To be Argued by:
ANDREW ZWERLING
(Time Requested: 30 Minutes)

APL-2021-0001
Columbia County Clerk's Index No. 14064/19
Appellate Division–Third Department Case No. 530190

Court of Appeals

of the

State of New York

THE COLUMBIA MEMORIAL HOSPITAL,

Plaintiff-Appellant,

– against –

MARCEL E. HINDS, M.D.,

Defendant-Respondent.

BRIEF FOR PLAINTIFF-APPELLANT

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CORPORATE DISCLOSURE STATEMENT

Plaintiff-Appellant Columbia Memorial Hospital ("Hospital") submits this Corporate Disclosure Statement, pursuant to 22 NYCRR 500.1(f), and states that Albany Medical Center is the sole corporate member and active parent of the Hospital. The Hospital is the sole corporate member of the CMH Foundation which is a separate 501(c)(3).

JURISDICTIONAL STATEMENT

Jurisdiction in this Court is premised upon an Order of this Court granting leave to appeal dated and entered on January 7, 2021.

RELATED APPEALS

The present appeal joins a related appeal, *Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.*, APL-2020-00169 (the "*Schoch* Appeal"), concerning the proper disposition of proceeds arising from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC"). We understand that the briefing and arguments in the *Schoch* Appeal have been aligned with the instant appeal by the Hospital, and that there will be additional parties seeking leave to serve and file briefs as *amici curiae*. We also understand that leave to appeal was recently granted in a similar case that was before the Second Department, *Maple Medical LLP v. Scott*, 191 A.D.3d 81 (2020).

TABLE OF CONTENTS

Page(s)

CORPORATE DISCLOSURE STATEMENT i

JURISDICTIONAL STATEMENT i

RELATED APPEALS i

INTRODUCTION 1

QUESTIONS PRESENTED..8

STATEMENT OF FACTS 10

1. The Hospital 10
2. Respondent's Employment Agreement..10
3. The Incentive Compensation Formula 11
4. The Hospital Paid And Administered The Respondent's Policy........13
5. Respondent Resigned From The Hospital And Expressly Disclaimed Entitlement To Monies Other Than Those Stated In His Employment Agreement 14
6. MLMIC's Demutualization..15
7. MLMIC Continues To Hold The MLMIC Funds Pending A Resolution Of The Parties' Dispute 19

PROCEDURAL HISTORY..20

1. The Complaint..20
2. Respondent's Motion to Dismiss 20
3. The Lower Court's Decision..21

5988592v.12

ARGUMENT

POINT I

INSURANCE LAW § 7307 EXPRESSLY LIMITS
RECEIPT OF THE CASH CONSIDERATION
TO THOSE WHO PAID THE PREMIUMS..24

A. Under Insurance Law § 7307, The Payer Of The Premiums Is Entitled To Receive The Cash Consideration..24

B. The Third Department's Flawed Statutory Analysis....................................28

POINT II

REGARDLESS OF WHICH PARTY IS ENTITLED TO
RECEIVE THE MLMIC FUNDS UNDER INSURANCE
LAW § 7307, THE HOSPITAL'S EQUITABLE CLAIMS SURVIVE.................31

A. The DFS Order And Decision Support The Conclusion That The Ultimate Issue Of Which Party Is Entitled To The Cash Consideration Should Be Based On Equitable Principals, And Not Statutory Analysis 31

B. Legal Title Does Not Preclude Claims In Equity..35

POINT III

THE HOSPITAL MAINTAINS A VIABLE CLAIM
FOR UNJUST ENRICHMENT BECAUSE IT PAID THE
PREMIUMS AND WAS THE DE FACTO OWNER OF THE POLICY 37

A. The Standard For Unjust Enrichment..37

B. Policyholders Received A Benefit From MLMIC At The Employers' Expense 38

C. Equity and Good Conscience Favors The Employers Who Paid For The Policies 39

D. The First Department And Courts Of Other Jurisdictions Support The Hospital's Unjust Enrichment Analysis 44

E. The Third and Fourth Departments Decisions That Found In Favor Of The Employees Are Fundamentally Flawed 49

CONCLUSION 52

CERTIFICATE OF COMPLIANCE 53

TABLE OF AUTHORITIES

Page(s)

Cases

Matter of Anonymous v. Molik,
32 N.Y.3d 30, 84 N.Y.S.3d 414, 109 N.E.3d 563 (2018) 31

Art & Fashion Grp. Corp. v. Cyclops Prod., Inc.,
120 A.D.3d 436, 992 N.Y.S.2d 7 (1st Dep't 2014)..22

Benoit v. Jamaica Anesthesiologist, P.C.,
Index No. 615476/2018 (Sup. Ct. Nassau Cnty. Nov. 26, 2019) 49

Brauer v. Dr. R. G. Geronemus, M.D., P.C.,
Index No. 70720/2018 (Sup. Ct. Westchester Cnty. Dec. 19, 2019)..................49

Chemical Specialties Mfrs. Assn. v. Jorling,
85 N.Y.2d 382, 626 N.Y.S.2d 1, 649 N.E.2d 1145 (1995) 28

Colon v. Martin,
35 N.Y.3d 75, 125 N.Y.S.3d 346 (2020)...24, 27, 30

Cordaro v. AdvantageCare Physicians, P.C.,
2020 WL 5582253 (Sup. Ct. N.Y. Cnty. Sept. 17, 2020)..................................49

Cruz v. McAneney,
31 A.D.3d 54 (2d Dep't 2006)...56

Diegelman v. City of Buffalo,
28 N.Y.3d 231, 43 N.Y.S.3d 803 (2016)...28, 32

Episcopal Health Services v. Henry,
Index No. 707615 (Sup. Ct. Queens Cnty. Dec. 10, 2019) 49

Gage v. Vill. of Hornellsville,
12 N.E. 817 (1887) 27

Greathouse v. E. Liverpool,
823 N.E.2d 539 (Ohio Ct. App. 2004)..53

Hornett v. Leather,
145 A.D.2d 814 (3d Dep't 1988)..43, 56

In re Interdiction of Lalehparvaran,
132 So.3d 439 (La. Ct. App. 2014)....................53

John T. Mather Memorial Hosp. of Port Jefferson, New York, Inc. v. Fadel,
Index No. 624734/2018 (Sup. Ct. Suffolk Cnty. Aug. 21, 2019)....................50

Long Island Radiology Associates, P.C. v. Koshy et al.,
Index No. 600195/2019 (Sup. Ct. Nassau Cnty. Oct. 7, 2019)....................50

Lopes v. Bain,
82 A.D.3d 1553 (3d Dep't 2011)....................22

Lynch v. City of New York,
35 N.Y.3d 517 (2020)....................24, 30

Majewski v. Broadalbin-Perth Cent. Sch. Dist.,
91 N.Y.2d 577 (1998)....................30, 31

Mandarin Trading Ltd. v. Wildenstein,
16 N.Y.3d 173 (2011)....................42

Maple Med., LLP v. Scott,
191 A.D.3d at 98....................41, 56

Maple Medical LLP v. Scott,
No. 51103/2019, 2019 WL 3070676 (Sup. Ct. Westchester Cnty. July 5, 2019)....................50

Maple-Gate Anesthesiologists P.C. v. Nasrin,
182 A.D.3d at 986....................41, 56

People ex rel. McCurdy v. Warden, Westchester County Corr. Facility,
2020 WL 6828846 (2020)....................32

McGrath v. Hilding,
41 N.Y.2d 625, 394 N.Y.S.2d 603 (1977)....................47

Matter of Medical Socy. of State of N.Y. v. Serio,
100 N.Y.2d 854, 768 N.Y.S.2d 423, 800 N.E.2d 728 (2003)....................34, 35

Mell v. Anthem, Inc.,
688 F.3d 280 (6th Cir. 2012) 52

Miamisburg, City of and FOP, Ohio Labor Council,
2003 WL 26071521 (Apr. 18, 2003) (Goldberg, Arb.) 53

Mid-Manhattan Physician Services, P.C. v. Dworkin,
No. 656478/2018 (Sup. Ct. N.Y. Cnty. Sept. 3, 2019).......................................50

Mobarak v. Mowad,
117 A.D.3d 998, 986 N.Y.S.2d 539 (2d Dep't 2014)..................................44, 46

Moran Towing & Transp. Co., Inc. v. New York State Tax Comm'n,
72 N.Y.2d 166, 527 N.E.2d 763, 531 N.Y.S.2d 885 (1988) 34

People ex rel. Nash v. Faulkner,
14 N.E. 415 (1887) 26

New York City Health & Hosps. Corp. v. Wellcare of New York, Inc.,
35 Misc. 3d 250, 937 N.Y.S.2d 540 (Sup. Ct. N.Y. Co. 2011) 47

New York State Land Title Ass'n, Inc. v. New York State Dep't of Fin. Services,
169 A.D.3d 18, 92 N.Y.S.3d 49 (1st Dep't. 2019) 32, 35

NRAD Med. Assoc., P.C. v. Kim,
Index No. 617351/2018 (Sup. Ct. Nassau Cnty. Oct. 28, 2019) 49

Paramount Film Distrib. Corp. v. State of New York,
30 N.Y.2d 415 (1972) 42

People v. Marquan M.,
24 N.Y.3d 1, 19 N.E.3d 480 (2014)...24, 30

People v. Page,
149 N.E.3d 905 (N.Y. 2020)...27, 28

Peyton v. New York City Bd. of Standards & Appeals,
2020 WL 7390864 (2020)..32, 34

Phelps Imaging Services v. Kroop,
Index No. 53243 (Sup. Ct. Westchester Cnty. Nov. 9, 2020) 49

Phelps Memorial Hosp. Assoc. v. Heier,
Index No. 652845/2019 (Sup. Ct. New York Cnty. July 27, 2020) 49

Phelps Memorial Hospital Assoc. v. Mendelowitz,
Index No. 652608/2019 (Sup. Ct. N.Y. Cnty. Sept. 19, 2019)...........................50

Phillip Fyman and Alexander Weingarten, M.D., P.C. v. Bax,
Index No. 601960/2019 (Sup. Ct. Nassau Cnty. Mar. 12, 2020) 49

Robert M. Schneider, M.D., P.C. v. Licciardi,
65 Misc. 3d 254, 108 N.Y.S.3d 720 (N.Y. Sup. Ct. 2019)...........................40, 43

Ruocco v. Bateman, Eichler, Hill, Richards, Inc.,
903 F.2d 1232 (9th Cir. 1990), *cert. denied*, 498 U.S. 899 (1990) 50, 51

Schmidt on Behalf of McNeil v. Roberts,
74 N.Y.2d 513, 548 N.E.2d 1284, 549 N.Y.S.2d 633 [1989] 27, 31

Schoch v. Lake Champlain Ob-Gyn, P.C.,
184 A.D.3d at 537...*passim*

Schoch v. Lake Champlain Ob-Gyn, P.C.,
64 Misc.3d 1215(A) (Sup. Ct. Saratoga Cnty. June 7, 2019).............................50

Shah v. Exxis, Inc.,
138 A.D.3d 970, 31 N.Y.S.3d 512 (2d Dep't 2016)..44

Sharp v. Kosmalski,
40 N.Y.2d 119, 351 N.E.2d 721, 386 N.Y.S.2d 72 (1976) 40

Shoback, CNM v. Broome Obstetrics and Gynecology, P.C.,
Index No. EFCA2018003334 (Sup. Ct. Broome Cnty. Sept. 10,
2019) 50

Simonds v. Simonds,
45 N.Y.2d 233, 408 N.Y.S.2d 359, 380 N.E.2d 189 (1979) 39, 42

State v. Barclays Bank of New York, N.A.,
76 N.Y.2d 533, 563 N.E.2d 11 (1990)..44

Sullivan v. Medical Liability Mutual Insurance Co.,
2019 WL 6496820 (N.Y. Sup. Ct. N.Y. Co., Dec. 2, 2019).........................36, 41

Sullivan v. Northwell Health, Inc.,
Index No. 656121/2018 (Sup. Ct. N.Y. Cnty. Dec. 2, 2019) 41, 49

Town of N. Haven v. N. Haven Educ. Ass'n,
2004 WL 113524 (Superior Ct. Conn. 2004) 53

Trans High Corp. v. Pollack Associates,
LLC, 74 A.D.3d 489, 902 N.Y.S.2d 83 (1st Dep't 2010) 27

Urgent Med. Care. PLLC v. Amedure,
64 Misc.3d 1216A (Sup. Ct. Greene Co. 2019) 40

Urgent Medical Care PLLC v. Amedure,
64 Misc.3d 1216(A) (Sup. Ct. Greene Cnty. July 12, 2019).............................50

Villar v. Howard,
126 A.D.3d 1297, 6 N.Y.S.3d 811 (4th Dep't 2015), *aff'd*, 64
N.E.3d 280 (2016) 27

White Plains Radiology Associates, P.C. v. Forcade,
Index No. 53247/2019 (Sup. Ct. Westchester Cnty. Nov. 9, 2020) 49

Women's Care in Obstetrics and Gynecology, P.C. v. Herrick et al.,
2019 WL 5691879, 2019 N.Y. Slip Op. 51776(U) (Sup. Ct.
Warren Co. Nov. 4, 2019)..49

Wyckoff Heights Medical Center v. Leonora Monroe & MLMIC Ins. Co.,
2020 WL 4561195 (N.Y. Sup. Ct. Aug. 07, 2020)...............................30, 38, 49

Zilkha Radiology, P.C. v. Schulze,
Index No. 622517/2018 (Sup. Ct. Suffolk Cnty. Nov. 1, 2019).........................49

Statutes

Banking Law § 6-l..26

CPLR §§ 3211(a)(1) and (7) 20, 22

Debt. & Cred. Law § 32 26

Envtl. Conserv. Law § 11-0713 26

Financial Services Law § 102(k) 34

Gen. Bus. Law § 349 26

Gen. Mun. Law § 99-b 26

Insurance Law § 7307(e)(3) .... *passim*

New York Insurance Law § 7307 .... *passim*

Not-for-Profit Corp. Law § 1610 25

Pub. Health Law § 2633 26

Pub. Health Law § 4124 26

Soc. Serv. Law § 28 26

Statutes § 97 32

INTRODUCTION

It is a bedrock rule of statutory construction that a court, in interpreting a statute, should attempt to effectuate the intent of the Legislature. Indeed, the primary focus of a court should be on the Legislature's intent, and the most compelling proof of that intent is found in the language of the statute itself.

The Appellate Division, Third Department disregarded such fundamental rules of statutory interpretation to supplant the Insurance Law with its own unsupported views. Even worse, as will be shown, the Third Department then relied on its erroneous statutory interpretation as the foundation for its analysis of the sole dispositive issue in this case: an equitable claim for unjust enrichment. Consequently, this Court should reverse the Third Department's decision and remand for further proceedings.

By way of brief background, Plaintiff-Appellant, The Columbia Memorial Hospital (the "Hospital"), is a small, not-for-profit rural health care system that employs approximately 64 physicians and mid-level providers and other clinicians at its hospital, primary care, and specialty clinics in Columbia, Greene and Dutchess counties. In 2012, it employed Defendant-Respondent Marcel Hinds ("Respondent"), an OB/GYN physician, pursuant to an employment agreement (the "Employment Agreement") for a base salary of $300,000 plus other benefits.

Consistent with the Employment Agreement, the Hospital obtained a policy for medical malpractice insurance coverage for Respondent (the "Policy") through Medical Liability Mutual Insurance Company ("MLMIC"). In doing so, the Hospital applied to and selected MLMIC as the insurer; paid all of the premiums associated with the Policy (which was $214,720.54 for the three relevant years in question); performed all of the administrative work managing the Policy, including, but not limited to, corresponding with MLMIC; and, was the sole party during Respondent's tenure to receive all dividends, credits, rebates or returns on premium issued by MLMIC. The Hospital undisputedly served as the de facto owner of the Policy, as it held all of the attributes of ownership and control. In sharp contrast, Respondent's sole connection to the Policy was that his name was put on the application form as the insured, which was required by MLMIC. Respondent otherwise devoted no time, money or resources with respect to the Policy, nor did Respondent treat the premium payments made by the Hospital as income on his annual tax forms. In fact, the payment of premiums is explicitly listed as a Hospital expense in the Employment Agreement.

In October 2018, MLMIC was sold and converted or "demutualized" from a mutual insurance company to a stock insurance company, pursuant to the New York Insurance Law § 7307. In connection with the sale and demutualization, and pursuant to a conversion plan (the "Conversion Plan" or "Plan of Conversion"),

MLMIC was supposed to distribute $2.502 billion in cash consideration to eligible policyholders based upon a formula using the amount of premiums that the policyholders had paid for malpractice policies between 2013 and 2016 (the "MLMIC Funds" or "Cash Consideration"). Under the Conversion Plan, MLMIC established a process by which policy administrators ("Policy Administrators"), such as the Hospital, could object to the distribution of the MLMIC Funds to the registered policyholders, even if the Policy Administrators were not specifically designated by the nominal policyholder to receive the MLMIC Funds. In such an instance, the monies would be held in escrow pending resolution of the dispute by the courts or through arbitration based on the "facts and circumstances of the parties' relationship and applicable law."

Importantly, the New York State Department of Financial Services ("DFS"), which is the state agency with expertise charged with oversight over the demutualization under the Insurance Law, considered the issue of who was entitled to the Cash Cconsideration, and specifically declined to name the nominal policyholders as automatic recipients of the MLMIC Funds. In its September 6, 2018 decision ("Decision"), and again in its January 14, 2019 Order (the "Order"), DFS refrained from taking the affirmative position that the policyholders were automatically entitled to the Cash Consideration under Insurance Law § 7307(e)(3). Rather, DFS stated that the "[t]he determination of who is entitled to

the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided either by agreement of the parties or by an arbitrator or court." In so providing, DFS acknowledged that Insurance Law § 7307(e)(3) did not specify who was entitled to receive the Cash Consideration when the named policyholder did not pay the premiums.

Given DFS's position that the determination of entitlement was a fact-based inquiry, hundreds of arbitrations and legal proceedings across New York were commenced by and between the policyholders and their employers who paid the policy premiums. Following years of litigation, a split of authority developed between the Appellate Divisions and within the lower courts. On the one hand, the First Department held that an unjust enrichment claim could be sustained by the employer who paid for the policy where the employee policyholder never bargained for such proceeds. Case law of other jurisdictions supports that decision. On the other hand, the Second, Third, and Fourth Departments have interpreted the statute to provide that the Cash Consideration automatically belonged to the policyholder under the Insurance Law, regardless of whether the policyholder paid any premiums. In addition, they held that there were no viable claims for unjust enrichment because the equities did not weigh in either party's favor. They reasoned that, since both parties received their bargained-for consideration (payment of salary and malpractice premiums in exchange for

professional services), the employer's payment of premiums was not a dispositive factor, and that there would be a windfall to either party. They also found that there were no allegations of mistake or fraud.

Given that the Hospital lies within the Third Department, the Hospital filed suit to obtain the MLMIC Funds relating to Respondent's Policy in that Department. Although initially dismissed based upon errors relating to a misinterpretation of the documentary evidence, the dismissal of the Hospital's claims was ultimately affirmed based upon the Third Department's decision in the related *Schoch* Appeal. The Hospital thereafter sought leave to appeal because this decision was flawed for several reasons.

Contrary to the rationale of the Second, Third and Fourth Departments, Insurance Law § 7307 explicitly links a party's entitlement to the Cash Consideration to the timely and proper payment of premiums by that party. In ruling as they did, those courts improperly rewrote the statute to mandate that a policyholder is always entitled to receive the Cash Consideration, even in instances where the policyholder paid no premiums at all. What should have resulted instead was a finding that, because the employer paid the premiums and otherwise exercised all attributes of ownership with respect to the policies, the employers should have received the Cash Consideration.

In any event, regardless of which party is entitled to receive the MLMIC Funds under the Insurance Law, the Hospital's equitable claims survived and should have prevailed. DFS expressly concluded that entitlement to the Cash Consideration depends on the facts and circumstances of the parties' relationship and applicable law. Reference to those fact-specific findings should have weighed conclusively and convincingly in favor of the Hospital receiving the Cash Consideration because equity and good conscience favors the employers who directly paid for and controlled the policies at all times.

To reiterate, Respondent's sole connection was that he was the named policyholder, a selection required by MLMIC and not by the Hospital's choice. He otherwise failed to exhibit any attributes of ownership of the Policy, did not assume any costs or burdens with respect to the Policy, and did not have any reasonable expectation of entitlement to any incidental benefits of the Policy. For example, there is no proof in the record that he ever claimed entitlement as the owner or true policyholder to any of the credits or dividends issued by MLMIC.

In stark contrast, the Hospital was responsible, as the de facto owner and policyholder, for all costs, including the payment of all premiums, and for all the burdens, such as administration, associated with the Policy. The Hospital was also

the sole party that received all dividends, credits, rebates or returns on premium issued by MLMIC.

Notwithstanding the employers' de fact ownership over the policies and their payment of the premiums, the Third and Second Departments, contrary to the First Department and courts in other jurisdictions, wrongfully transposed their flawed statutory interpretation onto the unjust enrichment analysis, concluding that "per the relevant statute and the conversion plan's definitions, plaintiff was entitled to the cash consideration." Moreover, the Third Department rejected the unjust enrichment claim because there was no proof (or allegations) that the policyholder acted tortiously or fraudulently when receiving the MLMIC Funds, even though New York law does not require a showing that the enriched party committed a wrongful act to sustain an unjustly enrichment claim. Also, the Third Department erroneously found that either party could make the same windfall argument regarding the unexpected Cash Consideration, but, in doing so, it failed to appreciate that the critical issue concerned the costs and burdens associated with maintaining insurance coverage, and the attributes of ownership respectively demonstrated by each party, and not with an artificially narrow view of the exchanged consideration.

In light of the foregoing, the Hospital respectfully asks that this Court reverse the erroneous interpretation of Insurance Law § 7307 advanced by the Second, Third, and Fourth Departments, and further hold, consistent with the holdings of the First Department and courts of other jurisdictions, that an unjust enrichment claim may be sustained against the nominal physician policyholder where the employer paid the premiums and bore all of the economic attributes policy ownership.

QUESTIONS PRESENTED

1. Whether the Second, Third, and Fourth Departments erroneously concluded that New York State Insurance Law § 7307(e)(3) entitles policyholders to receive the Cash Consideration from MLMIC's demutualization, as a matter of law, notwithstanding the absence of any payments of premiums by the policyholders, and notwithstanding that the Hospital held all the attributes of ownership?

The answer is in the affirmative. The Insurance Law expressly links a party's entitlement to receipt of the Cash Consideration to the economics of the parties' relationship, *i.e.*, the payment of the premiums.

DFS, the agency charged with interpreting and enforcing the Insurance Law, and MLMIC's Plan of Conversion, concluded that the statute was not dispositive

of this issue, and explicitly left the issue of entitlement to the determination of arbitrator and the courts based upon the relationship of the parties.

2. Whether an employer's claim for unjust enrichment may lie against a policyholder in light of Insurance Law § 7307(e)(3)?

The answer is in the affirmative. The Appellate Division, First Department concluded that unjust enrichment applied in favor of employers because the employers paid the policies that gave rise to the Cash Consideration. Thus, the presumption of entitlement lay in favor of the employers, unless employees expressly bargained for the proceeds. Courts from other jurisdictions have ruled likewise in analogous situations.

The Second, Third, and Fourth Departments erroneously concluded that employers could not establish unjust enrichment, even where the employers paid the premiums. Those courts held that unjust enrichment was not sustainable because the employers' payment of premiums was simply part of the employment bargain, and neither party could claim anything unjust or unfair where both sides received their bargained-for "consideration." This limited inquiry ignored the complete scope of the parties' bargain Those courts also imposed the mistaken requirement that, in the absence of any fraud or mistake, there was nothing to overcome the statutory presumption that payment be made to the policyholders.

STATEMENT OF FACTS

1. The Hospital

Plaintiff-Appellant The Columbia Memorial Hospital (the "Hospital") is a small, not-for-profit rural health care system that employs 64 physicians and other clinicians at its hospital, primary care, and specialty clinics in Columbia, Greene, and Dutchess counties. It has 192 acute-care beds in its Hudson facility and 40 outpatient locations. (R. 41) The Hospital's mission is to serve the healthcare needs of its rural community.

2. Respondent's Employment Agreement

In or about August 1, 2012, Respondent entered into a written employment agreement with the Hospital. (R. 20; 32-40) Pursuant to the Employment Agreement, the Hospital employed Respondent full-time, effective as of August 1, 2012, as an OB/GYN physician. (R. 20; 32; 35)

The Hospital compensated Respondent for his services with a $300,000 "Base Salary," the potential for earning incentive compensation based on productivity, and on-call compensation; in addition, he received various benefits, including health, disability and life insurance, retirement benefits, vacation time, and time/reimbursement for other allowed activities and expenses. Pursuant to Section 9 of the Employment Agreement, the Hospital purchased "an individual

occurrence-based medical malpractice insurance policy in the minimum amounts required for all members of the Medical Staff of the Hospital" for Respondent, and chose MLMIC for that policy. (R. 20; 35) In the Employment Agreement, the payment of premiums is expressly listed as the sole expense of the Hospital, unless the thresholds for incentive compensation are met. (R. 33, 35)

Upon the termination of the Employment Agreement, Respondent agreed that he would "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. 20; 36)

3. The Incentive Compensation Formula

In addition to his Base Salary, Section 3(b) of the Employment Agreement set forth a formula for determining incentive compensation based on the Hospital's actual operating figures. That section provides in whole:

> (b) Incentive Compensation: The amount equal to the annual professional component net revenue, which for purposes of this Agreement shall mean the amount actually collected by the Hospital in a given contract fiscal year from billing the professional component of any services provided by you, regardless of office location, ("Hinds Revenue"), shall be calculated quarterly for your review and shall be reconciled each contract fiscal year against the expenses directly attributable to your employment hereunder ("Hinds Expenses").

> If in a given fiscal quarter, 50% of the Hinds Revenue exceeds $75,000, you will receive additional compensation ("Incentive Compensation") for the amount exceeding $75,000 up to a total of $5000 per quarter. The Quarterly incentive, if achieved, will be paid May (for 1st qtr), August (for 2nd qtr), November (for 3rd qtr), February (for 4th qtr).
>
> If in a given fiscal year the Service Revenue[1] is in excess of the Service Expenses, the Hospital shall pay you additional compensation ("Incentive Compensation") from those Service Revenues in an amount equal to sixty-five percent (65%) of the amount equal to the difference of (a) the Hinds Revenue and (b) the Hinds Expenses, assuming such difference is a positive number. The Hinds Expenses, and the expenses for each of the Physicians in the Service shall be calculated as follows in any given fiscal year:
>
> 1. Base Salary $
> 2. Actual cost of benefits $
> 3. Malpractice premium $
> 4. Office and staff overhead figure $
>
> ____________
>
> Total amount to be exceeded per annum to earn Incentive Compensation in accordance with this Section 3(b) $

(R. 33)

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[1] While the Employment Agreement does not explicitly define the terms "Service Revenue" and "Service Expenses," these terms refer to the revenue and expenses, respectively, of the Hospital's "OB/GYN Service," which is defined on the first page of the Employment Agreement as the division of the Hospital devoted to providing OB/GYN care. Had the lower court not dismissed this case before disclosure, the Hospital would have shown that Respondent's Service Revenue never exceeded his Service Expense.

4. The Hospital Paid And Administered The Respondent's Policy

Before the demutualization, and in addition to Respondent, nearly all of the physicians and staff members of the Hospital were insured with professional liability policies issued by MLMIC, which were paid for and managed by the Hospital as if it were a group policy. (R. 20, 42) For the relevant time periods in question (*i.e.*, the three policy years between July 15, 2013 through July 14, 2016), the total amount of premiums paid by the Hospital to MLMIC for the Respondent's Policy was $214,720.54. (R. 21)

The Hospital was formally designated the Policy Administrator for Respondent's Policy. (R. 21, 42) As the Policy Administrator, the Hospital chose and obtained the policies for its physicians; paid the premiums for the policies; corresponded with MLMIC concerning the policies, such as in regard to changes and cancellations; received the benefits of any dividends, credits, rebates or returns on premium; processed renewals; took responsibility for any claims issues; and otherwise dealt with the policies for all intents and purposes. (R. 21)

Respondent never took any steps to revoke or change the Hospital's designation as Policy Administrator, nor did he seek to administer, manage, or otherwise oversee the Policy. In addition, he never bore any of the economic burdens of the Policy nor claimed any of its benefits. Respondent never inquired

as to the status of the policy, renewals of the policy, or the costs of the policy, nor did he object when the Hospital received any dividends or rebates in connection with the Policy. (R. 21)

At no time did Respondent make any contribution directly from his Base Salary for the Policy. Respondent never claimed the premium payments as income on his annual tax forms. The amounts paid for the policy by the Hospital were never treated by Respondent or the Hospital as income to Respondent. In fact, the Hospital claimed the premiums as an expense to the Hospital, as delineated annually on its tax forms. (R. 21)

A full explanation of the Hospital's role, including as a designated Policy Administrator, is detailed in a letter from the Hospital's President/CEO, Jay Cahalan, to the New York State Department of Financial Services on August 28, 2018. (R. 22; 41-43)

5. Respondent Resigned From The Hospital And Expressly Disclaimed Entitlement To Monies Other Than Those Stated In His Employment Agreement

Respondent resigned from the Hospital on August 1, 2017. (R. 22)

Pursuant to the Employment Agreement, upon its termination, Respondent agreed that he would "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. 20; 36)

6. MLMIC's Demutualization

MLMIC historically was a mutual insurance company subject to the supervision, and rules and regulations, of DFS. (R. 22) Sometime in or about 2016, MLMIC announced that NICO, a subsidiary of Berkshire Hathaway, would be acquiring MLMIC and that, as part of that transaction, MLMIC would be converted or "demutualized" from a mutual insurance company to a stock insurance company. Under New York Insurance Law § 7307, demutualizations are governed by a plan of conversion, which must be approved by the Superintendent of DFS. Such plans of conversion must set forth the "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." (R. 22)

The value of the consideration to be paid out for each policy is to be based on the amount of premiums "properly and timely paid to the insurer" during the three-year period preceding the plan of conversion. (R. 23); Insurance Law § 7307(e)(3).

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On July 15, 2018, the Board of Directors of MLMIC adopted a Plan of Conversion that governed the proposed demutualization, subject to DFS approval and a vote of eligible policyholders. (R. 44-97) In connection with that transaction, cash consideration in an amount calculated to be 1.9 times the sum of premiums timely paid during the payout period, which was defined as the period between July 15, 2013 and July 14, 2016, was to be paid to eligible policyholders or their "Designees." (R. 23; 58)

The Plan defines "Designees" as "Policy Administrators… to the extent designated by Eligible Policyholders to receive the portion of Cash Consideration allocated to such Eligible Policyholders." (R. 23; 49) The term "Policy Administrator," in turn, is defined as the person "designated on the declarations page of the applicable policy or otherwise as the administrator of the Policy." (R. 23; 50)

Thus, under the Plan, where a policyholder has "designated" the Policy Administrator as the recipient of Cash Consideration (either through the declarations page of the policy "or otherwise," the Cash Consideration must be paid to the Policy Administrator – as "Designee" – and not to the Policyholder. (R. 23)

MLMIC thereafter received both regulatory approval from the DFS on September 6, 2018, and policyholder approval on September 14, 2018, for the conversion of MLMIC to a stock company, and on October 1, 2018, it closed on the sale of MLMIC to NICO for cash consideration in the amount of $2,502,000,000. (R. 23-24; 98-125)

Recognizing that disputes might arise concerning the proper beneficiary of the cash consideration for a particular policy, the Conversion Plan set forth a procedure whereby objections could be filed with MLMIC, which would in turn trigger an escrow of the relevant cash consideration until the dispute was resolved either consensually or upon the final ruling of an arbiter or court. (R. 24) Specifically, Schedule I to the Conversion Plan provides as follows:

> Objection to Recipient of Cash Consideration
>
> If a Policy Administrator or EPLIP Employer has not been specifically designated to receive the Cash Consideration allocated to an Eligible Policyholder, but nevertheless believes that it has a legal right to receive such Cash Consideration, such Policy Administrator or EPLIP Employer may send MLMIC a letter (return receipt requested) or an e-mail (preferably an e-mail) that sets forth such position, along with a statement to the effect that it has provided a copy of such letter or e-mail to the applicable Eligible Policyholders, at any time prior to the date of the Superintendent's public hearing. If sent by mail, the objection will be considered to be received by MLMIC only when actually received. If MLMIC receives a properly filed objection, the allocated Cash Consideration will be held in escrow by the Conversion Agent until MLMIC receives joint written instructions from the Eligible Policyholder and the Policy

> Administrator or EPLIP Employer as to how the allocation is to be distributed, or a non-appealable order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the Policy Administrator or EPLIP Employer or the Eligible Policyholder.

(R. 63) (emphasis added)

In providing regulatory approval for the demutualization, DFS issued a decision that largely confirmed the dispute resolution process in the Plan (the "DFS Decision"). (R. 98-125) Importantly, the DFS Decision notes that the definition of Policy Administrator is not determinative of who is or is not entitled to the cash consideration, and that "[t]he determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided either by agreement of the parties or by an arbitrator or court." (R. 122)

Thus, the Conversion Plan's objection procedures for Policy Administrators, coupled with the DFS Decision's explanation for how the determination of entitlement should be made based "on the facts and circumstances of the parties' relationship and applicable law," confirmed that: (a) Eligible Policyholders were not automatically entitled to the Cash Consideration by simply refusing to execute an assignment of rights to the Policy Administrator; and (b) Policy Administrators had potentially viable claims to the cash consideration, even without being a

formal "Designee" specifically thereof, if otherwise appropriate under the factual circumstances and pursuant to applicable law.

On January 14, 2019, DFS issued a follow-up order concerning the MLMIC Funds and set forth a few deadlines for the parties to advise their respective tribunals and/or MLMIC of the on-going dispute and resolution status ("DFS Order"). (R. 25; 126-129) To those that did not advise MLMIC of any active dispute resolution processes, DFS authorized MLMIC to release the MLMIC Funds to the policyholder upon the expiration of the stated deadline. However, in the event that MLMIC released the remaining escrowed funds to policyholders, the DFS Decision reiterated that "the release of the escrow shall have no substantive effect on the parties' positions with respect to who is entitled to the payment under the relevant law." (R. 38; 122)

7. MLMIC Continues To Hold The MLMIC Funds Pending A Resolution Of The Parties' Dispute

Despite attempts by the Hospital to procure Respondent's cooperation regarding the MLMIC Funds, Respondent has refused to comply with the Hospital's request that the MLMIC Funds be turned over to the Hospital. Respondent failed and/or refused to sign an Assignment Agreement for the Cash Consideration (R. 25)

Consequently, the Hospital advised MLMIC that it objected to any distribution of the MLMIC Funds to Respondent. Based on that objection, MLMIC continues to hold the MLMIC Funds in escrow, and has not made any distribution to either the Hospital or to Respondent. (R. 25-26)

PROCEDURAL HISTORY

1. The Complaint

The Hospital commenced this action by the filing of a Summons and Complaint on February 20, 2019. (R. 17-31) The Hospital's primary claim is for declaratory judgment based on the equitable principles underlying unjust enrichment and moneys had and received causes of action. (R. 26-27) Out of an abundance of caution, the Hospital also asserted claims for unjust enrichment, moneys had and received, and breach of the implied covenant of good faith and fair dealing in the event that MLMIC prematurely released the funds to Respondent. (R. 27-29)

2. Respondent's Motion to Dismiss

On April 12, 2019, Respondent made a pre-answer motion to dismiss, pursuant to CPLR §§ 3211(a)(1) and (7). Respondent submitted a factual affidavit from Dr. Hinds, an affirmation from his attorney, agreements and correspondence between the parties and MLMIC, and certain documents from MLMIC. (R. 130-

182) Respondent did not submit any documentary evidence regarding the actual operating figures for the calculation of his incentive compensation, nor did Respondent submit (nor could he) any evidence that he actually paid his malpractice premiums through his incentive compensation or otherwise. Indeed, Respondent did not claim – nor could have he truthfully done so – that he ever earned sufficient revenue to qualify for incentive compensation payments.

3. **The Lower Court's Decision**

By Decision and Order, entered on September 12, 2019, the Supreme Court, Columbia County (Zwack, J.) granted dismissal of the Hospital's claims and found that Respondent was entitled to the cash consideration; the lower court's theory was that Respondent actually paid for the premiums through deductions to his prospective incentive compensation, an assertion that had no support in the record and conflicted with the Hospital's allegations that were presented and presumptively valid for purposes of a motion to dismiss. (R. 11-12)

In granting Respondent's motion to dismiss, the lower court made one critical factual determination that erroneously permeated the entire Decision: that Respondent alone paid the malpractice premiums for the Policy, based on its reading of the Employment Agreement. As a result, it found that the equities did not favor the Hospital. (R. 12)

Specifically, the lower court found that the Employment Agreement "establishes that the insurance premiums were deducted before the defendant received any incentive pay. That is, the defendant was to receive incentive pay, 65% of the amount by which his revenue exceeded the expenses paid by the hospital, and one [of] the expenses being his medical malpractice insurance. Stated differently, the defendant would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance." (R. 11-12)[2]

In accordance with its unsubstantiated (and incorrect) finding that Respondent actually paid for the malpractice premiums, the lower court dismissed

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[2] As established below, the Employment Agreement – the only proper "documentary evidence" before the lower court – only sets forth a formula for determining potential incentive compensation based on actual operating figures, such as revenue and expenses. That formula merely gave rise to the possibility of this occurrence depending upon facts that were never provided by Respondent and should not have served as the basis for dismissal under CPLR § 3211(a)(7). Additionally, there was no documentary evidence in the record regarding the Hospital's actual revenues, the actual cost of benefits afforded Respondent, or the share of his expenses relating to administrative overhead. The only thing that the lower court cited to was the Employment Agreement, which was literally blank as to any future operating figures. Given this record, the lower court could not and should not have found that Respondent actually paid the premiums by a deduction to his incentive compensation. Were the case have proceeded to fact-finding, indeed, the court's assumption would have been conclusively disproven.

Also, as argued by the Hospital before the Appellate Division, the lower court's decision was fundamentally flawed to the extent the lower court relied on the affidavits submitted by Respondent in resolving the motion to dismiss under CPLR § 3211(a)(7). Affidavits and affirmations do not constitute the type of "documentary evidence" considered in support of a motion to dismiss pursuant to CPLR § 3211(a)(1). *See Lopes v. Bain*, 82 A.D.3d 1553, 1554 (3d Dep't 2011); *Art & Fashion Grp. Corp. v. Cyclops Prod., Inc.*, 120 A.D.3d 436, 438, 992 N.Y.S.2d 7, 10 (1st Dep't 2014).

the Hospital's claim for unjust enrichment because it found no enrichment at the Hospital's expense. Notably, the lower court also found support for its determination in Insurance Law § 7307. The lower court (mis)interpreted the statute to require payment to the policyholder/owner absent an assignment. (R. 11) In so doing, the lower court ignored the Conversion Plan and DFS' Decision, which provided for the objection procedures, in its determination.

Upon appeal by the Hospital, the Third Department simply affirmed the judgment of the Supreme Court, by Memorandum and Order, dated and entered November 5, 2020, on the grounds articulated in *Schoch*, which had just been recently issued by the Third Department. (R. 262-265)

ARGUMENT

POINT I

INSURANCE LAW § 7307 EXPRESSLY LIMITS RECEIPT OF THE CASH CONSIDERATION TO THOSE WHO PAID THE PREMIUMS

A. Under Insurance Law § 7307, The Payer Of The Premiums Is Entitled To Receive The Cash Consideration

"It is fundamental that a court, in interpreting a statute, should attempt to effectuate the intent of the Legislature." *Majewski v. Broadalbin–Perth Cent. School Dist.*, 91 N.Y.2d 577, 582, 673 N.Y.S.2d 966, 968 (1998). Consistent with this principle, "a particular provision of an act is not to receive a special meaning at variance with the general purpose and spirit of the act." N.Y. Stat. Law § 98 (McKinney); *see Commonwealth of N. Mariana Islands v. Canadian Imperial Bank of Commerce*, 21 N.Y.3d 55, 63 (2013). Indeed, a court's "primary consideration" in interpreting a statute is "to ascertain the legislative intent." *Colon v. Martin*, 35 N.Y.3d 75, 78 (2020).

In assessing the legislative intent, courts should give plain meaning to clear and unequivocal language, which language "is presumptively entitled to authoritative effect." *People v. Marquan M.*, 24 N.Y.3d 1, 9 (2014). The "literal language of a statute controls 'unless the plain intent and purpose of [the] statute would otherwise be defeated.'" *Lynch v. City of New York*, 35 N.Y.3d 517, 523 (2020) (citation omitted).

The starting point for analysis in this case is thus Insurance Law § 7307(e)(3), which provides:

> The 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. The plan 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. The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the insurer on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors under subsection (b) hereof bears to the total net premiums received by the mutual insurer from such eligible policyholders. In computing a policyholder's equitable share, no credit shall be given for any net premiums which result from an endorsement which is effective on or after the date of adoption of the resolution; except that credit shall be given for any net premiums resulting from an audit or retrospective premium adjustment which is billed within one hundred eighty days after such date, provided such premium is paid timely. If the equitable share of the eligible policyholder entitles such policyholder to the purchase of a fractional share of stock, the policyholder shall have the option to receive the value of the fractional share in cash or purchase a full share by paying the balance in cash.

(emphasis added).

It is clear that the intent of the Legislature was to link the payment of premiums to the receipt of the Cash Consideration. The highlighted language

makes plain that it is only those policyholders who have "properly and timely paid" premiums in the last three years that are entitled to an equitable share of the Cash Consideration upon demutualization. This clear language, which evidences the intent of the Legislature, is dispositive and should have been given effect as written. *See Majewski v. Broadalbin-Perth Cent. Sch. Dist.*, 91 N.Y.2d 577, 583 (1998) ("if they have a definite meaning, which involves no absurdity or contradiction, there is no room for construction and courts have no right to add to or take away from that meaning"). *See also Colon v. Martin, supra*; *People v. Marquan M., supra; Lynch v. City of New York, supra*.

The statute does not address what party receives those funds where someone other than the nominal policyholder makes the payments. Clearly, however, it cannot be concluded that the Legislature intended no party to receive those funds under such instances. Given the absurdity of this untenable result and the undisputed presumption that the Legislature did not intend such an indefinite outcome, this Court is authorized to "substitute its own interpretation." *Matter of Anonymous v. Molik*, 32 N.Y.3d 30, 37 (2018). A court is authorized to "substitute its own interpretation of a statute where… 'literal construction would lead to absurd or unreasonable consequences…'" *New York State Land Title Ass'n, Inc. v. New York State Dep't of Fin. Services*, 169 A.D.3d 18, 92 N.Y.S.3d 49, 58 (1st Dep't. 2019); *see also People ex rel. McCurdy v. Warden, Westchester Cty. Corr.*

Facility, No. 73, 2020 WL 6828846, at *6 (N.Y. Nov. 23, 2020). It is only where "it is reasonable to suppose the Legislature intended intentionally to omit" language where a court is prohibited from including it by implication. *Diegelman v. City of Buffalo*, 28 N.Y.3d 231, 237 (2017).

An interpretation that would lead to a rational outcome, and that would not contradict the plain language of Insurance Law §7307(e)(3), would be one that entitles the party that actually paid the premiums, whether it is the policyholder or the employer, to receive the MLMIC Funds. Such an interpretation would harmonize and render internally compatible the above highlighted language from the statute, an objective that courts should strive to reach under basic rules of statutory construction. *People ex rel. McCurdy v. Warden, Westchester County Corr. Facility*, 2020 WL 6828846, at *3; *Peyton v. New York City Bd. of Standards & Appeals*, 2020 WL 7390864, at *4 (2020). *See also* New York Statutes § 97 ("[a]ll parts of a statute must be harmonized with each other). To reiterate, the statute's payment formula in which it explicitly intertwines the amount paid in premiums with the amount paid out as Cash Consideration, evinces a legislative intent to link the eligibility for receipt of the Cash Consideration to the party paying the premiums. This interpretation would be consistent with the reality that employers typically pay the premiums.

Other factors support this interpretation. For example, although the statute speaks of a "person who had a policy of insurance," the term "person" is defined under statutory and case law as including a "corporation" and even a "hospital." Gen. Constr. Law § 37 (McKinney); *People ex rel. Cornell Steamboat Co. v. Dederick*, 161 N.Y. 195 (1900); *In Re Erickson's Will*, 200 Misc. 1005, 104 N.Y.S.2d 507 (Surr. Ct. Suffolk Co. 1951). Thus, the Hospital would constitute a qualifying "person" under the statute. Likewise, it is notable that the term "policyholder" is not defined under the statute, let alone in a manner that rigidly limits its definition to the nominal policyholder. Indeed, reference to other authority allows for a definition of the term "policyholder" in Insurance Law § 7307(e)(3) to include a "corporation," such as the Hospital. *See* Insurance Law § 501 (e) and (g); Labor Law § 217 (concerning remittance of premiums).

B. **The Third Department's Flawed Statutory Analysis**

Viewed within this framework, it becomes apparent that the Third Department's decision was flawed.

The Third Department, adhering to its decision in *Schoch*, held that Insurance Law § 7307 requires that "entitlement to the MLMIC funds is not contingent on who paid the premiums for the subject policy," and that "the sole policyholder, here, defendant, is entitled to receive said funds unless he or she executed an assignment of such rights to third party." (R. 264) The Third

Department in *Schoch* added that the DFS, in its Decision and Order, and the MLMIC Plan of Conversion expressed the same conclusion.

In reaching this affirmative conclusion, the Third Department disregarded the explicit link between the policyholder's receipt of the cash consideration and the payment of premiums. It found that the language stating that a policyholder's entitlement to money is based upon the net premiums paid by a policyholder merely "pertains to how the considerations are to be calculated, rather than to whom they must be paid," and thereby rejected the idea that this language qualified when a policyholder is entitled to receive the MLMIC funds. (R. 264)

The problem with the Third Department's interpretation, however, is that it runs directly contrary to the explicit words and intent of the statute directly linking entitlement to the Cash Consideration to the payment of premiums, which words clearly state that "such policyholder" is only entitled to receive a sum based upon the premiums such policyholder paid. Such a link could not have been any clearer. Thus, the Third Department's attempt to minimize the conditional language cannot be viewed as anything but an attempt to improperly re-write the statute or to modify its intended meaning. Accordingly, because the Third Department's interpretation runs afoul of the plain and unequivocal language, it must be rejected. *See Wyckoff Heights Medical Center v. Leonora Monroe & MLMIC Ins. Co*., 2020

WL 4561195, at *2 (N.Y. Sup. Ct. Aug. 07, 2020) ("The arguments… that a policyholder need not pay the premiums as long as someone else pays them on her behalf is an expansion of Insurance Law § 7307 that is not compelled from the text of the statute"). Indeed, by linking receipt of the Cash Consideration to the payment of premiums, the Legislature must have wanted to deny policyholders from receiving any Cash Consideration when they failed to contribute to the fund in the first instance.

The Third Department's reasoning is flawed for yet another reason. If this Court were to accept the Third Department's premise – that the language concerning the amount of the equitable share was merely a formula to calculate how much the policyholder was entitled to receive – it would lead to an absurd result. If the amount of premiums paid by the policyholder paid is zero, then, under the Third Department's interpretation, the policyholder would be entitled to no Cash Consideration at all. Indeed, under that interpretation, no party, not even the one that actually paid the premiums, would be entitled to receive the MLMIC Funds. It is fundamental, however, that statutory interpretations, such as the one posited by the Third Department, must be rejected where they lead to "absurd" results. *See Majewski v. Broadalbin–Perth Cent. School Dist.*, 91 N.Y.2d 577, 583 (1988); *Schmidt on Behalf of McNell v. Roberts*, 74 N.Y.2d 513 (1989).

POINT II

REGARDLESS OF WHICH PARTY IS ENTITLED TO RECEIVE THE MLMIC FUNDS UNDER INSURANCE LAW § 7307, THE HOSPITAL'S EQUITABLE CLAIMS SURVIVE

Regardless of how the Court ultimately construes the Insurance Law, the Court's inquiry does not end there. Rather, the Hospital's equitable claims survive, as envisioned in DFS's Order and Decision, and pursuant to applicable case law.

A. The DFS Order And Decision Support The Conclusion That The Ultimate Issue Of Which Party Is Entitled To The Cash Consideration Should Be Based On Equitable Principals, And Not Statutory Analysis

DFS is the agency that is responsible for enforcing and interpreting the Insurance Law (*Matter of Medical Socy. Of State of N.Y. v. Serio,* 100 N.Y.2d 854, 863-864 [2003]), and whose agency interpretations are entitled to great weight and judicial deference. *See Peyton v. New York City Bd. of Standards & Appeals*, 2020 WL 7390864, at *4 (N.Y. Dec. 17, 2020); *Kurcsics v. Merchants Mut. Ins. Co.*, 49 N.Y.2d 451, 459 (1980).

Even DFS rejected the notion that the issue of entitlement to the Cash Consideration could be decided merely based upon reference to Insurance Law § 7307. Indeed, in its Decision, DFS specifically contemplated, yet declined to answer, the question of whether the Cash Consideration should be paid to the nominal policyholder or to the Policy Administrator who paid the premiums. In

particular, DFS rejected both the employers' assertion that the party that paid the premiums was automatically entitled to the MLMIC funds (finding that such factor was "not determinative" of the issue), as well as the policyholder's claim that they alone were entitled to such monies. In fact, the DFS therein acknowledged the anomaly of a 'policyholder' who had not paid the premiums, conceding that such policyholder "might or might not be the person who paid the premiums." (R. 120).

Instead of deciding the issue, the DFS established an escrow and dispute resolution process by which the policyholders and policy administrators could submit their disputes to arbitrators or courts concerning the issue of who was entitled to receive the cash consideration. (R. 120-121) The DFS explained that a Policy Administrator can file an objection to the payment of the funds to the Policyholder, and that the funds will be placed in escrow pending the determination by a court as to which party should receive the proceeds.

> The Superintendent stresses that the escrow arrangement is simply a method of holding in an escrow a certain amount of the cash consideration for a reasonable amount of time to allow the relevant parties to resolve their claims, a process that is fair and equitable and in the interests of the public. Nothing in this procedure or escrow arrangement shall affect the closing of the transaction. Moreover, nothing in the escrow arrangement is intended to shift the burden of proof or persuasion on the underlying issue. Nor does the definition of Policy Administrator represent the Department's view that anyone that falls within this definition is (or is not) entitled, under the particular facts or applicable law, to receipt of the cash consideration. <u>The determination of who is entitled to the cash consideration depends</u>

> on the facts and circumstances of the parties' relationship and applicable law, to be decided either by agreement of the parties or by an arbitrator or court. (emphasis added)
>
> (R. 121-122).

See Wyckoff Heights Medical Center, 2020 WL 4561195, at *2 ("These provisions have no meaning and there can be no possible basis for any disputes if the employee is automatically entitled to the benefits merely because she is a policyholder… there can be no possible reason to create a dispute resolution forum if there can be nothing to dispute."); *Sullivan v. Medical Liability Mutual Insurance Co.*, 2019 N.Y. Slip Op. 33566(U), at *5 (N.Y. Sup. Ct. N.Y. Co., Dec. 2, 2019) ("The Court is also not persuaded by Plaintiffs' argument that DFS 'affirmed' the decision to allocate the Cash Consideration to policyholders only. . . the Approved Plan specifically provided that the facts of individual cases would dictate the entitlement to the proceeds and established an objection procedure. . . [and] the ultimate legal right to the Cash Consideration, if disputed, must be decided by a court.");

Furthermore, the DFS's Decision emphasized that, even if MLMIC had released the remaining escrowed funds to policyholders (for those who did not strictly adhere to the objection/escrow requirements and process), "the release of the escrow shall have no substantive effect on the parties' positions with respect to who is entitled to the payment under the relevant law." (R. 122) This

determination (not to direct payment solely to the policyholder) is reiterated in DFS's subsequent Order (R. 128).

In parallel fashion, under the Conversion Plan, the MLMIC Funds are to be paid either to Eligible Policyholders or their "Designees." (R. 58) "Designees" are broadly defined as, *inter alia*, Policy Administrators "to the extent designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policy holder." (R. 49) Importantly, the Plan itself does not define or limit the manner in which an Eligible Policyholder may "designate" a Policy Administrator as a "Designee" to receive the Cash Consideration. Rather, as the Objection Procedure indicates, a Designee may be legally entitled to the Cash Consideration even if it has not been "specifically designated" with a formal assignment agreement (R. 63) ("If a Policy Administrator or EPLIP Employer has not been specifically designated to receive the Cash Consideration allocated to an Eligible Policyholder, but nevertheless believes that it has a legal right to receive such Cash Consideration," such person may file an objection and submit the dispute for court or arbitral resolution).

Interpreting this provision, the court in *Sullivan v. Northwell Health, Inc.*, *supra,* held that the Plan of Conversion, as approved by DFS, "specifically provided that the facts of individual cases would dictate entitlement to the proceeds

and established an objection procedure… that the ultimate legal right to the Cash Consideration, if disputed, would be decided by a court." *See Sullivan*, 2019 N.Y. Slip Op. 33566(U), at *5. The *Sullivan* court further noted that DFS confirmed this process for determining entitlement to the funds in its January 2019 Order, in which it made clear that a party's status as a "policy administrator" or "designee" are irrelevant to the issue of entitlement, as "nothing in the [Plan of Conversion] determines the underlying legal rights of the parties to the Cash Consideration." *See id.*; (R. 128-129).

B. Legal Title Does Not Preclude Claims In Equity

Case law further confirms the conclusion that courts need to consider the facts and circumstances of each case. Indeed, even assuming that Insurance Law §7307(e)(3) requires the policyholder to receive the MLMIC Funds – although it does not – that conclusion does not preclude consideration of the Hospital's equitable claims.

As this Court has held, legal title does not preclude claims based on equity. *Simonds v. Simonds*, 45 N.Y.2d 233, 239, 408 N.Y.S.2d 359 (1979) (claimant's equitable interest in insurance policies was superior to that of a named beneficiary who has given no consideration); *see also Sharp v. Kosmalski,* 40 N.Y.2d 119 (1976) (a constructive trust may be imposed when property has been acquired in such circumstances that the holder of the legal title may not, in good conscience,

retain the beneficial interest); *Robert M. Schneider, M.D., P.C. v. Licciardi*, 65 Misc. 3d 254, 262, (N.Y. Sup. Ct. 2019) ("a party may be legally entitled to a benefit through a contract but still equitably owe those funds to another"); *Urgent Med. Care. PLLC v. Amedure,* 64 Misc.3d 1216A (Sup. Ct. Greene Co. 2019) ("[l]egal title does not end the inquiry"). "Equity arose to soften the impact of legal formalisms; to evolve formalisms narrowing the broad scope of equity is to defeat its essential purpose." *Simonds v. Simonds*, 45 N.Y.2d at 239.

Accordingly, given the need to confront the equities of Hospital's claims against Respondent, the Court's inquiry should turn next to the unjust enrichment claim asserted by the Hospital.

POINT III

THE HOSPITAL MAINTAINS A VIABLE CLAIM FOR UNJUST ENRICHMENT BECAUSE IT PAID THE PREMIUMS AND WAS THE DE FACTO OWNER OF THE POLICY

As demonstrated below, the Hospital has a viable claim for unjust enrichment that should not have been dismissed, especially on a pre-answer motion to dismiss, because it paid all of the premiums for the Policy and was the de facto owner of the Policy for all intents and purposes.

A. The Standard For Unjust Enrichment

"The essential inquiry in any action for unjust enrichment or restitution is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered." *Paramount Film Distrib. Corp. v. State of New York*, 30 N.Y.2d 415, 421 (1972). Thus, for an unjust enrichment claim, "a party 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." *Mandarin Trading Ltd. v. Wildenstein*, 16 N.Y.3d 173, 182 (2011).

Notably, to reiterate, contractual and ownership rights do not necessarily trump equitable rights. *See Simonds v. Simonds*, 45 N.Y.2d 233, 237 (1978); *Robert M. Schneider, M.D., P.C. v. Licciardi*, 65 Misc. 3d 254, 262 (N.Y. Sup. Ct. 2019) ("a party may be legally entitled to a benefit through a contract but still

equitably owe those funds to another"). Furthermore, unjust enrichment does not require a showing that the party enriched committed a wrongful act. *See Simonds v. Simonds*, 45 N.Y.2d at 242; *Hornett v. Leather*, 145 A.D.2d 814, 816 (3d Dep't 1988).

B. Policyholders Received A Benefit From <u>MLMIC At The Employers' Expense</u>

As a threshold matter, policyholders have argued that employers' unjust enrichment claims must fail because the Cash Consideration is being paid by a third party, *i.e.* MLMIC, and not by them.

This Court has not required the benefit to be conferred directly by the plaintiff to the defendant in order to sustain an unjust enrichment claim. *See State v. Barclays Bank of New York, N.A.,* 76 N.Y.2d 533, 540, 563 N.E.2d 11, 15 (1990) ("It is an obligation which the law creates, in the absence of any agreement, when and because the acts of the parties **or others** have placed in the possession of one person money, or its equivalent, under such circumstances that in equity and good conscience he ought not to retain it") (emphasis added); *Shah v. Exxis, Inc*., 138 A.D.3d 970, 972 (2d Dep't 2016) (potential unjust enrichment claim against individual owner based on payment made to his company); *Mobarak v. Mowad*, 117 A.D.3d 998, 1001 (2d Dep't 2014).

Moreover, the only reason that the Cash Consideration is available under Insurance Law § 7307(e)(3) is because the employers "properly and timely paid" the premiums for the policyholders over the three relevant policy years. As a practical matter, Respondent cannot deny that the malpractice policies were literally purchased at the Hospital's expense,[3] and that those purchases formed the basis, pursuant to the Insurance Law, for the calculation and receipt of the Cash Consideration. This direct connection between the Cash Consideration and the employers' payment of premiums undermines any assertion that the benefits conferred by Cash Consideration were not at the employers' expense solely because a third party may be involved.

C. Equity and Good Conscience Favors The Employers Who Paid For The Policies

DFS found that ultimate entitlement to the Cash Consideration should depend upon the "facts and circumstances of the parties' relationship." This is consistent with this Court's position that an unjust enrichment analysis requires a "realistic determination based on a broad view of the human setting." *McGrath v. Hilding*, 41 N.Y.2d 625, 629 (1977); *see also New York City Health & Hosps.*

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[3] Incidentally, it should be noted that, in Respondent's specific case, the parties disputed who actually paid the malpractice policy. The Hospital pled and contends that Respondent never generated sufficient revenues from his work to cover the Hospital's payment of his salary, let along the costs of his practice's expenses and malpractice policies. (R. 18, 27) As a matter of law, this factual issue should have precluded a dismissal at the pleading stage of the Hospital's unjust enrichment claim. *See* p. 22, fn.2, *supra*.

Corp. v. Wellcare of New York, Inc., 35 Misc. 3d 250, 254 (Sup. Ct. N.Y. Co. 2011) (same). Reference to these facts compels the conclusion that the Hospital is entitled to the Cash Consideration.

In terms of the Policy, Respondent's sole connection was that he was named the policyholder, as required by MLMIC and not by the Hospital's choice. Other than this nominal designation, however, Respondent devoted no time, money or resources with respect to that Policy. Furthermore, Respondent never inquired as to the status of the Policy, renewals of the Policy, or the costs of the Policy, nor did Respondent ever object when the Hospital received dividends or rebates in connection with the Policy. (R. 21)

Additionally, at no time did Respondent make any contribution directly from his Base Salary or incentive compensation for the Policy.[4] Respondent never claimed the premium payments as income on his annual tax forms. The amounts paid for the Policy by the Hospital were never treated by Respondent or the Hospital as income to Respondent. In fact, the Hospital claimed the premiums as an expense to the Hospital, as delineated annually on its tax forms. (R. 21)

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[4] There is no proof in the record that Respondent contributed a single penny of his salary, or that his productivity ever met incentive compensation thresholds that would have led to an indirect contribution by him through any anticipated incentive compensation. *See* footnote 2, *supra*.

This is in stark contrast to the Hospital, which can readily be characterized as both an owner and administrator with respect to the "group policy" for all its employees. (R. 41-42) Specifically:

- The Hospital selected and obtained the Policy, which it did for 84 different physicians under its employ. (R. 41)
- The Hospital paid all of the premiums associated with Respondent's Policy, an amount of $214,720.54 for the years in question. (R. 21)
- The Hospital did all of the work administering and managing the policies, including, but not limited to, corresponding with MLMIC concerning the policies, such as in regard to changes and cancellations, processing renewals and handling claims issues. *Id.*
- During the time frame in question, the Hospital received all dividends, credits, rebates or returns on premium issued by MLMIC. *Id.*

In short, the Hospital showed all of the attributes of a policyholder and ownership with respect to the dozens of policies that it procured and managed, and assumed all the burdens and benefits associated with them. In sharp contrast, the Respondent's name was simply filled in on an application form, by the Hospital no less, because the Hospital was relegated to an Administrator on the MLMIC Consent Form. (R. 42)

Similarly, when one focuses objectively on facts that reflect the reasonable expectations of the parties with respect to the Policy and entitlement to economic incidents of the Policy, such analysis favors the Hospital's receipt of the Cash Consideration. For example:

- In the Employment Agreement, the malpractice premiums are expressly listed as a Hospital expense, unless Respondent's productivity meets thresholds for incentive compensation. *See* R 33. Coupled with the Hospital's allegation that it alone paid the premiums (R. 21), such facts support the conclusion that the Policy was not something of which Respondent could reasonably claim ownership.

- It is not disputed that the Hospital received all dividends, credits, rebates or returns on premium issued by MLMIC. (R. 21) Although dividends from MLMIC may be conceptually distinguishable from Cash Consideration, both are nonetheless indicia of ownership and entitlement, and the Hospital reasonably expected receipt of any financial payments from MLMIC. *See* IRS (Topic No. 404 Dividends)("[d]ividends are distributions of property a corporation may pay…if you own stock in that corporation).[5] Yet there is no proof in the record that Respondent ever claimed those other monies as the so-called true owner of the Policy.

- In the Employment Agreement, Respondent agreed that "[u]pon termination of this Agreement…[he] shall only be entitled to receive the accrued but unpaid Base Salary, and Incentive Compensation owed to you as of the date of [his] termination. (R. 36) This express language

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[5]https://www.irs.gov/taxtopics/tc404#:~:text=A%20shareholder%20of%20a%20corporation,adequate%20reimbursement%20to%20the%20corporation.

> further undermines Respondent's claimed entitlement to monies stemming from the Policy.

In short, with respect to what he was entitled to under his Employment Agreement, Respondent received exactly what he bargained for: Base Salary, benefits, and the Hospital's maintenance of "an individual occurrence-based medical malpractice insurance policy." He should not have expected more than that nor did he do anything to justify his entitlement to anything beyond that with respect to the Policy. The Hospital, on the other hand, took on all of the obligations of ownership of the Policy and exercised all rights with respect to it, including the right to receive the economic benefits of the Policy, such as dividends, credits, rebates or returns on premium issued by MLMIC. The Hospital's receipt of the Cash Consideration calculated based on the premiums it had paid is wholly consistent with this history and the parties' reasonable expectations.[6]

Given all of the above facts, equity favors granting the Hospital the MLMIC Funds. Permitting Respondent to keep the $412,418.93 in MLMIC Funds under these circumstances would result in the unjust enrichment that a court, in invoking its remedial powers of equity, should take steps to prevent. *See McGrath v. Hilding*, 41 N.Y.2d 625, 629 (1977).

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[6] *See generally* https://www.irs.gov/pub/irs-wd/0136024.pdf.

Finally, to bring the unjust enrichment analysis full circle back to the Insurance Law, the Court should not overlook the one factor imposed by the statute itself: timely and proper payment of the premiums. The Legislature clearly considered payment as the dispositive factor in determining what party is entitled to receive the Cash Consideration, a conclusion that strengthens the Hospital's unjust enrichment claim. As discussed below, the First Department found this factor to be the most determinative when analyzing whether it would be unjust to award the monies to the person that never paid a penny for it, or to the employer that did.

D. The First Department And Courts Of Other Jurisdictions Support The Hospital's Unjust Enrichment Analysis

In *Schaffer*, the First Department held that an employer who paid all policy premiums to MLMIC is entitled to the Cash Consideration, even if the employee is the named policyholder, on the grounds of unjust enrichment. Specifically, in *Schaffer*, the court held that:

> [a]lthough respondent was named as the insured on the relevant MLMIC professional liability insurance policy, petitioner purchased the policy and paid all the premiums on it. Respondent does not deny that she did not pay any of the annual premiums or any of the other costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds. Awarding respondent the cash proceeds of MLMIC's demutualization would result in her unjust enrichment.

171 A.D.3d 465.[7]

The two cases cited by the Court in *Schaffer* clearly illustrate the equitable considerations at play when considering the distribution of demutualization funds. That these cases concern ERISA and are not specifically New York unjust

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[7] Myriad lower courts throughout New York State followed and adhered to the reasoning in *Schaffer*. *See Phelps Imaging Services v. Kroop*, Index No. 53243 (Sup. Ct. Westchester Cnty. Nov. 9, 2020); *White Plains Radiology Associates, P.C. v. Forcade*, Index No. 53247/2019 (Sup. Ct. Westchester Cnty. Nov. 9, 2020); *Cordaro v. AdvantageCare Physicians, P.C.*, 2020 WL 5582253 (Sup. Ct. N.Y. Cnty. Sept. 17, 2020); *Wyckoff Heights Medical Center v. Monroe et al.*, 2020 WL 4561195 (Sup. Ct. Kings Cnty. Aug. 7, 2020); *Phelps Memorial Hosp. Assoc. v. Heier*, Index No. 652845/2019 (Sup. Ct. New York Cnty. July 27, 2020); *Phillip Fyman and Alexander Weingarten, M.D., P.C. v. Bax*, Index No. 601960/2019 (Sup. Ct. Nassau Cnty. Mar. 12, 2020); *Brauer v. Dr. R. G. Geronemus, M.D., P.C.*, Index No. 70720/2018 (Sup. Ct. Westchester Cnty. Dec. 19, 2019); *Episcopal Health Services v. Henry*, Index No. 707615 (Sup. Ct. Queens Cnty. Dec. 10, 2019); *Sullivan v. Northwell Health, Inc.*, Index No. 656121/2018, *3 (Sup. Ct. N.Y. Cnty. Dec. 2, 2019); *Benoit v. Jamaica Anesthesiologist, P.C.*, Index No. 615476/2018 (Sup. Ct. Nassau Cnty. Nov. 26, 2019); *Women's Care in Obstetrics and Gynecology, P.C. v. Herrick et al.*, 2019 WL 5691879, 2019 N.Y. Slip Op. 51776(U) (Sup. Ct. Warren Co. Nov. 4, 2019); *Zilkha Radiology, P.C. v. Schulze*, Index No. 622517/2018 (Sup. Ct. Suffolk Cnty. Nov. 1, 2019); *NRAD Med. Assoc., P.C. v. Kim*, Index No. 617351/2018, *23 (Sup. Ct. Nassau Cnty. Oct. 28, 2019); *Long Island Radiology Associates, P.C. v. Koshy et al.*, Index No. 600195/2019 (Sup. Ct. Nassau Cnty. Oct. 7, 2019); *Phelps Memorial Hospital Assoc. v. Mendelowitz*, Index No. 652608/2019 (Sup. Ct. N.Y. Cnty. Sept. 19, 2019); *Shoback, CNM v. Broome Obstetrics and Gynecology, P.C.*, Index No. EFCA2018003334 (Sup. Ct. Broome Cnty. Sept. 10, 2019); *Mid-Manhattan Physician Services, P.C. v. Dworkin*, No. 656478/2018 (Sup. Ct. N.Y. Cnty. Sept. 3, 2019); *John T. Mather Memorial Hosp. of Port Jefferson, New York, Inc. v. Fadel*, Index No. 624734/2018 (Sup. Ct. Suffolk Cnty. Aug. 21, 2019); *Urgent Medical Care PLLC v. Amedure*, 64 Misc.3d 1216(A) (Sup. Ct. Greene Cnty. July 12, 2019); *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 64 Misc.3d 1215(A), *2 (Sup. Ct. Saratoga Cnty. June 7, 2019); *Maple Medical LLP v. Scott*, No. 51103/2019, 2019 WL 3070676 (Sup. Ct. Westchester Cnty. July 5, 2019).

enrichment disputes does not mean that they are not instructive in this case, or that unjust enrichment sentiments are somehow different.[8]

For example, in *Ruocco v. Bateman, Eichler, Hill, Richards, Inc.*, 903 F.2d 1232 (9th Cir. 1990), *cert. denied*, 498 U.S. 899 (1990), a former employee disputed his employer's retention of demutualization funds received from a long-term disability insurance plan. 903 F.2d at 1234-35. The premiums for the plan had been paid by the employees, not the employer, via income deductions. *Id.* at 1234. Accordingly, the Ninth Circuit Court of Appeals upheld the district court's finding that "the balancing of the equities weighed in favor of the plan participants because the premiums for the plan were paid for by the participants and because outside of minor administrative costs, [the employer] paid nothing." *Id*. at 1232, 1238.

Similarly, in *Chicago Truck Drivers v. Local 710, Int'l Bhd. of Teamsters*, the court confirmed that demutualization funds in a 401(k) plan should revert to the employees, because "the contributions…were made entirely by the employees, outside of minor administrative costs," and the plan was "fully funded by the employees." No. 02-c-3115, 2005 WL 525427, *4 (N.D. Ill. Mar. 4, 2005).

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[8] Notably, at the time *Schaffer* was decided, there was a dearth of case law relevant to this dispute, and *Ruocco* and *Chicago Truck Drivers* were the most pertinent cases that could be identified.

"[A]warding this compensation to the employers would give them an undeserved windfall-they would be receiving money as a result of the investment of the participants of the plans, not their own efforts." *Id*.

There were three other benefit plans at issue in *Chicago Truck Drivers*, and the court had to analyze whether the demutualization funds for those plans constituted plan assets, held by the plan for the benefit of its participants, or if they should be paid to the employers who funded the plans. *See id.* The court's holding repeatedly considered the equities of who paid for the plans, and strayed from them only when necessary. For two of the three plans, the court held that the funds should be plan assets, despite this constituting an "undeserved windfall" to the plans (*id.* at *4) – it so held specifically because of a Department of Labor Advisory Opinion concerning the specific type of ERISA pension plans at issue, and plan language suggesting that dividends would become plan assets (neither of which exist in the instant case). *Id.* at *5. However, the court also held that the plans should use the money to pay off their liabilities and reduce future employer contributions, and that once the liabilities were paid off, "the demutualization compensation reverts to the contributing employers." *Id.* at *6-7. The court further noted that "it is undisputed that the employers were responsible for the contributions to the plans, not the employees. Therefore, no equitable distribution to the [employee] participants need be made." *Id.* at *6.

For the final plan, the court held that "it is undisputed that the employers made all of the contributions to the plans. Therefore, there is no reason to treat any portion of the demutualization compensation as a plan asset." *Id.* at *8.

In other words, the court in *Chicago Truck Drivers* is clear and consistent in its findings that, absent contractual language or law to the contrary, demutualization funds should go to the entity that paid the premiums. Both *Ruocco* and *Chicago Truck Drivers*, are therefore relevant, because they clearly demonstrate that the most critical analysis when considering the distribution of demutualization proceeds is a balancing of the equities. *See also Mell v. Anthem, Inc*., 688 F.3d 280, 286 (6th Cir. 2012) (district court found that Plaintiffs cannot be the owners of the group policy because as employees and retirees Plaintiffs "had nothing to do with the choice of insurance carrier, nor with its governance, and they received what they bargained with the City to get: insurance coverage"); *Greathouse v. E. Liverpool*, 823 N.E.2d 539 (Ohio Ct. App. 2004) (city was entitled to proceeds from city's sale of stock to insurer after demutualization of insurer where city purchased health insurance for benefit of employee and other employees, city could have changed insurers without employee's permission, employee did not negotiate with insurer, and employee did not deal with insurer in any way; "[a]s a benefit of his employment, the city provided appellant with health insurance—nothing more"); *Town of N. Haven v. N. Haven Educ. Ass'n*, 2004 WL

113524, at *2 (Superior Ct. Conn. 2004) ("Fairness dictates that the teachers should share in the proceeds received by the Town to the extent that the amount of the premiums paid by them bears to the total amount of the premiums paid by the Town upon which the total stock distribution was based"); *Miamisburg, City of and FOP, Ohio Labor Council*, 2003 WL 26071521 (Apr. 18, 2003) (Goldberg, Arb.) (arbitrator awarded demutualization funds to employer and union proportionally, based on the percentage of contribution to health plan's profits); *Cf., In re Interdiction of Lalehparvaran*, 132 So.3d 439 (La. Ct. App. 2014) (the status as the insured does not make the insured a party to the contract and does not give the insured the rights of ownership).

E. The Third and Fourth Departments' Decisions That Found In Favor Of The Employees Are Fundamentally Flawed

The other Appellate Divisions have, in contrast with the First Department, found in favor of the employees on the unjust enrichment claim, but they were founded upon a fundamentally flawed premise that misread the Insurance Law, the Plan of Conversion, and the DFS Decision, as addressed above. *See supra*, Point I. To be sure, the Third Department in *Schoch*, when discussing the unjust enrichment claim, explicitly based it unjust enrichment conclusion on the premise that "per the relevant statute and the conversion plan's definitions, plaintiff was entitled to the cash consideration." 184 A.D.3d 338, 341 (3d Dep't 2020).

Moreover, *Schoch* erroneously dismissed the employer's direct payment of premiums on the grounds that consideration had been mutually exchanged (by the physician's labor), and thus either party could make the same windfall argument regarding the unexpected Cash Consideration. But the issue is not which party is entitled to a windfall or what consideration was exchanged. Rather, the pertinent question is which party is the true owner of the policies, as demonstrated by the general attributes of ownership, as well as the parties' expectations. Thus, the relevant factors include the costs and burdens associated with obtaining, paying, and managing the insurance coverage, and the receipt of any dividends, credits, and rebates without objection from the physician. This analysis – and not the technical and conceptual exchange of legal consideration – should underlie the unjust enrichment analysis and the receipt of the Cash Consideration arising from the demutualization.

Moreover, the Third Department's finding inexplicably and inappropriately disregarded the significant sums of money that the employer paid in premiums – here, approximately $215,000 for Respondent – that gave rise to the Cash Consideration in the first place. Paying the Cash Consideration of $412,418 to Respondent instead, who paid nothing in premiums, and never expected anything from MLMIC, would unjustly enrich Respondent. This gut-wrenching reaction, which the First Department in *Schaffer* (and the cases cited therein) wanted to

avoid, makes sense because the equites call for the return of monies back to where it originated. Thus, the Hospital should receive the Cash Consideration, which would be the right thing to do for its payment of premiums.

Finally, *Schoch* erroneously rejected the unjust enrichment claim because there was no indication that the policyholder acted tortiously or fraudulently when receiving the funds. This argument is a straw man. To reiterate, unjust enrichment does not require a showing that the enriched party committed a wrongful act, as innocent parties may frequently be unjustly enriched. *See Cruz v. McAneney*, 31 A.D.3d 54, 59 (2d Dep't 2006) ("Unjust enrichment, however, does not require the performance of any wrongful act by the one enriched"); *Hornett v. Leather*, 145 A.D.2d 814, 816 (3d Dep't 1988).

Given that the Second Department's holding in *Maple Med., LLP v. Scott*, 191 A.D.3d 81 (2d Dep't 2020) borrowed heavily from *Schoch*'s flawed reading of the Insurance Law and erroneous unjust enrichment analysis, *Maple Med., LLP v. Scott* need not be followed either. The Fourth Department's decision in *Maple-Gate Anesthesiologists, P.C. v. Nasrin* is short on analysis, but also improperly relies on Insurance Law § 7307 and the Plan of Conversion, which it too erroneously interpreted as giving policyholders exclusive rights to demutualization proceeds absent an assignment. 182 A.D.3d 984 (4th Dep't 2020).

CONCLUSION

For the reasons set forth above, the Hospital respectfully asks that this Court reverse the Appellate Decision below, reinstate the Complaint, remand the case for further proceedings, and grant the Hospital such other relief as this Court may deem just, equitable or proper.

Dated: Great Neck, New York
March 5, 2021

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NEW YORK STATE COURT OF APPEALS
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