To be Argued by:
SETH A. NADEL
(Time Requested: 15 Minutes)

Court of Appeals
of the
State of New York

APL-2021-00001

THE COLUMBIA MEMORIAL HOSPITAL,

Plaintiff-Appellant,

– against –

MARCEL HINDS, M.D.,

Defendant-Respondent.

BRIEF FOR DEFENDANT-RESPONDENT

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PRELIMINARY STATEMENT

Respondent Marcel E. Hinds, M.D. ("Dr. Hinds") respectfully submits this brief in opposition to the appeal of Appellant Columbia Memorial Hospital ("Hospital"), seeking reversal of the "Memorandum and Order" of the Appellate Division, Third Department, dated November 5, 2020 [R.262].[1] The Third Department affirmed the Supreme Court, Columbia County, which dismissed the Hospital's complaint under Rule 3211(a)(1) and (a)(7) of the Civil Practice Law and Rules ("CPLR"), and awarded the proceeds from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC") to Dr. Hinds in accordance with the legal and regulatory authorities governing MLMIC's demutualization.

In brief summary, this appeal is the culmination of the Hospital's persistent efforts to convince the courts to award it demutualization proceeds from the sale of MLMIC despite the absence of any legal, contractual or equitable entitlement to those funds. Every argument advanced by the Hospital here, along with other arguments which appear to have been abandoned, were thoroughly considered and properly rejected by the Columbia County Supreme Court and the Third Department. Additionally, in the time it has taken this case to wind through the courts, identical arguments by similarly-situated employers have been roundly rejected by the Second and Fourth Departments, establishing a broad judicial consensus that the Hospital

[1] Numbers in brackets preceded by "R" refer to pages in the Record on Appeal.

has no right to the relief it seeks and that its arguments to the contrary are meritless. Now seeking to convince the Court of Appeals to eschew proper application of the relevant law in favor of indulging the Hospital's subjective notions of fairness, the Hospital presses the same arguments and the same result is warranted: The Third Department's determination should be affirmed.

A straightforward analysis the of legal authorities governing MLMIC's demutualization, coupled with the undisputed facts and documentary evidence presented in this case, demonstrate that the decisions of the Supreme Court and Third Department were correct. The demutualization of a mutual insurance company is a highly regulated process, subject to New York's Insurance Law ("Insurance Law"), a plan of conversion promulgated by MLMIC and approved by its policyholders ("Plan"), and approval of the Plan by the New York State Department of Financial Services ("DFS") thereby ensuring that the Plan followed the Insurance Law and was in the best interest of MLMIC's *policyholders*.

In connection with the demutualization and under the approved and implemented Plan, eligible policyholders – like Dr. Hinds – were granted the statutory right to receive demutualization proceeds ("Cash Consideration") in exchange for surrendering their respective ownership interests in MLMIC. Under the clear terms of the Plan, the *only* exception to this statutory entitlement was in cases where the policyholder *affirmatively* assigned his or her right to receive the

Cash Consideration to a third party. It is undisputed and dispositive of this appeal that neither Dr. Hinds's employment agreement ("Employment Agreement") nor any other document was ever executed by Dr. Hinds assigning the Cash Consideration to the Hospital. The Hospital's own Verified Complaint ("Complaint") flatly concedes that the Hospital had demanded that Dr. Hinds assign his rights to the Cash Consideration to the Hospital, and he refused. The relevant legal inquiry does not extend any further.

For the purposes of this appeal, the Hospital appears to have streamlined its position, presenting two principal arguments: (1) that contrary to the plain language of relevant authorities and comprehensive holdings of courts that have examined and applied those authorities, the Insurance Law awards demutualization proceeds not to policyholders who, by statute, own a mutual insurer, but to whomever pays the policyholder's insurance premiums; and (2) that even if applicable law entitles the policyholder to the Cash Consideration, the law should be disregarded because awarding the Cash Consideration to the policyholder is not fair or equitable.

For its *statutory* argument, the Hospital focuses exclusively on Insurance Law § 7307(e), which provides specific requirements for a plan of conversion promulgated by the insurer setting forth the governing terms and methodology for its demutualization. Specifically, the Hospital culls a few words from Insurance Law § 7307(e)(3), which set forth a formula to calculate a policyholder's ownership

interest in the insurer based on insurance premiums "such policyholder has properly and timely paid" to the insurer over a specified time period. From this, the Hospital erroneously concludes that the purported link between the entitlement to demutualization proceeds and payment of premiums is proof positive that the Legislature did not intend a policyholder whose premiums were paid by someone else to receive anything. Rather, the only "rational outcome," in the Hospital's estimation, would be to cut out policyholders who actually *owned the insurer* and instead pay the proceeds to the party that paid the premiums.

The plain language of the Insurance Law §7307, as extensively analyzed and discussed in the well-informed decisions of the Second, Third and Fourth Departments, is clear that the statute protects the rights of policyholders and entitles *only policyholders* to demutualization proceeds as the owners of the liquidated interest in the demutualized insurer. The Hospital's argument that the Legislature intended anyone but the policyholder to receive demutualization proceeds is simply not supported by the text of the Insurance Law.

In addition, the Hospital's argument rests on the fundamental misconception that solely Insurance Law § 7307 governs MLMIC's demutualization, ignoring the fact that the approved Plan requires Cash Consideration to be paid to *policyholders* unless they assign their rights to third-parties. While Insurance Law § 7307 sets out the basic parameters for a plan of conversion which must be promulgated by the

insurer and approved by DFS before demutualization may take place, it is the Plan that defines the rights of parties in each individual insurer's demutualization under the Insurance Law.

The relevant terms of the Plan, conspicuously omitted from the Hospital's brief, govern MLMIC's demutualization and provide that a policyholder's share of the Cash Consideration is calculated based on premiums "*properly and timely paid under their Eligible Policies*." In other words, in establishing the policyholders' entitlement to the Cash Consideration, the Plan itself draws *no distinction* between policyholders who paid their own premiums and policyholders whose premiums were paid on their behalf. Accordingly, even if the Hospital's statutory-interpretation argument had any validity (which it does not), the Plan itself requires that Cash Consideration be paid to *policyholders* regardless of who paid their premiums.

This simple clarification in the Plan refutes the Hospital's argument that there is a statutory basis for awarding it Cash Consideration, or any legislative intent that policyholders must personally pay premiums to be entitled to demutualization proceeds. Likewise, similar arguments made by the Hospital, such as the absence of a definition of "policyholder" in the Insurance Law, are easily addressed by the definitions section of the Plan, where operative terms such as "policyholder," "eligible policyholder," and "designee" are all clearly defined. Overall, only by

ignoring the existence and legal effect of the Plan could the Hospital's position even appear to have merit.

As for its *equitable* argument, the Hospital essentially asserts that notwithstanding the governing law and the Plan, it would be against equity and good conscience to allow Dr. Hinds to retain the Cash Consideration when the Hospital selected and administered the policy, and paid Dr. Hinds's insurance premiums in consideration for Dr. Hinds's work, labor and services.

However, the Plan is abundantly clear that neither payment of a policyholder's premiums, status as policy administrator, nor undertaking of other clerical duties are sufficient to entitle a third-party to the Cash Consideration without an assignment or designation by the policyholder. The Hospital's claim that it possesses any rights *in equity* is tantamount to alleging that courts are empowered to flatly disregard statutes and contracts, so long as the result could be justified as equitable. This proposition is legally untenable.

The Hospital's "equity" argument also ignores the fact that the Hospital did not procure MLMIC premiums out of generosity or altruism; it explicitly agreed to do so in order to secure Dr. Hinds's services as a skilled physician. When the Hospital provided Dr. Hinds with a malpractice policy from a mutual insurer pursuant to its contractual obligations, it knew Dr. Hinds would be the policyholder and owner of that policy and entitled to all legal benefits thereunder. Had the

Hospital wished to negotiate for a right to demutualization proceeds, it could have done so. That it failed to anticipate the possibility that MLMIC might demutualize at the time it drafted the contract does not give the Hospital grounds, years after the Employment Agreement was signed, to compel the Court to rewrite the contract to grant the Hospital a benefit it never bargained for.

Beyond this, the Hospital leans on an early First Department decision, two out-of-state cases involving questions under federal law that have no relation to the instant dispute, and on Supreme Court decisions previously constrained to follow the First Department, all of which have been almost entirely abrogated by subsequent decisions from the Second, Third and Fourth Departments. In light of the subsequent, comprehensive decisions of the other Appellate Divisions, none of the cases the Hospital relies on provide any basis for adopting the sparsely worded conclusory determination of the First Department over more recent, better-informed precedent.

In sum, the Hospital has no right to the relief that it seeks. In the absence of any legal, contractual or equitable entitlement, the Cash Consideration is the rightful property of Dr. Hinds as a matter of law. Because the Hospital has stated no cognizable claim, the Third Department's "Memorandum and Order" should be affirmed.

QUESTIONS PRESENTED

1. Does the Hospital have any right to the Cash Consideration allocated to Dr. Hinds under the Insurance Law and Plan, where Dr. Hinds was the sole policyholder and owner of the subject MLMIC policy and never assigned his legal right to the Cash Consideration to the Hospital, as is required for a third-party to receive demutualization proceeds?

Decisions from the Third Department, as well as the Second and Fourth Departments, have properly determined that the Hospital does not. The Hospital's contention that the Insurance Law "expressly links a party's entitlement to receipt of the Cash Consideration… to the payment of premiums" (Appellant's Brief, p.25) completely disregards the plain language of the Insurance Law and the Plan governing MLMIC's demutualization, and which was endorsed and approved by DFS. The Insurance Law and Plan are clear and unambiguous on this point, and resolve every question raised by the Hospital to fabricate a claim to the Cash Consideration from the language of the Insurance Law. The Hospital has no legal right to the funds.

2. In the absence of any legal right to the Cash Consideration, may the Hospital stake a claim the disputed funds under a theory of unjust enrichment based on its payment of insurance premiums, despite both Dr. Hinds's and the Hospital's having received everything they bargained for under the parties' Employment

Agreement, which contained no provision granting the Hospital the right to demutualization proceeds arising from Dr. Hinds's policy?

The Third Department properly determined that the Hospital may not resort to equity to create a right to the Cash Consideration where none exists, and that receipt of the Cash Consideration would be a windfall to either party where both the policyholder and the employer received everything they were entitled to under the parties' Employment Agreement. The Second and Fourth Departments are in accord. Moreover, the law does not permit courts to add words to or subtract words from a statute, or to review the discretion of the Legislature.

STATEMENT OF UNDISPUTED FACTS

The material facts are undisputed and justified the Supreme Court's dismissal of the Hospital's action under CPLR Rule 3211(a)(1) and (a)(7), and the Third Department's affirmance.

Dr. Hinds was employed by the Hospital from 2006 through August 2017 [R.133-34] as an OB-GYN physician under a written Employment Agreement [R.140-48], effective as of August 2012. The Employment Agreement set forth Dr. Hinds's compensation and benefits and reflected the Hospital's agreement to "maintain an individual occurrence-based medical malpractice insurance policy" on his behalf through an insurance carrier "as the Hospital [deemed] reasonable and appropriate" [R.143]. In other words, the Hospital agreed to provide Dr. Hinds with a malpractice insurance policy as part of the compensation paid to Dr. Hinds in exchange for his professional services.

In accordance with its obligations under the Employment Agreement, the Hospital provided Dr. Hinds with a malpractice insurance policy through MLMIC [R.165], for which Dr. Hinds was the named policyholder and owner [R.149]. Notably, the Employment Agreement was silent as to the disposition of any demutualization proceeds, should any ever arise. The Hospital, for its part, was identified on Dr. Hinds's insurance policy declaration page as Policy Administrator [R.149], which provided that the Hospital was the "agent of [the Insured] for the

paying of premiums, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return premiums when due [R.180].” Nothing in the policy-administrator designation confers any rights in the policy administrator to demutualization proceeds [R.180].

In mid- to late-2018, MLMIC announced its intention to be sold to National Indemnity Company – a subsidiary of Berkshire Hathaway – and demutualize. This meant that MLMIC would be converted from a mutual insurance company owned by its policyholders to a stock insurance company owned by conventional shareholders [R.47]. In connection with MLMIC’s proposed sale and demutualization, policyholders such as Dr. Hinds became eligible to receive compensation in consideration of the surrender of their ownership interests in MLMIC [R.47].

After learning of MLMIC’s impending demutualization and payment of Cash Consideration, the Hospital demanded that Dr. Hinds designate the Hospital as recipient of the Cash Consideration because the Hospital had paid his MLMIC premiums and served as policy administrator [R.150-62]. Despite threats of litigation – and as was his prerogative – Dr. Hinds refused to assign his rights to the Hospital [R.25, 134-36].

Following Dr. Hinds’s refusal, the Hospital commenced this action attempting to stake a claim to the Cash Consideration [R.17-30]. The Hospital’s Complaint

asserted four causes of action: (1) a declaratory judgment that the Hospital was legally entitled to the Cash Consideration; (2) a claim for unjust enrichment if Dr. Hinds were to receive the Cash Consideration; (3) an equitable claim for money had and received; and (4) a breach of the implied covenant of good faith and fair dealing by Dr. Hinds [R.18-30].

In lieu of answering, Dr. Hinds moved to dismiss the Complaint under CPLR Rule 3211(a)(1) and (a)(7) upon the grounds that controlling legal authorities, undisputed facts, and lack of any contractual entitlement to the Cash Consideration, foreclosed any claim the Hospital might have to the funds, as a matter of law [R.163-178]. The Supreme Court granted Dr. Hinds's motion, issuing a comprehensive decision dismissing the Hospital's complaint in its entirety, and determining that Dr. Hinds was entitled to the Cash Consideration, as a matter of law [R.5-16]. The Third Department affirmed the Supreme Court's decision [R.262-265], precipitating the instant appeal.

LEGAL ARGUMENT

I. ONLY POLICYHOLDERS IN A MUTUAL INSURANCE COMPANY ARE ENTITLED TO DEMUTUALIZATION PROCEEDS, AS A MATTER OF LAW

Despite the Hospital's obfuscations, and those of numerous other employers in dozens of identical lawsuits brought after MLMIC's demutualization, the determination of who is entitled to the Cash Consideration is straightforward. The

law clearly provides that policyholders in a mutual insurer are entitled to demutualization proceeds in the absence of an affirmative designation of that right by the policyholder to a third-party.

A. **The Insurance Law provides that the policyholders own a mutual company, and no others are entitled to cash <u>consideration resulting from a demutualization and sale.</u>**

Prior to demutualization, MLMIC was a mutual insurance company "organized, maintained and operated for the benefit of its members as a non-stock corporation." Insurance Law § 1211(a). Every MLMIC policyholder – including Dr. Hinds – was a *member* of MLMIC and had an *ownership* interest in the company. *Id.*

Importantly, a policyholder's ownership interest is not "bought" through payment of insurance premiums, but rather arises as an operation of law incident to the structure of a mutual insurer. *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338 (3d Dep't 2020) (*citing Dorrance v. United States*, 809 F.3d 479, 482 [9th Cir. 2015]); *accord Maple Med., LLP, v. Scott*, 191 A.D.3d 81 (2d Dep't 2020).

The basic requirements for demutualization of a mutual insurer are set forth in Insurance Law §7307. The terms and procedures of a specific insurer's demutualization are set forth in a "plan of conversion," to be duly promulgated by the insurer, and approved by DFS. Insurance Law §7307(d).

Insurance Law §7307(e)(3) expressly sets forth the requirements for a plan of conversion, and plainly specifies who is entitled to the proceeds from the sale of a mutual insurer. The Insurance Law states, in pertinent part: "The plan [of conversion] shall also provide that *each person who had a policy of insurance in effect at any time during the three-year period* immediately preceding the date of adoption of the resolution described in subsection (b) hereof *shall be entitled to receive in exchange for such equitable share*, without additional payment, *consideration* payable in voting common shares of the insurer or other consideration, or both." Insurance Law §7307(e)(3) (emphasis added). Nothing in the statute provides that any party except the "person who had a policy of insurance" is entitled to receive consideration upon demutualization and sale.

B. The MLMIC Plan of Conversion confirms that policyholders are entitled to demutualization proceeds; the only exception being where the <u>policyholder affirmatively assigned those rights.</u>

Per DFS: "Under the Insurance Law, a plan of conversion is the operative document governing a demutualization, with such document subject to various procedural requirements and the Superintendent's approval [R.100-01]."

Insurance Law §7307(c) and (d) provide that before granting or denying permission to submit a plan of conversion, DFS must appoint an appraiser to report on the insurer's value, taking into consideration its assets and liabilities and any other

factors bearing on value. After receiving these reports, DFS may grant or deny permission to submit a plan of conversion.

Insurance Law §7307(e)(3) provides that a conversion plan must include the manner and basis of exchanging the equitable shares of each eligible *policyholder* for the stock of the converted insurer or other consideration. The statutory scheme, followed by the Plan, recognizes the right of *policyholders* to the cash consideration, and is central to determining the instant case.

Under the Insurance Law, on May 22, 2018, DFS granted MLMIC permission to file an application to approve the Plan [R.52]. The Plan was adopted by MLMIC's board on May 31, 2018 and was submitted to DFS for consideration on June 15, 2018 [R.98]. The Plan proposed MLMIC's conversion to a stock corporation, and the sale of the newly authorized MLMIC shares to National Indemnity Company according to an Acquisition Agreement, dated February 23, 2018 [R.47].

In accordance with the language of the Insurance Law, the Plan identifies *policyholders* as those whose rights are affected [R.47-48]. The Plan defines Cash Consideration as an amount equal to $2,502,000,000.00 [R.48] and states that the Cash Consideration allocable and paid to *Eligible Policyholders* is adequate consideration paid for MLMIC [R.54]. Article 2 of the Plan defines "eligible policyholders," "policy administrators," "policyholders," and "policyholder membership interest" as follows:

‘*Eligible Policyholder*’ means the Policyholder of an Eligible Policy. For Eligible Policies that identify multiple insureds, each Person so identified on the declarations page of such Policy shall be an Eligible Policyholder. Each such Eligible Policyholder that is a Record Date Policyholder shall be entitled to vote at the Special Meeting. In addition, each such Eligible Policyholder shall be entitled to an allocation of the Cash Consideration based on the Eligible Premium with respect to such Eligible Policyholder as set forth in the definition of Eligible Premium.

*　　　　*　　　　*

‘*Policy Administrator*’ means a Person designated on the declarations page of the applicable Policy or otherwise as the administrator of the Policy on behalf of the applicable Policyholder, or any successor to such Person. For the avoidance of doubt, such Person may be an organization, a professional practice group or a third party.

*　　　　*　　　　*

‘*Policyholder*’ means, with respect to any Policy, the Person(s) identified on the declarations page of such Policy as the insured. For Policies that identify multiple insureds, each Person so identified on the declarations page of such Policy shall be a Policyholder. For the avoidance of doubt, no Person(s) identified as an additional insured under any Policy shall be considered a Policyholder with respect to such Policy.

*　　　　*　　　　*

‘*Policyholder Membership Interests*’ means, with respect to MLMIC, the interests of Members arising under the New York Insurance Law and under the charter, bylaws and Policies of MLMIC prior to the Conversion, including the right to vote, the right to participate in any distribution of surplus, earnings and profits of MLMIC (including

> dividends), and the right to participate in meetings of members. 'Policyholder Membership Interests' do not include insurance coverages provided under the Policies.

[R.49-51] (emphasis in original).

In accordance with the Insurance Law, the Plan provided that the conversion *will provide Eligible Policyholders, or their Designees, with Cash Consideration*. The amounts allocated to Eligible Policyholders vary according to the *premiums properly and timely paid under their Eligible Policies* [R.48].

Finally, the Plan identified the only circumstance under which anyone other than the policyholder could receive Cash Consideration: "*the amount distributable to each Eligible Policyholder shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has affirmatively designated a Policy Administrator… to receive such amount on its behalf, in which case such amount shall be distributed to such Designee* [R.57 (emphasis added)]." *Designees*, under the Plan, are defined as "Policy Administrators and EPLIP Employers, in each case, *to the extent designated by Eligible Policyholders* to receive the portion of the Cash Consideration allocated to such Eligible Policyholders" [R.49] (emphasis added)."

C. The DFS Decision approves the Plan.

To effect a demutualization, Insurance Law §7307(b) requires a mutual insurer, by and through its board of directors, to apply to DFS for leave to convert to a stock insurer. The application must be made pursuant to a resolution adopted by

the board of directors, "specifying the reasons for and the purposes of the proposed conversion, *and the manner in which the conversion is expected to benefit policyholders and the public*." Insurance Law §7307(b) (emphasis added). Under Insurance Law §7307(h)(1), the mutual insurer must demonstrate to DFS, among other things, the benefit of demutualization to *policyholders* and the public.

Upon receipt of MLMIC's proposed Plan, and as part of the statutorily mandated approval process provided in Insurance Law §7307, DFS held a public hearing and solicited oral testimony and written public comments from interested parties. Insurance Law §7307(h)(1) requires that upon conclusion of the public hearing, DFS shall either approve the conversion plan as submitted, refuse to approve it, or request modification before approval.

Once approved, a conversion plan is submitted to a vote by the *policyholders*. Insurance Law §7307(i). The approval of two-thirds of all votes cast by *policyholders* are necessary to adopt the plan. Insurance Law §7307(j).

In June and July 2018, DFS published notice of a public hearing in various daily newspapers and sent notice to policyholders whose rights would be affected by the demutualization [R.107-108]. DFS held the public hearing on August 23, 2018, after publishing notice in the New York Register and on DFS' website [R.107]. Excluding DFS personnel, 64 individuals attended the public hearing and eight interested individuals asked to speak [R.108].

Following the hearing, the DFS rendered a decision on September 6, 2018, approving the Plan ("DFS Decision") [R.98-125]. The DFS Decision thoroughly outlined the procedure for demutualization as codified in Insurance Law §7307, and acknowledged DFS's authority under Insurance Law §7307(h)(1) to approve the Plan if it "is not inconsistent with law, is fair and equitable, and is in the best interest of the *policyholders* and the public [R.109 (emphasis added)]." DFS determined that Insurance Law parameters were met [R.109], and that the purchase price was negotiated at arm's length and was fair and equitable [R.110].

The DFS Decision also addressed public comments, mainly from hospitals and other employers of physicians who believed they should receive the Cash Consideration instead of physician-policyholders [R.118-119]. Relevant here, one such commenter raised the argument referring to the language of Insurance Law §7307(e)(3), noting that the statute based the amount of cash consideration on premiums "properly and timely paid to an insurer." *Id.* The commenter argued that if an employer paid the MLMIC premiums, the employer should be entitled to the Cash Consideration [R.120].

Contrary to characterizations made by the Hospital in its Brief, *DFS rejected this argument*, citing the Insurance Law, and finding that a third party's payment of premiums "is not determinative because [Insurance Law §7307(e)] refers to 'policyholder,' which may or may not be the person who paid the premiums

[R.120].” *Maple Med., LLP, v. Scott*, 191 A.D.3d 81, 86 (2d Dep’t 2020) (“DFS considered, and rejected, this precise argument in its decision”)*; see GHVHS Medical Group, P.C. v. Cornell*, 2020 N.Y. Slip Op. 20104 (Sup. Ct. Orange Co. 2020) (“A close reading of the [DFS Decision] reveals that Plaintiff's claims were considered during the [MLMIC] demutualization process, but they did not change the language of what constitutes an ‘eligible policyholder’, even though [plaintiff] and others made objections at the public hearing”).

Most importantly, the DFS Decision confirmed that “*Insurance Law §7307(e)(3) explicitly defines those policyholders who are eligible to receive the purchase price consideration*” [R. 120 (emphasis added)], and confirmed the *one and only* instance when cash consideration may be paid to someone other than the policyholder:

> Insurance Law §7307(e)(3) defines the policyholders eligible to be paid their proportional share of the purchase price, but also recognizes that *such policyholders may have assigned such legal right to others*. Therefore, the Plan appropriately includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to the payment in a given case.

[R.120 (emphasis added)].

Following the demutualization and an initial spate of objections by various employers, including the Hospital [R.25], the DFS Decision was followed by an “Order Pursuant to the Superintendent’s Decision Dated September 6, 2018” (“DFS

Order"), dated January 14, 2019 [R.126-29]. The DFS Order, at footnote 1, cites Insurance Law §7307(e)(3), which defines eligible policyholders as persons who had policies in effect during the three-years preceding MLMIC's resolution to demutualize [R.126].

Consistent with the Plan and DFS Decision, the DFS Order acknowledges that cash consideration is payable only to eligible policyholders, "except that such Eligible Policyholders could assign their legal rights to such consideration to other persons" [R.126-27]. The DFS Order is otherwise consistent with the Plan and DFS Decision. Neither the Insurance Law, the Plan, nor the DFS Decision granted any ownership interest in MLMIC or the rights to Cash Consideration to a policy administrator or any other third party *unless the policyholder expressly assigned those rights*.

Based on the express provisions of the Insurance Law, the Plan and DFS's findings, the present dispute may thus be resolved by answering two simple questions: (1) who was the eligible policyholder; and (2) did the eligible policyholder ever assign the Cash Consideration to a third party?

The uncontested facts and documentary evidence presented to the Supreme Court and Third Department demonstrated, as a matter of law, that Dr. Hinds was the policyholder and a mutual owner of MLMIC [R.149], and that he never made an assignment to or otherwise designated the Hospital to receive the Cash

Consideration [R.25]. Accordingly, and as further articulated below, the Supreme Court and Third Department's determinations that Dr. Hinds is legally entitled to the Cash Consideration were correct and should be affirmed.

II. THE INSURANCE LAW VESTS THE HOSPITAL WITH NO RIGHT TO DEMUTUALIZATION PROCEEDS

The Hospital's statutory argument focuses myopically on a portion of Insurance Law §7307 to bolster its unsupportable position that the Insurance Law does *not* conclusively deem a policyholder as the proper recipient of the Cash Consideration. As has become typical in these disputes, the Hospital points to language in Insurance Law § 7307(e)(3) referring to premiums "properly and timely paid to the insurer," and implies that if a policyholder did not personally "pay" such amounts out of his or her own pocket, then the policyholder cannot receive Cash Consideration. The Hospital then proceeds to cogitate at length that the Legislature must have intended that Cash Consideration be paid instead to the person who *did* pay the premiums. This theory is undermined by both the plain language of the statute, the terms of the Plan, and every applicable rule of statutory interpretation.

Initially, Insurance Law §7307(e)(3) is unambiguous, and "[where] the terms of a statute are clear and unambiguous, 'the court should construe it so as to give effect to the plain meaning of the words used…" *Lubov v. Welikson*, 21 Misc. 3d 896, 900–01 (Sup. Ct. 2008) (internal citations omitted). *People ex rel. McCurdy v. Warden, Westchester Cty. Corr. Facility*, 36 N.Y.3d 251, 257, 163 N.E.3d 1087,

1091 (2020) (clearest indicator of legislative intent is statutory text; the starting point in any case of interpretation must always be the language itself, giving effect to the plain meaning thereof).

Based on only a snippet of §7307(e)(3), the Hospital's argument to the contrary is fundamentally flawed. Insurance Law § 7307, titled "Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers not in rehabilitation," provides a detailed and unambiguous roadmap for the demutualization process, which includes the necessity for a demutualization plan to protect the ownership interests of each *policyholder*.

The beginning of subsection (e) specifies the requirements of a plan of demutualization. It describes five items "[t]he plan shall include…" *Id.* The third item, specified in Subsection (e)(3), expressly addresses and protects *policyholders*. It states that the plan shall include "[t]he manner and basis of exchanging the equitable share of each eligible mutual *policyholder* for securities or other consideration, or both, of the stock corporation into which the mutual insurer is to be converted and the disposition of any unclaimed shares." *Id. (emphasis added).* The balance of §7307(e)(3) is equally zealous about protecting the ownership interests of each *policyholder*. It establishes a formula for determining the *policyholder's* equitable interest in the successor stock corporation, as only

policyholders are entitled to convert their equitable shares in the mutual insurer to shares in the successor entity.

On its face, the statute grants no one except *policyholders* – identified eight times in subsection (e)(3) – any rights or protections. Suggesting that the Hospital – a third party with no identifiable legal interest – is entitled to an ownership interest in the successor entity or to the money realized from a *policyholder* surrendering his or her ownership, is unsupported by the clear and unambiguous language of the statute, and its legislative intent. Indeed, the sentence from which the Hospital cites a few words, begins as follows: "The equitable share *of the policyholder* in the mutual insurer shall be determined by…" *Id.* (emphasis added). The words the Legislature chose are clear and specific; it is the equitable share *of the policyholder* that is being determined. It is irrelevant *who* pays the premiums so long as premiums are "timely paid to the insurer…" *Id.*

N.Y. Statutes Law § 74 specifically provides that "[a] court cannot by implication supply in a statute a provision which is reasonable to suppose the Legislature intended intentionally to omit; and the failure of the Legislature to include a matter within its scope may be construed as an indication that its exclusion was intentional." *Id.*; N.Y. Statutes Law § 240 (where a law expressly describes a particular act, thing or <u>person</u> to which it shall apply, an irrefutable inference must

be drawn that what is omitted or not included was intended to be omitted or excluded) (emphasis added).

Furthermore, under N.Y. Statutes Law § 76 "[w]here words of a statute are free from ambiguity and express plainly, clearly and distinctly the legislative intent, resort may not be had to other means of interpretation." *Id.* Lastly, N.Y. Statutes Law § 73 states that courts should avoid judicial legislation in construing statutes, as "they do not sit in review of the discretion of the Legislature or determine the expediency, wisdom or propriety of its action on matters within its powers." *Id.*

Had the Legislature intended to create ownership interests, or any rights, in anyone other than the *policyholder*, it would have said so explicitly. The Legislature could have easily stated the following: "*The equitable share of any person paying the premiums to the mutual insurer shall be determined by…"* The Legislature, however, did not choose that language.

As the Court of Appeals wrote in *McNerney v. City of Geneva*, 290 N.Y. 505, 511 (1943), "[t]he power of extending the meaning of a statute beyond its words, and deciding by the equity, and not the language, approaches so near the power of legislation, that a wise judiciary will exercise it with reluctance and only in extraordinary cases." *Id.* (argument invoking fairness of a looser construction of statute was out of place; Court of Appeals saw no substantial reason for thinking letter of statute did not completely express intent of Legislature).

That said, *policyholders* did have the right to assign their respective interests in demutualization proceedings as *they* saw fit. Such a mechanism was put in place under the Plan for any employer – like the Hospital – to negotiate for demutualization proceeds. Many policyholders did assign their rights. Others – like Dr. Hinds – did not, and there is no legal basis to force them to do so. Most courts that have examined this issue are in accord. *See Maple Med., LLP v. Scott*, 191 A.D.3d 81, 92 (2d Dep't 2020) ("The plain language of Insurance Law § 7307, the plan of conversion, and the DFS decision make clear that the policyholder is entitled to the consideration paid in connection with the MLMIC demutualization"); *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338, 342 (3d Dep't 2020) ("The first quoted sentence of this statute explains who is entitled to receive the consideration, whereas the second quoted sentence explains how the consideration for each eligible person is to be calculated.")

Furthermore, "a statute must be construed as a whole and… its various sections must be considered together and with reference to each other." *New York Cty. Lawyers' Ass'n v. Bloomberg*, 19 N.Y.3d 712, 721 (2012) (internal citations omitted).

Construed as a whole, Insurance Law § 7307 references the rights of policyholders *26 times*. It makes absolutely no mention of anyone's entitlement to demutualization proceeds except policyholders, nor vests any rights in third parties

because they paid a policyholder's insurance premiums or for any other reason. In the context of a statute specifically *conferring* rights upon the owners of a mutual insurer, the Hospital's argument that the Legislature intended the same statute to *divest* those rights without explicitly stating so is absurd. As mentioned, had the Legislature so intended, it could have very clearly provided that the person paying a policyholder's insurance premiums was the one entitled to demutualization proceeds. Instead, it is clear that the Legislature intended that only eligible policyholders (who are, by definition, *owners* of the liquidated insurer), and no others, receive Cash Consideration in exchange for their ownership interests.

Finally, the Hospital's argument regarding the language of the Insurance Law and the purported legislative intent are premised on a fundamental misunderstanding of the authorities governing demutualization.

The Insurance Law sets forth the *basic parameters of the conversion plan* required for approval of a demutualization plan by DFS. *See* Insurance Law §7307(d)-(e). However, subject to DFS' approval (and subsequent approval by a mutual insurer's policyholders), *the conversion plan is the operative authority which governs and defines the rights of the parties in a demutualization, and payment of demutualization proceeds*. Insurance Law §7307(d)-(e); *See Bank of New York v. Janowick*, 470 F.3d 264, 266 (6th Cir. 2006) (plan defines rights to demutualization

proceeds); *Praxair, Inc. v. Union Carbide Corp.*, 2008 WL 222321 *2 (D. Conn. Jan. 25, 2008) (plan sets forth allocation principals for distributing proceeds).

Among other things, a demutualization plan must set forth "[the] manner and basis of exchanging the equitable share of each eligible mutual policyholder into which the mutual insurer is to be converted and the disposition of any unclaimed shares." § 7307(e)(3). In MLMIC's case, its Board voted to satisfy the requirements of Insurance Law § 7307(e)(3) in Article I of the Plan, by providing as follows:

> Article I
> Purpose of the Conversion
>
> The principle purpose of the Conversion is to convert MLMIC from a mutual insurance company into a stock insurance company. The Sponsored Conversion will provide Eligible Policyholders, or their Designees, with Cash Consideration. The Board believes that the transaction is fair and equitable, is consistent with the purport and intent of Section 7307 of the New York Insurance Law, and will not prejudice the interests of the policyholders of MLMIC. The Sponsored Conversion will not reduce insurance coverages provided to the MLMIC policyholders under the Policies issued by MLMIC.
>
> *The amounts allocated to Eligible Policyholders shall vary according to the premiums <u>properly and timely paid under their Eligible Policies</u>, and shall be payable to Eligible Policyholders, or their Designees, as described in Article 8 of this Plan of Conversion*, in respect to the extinguishment of all Policyholder Membership Interests. The portion of the Cash Consideration allocated to Eligible Policyholders will be based on qualifying premiums in accordance with the provisions of Article 8 of this Plan of Conversion and Section 7307 of the New York Insurance Law.

Plan, Article I (emphasis added) [R.47-48].

As is clear from the quoted text of the Plan, the Hospital's parsing of §7307(e)(3) by referring only to premiums "properly and timely paid to the insurer," and the Hospital's related musings of legislative intent, are a red herring. *Nowhere in the Plan does any such language appear*. The Plan instead provides that Cash Consideration is allocated based on premiums paid "*under the [policyholders'] Eligible Policies*," thereby drawing no distinction as to whether a policyholder paid their premiums. There is no ambiguity.

Indeed, MLMIC's demutualization could only move forward after DFS determined that the Plan "[did] not violate this chapter [of the Insurance Law] and is not inconsistent with law." Insurance Law § 7307(h)(1). DFS approved the Plan as written pursuant to the DFS Decision [R.125]. This clearly demonstrates that the language MLMIC's Board chose relating to the calculation of Cash Consideration – adopting the "under-their-policy" language – satisfied the Insurance Law.[2] Accordingly, even if the Hospital's interpretation of the Insurance Law had some

[2] Following DFS's approval of the Plan, Maple Medical LLP – an employer that had urged the rejected interpretation of Insurance Law §7307(e)(3) at the public hearing – commenced an Article 78 proceeding against DFS in the Supreme Court, Westchester County, arguing that DFS's interpretation of Insurance Law §7307(e)(3) was erroneous, and that the *employer* be declared to be the policyholder to whom demutualization proceeds should be paid. Maple Medical's petition was dismissed on procedural grounds, but the Supreme Court noted that if the merits had been reached, the Court would not have annulled DFS's interpretation of the Insurance Law. *Maple Medical LLP v. New York State Department of Financial Services*, Index No. 65929/2018, NYSCEF Doc. 59, at 3 (Sup. Ct. Westchester Co. 2018) (DFS properly considered and weighed relevant criteria; determination had rational basis).

validity, the express terms of the Plan unambiguously vest Cash Consideration in MLMIC's policyholders regardless of who paid their premiums.[3]

In sum, the Hospital's fanciful interpretation of Insurance Law §7307 finds no support in the text of the statute or the terms of the Plan, and the Hospital's attempts to judicially overrule the Legislature and rewrite the statute to support a claim to the Cash Consideration are unavailing.

III. THE HOSPITAL CANNOT USE EQUITY TO CIRCUMVENT THE LAW GOVERNING MLMIC'S DEMUTUALIZATION

A. The Hospital cannot circumvent a statutory entitlement by asserting equitable claims.

"[T]he Court's objective is, of course, to discern and apply the will of the Legislature, not the court's own perception of what might be equitable." *Sutka v. Conners*, 73 N.Y.2d 395, 403 (1989). *See McNerney v. City of Geneva*, 290 N.Y. 505 (1943). Recognizing that its claim is not supported by the Insurance Law or the Plan, the Hospital relies on equity to supersede the Insurance Law and award it the Cash Consideration. Indeed, the basic thrust of the Hospital's argument is that this Court may disregard an express statutory and regulatory mandate because the Hospital feels that adherence to these authorities would be unfair. *See Maple Med.,*

[3] The Hospital also claims, at page 28 of its Brief, that the Insurance Law does not define the term "policyholder," leaving open the possibility that the Hospital, rather than the "nominal policyholder" might be entitled to the Cash Consideration. Again, the Hospital ignores the Plan's specific definition of "Policyholder" as "the Person(s) identified on the declarations page of such Policy as the insured" [R.51], which in this case is Dr. Hinds and *not* the Hospital [R.149].

LLP v. Scott, 191 A.D.3d 81, 103 (2d Dep't 2020) ("The essence of Maple Medical's unjust enrichment claim is an effort to use the principles of unjust enrichment to overcome the medical professionals' entitlement to the proceeds of demutualization, which entitlement derives from this State's Insurance Law.")

As a threshold matter, this is a legally unsupportable proposition. As stated by this Court: "In interpreting statutes, which are the enactments of a coequal branch of government and an expression of the public policy of this State…; statutes are to be applied as they are written or interpreted to effectuate the legislative intention." *Niesig v. Team I*, 76 N.Y.2d 363, 369 (1990). *See Bordell v. Gen. Elec. Co.*, 208 A.D.2d 219, 221 (3d Dep't 1995). "It is not the duty of courts to disregard the plain words of a statute, even in favor of what may be termed an 'equitable construction,' in order to extend it to some supposed policy not included in the act." *Tompkins v. Hunter*, 149 N.Y. 117, 123 (1896) (internal citations omitted).

This principle is universally recognized. As stated by the United States Supreme Court in *Guidry v. Sheet Metal Workers National Pension Fund*, 493 U.S. 365, 376 (1990), "courts should be loath to announce equitable exceptions to legislative requirements or prohibitions that are unqualified by the statutory text." *Id. A statute "should not be supplemented by extratextual remedies, such as common-law doctrines…*" *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 497 (1999), *citing*, *Guidry*, *supra* (emphasis added); *see also National Railroad*

Passenger Corp. v. National Association of Railroad Passengers, 414 U.S. 453, 457 (1974) (when legislation expressly provides particular remedy, court should not expand statute's coverage to subsume other remedies).

In light of these facts and controlling authority, the Hospital may not look to equity to create a right where none exists, and none of the cases cited by the Hospital support the proposition that a court may flatly disregard a statute based solely on subjective notions of fairness.

B. <u>The Hospital has failed to state a claim for unjust enrichment.</u>

"The essential inquiry in any action for unjust enrichment… is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered." *Paramount Film Distribution Corp. v. State of New York*, 30 N.Y.2d 415, 421 (1972), *rearg. den.*, 31 N.Y.2d 709 (1972). Thus, to prevail on a claim for unjust enrichment, a plaintiff must show "that (1) the other party was enriched, (2) at that party's expense, and (3) that 'it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered.'" *Citibank, N.A. v. Walker*, 12 A.D.3d 480, 481 (2d Dept. 2004), *citing, Paramount*, *supra*.

It is axiomatic that to establish a claim for unjust enrichment, it is necessary to demonstrate that the defendant had been *unjustly enriched at the plaintiff's expense*. *E.J. Brooks Co. v. Cambridge Sec. Seals*, 31 N.Y.3d 441 (2018). Even

leaving all other considerations aside and disregarding legal and statutory authority supporting Dr. Hinds's entitlement to the Cash Consideration, there can be no unjust enrichment, as a matter of law, because Dr. Hinds has not been enriched *at the Hospital's expense*.

The Hospital presses the fact that it remitted Dr. Hinds's policy premiums. Thus, according to the Hospital and in the most literal interpretation of the term, the Cash Consideration arose *at its expense*. The argument fails. The Hospital paid premiums pursuant to its Employment Agreement with Dr. Hinds only as an inducement for Dr. Hinds's work, labor and services. By fulfilling its contractual obligation to do so, the Hospital received the services of a skilled physician covered by a malpractice policy, and the benefits of Dr. Hinds's professional services to generate revenue for the Hospital. In other words, the Hospital received *exactly what it bargained for*.

"Enrichment alone will not suffice to invoke the remedial powers of a court of equity. Critical is that under the circumstances and as between the two parties to the transaction the enrichment be *unjust*." *McGrath v. Hilding*, 41 N.Y.2d 625, 629 (1977) (emphasis added). The mere fact that one's activities bestowed a benefit on another is insufficient to establish *unjust* enrichment. Generally, courts will look to see if a benefit has been conferred under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the

defendant, and whether the defendant's conduct was tortious or fraudulent. *Clark v. Daby*, 300 A.D.2d 732, 732, 751 N.Y.S.2d 622, 623–24 (3d Dep't 2002).

It is not unjust that Dr. Hinds is entitled to the Cash Consideration based on his ownership of MLMIC, the Insurance Law, and the Plan. There was no mistake of law or fact when the parties entered into and fulfilled the terms of their Employment Agreement. The Hospital was or should have been aware that it was procuring an individual malpractice policy for Dr. Hinds from a mutual insurer and that he would be policyholder and owner. Dr. Hinds's conduct with respect to the MLMIC funds has been neither tortious nor fraudulent. He merely asserts a right to what is unequivocally and lawfully his.

By now, the issue of whether an employer's unjust-enrichment claim may supersede relevant legal authorities in the context of the MLMIC demutualization has been centrally featured in decisions from the Second, Third and Fourth Departments. These courts have universally agreed that it does not.

The Second Department's analysis in *Maple Med., LLP v. Scott*, 191 A.D.3d 81 (2d Dep't 2020) is particularly comprehensive:

> Applying these principles [of unjust enrichment] here, Maple Medical has not proven, and cannot prove, a cause of action for unjust enrichment. It has not provided the benefits in question to its employee-physicians—those benefits are provided by the plan of conversion and, ultimately, by the acquiring entity. At most, Maple Medical provided malpractice insurance premium payments, surely a benefit, but a benefit of the

employment contracts between Maple Medical and its physician-employees for which the physician-employees paid valuable consideration in the form of their labor. Since the physicians provided their services to Maple Medical in exchange for the benefits paid to them, or for them, under the employment agreements, it simply cannot be said that the employees have not already adequately compensated Maple Medical for the benefits paid. The payment of the medical malpractice insurance premiums was not a gratuitous act; it was part of the bargained-for consideration for the employment services that the physicians provided to the medical group. Moreover, the medical group itself benefitted from the payment of premiums for the malpractice policies to the extent that they covered the group's vicarious liability for the acts of its employees.

Analyzed somewhat differently, we agree with our colleagues in the Third Department that it cannot be said that any benefit was paid here under a mistake of law or fact. The demutualization proceeds are properly payable to the policyholders (or their written designees) based upon the appropriate construction of the governing statute and the conversion plan. No mistake of fact exists. No party changed its position. There was no fraud or other tortious conduct.

The thrust of Maple Medical's argument is that Scott and the other physicians are receiving a windfall as the result of the demutualization of MLMIC. However, as our colleagues in the Third Department have written, the reality is that the consideration would equally be a windfall to Maple Medical if it were to receive it. Neither party bargained for it and neither party can be said to have paid for it. Membership interests in a mutual insurance company are not paid for by the premiums; rather, such rights are acquired, at no cost, as an incident of the structure of the mutual insurance policy, through operation of law and the company's charter and bylaws (*see Schoch v. Lake Champlain OB–GYN, P.C.*, 184 A.D.3d at 345–

> 346, 126 N.Y.S.3d 532, *citing Dorrance v. United States*, 809 F.3d 479, 485).
>
> *   *   *
>
> We therefore conclude that Maple Medical has no cognizable unjust enrichment cause of action against Scott or any of the other physicians.

Id. at 103–05.

In the final analysis, both parties have received the full benefit of their bargain. The Hospital agreed to procure the MLMIC policy for Dr. Hinds, and Dr. Hinds agreed to devote his professional efforts to the Hospital. Any notions of "unfairness" on the part of the Hospital in light of the benefits the demutualization confers on Dr. Hinds do not rise to the level of an equitable claim.

C. None of the "attributes of ownership" cited by the Hospital in favor of its equitable claim can divest Dr. Hinds of his rights as actual owner of the policy.

Focusing on *dicta* in the DFS Decision, the Hospital maintains that entitlement to the Cash Consideration depends not on the explicit terms of the Insurance Law or the Plan, but on an examination of "the facts of individual cases," which the Hospital claims must take place before the rightful ownership of the Cash Consideration can be determined. Appellant's Brief, at 31-35

Initially, the Hospital's position that the "facts and circumstances" of each case dictate entitlement to the Cash Consideration, rather than governing law, was

specifically rejected by the Third Department in *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338 (3d Dep't 2020)¸ which stated as follows:

> According to DFS, the determination of who is entitled to the cash in these situations depends on the facts and circumstances of the parties' relationship and the applicable law. Defendant attempts to take this last portion of DFS's decision out of context, as if all determinations of the proper payee are based on the parties' relationship. However, that only applies if an objector raises a legitimate assertion that it is entitled to the consideration *based on an assignment from the policyholder . . . which does not exist here*.

Id. at 343 (emphasis added); *accord Maple Med., LLP v. Scott*, 191 A.D.3d 81 (2d Dep't 2020).

Notwithstanding this sound analysis, the Hospital makes the following arguments to support its claim: (1) the Hospital selected the policy and paid the premiums; (2) the Hospital was policy administrator; (3) the Hospital received dividends, rebates or refunds under Dr. Hinds's MLMIC policy; and (4) Dr. Hinds was never intended to be eligible for further monies beyond those specified in the Employment Agreement.

Initially, these allegations constitute the Hospital's attempt to distract the Court from the undisputed fact that Dr. Hinds was the *sole* owner of the policy, in which the Hospital never had any interest of any kind.

That said, none of the Hospital's allegations support any *equitable* claim to the Cash Consideration. As previously discussed, neither selection of the policy nor

payment of premiums gives the Hospital any rights to the Cash Consideration where it specifically undertook those duties for consideration it received in full. Likewise, the Hospital's status as policy administrator and its receipt of refunds or dividends in that capacity has no bearing on the disposition of the Cash Consideration. Finally, the Employment Agreement makes no reference to demutualization proceeds, and it is disingenuous for the Hospital to suggest that the Employment Agreement supports its *equitable* claim even though it confers no such *contractual* right.

D. The Hospital's role as Policy Administrator has no relevance to Cash Consideration.

In past briefings, the Hospital argued that its status as "policy administrator" should entitle it to the Cash Consideration. That specific argument has now been abandoned and the Hospital appears to concede that policy-administrator designation has no concrete legal significance to payment of the Cash Consideration. Still, the Hospital's present submission makes several references to its status as policy administrator and its receipt of "premium refunds," "rebates," or "dividends," claiming they indicate *de facto* ownership of Dr. Hinds's policy, entitling it to the Cash Consideration. Appellant's Brief, at 40-43.

In reality, the Hospital's receipt of premium refunds, rebates or dividends are not proof of ownership, but were merely clerical functions pertaining to the Hospital's role as policy administrator, in which the Hospital's agreed to undertake

mundane administrative functions to maintain the policy. For context, the MLMIC policy-administrator-designation form states as follows:

> The policy administrator is the *agent* of all Insureds herein for the paying of premiums, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return premiums when due.

[R.180] (emphasis added).

Despite the Hospital's apparent concession that dividends from MLMIC *may* be distinguishable from Cash Consideration (which is in contrast to earlier submissions where the Hospital specifically conflated the two), the Hospital's position that receipt of refunds, rebates or dividends indicates some abstract ownership in Dr. Hinds's policy is still unsupportable.

First, Cash Consideration is definitively *not* a dividend or return of premiums. The plain terms of Insurance Law §7307(e)(3), in setting forth how to calculate a policyholder's equitable share in the demutualized insurer, provide that the net premium payment for the purposes of determining Cash Consideration shall consist of "*gross premiums less return premiums and dividends paid…*" *Id.* In other words, the statute itself distinguishes between Cash Consideration, on the one hand, and dividends or return premiums, on the other. This distinction is echoed in the Plan, where "Eligible Premiums" upon which the Cash Consideration is calculated exclude returned premiums and dividends [R.59].

Second, the plain language of the policy administrator designation form, as quoted above, provides that the policy administrator is the *agent* of the insured for paying premiums and receiving dividends and return premiums. "An agency relationship results from a manifestation of consent by one entity to another that the agent shall act on the principal's behalf and subject to the principal's control." *Quik Park W. 57, LLC v. Bridgewater Operating Corp.*, 148 A.D.3d 444, 445 (1st Dep't 2017).

In other words, as a mere policy administrator and *not* an owner of the policy, the Hospital is not entitled to receive and retain any such funds for its own benefit, but rather holds those funds as a fiduciary for its principal – Dr. Hinds. *See* Restatement Third, *Agency* § 1.01. Overall, despite the Hospital's attempt to create the impression otherwise, the Hospital's status as policy administrator and receipt of dividends in no way substitutes for the absence of actual ownership of the policy.[4]

The Hospital's exact argument was considered and rejected by the Second, Third and Fourth Departments. As stated by the Third Department in *Schoch*:

> Defendant's designation as policy administrator gave it no greater right to the cash consideration, and plaintiff did not explicitly assign that right to defendant and declined to do so (*see Maple–Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc.3d 703, 709 [Sup. Ct., Erie County 2019], *affd* 182

[4] Despite the Hospital's attempts to create the impression that it was receiving dividend checks arising from Dr. Hinds policy and retaining them for its own benefit, dividends were merely reflected as credits towards future premiums thereby reducing subsequent invoices. *See Maple Med., LLP v. Scott*, 191 A.D.3d 81 (2d Dep't 2020) (dividends paid by MLMIC used to reduce premiums).

> A.D.3d 984, 122 N.Y.S.3d 840 [2020]). Although the conversion plan gives a policy administrator the right to object if it believes that it has a legal right to the cash consideration, the right to object carries no rights, in and of itself, to the consideration, and the objector must prove its claimed legal right thereto. Defendant has failed to provide any proof in that regard, as it has not demonstrated that plaintiff assigned it that right through a designation form or contractual arrangement.

Schoch v. Lake Champlain Ob-Gyn, P.C., 184 A.D.3d 338, 342 (3d Dep't 2020). *See, e.g., Maple Med., LLP v. Scott*, 191 A.D.3d 81, 138 N.Y.S.3d 61, 74 (2d Dep't 2020) ("Here, like in *Schoch* and *Maple–Gate Anesthesiologists, P.C.*, there is no dispute that, while some of the physicians employed by Maple Medical assigned to their employer some rights as policy administrator, none of the physicians designated Maple Medical to receive the cash consideration"); *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 182 A.D.3d 984, 122 N.Y.S.3d 840, 842 (4th Dep't 2020) (although policyholders had assigned some of their rights as policyholders to their employer as Policy Administrator, they had not designated the employer to receive demutualization payments); *Maple–Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc.3d 703, 709 (Sup. Ct., Erie County 2019) ("Being designated as the policy administrator did not make the plaintiff a policyholder, did not make the plaintiff a member of MLMIC and did not entitle the plaintiff to the cash consideration").

Accordingly, the Hospital has no greater entitlement to the Cash Consideration simply for serving as Dr. Hinds's policy administrator or receiving credits or dividends as Dr. Hinds's agent in the course of doing so.

E. The Employment Agreement is silent on the issue of Cash Consideration and does <u>not support the Hospital's equitable claims.</u>

In its Complaint, despite the absence of language in the Employment Agreement that might even arguably relate to Cash Consideration, the Hospital alleged a breach of the implied covenant of good faith and fair dealing [R.28-29]. In the Hospital's brief to the Court of Appeals, this argument appears to have been reduced to another purported "indicator of ownership," to support the Hospital's equitable claim. Appellant's Brief, at 42-43.

The language cited by the Hospital is at Section 11(a) of the Employment Agreement, which provides how Dr. Hinds's employment could be terminated for cause [R.143-144]. Section 11(b) of the Employment Agreement, states that "upon the termination of this Agreement for any of the foregoing causes, you shall only be entitled to receive the accrued but unpaid Base Salary, and Incentive Compensation, owed to you as of the date of your termination" [R.144]. Basically, this provision

recites the uncontroversial proposition that had Dr. Hinds been terminated for cause, the Hospital would not need to keep paying him.[5]

In the Hospital's creative interpretation of this provision in its Complaint, the Hospital stated that "Defendant agreed that he would not be entitled to receive any further monies arising from his employment relationship except for any accrued but unpaid compensation," and that "[implicit] within that provision is an agreement that Defendant would not attempt to obtain any additional compensation from third parties that would otherwise be due to the Hospital [R.28]."

The Hospital's argument that this language in the Employment Agreement pertains to Cash Consideration – money being paid to Dr. Hinds in consideration for his surrendering his statutory ownership interest in MLMIC under the Plan to which the Hospital is not a party – is without merit. There is absolutely no allegation in the Complaint or language in the Employment Agreement to indicate any "meeting of the minds" with respect to disposition of Cash Consideration. Once again, if the Hospital, at the time it entered into the Employment Agreement, wanted to include terms covering demutualization proceeds, it could have simply bargained for such a provision. It did not.

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[5] Even if this provision was somehow applicable to this dispute, which it is not, the Hospital admits in its Complaint that Dr. Hinds was not fired for cause, but simply resigned in 2017 [R.22].

Accordingly, there is nothing in the Employment Agreement to support any *equitable* entitlement to the Cash Consideration, and the Hospital's argument amounts to nothing more than a demand that the Court rewrite the Employment Agreement to include a right it never bargained for. However, it is well-established that courts will not read supplemental or inconsistent provisions into a contract long after both parties have rendered full performance thereunder. *Reiss v. Fin. Performance Corp.*, 97 N.Y.2d 195, 199 (2001) (courts may not by construction add or excise terms, nor distort meaning of those used, thereby making new contract under guise of interpreting writing).

Finally, seemingly missing the irony, the Hospital claims that "with respect to what he was entitled to under his Employment Agreement, Respondent received exactly what he bargained for… he should not have expected more than that, nor did he do anything to justify his entitlement." Appellant's Brief, at 43. This perfectly summarizes why the Hospital has no right to the Cash Consideration. The Hospital agreed to provide Dr. Hinds with a MLMIC policy, while failing to properly consider any possible future benefit which might arise from a demutualization. Having failed to bargain for any such prospective benefit, the Hospital now requests that this Court essentially rewrite the Employment Agreement and add favorable terms under the cloak of equity.

In sum, the unambiguous terms of the Employment Agreement contain nothing to support the Hospital's equitable claim.

F. The overwhelming weight of precedent rejects the Hospital's position.

Until recently, the state of authority pertaining to lawsuits over the Cash Consideration has been unsettled and has taken a central role in this and similar disputes. Recently, however, all Appellate Divisions have weighed in on the issue, and the weight of authority clearly favors Dr. Hinds's position. Since the Hospital continues to lean on what is now the minority view first expressed by the First Department, the unusual evolution of precedent in the context of MLMIC's demutualization merits discussion.

(i) The early decision of the First Department under CPLR 3222.

The Hospital's grounds to oppose Dr. Hinds's motion to dismiss – and indeed the lynchpin of every employer's position in MLMIC disputes until recently – rested on *Schaffer, Schonholz & Drossman v. Title*, 171 A.D.3d 465, 96 N.Y.S. 526 (1st Dep't 2019) [R.185-186, 190-191]. In *Schaffer*, the First Department summarily held that equity dictated that proceeds from MLMIC's demutualization be paid to the medical practice that employed the policyholder and paid MLMIC premiums. For reference, *Schaffer* was an expedited proceeding submitted directly to the First Department as a court of first impression on stipulated facts pursuant to CPLR Rule 3222 [R.200].

A review of the stipulated facts[6] reveals that the parties in *Schaffer* omitted undisputed material facts, made no mention of the Insurance Law, and referred to (but did not attach) a letter which allegedly informed the defendant-physician that she had been added onto the employers' professional liability insurance policy, giving the misleading impression that the employer (rather than the physician) had an ownership interest in the policy [R.202-03].

Inexplicably, the respondent-physician in *Schaffer* did not cite Insurance Law §7307 or to any relevant sections of the Plan [R.226-38]. Taking advantage of the respondent-physician's failure to make the relevant legal arguments, the plaintiff medical practice did not disclose to the First Department or even hint at the existence of the regulatory scheme governing demutualization under the Insurance Law and the Plan [R.238-256]. The medical practice even titled one section of its reply, "The Opposition Identifies No New York Law that Would Entitle Dr. Title to the Cash Consideration," conspicuously avoiding reference to Insurance Law §7307 [R.244].

Based on these omissions and the limited facts and legal arguments presented, the First Department summarily decided – by way of a four-sentence analysis – that the medical practice was entitled to the policyholder's money based on unjust enrichment [R.190-191]. Neither the parties' briefs nor the First Department's

[6] The stipulated facts and parties' submissions in *Schaffer* were provided to the Supreme Court in support of Dr. Hinds's motion to dismiss [R.200-57].

decision referenced any relevant provisions of the Plan, and neither Insurance Law §7307 nor the DFS Decision were mentioned once in the entire proceeding.[7]

Because the Court was not presented with the relevant arguments, the First Department's decision in *Schaffer* apparently did not take the Insurance Law or the Plan into consideration. This supposition was confirmed during the recent oral argument in *Mid-Manhattan Physician Services v. Dworkin*, Case No. 2019-03771 (1st Dep't) (decision pending), which is the first MLMIC case argued to the First Department after *Schaffer*. For reference, the Supreme Court, New York County, had determined that it was bound by *Schaffer* and granted summary judgment in favor of the employer. *Mid-Manhattan Physician Services v. Dworkin*, 2019 WL 4261348 (Sup. Ct. N.Y. County 2019). At oral argument in the First Department in January 2021, the following exchange took place between Justin Heller, Esq.[8], counsel for the policyholder and the Court:

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[7] In awarding the MLMIC proceeds to the medical practice, the First Department cited no New York law. The Court only referenced two out-of-jurisdiction federal cases: *Ruocco v. Bateman, Eichler, Hill, Richards, Inc.,* 903 F.2d 1232 (9th Cir. 1990) and *Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int''l Brotherhood. of Teamsters*, 2005 U.S. Dist. LEXIS 42877 (N.D. Ill. 2005). Both cases involved esoteric questions of whether demutualization proceeds constituted "plan assets" under ERISA, an issue which has no relevance to our dispute. Accordingly, in light of the numerous relevant cases decided after *Schaffer* pertaining to MLMIC's demutualization under New York law, no extended discussion of these inapplicable cases is warranted *here*. However, these cases were thoroughly discussed and deemed inapplicable by the Second Department in *Maple Medical*. *Maple Medical*, 138 N.Y.S.3d at 75-77.

[8] Mr. Heller also represents the policyholders in *Maple Medical* and *Schoch*, anticipated to be heard and decided concurrently with the instant appeal.

> *Justin Heller, Esq.*: I would just close by saying that I think there is good reason for the Court to reverse its decision, and again, whether the Court decides to wait [for the Court of Appeals] or not is another question, but the briefs that the parties submitted in the *Schaffer* decision did not discuss the legal framework that establishes the policyholders' right to the money
>
> *Hon. Cynthia S. Kern*: This is Judge Kern, you're 100 percent right, I was on that panel, none of the analysis that was in the decisions from the other departments were brought to our attention in that case; there's no question about that. And we did not put our analysis in the context of those cases and that analysis, so you're 100 percent correct about that. The real question is whether we should address it again or wait for the court of appeals and then what should we do, but we did not address those arguments yet.[9]

Accordingly, the one case the Hospital principally relies on did *not* consider the dispute in the context of the statutory framework governing MLMIC's demutualization. This should conclusively foreclose any further reliance on *Schaffer*. While the Hospital continues to lean on *Schaffer* because it likes the end result, it cannot credibly rest its position on a case which failed to consider the comprehensive statutory and regulatory framework governing the dispute.

By way of context, the parties in *Schaffer* submitted their dispute to the First Department in late-2018, before almost any other MLMIC disputes had been adjudicated. In addition to *Schaffer's* unusual procedural posture, absence of

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[9] A recording of the First Department's proceedings in *Dworkin* is available at http://wowza.nycourts.gov/vod/vod.php?source=ad1&video=AD1_Archive2021_Jan05_14-19-19.mp4.The quoted discussion is at timestamp 1:57:07,

substantive legal arguments or determinations, and lack of any analysis of relevant law, *Schaffer* was the only Appellate Division decision related to MLMIC's demutualization for over a year, constraining lower courts to follow it as precedent. A number of these lower court cases are cited in the Hospital's brief, without explicit mention that the majority of them have been abrogated by subsequent decisions of the other Appellate Divisions.

(ii) The Second, Third and Fourth Departments have rejected the holding in Schaffer, determining that the Cash Consideration is the rightful property of the Policyholder, absent an express assignment.

It took more than a year after *Schaffer* for any other Appellate Division to consider a MLMIC case. That court was the Fourth Department in *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 182 A.D.3d 984 (4th Dept 2020), which issued its decision on April 24, 2020. Declining to follow the reasoning in *Schaffer*, the Fourth Department held that the policyholder's motion to dismiss was properly granted because the documentary evidence, consisting of the policy declaration pages showing the defendant as lawful policyholder, "established as a matter of law that the plaintiff [employer] had no legal or equitable right of ownership to the demutualization payments." *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 182 A.D.3d 984 (4th Dept 2020). The Fourth Department further held as follows:

> In support of their motion, defendants submitted the MLMIC plan of conversion (plan), which, in accordance with that provision of the Insurance Law, provided that cash distributions were required to be made to those

> policyholders who had coverage during the relevant period prior to demutualization in exchange for the 'extinguishment of their Policyholder Membership Interests.' The plan stated that the cash distribution would be made to the policyholder unless he or she 'affirmatively designated a Policy Administrator ... to receive such amount on [his or her] behalf' …The mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments.

Id. In sum, the Fourth Department determined that in the absence of an assignment or designation, policyholders like Dr. Hinds are entitled to the Cash Consideration as a matter of law.

Shortly after the Fourth Department decided *Maple-Gate*, the Third Department was given its first opportunity to consider the MLMIC issue in *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338 (3d Dep't 2020), and *Shoback v. Broome Obstetrics & Gynecology, P.C.*, 184 A.D.3d 1000 (3d Dep't 2020).

In two well-reasoned decisions, the Third Department likewise rejected the employers' arguments, and followed the plain language of the Insurance Law and the Plan and properly determined that the policyholders were legally entitled to the demutualization proceeds in the absence of any assignment to their employer. In so holding, the Third Department reversed the decisions of two lower courts which had deemed themselves bound by *stare decisis* to follow *Schaffer*.

The employers' rejected claims in *Schoch* and *Shoback*, as in most MLMIC disputes, were essentially identical to the ones advanced by the Hospital in the

instant case. As to the unjust-enrichment claims, the Third Department in *Schoch* stated as follows:

> [The employer] asserts that the cash consideration would be a windfall to [the policyholder]. While true, the converse is also true; the consideration would be a windfall to [the employer] if [the employer] were to receive it. Demutualization has been referred to as a 'windfall' in some cases because it is often unclear if parties knew the ownership stake even existed prior to the demutualization plan… The reality is that neither party here bargained for the demutualization proceeds. Moreover, neither party actually paid for them, because membership interests in a mutual insurance company are not paid for by policy premiums; such rights are "acquired ... at no cost, but rather as an incident of the structure of mutual insurance policies," through operation of law and the company's charter and bylaws… The fact that one party will receive these benefits does not mean that such party has unjustly enriched itself at the other's expense.

Schoch, 184 A.D.3d at 345-46 (emphasis added) (internal citations and quotation marks omitted). Commenting on *Schaffer*, the Third Department stated that:

> Based on our analysis, we decline to follow *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465, 96 N.Y.S.3d 526 [2019], supra), which summarily held, without any analysis, that awarding an employee a cash consideration related to MLMIC's demutualization would constitute unjust enrichment where the employer had paid the policy premiums… Accordingly, [the policyholder] was entitled to a declaratory judgment entitling her to receive the cash consideration from MLMIC's demutualization.

Schoch, 184 A.D.3d. at 346-47.

Following its decisions in *Schoch* and *Shoback*, the Third Department resolved the instant case in Dr. Hinds's favor.

On December 9, 2020, the Second Department – the last Appellate Division Court to weigh in on the issue – published its long-awaited decision *Maple Med., LLP, v. Scott*, 191 A.D.3d 81 (2d Dep't 2020). The Second Department extensively analyzed and categorically rejected every argument advanced by the employer, and held that a MLMIC policyholder is entitled to retain the Cash Consideration as a matter of law, unless the policyholder assigned its rights to, or designated a third party to receive, the funds.

(iii) The Hospital presents no reasonable basis to reject <u>the Second, Third and Fourth Department decisions.</u>

The decisions of the Second, Third and Fourth Departments present a solid judicial consensus among the courts which have evaluated this dispute. Each appellate court scrupulously analyzed and rejected every argument advanced by the Hospital.

While the Hospital broadly paints these decisions as fundamentally wrong, it offers nothing convincing in support of this notion. The Hospital argues that the Third Department's decision "disregarded the explicit link between the policyholder's receipt of the cash consideration and the payment of premiums." Likewise, the Hospital takes issue with the Third Department's delineation under the Insurance Law as to how the Cash Consideration is calculated versus who is entitled

to receive it, creating what the Hospital characterizes as an "absurd result," awarding Cash Consideration to the policyholder receiving Cash Consideration despite his not paying premiums.

Leaving aside the fact that this issue is covered by the Plan, as discussed above, there is nothing absurd about a statute which specifically pertains to an insurer's demutualization specifying how the ownership interest of each mutual owner is to be calculated, and stating the obvious proposition that the owners of a mutual insurer are the ones entitled to the proceeds from the sale of the company.

Finally, the Hospital addresses the Third Department's rejection of its unjust enrichment claim, alleging that the court "disregarded the significant sums of money the employer paid in premiums," and makes an appeal to the court's emotion by characterizing the determination that the policyholder was entitled to the Cash Consideration as "gut wrenching." Appellant's Brief, at 50-51. In reality, the Third Department *fully acknowledged* that the employer paid the premiums and held that this was not a basis for any equitable claim *when the employer had only done so as a result of its contractual obligations to the physician-policyholder*. The Hospital takes no specific issues with the Second and Fourth Department decisions, only contending that they are based on flawed reasoning.

Aside from this, the Hospital cites two Supreme Court decisions: *Wyckoff Heights Medical Center v. Monroe*, 2020 WL 4561195 (Sup. Ct. Kings County

2020), and *Sullivan v. Northwell Health, Inc.*, Index No. 656121/2018 (Sup Ct. N.Y. County 2019). *Wyckoff Heights* was an isolated decision on a motion to reargue which has now been abrogated by the Second Department's decision in *Maple Medical*. *Sullivan*, meanwhile, was a decision under the jurisdiction of the First Department, and was simply decided in light of *Schaffer*.

As to the apparent endorsement by those courts to evaluating "facts and circumstances" to determine entitlement to Cash Consideration, the Hospital's argument simply repackages its unsupportable position that a court may disregard relevant law in the name of equity, a theory considered and specifically rejected by the Second and Third Departments, as discussed above. Overall, with the weight of judicial authority now firmly against it, the Hospital presents nothing persuasive to support reversal of the Third Department.

It is abundantly clear that the Hospital is offended that the Cash Consideration is legally payable to Dr. Hinds. The Hospital's feelings on the matter, however, do not create *equitable* rights, or justify rewriting the Insurance Law, the Plan or the Employment Agreement. The Hospital agreed to procure a malpractice insurance policy for Dr. Hinds and pay the premiums. In consideration, Dr. Hinds promised to devote his professional services to the Hospital, which he did for over 11 years. Although the Cash Consideration will undoubtedly benefit Dr. Hinds, it does that come at the Hospital's expense. Nor is it against principles of equity and good

conscience for Dr. Hinds to receive those funds when the Hospital received everything it anticipated and bargained for under the Employment Agreement. In light of the foregoing, the Hospital has no equitable claim to the Cash Consideration.

CONCLUSION

The pertinent facts are undisputed and prove conclusively and as a matter of law that Dr. Hinds is entitled to retain the proceeds from the sale of his mutual ownership interest in MLMIC. The Hospital has no claim.

Insurance Law §7307(e)(3), the Plan, and DFS' legal determinations all provide that demutualization proceeds are payable to an eligible *policyholder*, and no other party, absent an assignment of those rights. The Hospital admits Dr. Hinds made no such assignment. The Employment Agreement, in plain terms, vests no right in the Hospital to the Cash Consideration, and the Hospital's equitable claims consist of nothing more than a call to rewrite controlling authority and the parties' agreement and grant the Hospital the Cash Consideration without having bargained for it.

In the clear absence of any statutory, equitable, or contractual right to the Cash Consideration, the Hospital's Complaint – essentially amounting to the unsupportable assertion that both the governing law and the language of the contract the Hospital itself drafted are unfair – was correctly dismissed.

Dr. Hinds respectfully requests that the holdings of the Supreme Court and Third Department be affirmed.

Dated: May 6, 2021

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NEW YORK STATE COURT OF APPEALS
CERTIFICATE OF COMPLIANCE

I hereby certify pursuant to 22 N.Y.C.R.R. Section 500.1(j) that the forgoing brief was prepared on a computer using Microsoft Word.

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Dated: New Hyde Park, New York
May 6, 2021

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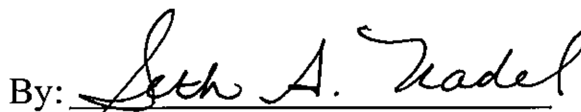
By: 

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AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
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Brian R. Landy, Jr., being duly sworn, deposes and says that deponent is not a party to the action, is over 18 years of age, and resides at 38 Davis Avenue, Rye, New York 10580.

That on the 7th day of May, 2021 deponent served the within:

Brief for Defendant-Respondent

upon designated counsel for the parties indicated herein at the addresses provided below by depositing 1 true copy thereof enclosed in a post-paid wrapper, in an official depository under the exclusive care and custody of the U.S. Postal Service within New York State.

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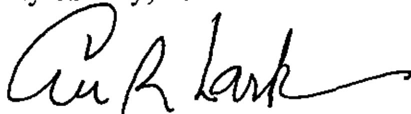

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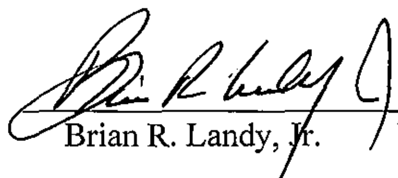

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