AMERICAN BAR ASSOCIATION
Tort Trial and Insurance Practice Section

Spring 2025

COMMITTEE NEWS

Life, Health and Disability Insurance Law

Member Spotlight: Tim Penn

Tim Penn is an Assistant Vice President in Property Claim for Travelers in Hartford, where he oversees a litigation team, a forensic accounting team, and a coverage support team. He has been active in TIPS for most of his career and served as Chair of three general committees (Dispute Resolution, Insurance Regulation, and Property Insurance Law). Tim admits to being a shameless ERISA nerd after first learning about it while attending Baylor Law School. He appreciates the programs and publications of the Life, Health and Disability Insurance Law Committee for helping him stay informed on the latest ERISA news.

Tim has been an essential member of the planning committee for the 2025 Midwinter Symposium in La Jolla in February, helping us all stay on track and on task every step of the way. We are thrilled that Tim will continue his role on the planning committee for next year's Symposium as well. We are so appreciative of his diligence and dedication to TIPS.

In This Issue

Outside of work Tim enjoys fitness activities and travel with his wife, Angela. He has been to many beautiful places, but he most enjoys visiting the Monterey and Pebble Beach areas in California. Please make sure to introduce yourself to Tim at our 2025 Midwinter Symposium!

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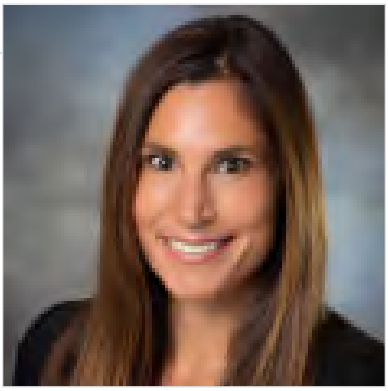
Editor Message



Jaclyn Conover
Newsletter Editor and Chair Elect
jconover@kantorlaw.net

Dear Committee Members,

I hope this letter finds you all in great spirits as we say goodbye to a long winter and hello to spring. It is with immense enthusiasm that I would like to thank each of you to the Life Health and Disability Insurance Committee of the American Bar Association's Trial & Insurance Practice Section.

I am thrilled to share that our 49th Annual TIPS Mid-Winter Symposium on Employee Benefits, ERISA, Life, Health & Disability Insurance, and Insurance Regulation was a huge success. This year's Symposium took place on February 21-22, 2025 at the beautiful Estancia La Jolla Hotel & Spa in La Jolla, California. We had a breadth of interesting panels, including Long-Term Care Insurance Litigation, ERISA Hot Topics, and Appellate Advocacy. The Mid-Winter Symposium is a cornerstone event for our committee, offering a unique opportunity to engage with fellow professionals, share insights, and explore the latest developments in our field. This gathering is not only a chance to enhance our knowledge and skills but also to foster meaningful connections and collaborations that can drive our practice forward.

For those of you who have not joined us in the past, I strongly encourage you to come out and meet your fellow committee members next year for our 50th Anniversary. It will truly be a special event. Your participation and contributions were vital to the success of this year's Symposium. I encourage each of you to bring your ideas, expertise, and enthusiasm to the table as we work together to prepare for next year's symposium. Whether through panel discussions, workshops, or informal networking, your involvement will undoubtedly enrich the experience for all attendees. I look forward to collaborating with each of you and am excited about the possibilities that lie ahead. If you'd like to get more involved with our planning committee, please feel free to reach out to me directly.

Warm regards,

Jaclyn Conover

Mental Health Parity: Departments Up the Ante in New MHPAEA Final Rules

Jon Breyfogle
Lisa Campbell
Elizabeth LaPaugh
Emily Lucco, and
Ryan C. Temme
Groom Law Group

The Departments of Labor, Health and Human Services, and Treasury ("Departments") recently released the Mental Health Parity and Addiction Equity Act ("MHPAEA") Final Rule. This long-awaited rule implements the requirements of the Consolidated Appropriations Act, 2021 ("CAA"), which established a new mandate on the Departments to: (1) investigate group health plans' and health insurance issuers' compliance with "non-quantitative treatment limits" ("NQTLs"); (2) publish the names of non-compliant plans and issuers in a report to Congress; and (3) provide guidance on how to properly document NQTLs.

In comparison to the 2023 Proposed Rule that we summarized here, the Final Rule imposes less burdensome requirements on plans and issuers, but the Final Rule will continue to pose significant compliance challenges for plans and issuers with new requirements related to the documentation and justification of NQTLs. Plans and issuers must continue to perform and document NQTL comparative analyses (i.e., the requirement has been effective since 2021), and these new rules will require plans and issuers to update existing NQTL comparative analyses documentation to comply with these new requirements.

1. Effective Date

- Plans and issuers offering group health insurance coverage must comply with a number of the Final Rule's requirements by the first day of the first plan year beginning on or after January 1, 2025 (e.g., for calendar year plans, the plan/issuer offering group health insurance coverage must comply by January 1, 2025). These requirements primarily relate to the design and application of the NQTLs for mental health/substance use disorder (MH/SUD) being no more restrictive than medical/surgical (M/S), the effect of noncompliance, the disclosure requirements, and the comparative analysis content requirements that do not relate to outcomes data.

- Plans and issuers offering group health insurance coverage have until the first day of the first plan year beginning on or after January 1, 2026 (e.g., for calendar year plans, the plan/issuer offering group health insurance coverage must comply by January 1, 2026) to comply with the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related comparative analyses requirements.

Read more on page 10

Understanding Evidence of Insurability in Group Life Insurance: Employer Obligations and Employee Rights

Mark DeBofsky

Unlike individual life insurance, which requires rigorous underwriting to assess risk, group life insurance from employers does not require underwriting. Employers offering group life insurance allow new employees to enroll immediately without providing evidence of insurability (EOI). The reasoning is that a new employee is likely to be healthy, and the risk of adverse selection is low.

If an employee forgoes enrolling in the life insurance program at the commencement of employment, seeks to enroll a dependent or spouse later, or seeks to increase the amount of insurance, they must provide evidence of insurability. This allows the insurer to assess the added risk. Insurance companies rely on employers to obtain evidence of insurability. But what happens if employers fail to do so?

Employee Rights and Responsibilities

An employee's right to enroll in a group life insurance plan is based on the plan's requirements. If the employee is a late enrollee and fails to submit evidence of insurability, additional coverage may be declined. If the employee submits the EOI form and the insurer has denied coverage, the employee has a right to appeal the denial. However, if the employee fails to meet the insurer's underwriting standards, the employee is unlikely to receive the new or added coverage.

The employer, not the insurer, is responsible for obtaining evidence of insurability. Indeed, group insurance policies typically impose a duty on the employer to do so. If the employer fails to obtain an EOI form from the employee, and the insurance company denies life insurance benefits if the employee dies, the employer may be liable to the employee for breach of fiduciary duty under ERISA. ERISA is the federal law governing employee benefits.

Several court rulings have found employers liable for failing to obtain evidence of insurability from their employees when they were required to do so. That failure led to a denial of life insurance payments. These are complex cases, and the specific facts of each situation dictate the outcome. However, the overriding rule of law cited by the courts is that ERISA imposes a fiduciary obligation on employers to act in accordance with benefit plan terms. If the failure to do so results in a benefit denial, the employer is liable for the loss.

Read more on page 16

Fifth Circuit Joins Chorus of United Healthcare Critics

Peter Sessions

The Fifth Circuit Court of Appeals recently reversed the district court's decision in *Dwyer v. United Healthcare Ins. Co.*, No. 23-50439, 115 F.4th 640, 2024 WL 4230125 (5th Cir. Sept. 19, 2024), ruling in favor of an insured who challenged United Healthcare's denial of mental health benefits to his daughter under his employee group benefit health plan governed by ERISA. In doing so the Fifth Circuit joined a number of other courts which have criticized the way United handles benefit claims.

Plaintiff Kelly Dwyer is the father of E.D., who as a preteen was diagnosed with anorexia nervosa, which has the highest mortality rate of any psychiatric disorder. Mr. Dwyer sought treatment for E.D. from an eating disorder specialist near the Dwyers' home in Texas, but it quickly became apparent that her condition was too serious for outpatient treatment. As a result, E.D. was admitted to Avalon Hills, a residential treatment center in Utah that specializes in the treatment of eating disorders.

Mr. Dwyer submitted claims for E.D.'s treatment at Avalon Hills to defendant United Healthcare Insurance Company under his ERISA-governed medical benefit plan. At first there were no problems and United paid Mr. Dwyer's claims. However, as E.D.'s treatment at Avalon Hills progressed, United began to push back.

First, United refused to keep paying for residential treatment, and insisted that E.D. was ready to step down to Avalon's next lower level of treatment, a partial hospitalization program ("PHP"). United denied Mr. Dwyer's appeal of this decision, and thus E.D. stepped down to PHP.

However, E.D. continued to struggle in PHP. She spent hours per day in treatment and every meal needed to be monitored. A three-day weekend pass designed to test whether E.D. was ready for discharge was a disaster, "filled with difficult, negative experiences," during which she lost two pounds.

At this time, "[f]or reasons that are difficult to understand…United decided it was appropriate to discharge E.D. entirely." United terminated coverage of E.D.'s PHP treatment, contending that she was ready for outpatient-only treatment. Mr. Dwyer appealed this decision, but again United upheld it. This time Mr. Dwyer rejected United's assessment, kept E.D. in the PHP program at Avalon Hills, and paid out of pocket for her treatment.

Meanwhile, Mr. Dwyer was engaged in another battle with United over the cost of E.D.'s treatment. United did not have a contract with Avalon Hills. However, it did

have a contract with MultiPlan, a network provider that "connects insurers with out-of-network providers so that insurers do not have to make arrangements individually with those providers."

As a result, because United had an agreement with MultiPlan, which in turn had an agreement with Avalon Hills, Mr. Dwyer reasonably believed that he would be required to pay the rate negotiated by United and MultiPlan for E.D.'s treatment instead of United's more onerous out-of-network rates. Indeed, at first United paid claims at the MultiPlan rate. However, without warning it suddenly stopped doing so, resulting in substantial out-of-pocket payments by Mr. Dwyer.

Mr. Dwyer and Avalon Hills "repeatedly asked United to explain this discrepancy" but they did not get satisfactory answers. Eventually, Mr. Dwyer submitted an appeal in which he asked why United had shifted its payment rationale. He explained that it was difficult for him to "make critical coverage decisions" about E.D.'s treatment when he had "no idea what reimbursement formula" United would apply. United never responded to this appeal.

As a result, Mr. Dwyer initiated this action in 2017. In 2019 the district court held a bench trial, and then issued a written decision almost four years later, in April of 2023. The court ruled in United's favor on both issues presented, deciding that United did not err in terminating E.D.'s PHP coverage, and that its payment rate was appropriate. Mr. Dwyer appealed.

Under de novo review, the Fifth Circuit reversed on both issues. On the medical necessity of E.D.'s PHP treatment, the court ruled that "United's denial letters are not supported by the underlying medical evidence. In fact, they are contradicted by the record." The court listed each of United's justifications for denying E.D.'s claim, including "you have made progress," "you have achieved 100% of your ideal body weight," "you are eating all your meals," and "you are not trying to harm yourself… [or] others," and, most cryptically, "you are better," and explained why each item was either untrue or irrelevant. The Fifth Circuit agreed with Mr. Dwyer that to the extent E.D. had improved, it was because she was constantly monitored in daily treatment. These gains would have quickly evaporated if she had been discharged and therefore did not justify the denial of ongoing treatment coverage.

The Fifth Circuit also criticized the way United handled E.D.'s claim, emphasizing that ERISA requires a "full and fair review" involving a "meaningful dialogue between the beneficiary and administrator." The court ruled that United had failed this test: "United not only failed to engage in a 'meaningful dialogue' with Mr. Dwyer; the ERISA fiduciary engaged in no dialogue at all." The court found that "[n]o explanation was provided or offered" for United's denial, and that its letter "said nothing about

the plan provisions or how E.D.'s medical circumstances were evaluated under the plan." The court cited cases from the Ninth and Tenth Circuits in stating, "We therefore join a growing number of decisions rejecting similar denial letters issued by United across the country."

Finally, the court addressed the MultiPlan issue. Citing its en banc precedent *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999), the court noted that "ERISA requires both the beneficiary and the fiduciary to avail themselves of the administrative process… When one party forfeits that process, it requires us to direct entry of judgment for the opposing party." Because United never responded to Mr. Dwyer's appeal on this issue, this rule ended the court's inquiry and required judgment in his favor.

The court rejected United's arguments to the contrary, ruling that (1) United's hearsay argument was "bizarre" because hearsay rules do not apply to ERISA proceedings, (2) waiver and estoppel may not be able to create coverage under state insurance laws, but those doctrines do apply in ERISA cases, and (3) United could not advance new arguments in litigation about the plan's payment provisions because "United is not entitled to offer such post hoc arguments… United is limited to the arguments it made at the administrative level, which were none." In any event, the Fifth Circuit ruled that Mr. Dwyer's understanding was correct, and that the agreed-upon MultiPlan rate should apply.

As a result, although it took seven years of litigation, the case was an unqualified success for Mr. Dwyer and another appellate defeat for United. The action will now be remanded to the district court for further proceedings as to the appropriate remedies.

Mental... Continued from page 4

- Issuers offering individual health insurance coverage have until the first day of the first policy year beginning on or after January 1, 2026 to comply with the new requirements.

2. Application of the Substantially All/Predominant Mathematical Test to NQTLs was not finalized.

- The Proposed Rule would have required that plans and issuers demonstrate that an NQTL, such as pre-authorization for outpatient benefits, apply to two-thirds of all M/S outpatient benefits before it could apply to MH/SUD. Dropping this provision is a major victory because application of this mathematical test to NQTLs could have eliminated the ability to use common medical management techniques, and it was not required by the CAA.

- In the Final Rule, the Departments framed an alternative approach to the "substantially all" requirement and imposed: (1) additional requirements related to the design and application of NQTLs; and (2) data evaluation requirements. As part of the "design and application" requirement, plans and issuers must determine if information or standards are biased or not objective, which is prohibited. Usefully, the Departments specified: (1) generally recognized independent professional medical or clinical standards; and (2) reasonably and appropriately designed measures to detect or prevent and prove fraud and abuse are considered objective and may be used to justify a material difference in a comparative analysis. However, this allowance for generally recognized independent professional medical or clinical standards and reasonably and appropriately designed measures to detect or prevent and prove fraud and abuse in the final rule is different than the proposed rule's broader exception from compliance with the proposed no more restrictive requirement, the prohibition on discriminatory factors and evidentiary standards, and the relevant data evaluation requirements. The Final Rule provides several examples illustrating this parity standard.

3. The mandate to collect and evaluate outcomes data and the material difference standard were altered and finalized.

- Under the final rule, plans and issuers are obligated to collect and evaluate relevant data in a manner reasonably designed to assess the impact of an NQTL on access to MH/SUD benefits and M/S benefits. Plans and issuers must consider whether an NQTL, in operation, complies with the "no more restrictive" and the design and application requirements.

  - This data collection requirement may pose a substantial compliance challenge for plans and issuers. The Departments did not provide an exhaustive list of outcomes data that should be collected and evaluated, even though this was requested.
  - The preamble to the Final Rule indicates that the Departments intend to update the MHPAEA Self-Compliance Tool and provide additional information on the data plans and issuers should collect and evaluate.

- The Departments' clear focus in the Final Rule is on access to network providers. The Final Rule creates a "network composition" NQTL that reflects the Departments' ongoing enforcement position around network access and will require robust data measures related to out-of-network utilization, network adequacy measures (such as time and distance standards), and provider reimbursement comparisons to benchmarks.
- Depending on how the Departments apply these standards, this could have the practical effect of imposing network adequacy on self-insured group health plans, a requirement that could have far-reaching impacts on plan design, including the value of certain networks and the use of value-based structures like centers of excellence.
- The Departments removed the language suggesting that a material difference in outcomes data constitutes an automatic MHPAEA violation for the network composition NQTL.
  - The Departments specified plans and issuers could evaluate utilization rates, network adequacy data, and reimbursement rates to evaluate whether this NQTL is compliant with the Final Rule. The Departments further noted they may specify the type, form, and manner of data required to be evaluated in future guidance.
- The Final Rule includes a provision that a material difference in outcomes data is viewed as a "strong indicator" of noncompliance. The Final Rule obligates plans and issuers to take reasonable steps to address material differences in access to MH/SUD benefits resulting from application of NQTLs if relevant data indicates such NQTLs contribute to these differences. A robust list of steps plans and issuers will be asked to take is set out in the preamble and, for the network composition NQTL, includes efforts to add providers to networks, streamlining credentialing requirements, increasing provider compensation, adopting telehealth, outreach to participants to find network providers, and improving provider directory accuracy.

- The definition of a "material" difference is not clearly defined. The Departments indicated it will be a fact-specific determination. However, the Departments explained differences in MH/SUD benefit access will not be treated as material if such distinctions are attributable to generally recognized independent professional medical or clinical standards or reasonable fraud and abuse prevention or detection measures.

- The lack of definition of "material" differences effectively means that plans and issuers must establish the basis for any difference in outcomes, relying solely on the objective factors that the Final Rule permits. So, reliance on internal metrics or goals in justifying a difference in outcomes would presumably not be sufficient and would lead to the difference being viewed as "material."

4. The meaningful benefits standard was finalized.

- This standard essentially works as a benefit mandate and a requirement to provide meaningful benefits for each covered MH/SUD condition in every benefit classification in which M/S benefits are provided. As finalized, the standard remains vague.

- A plan or issuer will not provide "meaningful" benefits under the Final Rule unless it provides benefits for a "core treatment" for a MH/SUD condition or disorder in each classification in which the plan (or coverage) provides benefits for a M/S core treatment.

- This is a provision to watch. As MHPAEA was not intended to be a benefit mandate, stakeholders may seek review of this standard post-Loper Bright.

- The "core treatment" definition relies on generally accepted standards of care, which could pose significant challenges in plan design for plan sponsors of self-insured plans that want a customized plan design who will likely have to rely on third-party clinical data to guide any custom exclusion or limitation on MH/SUD treatment benefits the plan seeks to adopt. While issuers/TPAs are better positioned to address these issues generally, we expect that issuers/TPAs will be required to rely on third-party clinical literature, rather than their own clinical experience, in justifying what is considered the generally accepted standard of care.

5. The comparative analysis requirement to evaluate the impact of NQTLs was finalized.

6. The requirement of fiduciaries to certify MHPAEA Comparative Analysis compliance was altered and finalized.

- The Proposed Rule would have imposed an unprecedented duty on plan fiduciaries to certify compliance with the NQTL content requirements. This would have imposed tremendous liability on plan sponsors for compliance with technical requirements.

- The Final Rule changes the standard and focuses on the requirement for plan fiduciaries to engage in a prudent selection and monitoring process for selecting a vendor to perform and document an NQTL comparative analysis. The Final Rule provides that the comparative analysis must include a certification that the fiduciary engaged in a prudent process to select a qualified service provider(s) to perform and document a comparative analysis in connection with the imposition of any NQTLs applied to MH/SUD benefits under the plan, in accordance with MHPAEA, and satisfied the duty to monitor the service provider(s). This provision attempts to conform to ERISA's more typical fiduciary standard for selecting plan vendors.

- While plan sponsors will not have to become experts in the various clinical and procedural information that constitute many NQTLs, they will have to develop a means for selecting quality service providers to perform and document the analysis. There may be more pressure on TPAs to respond to the requests and testing methodology of the service provider performing the comparative analysis (if the NQTL service provider is different from the TPA).

7. The Final Rule revised or added definitions for key terms, including: "medical/surgical benefits"; "mental health benefits"; "substance use disorder benefits"; "evidentiary standards"; "factors"; "processes"; and "strategies."

- Plans and issuers must define whether a condition or disorder is an MH condition or SUD in a manner that is consistent with the most current version of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).

- Notably, the Departments removed the reference to state guidelines in the definitions of MH benefits, SUD benefits, and M/S benefits.

8. DOL or HHS may require cessation of an NQTL.

- The Final Rule provides that the DOL or HHS may prohibit a plan or issuer from imposing an NQTL if the Department issues a final determination

that the NQTL is noncompliant. The plan or issuer will be obligated to demonstrate the NQTL's compliance with MHPAEA or take appropriate action to remedy the violation.

9. The sunset provision for a MHPAEA opt-out for self-funded, non-federal governmental plans was finalized.

For more information about the Final Rule, please see the resources below:

- Final Rules, available at https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/requirements-related-to-mhpaea-finalrules.pdf
- Fact Sheet, available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-underthe-mental-health-parity-and-addiction-equity-act-mhpaea
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Participants and Beneficiaries, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-forparticipants-and-beneficiaries.pdf
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Providers, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-forproviders.pdf
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Plans and Issuers, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-forplans-and-issuers.pdf
- White House Fact Sheet, available at https://www.whitehouse.gov/briefing-room/statements-releases/2024/09/09/fact-sheet-bidenharris-administration-lowers-mental-health-care-costs-by-improving-access-to-mental-health-and-substance-use-care/
- News Release, available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20240909
- Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rules Webinar, available at https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/mhpaea-final-rules-09192024.pdf#zoom=200

Understanding... Continued from page 5

Employer Obligations

What Employers Must Do About Evidence of Insurability

When employers fail to secure evidence of insurability and a subsequent life insurance claim is denied, the court may order the employer to pay the amount of insurance that was lost on account of that failure. This applies regardless of whether the employer acted intentionally or negligently. However, if the employee or their dependent enrolls in the life insurance plan without EOI and premiums are collected, the insurance company may also face liability.

There is a principle of insurance law known as contestability. Under the principle of contestability, insurers can contest coverage within two years of a policy's issuance due to omissions or misstatements made during enrollment. Thus, if more than two years pass after evidence of insurability was required and premiums have been paid throughout, an insurer may not be able to avoid paying the life insurance benefits.

Insurer Obligations

The U.S. Department of Labor has addressed evidence of insurability and settled with insurers to stop them from denying coverage once premiums have been accepted for at least 90 days. The Department of Labor issued the following statement in relation to one of its settlements:

"Workers pay premiums believing they will receive their promised benefits," said Assistant Secretary for Employee Benefits Security Administration Lisa M. Gomez. "Once workers pay these premiums, life insurance companies must verify that plan participants satisfy eligibility requirements. EBSA will not allow companies to neglect their responsibility for making timely eligibility determinations, collect premiums for months or years, and then deny payment of death benefits to beneficiaries because the company failed in its legal responsibility."

The position taken by the Department of Labor emphasizes that it is not only employers who have the responsibility to collect evidence of insurability from employees. Insurers must ensure that new enrollees are qualified to receive coverage before accepting premiums. The Department of Labor is also sending a message to insurers that they cannot wait until a claim is made to begin investigating whether the issuance of coverage was appropriate.

Best Practices for Employers and Employees

On the other hand, employers are not being left off the hook. Employers can avoid these situations by implementing strict practices to ensure EOI is obtained before

processing late enrollments or coverage increases. Obviously, employers should also implement procedures to prevent situations where employees think they have coverage, only to discover otherwise after a loved one's death.

For employees, it is important to keep records of life insurance enrollments and any communications with the employer surrounding the enrollment. If questions arise about EOI, employees must show either that no request for an EOI form was made or that they submitted the form and the employer didn't act.

What to Do if an EOI Issue Arises

Life insurance is critical in the event of an anticipated death and there is a need for financial support. Therefore, if there is any question about life insurance enrollment, employees should seek consultation with an attorney as soon as a problem arises.

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Calendar

April 23-25, 2025	Motor Vehicle Product Liability Conference Contact: Janet Hummons – 312/988-5656 Yasmin Koen – 312/988-5653	**Omni Scottsdale Montelucia** Scottsdale, AZ
May 7-10, 2025	TIPS Section Conference Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Capital Hilton** Washington, DC
May 22-24, 2025	Fidelity & Surety Law Spring Conference Contact: Janet Hummons – 312/988-5656 Yasmin Koen – 312/988-5653	**Wild Dunes Resort** Isle of Palms, SC
June 2025	TIPS/ABOTA National Trial Academy Contact: Janet Hummons – 312/988-5656	**National Judicial College** Reno, NV
August 6-12, 2025	ABA Annual Meeting Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**TBD** Toronto, CA

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