogether, and publishing the rule as final. While there is no crystal ball to inform the industry how CMS will proceed, there are some indications in CMS' actions since April 2020. Most significantly, CMS has been updating the MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide in a manner that suggests that the proposed rule will be published as final in the near future.

Until the proposed rule is finalized, we can't be certain how penalties will be imposed. However, the industry at least has a heads-up and some guidance for getting their Section 111 programs in shape. The threat of civil money penalties is already impacting claims operations. Many RREs are undertaking third-party audits or reviews of their reporting practices. Third-party system reviews can help RREs ensure that their data is clean and accurate, and that their reporting practices have the health and integrity required to avoid inaccurate reporting that may lead to penalties. Further, system reviews can validate TPOC reporting and handling of conditional payments to avoid costly mistakes.

As the likelihood of civil money penalties grows, many claims operations will spend money to update their reporting systems, building out improved workflows and procedures, and will likely hire additional personnel to assist in the reporting process. Still other operations will elect to move their reporting programs to outside vendors that have subject matter expertise and can maintain reporting integrity without the prohibitive cost of updating software to account for the new rules.

Finally, many claim operations will be implementing robust training programs and revising their documentation to aid staff in compliance efforts.

Regardless of exactly how the proposed rule comes to fruition, we can be sure that civil money penalties will come and will change the way we report claims; and for some, it will ultimately come at the steep cost of actual payment of civil money penalties.

PAID Act

For the past 20 years, MSP compliance has been largely focused on resolving conditional payments (liens) arising from traditional Medicare, Part A and Part B, and Medicare set-asides (MSAs) to avoid conditional payments that might arise post-settlement. Despite the MSP applying equally to Part C and Part D, MSP compliance programs have mostly ignored Part C and Part D liens.

Over the past 5-10 years, there has been increased activity in the courts whereby Part C and Part D contractors or their proxies have sought reimbursement of payments made through these programs where a primary payment source was available. The reason that court action was necessary is that there is no easy way to determine which Part C and Part D plans may have provided benefits to a

given claimant. With more than 3,000 plans nationwide, identifying which plans to even contact is nearly impossible.

To address the inherent problem with the MSP relative to Part C and Part D recovery, The Provide Accurate Information Directly (PAID) Act was signed into law on December 11, 2020, as part of

H.R. 8900. The purpose of the Act was to improve claims coordination and repayment between Part C and Part D plans and primary payers.

Although the MSP was once thought only to apply to conditional payments made by traditional Medicare plans, Part C and, to an extent, Part D plans began asserting conditional payment recovery rights under the MSP. The issue of whether a Part C plan had standing to bring an action to recoup conditional payments was first addressed by the Third Circuit Court of Appeals in In re Avandia Marketing, 685 F.3d 353 (3d Cir. 2012). The Court determined that Part C plans have standing to bring an action under the MSP and could seek double damages for the failure to timely reimburse conditional payments made by the Part C plan. Since the Avandia decision, other district courts have followed suit expanding and broadening Part C and D plan recovery rights.

The ability to determine a claimant's Medicare eligibility status is paramount to identifying if conditional payments exist and if you have an obligation to reimburse Medicare for the same. Through the Section 111 reporting process, CMS is developing a tool for RREs to obtain this information. RREs or their agents can submit a query to CMS containing five (5) data elements to determine if a claimant is Medicare eligible. Once Medicare eligibility is established, RREs provide certain claims data to CMS if there has been a settlement, judgement, award, or other payment made by the RRE. This information is then utilized by CMS to determine if conditional payments have been made for any injury-related expenses.

Currently, the Section 111 query process will only identify whether a claimant is enrolled in a Part A or B Medicare plan. Although Part C plans and Part D plans have become increasingly more aggressive in pursuing their recovery rights, primary payers/RREs often have a difficult time discerning if a claimant has enrolled in a Part C or Part D plan as there is no centralized database or query process available to obtain this information. Plan types can also change from year to year adding to this complexity.

The PAID Act was developed to remedy this situation by expanding the Section 111 query process to include Part C and Part D plan information. Specifically, the PAID Act provides in pertinent parts as follows:

In responding to any query made on or after the date that is 1 year after the date of the enactment of this clause from an applicable plan …the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan— "(I) whether a claimant subject to the query is, or during the preceding 3-year

period has been, entitled to benefits under the program under this title on any basis; and "(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under H. R. 8900—6 part D in which the claimant is enrolled or has been enrolled during such period."

Effective December 11, 2021, the CMS query process will include information on whether the claimant has been enrolled in an MAP or Part D plan during the preceding three-year (3) period. In addition, and "to the extent applicable," CMS will also need to include the name and address of any Part C plan or Part D prescription drug plan.

This much needed transparency will enable primary payers to address not only traditional Medicare liens, but Part C and Part D conditional payments to avoid post-settlement exposure and potential litigation. The PAID Act will also require CMS to issue technical changes to the Section 111 Reporting process that will need to be implemented by RREs if they choose to utilize the query process. Depending on the type of Section 111 Reporting system an RRE is utilizing, these changes may come at no cost or may require additional technological updates and costs that will need to be considered.

In addition, RREs will need to consider how and if their internal query process will change. Because Medicare plan types can change from year to year, RREs will need to decide when claims should be taken out of the query process or if queries should be done on an annual basis, bi- annual basis, before reporting closure of medicals, or every month until the claim is completely closed for reporting purposes. The number of queries performed on a claim could impact whether RREs are able to identify potential lienholders.

With information regarding Part C and D status readily available, RREs will also need to consider how these potential conditional payments will be addressed, resolved and if there is a mechanism to internally capture this data. Part C and Part D plans may become even more aggressive knowing the RREs have access to plan information.

The PAID Act is a welcome and important development in the MSP compliance arena. Now is the time for RREs to determine if they have the technical capability or their reporting agent or partner has the technical capability to implement any necessary changes to the query process when this is defined by CMS; what policies and procedures will be implemented to capture the information contained in the query process; and how conditional payments potentially asserted by one or more Medicare plan types will be addressed and resolved. The clock is ticking, on June 23, 2021, CMS hosted a webinar to the review changes that will be made to the Section 111 query process in response to the requirements of the PAID Act. At the webinar, CMS announced that the query response record will increase from approximately 300 characters to over 5,000 characters and that the testing period will run from September 13, 2021, through December 10, 2021.

COVID Impact

The COVID-19 pandemic had a significant impact on all sectors of the World economy, including workers' compensation claim related services such as MSP compliance. Public health concerns associated with COVID, led various states and municipalities to lockdown, which resulted in previously unseen unemployment rates. Under normal circumstances, as unemployment rates increase, workers' compensation claim frequency declines primarily since there are fewer employees in the work force. In addition, those remaining in employment tend to be more experienced and less likely to have minor injuries and may be more

reluctant to file a claim for fear of losing their job. Conversely, increased unemployment tends to result in increased severity of claims filed. The remaining workers being older tend to have more costly claims, and an uncertain job market may cause injured workers to delay settling their claims longer.

Notwithstanding decreased claim frequencies, MSA referrals normally tend to be unaffected since MSAs only come into play when mature claims are heading to settlement. Further, when new claim frequencies decline, carriers, and third-party administrators (TPAs) tend to reallocate resources to settle older claims, which frequently result in the use of MSAs. As unemployment rates stabilize and new claim numbers increase, MSA referrals will usually see a decline as attentions are shifted to new claims and any claims that are maturing are more challenging to settle because of the likely increased severity of the claims that arose among the older worker population in the preceding high-unemployment period.

COVID upended the traditional wisdom. While unemployment increased and the non-COVID related claims declined as normally expected, the COVID related claims resulted in an unprecedented frequency of claims within certain sectors, e.g. healthcare. Similarly, where it would be expected to see increased severity of claims, claim severity overall appears, at least anecdotally, to have declined. While COVID related claims initially appeared to have increased severity (in part due to delays in obtaining medical treatment), severity overall stabilized and late indications are that severity of claims during the economic downturn associated with COVID decreased overall.

Due to fewer, non-COVID workers' compensation claims and claims operations dealing with COVID related claims, most MSP vendors surprisingly saw decreases in referral counts for MSAs and related services. In addition, the allocation costs of MSAs during the pandemic seem to have jumped significantly. While there is no clear data as to why this happened, one theory includes the fact that carriers not dealing with significant new claims related to COVID took the opportunity to settle their legacy claims. These types of claims tend to be older workers with more severe injuries, which translates to increased costs. So, while there were fewer claims the MSAs were more costly.

As we start to come out of the pandemic, MSA vendors are prognosticating an increase in MSA referrals over the coming 12-18 months, which is contrary to the normal trend following a period of increased unemployment. With many carriers having diverted their attention to COVID response, there is a backlog of claims that will need to be resolved. More claims have matured (again, mostly older workers with more severe claims) and more injured workers may feel more comfortable settling their claims. During COVID, many courts were inaccessible, and settlements stalled out or simply were not pursued. Further, for most of 2020 the Social Security Offices throughout the Country were closed and due to privacy and security concerns. Social Security staff were unable to process eligibility verifications or respond to related queries. As a result, significant backlogs developed that continue in some parts of the Country to confirm Social Security eligibility for some claimants.

What Is Next and What to Keep an Eye On

Over the next six months, there will be an abundance of activity related to implementation of the PAID Act. The industry is expecting CMS to issue revised and updated user guides for Section 111 that will require major material changes to reporting and claim systems. Section 111 reporting systems will need to undergo extensive review to ensure reporting capability and integrity. Program documentation, procedures and workflows will need to be revamped and staff will need training or retraining. Should CMS publish the final rule during this same period for imposition of civil money penalties, the challenges for claim operations may be exponential.

In addition to these challenges, claims operations will be adjusting to the aftermath of COVID and the likely onslaught of delayed claim resolution and increased MSA cost. With CMS approved MSAs becoming more and more expensive due to CMS' onerous calculation methodology, settlements including MSAs will be delayed, if not lost. As a result, more and more programs may look to forego submission of MSAs to Medicare for CMS review and approval and instead will avail themselves of non-submit MSA options to consider Medicare's interests more reasonably.

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LOST HORIZONS

MONTROSE, BRAUN, AND THE POSSIBLE DISAPPEARANCE OF "HORIZONTAL EXHAUSTION" IN CALIFORNIA

*By Sara M. Thorpe, Matthew C. Lovell, Alison V. Lippa, Nicolaides Fink Thorpe Michaelides Sullivan LLP**

I. Introduction/Overview

The task of allocating responsibility to defend and indemnify continuous or "long-tail" liability claims is a complex process that has challenged courts and insurers for years. Long-tail claims typically result from property damage caused by pollution or construction defects, or bodily injury for diseases with long latency periods resulting from exposure to toxic substances.

Insurers face substantial exposure for these claims due to the significant damages, numerous claimants, and years of coverage implicated. As the California Supreme Court noted, long-tail claims are complex: "Typically they involve dozens of litigants and even larger numbers of insurance policies covering multiple time periods that stretch back over many years."[1] The tension between spreading liability across the horizontal (temporal) axis and the vertical (policy limits) axis of a coverage block has led to battles over insurance allocation among insurers and between insurers and their policyholders.

The adoption of a "continuous trigger" for long-tail claims and the logical notion that primary (first level) policies bear primary responsibility for a loss led to the judicial adoption in California and many other jurisdictions of the concept of "horizontal exhaustion." Horizontal exhaustion provides that all primary insurance exposed for a loss should pay before any excess policies are called on to participate.[2] For almost 40 years, excess insurers could cite a growing body of California law to support this structure. Horizontal exhaustion, repeatedly referred to as a "rule," was the law of the land, embodied in case law and defense and indemnity cost share agreements.

In 2020, however, two decisions from California's appellate courts ("*Montrose III*" and "*Braun*")[3] call into question the viability of horizontal exhaustion as a framework for payment of claims involving progressive loss. This article traces the history of horizontal exhaustion, examines the *Montrose III* and *Braun* rulings, and presents practical steps insurers can

take in light of this "lost horizon."

II. Important Concepts Discussed in this Article

Several concepts are important in analyzing exhaustion of insurance policies triggered by long-tail claims.

A. Continuous Trigger

For coverage to apply, a claim must "trigger" the insurance policy – that is, something (usually the injury), has to happen during the policy period. Long-tail claims involve a series of indivisible injuries arising from continuing events that lack a single unambiguous cause. In such cases, it is often virtually impossible for an insured to prove what specific damage occurred during each of the multiple consecutive policy periods in a progressive property damage case, whether the property damage was caused by environmental pollution or latent construction defects. The same holds true for progressive bodily injuries, such as diseases caused by exposure to asbestos fibers, chemical exposure that causes cancer, or noise-induced hearing loss.

For cases of progressive injury or damage, the California Supreme Court resolved the issue of when coverage is triggered under a comprehensive general liability ("CGL") policy in *Montrose II.*[4] There, the court analyzed the duty to defend underlying claims of bodily injury and property damage allegedly caused by the insured's disposal of hazardous wastes before the commencement of the policy periods. The *Montrose II* court applied a continuous injury trigger of coverage, holding that bodily injury and property damage which is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods, even though acts giving rise to the damage or injury occurred before the policies were issued. Since then, courts applying California law have reliably adopted the continuous injury trigger of coverage for third party liability insurance policies faced with progressively deteriorating losses.[5]

B. "All Sums"

The issue of how to allocate defense and indemnity among applicable policies arises in long-tail claims that trigger more than one policy period. The *State of California* court identified two approaches courts use to allocate defense and indemnity among triggered CGL policies: "pro rata" and "all sums."

Pro rata allocation apportions defense and indemnity among all policies in effect (or all uninsured periods) during years in which the damage or injury occurred. Pro rata allocation is based on policy language that provides the policy only pays for property damage or bodily injury that occurs during the policy period.

By contrast, all sums allocation allows the policyholder to select the policy period to pay all defense and indemnity in full, up to the policy limits in each layer of insurance during that period. The all sums approach is based on policy language that states that the insurer will pay "all sums the insured is legally obligated to pay." In most jurisdictions, insurers selected under an all sums allocation may seek contribution against other responsible insurers.[6] The all sums approach is favorable to insureds because the insured is only required to identify one policy period that provides coverage (rather than all years of primary insurance); it places on the insurers the burden of getting all triggered policies to contribute to the loss.

The California Supreme Court recognized the all sums approach in *Aerojet*, holding that an insurer's promise to pay "all sums" means the insurer's duty to indemnify "extends to all specified harm caused by an included occurrence, even if some such harm results beyond the policy period."[7]

C. "Stacking" and Implications for Exhaustion Rule

Where the initial allocation is insufficient to cover all the damages from a continuous loss, the insured may still have significant damages to pay after obtaining recovery under the policy limits of one policy. Many jurisdictions allow the insured to "stack" consecutive policies' limits to obtain the necessary amounts to cover all damages. The *State of California* court recognized that "stacking" means that when more than one policy is triggered by an occurrence each policy must respond to the claim up to the full limits of the policy. According to the court, this approach gives the insured immediate access to its insurance, and insurers can sort out their shares through equitable contribution or subrogation.

D. Primary versus Excess Insurance

In 1981, the California Court of Appeal in *Olympic*[8] observed that a primary insurer's liability attaches immediately upon the happening of the occurrence that gives rise to liability; but excess policies do not kick in until the primary insurance has been exhausted. The court observed that this is true even where there is more underlying primary insurance than contemplated by the terms of the secondary policy. Excess insurance is expressly understood by both the insurer and insured to be secondary to specific underlying coverage and does not pay until after that underlying coverage is exhausted.[9]

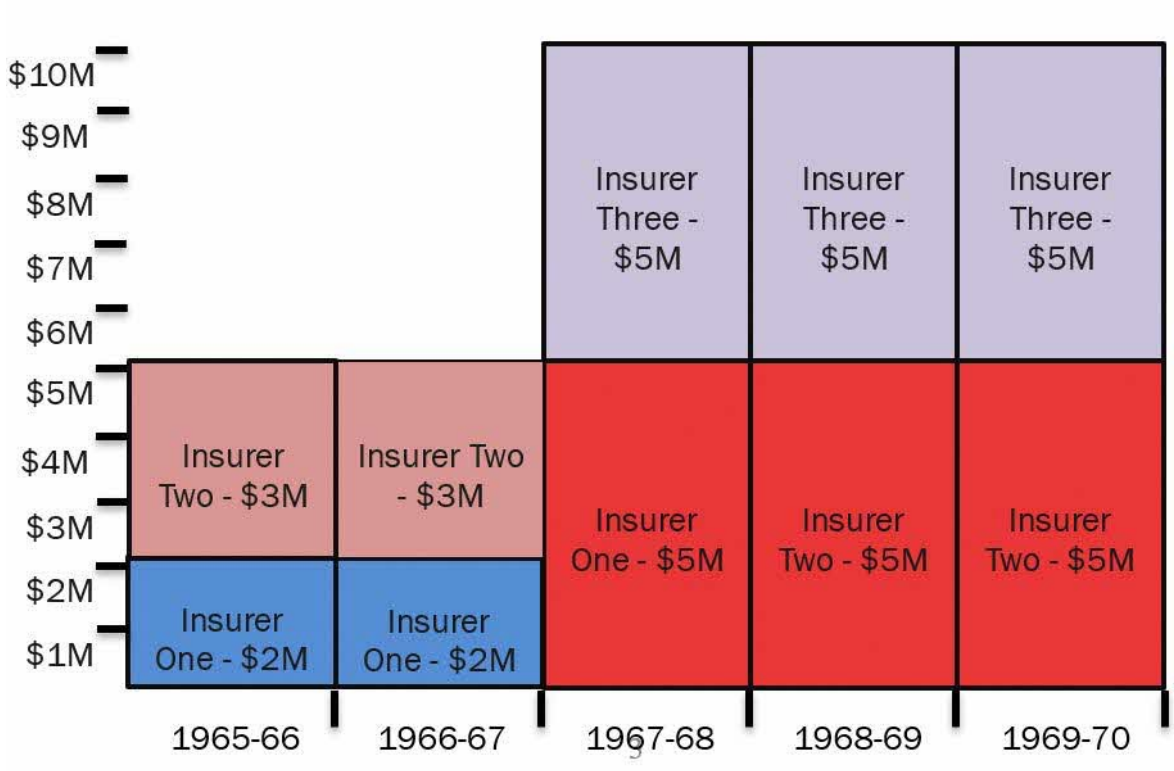
III. Horizontal Exhaustion Explained

Horizontal exhaustion follows logically from: (1) continuous trigger, (2) stacking, and (3) the fundamental distinction between primary and excess insurance.

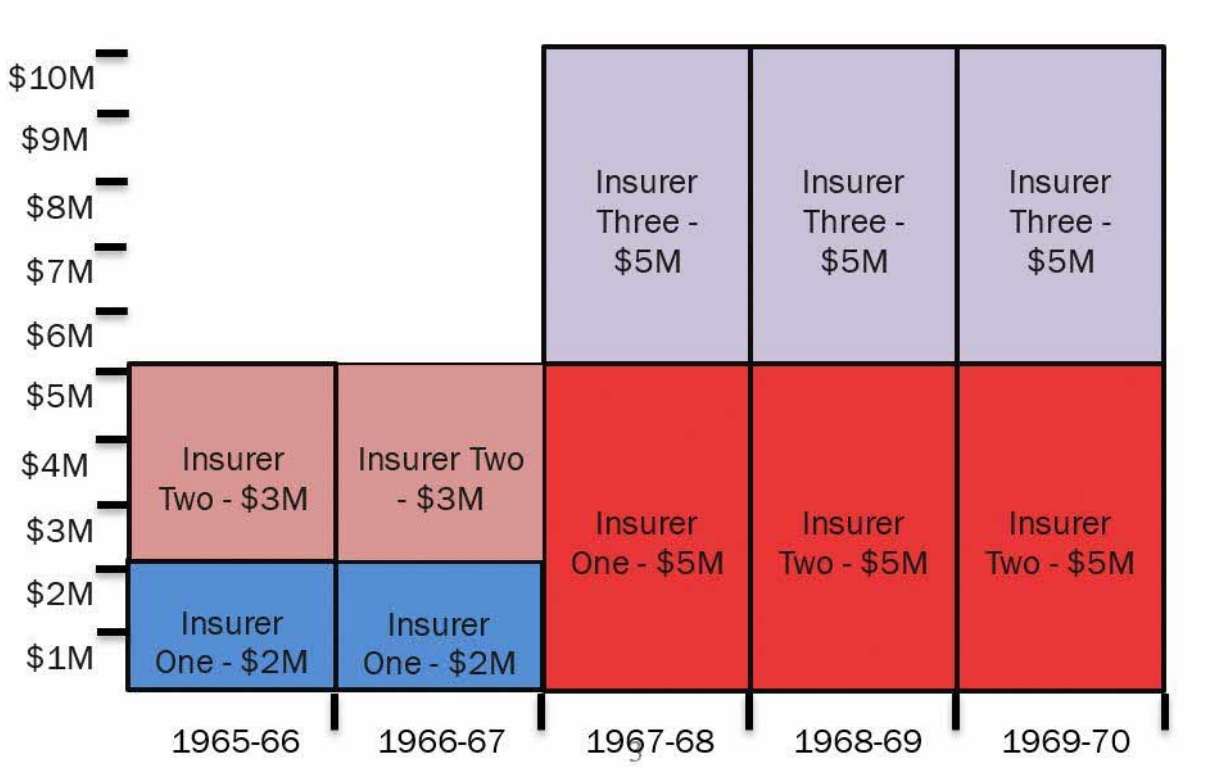
In 1996, the California Court of Appeal applied horizontal exhaustion in the context of continuing property damage in *Community Redevelopment*.[10] There, a primary insurer sought contribution from an excess insurer for costs paid defending a construction defect case. The court cited *Olympic* as the leading case on the point that all primary insurance must exhaust before excess coverage is implicated, and stated that the general California rule favors and results in what is called "horizontal exhaustion." By contrast, under vertical exhaustion, coverage attaches under an excess policy when the limit of a specifically scheduled underlying policy has exhausted and the language of the excess policy provides that it shall be excess only to that specific underlying policy.

Horizontal and vertical exhaustion is illustrated by the following depictions. In the first, all primary policies pay before any excess policies (horizontal exhaustion). In the second, the primary and the excess policies in the same (green) period pay before any other primary policy pays (vertical exhaustion).

Horizontal Exhaustion – requires all the blue and red primary to pay first



Vertical Exhaustion – green policy period pays



The Community Redevelopment court noted that horizontal exhaustion is "a particular problem" in light of the continuous trigger rule stated a year earlier in Montrose II, under which primary policies may have coverage obligations which make them underlying insurance to excess policies in effect in entirely different time periods. The court held that in this situation, "[a]bsent a provision in the excess policy *specifically describing* and *limiting* the underlying insurance, a horizontal exhaustion rule should be applied in continuous loss cases because it is most consistent with … [*Montrose II*]."[11] As the court held, this means all the primary policies in force during the period of continuous damage will be deemed primary to each excess policy covering that same period, and must exhaust before any excess policy will have coverage exposure.

After 1996, *Community Redevelopment's* horizontal exhaustion rule was applied in continuing injury cases involving bodily injury[12] and property damage.[13]

While courts and parties followed a horizontal exhaustion approach as to primary policies, no court had addressed whether this rule applied to excess insurance. That changed with *Montrose III*.

IV. Montrose III and Braun – How Much Do They Alter the Landscape?

A. Montrose III

Montrose Chemical Corporation manufactured the insecticide DDT in Torrance, California from 1947 to 1982. In 1990, the United States and the State of California sued Montrose for environmental contamination caused by its operations, which had damaged land, water, and wildlife in and near the Los Angeles Harbor. Coverage litigation followed.

The contaminated area left by Montrose has been fertile ground for significant insurance coverage opinions, including three California Supreme Court decisions. In Montrose I, the California Supreme Court solidified key rules regarding the duty to defend, including that: (1) evidence extrinsic to the underlying complaint can create a duty to defend; and (2) an insurer can rely on undisputed extrinsic evidence to eliminate the possibility of coverage and a duty to defend. A year

later, in *Montrose II*, the court adopted the continuous injury trigger of coverage.

By the time the dispute returned to the California Supreme Court in October 2017, Montrose had signed consent decrees to pay for environmental cleanup. Past and future costs were roughly $200 million. Montrose had already exhausted or settled with its primary insurers, and some first layer excess insurers were paying. The issue for the *Montrose III* court was the order in which Montrose could access higher excess insurance policies in a multi-layer insurance program from 1961 to 1985.

Montrose claimed it was entitled to coverage under any excess policy once Montrose exhausted the directly underlying excess policy for the same policy period and requested the court adopt this rule of vertical exhaustion or elective stacking. The insurers urged the court to instead adopt a rule of horizontal exhaustion on the excess level consistent with the policies' terms and conditions and *Community Redevelopment*, so Montrose could not obtain coverage under any higher level of excess policies until it exhausted every triggered excess policy in the lower level. The lower appellate court ruled in favor of the insurers, holding the excess policies attached upon exhaustion of all available underlying insurance.

The California Supreme Court in *Montrose III* disagreed, reversed, and remanded. The court agreed with Montrose that a rule of vertical exhaustion is appropriate, and that, where all primary insurance has been exhausted, Montrose could access otherwise available coverage under any excess policy once it exhausted directly underlying excess policies for the same policy period. The court confirmed that an insurer whose policy was chosen to indemnify could seek reimbursement from other insurers that would have owed coverage under excess policies issued for any period in which the injury occurred.

In reaching this conclusion, the *Montrose III* court disregarded all the excess policies' "other insurance" clauses, i.e., any policy provision that referred to other insurance. The policies required Montrose to exhaust both its underlying insurance coverage (described in varying degrees of detail) and "other insurance" before the excess policies were obligated to pay. The other insurance was defined variously to include "other insurances," "any other underlying insurance collectible by the insured," "all underlying insurance," and "other valid and collectible insurance with any other insurer [that] is available to the insured." The insurers argued these provisions required horizontal exhaustion because, in long-tail cases, "all other available insurance" means every policy with a lower attachment point from every policy triggered by the continuous injury.[15]

The court held that, while the insurers' interpretation was "not unreasonable," it was not the only possible interpretation. The policies did not clearly state that Montrose must exhaust insurance with lower attachment points in *different policy periods*, and "could fairly be read to refer only to other directly underlying insurance in the same policy period that was not specifically identified in the schedule of underlying insurance[.]"[16] The court ruled that "other insurance" clauses typically address apportionment among multiple insurers during concurrent policy periods; not obligations among successive insurers in long-tail claims. Finding "no persuasive indication" to the contrary, the court held that the excess policies

"are most naturally read" to mean that Montrose may access its excess insurance whenever it has exhausted the other directly underlying excess insurance policies for the same policy period. That the "other insurance" clauses did not specifically call for horizontal or vertical exhaustion was an ambiguity that supported Montrose's argument for vertical exhaustion.[17]

The *Montrose III* court also noted that if a given excess policy attached at $30 million, the insurers' theory would require Montrose to exhaust much more coverage before accessing that excess policy, i.e., $30 million for every triggered policy period.[18] The court also pointed to practical difficulties in administering horizontal exhaustion, including the asymmetry of the blocks in the coverage tower and different policy terms. The court noted that: "the parties could not have intended to require the insured to surmount" the hurdles of proving coverage under all policies with lower attachment points to be able to access "the excess insurance the insured has paid for." The court minimized the complaints of unfairness of the excess insurance during the "unlucky" chosen years. Those claims had been addressed and rejected when California adopted all-sums-with-stacking in *State of California* (discussed above).[19]

While the result in *Montrose III* was not unexpected, how the court got there was inconsistent with the court's policy language-driven past decisions. The court noted there was no specific precedent for interpreting "other insurance" clauses to require horizontal exhaustion at the excess level. *Montrose III* gave short shrift to *Community Redevelopment*, which the court viewed as a contribution action between insurers that differed "in fundamental respects." The court noted that: "[r]egardless of whether *Community Redevelopment* was correct to apply a rule of horizontal exhaustion in that distinct context [primary insurance]—a question not presently before us—we are unpersuaded that the [continuous trigger rule] of [*Montrose II*] requires us to apply a rule of horizontal exhaustion … [to excess policies]."[20] The Braun case suggests the most important aspect of *Montrose III* is that court's conclusion that policy provision referring to "other insurance" do not require horizontal exhaustion.

B. Braun – Rejection of Decades of the Horizontal Exhaustion "Rule"

Braun, another decades-long coverage dispute, was filed in 2004. Braun claimed it had exhausted all its primary insurance, which had been paying asbestos claims on a horizontal basis. The primary policies did not have applicable aggregates unless the claims against Braun -- a contractor with few asbestos-containing products -- involved products or completed operations. Thus, there was a question about whether the primary policies were actually exhausted and, after settling with the primary, the debate ensued over whether Braun had to exhaust one or all primary policies to access its excess policies.

The insurers won at the trial court, obtaining rulings that, under *Community Redevelopment's* "rule" or "presumption" of horizontal exhaustion, Braun had to prove horizontal exhaustion of all primary insurance. Braun failed to do so. At a later phase of trial, the court agreed that without the exhaustion of primary policies, Braun could not access any excess policies higher in the towers of insurance in each year. Braun appealed, arguing the trial court had erred in determining that the excess policies required the exhaustion of all underlying primary insurance.

On July 13, 2020, the California Court of Appeal (First District) issued its decision. Adopting the reasoning of *Montrose III*, the court applied a rule of vertical exhaustion, holding "the trial court erred in interpreting the relevant policies to require horizontal exhaustion of all primary and underlying excess insurance coverage before accessing coverage under the excess policies at issue."[21]

In doing so, *Braun* took direct aim at *Community Redevelopment* and *Padilla*. After quoting those cases for the "rule" of horizontal exhaustion, the court explained that those decisions "rely on an interpretation of policy language rejected … in *Montrose III*. … While those cases had held that "other insurance" clauses required horizontal exhaustion, "*Montrose III* holds otherwise." The court found it worth mentioning that *Community Redevelopment* was not a dispute between the policyholder and its insurers (like Braun). And, while *Padilla* was closer on the facts, that court's extension of *Community Redevelopment* "can no longer be justified after *Montrose III*."[22] The ruling in *Braun*, if followed negates horizontal exhaustion under virtually all common primary insurance policy forms. The *Braun*

court noted that an insurer is free to contract otherwise; but, of course, that is not possible in policies that were often written 40-70 years earlier.

The California Supreme Court denied review, and the case was remanded for further proceedings consistent with the appellate court's ruling.

V. What Does It All Mean?

Montrose III and *Braun* threaten any excess insurer's ability to require horizontal exhaustion of primary policies (as opposed exhausting only the directly underlying primary policy) before the excess policy is required to pay. These cases make it decidedly easier for policyholders to access a chosen tower of coverage, without having to first seek coverage from primary policies in earlier or later triggered years. Further, a review of policyholder-friendly websites indicates that insureds' counsel view *Montrose III* and *Braun* as decisions that will enable them to move freely around coverage towers. That likely is the next battle ground. Policyholders use the terms "selective tender," "target tender," "hopscotch," and similar terms to denote that they want, once one primary policy has exhausted, to be able to move about in the excess policies to side-step insolvent insurers, exhausted policies, deductibles and self-insured retentions, and policies with more restrictive coverage.

Despite *Braun* and *Montrose III*, excess insurers may still be able to invoke horizontal exhaustion of primary insurance in some instances. One way is by limiting the reach of Braun. In December 2020, in Rohr, the Connecticut Court of Appeal applied California law to require the insured to horizontally exhaust all primary policies before accessing excess policies to indemnify costs incurred to remediate property damage caused by environmental contamination.[23] The court found *Montrose III* inapposite because it involved horizontal exhaustion of excess policies. The court also rejected Braun, noting that under California procedure, one appellate district court's decision was not binding on other courts of appeal. The court instead chose to "follow the long line of California cases that adhere to the well settled rule under California law that an excess policy does not cover a loss until all primary insurance has been exhausted."[24]

VI. Insurer Best Practices

The burden of applying horizontal exhaustion has changed in California and there are several practical steps excess insurers can take to when selected as the insurer to defend or pay a claim.

Preserve and pursue contribution rights. *Montrose III* and *Braun* did not change insurers' rights to obtain contribution from other triggered insurers. To strengthen claims against other insurers, carriers should gather the best available information about the insured's coverage profile: what policies were issued, by which insurers, with what limits, in what time periods, and with what relevant policy terms? Policyholders have the greatest incentive to compile this data, to enable them to make the best decision about which year to choose to respond to a loss in the first instance. An insurer selected by the policyholder has an equal incentive to gather that information to determine if there are grounds to recover from other insurers at the same level in the coverage tower (through equitable

contribution), or at different levels (through equitable subrogation and restitution). At the outset of the claim, the insurer should request information about its insured's insurance program and obtain the insured's cooperation with any contribution claim. The insured has no reasonable basis to decline such a request.

Confirm proper underlying exhaustion. The selected insurer should insist that the policyholder provide detailed information about the exhaustion of the underlying policies to verify that claims are within the scope of coverage of those policies, and validly erode applicable underlying policy limits. For example, if the relevant "loss" is an insured's liability for bodily injury claims resulting from asbestos exposure, and the primary policies have aggregate limits for products liability claims but not for premises liability claims, the analysis of whether an underlying claim is a "products" claim or a "premises" claim is vital to determine when an excess insurer's duties may be triggered. The insured bears the burden to prove exhaustion. To investigate erosion, excess insurers should require loss runs from primary insurers showing actual payment and information about the paid claims to confirm those claims fit within the scope of coverage of the primary policies. Such documents may include discovery materials (answers to interrogatories, deposition transcripts, and expert reports), pleadings, defense counsel's settlement evaluations, or motions for summary judgment. These records may show (for example) whether a claimant alleged that the insured is strictly liable for its role in the manufacture and distribution of dangerous asbestos-containing products or is liable for negligent workplace safety practices that allegedly caused the claimant's exposure to asbestos-containing products. The first category of claims implicates products aggregate limits; the latter category does not.

Analyze vertical attachment requirements. Although horizontal exhaustion of all primary insurance is not required, there may be other requirements prior to attachment of the excess policy. The policy's trigger requirement may differ from the underlying policy. The excess policy may require that only underlying claim payments that involve an occurrence (rather than injury or damage) suffice to reduce or exhaust the underlying limit. Some policies make clear that the insurer alone (not the insured) must pay the underlying limits. Anti-stacking provisions and non-cumulation provisions may reduce the amount of limits available if other policies issued by that insurer pay for that same occurrence.

Consider alternatives to litigating contribution suits. Contribution lawsuits are expensive to litigate and inevitably make "bad law." An insurer is always the losing party in a contribution action. Insurers and their counsel need to find ways to make contribution efficient and fair, and driven by the policy language. There are common facts about the claims and the policies that all insurers need, and should agree to share, to make the litigation of contribution claims, if necessary, as efficient as possible.

Consider policy language changes. Insurers should consider adapting policies to address the ambiguity the *Montrose III* court perceived. This obviously does not help legacy policies but can address long-enduring claims, which continue to happen. For example, policy wording should be considered that requires attachment only after all scheduled underlying insurance and all primary policies issued in any year before or after the policy period of this policy have paid or been held liable to pay the full amount of their respective limits.

VII. Conclusion

The rule of horizontal exhaustion makes sense in light of common policy language, the continuous trigger, and the primary-excess distinction. Montrose III and Braun did not change that. However, those cases mean the burden of spreading defense or indemnity horizontally has fallen on the insurers. Policyholders no longer have the initial burden to obtain primary coverage and prove its exhaustion before moving into the excess layers. Excess insurers need to take the lead on risk transfer and make sure other insurers are at the table and ready to contribute.

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1 State of California. v. Continental Ins. Co., 55 Cal. 4th 186, 195–96 (2012). All references to "State of California" are to this citation.
2 See, e.g., Padilla Constr. Co. v. Transp. Ins. Co., 150 Cal. App. 4th 984, 986 (2007) ("California's rule of 'horizontal exhaustion' in liability insurance law requires all primary insurance to be exhausted before an excess insurer must 'drop down' to defend an insured, including in cases of continuing loss.").
3 All references to "Montrose III" are to Montrose Chemical Corp. v. Superior Ct., 9 Cal. 5th 215 (2020), as modified, May 27, 2020. All references to "Braun" are to SantaFe Braun, Inc. v. Ins. Co. of N. Am., 52 Cal. App. 5th 19 (2020), review denied, California Supreme Court, Docket No. S264060 (September 30, 2020).
4 All references to "Montrose II" are to Montrose Chem. Corp. v. Admiral Ins. Co., 10 Cal.4th 645 (1995).
5 See, e.g., Padilla, 150 Cal. App. 4th at 987 (continuous trigger generally means that "all primary insurers over the time of the alleged continuous injury will be obligated to defend an underlying action claiming such continuous damage"); Armstrong World Indus., Inc. v. Aetna Cas. & Surety Co., 45 Cal. App. 4th 1 (1996) (applying continuous trigger to asbestos claims).
6 See, e.g., Illinois Sch. Dist. Agency v. St. Charles Cmty. Unit Sch. Dist. 303, 2012 IL App (1st) 100088 ¶ 39, 971 N.E.2d 1099, 1110 (2012) (Illinois's "targeted tender" rule did not preclude equitable contribution among consecutive insurers covering different policy periods). But see Mut. of Enumclaw Ins. Co. v. USF Ins. Co., 164 Wash. 2d 411, 421 (2008) ("selective tender" rule prevents settling insurers from seeking equitable contribution from another insurer to which the insured never tendered the claim).
7 All references to "Aerojet" are to Aerojet-Gen. Corp. v. Transp. Indem. Co., 17 Cal. 4th 38, 56–57 (1997).
8 All references to "Olympic" are to Olympic Ins. Co. v. Employers Surplus Lines Ins. Co., 126 Cal. App. 3d 593 (1981).
9 Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London, 161 Cal. App. 4th 184, 194 (2008) ("California case law has consistently protected the limited and shielded position of the excess carrier when the obligations of the excess carrier are set in clear phrases.").
10 All references to "Community Redevelopment" are to Community Redevelopment Agency v. Aetna Cas. & Surety Co., 50 Cal. App. 4th 329 (1996).
11 Community Redevelopment, 50 Cal. App. 4th at 340 (emphasis in original).
12 See, e.g., Fuller-Austin Insulation Co. v. Fireman's Fund Ins. Co., et al., No. BC116835 (Cal. Super. July 31, 2003) (Phase IA Statement of Decision) (personal injuries arising from asbestos exposure).
13 See, e.g., Montrose Chem. Corp. v. Superior Ct., 14 Cal. App. 5th 1306, 1335 (2017), as modified (Sept. 8, 2017), rev'd and remanded by Montrose III (May 27, 2020) (property damage resulting from pollution).
14 Montrose Chemical Corp. v. Superior Court, 6 Cal.4th 287, 292 (1993). All references to "Montrose I" are to this citation.
15 Montrose III, 9 Cal. 5th at 230.
16 Montrose III, 9 Cal. 5th at 230-31 (emphasis in original).
17 Montrose III, 9 Cal. 5th at 234.
18 In Montrose III, where the continuous injury occurred over 25 years, "such a rule would increase the operative attachment point for this policy from $30 million to upwards of $750 million." Montrose III, 9 Cal. 5th at 233-34.
19 Montrose III, 9 Cal. 5th at 233-34, citing State of California, 55 Cal.4th at 200-01.
20 Montrose III, 9 Cal. 5th at 237.
21 Braun, 52 Cal. App. 5th at 22.
22 Braun, 52 Cal. App. 5th at 30.
23 Continental Casualty Co. v. Rohr, Inc., 201 Conn. App. 636, 712 (2020) ("Rohr").
24 Rohr, 201 Conn. App. at 702-03, 706-12 (citing Community Redevelopment and more than ten other California appellate decisions).

CYBER BUSINESS INTERRUPTION

WHY EVERY ORGANIZATION CAN'T LIVE WITHOUT IT

By

Jeanette L. Dixon

Partner, Manning & Kass Ellrod, Ramirez, Trester, LLP

Cyber business interruption occurs when a company faces a direct loss of income due to a system failure caused by criminal hacking, malicious inside elements, or distributed denial of service (DDoS) attacks. In recent years technological advancement through the increasing acceptance of the internet and high demand for cloud solutions has caused an exponential rise in cyberattacks and the resultant cyber business interruption. This rise has been unexpectedly exacerbated by the Covid-19 pandemic as the workforce is now mainly remote and organizations are forced to have an increased reliance on third party providers for hosting and connectivity. As organizations move online and digital technologies become their way of life, business interruption plays a much larger role in cyber insurance and cyber coverage causing more organizations to begin to evaluate their potential business interruption exposure prior to loss, thereby proactively managing their risks. Yet, unlike traditional business interruption risks, organizations and subsequently insurance companies are finding cyber business interruption risk difficult to estimate and manage.

Cyber business interruption is a relatively new and rapidly evolving coverage concept in the cyber insurance world. Contrary to when cyber insurance first came to life in the 1990's, wherein it was developed to protect the first breed dot-com companies against perils like the destruction of data, unauthorized system access and computer viruses, cyber insurance has evolved and transformed to reflect the ever-evolving risks faced by various organizations. Today any organization that holds personally sensitive data, whether such data is financial, health or simple personally-identifiable information is vulnerable to cyber business interruption due to a cybercrime or accidental data breach. Expected to grow at a compound annual growth rate of 12% to reach $340.33 billion by 2027, organizations are trending towards having a greater focus on the devastating financial disruption that they may face in the event their business is interrupted by a cyber-event and look to protect their interests through cyber insurance.

Business interruption coverage, now offered as part of cyber insurance in combination with data breach liability or as a stand-alone business interruption policy, is one of the most significant events in cyber insurance in recent years. Business Interruption coverage is a first-party coverage that provides monetary assistance to soften the impact of cyber-attacks and data breaches experienced by an organization as it covers the loss suffered from a cyber-event. Cyber business interruption insurance should be obtained by all organizations, regardless of the industry it services, as business interruption insurance covers the net profits before taxes that would have been earned by the organization had there not been an interruption in service as a result of a cyber-event. These losses generally include extra expenses such as the costs associated with continuing to run the organization, which may include payroll expenses, utility bills, and the cost associated with reducing the impact of the organization's income loss. A noteworthy factor of cyber business interruption insurance is that it does not require that the organization be completely shut down by a cyber-event to trigger coverage, as a system slowdown due to network issues or malicious elements can also be classified as a trigger. Nonetheless, in the case of business interruption, time is one of the most important factors, as income loss can continue to grow until the system is back to normal and the same level of service functionality is restored.

Traditional Business Interruption vs. Cyber Business Interruption

Unlike traditional business interruption exposure and subsequent coverage offered by the applicable policies, cyber business interruption greatly differs from traditional business interruption when it comes to the period of measurement, period of restoration, personnel involved, geographic constraints, and reputational risk faced by an organization. The amount of time an organization is interrupted by a cyber-event is crucial, yet often difficult to estimate and manage, due to the fact that the period of measurement is generally relatively short and lasts for either a few hours or a few days. As most cyber insurance policies have a designed waiting period between six and twenty-four hours for business interruption, which time is required to elapse before a recovery under the policy is possible, the clock begins to run at the earlies point when an organization's service has been interrupted or there is an degradation in service. As the measurement of time related to the business interruption suffered by an organization due to a cyber-event is shorter in duration, the evaluation of the impact upon and subsequent potential loss suffered by an organization requires very detailed data. As a result, income loss calculations, which can accrue until the organization's systems are back to the original functionality and level of service that existed prior to the incident, may be limited to hourly or daily revenue or sales data. This is contrary to traditional business interruption wherein the disruption to an organizations business can be quantified into a period of weeks, months or years making it easy to evaluate the impact of an organizations loss through monthly profit and loss statements.

Another equally crucial issue that differs for cyber business interruption is the period of restoration. Determining when a cyber-event has both started and ended, which includes when the system was repaired and the breach no longer exists, is extremely important because this period of time drives the ultimate value of the cyber business interruption loss to an organization. The period of restoration in a traditional business interruption exposure begins on the date of loss, which is defined as the date of physical damage, and ends on the date when the repairs should have been diligently completed. However, due to the fact there is much less defined certainty as to when a cyber-event begins and ends, inclusive of when the system was actually repaired and the breach no longer exists, it is far more difficult to determine the period of restoration when an organization's business is interrupted by a cyber-event.

The complexities surrounding both the time period and period of restoration related to a business interruption suffered by an organization from a cyber-event often requires the contribution and assessment of different types of data which necessitates the utilization of more personnel within an organization, such as the risk manager, legal counsel, technology and operations officers. These individuals are often needed to collectively determine what may have caused the cyber event to occur and ultimately to properly

quantify the loss suffered by the organization. This ultimately narrows down the exact period of indemnity and restoration due to the cyber business interruption loss thereby allowing an organization to fully connect the actual financial calculations to the impact faced by the organization. Hence, the quantification of the actual financial impact suffered by the organization is easier to evaluate once the breach no longer exists and the organization becomes fully operational. Notwithstanding the benefits realized from the contribution and assessment of essential personnel after a cyber-event to quantify the impact of the business interruption on the organization, it should be noted that bringing in these additional individuals may ultimately add to the complexity of the process.

Further, unlike claims related to traditional business interruption that are generally geographically constrained, cyber business interruption constraints, locally, regionally or globally, do not exist and can thereby impact the systems of a global organization both immediately and simultaneously. Hence, unlike traditional business interruption in which an organization can mitigate their risk by spreading out their operations geographically, which allows them to prevent a catastrophic event from completely crippling their organization, no such constraints exists when a cyber-event occurs to an a global organization which is running systems used by the entire workforce around the globe.

Finally, and most importantly, a cyber-business interruption can severely impact and subsequently harm an organization's reputation, which often results in extended financial losses. In traditional business income exposure customers and the general public usually do not have any reaction when an organization's business is interrupted simply because they are not aware of the event that subsequently caused the business interruption. However, when an organization that is hacked and its' customers personal identifiable information is compromised, the customer and general public sees this as a breach of trust by the organization. Hence, although a cyber-incident is repaired and the breach is fixed, the organization can be significantly harmed due to the resultant extensive financial losses.

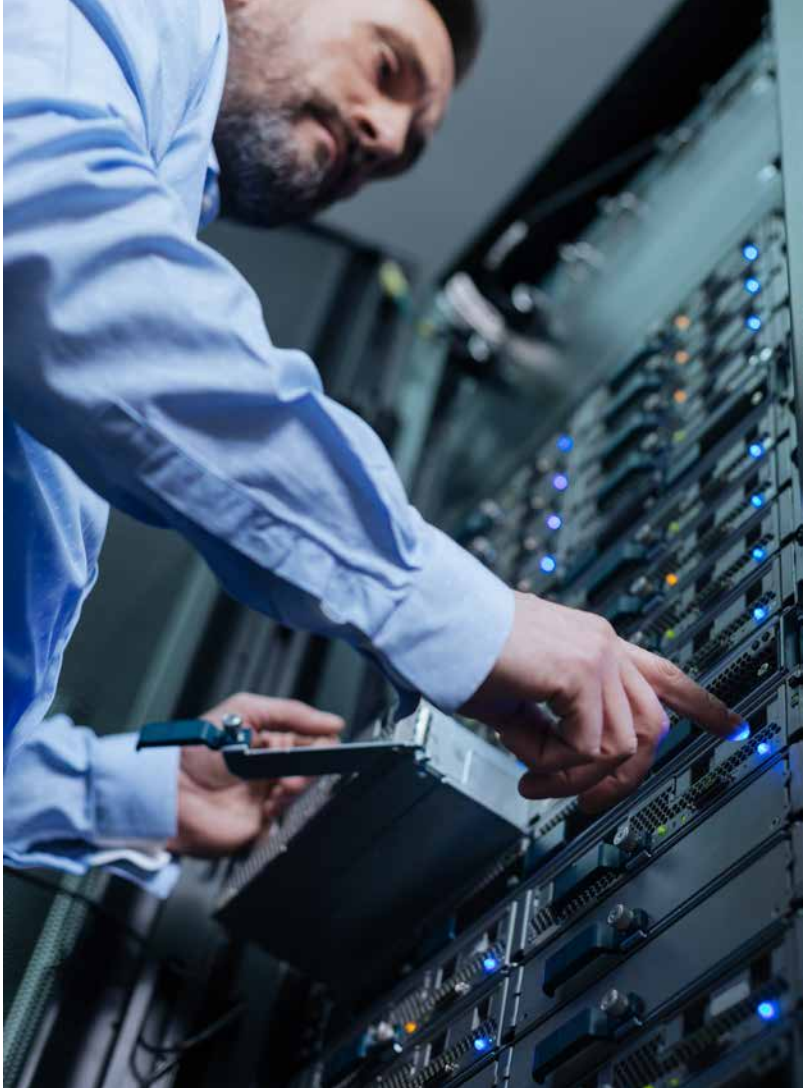
What is Contingent Business Interruption Loss Coverage

Another relatively new yet important concept in cyber insurance is contingent business interruption loss coverage. Contingent business interruption occurs when an organization suffers loss of income as a result of an interruption in a service of a shared computer system, such as cloud services, data storage and other processing functions. Outsourcing to third party provider, whether a cloud provider, a hosted software provider or a non-IT related service provider does not outsource the risk or the exposure often faced by an organization once a cyber-event occurs and thereby causes a business interruption. Organizations must recognize that migrating to the cloud does not equate to migrating their exposure to the cloud. Many third party vendors, who offer cloud services or hosted software services, have put into place contractual agreements that typically limit the liability exposure that the third-party providers will have to undertake to the actual fees

that were paid for the services. Hence, organizations who outsource to third party providers may want to consider obtaining cyber contingent business interruption, which often covers security failure at a providers location or customer location, as it is critical to protect the organization's business.

Protecting Your Organization In The Event Of A Cyber Breach

An organization can mitigate a cyber-event that causes the interruption of their business by implementing an incident response plan such as keeping an up to date backup of their data available and away from any potential threats. However, in the event an organization's workflow is interrupted due to a network failure or a loss to their system that is being hosted by a provider, which indirectly impacts the organization, there are best practices that an organization should follow before submitting a claim. An organization must first perform a technical evaluation of the incident and any compromised equipment as this will help the organization to understand the scope of damages, impact, period of recovery, and identify any upgrades or betterments. A thorough technical evaluation of the cyber-claim is an important aspect of the business interruption evaluation because it will allow the organization to confirm the cause of the event or loss. Further, a technical evaluation will allow the organization to identify the systems specifically affected and the impact of those systems to the business. Finally, a technical evaluation will also identify the proper corrective action and most efficient recovery time, as well as any, necessary and required technical upgrades



or changes that may have been completed concurrently with the event recovery that may impact the period of recovery. An organization must understand that the collection of this technical information is imperative and should always be gathered at the onset of a loss evaluation, as this will assist insurance carriers to understand how the loss applies to their policies and similarly understand the total exposure.

Above all, an organization that falls victim to a cyber-event that causes their business to be interrupted must immediately notify its insurance carrier after the cyber breach is detected or once the organization receives notification of the breach from its third party provider. In the event the interruption is caused indirectly through a cloud service, data storage or other processing functions from a third party provider, an organization must determine if the vendor has adequate coverage for business interruption claims and if such coverage is favorable. Finally, as with all claims, an organization must always keep detailed and thorough records, which will ultimately help support the organization's claim and subsequent loss with the carrier.

About the Author

Jeanette L. Dixon is a founding and managing partner of the New York office of Manning & Kass Ellrod, Ramirez, Trester LLP. Ms. Dixon, who joined the firm in 2014 with more than 14 years of experience within the areas of insurance coverage and defense, presently heads the firm's Insurance Coverage/Bad Faith Practice Area. Ms. Dixon developed an expertise in insurance coverage early in her career and is nationally regarded as one of the leading experts in insurance coverage/bad faith law. Dixon practices in the areas of insurance coverage/bad faith, cyber liability, employment law, professional liability, commercial general liability, general liability, miscellaneous professional liability, healthcare liability, corporate and commercial transactions and insurance regulatory matters.

On June 2, 2013, Ms. Dixon appeared as a legal analyst on Fox News Channel's America's News Headquarters with Gregg Jarrett, wherein she participated in a live panel discussion regarding the admissibility of audio evidence against George Zimmerman in the Trayvon Martin murder case venued in Florida. She is currently a finalist in the inaugural University at Buffalo Fast 46 competition. Ms. Dixon was also an active arbitrator on behalf of the New York State Small Claims Court for numerous years.

Ms. Dixon is admitted to the State Bar of New York, Southern and Eastern Districts of New York, and the United States Supreme Court. She was named the 2020 New York State Attorney of the Year and a Lawyer of Distinction within the area of Insurance Coverage in 2019. Ms. Dixon is a an adjunct attorney member of the International Associations of Claims Professionals (IACP), member of the Federation of Defense and Corporation Counsel (FDCC) and Claims, Litigation Management Alliance (CLM), and the Plus Liability Underwriting Society (PLUS).

Ms. Dixon received her Juris Doctorate from the State University of New York at Buffalo School of Law and her BA in Social Science Legal Studies/English from the State University of New York at Buffalo.

COMBATTING POST-COVID RESURGENCE OF JURY BIAS AND THE REPTILE APPROACH

By Timothy W. Hassinger, Managing Director of the Mandeville, Louisiana office of Galloway, Johnson, Tompkins, Burr & Smith

Earlier this year, the Supreme Court of Louisiana issued a guide for resuming jury trials in district courts across the state. *Guide to Resuming Jury Trials, Louisiana District Courts* (March 2021). To prepare this "guide," the Court "convened a small committee of district judges" and identified resources "that offered constructive and helpful strategies." Other courts across the United States have published similar guidelines.

Of course, no Justice or Judge who was involved with this Louisiana guidance has ever experienced a pandemic before now or has any experience resuming jury trials in a situation even remotely like this. Instead, the focus apparently was on the mechanics of resuming trials within the court system and medical assurances of doing so safely.

One piece of guidance offered by the highest court in Louisiana, for example, was the use of masks for witnesses. "Clear masks (not face shields) are available for identification and credibility purposes of a witness or defendant," the Guide naively says, as if a juror who has never participated in the legal process or served on a jury can assess the credibility of a witness who is straddled with a mask, whether clear or not. As one recent author argues, "[T]he mask requirement contravenes a central tenet of this country's credibility jurisprudence: that demeanor is fundamental to assessing the credibility of witnesses." *Unmasking Demeanor*, 88 Geo. Wash. L. Rev. Arguendo 158, 160 (2020), Julia Ann Simon-Kerr.

The Supreme Court of Louisiana, however, offered no direction to the lower courts for properly addressing this issue of credibility, on which fundamental tenets of due process rely. And the credibility of a witness is so fundamental that the law in both state and federal courts imposes a heightened standard of review for factual findings, such as those based on the credibility of a witness, to be overturned by a higher court. See Fed. R. Civ. P. 52(a)(1)(6).

But witness credibility—whether that person wears a mask in person or appears without one at a trial held remotely for social distancing reasons—is only one issue. Something that often cannot be seen, an even more basic and fundamental issue, is bias. How do courts protect against the effects of juror bias, attitudes, and predispositions, and ensure a fundamentally fair trial and outcome? No courts have adequately addressed the psychological impacts of the COVID-19 pandemic or how the pandemic has affected

individual predilections, or how courts can ensure an impartial jury is empaneled post-COVID.

Mental Health Post-Covid

Undoubtedly, most trial judges would say that bias can be flushed out during the process of *voir dire*, before the jury is seated. But then again jury bias, attitudes, tendencies, and predispositions were difficult to assess before the pandemic or COVID-19 ever became the topic of every day and seemingly every hour. That burden will likely be even more difficult now as individuals recover, suffer long-tail physical effects, and attempt to cope with the non-physical fallout of this catastrophe.

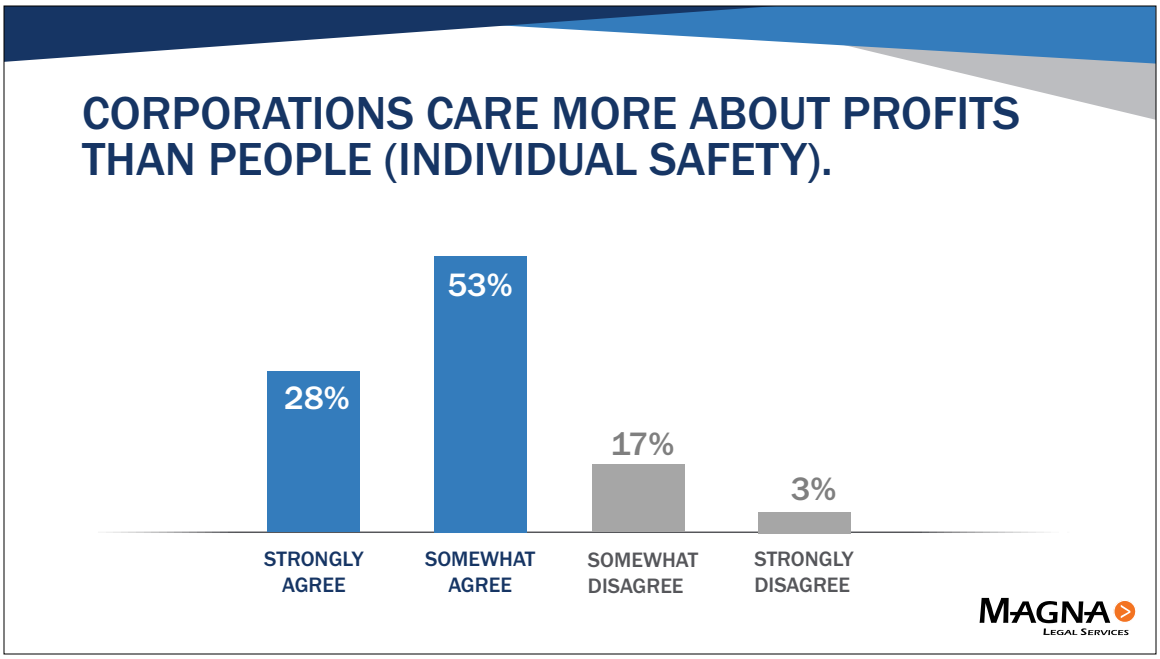
In a recent study published in April 2021, for instance, approximately one third of over 230,000 patients who were diagnosed with COVID-19 had a neurological or psychological diagnosis in the following six months. There was evidence of substantial neurological and psychiatric morbidity in the months after infection. (Taquet M, Geddes J, Husain M, et al. 6-month neurological and psychiatric outcomes in 236 379 survivors of COVID-19: a retrospective cohort study using electronic health records. Lancet Psychiatry 2021, 8:416-27).

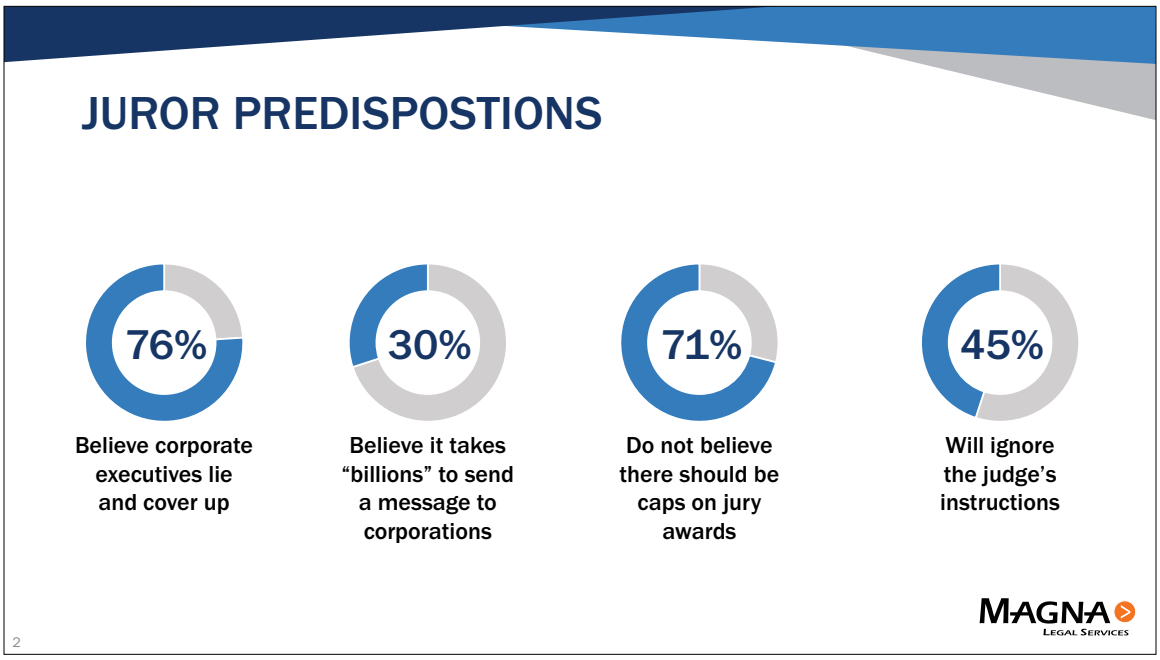
Apart from those who actually suffered with the disease, however, the study does not account for those who did not contract the disease but had family members, friends, and co-workers who did. Some were quarantined in the same household with those who were infected, while others could only communicate with relatives or friends remotely or through hospital staff, awaiting word on whether their mother or father, for example, would ever recover. And many of those same people will be jurors on your next case—or maybe a case two years from now—that you take to trial.

Jury Bias and Predispositions

Combatting jury bias, attitudes, and the cognitive partiality that an individual brings to everyday issues, some of which are the focus of critical issues in a lawsuit, has been the subject of decades of research. Magna Legal Services, a firm with operations across the United States and particular expertise in jury research and litigation consulting, has studied juror predispositions extensively. And this is a topic on which our firm has presented with Magna at seminars as well.

Before COVID-19, for example, Magna's research as part of a recent study in the United States showed that approximately 81% of respondents strongly agree or somewhat agree with the concept that corporations care more about profits than people or individual safety. Likewise, over 75% of those surveyed believe corporate executives lie and cover up, while 30% believe it takes "billions" to send a message to corporations.



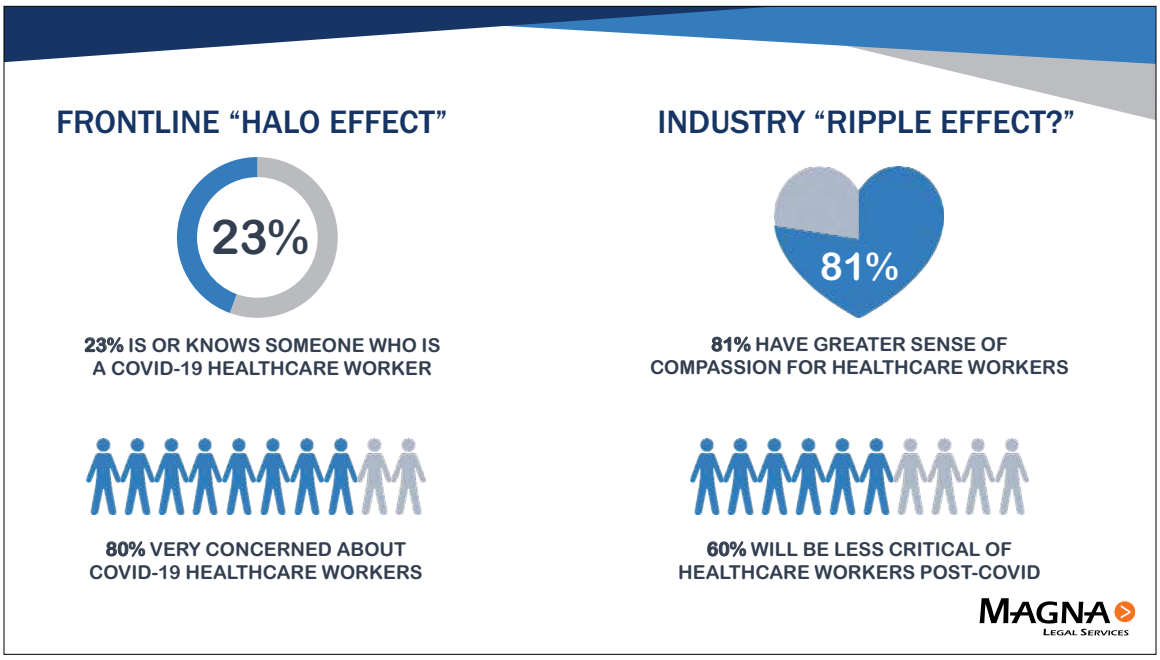


Think for a moment more about this concept when reserves are being established and exposure is being evaluated—almost one-third of those surveyed believed billions, not millions, are required for a company to understand what they purportedly did wrong. From a defense perspective in civil litigation—whether you are defending companies, insurers, or both—those attitudes are often difficult hurdles to overcome. And courts do little to address this bias, making it more important for defense counsel to ensure that it is being combatted from the very moment a claim is presented or litigation is filed.

Halo and Other Effects

Civil litigants have wondered over the past year plus how these predispositions changed, if at all, during and as a result of the COVID-19 pandemic. In 1920, psychologist Edward Thorndike recognized a "halo effect," or a form of cognitive bias where the perception of someone is influenced by opinions of that person's other traits, sometimes as simple as how someone looks or their physical attributes. Often, for example, the order or sequence in which we observe a person's characteristics is critical. In other words, first impressions matter. As one noted psychologist and economist has explained, first impressions are often so important "that subsequent information is mostly wasted." (Daniel Kahneman, Thinking, Fast and Slow, 2011).

In another recent study from Magna on the effect of COVID-19 on potential jurors' predispositions, over 80% of those surveyed had a greater sense of compassion for healthcare workers. Understandably, 80% were very concerned about the healthcare workers who are battling the crisis. And 60% claimed they will be less critical of healthcare workers following the pandemic, exhibiting a potential "halo effect" for those on the front line and potential ripple effect for those in the medical community at large.

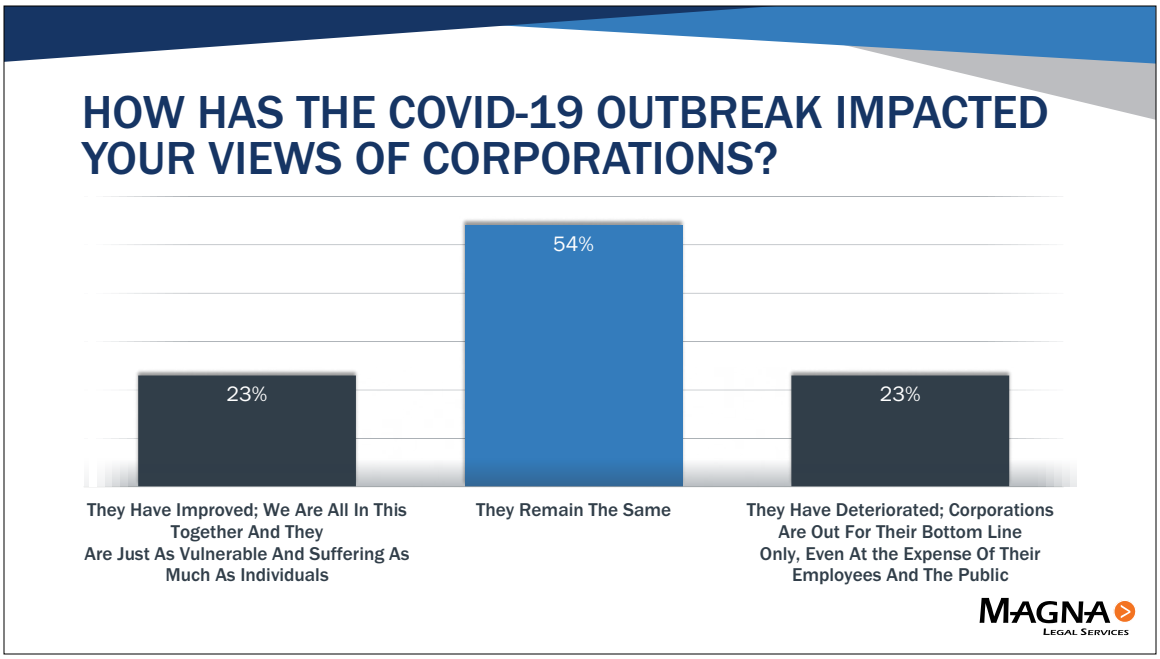


But how far that effect flows is unclear, as well as for how long and to what tangential industries or businesses.

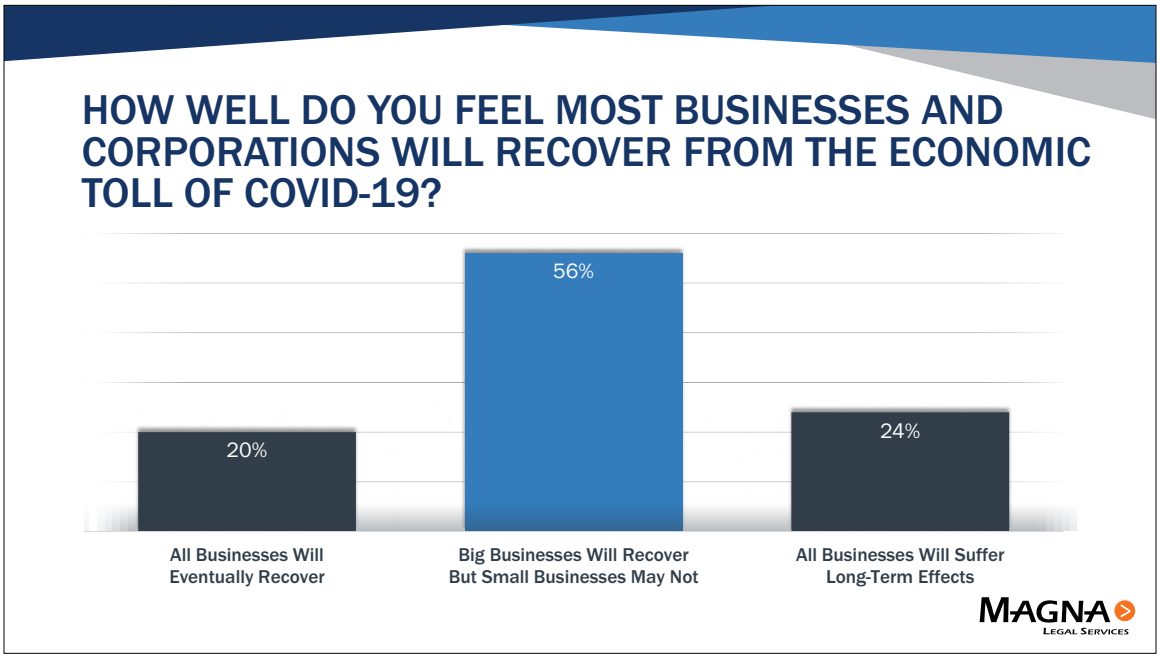
Potential Resurgence of the Reptile Theory

Despite any ripple effect in favor of the medical community, the pandemic has affected the public's perception of corporations. In the same Magna survey, while 54% of respondents had no change in their views of corporations, 23% of the respondents' views of corporations have improved. Why? Because of the sentiments that we are all in this together or because companies are just as vulnerable to the pandemic and suffering as much as individuals.

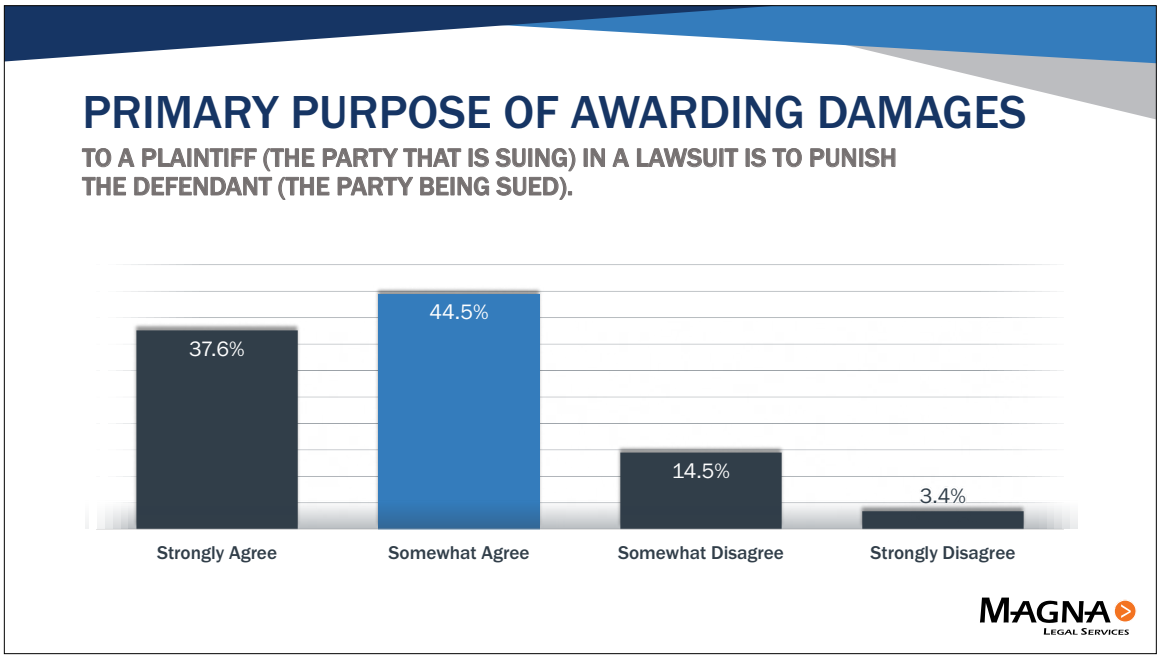
Critically, though, the same percentage (23%) of respondents had a more negative perception of corporations as a result of the pandemic, which according to those surveyed are only out for their bottom line. And we cannot forget that negative perceptions of corporations were already present, in fact rather pervasive, before this pandemic ever began.



Similarly, over 50% of respondents believed that only big businesses will recover from the pandemic while small businesses may not.



This type of data is key to (a) developing the proper theme for the defense of a case in litigation, (b) assessing risk from a claims perspective, and (c) combatting reptilian tactics from the other side. The "reptile theory" or "reptile approach" is where a plaintiff's attorney employs a strategy to call on the primal, survival, or reptilian part of the minds of those on a jury, provoking feelings of danger and fear, and that ruling against the defendant is one way to survive that danger. Often, the focus is on safety or similar rules and how those rules were broken by the defendant, trying to provoke and empower jurors with the power



to eliminate the dangers posed by an allegedly unsafe, callous, and dreadful corporate defendant.

In other words, juries can force corporations to change—whether it's a product, safety rule, or basic bad behavior—by awarding significant damages. That is the scheme and the objective of this tactic, leading to potential nuclear verdicts whose purpose is not only to compensate a plaintiff but also, or even primarily, to punish a defendant, as additional Magna research shows.

During this pandemic, and after, many jurors understandably will have a heightened recognition of their own vulnerabilities and the need/desire to protect their own safety as well as that of their friends and family. Dr. Rachel York Colangelo is the National Managing Director of Jury Consulting for Magna Legal Services. As Dr. Colangelo explains, "Understandably, 52% of those we have surveyed around the country report feeling more vulnerable now than pre-pandemic. People are not only feeling vulnerable with regard to their health and safety, but there is also a great deal of anxiety and hardship related to COVID-adjacent employment and financial concerns, as well as a general feeling of uncertainty about the future."

According to Dr. Colangelo, "This vulnerability leaves potential jurors primed for strategies such as the reptile, which prey on people's innate fears and instinctual responses. A juror who enters the courtroom already feeling vulnerable, fearful, and anxious is more likely to latch onto a plaintiff's theme that this defendant's conduct has not only put this particular plaintiff at risk, but is also potentially putting the broader community—including the juror and his/her loved ones—in harm's way. This fear quickly turns to anger and a desire to lash out at and punish a corporate defendant. Jurors recognize that their only power—the only manner through which they can get a company's attention and motivate change within the corporation—is by hitting the defendant where it hurts the most: the bank account, resulting in very large damages awards. Thus, vulnerable jurors often become reptilian or punitive jurors, who are the driving forces behind the nuclear verdicts we are seeing more and more of around the country."

In Search of a Vaccine for the Defense

As the Louisiana Supreme Court explained in its guide to reopening and resuming jury trials, "[p]lexi-glass barriers inside the courtroom can offer another layer of protection but do not eliminate the risk of infection." At the time of this writing, however, there is a resurgence of COVID-19 throughout Louisiana and other states, placing jury trials again in doubt for the foreseeable future and further impacting the mindset of those living through this nightmare.

Yet, there is no guidance being issued for courts to assist in selecting a jury in this current environment or to address how the pandemic may affect jury attitudes. There is no guide for assessing jury bias or ensuring

juror predispositions do not adversely affect the outcome of a case during or following this pandemic. There is no guide for assessing risk or setting reserves from a claims perspective either. And there will be no attempt by the plaintiff bar to suddenly retreat from reptile theory tactics in litigation when this pandemic ends.

Instead, from a litigation perspective in the United States, our firm and other litigation firms are seeing these tactics used repeatedly and routinely in most cases, from minor car accidents to more catastrophic injuries and other litigation. And the more recent data is showing a trend back to pre-pandemic jury attitudes against corporations, according to Dr. Colangelo. "The anti-corporate and reptilian/punitive juror trends we have observed for many years pre-pandemic seemed to plateau temporarily during the pandemic, in part due to halo effects benefiting certain industries such as healthcare and trucking, and also due to the effect COVID-19 had on the unwillingness of typically plaintiff-friendly jurors to serve. However, as the country has mostly reopened—at least for now—and people become more comfortable returning to public life, including serving on juries, my colleagues and I expect that the trend of increasing numbers of nuclear verdicts will unfortunately pick up where it left off pre-pandemic."

There will be no sudden cure or vaccine for this type of litigation tactic and approach. So, what should claims professionals and defense attorneys do? First, waiting to address it in a pre-trial report or conference 30 or 60 days before trial is too late. Second, merely attempting to ensure that proper jury instructions on bias are given or potential jurors are vetted during voir dire is too little. Here's an initial approach for doing so:

1. Training Claims Professionals and Counsel. Most claims professionals have not sat through depositions or hearings and trust that their attorneys—panel counsel, for example—know how to effectively navigate bias and reptilian tactics. But these are complex issues involving cognitive bias and psychological tendencies for which claims professionals and attorneys receive little training. That should end now, with training on these issues being a required component of professional development for those handling litigation.

2. Assessing the Venue and Risk for this Particular Case. Some will say, of course, that "we always do this." Unfortunately, you probably don't. Instead, you often see a generic question raised about the venue of the case or the judge to whom the case is allotted and receive a generic response in return that the venue or judge is liberal, moderate, or conservative. But these should be more than merely standard and non-specific questions and replies, and deserve a more considered analysis tailored to the particular issues and allegations of the case at hand.

3. Reporting by Defense Counsel on Bias and Reptile Tactics. To focus and raise awareness, potential bias and reptile or inflammatory tactics are issues that should be requirements for reporting internally and reporting by defense counsel in any initial report and ongoing assessments as the facts of the case are developed.

4. Developing the Proper Themes and Storyline to Combat Bias or Tactics. What is our storyline, and what are our themes in this case? What is the concept that we are attempting to weave into every aspect of this case? If a claims professional or defense counsel cannot answer these questions, then you are likely playing catch up no matter what stage your case is in at this time. The tactic being employed or potential theme from the other side need to be pinpointed so a proper counternarrative can be deployed, developed, and fine-tuned throughout the case.

5. Playing Offense, not Defense, during Depositions and Discovery. So often this begins and ends with witness preparation. As someone who has conducted hundreds of depositions, the lack of preparation of corporate, fact, and expert witnesses by other parties—and the defensive mindset that is often utilized—are astonishing at times. Ensuring that witnesses testify truthfully, while properly responding to the questions and tactics that are often employed by opposing counsel, is critical. And it is something for which so many are too frequently unprepared.

There may not be a guide that any court is going to offer or any simple cure to counter the effects of post-COVID jury perceptions, attitudes, and anti-corporate bias. But there should be a guide—a specific plan and approach—that we are using to assess risk and potential bias, and to combat the tactics for which so many claims professionals and counsel are unprepared. And as we grapple with a resurgence of COVID-19 and variants of the disease, or the fallout from the same months or years from now, we need to recognize that any pandemic halo effect for certain industry sectors and specific corporate defendants is likely short-lived, as the trends and data may be showing already.

About the Author

Timothy W. Hassinger is the Managing Director of the Mandeville, Louisiana office of Galloway, Johnson, Tompkins, Burr & Smith, a litigation firm with over 100 attorneys in multiple states across the Gulf South. He can be reached at thassinger@gallowaylawfirm.com or 985-674-6680.

2021 VIRTUAL EVENTS

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SAVE THE DATES

November 18, 2021

IACP New York Conference

The Dream Hotel, Downtown New York, USA

April 4 - 5, 2022

IACP European Conference

The Fairmont, St. Andrews, Scotland

September 18 - 21, 2022

IACP Annual Conference

New Location to be Announced Soon!

September 10 - 13, 2023

IACP Annual Conference

The Ritz-Carlton Reynolds,
Lake Oconee, Greensboro, Georgia, USA

September 29 - October 2, 2024

The Fairmont Southampton, Bermuda

INTERNATIONAL ASSOCIATION OF CLAIM PROFESSIONALS

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The Dream New York | Downtown New York City

November 18, 2021






Registration is now open!

Register & Sponsor on-line at **www.iaclpro.org**

Registration fee includes breakfast, lunch, breaks and cocktail reception

Members USD **$395** ; Non-Member USD **$595**

Student Rate **$95**

Final Keynote & Cocktail Reception Only:
$125 members; **$150** non-member

Conference Details:

Registration & Continental Breakfast: 8:00am

Opening remarks: 8:55am

Networking Luncheon: 12:15pm

Cocktail Reception: 5:00pm - 7:00pm
The Electric Room, Dream Downtown Hotel

Dress Code: Business Casual

KEYNOTE SPEAKER

Joe Cellura

President North America Casualty, Allied World

CLOSING SPEAKER

Jim D'Onofrio

Executive Vice President & General Manager, Liberty Mutual Re

SPEAKERS

School Shootings – Maze of Liability Complexity

David S. Henry Esq.
Kelley Kronenberg

Gun Lobby - "Will Third-Party Liability for Shootings Break Through?"

Walter Olson
Senior Fellow - Robert A. Levy Center for Constitutional Studies at the Cato Institute

The COVID-19 Claims and Litigation Experience: A View from New York

Laura Alfredo
General Counsel, NY Greater Hospital Group

Janette Baxter, RN
Corporate Risk Manager, NYC Health + Hospitals

Suzanne S. Blundi, Esq.
Vice President of Claims, MCIC Vermont, LLC

Employment Practices: Issues in the Post-COVID Era

Japhet Boutin
VP Director Financial Lines Claims, Zurich North America

Data Science – What's it Got To Do With Text Messages and Customer Sentiment?

Bernard Ong
Advanced Analytics and Customer Insights Director, AFICS

Ujjval Patel
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Nuclear Verdicts & the Techniques Plaintiff Attorneys Rely On

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