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

APL-2021-0001
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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.

REPLY BRIEF FOR PLAINTIFF-APPELLANT

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INTRODUCTION

In three related appeals, the Court must determine which party – the employer/Columbia Memorial Hospital (the "Hospital") or its former employee/physician Marcel Hinds ("Respondent") – is entitled to cash consideration ("Cash Consideration" or "MLMIC Funds"), currently held in escrow, that was calculated based on malpractice insurance policy premiums paid by employers for policies issued by Medical Liability Mutual Insurance Company ("MLMIC") between 2013 and 2016.

Following extensive litigation in New York State concerning this issue, a two-part analysis has emerged in resolving this issue: first, an analysis of Insurance Law § 7307(e)(3) and related documents issued by MLMIC and the New York State Department of Financial Services ("DFS"), all of which attempt to address which party is entitled to the receipt of the Cash Consideration; and second, an analysis of which party is ultimately entitled to retain those monies under a theory of unjust enrichment, notwithstanding any preliminary determination of distribution of the Cash Consideration under the statute.

As the Hospital demonstrated in its main brief, Insurance Law § 7307(e)(3) expressly links the policyholder's payment of premiums to the receipt of the Cash Consideration, explicitly providing that the amount due is determined by "the net

premiums…such policyholder has properly and timely paid the insurer." As the Hospital added, fundamental rules of statutory construction permit the Court to interpret the statute to mean that the party that actually paid the premiums, whether it is the nominal policyholder or the employer, to receive the Cash Consideration, because otherwise no party would receive such monies in instances where the nominal policyholder did not make the premium payments. Here, because the Hospital paid the MLMIC premiums, the legislative intent was for the Hospital, as the payer, to receive the Cash Consideration.

In response, Respondent argues that the Insurance Law, MLMIC's Conversion Plan (the "Plan"), and a decision (the "Decision") and order ("Order") of the DFS, the government agency charged with oversight of the demutualization, all rigidly limit distribution of the Cash Consideration to only the nominal policyholder or a party to whom the policyholder has expressly assigned the rights to receive the monies. That argument, however, is undermined by certain objective realities. The Insurance Law provides for payment to the party that paid the premiums. Additionally, both the Plan and the Order and the Decision of the DFS expressly provide for an objection process in which even parties who "had *not* been specifically designated by the Eligible Policyholder to MLMIC to receive…the consideration" (emphasis added) can make a claim for the Cash Consideration.

Respondent next asserts that the statutory language – which expressly provides that receipt of Cash Consideration is dependent upon the premiums paid by the policyholder – should be construed as merely a formula for calculating the amount of Cash Consideration due a policyholder. Specifically, Respondent argues that this statutory language should be interpreted to mean that the policyholder's entitlement to the Cash Consideration depends upon the premiums "paid under" the policy, not by the policyholder itself. But the statute does not use that language, and Respondent's attempt to thereby rewrite the statute must be rejected. Even more importantly, the language from the Plan that Respondent cites is from the definition of "Eligible Premium," not "Eligible Policyholder," and therefore cannot be used to define the party entitled to receive the Cash Consideration.

As further shown by the Hospital in its main brief, regardless of which party is entitled to receive the Cash Consideration under Insurance Law 7307(e)(3), the Hospital's equitable claims for unjust enrichment survive. This conclusion is reinforced by reference to language from the Plan, the DFS Order and Decision, language in the statute itself and case law of this Court that stresses that legal title does not preclude claims in equity. Although Respondent argues that to permit an unjust enrichment analysis would constitute a wrongful circumvention of Insurance Law 7307(e)(3), putting aside that the statute provides that the party that paid the

premiums is entitled to the Cash Consideration, there is nothing in the statutory language that precludes a subsequent analysis of equitable claims. In any event, to reiterate, legal title does not impede claims in equity. Notably, all four Appellate Divisions hearing this issue, while reaching different conclusions, rendered decisions based upon an analysis of the unjust enrichment claim.

Finally, and in dispositive fashion, the Hospital conclusively established in its main brief that because it paid the premiums and was the de facto owner of the MLMIC policy, it was entitled to receive and retain the Cash Consideration. This is particularly so given this Court's emphasis that resolution of unjust enrichment claims depend upon broad considerations of equity and justice, and should focus on the "'human setting involved,' not merely the transaction in isolation." *McGrath v. Hilding*, 41 N.Y.2d 625, 629 (977).

Here, the not-for-profit Hospital paid the premiums, and those payments were explicitly characterized as an "expense" in Respondent's employment agreement ("Employment Agreement"). Moreover, to accept Respondent's suggestion that the payment of policy premiums was part of his compensation package is to ignore the parties' practice, throughout, *not* to treat the payments as an element of compensation. The Hospital never reported the premiums as income to Respondent, nor did Respondent ever claim the income on his tax returns. To

now treat the premiums paid as compensation would create a retroactive tax morass for these parties and all those similarly situated throughout the State.

Furthermore, other than having his name listed on the application form for the policy as required by MLMIC, Respondent did absolutely nothing with respect to the policy. The Hospital alone: 1) selected and purchased the policy; 2) paid the premiums; 3) administered and managed the policy; and 4) received all dividends, credits, rebates or returns on premiums issued by MLMIC. As to the fourth factor, if Respondent truly felt he was the owner of the policy entitled to all benefits flowing from it, he would have claimed dividends, credits, rebates or returns on premiums as his and insisted on monetary payment for them. That he did not do so deepens the reality that it was recognized by the parties that the Hospital was the de facto owner of the policy entitled to the benefits of ownership, as well as the liabilities of ownership (*e.g.*, potential malpractice cases and ensuing increases in premiums), while Respondent only assumed the benefits of coverage.

In response, Respondent argues that the Hospital was contractually obligated to obtain a "MLMIC policy," and therefore cannot use the fact that it obtained and paid for such a policy to support an unjust enrichment claim. But that is not true. The Employment Agreement did not require the Hospital to specifically purchase a MLMIC policy; rather, it explicitly left it up to the Hospital to decide which policy

to obtain. Nor, as reference to the Employment Agreement makes plain, did the purchase of the policy constitute any part of Respondent's compensation or benefits contractually due to him. In fact, the Employment Agreement makes it explicit that payments of the premiums were a Hospital expense, and therefore not income to Respondent.

Respondent next argues that 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. But that argument misses the practical reality that his status as a nominal policyholder with membership interests only happened as a result of the Hospital paying the premiums and assuming all of the administrative functions associated with obtaining a policy. Such form over substance arguments are not dispositive when considering the equities.

Finally, Respondent argues that the unjust enrichment analysis should fall in his favor based upon his view that Insurance Law § 7307(e)(3) mandates payment of the Cash Consideration to the policyholder. As has been shown, the statute does not mandate such an outcome, but, rather, only states that the Cash Consideration should flow to the policyholder that paid the premiums, which Respondent

admittedly is not. Moreover, under the DFS Decision and Order, the Plan, and governing case law, this dispute rests upon equitable principles of unjust enrichment determined by the courts on a case-by-case basis.

Therefore, 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 of policy ownership.

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

The Hospital demonstrated in its main brief (*see* pp.24-30) that the clear and unequivocal language of Insurance Law § 7307(e)(3), which "is presumptively entitled to authoritative effect" (*People v. Marquan M.*, 24 N.Y.3d 1, 9 [2014]), expressly linked the payment of premiums to the receipt of the Cash Consideration. As the statute states, "[t]he equitable share of the policyholder in the mutual

insurer shall be determined by the ratio which the net premiums…such policyholder has properly and timely paid to the insurer…" (emphasis added). The Hospital further argued that, in order to avoid the unacceptable and absurd result of no party receiving the Cash Consideration where the nominal policyholder did not pay the premiums, the Court was authorized under fundamental rules of statutory construction to "substitute its own interpretation" (*see Matter of Anonymous v. Molik*, 32 N.Y.3d 30, 37 [2018]), and to interpret the statute to mean that the party that actually paid the premiums, whether it is the nominal policyholder or the employer, should receive the Cash Consideration.

Respondent claims (*see e.g.*, pp. 13, 21 of Respondent's Brief) that the Insurance Law, the DFS, and the Plan leave absolutely no room for such interpretation, and uniformly, expressly and rigidly conclude that "the policyholders own a mutual company, and no others are entitled to cash consideration resulting from a demutualization and sale," "unless the policyholder expressly assigned those rights." Respondent's position, however, is squarely refuted by the plain and explicit language of the statute, the DFS Order and Decision and the Plan. To reiterate, the statute draws an explicit link between the policyholder's receipt of the Cash Consideration and the payment of premiums, a link that should not and cannot be ignored. *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").

In the face of this language, Respondent argues (*see* pp. 3, 23-24 of Respondent's Brief) that the language quoted above – that a policyholder's entitlement to money is based upon the net premiums paid by a policyholder – is merely a formula for calculating the Cash Consideration due a policyholder. In an attempt to support that contention, Respondent asserts (*see* pp. 5, 29 of Respondent's Brief) that the Plan provides "that a policyholder's share of the Cash Consideration is calculated based on premiums "*properly and timely paid under their Eligible Policies"* and that "the Plan itself draws *no distinction* between policyholders who paid their own premiums and policyholders whose premiums were paid on their behalf."

It is significant, however, that such language is not found in Insurance Law § 7307(e)(3), and Respondent's request to have such clear language replace the existing language – which makes receipt of the Cash Consideration dependent upon the party that paid the premiums – must be rejected as a wrongful attempt to rewrite the statute. *Henry Modell & Co., Inc. v. Minister, Elders & Deacons of Reformed Protestant Dutch Church of City of New York*, 68 N.Y.2d 456, 463 (1986) (court

declined "to rewrite the statute to add language that the Legislature did not see fit to include").

Even more critically, however, the language that Respondent quotes from the Plan to support his misleading argument – "premiums…properly and timely paid on each Eligible Policy" – is taken from the Plan's definition of the term, "Eligible Premium," and *not* from the Plan's definition of "Eligible Policyholder," which is the dispositive term at issue. *See* R49, 59. Indeed, it is only logical that in defining "Eligible Premium," the Plan focuses on the premiums "paid on each Eligible Policy." This same language, however, is *not* contained in the Plan's definition of "Eligible Policyholder," (*see* R49), nor is such language otherwise used by the Plan to restrict the identity of the party entitled to receive the Cash Consideration to the nominal policyholder.

Respondent's claim (*see* Respondent's Brief p.20) that the DFS Decision and Order restricts payment of the Cash Consideration solely to the nominal policyholder or a specified designee/assignee is equally baseless. In fact, the DFS never made such a declaration, and clearly rejected the bright-line test advocated by Respondent. As it stated (R120, 122, 127):

> WHEREAS, pursuant to the Plan, an EPLIP Employer or Policy Administrator who had *not* been specifically designated by the Eligible Policyholder to MLMIC to

receive the Eligible Policyholder's consideration but nevertheless believed it had a right to such consideration could submit an objection to MLMIC before the public hearing held by the Department of Financial Services (the "Department") on August 20, 2018, such that MLMIC' s agent would hold the consideration relating to such objection in escrow until MLMIC received joint written instructions from the Eligible Policyholder and the objector or a non-appealable order of an arbitration panel or court with proper jurisdiction directing how such payment should be distributed… (emphasis added)

* * *

The Objection Procedure provides a reasonable framework for the resolution of disputes between certain policyholders and entities that claim to be Policy Administrators. Importantly, the Objection Procedure does not, in any way, impact any person's rights to resolve their dispute in any forum of their choosing or as required by contract or law. Rather, the sole purpose of the Objection Procedure is to create a category of disputed claims for which the cash consideration attributable to such claims will be placed in an escrow and released by MLMIC upon one of two events: MLMIC either receives (a) "joint written instructions from the Eligible Policyholder and the Policy Administrator . . . as to how the allocation is to be distributed," or (b) "a non-appealable order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the Policy Administrator , .. or the Eligible Policyholder."

* * *

The 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 similar fashion, Respondent's myopia pervades its argument (*see* pp. 2, 14, 17 of Respondent's Brief) that under the Plan, "the only exception to this statutory requirement [of the nominal policyholder receiving the Cash Consideration] was in cases where the policyholder *affirmatively* assigned his or her right to receive the Cash Consideration to a third party." But the Plan expressly states otherwise, a reality that readily defeats Respondent's claim. The Plan states in the section entitled, "Objection to Recipient of Cash Consideration" (R63):

> 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 MIMIC 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 MIMIC 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.

Thus, the Plan, like the DFS Decision and Order, expressly provides that even a party that has *not* been assigned the right to receive the Cash Consideration is entitled to make a claim for such monies.

Yet other language further buttresses the conclusion that neither DFS nor the Plan limited the receipt of the Cash Consideration to either the nominal policyholder or his/her designee. If the inquiry into entitlement to receipt of the monies was as simple as confirming whether the party was the nominal policyholder or whether a document exists in which the nominal policyholder assigned his/her rights, neither the DFS nor the Plan would have created elaborate grievance processes for parties to claim such entitlement. Nor would hundreds of litigations have erupted throughout New York State if the inquiry was so lacking in depth. The disputes would be readily and expeditiously susceptible to resolution simply by discerning the existence of an assignment document. *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. 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").[1]

Nor did DFS, as Respondent asserts (*see* Respondent's Brief p.19), "reject" the argument that a third party's payment of the premiums was determinative of the issue of which party was entitled to the Cash Consideration. Rather, DFS merely stated (R120) that the identity of the party that paid the premiums was not "automatically" dispositive of the issue and, to reiterate, added (R122) that the "determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law."

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[1] Of particular relevance is the fact that the Hospital (and other employers) did not treat the premiums paid as compensation to the physician, the amounts paid were not included as income on tax forms provided to the employee, and the employee did not report the (significant) amounts as income or pay taxes on such monies.

POINT II

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

As demonstrated in the Hospital's main brief (*see* pp. 31-36) and above, DFS and the Plan make it clear that Insurance Law § 7307 is not conclusive as to which party is entitled to keep the Cash Consideration, and that this determination should be subject to resolution by the courts and arbitrators based on "the facts and circumstances of the parties' relationship and applicable law…" R122. The Hospital also established that legal title does not preclude claims in equity, and that, even assuming that Insurance Law §7307(e)(3) mandates that the policyholder receive the MLMIC Funds – although it does not – that conclusion does not preclude inquiry into the Hospital's equitable claims.

Respondent argues (*see* p.30 of Respondent's Brief) that, as the nominal policyholder and thereby the party with the ownership interest in MLMIC, his (self-proclaimed) entitlement as the sole party to receive the Cash Consideration under Insurance Law §7307(e)(3) cannot be upset by resort to equitable principles. Respondent argues that reliance on equitable principles to bypass what he considers to be the mandate of the statute would be tantamount to a wrongful and unauthorized revision of the statute by the courts.

To reiterate, however, the statute does not mandate payment of the Cash Consideration to a nominal policyholder who did not pay the premiums. Nor does the statute otherwise specifically preclude distribution to a party other than the nominal policyholder. Rather, it merely calls for receipt of the proceeds to "such policyholders" that timely and properly paid the premiums.[2]

In any event, legal title does not preclude claims in equity, and relying on equitable principles to decide which party is entitled to retain the Cash

[2] The plain language of the statute only addresses which party is entitled to "receive" the MLMIC funds; the statute is silent on what party is ultimately entitled to "keep" or "retain" those monies, regardless of which party initially receives such monies from MLMIC. Statutory law certainly draws a distinction between those terms. *See e.g.*, Not-for-Profit Corp. Law § 1610 ("a land bank may receive and retain payments for services rendered"); EMER TEN PROT § 2505.4 ("no owner shall demand, receive or retain a security deposit or advance payment"); Gen. Mun. Law § 99-b ("is required to receive, retain and/or produce for examination or audit a cancelled check"); Pub. Health Law § 2633 ("the board of visitors or the duly appointed treasurer of the homes, as agent of the department, may receive, retain and expend receipts"); Debt. & Cred. Law § 32 ("Any secured creditor… shall not be entitled to receive or retain dividends"); Envtl. Conserv. Law § 11-0713 ("issuing officers shall be entitled to receive and keep the same fees"); Soc. Serv. Law § 28 ("[t]he department may receive and retain any money); RENT & EVICT § 2105.6 ("the landlord shall be authorized to demand, receive and retain"); RENT STAB § 2525.4 ("no owner…shall demand, receive or retain a security deposit"); RENT & EVICT § 2205.5 ("no person shall demand, receive or retain a security deposit"); Pub. Health Law § 4124 ("[l]ocal health officer may serve as registrar of vital statistics and is entitled to receive and keep the fees"); Banking Law § 6-l ("no lender shall have no right to collect, receive or retain any principal"); Gen. Bus. Law § 349 ("consumers may nevertheless receive and retain the benefits"). *See also People ex rel. Nash v. Faulkner*, 14 N.E. 415, 417 (1887)(referring to public officers who are appointed or elected to receive, disburse and keep public monies); *Gage v. Vill. of Hornellsville*, 12 N.E. 817, 817 (1887)(the chief fiscal officer of such a corporation is the officer who receives, keeps, and disburses the moneys of the corporation); *Trans High Corp. v. Pollack Associates, LLC*, 74 A.D.3d 489, 902 N.Y.S.2d 83, 84 (1st Dep't 2010)(referring to "receipt" and "retention" of insurance policy).

Consideration does not affect in any way what Respondent considers the statutory mandate as to which party is entitled initially to receive such monies.

Notably, all four Appellate Divisions, who have addressed the issue of the ultimate disposition of the Cash Consideration while arriving at different conclusions, based their decisions on equitable principles. *See e.g., Schoch v. Lake Champlain Ob-Gyn, P.C.*, 126 N.Y.S.3d 532, 536–37 (3d Dep't 2020) ("[h]aving determined who is legally entitled to receive the cash consideration, we must now address defendant's alternate argument, namely, whether plaintiff would be unjustly enriched if she received the cash consideration as required by the statute and MLMIC's conversion plan").

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

The Hospital demonstrated in its main brief (*see* pp.37-52) that it 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 otherwise was the de facto owner of the Policy for all intents and purposes. Furthermore, it showed that the only reason that the Cash Consideration is available under Insurance Law § 7307(e)(3) is because the Hospital "properly and timely paid" the premiums for Respondent over the three relevant policy years. Put another way, it established that should Respondent be allowed to retain the Cash Consideration, he would be enriched at the Hospital's expense, and that it would be against equity and good conscience to allow such an outcome.

Essentially, in response Respondent argues that the unjust enrichment analysis should fall in favor of Respondent based upon the following:

- "The Hospital agreed to provide Dr. Hinds with a MLMIC policy…," and therefore the policy was not purchased at the Hospital's expense, but, rather, the Hospital paid the premiums as consideration for his services (*see* pp.33, 44 of Respondent's Brief).

- "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 p.35 of Respondent's Brief).

- Insurance Law § 7307(e)(3) establishes Respondent as the nominal policyholder the party entitled to receipt of the Cash Consideration.

First, reference to Respondent's Employment Agreement (*see* R34) makes it clear that the Hospital did not agree to "provide Dr. Hinds with a *MLMIC* policy." (emphasis added) Rather, the Employment Agreement merely states that the "Hospital shall maintain an individual occurrence-based medical malpractice policy in the minimum amounts required for all members of the Medical Staff of the Hospital through such insurance carrier as the Hospital deems reasonable and appropriate, and shall provide [Respondent] with evidence of same upon request." The Employment Agreement left it entirely up to the Hospital as to what insurance carrier to use and how to bear the expense of providing the requisite malpractice coverage.

Nor did purchase of a policy by the Hospital constitute any part of Respondent's compensation or benefits promised to him under the Employment Agreement in exchange for his services. Reinforcing this fact is that Respondent never claimed the premium payments as income on his annual tax forms; likewise, the amounts paid for the Policy by the Hospital were never treated by Respondent

or the Hospital as income to Respondent. Rather, the Employment Agreement expressly states the malpractice premiums were an "expense" of the Hospital – similar to the office space, support personnel and supplies the Hospital agreed to provide (*see* R34) – and otherwise described Respondent's compensation and benefits in the form of "Base Salary," "Incentive Compensation," "Call Compensation," and benefits described in Exhibit A that was annexed to the agreement. *See* R33, 34, 40. Indeed, given that for years, in writing, and on his tax returns, Respondent acknowledged that the payment of premiums was *not* part of his compensation package under the Agreement, he is estopped from taking a contrary position in this case and before this Court. *Cf., Matter of Kincaid v. Barristers Tavern Corp*., 187 A.D.2d 593 (2d Dep't 1992)(since the petitioner permitted years to elapse before registering an objection to the manner in which the corporation authorized the issuance of certain shares of stock, he is estopped from arguing that the issuance was improper); *Tafnet Realty Corp. v. City of New York*, 118 Misc.2d 498 (Sup. Ct. N.Y. Co. 1983)(where city issued building permit enabling alteration of single-room occupancy housing to multi-dwelling structure, city was estopped from arguing that conversion, in and of itself, amounted to nuisance).[3]

[3] Were this Court to now rule that the premium payments were part of the compensation package

Second, the notion that the payment of premiums by the Hospital had no relation to Respondent's status as the nominal policyholder and attendant membership interest in MLMIC is absurd. But for the Hospital's actions in paying the premiums and assuming the administrative burdens associated with maintaining malpractice coverage for Respondent through MLMIC, Respondent never would have become a nominal policyholder and the Cash Consideration never would have been made available.

Third, Respondent's reliance on the statutory argument in the context of unjust enrichment is misplaced because under the statute, the DFS Decision and Order, the Plan, and decisional law, regardless of how the statutory analysis is resolved, this dispute rests upon equitable principles of unjust enrichment. (And, the Legislature clearly considered payment as the dispositive factor in determining what party is entitled to receive the Cash Consideration under Insurance Law § 7307(e)(3), a conclusion that strengthens the Hospital's unjust enrichment claim.)

In short, Respondent's arguments miss the essence of unjust enrichment analysis, which has the objectives of achieving fairness and justice. *Simonds v. Simonds*, 45 NY2d 233, 239 (1978). A claim for unjust enrichment "is undoubtedly equitable and depends upon broad considerations of equity and

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of Respondent and similarly situated physicians, after years where taxes were not paid on such monies, the necessary retroactive tax adjustments (for all of the affected employers and providers) would upset the parties' practices and create chaotic tax consequences.

justice." *Paramount Film Distrib. Corp. v. State of New York*, 30 N.Y.2d 415, 421 (1972); *Philips Int'l Investments, LLC v. Pektor*, 117 A.D.3d 1, 7 (1st Dep't. 2014). Ultimately, "to determine whether there has indeed been unjust enrichment the inquiry must focus on the 'human setting involved,' not merely upon the transaction in isolation." *McGrath v. Hilding*, 41 N.Y.2d 625, 629 (1977).[4]

Here, this analysis should result in the conclusion that the Hospital is entitled to the Cash Consideration, particularly when one juxtaposes the actions of the Hospital with those of Respondent in relation to the MLMIC policy.

There is no proof in the record that any party other than the Hospital bore the expense of paying $215,000 in premiums. Even Respondent's Employment Agreement referred to those payments as a Hospital "expense." This factor alone was the reason why the Appellate Division, First Department in *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465, 96 N.Y.S.3d 526 (1st Dep't 2019) found that the employer was entitled to the Cash Consideration under a theory of unjust enrichment. (That the court in Schaffer did not engage in any statutory analysis does not, as Respondent seemingly argues, undermine its unjust enrichment conclusion, particularly given that the statutory analysis is not

[4] One aspect of the "human setting" in this case is the fact that the Hospital is a not-for-profit entity, meaning that Cash Consideration that should flow to it will benefit the rural community that it serves. This stands in stark contrast to Respondent's status, where the benefit will merely serve him personally.

dispositive of the ultimate issue of entitlement to the Cash Consideration.) It is also the reason why so many lower courts throughout New York State reached the same conclusion.[5] (Given that the Court of Appeals, as the highest court in New York State, is not bound under *stare decisis* by Appellate Division decisions, it is free to rely on the logic of those lower court decisions, even if they may have been reversed or effectively overruled by the Appellate Divisions.)

Moreover, whereas Respondent literally did nothing with respect to the MLMIC policy other than have his name listed on an application form as the

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[5] 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).

nominal policyholder, a result required by MLMIC, the not-for-profit Hospital assumed every burden associated with that policy, the potential for malpractice claims, and, unlike Respondent, exhibited all of the typical attributes of an actual policyholder and owner of the policy, including, but not limited to:

- Solely the Hospital decided to purchase a MLMIC policy in lieu of coverage from another carrier.
- Solely the Hospital paid the premiums.
- Solely the Hospital performed 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.
- Solely the Hospital received all dividends, credits, rebates or returns on premium issued by MLMIC.

Essentially, Respondent turned a blind eye to the MLMIC policy, never inquiring 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) As to this latter fact, although Respondent (*see* Respondent's Brief p. 38) attempts to cast the Hospital's receipt of such dividends and rebates as a mere "clerical function" used to offset the cost of premiums, if Respondent actually perceived himself as the actual owner of the MLMIC policy entitled to all fruits stemming from the policy, such dividends and

rebates should have passed to him in monetary form, rather than be used by the Hospital to reduce the cost of premiums.

Given all of the above facts, equity clearly favors granting the Hospital the MLMIC Funds. Permitting Respondent to keep the $412,418.93 in MLMIC Funds under these circumstances would exalt form over substance, and 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).

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
June 11, 2021

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NEW YORK STATE COURT OF APPEALS
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