PROGRAM DETAILS AND HANDOUTS

Day 1 - Sunday, October 18th | 5:00 - 8:00 PM

Museum of Science & Technology (MOST) - from 5:00-6:00 PM tour the museum and view exhibita. From 6:00-8:00 PM assemble for a networking reception. This is a nice opportunity to meet guest speakers, sponsors, and attendees ahead of the conference.

Day 2 - Monday, October 19th | 8:00 AM - 4:00 PM (breakfast begins at 7:00 AM

Marriott Downtown Syracuse - A full-day conference featuring special Keynote Speaker, Senator Christopher J. Ryan and special appearance by Katie DeFresne, President of ASHRM. The program includes dynamic breakout sessions led by distinguished industry professionals, along with dedicated exhibitor and sponsor table displays throughout the venue.

Handouts provided in this packet are shown in blue font. Handouts not included may be requested after the conference.

- **Program Flyer**
- **Registration List**
- 8:30 AM - KEYNOTE ADDRESS - Senator Christopher J. Ryan
- 9:45 AM - A Blueprint for Proactive Risk Management and Optimized Resource Allocation
  - Lora Giacomoni and Christine Keenan
- **9:45 AM - Nuclear Deterrence Panel: Mitigating the Risk of Excessive Verdicts**
  - William Melchior, Shelly Kriete, Marc Craw, John Neuburger, and Charles Patton
- **11:00 AM - Healing the Healers: A Risk Management Approach to Second Victims**
  - Mario Giannettino and Andrea Crawford
- **11:00 AM - Mitigation of Future Economic Damages in Catastrophic Injury Cases Part II**
  - Samantha Quinn and Stephanie Campbell
- **1:00 PM - ASHRM Updates - Katie DuFresne**
- 1:45 PM - Aligning Communication & Disclosure: Turning Training into System-Wide Practice
  - Kathleen Shostek and Douglas Shaw
- 1:45 PM - Working with Vendors and Indemnity Clauses in Litigation
  - Anna Berent, Jennifer Yuen, and Lisa Gibbons
- 3:00 PM - Balancing AI Efficiency, Practitioner Judgment, and Liability in Healthcare
  - Jennifer Puglisi and Kamrin Kucera
- 3:00 PM - Beyond the Application: Positing Your Organization for Success in Today's Insurance Market
  - Julio Martinez, William McDonough, Laura Moran, Gina Leddy, Janell Forget

Continuing Education Credits:

The program has been approved for 5.0 Risk Management credits by the American Society for Health Care Risk Management (ASHRM). Certificates will be emailed to attendees within two weeks after the event.

This program is also under review by the New York State Continuing Legal Education (CLE) Board. Upon approval, CLE certificates will be distributed to all attending attorneys.

AHRMNY

The Association for Healthcare Risk Management of New York, Inc.

AHRMNY AND OUR SPONSORS PRESENTS

2026 Upstate New York Educational Conference

Marriott Syracuse Downtown Hotel

Monday, October 19th
8:00 am - 4:00 pm





KEYNOTE SPEAKER

NEW YORK STATE SENATOR

Christopher J. Ryan

Chair, Senate Cities 2 Committee

(D) 50TH Senate District

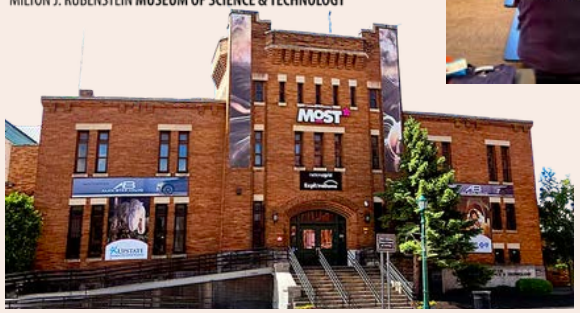
CLICK HERE FOR FULL PROGRAM FLYER AND REGISTRATION

AHRMNY invites you to join us in Syracuse for our Upstate New York Educational Conference & Reception at the Downtown Marriott Hotel on **Monday, October 19th**. This annual event brings the risk management community together to exchange knowledge, strengthen skills, and engage in meaningful connections.

To kick off the conference, AHRMNY is hosting a networking reception on **Sunday, October 18th from 5:00–8:00 PM** at the Museum of Science and Technology. Conference attendees are invited to explore the museum, enjoy the exhibits, and then connect with colleagues, meet sponsors and speakers, and set the tone for a productive program. Museum entry is complimentary and included with your conference registration fee.

MOST

MILTON J. RUBENSTEIN MUSEUM OF SCIENCE & TECHNOLOGY









Special Thanks to Our Sponsors

AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

2026 Upstate New York Conference

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TDC GROUP

LG&T
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Conference and Registration Details

SUNDAY, OCTOBER 18

5:00 PM - 8:00 PM **NETWORKING COCKTAIL RECEPTION**

Visit the Milton J. Rubenstein Museum of Science & Technology (MOST) and explore exhibits from 5:00-6:00 pm. Afterwards, attendees will gather together for a networking reception where lite bites and beverages will be served. The museum is located at 500 South Franklin Street, Syracuse, New York, about an 8-minute walk from the Downtown Marriott Hotel. Free street parking and paid garage parking is available. Additional details will be provided in the registration confirmation email.



MONDAY, OCTOBER 19

7:00 AM - 4:00 PM **EDUCATIONAL PROGRAM**

Hosted at the Marriott Syracuse Downtown Hotel. Attendees will enjoy a full day educational program starting off with breakfast, keynote address, and morning breakout sessions.

Enjoy a delightful lunch break. Network and catchup with colleagues and visits to sponsor and exhibitor tables.

Round out the afternoon with ASHRM updates and additional breakout sessions.

REGISTRATION & LODGING

TICKET FEES (includes networking reception at the Museum of Science & Technology on Oct 18th)

$150 Current AHRMNY Member

$200 Nonmember

$175 Membership/Conference Bundle - Unlock More Than Just a Seat—Join and Save!

Nonmember attendees may wish to sign up for a one-year membership today and enjoy an exclusive discount on conference registration fee. It's the perfect way to get the most value for your investment.

LODGING - The host hotel, Marriott Syracuse Downtown, is offering a discounted room rate on October 18th for $189 (not including taxes and fees) through **September 25th**. After this date, the regular daily rate will apply. After registering for the conference you will receive instructions to reserve lodging.

Read about AHRMNY's Financial Aid Policy Here

CONTINUING EDUCATION CREDITS

This program is being submitted to the American Society for Health Care Risk Management (ASHRM) and the New York State Continuing Legal Education Board for review. Continuing education and legal credits are currently pending approval from these accrediting organizations.

Guest Speakers

KEYNOTE SPEAKER



CHRISTOPHER J. RYAN

New York State Sentaor
(D) 50th Senate District



LORA GIACOMONI

RN, MSN, F-AB
Vice President, Ambulatory Quality
Northwell Health



CHRISTINE KEENAN

MS, PA-C, CPHRM
Director, Clinical Risk Management
Northwell Health Nuvance Market



WILLIAM MELCHIOR

Vice President, Marketing and Company Relations
MLMIC Insurance Company



SHELLY KRIETE

Sr. Risk Management Consultant
MLMIC Insurance Company



MARC CRAW

Esq., Senior Director of Government Affairs
MLMIC Insurance Company



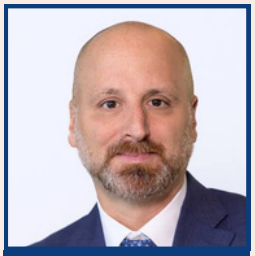
JOHN NEUBURGER

Vice President of Claims
MLMIC Insurance Company



CHARLES PATTON

Esq., Managing Partner
Martin, Ganotis, Brown, Mould, and Currie



MARIO GIANNETTINO

Esq, CPHRM
Partner
Kaufman Borgeest & Ryan



ANDREA CRAWFORD

Esq, CPHRM
Consultant
MMC Risk Consultants LLC



STEPHANIE CAMPBELL

Esq., Partner
Schiavetti Corgan DiEdwards Weinberg & Nicholson



SAMANTHA E. QUINN

Esq., Partner
Schiavetti Corgan DiEdwards Weinberg & Nicholson



KATHLEEN SHOSTEK

RN, ARM, MBA, DFASHRM, CPHRM, CPPS
Risk Management & Patient Safety Professional/Consultant



DOUGLAS SHAW

Esq., Vice President
Risk Management and Insurance
RWJ/Barnabas Health



ANNA BERENT

Assistant Vice President
Allied Healthcare Claims
Hiscox USA



JENNIFER YUEN

Esq., Partner
Lewis Brisbois Bisgaard & Smith



LISA GIBBONS

Esq., MA, Regional Vice President, Risk Management
Westchester Medical Center



JENNIFER PUGLISI

Esq., Partner
Kaufman Borgeest & Ryan



KAMRIN KUCERA

MJHL-CC, BSN, BA, RN, CPHRM
Director, Risk Management
SUNY Upstate University Hospital



JULIO MARTINEZ

CPCU, AU-M, AU
Vice President, Sales Executive
Marsh



WILLIAM MCDONOUGH

MPAH, ARM, PhD, FASHRM
Managing Director
Marsh



LAURA MORAN

MBA, Senior Vice President
Analytics Client Engagement Leader
Marsh



GINA LEDDY

CPCU, RPLU
Vice President
SOMPO, Us Healthcare



JANELL FORGET

RN, BSN, JD, CPHRM, DFASHRM
Asst Vice President, Risk Management
UMass Memorial Health

Learn more about our distinguished guest speakers Read their bios here

PROGRAM AGENDA



7:00 AM - 8:00 AM **Registration and Networking Breakfast**



8:00 AM - 8:30 AM **Welcome, Announcements, Sponsor Introductions**

- **Stephanie Campbell, AHRMNY President**

KEYNOTE ADDRESS

8:30 AM - 9:30 AM

- **KEYNOTE SPEAKER: Christopher J. Ryan, New York State Senator**

Senator Ryan is a dedicated public servant representing New York's 50th Senate District, which includes parts of Onondaga and Oswego counties. He proudly serves as chair of the Cities 2 Committee and is a member of the committees on Agriculture; Health; Commerce; Economic Development and Small Business; Energy and Telecommunications; Labor and Consumer Protection. Senator Ryan will discuss recent and pending legislation pertinent to the provision of healthcare and medical professional liability in New York State.

BREAK & TRANSITION TO BREAKOUT SESSIONS #1

9:30 AM - 9:45 AM

BREAKOUT SESSIONS #1

9:45 AM - 10:45 AM

1A) A Blueprint for Proactive Risk Management and Optimized Resource Allocation

- **Lora Giacomoni and Christine Keenan**

Northwell Health is shifting ambulatory oversight from reactive problem-solving to a proactive, data-driven risk model. Using the Ambulatory Practice Clinical Profile (APCP) Framework, 800+ practices were objectively stratified to identify elevated-risk sites and target quality improvement. Attendees will learn a practical, scalable approach for strengthening outcomes, reducing liability, and improving performance across diverse outpatient settings.

1B) Nuclear Deterrence Panel: Mitigating the Risk of Excessive Verdicts

- **William Melchior (Moderator), Shelly Kriete, Marc Craw, John Neuburger, and Charles Patton**

Healthcare providers are increasingly facing nuclear verdicts across all specialties, driven by social inflation, shifting juror attitudes, and aggressive plaintiff strategies. These catastrophic awards can significantly impact operations and patient access to care. This panel of experts will review data on excessive verdicts, examine their impact on New York providers, and share practical strategies to reduce organizational exposure.

BREAK & TRANSITION TO BREAKOUT SESSIONS #2

10:45 AM - 11:00AM

BREAKOUT SEESIONS #2

11:00 AM - 12:00 PM

2A) Healing the Healers: A Risk Management Approach to Second Victims

- **Mario Giannettino and Andrea Crawford**

Adverse events affect not only patients and families but also the clinicians involved. These "second victims" may experience acute distress, self-doubt, burnout, and long-term psychological impact. This session highlights risk-management strategies, early-identification approaches, and structured, compassionate support models that strengthen safety culture and workforce resilience.

2B) Mitigation of Future Economic Damages in Catastrophic Injury Cases Part II: The Collateral Source Hearing

- **Samantha E. Quinn and Stephanie Campbell**

Future care costs represent one of the largest components of damages in serious injury cases. Plaintiff life-care plans frequently rely on flawed life-expectancy projections and inflated cost estimates which disregard available insurance coverage, including Medicaid and Medicare. Building on the discussion from 2024 of challenging these plans pre-trial, this session shifts to strategies for reducing damages in a post-trial collateral source hearing. Presenters will review a recent hearing, outline key preparation steps, and highlight practical approaches to facilitate limiting exposure and supporting reasonable case resolution.

PROGRAM AGENDA (continued)

LUNCH BREAK
VISIT SPONSOR & EXHITOR TABLES

12:00 PM - 1:00 PM



1:00 PM - 1:30 PM
ASHRM Updates and other Announcements
- **Katie DuFresne, ASHRM President**

BREAK & TRANSITION TO BREAKOUT SESSIONS #3

1:30 PM - 1:45 PM

BREAKOUT SEESIONS #3

1:45 PM - 2:45 PM

3A) Aligning Communication & Disclosure: Turning Training into System-Wide Practice
- **Kathleen Shostek and Douglas Shaw**

The CMS Patient Safety Structural Measures require hospitals to demonstrate consistent prioritization of safety, including an effective Communication and Resolution Program (CRP) with transparent communication after adverse events. RWJBarnabas Health developed a systemwide approach to align disclosure practice, support compliance, and strengthen readiness for positive attestation. This session outlines RWJBH's pathway from policy to reliable practice—covering assessment, compassionate disclosure training, CRP activation, train-the-trainer implementation, and facilitator tools for local leaders—supported by case-based learning and post-training results.

3B) Our Relationship is Tender: Working with Vendors and Indemnity Clauses in Litigation
- **Anna Berent, Jennifer Yuen, and Lisa Gibbons**

Hospital systems rely on numerous vendors—from food services to clinical groups—making contract clarity essential when litigation arises. This session outlines best practices for reviewing vendor agreements, understanding when and how to tender, and weighing the pros and cons of tendering or impleading. Speakers will also highlight effective internal communication strategies and how to identify the right organizational partners to help navigate vendor relationships during complex claims.

BREAK & TRANSITION TO BREAKOUT SESSIONS #4

2:45 PM - 3:00 PM

BREAKOUT SEESIONS #4

3:00 PM - 4:00 PM

4A) Balancing AI Efficiency, Practitioner Judgment, and Liability in Healthcare
- **Jennifer Puglisi and Kamrin Kucera**

Artificial intelligence is rapidly expanding in healthcare, improving diagnostic accuracy, documentation, and access to care. Yet its success depends on accuracy, appropriate use, and the continued judgment of clinicians who remain accountable for outcomes. This session highlights how an Upstate NY health system is applying AI to address financial, workforce, and geographic challenges while underscoring the irreplaceable role of practitioner oversight in both patient care and legal risk.

4B) Beyond the Application: Positioning Your Organization for Success in Today's Insurance Market
- **Julio Martinez, William McDonough, Laura Moran, Gina Leddy, and Janell Forget**

Healthcare organizations face a challenging insurance market. A strong narrative—supported by clear data on safety, quality, loss prevention, cybersecurity, and workforce protection—helps influence underwriting, improve pricing and coverage, and strengthen long-term resilience. Presenters will walk attendees through the essential elements of a strong renewal submission, demonstrate how risk initiatives and data analytics influence underwriting decisions, and share practical strategies for strengthening collaboration with brokers and underwriters during the renewal process.

WRAP UP
END OF CONFERENCE

4:00 PM - 4:15 PM

First Name	Last Name	Title	Company
Mark	Ambrose	Senior Risk Management Consultant	MLMIC Insurance Company
Pascal	Babmatee	Claims Analyst	Catholic Health
John	Barous	Partner	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Katrine	Beck	Partner	Fullerton Beck
Eileen	Becker	Partner	Fullerton Beck
Melissa	Bedward	Clinical Risk Manager	Mercy Health-Catholic Health
Irini	Bekhit	Director of Panel Relations	NAM (National Arbitration and Mediation)
Jeffrey	Benjamin	Claims Supervisor	EmPRO Insurance
Anna	Berent	Consultant	Berent Claims Strategies
Hali	Buckley	Partner	Brown Gruttadaro & Prato
Stephanie	Campbell	Partner	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Molly	Casey	Partner	O'Connor O'Connor Bresee & First
Daniel	Corcoran	Founder & CEO	SafeQual
Marc	Craw	Sr. Director, Government Affairs	MLMIC Insurance Company
Andrea	Crawford	Consultant	MMC Risk Consultants LLC
Libby	Cruz	Clinical Risk Manager	Centralus Health
Marie	Danek	Partner	Phelan Phelan & Danek
Laura	Del Vecchio	Partner	Heidell Pittoni Murphy & Bach
Anthony	DellaCroce	SVP, Healthcare Practice	HUB International
Michelle	Dolaway	Risk Management Specialist	United Health Services
Katie	DuFresne	President	ASHRM
Julie	Dumas	Risk Management & Patient Safety Professional	SUNY Upstate Medical University
Melissa	Dziak	Partner	Lucosky Brookman
Ashley	Egnoto	Risk Manager	SUNY Upstate Medical University
Lacie	Eldred	Risk Management Nurse Manager	Upstate University Medical Associates at Syracuse Inc.
Tanya	Enigk	VP, Chief Compliance Officer/Risk Management	Mohawk Valley Health System
Jonathan	Erman	Partner	Amabile & Erman
Alexia	Esposito	Risk Management Assistant	SUNY Upstate Medical University
Erica	Fordham	Underwriting Account Manager	EmPRO Insurance
Janell	Forget	AVP Risk Management	UMASS Memorial Health
Eileen	Fullerton	Managing Partner	Fullerton Beck
Mark	Gallo	Business Development Manager	Taylor Healthcare
Lora	Giacomoni	Vice President, Ambulatory Quality	Northwell Health
Mario	Giannettino	Partner	Kaufman Borgeest & Ryan
Lisa	Gibbons	Regional Vice President, Risk Management	Westchester Medical Center
Lesli	Giglio	SVP, Chief Risk Officer / Chief Privacy Officer	Catholic Health
Glen	Gilman	Business Development Manager	Taylor Healthcare
Jeffrey	Gralnick	Partner	Rubin Paterniti Gonzalez Rizzo Kaufman
Tom	Gray	SVP, Risk Management	MLMIC Insurance Company
Dennis	Gruttadaro	Member	Brown Gruttadaro & Prato
Esha	Gupta	Director of Claims	One Brooklyn Health
Courtney	Haskins	Partner	McPhillips Fitzgerald & Cullum
Brandilyne	Husenitza	Chief Compliance, Risk & Privacy Officer	Oneida Healthcare
Baird	Joslin	Managing Partner	O'Connor O'Connor Bresee & First
William	Kalish	Partner	Brown Gruttadaro & Prato
Christine	Keenan	Director, Clinical Risk Management	Northwell Health-Nuvance
Gina	Kittek	System Director, Risk Management	United Health Services
Jennifer	Kozlowski	Senior Clinical Quality Coordinator	SUNY Upstate Medical University
Shelly	Kriete	Sr. Risk Management Consultant	MLMIC Insurance Company
Kamrin	Kucera	Director of Risk Management	SUNY Upstate Medical Hospital
Matthew	Lamb	AVP, Risk Management	MLMIC Insurance Company
Meredith	Lander	Senior Associate	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Gina	Leddy	Vice President	Sompo
Dawn	Lewis	SVP, Business Development & Corp Communication	EmPRO Insurance
Steve	Lubinsky	SVP & Segment Lead, Hospital & Health Systems Underwriting	TDC Specialty
Besmir	Martinaj	Attorney	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Julio	Martinez	Vice President, Sales Executive	Marsh
Joyce	McCormack	Sr. Risk Management Consultant	MLMIC Insurance Company
William	McDonough	Managing Director	Marsh
Colleen	McGill	Risk Manager	SUNY Upstate Medical University
Matthew	McNamara	Partner	Heidell Pittoni Murphy & Bach
William	Melchior	Vice President, Marketing & Company Relations	MLMIC Insurance Company

First Name	Last Name	Title	Company
Tracy	Melina	AVP	Nuvance Health-Northwell
Julie	Mickiewicz	Partner	Fullerton Beck
Deanna	Mirro-Altmann	Risk Management Consultant	MLMIC Insurance Company
Jad Bou	Monsef, MD	Spine Surgeon, Asst Professor, Orthopaedic Surgery	SUNY Downstate, Maimonides
Michele	Monserrate	Partner	O'Connor O'Connor Bresee & First
Laura	Moran	SVP, Analytics Client Engagement Leader	Marsh
John	Neuburger	Vice President of Claims	MLMIC Insurance Company
Wilhemina	Nyarko	AVP, Risk Management & Associate General Counsel	The Brooklyn Hospital Center
Lori	Paine	VP, Patient Safety Officer	Rochester Regional Health
Charles	Patton	Attorney	Martin Ganotis Brown Mould and Currie
Duane	Perricelli	SVP	The Doctors Company, TDC Specialty
Carol	Poles	Partner	O'Connor O'Connor Bresee & First
Rebecca	Priest	Director of Clinical Risk Management	Rochester Regional Health
Jennifer	Puglisi	Partner	Kaufman Borgeest & Ryan
Christine	Quinn	Vice President & Chief Risk Officer	EmPRO Insurance
Samantha	Quinn	Partner	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Peter	Reilly	North American Healthcare Practice Leader	HUB International
Jonathan	Rubin	Partner	Kaufman Borgeest & Ryan
Michelle	Rusaw	Compliance Officer	Clifton-Fine Hospital
Christopher J.	Ryan	New York State Senator	50th Senate District
Jamie	Schenk-Allyn	AVP, Claims Counsel	Sompo
Douglas	Shaw	Vice President, Risk Management & Insurance	RWJ/Barnabas Health
Jennifer	Shippee	Litigation & Claims Specialist	Rochester Regional Health
Kathleen	Shostek	Consultant	Risk Management & Patient Safety Professional
Alexander	Sikoscow	Partner	Kaufman Borgeest & Ryan
Taylor	Sims	RN	SUNY Upstate Medical University
Jeffrey	Sirard	Clinical Risk Analyst	Saint Joseph's Hospital
Michelle Paltrowitz	Thweatt	Director of Risk Management	Bassett Healthcare Network
Henry	Tilson	Attorney	Kaufman Borgeest & Ryan
Marco	Tomakin	Senior Compliance Officer	Albany Medical Center
Lynn	Trentini	Business Insurance Account Executive	OneGroup
Suhlail	Villa	Partner	Schiavetti Corgan DiEdwards Weinberg & Nicholson
Katrina	Vollmer	Partner	Phelan Phelan & Danek
Erin	Weaver	Claims Supervisor	EmPRO Insurance
Claudine	Weis	Attorney	Wilson Bave Conboy Cozza & Couzens
Tiffany	Wickes-DeMillio	AVP, Safety and High Reliability	Catholic Health
Taylor	Wilcox	Manager, Risk Management	Samaritan Medical Center
Natalia	Williamson	VP, Sales	Electronic Paralegal
Bob	Worden	Hearing Officer	NAM (National Arbitration and Mediation)
Jennifer	Yuen	Partner	Lewis Brisbois Bisgaard & Smith
Brittany	Zoeckler	Senior Risk Quality Investigator	SUNY Upstate Medical University

This list contains only attendees who opted in. Others are attending but not listed.

Nuclear Deterrence: Mitigating the Risk of Excessive Verdicts



Moderator:

Bill Melchior, MLMIC VP Marketing & Customer Relations

Panelists:

Shelly Kriete, CPHQ, CPHRM - MLMIC Senior Risk Management Consultant

Marc Craw, Esq. – MLMIC Senior Director of Government Affairs

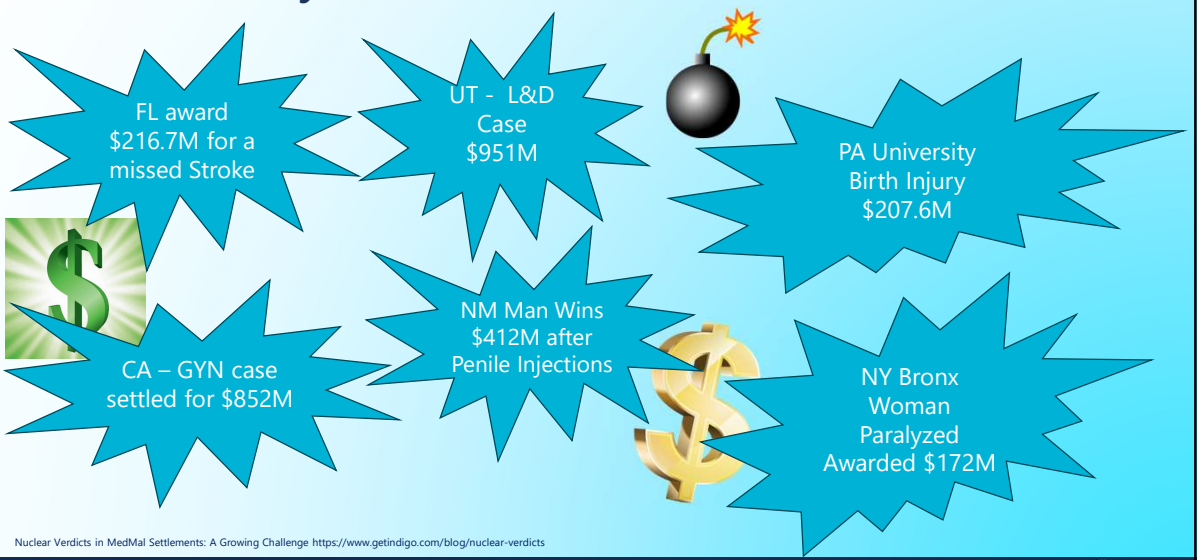
John Neuburger – MLMIC VP of Claims

Chuck Patton, Esq. – Martin, Ganotis, Brown, Mould & Currie, P.C.

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

1

The number of nuclear verdicts in the US increased by 52% between 2023 and 2024



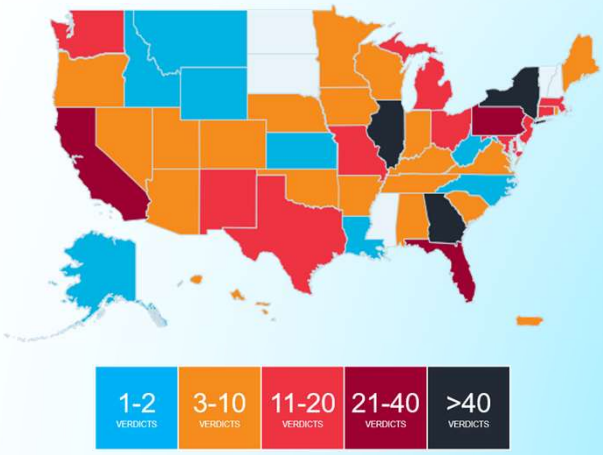
Nuclear Verdicts in MedMal Settlements: A Growing Challenge https://www.getindigo.com/blog/nuclear-verdicts

MLMIC

2

The Value of Risk Management

Increasing Shock Verdicts and Social Inflation Nationwide



New York > $10M

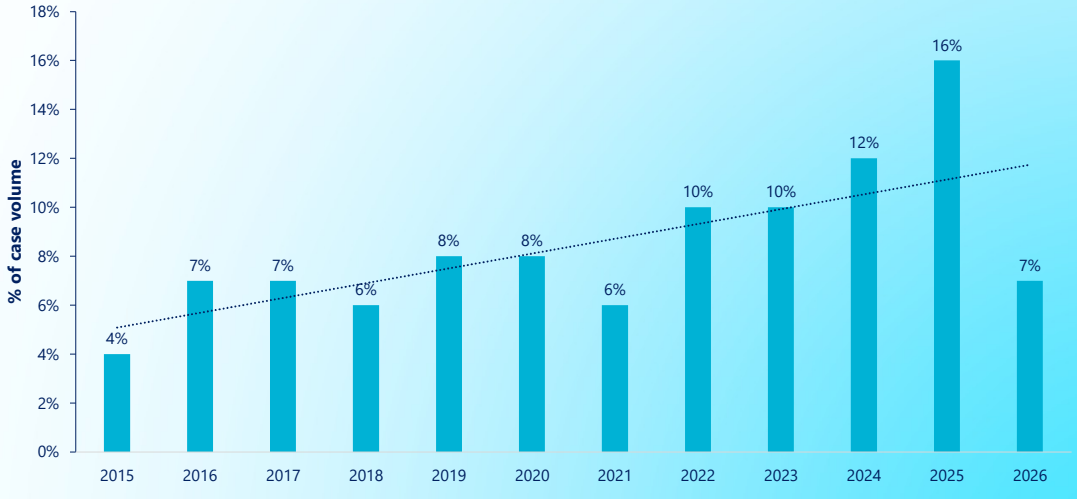
Neurology, Hospital	$120
Unknown, Hospital	$111
Obstetrics, Hospital	$94
Obstetrics, Hospital	$80
Obstetrics, Hospital	$79
Pain Medicine	$60
Neurosurgery, Hospital	$56
Obstetrics, Hospital	$50
Obstetrics, Hospital	$48
Unknown, Hospital	$41
Emergency Medicine, Neurosurgery, Hospital	$40
Obstetrics	$35
Obstetrics, Hospital	$35
Orthopedic Surgery, Hospital	$29
Obstetrics, Hospital	$29
Emergency Medicine, Hospital	$28
Obstetrics, Hospital	$26
Nursing, Hospital	$23
Unknown	$23
Pediatrics	$22
Unknown, Hospital	$21
Unknown	$21
Neurosurgery, Hospital	$21
Unknown, Hospital	$20
Vascular Surgery, Radiology	$20
Emergency Medicine, Hospital	$18
General Surgery, Hospital	$18
Obstetrics, Hospital	$18
Obstetrics, Hospital	$16
Emergency Medicine, Hospital	$15
Obstetrics, Hospital	$15
Oncologist	$15
Unknown, Hospital	$15
Emergency Medicine, PA, Hospital	$14
General Surgery, Hospital	$13
Colorectal Surgery, Hospital	$13
Anesthesiology	$13
Radiology, Hospital	$12
Internal Medicine, Hospital	$11
Infectious Disease, Hospital	$11
Physical Medicine & Rehabilitation, Hospital	$10
Neurosurgery	$10
Senior Care	$10
Vascular Surgery, Hospital	$10
Gynecology, Hospital	$10
Family Medicine, Hospital	$10

Sources: Chart: Trans Re and various internet articles with publication dates between 01/01/2014 and 09/11/2026.

3 MLMIC

3

Cases by case closed year

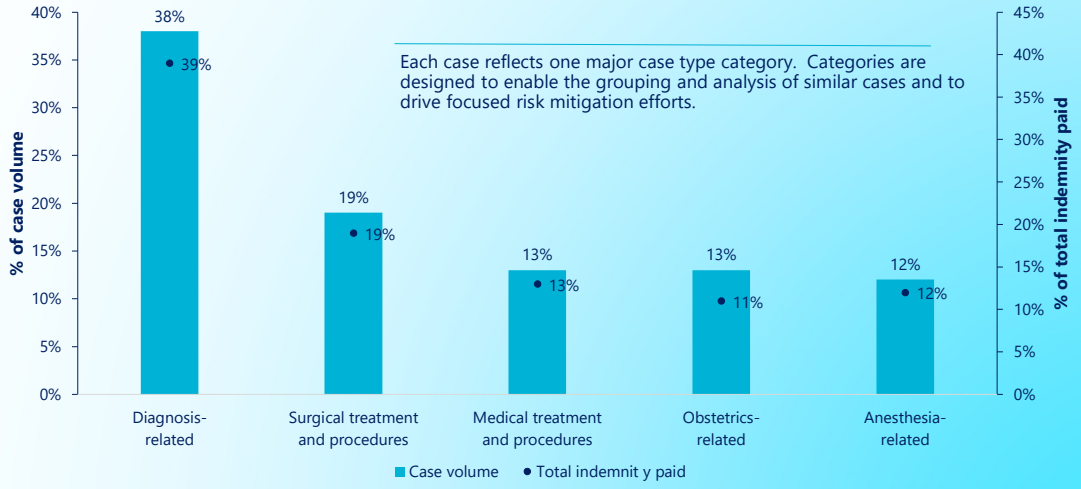


MLMIC & MedPro Group closed cases 2015-2026 with indemnity paid >/=$2M, n= 382

4 MLMIC

4

Primary case type categories and financial severity



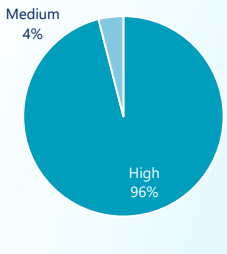
MLMIC & MedPro Group closed cases 2015-2026 with indemnity paid >/=$2M, n= 382

5

Injury severity*

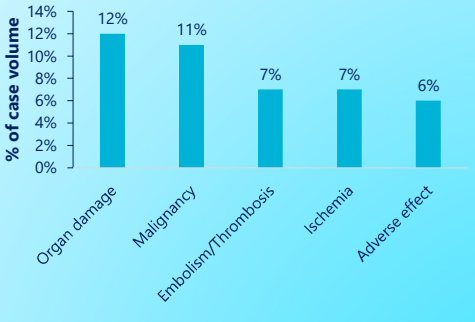
High level severity details

- **(% of cases):**



High Severity Subcategories:
Permanent significant: 23%
(ex. Deafness, loss of limb, eye, one kidney or lung)
Permanent major: 28%
(ex. Paraplegia, blindness, loss of two limbs or brain damage)
Permanent grave: 23%
(ex. Quadriplegia, severe brain damage, life-long care or fatal prognosis)
Death: 26%

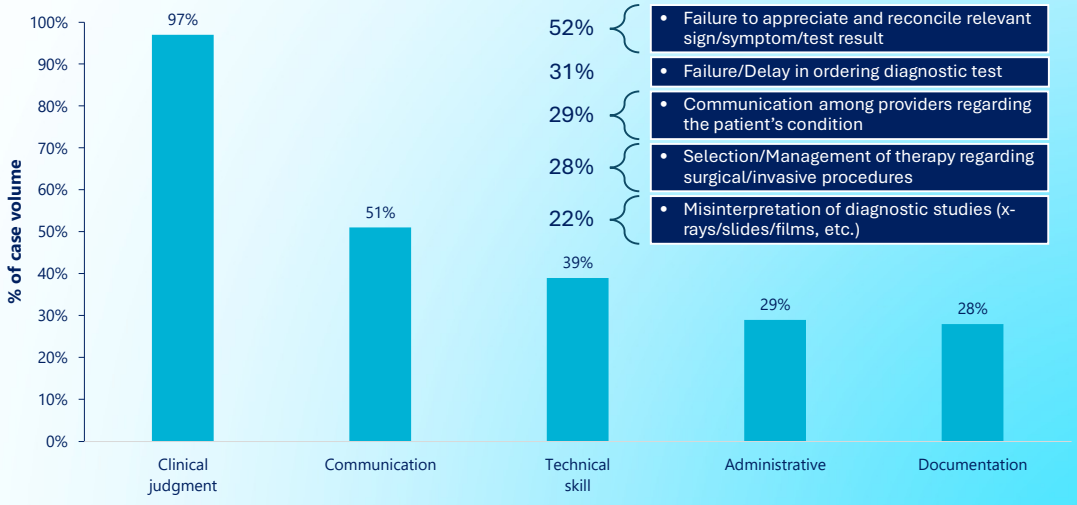
- **Most Common Injuries:**



MLMIC & MedPro Group closed cases 2015-2026 with indemnity paid >/=$2M, n= 382
* Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

6

Most common contributing factor categories

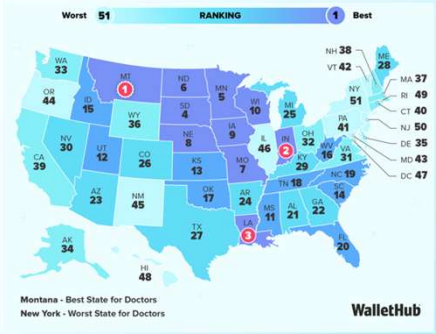


MLMIC & MedPro Group closed cases 2015-2026 with indemnity paid >/=$2M, n= 382; more than one contributing factor possible per case therefore totals > 100%

7 MLMIC

7

Impacts



Whats

- Increased Premiums
- Increased Stress & Burnout
- Facility & Practice Closures
- Provider Shortages

Whys

- Shifts in Societal Attitudes
- Emotional Appeals in the Courtroom
- Medical Complexity/Risk
- Lack of Tort Reform
- Third Party Litigation Funding

8 MLMIC

8

Nuclear Deterrence: Mitigating the Risk of Excessive Verdicts



Moderator:

Bill Melchior, MLMIC VP Marketing & Customer Relations

Panelists:

Shelly Kriete, CPHQ, CPHRM - MLMIC Senior Risk Management Consultant

Marc Craw, Esq. – MLMIC Senior Director of Government Affairs

John Neuburger – MLMIC VP of Claims

Chuck Patton, Esq. – Martin, Ganotis, Brown, Mould & Currie, P.C.

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

9

Thank You!

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

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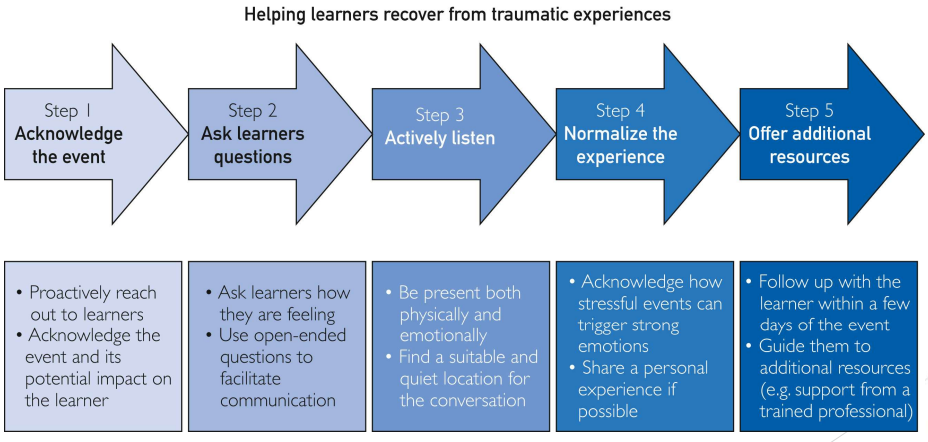
Healing the Healers: A Risk Management Approach to Second Victims

Presented By: Andrea Crawford, Henry Tilson
Prepared By: Andrea Crawford, Mario Giannettino

1

Evaluating a Hospital Second Victim Support Program

Focus: Program Structure, Utilization, Outcomes, and Continuous Improvement



2

1. Program Design & Structure

- When was the program established?
- What events trigger activation?
- Is activation automatic or referral-based?
- Who administers and oversees the program?
- How are peer supporters selected and trained?
- Is support available 24/7?
- What written policies govern the program?
- How is confidentiality maintained?

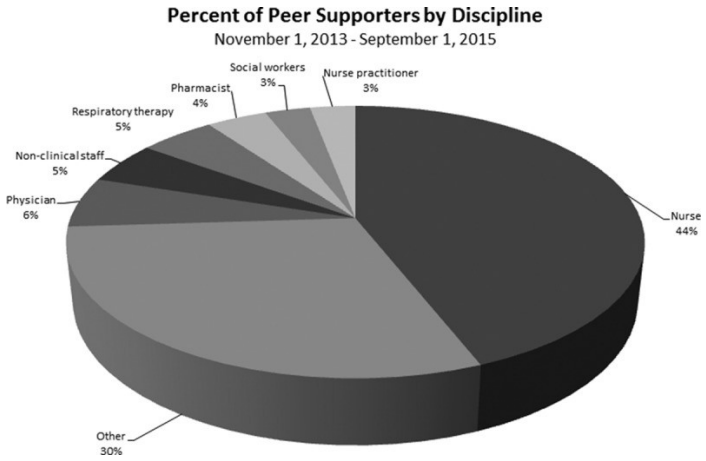
3

2. Access & Utilization

- How many employees use the program each year?
- What percentage of eligible staff participate?
- What disciplines use the program the most (see next slide)
- Are utilization rates tracked by department or profession?
- How are staff informed about the program?
- Are physicians, nurses, APPs, and ancillary staff equally able to access support?
- How quickly after an adverse event is support offered?
- What is the average time from event to first contact?

4

2. Access & Utilization



Source: Deployment of Second Victim Support. 2017 Jun 21;2(4):e031. doi: 10.1097/pq9.0000000000000031

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3. Measuring Staff Outcomes

- Are anxiety, depression, PTSD symptoms, or emotional exhaustion assessed?
- Can the hospital demonstrate changes attributable to the program?

6

4. Workforce Outcomes

- Has staff turnover changed since implementation?
- Have retention rates changed?
- Have sick leave or absenteeism rates changed?
- Has employee engagement changed?

7

5. Patient Safety Outcomes

- Has safety-event reporting changed?
- Have near-miss reports changed?
- Has willingness to report errors changed?
- Have patient-safety-culture scores changed?
- Have serious safety events changed?
- Does the hospital analyze whether second-victim support affects safety behavior?

8

6. Data Collection & Governance

- What performance data are collected?
- How often are data analyzed?
- Who reviews the results?
- Are formal reports generated?
- What constitutes program success?
- Are findings reported to senior leadership or the board?

9

7. Continuous Quality Improvement

- Has the program been modified based on collected data?
- Can you identify specific changes resulting from participant feedback?
- Are formal annual evaluations performed?
- Are gaps in access or utilization addressed?
- Is there a documented quality-improvement process?

10

9. Evidence Base

- What data was used to create or improve the program?

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Questions?

12

MITIGATION OF FUTURE ECONOMIC DAMAGES IN CATASTROPHIC INJURY CASES
PART II:
THE COLLATERAL SOURCE HEARING

- Samantha E. Quinn, Esq.
- Appellate Partner
- Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP

- Stephanie Campbell, Esq.
- Partner
- Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP

1

SAMANTHA E. QUINN, ESQ.

APPELLATE PARTNER
SCHIAVETTI, CORGAN, DIEDWARDS, WEINBERG & NICHOLSON, LLP.

Samantha E. Quinn is a partner with the firm of Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP, which specializes in the defense of hospitals, doctors, and other health care providers. She heads the office's appellate practice and has briefed and argued numerous appeals. She has also had significant success overturning unsuccessful verdicts, including the dismissal of several multi-million dollar verdicts later upheld on appeal. Ms. Quinn has handled OPMC investigations for individual physicians, treatment over objection applications for hospital clients, and counseled hospital clients during the course of DOH investigations and other quality assurance matters. Ms. Quinn has a Bachelor of Arts with Honors in History from Brown University and a Juris Doctor from Boston College Law School and has been a contributing author to the AHRMNY Journal since 2007.

2

STEPHANIE CAMPBELL, ESQ.

PARTNER
SCHIAVETTI, CORGAN, DIEDWARDS, WEINBERG & NICHOLSON, LLP

CURRENT PRESIDENT OF AHRMNY
ASHRM MEMBER SINCE:2018

Stephanie Campbell, Esq. is a partner at Schiavetti Corgan DiEdwards Weinberg & Nicholson, LLP, where she defends hospitals, health systems, and individual practitioners in complex medical malpractice and general liability claims. She is also licensed to practice law in Connecticut. She is currently the President of AHRMNY.

3

One of the largest components of damages in a serious injury case is the cost of future care. Plaintiff LCPs typically use inflated costs without regard for the availability of insurance, including coverage through Medicaid / Medicare.

In 2024, we discussed attacking these LCPs before trial with experts in this field. Inflated estimates of life expectancy, in particular, can have significant impact on damage exposure and addressing these may facilitate reasonable settlement discussions.

In this year's presentation, we will be briefly reviewing the concept of these strategies, and focusing on how to reduce future care damages in a post-trial collateral source hearing, discussing a recent hearing, as well as components of entitlement to and preparation for these hearings.

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LEARNING OBJECTIVES

- Review the notion of challenging plaintiff LCP and economic experts to help mitigate future economic damages which defendants are often hesitant to do.
- Discuss recent collateral source hearing which dealt with Medicare / Medicaid, how it proceeded and how it impacted the resolution of the case.
- Introduce practical strategies to prepare for a collateral source hearing, as well as information to develop during discovery, pretrial and post trial to facilitate

5

Sustainable verdict values in New York State increasing at alarming rate over past few years

Prior to 2020, pain and suffering awards used to have an "unofficial cap" of $10 million, with very few exceptions. Then 3 nuclear First Department Verdicts in 2021

Yanes v. City of New York, 199 A.D.3d 551 (1st Dept. 2021)

$29 million pain and suffering sustained

Perez v. Live Nation, 193 A.D. 517 (1st Dept. 2021)

$20 million pain and suffering sustained

Hedges v. Planned Sec. Serv. Inc., 190 A.D.3d 485 (1st Dept. 2021)

$ 13 million pain and suffering sustained

Liciaga v. New York City Transit Authority, 2024 Slip Op 04257 (2nd Dept. 2024)

$16 million pain and suffering sustained

**Collateral source hearing granted re $40 million future medical expenses

6

Juries inured to huge numbers by plaintiff tactics

- **Anchoring**
  - suggesting award multiple times highest sustainable verdict
- **Economic extrapolation**
  - calculating future damages over time rather than for current year only required by 50-A

Result = Runaway Verdicts which threaten viability of our health systems

Future Care - one of the most significant components of damages in a serious injury case

- **defense attorneys often hesitant to challenge**
  - cross of plaintiff's economist
  - cross of plaintiff's lifecare planner
  - post trial 5501(c) analysis (deviates materially)

Challenging before or even during trial can prevent jury exposure to inflated numbers and help mitigate damages

7

Plaintiff Life Care Plans typically use inflated costs without regard for the availability of insurance, including coverage through Medicare / Medicaid.

Challenging plaintiff LCPs

- Life Expectancy Expert
- Insurance Expert
- Medicare / Medicaid Expert
- Economist

Attacking these Life Care Plans can have a significant impact on damage exposure and facilitate reasonable settlement discussions.

- Pretrial Mediation
- Trial Strategies
- Post-trial Collateral Source Hearing

8

Three different potential components to challenging future costs put forth in a plaintiff's Life Care Plan

1. **Life Expectancy-** always relevant
2. **Potential private insurance coverage-** may apply
3. **Potential coverage through Medicare/Medicaid-** may apply

Today's presentation will discuss these issues in the context of **catastrophic injuries <u>excluding</u> cases involving birth injuries**

- ❖ Examples of Insurance and Medicare / Medicaid Analysis
- ❖ Collateral Source Hearing
- ❖ Evolving case law and practical implementation
- ❖ Medical Indemnity Fund (MIF) excluded although some arguments applicable

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Insurance analysis

Evolved since the Affordable Care Act made it illegal to exclude anyone from insurance coverage for pre-existing condition and mandated coverage. Argument is that plaintiff can and should obtain insurance policy to mitigate cost of future care.

- Insurance expert evaluates case to obtain cost of the specific care forecasted by the plaintiff's life care plan
- Uses demographic information and actuarial data to determine most comprehensive and appropriate health plan at the least out-of-pocket costs
- Assessment of non-covered items by defense life care planner Analysis of life expectancy by expert - often rehabilitation or neurology
- Possible analysis by economist
- Plaintiff must be eligible for individual health insurance through New York's State-run Marketplace
  - Must be non-incarcerated lawfully present U.S. resident

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Example of Insurance Analysis

MP case

29-year-old woman found unresponsive surrounded by multiple empty pill bottles including benzodiazepines and Adderall with history of prior substance abuse and suicide attempts

Presumed overdose; CT done timely; initial imaging mis-read as negative; subsequent imaging confirmed vertebral artery dissection

Patient ultimately was diagnosed as "locked in" – quadriplegic and unable to speak; only able to communicate with eye movements.

The plaintiff's life care plan over an estimated life expectancy of 82.5 years (53 years from the date of injury)

$29,962,624 total / $330,958 annually for home care

$23,868,112 total / $239,410 annually for facility care

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Evaluation

The applicability of insurance lowered future care costs by millions of dollars

$5,034,689.35 total for home care

Almost **$25 million less** than plaintiff LCP total

$3,635,990.67 total facility care

Over **$20 million less** than plaintiff LCP total

Key points

- Difference of 30 years in defense life expectancy versus plaintiff LCP
- Insurance analysis but not economist's analysis, so no growth rate applied
- Nonetheless facilitated settlement at pre-trial mediation

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Medicare/Medicaid analysis

Can work in conjunction with Insurance analysis or separately

Similar argument to the insurance analysis – demonstrating the difference in the cost of care through Medicare or Medicaid versus plaintiff LCP

Medicare

- Medicare age based – must be over 65; can also be based on disability
- Medicare is similar to private insurance, and different plans are available to individuals over 65 and those with qualifying disabilities.
- Medicare often does not pay for long term home nursing care / long term facility care which are big ticket items

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Medicaid

- Medicaid need-based – income below a certain level and/or disability
- Medicaid is provided by the government at no cost but can be subject to a lien
- Among the changes under the ACA was the expansion of the scope of Medicaid coverage
- Significant issue w Medicaid is requirement of Special Needs Trust to maintain eligibility
- Critical payor of long term home nursing care / long term facility care

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A Special Needs Trust allows the receipt of a substantial amount of money to someone under Age 65 to retain Medicaid benefits so long as

1. the Trust is not controlled by the individual beneficiary; and
2. the "State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual" (i.e., the future Medicaid costs related to the case)

Well-recognized and frequently utilized powerful planning tools directly designed to benefit individuals exactly like plaintiffs with serious injuries.

It is reasonable to assume a plaintiff's counsel would give her the proper guidance, which includes the creation of a Special Needs Trust or an equivalent Medicaid preservation Trust vehicle.

Special Needs Trust is a statutory vehicle authorized by federal law, 42 U.S.C. §1396p(d)(4)(A), and designed for the express purpose of receiving a substantial sum of money (i.e., through verdict or settlement in a personal injury action) into a Trust that is not controlled directly by the plaintiff.

Public entity such as Medicaid is then forbidden from counting that same award as income for the purposes of excluding Plaintiff from the benefits of Medicaid based health insurance.

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Medicaid Not a viable option in MP case

Personal dynamics with relatives made ceding control of funds as required for SNT** a non-option

Nonetheless, under Medicaid analysis annualized costs of facility care based on Pltf LCP rates and Medicaid rates:

Pltf LCP annualized cost: $178,850

Medicaid annualized cost: $96,725 - $147,460

And annualized costs of a home health aide based on Pltf LCP rates and Medicaid rates:

Pltf LCP annualized cost: $239,410.80

Medicaid annualized cost for 24 hours/day: $174,674.40

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Example of Medicare / Medicaid Analysis

PJ case

56-year-old underwent neurosurgery and suffered a spinal cord infarct on the second postoperative day, rendering her quadriplegic.

Significant verdict including roughly $25 million in future economic damages

All analysis post-verdict; post-trial motion and appeal argued that awarded cost of certain items of future medical care deviated materially pursuant to CPLR 5501(c) and showed plaintiff was Medicare / Medicaid recipient and requested 4545 hearing

Collateral source hearing held over two days in December 2025
Question of future damages very significant, particularly in light of the plaintiff's death less than a year after the verdict given a 20-year life expectancy (to 85).

Plaintiff LCP made no adjustment to her life expectancy based on the fact that she had been quadriplegic for 10 years at time of the verdict and had frequent medical complications and comorbidities

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impairment, disability, advancing age-predisposition to medical complications, reduction in endurance and decrease in mobility.

Unanticipated hospitalization costs include those costs incurred by the medical and surgical complications of spinal cord injury that require hospitalizations. These costs include, but are not limited to physician costs, hospital costs, rehabilitation costs, intravenous antibiotics, medications, diagnostic and laboratory testing and therapeutic interventions. These costs also include, but are not limited to those oral antibiotics, medications and therapeutic interventions that will occur as a direct result of complete cervical spinal cord injury.

Careful thought and consideration is given to [redacted]' comprehensive life care medical and service needs. Justification for the services and items contained are mandatory given the profound impairment, disability and handicap caused by the iatrogenic C4 complete tetraplegia that occurred on August 18, 2009.

LIFE EXPECTANCY

Life expectancy for [redacted] is estimated to be 85 years. This is based upon current published data which postulates that life expectancy for females now at 65 years of age have a life expectancy of 20 years. With the Life Care Plan and Specified Care delineated, there is no medical justification that [redacted] will not attain her life expectancy.

Lois S. Saltzman, M.D.
Diplomate, American Board of Physical Medicine and Rehabilitation
Diplomate, National Board of Medical Examiners
Medical Director, Inpatient Rehabilitation, Northport VAMC, NY
Assistant Clinical Professor, Rehabilitation Medicine, Stony Brook University, NY
Diplomate and Lifetime Member, Senior Disability Analyst
Spinal Cord Injury Medicine – Sub-specialty Board Certification #75
Medical Acupuncturist

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Date of Verdict 8/2/2019
10-Year Treasury Rate 1.86%

III. DETERMINE PRESENT VALUE OF FUTURE DAMAGES

	1st Year PMT	# of Years	Growth Rate	Discount Rate	Present Value
Future Pain & Suffering Paid Periodically	$ 487,500.00	8.00	4.00%	1.86%	$ 4,161,238.84
Future Physician Care	$ 11,200.00	19.80	4.35%	1.86%	$ 278,746.33
Future Nursing Care	$ 283,240.00	19.80	2.75%	1.86%	$ 6,044,459.19
Future Therapies	$ 312,000.00	19.80	6.46%	1.86%	$ 9,586,579.14
Future Medical Care Professionals	$ 19,600.00	19.80	2.75%	1.86%	$ 418,271.43
Future Medications	$ 8,234.52	19.80	5.33%	1.86%	$ 225,772.02
Future Medical Equipment	$ 23,139.00	19.80	4.35%	1.86%	$ 575,887.24
Future Bowel and Bladder Care	$ 2,340.80	19.80	0.20%	1.86%	$ 39,554.07
Future Diagnostic Care	$ 2,844.00	19.80	6.46%	1.86%	$ 87,385.50
Future Misc Medical Supplies	$ 713.00	19.80	0.20%	1.86%	$ 12,048.80
Future Hospitalizations	$ 68,500.00	19.80	5.51%	1.86%	$ 1,912,197.24
Future Dental Care	$ 1,000.00	19.80	4.93%	1.86%	$ 26,348.39
Future House Cleaning	$ 7,800.00	19.80	2.55%	1.86%	$ 163,349.04
Future Vehicle Costs	$ 16,000.00	19.80	0.08%	1.86%	$ 267,502.80
Future Computer Costs	$ 1,666.67	19.80	-8.33%	1.86%	$ 14,461.50
Future Lost Earnings	$ 79,397.72	3.00	1.78%	1.86%	$ 235,953.85
				TOTAL	$ 24,049,755.38

IV. DETERMINE FUTURE DAMAGES PAID IMMEDIATELY AND PERIODICALLY

	Present Value	35% Paid Immediately	65% Paid Periodically	Adjusted 1st Year PMT	8 Month PMTs Verdict to Death
Future Pain & Suffering Paid Periodically	$ 4,161,238.84	NA	$ 4,161,238.84	$ 487,500.00	$ 325,000.00
Future Physician Care	$ 278,746.33	$ 97,561.22	$ 181,185.11	$ 7,280.00	$ 4,853.33
Future Nursing Care	$ 6,044,459.19	$ 2,115,560.72	$ 3,928,898.47	$ 184,106.00	$ 122,737.33
Future Therapies	$ 9,586,579.14	$ 3,355,302.70	$ 6,231,276.44	$ 202,800.00	$ 135,200.00
Future Medical Care Professionals	$ 418,271.43	$ 146,395.00	$ 271,876.43	$ 12,740.00	$ 8,493.33
Future Medications	$ 225,772.02	$ 79,020.21	$ 146,751.81	$ 5,352.44	$ 3,568.29
Future Medical Equipment	$ 575,887.24	$ 201,560.53	$ 374,326.71	$ 15,040.35	$ 10,026.90
Future Bowel and Bladder Care	$ 39,554.07	$ 13,843.92	$ 25,710.15	$ 1,521.52	$ 1,014.35
Future Diagnostic Care	$ 87,385.50	$ 30,584.93	$ 56,800.58	$ 1,848.60	$ 1,232.40
Future Misc Medical Supplies	$ 12,048.80	$ 4,217.08	$ 7,831.72	$ 463.45	$ 308.97
Future Hospitalizations	$ 1,912,197.24	$ 669,269.03	$ 1,242,928.21	$ 44,525.00	$ 29,683.33
Future Dental Care	$ 26,348.39	$ 9,221.94	$ 17,126.45	$ 650.00	$ 433.33
Future House Cleaning	$ 163,349.04	$ 57,172.16	$ 106,176.88	$ 5,070.00	$ 3,380.00
Future Vehicle Costs	$ 267,502.80	$ 93,625.98	$ 173,876.82	$ 10,400.00	$ 6,933.33
Future Computer Costs	$ 14,461.50	$ 5,061.53	$ 9,399.98	$ 1,083.34	$ 722.23
Future Lost Earnings	$ 235,953.85	$ 82,583.85	$ 153,370.00	$ 51,608.52	$ 34,405.68
TOTALS	$ 24,049,755.38	$ 6,960,980.79	$ 17,088,774.59		$ 687,992.80

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Date of Verdict 8/2/2019
10-Year Treasury Rate 1.86%

III. DETERMINE PRESENT VALUE OF FUTURE DAMAGES

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Future Lost Earnings	$ 79,397.72	3.00	1.78%	1.86%	$ 235,953.85
				TOTAL	$ 24,049,755.38

Plaintiff projections

- **Future Medical costs of roughly $14.5 million**
- **$19 million when growth rate applied**

Impact of Medicare and Medicaid analysis on 50A calculations

- Reduces annual cost from $732,810 to approximately $150,000
- **Reduces total cost from $14.5 million to approximately $3,000,000**
- Reduction of judgment of $11.5 million before application of growth rate

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- Initial analysis dealt with all aspects of future damages potentially covered by Medicare or Medicaid
- For the hearing we narrowed it down to four categories
- We left out Medicaid (nursing care) as that was a more complicated argument with less benefit
  - Saltzman: ($27 x 5,840 hours) multiplied by 20 years = $3,153,600
  - Medicaid: ($26.16 x 5,840 hours) multiplied by 20 years = $3,055,488
  - The difference between these two totals is $98,112.
  - Also questions about continued entitlement to coverage after settlement with co-defendants and
  - existence of prior SNT
- Also left out durable medical equipment and home modifications
- We went with the largest and most straightforward:
  - **Physician Care**
  - **Physical Therapy and Occupational Therapy**
  - **Medical Care Professionals**
  - **Hospitalizations**

Type of Future Care (Question #)	Annual Amount Awarded By Jury	Annual Amount Accounting For Collateral Sources
Physician Care (#12)	$11,200	$3,771.89
Nursing Care (#14)	$283,240	$253,018
Physical Therapy and Occupational Therapy (#15)	$312,000	$35,965.80
Medical Care Professionals (#16)	$19,600	$7,701.76
Durable Medical Equipment (#18)	$23,139	$16,445.99
Hospitalizations (#22)	$68,500	$27,868.73
Home Modifications (#25)	$762,500 (one time cost)	$750,714.08 (one time cost)

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COLLATERAL SOURCE HEARINGS

What is a collateral source hearing?

- Post verdict proceeding to provide a more accurate estimate of plaintiff's medical costs when taking collateral sources into consideration
  - Akin to mini trial; evidence and testimony admitted; possibly argument
  - Decided by judge only; no jury
  - Actually proceed very infrequently
- Authorized under CPLR 4545 to prevent double recovery where cost will be replaced or indemnified by a collateral source
  - CPLR 4545(a) modifies the common-law collateral source rule which traditionally sought to ensure that tortfeasors pay for all damages caused by their tortious conduct and thus prohibited tortfeasors from reducing their liability by the proceeds of insurance or some other source to which they had not contributed
  - The principle goal of the statutory rule was to do away with the duplicative recoveries that the common-law rule accepted, to assure that plaintiffs are fully compensated – but not overcompensated
- Analysis for offset of future medical care under Medicare, Medicaid and/or private insurance has evolved over past 10 years

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Relevant Case Law

California

Cuevas v. Contra Costa County, 11 Cal. App. 5th 163, 217 Cal. Rptr.3d 519 (Ct of Appeal California, 2017)

- Plaintiff brought malpractice case against physician who allegedly caused her to suffer brain damage.
- At trial, parties presented competing life care plans to prove plaintiff's future medical costs.
  - Plaintiff's plan used undiscounted medical expense,
  - Defendants used anticipated discounted rates that would be accepted as payment should plaintiff maintain coverage under MediCal, or ACA.
- Trial court precluded defendant from introducing evidence of MediCal or ACA under collateral source rule.
- Ct of Appeals determined this was an error. Court concluded collateral source rule is not violated when defendant is allowed to offer evidence of market value of future medical benefits

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NEW YORK

Liciaga v. New York Transit Authority et al, 2024 WL 3882279, 2024 NY Slip Op 04257 (2nd Dept. August 21, 2024)

FACTS:

- Plaintiff (23) was riding a bicycle when railroad tie from above ground track struck his back causing fractured vertebrae, severed spinal cord, and permanent paralysis below T7.

PROCEDURAL HISTORY

TRIAL:

- Jury awarded plaintiff the following:
  - Pain and suffering: **Past**: $9 million; **Future**: $60 million (48 years)
  - Medical: **Past**: $1,174,972; **Future**: $40 million

POST TRIAL MOTION BY DEFENDANTS:

1) Set aside verdict
2) Alternatively: collateral source hearing on issue of future medical expenses (CPLR 4545)

- Defendant's argument: Plaintiff, uninsured, was eligible for insurance coverage through ACA

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- Application:
  1. Defendant submitted affidavit from licensed insurance broker and forensic economist.
  2. Expert opined that if plaintiff obtained Fidelis policy future medical expenses would be reduced from $40 million to $36,348,230, an offset of approx. $3.75 million

- Considerations by court:

  1. Collateral source offset might improperly compel plaintiff to procure insurance against his will

  2. "stands to reason that the plaintiff would act in his own economic self-interest by taking minimally burdensome steps required to obtain available insurance coverage and defendant should be afforded opportunity to offer evidence at a hearing to demonstrate why plaintiff could be expected to obtain coverage and whether it would reduce out of pocket expenses"

  3. Plaintiff is also legally obligated to obtain health insurance pursuant to ACA, thus you can't say its improper to expect plaintiff to perform an act that he is required to perform under federal law

     - Plaintiffs are expected to mitigate damages and can't decline to do so without plausible explanation

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TRIAL COURT DECISION:

a. Future medical expenses: affirmed
b. Past and future pain and suffering: Past reduced from $9 million to $4 million ; Future reduced from $60 million to $12 million

1) Collateral source hearing: denied

- Defendants Appealed

APPELLATE COURT DECISION:

1. Is defendant entitled to collateral source hearing pursuant to CPLR §4545

Discussion by court:

- Trial court should have held a collateral source hearing on issue of future medical expense
- Burden of defendant at hearing to establish entitlement to collateral source
- Standard of proof is reasonable certainty (more than preponderance but less than beyond reasonable doubt) i.e. clear and convincing that result is highly probable
- To be entitled to collateral source hearing defendant must merely tender some competent evidence that plaintiff's economic losses may be replaced or indemnified by collateral source. There, defendant offered expert affidavit from insurance broker and economist who identified a specific policy available on the marketpace
- Application for collateral source hearing may be made at any time before judgment is entered (unless directed otherwise by court)

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- Court looked at language of §4545
- Statute doesn't require plaintiff to have applied for or currently be in receipt of the benefits in order for defendant to be entitled to the offset (compare that with Dowdy)
- Will particular health insurance policy limit plaintiff's treatment options?

HOLDING:

- Providing defendant with offset under this circumstance would **serve ultimate goal of 4545** which was to eliminate duplicate recovery by the plaintiff, and therefore **defendant was entitled to collateral source hearing**
- Matter was remitted to trial court for a collateral source hearing on value of those damages

Post Decision:

- Defendant -NYCTA made a motion to obtain post verdict discovery to investigate plaintiff's residence and medical treatment which they argued was necessary for the collateral source hearing.
- NYCTA argued that plaintiff was eligible for certain insurance plans based upon his residence in Coler and Coler but that he subsequently lived in 2 apartment buildings and there was a question as to what insurance he would qualify for based upon his residency.
- Plaintiff's opposition argued that whatever treatment plaintiff underwent post-verdict was not discoverable and was irrelevant to a collateral source hearing
- Plaintiff also argued that defendant was essentially asking for a new damages trial, and that it was no surprise plaintiff left the terrible rehab facility due to sub-optimal care

CASE SUBSEQUENTLY SETTLED BEFORE COLLATERAL SOURCE HEARING COULD BE HELD

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Case that distinguishes Liciaga:

Dowdy v Brooklyn Hospital Center, 248 A.D.3d 1193 (2nd Dept. April 2026)

Plaintiff's argument to appellate division:

1) No evidence plaintiff received health insurance benefits under ACA, that it was not certain it would be available to her or in the future
2) Defendant didn't offer any evidence that ACA coverage would be available to plaintiff or that it would cover costs of her care

Defendant's response:
That the issue of whether plaintiff could obtain health insurance to pay for treatment should be determined at a collateral source hearing.

Different from Liciaga in that in Liciaga defendant presented two experts (one insurance broker and one forensic economist) in post-trial application for collateral source hearing and specified which health insurance plan plaintiff would qualify for.

*In JP – plaintiff admitted evidence of Medicare and Medicaid liens into evidence at trial, and on this basis we moved for collateral source hearing. But we did not submit our expert evidence until 3101(d) disclosure in preparation for hearing.

Take away: Collateral source hearing is not the place to figure out what plan the plaintiff would qualify for. Need qualified expert analysis and specifics going in and need to be sure to establish entitlement.

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Collateral Source Hearing: What to expect:

Who has the burden of proof?

- Burden is placed on defendant
- Burden remains the same whether considering Medicare/Medicaid/private insurance
- Defense must establish that the future costs awarded to the plaintiff by the jury will be replaced or indemnified by the collateral source.
- Reasonable certainty

What does defendant need to establish on direct?

- That plaintiff's estimated future medical costs are inflated and can be mitigated by a collateral source
- Have the expert establish the plaintiff is entitled to the collateral source (Medicare, Medicaid/private insurance)
- Have expert ready to testify as to the actual cost of future medical care under this program.
- Make sure they assume the same frequency of visits/care that plaintiff is alleging.
- We are not questioning the treatment per se, only the cost of the treatment*

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REASONABLE CERTAINTY

- Reasonable certainty test necessarily implicates a two-tiered evaluation of defendants' collateral source proof. Kihl v Pfeffer, 47 AD3d 154, 167 (2nd Dept 2007)
- **First, Defendants must establish with reasonable certainty that the plaintiff has received, or will receive, payments from a collateral source."**
  - health insurance benefits are one of the many types of benefits that could be relied upon in reducing a jury verdict pursuant to CPLR 4545.
  - To establish reasonable certainty of future collateral source benefits "an affirmative finding by the court that a contract or other enforceable agreement entitles the plaintiff to the ongoing receipt of such benefits, conditioned only upon the continued future payment of premiums and other financial obligations required by the agreement" is necessary.
  - Court of Appeals has found that a "reasonable interpretation of the statute," is that the "contract" requirement can be satisfied where the plaintiff has a protected interest in a government entitlement such as Medicare or Medicaid
    - Expert will address reasonable certainty that Medicare and Medicaid will exist in future
- **Second, Defendants must establish "collateral source payments which have been or will be received by the plaintiff . . . specifically correspond to particular items of economic loss awarded by the trier of fact."**

- Defendants entitled to an offset of the amounts written off by the medical providers based upon benefits provided by Medicare and Medicaid. Kastick v Uhaul, 292 A.D.2d 797 (4th Dept. 2002)
  - This is why analysis is not zero, but factors in what cost plaintiff will actually incur, plus applicable co-pays, premiums, etc.
  - Life insurance only type of collateral source excluded from rule
  - Also excepted are payments as to which there is a statutory right to reimbursement.
  - Plaintiff will argue that Medicare and Medicaid are NOT collateral sources for this reason.
    - Where prior liens are concerned, that is correct
    - Where it is future care, Medicare and Medicaid have no right to reimbursement for the written off amounts that neither they nor plaintiff will ever be obligated to pay.
    - Consistent with CPLR 4545 purpose of avoiding double recovery

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JP – narrowed down to 4 categories for hearing – showed difference in annual cost

- Physician Care $11,200 LCP versus $3,771.89 Medicare
  - ($148,562 difference over 20 year life expectancy)
- PT and OT $312,000 LCP versus $35,965.80 Medicare
  - ($5,520,684 difference over 20 year life expectancy)
- Medical Care Professionals $19,600 LCP versus $7,701.76 Medicare
  - ($237,965 difference over 20 year life expectancy)
- Hospitalizations $68,500 LCP versus $27,868.73 Medicare
  - ($812,625 difference over 20 year life expectancy)

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Testimony from Defense Expert

Expert goes through each category of services and testifies as to specific reimbursement rates for those services. Then compares those rates to plaintiff's life care plan (using LCP frequency) to demonstrate savings / amount by which future medical costs would be mitigated.

Q: The first physician service that plaintiff's expert included in their life care plan was for rehabilitation physicians. And what amount did [plaintiff's expert] indicate was the per session cost of a rehabilitation physician?
A: $350
Q: Ok. In your research did you come to a different number?
A: Yes, I did.
Q: How did you do that?
A: As I described earlier, I used the CMS physician fee lookup tool and the appropriate CPT code and geographic modifier in order to isolate that particular price, and the database produces those prices for you.
Q: Can you tell me what was the reimbursement rate for Medicare for a session with the rehabilitation physician at the time you looked into it
A: Sure. $145.28 per session
Q. Okay. Now, in order to come to an annual cost of that, what did you do?
A: I multiplied it by 6 because it was 6 times a year.
Q: And what was the final figure on that?
A: $871.68 for the year
Q: Ok, now for these other five categories, did you do the same thing for each of these other five categories?
A: Yes. All the way through. I followed [plaintiff's expert]

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Need to Establish Medical Necessity

Medicare will cover unlimited annual PT and OT if medical necessity is established

Plaintiff will argue that its not "reasonably certain" that continued therapy will be approved without interruption or limitation

We argue that medical necessity is established by the plaintiff's own LCP

Medicare is going to get paid their rate no matter what; they have no motivation to deny

- no one is actually paying private payor rate plaintiff LCP cites
- PJ case – $1,000 per session for PT/OT at a place like Rusk
- Expert established that Rusk accepts Medicare

Jimmo Settlement

The Jimmo Settlement Agreement (January 2013) clarified that when a beneficiary needs skilled nursing or therapy services under Medicare's skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits in order to maintain the patient's current condition or to prevent or slow decline or deterioration (provided all other coverage criteria are met), **the Medicare program covers such services and coverage cannot be denied based on the absence of potential for improvement or restoration**.

In short, what the Settlement Agreement and the resulting revised manual provisions clarify is that **Medicare coverage for skilled nursing and therapy services in these settings does not "turn on" the presence or absence of a beneficiary's potential for improvement, *i.e.*, it does not matter whether such care is expected to improve or maintain the patient's clinical condition.**

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Plaintiff's Cross Examination

Plaintiff's themes:

- Defendant's expert is not a physician - does not prescribe therapy, does not treat patients, does not approve or deny claims
- Defendant's expert's opinion is speculative. They will argue defense expert cannot know with certainty whether coverage will be approved or denied in the future
- Approvals are time limited. Each re-evaluation coverage may be reduced or denied entirely
- Statistics on % of claims that have been denied – ie 61% of Medicare Part B outpatient PT claims failed to comply with Medicare requirements due to necessity, coding, documentation errors, etc.
- Reimbursement rates are not replacement and a rate guarantees nothing about participation, frequency, duration, or continuity of care
- Defense expert cannot guarantee future care will be covered, therefore defense has not established reasonable certainty burden
- Eligibility does not equal approval
- Plaintiffs may elect to choose physician outside Medicare/Medicaid/insurance coverage and should be permitted that option

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Q: **What you do, and you've lectured on this, what you do is you take the liability or the damages away from the casualty or the liability company and you put it squarely on the hands or head of the health insurance industry; correct?**
OBJECTION
COURT: I think you need to rephrase it. Sustain the objection.
Q. Sure. Sure. First of all, there is something called a tortfeasor; correct?
A: Yes.
Q: And the way society is geared is that it's the tortfeasor who causes the harm, causes the need for medicals to be accountable and pay those damages; correct?
A. Part of the system, yes.
Q. Well, its part of the system if the plaintiff wins.
A. Right. That's a little bit why I was qualifying it here.
Q. And that's why we have that system; right? Yes?
A. Yes.
Q. Now, the doctors, you know, are insured by a liability company; correct?
A. Yes.
Q. Now, what you're saying, this collateral source rule here, by saying that it I's reasonably certain that she would get that money, is you're taking the onus off the liability insurance company and you're making the health insurance companies pay for it. That's what you do in all of your cases; right?
OBJECTION
A. In this instance, I'm following what I believe 4545 tells me to do.
Q. Sir, I have it. You gave a lecture on it. You got a whole PowerPoint on it. You're taking the burden off the casualty companies and you're putting them on the health insurance companies; correct?
OBJECTION
COURT: It could possibly be hearsay at this point.

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Q: Yes?
COURT: So I'll sustain the objection
Q. What you're doing – forgetting about the fact that [plaintiff] died, what you're doing in cases like this is you're saying that Medicare should pay for the harm that this insurance company caused, or their clients, rather than their clients and their insurance company; true?
OBJECTION
A. Not true.
Q. Well, isn't that – okay. If Medicare has to pay, right, that means that the liability company doesn't; true?
A. No. The number is being adjusted so that your client is awarded the proper money to pay for the medical services, and that is not Medicare paying, that's just Medicare prices.
Q. My question was very simple: Instead of the liability company paying for a thousand dollars a session three times a week for the rest of her life, you're having, by your testimony, if she was still alive, which she's not, Medicare paying for it, at whatever reduced rates there are, whether that's your intention or not, that's what's happening; true?
A. No.
Q. Because she's dead; right?
A. No.
Q. Did you ever say the collateral source slug test?
A. I'm sure, yes.
Q. Okay. Did you ever say its aims shift the burden of medical costs related to tort injuries, whenever possible, from liability insurers and thereby keep liability insurance premiums down and put them on the health insurers? Did you ever say that?
A. I'm sure it was part of discussion.
Q. So what I said ten minutes ago was right?
A. No. It doesn't apply here.
Q. Now, what you're doing is you're putting it on the shoulder of taxpayers like us-
A. No, No,

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Q. Whoa, Whoa. Assuming that she lived and we had a collateral source hearing, what you'd be doing is you would be shifting the burden of treating her from them who made her paralyzed, to the taxpayers who pay into Social Security and Medicare; true?

A. No. That would only be true if we were seeking to calculate her revised amounts at zero dollars. Instead, we're trying to calculate them at the correct rates so that she is in receipt of that exact amount of money.

Q. Okay. But she's not. She's in receipt of $120 to go to some God awful place instead of $1,000, right, per session at the place she chooses; right?

A. No. And we're talking about rates available in this area at facilities like Rusk, in that example.

Q. And then Medicare would pay for it rather than them; true?

A. She would be acquiring - -

Q. That Medicare would pay for it?

A. No, not true.

.....

Q. So one of the interesting things, is that there are many ways that Medicare could deny a claim; correct?

A: Any claim?

Q. Yes.

A. Possibly.

Q. Okay. One of the ways – first of all, let's say she goes to a doctor, right, even though [plaintiff's expert] testified to the jury that she needed physical therapy and occupational therapy and all these – all these treatments that now that she isn't her doctor anymore, she could go to a doctor who decides that she doesn't need those treatments; right?

A. I can't operate under that standard.

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PRACTICAL APPLICATION

Items for Analysis

- Importance of development of data during discovery
- Importance of consideration of the issue of damages from the beginning of the case
- General hesitancy of defense to develop their own life care plan; strategy considerations
  - At least have expert to consult with even if you don't call

Preparation for Collateral Source Hearing

- Need to establish entitlement at trial and/or in post trial motion
- Need certified copies of ALL Insurance, Medicare, Medicaid Records to admit at hearing
- Demand proof of out of pocket expenses which plaintiff intends to utilize at hearing
- Demand documentation of any existing trusts
- Need 3101(d) disclosure for expert(s)
  - Make sure your demand for 3101(d) covers trial and post trial
- Should have pre-hearing submission on law

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Items for Insurance Analysis:

1. Plaintiff Life Care Plan
2. Defense Life Care Plan
3. Plaintiff Name & Sex
4. Date of Birth of Plaintiff (the age must be under 65 in order to do an insurance evaluation)
5. Address of the Plaintiff (including zip code) –
6. Life Expectancy of Plaintiff (from Plaintiff's Expert & Defense Expert) –
7. "Reasonable value" report or the cost of the non-covered items from defense Life Care Planner
8. If there is current coverage in place, the Summary of Benefits & Coverages (SBC), Policy Copy (sometimes referred to as an Employee Handbook or Evidence of Coverage), and the premium portion the plaintiff is currently paying out of paycheck on a monthly basis for the coverage.

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Items for Medicare/Medicaid Analysis

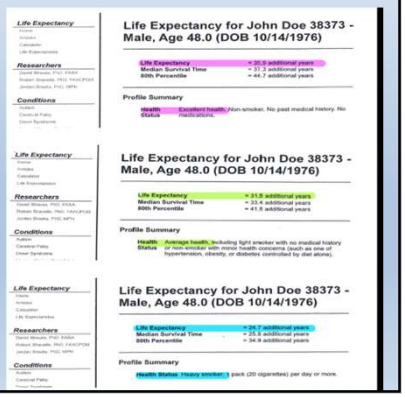
1. Discovery or other information that confirms Plaintiff's current health insurance situation (an insurance card would be ideal along with answers to interrogatories along those lines).
2. A list of the interrogatories/document requests you have served that deal with health insurance, liens, or related concepts.
3. Insurance face sheets from hospital treatment/or significant medical treatment (the most current ones you have again to show insurance coverage.
4. Whether Plaintiff is on SSI or Supplemental Security Income.
5. Whether Plaintiff is on SSDI or Social Security Disability Income.
6. Lien letters (hopefully itemized for charges/payments) for health bills accumulated to date.
7. Deposition of Plaintiff where applicable.
8. Any deposition testimony from a family member or caretaker that touches on day-to-day care for the Plaintiff and/or coordination of insurance issues.
9. Any correspondence with Medicaid or Medicare.
10. Life care plans from both sides if available
11. Economic reports from both sides if available
12. Life expectancy reports if available
13. Any formal information/discovery on guardianship/conservatorship type proceedings. Probate issues are significant to this analysis.

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Life Expectancy Analysis

- probably the single most important number. plaintiff experts do not account for factors which impact it but rely on general statistical tables
  - JP – "no medical justification for JP not living to full life expectancy." She died 8 months after verdict
  - MP – 30 year difference between plaintiff and defendant life expectancy; defense accounted for impact of medical condition
- An appropriately evaluated life expectancy is the multiplier of every life care plan.
  - Confirm that it is based on the correct age, sex, and race.
  - Do you have all the important past medical history?
  - Discuss if a life expectancy expert would be of benefit.
- International research on how life expectancy is impacted by:
  - BMI over 35
  - 60+ years of Spinal cord injury/TBI
  - Cerebral Palsy
  - Cancer History
  - Cardiovascular/Pulmonary Disease
  - Lifestyle Factors e.g. 48 y/o male:

non-smoker	35.9 years
light-smoker	31.5 years
heavy smoker	24.7 years



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Life Expectancy very delicate subject to address

If diminishment is on account of subject injury, plaintiff will make arguments like "they killed my client and now they want to benefit from that"

Consider pretrial application outside presence of jury s/a "Frye" type application on the issue of life expectancy

Similar to "Frye" notion that it is not valid science to fail acknowledge the diminishment of life expectancy of patient with certain conditions

We can't do anything about the number after the fact because part of verdict

Can be more easily addressed in the context of a mediation like MP

Riley v. Rupp, 233 A.D.3d 1313 (3rd Dept 2024) decided a few months after Liciaga rejected the idea of a pre-trial assessment of collateral sources in a summary judgment motion, citing statutory mandate of CPLR 4545

Procedurally, the Legislature has amended CPLR 4545 to clarify the process a court is to follow to apply a collateral source deduction (see L 2009, ch 494, § 2; Andino v. Mills, 31 N.Y.3d 553, 557 n. 2, 81 N.Y.S.3d 331, 106 N.E.3d 714 [2018]). The statute now clearly mandates that any such deduction "shall be made by the trial court after the rendering of the jury's verdict," and, thus, "[t]he plaintiff may prove his or her losses and expenses at the trial irrespective of whether such sums will later have to be deducted from the plaintiff's recovery" (CPLR 4545[a]; see Liciaga v. New York City Tr. Auth., 231 A.D.3d 250, 257, 218 N.Y.S.3d 359 [2d Dept. 2024]; Blanche, Verte & Blanche, Ltd. v. Joseph Mauro & Sons, 79 A.D.3d 1082, 1083, 913 N.Y.S.2d 342 [2d Dept. 2010]). We recognize that it would greatly enhance the potential of settlement here if the collateral source *1316 question were resolved sooner, rather than later. Nonetheless, in view of this plain statutory language, in addition to our precedent, we reject any argument that the damages allegedly sustained by plaintiff are diminished by the alleged existence of a collateral source payor. Supreme Court therefore properly denied defendants' motion (see CPLR 4545[a]; Foote v. Albany Med. Ctr. Hosp., 71 A.D.3d at 28, 892 N.Y.S.2d 203).

Defendants need to keep trying new methods of challenging hugely inflated LCP numbers which are leading to nuclear verdicts

Need the right facts and circumstances

Sharing and collaboration among defense counsel key

Riley rejects notion of pretrial collateral source reduction on motion but not aware of any case where life expectancy was addressed pretrial

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Recommendations

- **Discovery**
  - Obtain insurance and Medicare / Medicaid records and ask for copy of insurance card
  - Request lien information at case inception and periodically, including correspondence from Medicaid or Medicare
  - Ask whether plaintiff is on SSI or SSDI
  - Develop damages data during depositions, including asking about cost of medical insurance premiums and out of pocket costs
  - Ask detailed questions about ongoing medical treatment and future recommended treatment
  - Take deposition of family member(s) involved in management of medical / financial issues if applicable
  - If guardianship / conservatorship, request all supporting documentation
- **Pretrial**
  - Engage experts in LCP, Life Expectancy, Insurance, Medicare/Medicaid, Economics
  - Develop damages arguments in mediation
  - Consider motion for "Frye Hearing" on issues such as life expectancy or applicability of collateral sources
- **Trial**
  - Consult with LCP and consider putting on affirmative evidence to challenge plaintiff LCP
  - Consider motion *in limine* to limit damages / prevent economic extrapolation
  - Consider *voir dire* of plaintiff damages expert on issues of insurance / Medicare / Medicaid Coverage
  - Utilize experts to prepare cross of plaintiff witnesses
- **Post Trial**
  - Post trial motion – 5501 (c) analysis re economic damages and move for collateral source hearing
  - Include affidavits of insurance and/or benefits experts in post trial motion to ensure right to collateral source hearing
  - Obtain updated insurance and Medicare / Medicaid records plus proof of out of pocket expenditures for hearing
  - Disclose experts and expert reports in 3101(d) disclosure prior to hearing
  - Conduct collateral source hearing

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ASHRM Update

AHRMNY

October 19, 2026

AHA Events

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Creating meaningful learning, collaboration, and recognition

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Strategic Plan 2025-2027

CORE PURPOSE
To advance safe and trusted health care.

MISSION STATEMENT
To lead and represent health care risk professionals and support them with resources and knowledge to manage enterprise risk across the health care continuum.

CREATE AND DELIVER TIMELY INSIGHTS

Generate timely content on key topics of interest by cultivating relationships with external industry partners and thought leaders.

Strengthen our collaboration with AHA on critical issues important to ASHRM, its members, and stakeholders.

Optimize ASHRM's communication channels to deliver timely information to members.

DRIVE GREATER GLOBAL RECOGNITION

Actively seek opportunities to increase ASHRM's presence in the global risk management market.

Amplify international engagement in ASHRM's products and services.

INCREASE MEMBER VALUE

Facilitate a welcoming environment that fosters a sense of belonging for members.

Create structured pathways for members to advance their skills from novice to expert.

Expand resources to address the priorities of risk professionals across the spectrum of health care.

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Strategic Plan 2025-2027

What's Happening:

- Resources to help you with planning for increasing cyber risk threats
  - ✓ A new dedicated webpage with a compendium of resources launched on ASHRM website!
- An increased presence at international and national health care conferences
  - International Forum on Quality and Safety in Healthcare (May 2025)
  - Association of Perioperative Registered Nurses (April 2026)
  - RIMS RiskWORLD2026 – (May 2026)
  - American College of Healthcare Executives (March 2026)
  - AAMI (April 2026)
- Member spotlights highlighting the great work you and your peers do every day
- Enhanced engagement through the ASHRM Exchange and Forum
- A deeper focus on patient safety and the AHA Patient Safety Initiative
  - ASHRM presentation and participation at AHA Rural Patient Safety Convening (Oct 2025)
  - ASHRM presentation and participation at AHA Maternal Health Convening (Nov 2025)

View and download the Strategic Plan at ashrm.org/strategic-plan-2025-2027

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Increasing Member Value



ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

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Ways You Can Get Involved!

Member Spotlights

- Encourage members to submit!
- https://www.ashrm.org/ashrm-member-spotlight

New Member Welcome Virtual Meet-up (next one: November 11, 2026)

Answer call for volunteers



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On-Demand Professional Development Resources for Health Care Risk Professionals

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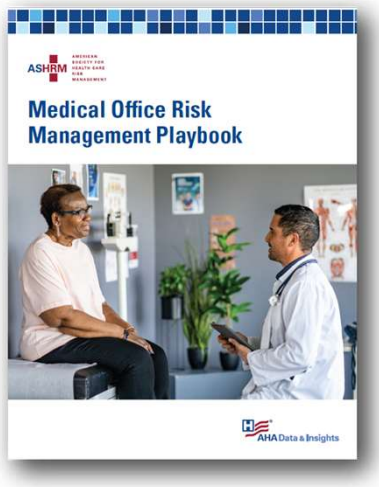
In-Person Learning & Networking

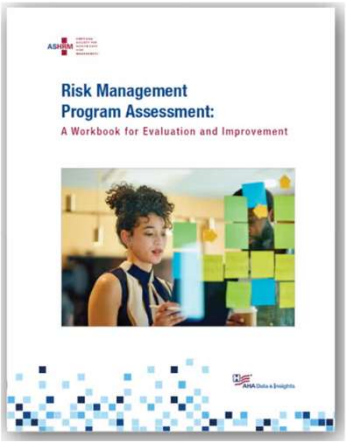
- HRM Essentials course
  - Revamped content!
  - Foundational education on health care risk management fundamentals
  - Targeted education for those 0-3 years of health care risk experience
  - Inaugural offering was May 12-14 in Dallas.
- ASHRM Learning Symposium
  - All new, live education event!
  - Networking and hands-on learning
  - Inaugural offering was July 20-23 in Rosemont, IL (right by Chicago O'Hare airport)
  - Next Offering: July 25, 2027, in Rosemont, IL

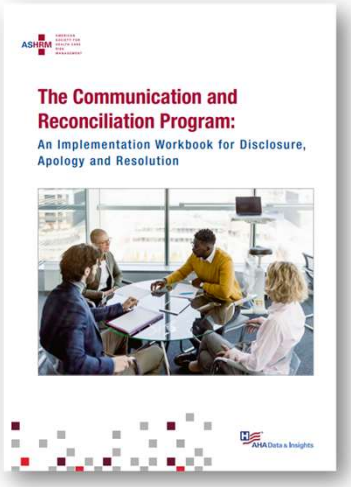
Questions? Reach out to ASHRMED@aha.org or check: https://www.ashrm.org/calendar-events

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Newest ASHRM Publications







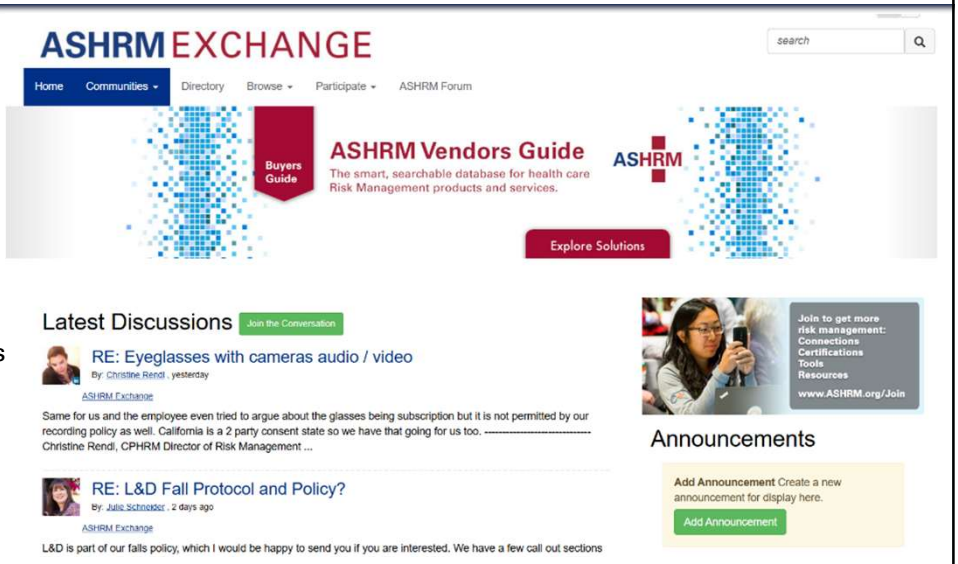
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A Space to Connect

24/7 Access to Risk Management Advice

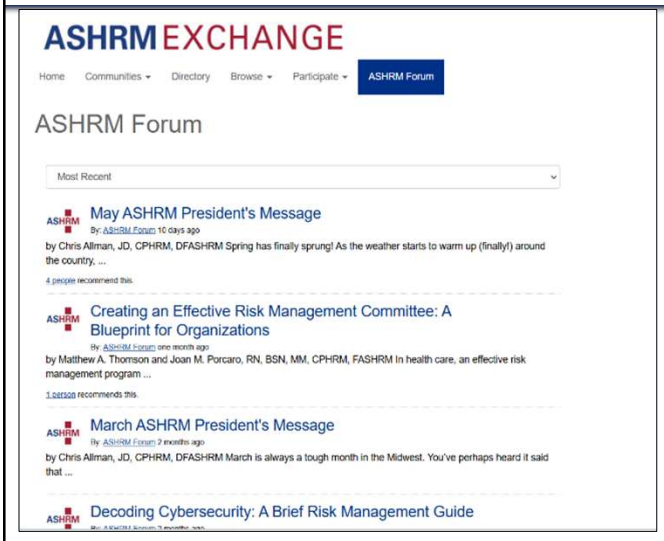
- Discussion Boards
- Resource Library
- Networking
- Member Directory
- Event Announcements
- Emailed Digest



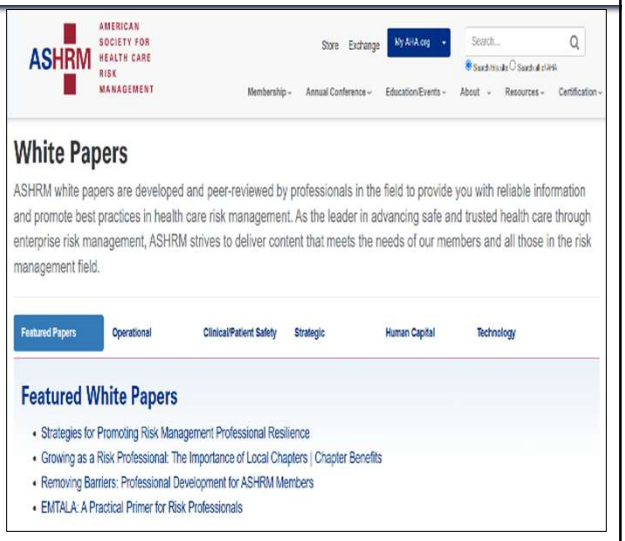
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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Timely Content



https://exchange.ashrm.org/blogs



https://www.ashrm.org/whitepapers

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Elevating the Profession



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Award Winning Journal

2025 APEX® AWARDS FOR PUBLICATION EXCELLENCE

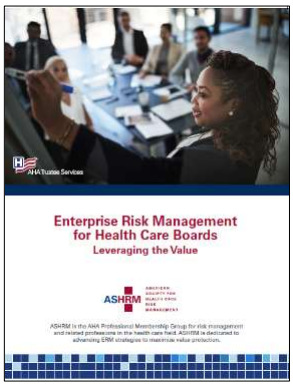
- Insightful, peer-reviewed content
- Published quarterly
- Opportunities for contributing
- Awards CEs
  (1 credit per feature article)



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Resources for the C-Suite



ashrm.org/ERM-Trustees

Supporting Resources & Tools

ERM Quick Reference Tool
A two-page document to help keep the ERM domains and guiding principles top of mind. Download Tool

Enterprise Risk Management: Readiness Assessment Tool
Gain insight into your organization's readiness to implement ERM practices, or the maturity of ERM initiatives already initiated with this helpful tool. Download Tool

ERM Enterprise Risk Management: Implementing ERM
For more in-depth information and insight into ERM implementation, this white paper outlines the implementation of an ERM program, defines its key structural components in any health care setting, and will help to build consistency in your efforts to develop or move forward your ERM efforts. Download White Paper



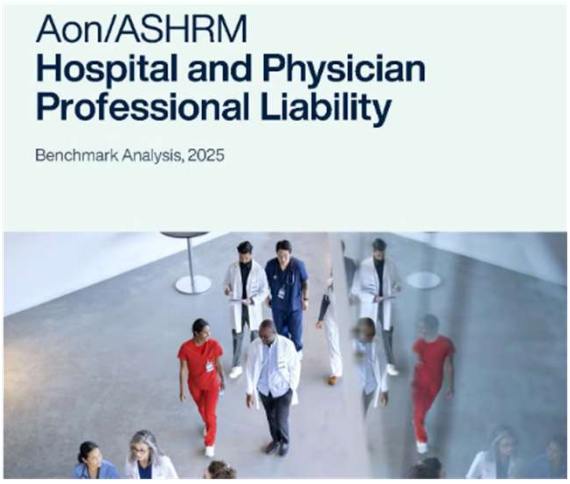
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Benchmark Report



- 2025 report is available: https://www.ashrm.org/aon-ashrm-hospital-and-physician-professional-liability-benchmark-report
- 125 participating health care systems – participant base represents 41% of the total US hospital industry
- A data-based tool for better estimating and understanding self-insured medical malpractice costs relative to those for your peers

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Fellow & Distinguished Fellow

- Opportunity to establish authority
- Avenue to contribute your professional experience
- Lead the next generation through teaching

https://www.ashrm.org/fashrm-designation

https://www.ashrm.org/dfashrm-designation

Recognizing the contribution of our members to risk management

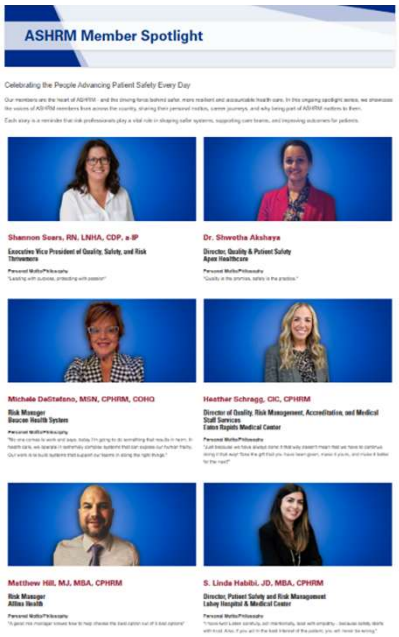
Designation is earned through

Professional experience	Leadership	Continuing education	Professional designations	Publishing	Lecturing

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Supporting You Everyday



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Katie Du Fresne, RN, MSN, CPHRM, FASHRM
kdufresne@iuhealth.org

Save the Date for
ASHRM Annual Conference 2027!
In Columbus Ohio
September 12-15

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