COURT OF APPEALS
STATE OF NEW YORK

THE COLUMBIA MEMORIAL HOSPITAL, Plaintiff-Appellant, -against- MARCEL HINDS, M.D., Defendant-Respondent.	**NOTICE OF MOTION FOR LEAVE TO APPEAL AND TO CONSOLIDATE** Appellate Division Third Department Docket No. 530190 Columbia County Index No. 14064-19

PLEASE TAKE NOTICE that, upon the annexed statement in support of the motion for leave to appeal and to consolidate with appendices, the briefs and records filed in the Appellate Division, Third Department on the appeal in this action, and all the papers and prior proceedings in this action, the undersigned will move this Court of Appeals at the courthouse located at 20 Eagle Street, Albany, New York, on December 14, 2020, for an order pursuant to CPLR § 5602(a)(1) granting Plaintiff-Appellant The Columbia Memorial Hospital leave to appeal to the Court of Appeals from the order of the Appellate Division, Third Department, entered on November 5, 2020, which affirmed the decision by the lower court granting Defendant-Respondent's motion to dismiss the complaint, and upon granting leave to appeal, consolidating this appeal with another pending appeal, *Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.*, for which this Court recently granted leave to appeal by Order, dated November 23, 2020, for

the purposes of briefing, argument, and determination, on the identical issues involving Medical Liability Mutual Insurance Company's demutualization and the distribution of certain cash consideration; and for such other and further relief as the Court deems just, proper, and equitable.

PLEASE TAKE FURTHER NOTICE that opposition papers, if any, must be filed with the Clerk's office on or before the return date per Rule 500.21(c) and should state concisely any arguments for denial of the motion per Rule 500.22(d).

Dated: Great Neck, New York
December 4, 2020

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PRELIMINARY STATEMENT

Plaintiff-Appellant The Columbia Memorial Hospital (the "Hospital") is a small, rural health care system that employs 64 physicians and other clinicians at its hospital, primary care, and specialty clinics in Columbia and Greene counties. Defendant-Respondent Marcel Hinds, M.D. ("Respondent" or "Dr. Hinds") was a physician formerly employed by the Hospital between 2012 and 2017.

As true in the case of Respondent, the Hospital's employment agreements with its physicians required the Hospital to obtain medical malpractice coverage and to pay the premiums for such coverage, which the Hospital did through non-party Medical Liability Mutual Insurance Company ("MLMIC"). The Hospital not only bore the burden of administering the policies, but it was assigned the attributes of ownership: it chose the insurer, paid the premiums, administered the policies, and received the benefits of any dividends, credits, rebates or returns on premiums. In many respects, given the volume of policies involved and the burdens assumed by the Hospital in managing those policies, the coverage obtained and managed by the Hospital functioned very much like a group policy or plan. The Respondent never paid any premiums directly, although he might have indirectly shared in some of the costs if he reached a certain level of revenue under an incentive compensation provision. In Respondent's case, however, the Record contained no proof that he ever earned at this level during his employment; the

Hospital alleged that it alone fully paid Respondent's premiums. Respondent, together with all other employee-physicians similarly situated throughout the State, were necessarily named the policyholder of the malpractice policies.

In October 2018, more than a year after Respondent terminated his employment with the Hospital, MLMIC was sold and converted or "demutualized" from a mutual insurance company to a stock insurance company. In connection with the sale and demutualization, and pursuant to a Conversion Plan, MLMIC was supposed to distribute $2.502 billion in cash consideration to eligible policyholders or their assignees based upon the amount of premiums that had been paid for the malpractice policies between 2013 and 2016.

Importantly, according to a September 6, 2018 decision of the New York State Department of Financial Services ("DFS") concerning the implementation of the conversion (the "Decision"), 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 expressly addressed Insurance Law § 7307(e)(3), specifically noting that its language was not dispositive of the issue of which party was the proper recipient of the cash consideration, because the statute only addressed a context in which the named policyholder paid the premiums, but not one where another party made such payments.

Entitlement to the anticipated distribution thereafter engendered hundreds of lawsuits between the employee-policyholders of those policies and their employers who actually paid the policy premiums. Following years of litigation, a split of authority has developed between the Appellate Divisions.

The First Department has held that employers that paid the premiums for MLMIC policies are entitled to the cash consideration based on a theory of unjust enrichment. The Second Department has not yet ruled, but lower courts in the Second Department have uniformly followed the First Department.

Conversely, the Third and Fourth Departments have held that the employee-policyholders are entitled to those funds, regardless of whether they paid any of the policy premiums. Including the Third Department case of *Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.* (the "Schoch Decision"), these courts emphasized language in Insurance Law § 7307(e)(3) (the demutualization statute) that speaks of policyholders receiving such monies. In doing so, however, those courts ignored adjacent language in the statute that had been highlighted by DFS in the Decision – language that specifically compelled the conclusion that it was only those policyholders who had paid the premiums being entitled to such funds; the Third and Fourth Departments failed to address the absence of any language concerning circumstances where the policyholder had not paid the premiums, as is the case here.

The Hospital's lawsuit against Respondent became a victim of this split of authority. Given that the Hospital lies within the Third Department, the Hospital's claims were dismissed based upon the rationale of the Schoch Decision. The Third Department, relying purely on the Schoch Decision and an incomplete reading of Insurance Law § 7307(e)(3), and in an Opinion and Order dated and entered November 5, 2020 ("Opinion"), found that the MLMIC funds belonged to Respondent simply because he was the named policyholder, regardless of who actually paid for the premiums. It is from the Opinion that the Hospital seeks leave to appeal.

The predicates for granting leave to the Hospital are compelling. First and foremost, this Court has already recognized the need to adjudicate this specific dispute. Specifically, in its recent Order, dated November 23, 2020, this Court granted permission for leave to appeal in the matter of *Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.*, APL-2020-00169 (the "Schoch Appeal"). The parallel between this case and the Schoch Appeal should lead to the same result in this case. Moreover, given the manner in which the Hospital assumed even greater burdens acting as it did as the administrator of what was tantamount to a group policy for its many physicians, which apparently is unlike the situation in Schoch, there is an even more compelling basis for granting leave in this case. In addition, the Court should take this appeal to address the incidental

issue, presented by this case, but not in Schoch, of whether a physician's potential contribution to malpractice premiums before receiving incentive compensation (as distinct from his/her guaranteed base salary), should alter the results of the case.

Other grounds for granting leave exist. These include the split in authority before the Appellate Departments, the novel legal issues arising from a demutualization under the Insurance Law and governing regulations, the public interests of numerous health care providers throughout New York State, and the economic unfairness of granting a windfall to physicians while withholding funds from the parties who paid their premiums and otherwise exercised the attributes of ownership.

Assuming that this Court grants permission for leave to appeal, the Hospital also seeks to consolidate this appeal with the Schoch Appeal for the purposes of coordinating simultaneous briefing schedules, oral argument, and a determination.[1] Given the overlapping nature of the identical factual and legal issues at stake, the Hospital's significant interests in being heard (especially where multiple lawsuits are still pending against former and current employees of the Hospital), and the Hospital's ability to move quickly within the deadlines set in the Schoch Appeal,

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[1] To the extent that the Court grants the Respondent Schoch's currently pending request for an appeal under the alternative procedure, which was made by letter dated November 30, 2020, the Hospital seeks consolidation in accordance with the procedures and deadlines set forth under those rules.

the Hospital respectfully submits that one combined appeal would be a more effective use of judicial resources and would further the interests of justice.

We note that counsel for the appellant Lake Champlain has given consent for consolidation of the Hospital's appeal with the Schoch Appeal.

PROCEDURAL HISTORY OF THE CASE AND THE TIMELINESS OF THE MOTION PURSUANT TO RULE 500.22(b)(2)

The Hospital commenced this action by the filing of a Summons and Verified Complaint on February 20, 2019. Respondent served a pre-answer motion to dismiss, pursuant to CPLR §§ 3211(a)(1) and (7), on April 12, 2019. No discovery occurred in the underlying action.

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 incentive compensation, an assumption that had no support in the record and conflicted with the allegations that were presented. (R. 11-12) 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. *See* Appendix A.

Respondent served a notice of entry via NYSCEF on November 5, 2020. *Id.* Thus, by this December 4, 2020 application, the Hospital moves herein for leave to appeal within thirty (30) days of entry and service of the order of the Appellate Division. Accordingly, the instant motion is timely under CPLR 5513(b).

On November 23, 2020, this Court granted leave to appeal in connection with the *Schoch* Appeal. *See* Appendix B. The Court also granted Samaritan Medical Center's motion for leave to appear amici curiae, and accepted the brief for consideration, by Order dated November 23, 2020. *See* Appendix C. By letter, dated November 30, 2020, the Respondent in the *Schoch* Appeal requested that the Court consider the appeal upon the alternative procedure, as described in Rule 500.11 of the Rules of Practice. That application, which was opposed by the Appellant Lake Champlain (and the Hospital), is currently pending. *See* Appendix D.

JURISDICTIONAL SHOWING PURSUANT TO RULE 500.22(b)(3)

The Court of Appeals has jurisdiction over the instant motion and proposed appeal under CPLR § 5602(a)(1) because: (1) the action originated in the Supreme Court; (2) the Decision appealed from is not appealable as a matter of right; and (3) the order appealed from is a final determination as defined in CPLR § 5611 whereby it disposes of all the issues in the action.

QUESTIONS PRESENTED

1. Whether health care employers, who purchased and administered the malpractice insurance policies from MLMIC, are entitled to the distribution of the demutualization proceeds, *i.e.,* "Cash Consideration," under a theory of unjust enrichment, or whether the insured employees are entitled to the Cash Consideration solely by virtue of being a named policyholder, under the Insurance Law?

There is a split in authority on this novel issue. The Appellate Division, First Department, has ruled that the employers who paid for the underlying malpractice insurance policies and otherwise handled the administrative responsibilities attendant to such policies are entitled to the Cash Consideration under the theory of unjust enrichment. The Appellate Divisions, Third Department and Fourth Department, concluded that the policyholders are entitled to the Cash Consideration as a matter of law, absent an explicit assignment of rights, pursuant to the Insurance Law and governing documents. Lower courts in the Second Department have uniformly followed the First Department, even after the conflicting decisions from the Third and Fourth Departments, based on a differing interpretation of the statute and governing documents.

2. Whether the lower court improperly found, on a CPLR §§ 3211(a)(1) & (a)(7) motion, that Respondent had paid for the malpractice premiums based

solely on the parties' employment agreement, and in the absence of any documentary evidence in the Record to support such a payment by Respondent, whether directly or indirectly through a deduction to his incentive compensation, and thus improperly dismissed the Hospital's unjust enrichment claim?

The Third Department did not reach this issue because it found, as a matter of law and based on the Schoch Decision, that Respondent was entitled to the Cash Consideration.

3. Whether the lower court improperly dismissed the Hospital's breach of contract and implied covenant of good faith and fair dealing claim, or claim for moneys had and received.

The Third Department did not reach these issues because it found, as a matter of law and based on the Schoch Decision, that Respondent was entitled to the Cash Consideration.

DISCLOSURE STATEMENT PURSUANT TO RULE 500.22(b)(5)

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).

STATEMENT OF FACTS

A. Respondent's 2012 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 guaranteed $300,000 "Base Salary," the opportunity to earn incentive compensation, and the right to certain on-call compensation, as well as 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)

B. The Incentive Compensation Formula

In addition to his Base salary, Section 3(b) of the Employment Agreement sets forth a formula for determining incentive compensation, if any, based on the Hospital's actual operating figures. Incentive compensation would be awarded

only after certain basic costs of the practice had been covered. 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[2] 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 $

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[2] 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 agreement as the division of the Hospital devoted to providing OB/GYN care.

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)

The Record is devoid of any evidence as to Respondent's actual revenues. In other words, there was no evidence that his practice generated revenue sufficient to cover his expenses, whether base salary, benefits, or malpractice premiums.

C. The Hospital Paid For And Administered The Respondent's MLMIC Policy

Besides 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 administered by the Hospital. (R. 20) 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 Respondent's Policy was $214,720.54. (R. 21)

As the formally designated 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; and, importantly, received the benefits of any dividends, credits,

rebates or return on premiums; it also processed renewals, took responsibility for any claims issues, and otherwise dealt with the policies for all administrative purposes. (R. 21) Therefore, to that extent, and with the complete understanding and agreement of Respondent, the Hospital exercised all attributes of de facto ownership with respect to the policy.

Respondent never took any steps to administer, manage, or otherwise oversee the Policy. Furthermore, Respondent never inquired as to the status of the policy, renewals of the policy, or the costs of the policy, or objected 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)

D. <u>Respondent Resigned From The Hospital</u>

Respondent subsequently resigned from the Hospital on August 1, 2017. (R. 22) Pursuant to Section 11(b) of the Employment Agreement, Respondent was not entitled to any further compensation other than any unpaid base salary and incentive compensation. (R. 144)

E. Recent Events Involving MLMIC's Demutualization

MLMIC was a mutual insurance company subject to the supervision, and rules and regulations, of New York State's Department of Financial Services ("DFS"). (R. 22) In or about 2016, MLMIC announced that 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 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)

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 (the "Conversion Plan"). (R. 44-97) In connection with that transaction, certain 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 necessarily 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," if otherwise provided for 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)

F. 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 the Assignment Agreement. (R. 25)

Consequently, the Hospital advised MLMIC that it was the Policy Administrator, and that the Hospital objected to any distribution of the MLMIC Funds to Respondent. Based on the objection lodged by the Hospital, 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)

POINT I

THE COURT SHOULD GRANT THE HOSPITAL'S MOTION FOR LEAVE TO APPEAL, WHERE THE NOVEL QUESTION OF LAW HAS ENGENDERED A SPLIT IN APPELLATE AUTHORITY, AND LEAVE WAS ALREADY GRANTED IN THE *SCHOCH* APPEAL

A. The Court Is Presented With A Novel Issue Of Law

The Court is presented with a novel issue of law: whether employees who were the named policyholders, or the employers who paid the insurance premiums for the policies, are entitled to the proceeds of the MLMIC demutualization.

To be sure, when the Erie County Supreme Court issued the first substantive decision in these cases, *Maple-Gate Anesthesiologists v. Nasrin*, 63 Misc.3d 703, (Sup. Ct., Erie County 2019), it relied entirely on its own interpretation of the statute and regulations; no precedent had been cited. The first case to reach any of the Appellate Divisions, *Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't 2019) ("*Schaffer*"), likewise reached its determination without any New York precedent, and relied instead on decisions from the 9th Circuit and from the District Court, Northern District of Illinois.

As discussed below, those cases ultimately engendered a split of authorities between the Third and Fourth Departments, and the First Department. The lower courts in the Second Department have uniformly followed *Schaffer*.

B. A Split Exists Between the Appellate Departments

A split exists between the First and Third/Fourth Appellate Departments. Copies of the decisions from the Appellate Divisions are respectively annexed hereto as Appendices E, F, and G.

As noted above, in *Schaffer*, the First Department ruled that a medical practice group, who was the Policy Administrator and paid all of the policy premiums, was entitled to the cash proceeds from the demutualization of MLMIC. The *Schaffer* court held that to award the cash proceeds to the named insured physician who never paid any policy premiums would constitute unjust enrichment:

> Although 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 at 465. In support of its ruling, the First Department cited foreign precedents on the distribution of insurance demutualization proceeds among employers and employees. *See id*.

Subsequently, in *Maple-Gate Anesthesiologists, PC. v. Nasrin*, 182 A.D.3d 984 (4th Dep't 2020), the Fourth Department split with the First Department and ruled that an employer who paid all of the policy premiums had no "legal or equitable right of ownership to the demutualization proceeds" based on its interpretation of the Insurance Law. *Id*. at 842. The Fourth Department's decision did not cite or discuss any caselaw precedent involving the demutualization of insurance companies.

In *Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.*, the Third Department also split with the First Department and ruled that the demutualization proceeds were not bargained for by either party, constituted an unexpected windfall, and that Defendant Lake Champlain failed to establish a claim of unjust enrichment.

Although the Second Department has not yet weighed in, cases from the Second Department uniformly follow *Schaffer*, and have explicitly disagreed with the reasoning and analysis in *Schoch.*[3] For instance, in the recent case of *Wyckoff Heights Medical Center v. Monroe et al*., 2020 WL 4561195 (Sup. Ct. Kings Co.

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[3] *See, e.g., John T. Mather Memorial Hosp. of Port Jefferson, New York, Inc. v. Fadel*, Index No. 624734/2018 (Sup. Ct. Suffolk Co. Aug. 21, 2019); *Long Island Radiology Associates, P.C. v. Koshy et al.*, Index No. 600195/2019 (Sup. Ct. Nassau Co. Oct. 7, 2019); *Brauer v. Dr. R. G. Geronemus, M.D., P.C.*, Index No. 70720/2018 (Sup. Ct. Westchester Co. Dec. 19, 2019); *see also Cordaro v. AdvantageCare Physicians, P.C.*, 69 Misc. 3d 787, 131 N.Y.S.3d 523 (Sup. Ct. N.Y. Co. Sep't 2020).

Aug. 7, 2020) ("*Wyckoff Heights*"),[4] the Kings County Supreme Court held that Insurance Law § 7307(e)(3) did not specifically contemplate a situation where the policyholder did not pay the premiums, and thus it was not definitive on what should happen with the demutualization proceeds in that scenario. The lower court thus held that *Maple-Gate* and *Schoch*'s interpretation of Insurance Law § 7307(e)(3) – *i.e.* the proceeds automatically belonged to the policyholder, unless a written assignment is given – was problematic because it placed undue emphasis on the "policyholder" language in the first sentence, but failed to accord any weight to the explicit qualifier in the second sentence that such policyholder "properly and timely paid" the premiums. By downplaying the second sentence as merely describing the formula for calculating payments, *Schoch* blatantly ignored pertinent statutory language in its interpretation (and indeed, even the DFS's Decision explicitly referred to the absence of language to resolve who is entitled to the consideration where the policyholder did not pay the premiums). The lower court found this outcome, which impermissibly expanded the statutory language by granting the MLMIC funds to policyholders who did not pay for the policies, to be an untenable and unintended interpretation of Insurance Law § 7307(e)(3). The lower court found further inconsistencies when comparing *Schoch*'s interpretation of the Insurance Law to the DFS' stance, which had recognized that there was a

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[4] A copy of the *Wyckoff Heights* decision is annexed as Appendix H.

"tension" between policyholders and employers that could not be resolved solely from the language of the statute, and that a dispute resolution framework was required.

In light of the conflicting determinations between the Third and Fourth Departments, and the First Department and lower courts in the Second Department, there is a split between the Appellate Divisions that warrants this Court's review.

C. This Court Has Already Recognized The Need To Resolve This Issue In *Schoch*

The importance of this novel issue and split in authorities has not been lost on this Court. Indeed, this Court has already granted the Defendant-Appellant in the *Schoch* Appeal leave to appeal by Order, dated November 23, 2020, and has further granted a third party leave to appear amici curiae. Because the issues here are identical, there is no reason why this Court should not likewise grant the Hospital's motion.

D. The Statewide Significance Of These Issues

Finally, it should be noted that hundreds of healthcare providers are affected by the outcome of these issues, and have vested interests in the hundreds of millions left to be distributed by MLMIC (out of the $2.5B cash consideration generated by the demutualization). Such interest is particularly true for providers, such as the Hospital, who serve rural communities, where it is frequently difficult

to maintain financial and operational viability, and even more so now because of the pandemic. This Court's resolution is thus of great significance to the Hospital and other providers statewide.

In addition, because the Supreme Court's decision in this case was based on the existence of an incentive compensation provision that weighed in favor of the employee – a fact not present in Schoch but nonetheless relied upon in a number of cases throughout New York to distinguish their respective facts – if complete resolution of all the cases is to be accomplished, this Court should also entertain this specific matter.

POINT II

THE HOSPITAL'S APPEAL SHOULD BE CONSOLIDATED WITH THE *SCHOCH* APPEAL

Should the Court grant the Hospital leave to appeal, the Hospital respectfully seeks to consolidate its appeal with the *Schoch* Appeal for the purposes of scheduling simultaneous briefing and oral arguments, and for a determination. To the extent that the Court proceeds with the *Schoch* Appeal under its Rule 500.11 alternative procedure – based on an application which was just made by the Respondent Schoch on November 30, 20202 – the Hospital seeks alignment and consolidation under those separate protocols.

As established from the papers, there is an identity of issues and facts that are before the Court on this appeal and the *Schoch* Appeal. Although the timing of this motion and appeal slightly trails that of *Schoch*, these cases are both still in the early procedural stages such that there will be no significant delay. In fact, the Hospital is committed to adhering to the deadlines of the *Schoch* case to the extent possible, and will coordinate briefing so that the Court will have simultaneous submissions in the coming months. By all accounts, there can be no legitimate claim of prejudice to any of the parties to have the cases resolved simultaneously, as all parties will be given the opportunity to be heard on these critical issues.

CONCLUSION

For the reasons set forth above, the Hospital respectfully asks that this Court grant the Hospital's motion for leave to appeal, and upon such leave, consolidating the appeals, and for such other relief as this Court may deem just, equitable or proper.

Dated: Great Neck, New York
December 4, 2020

GARFUNKEL WILD, P.C.
Attorneys for Plaintiff-Appellant

By: Andrew L. Zwerling

Andrew L. Zwerling
Jason Hsi
111 Great Neck Road
Great Neck, New York 11021
(516) 393-2200

COURT OF APPEALS
CERTIFICATE OF COMPLIANCE

I hereby certify Pursuant to Part 500.13(c)(1) of the Rules of Practice of the Court of Appeals, State of New York that the foregoing brief was prepared on a computer using Microsoft Word.

A proportionally spaced typeface was used, as follows:

Name of typeface:	Times New Roman
Point Size:	14
Footnote Point Size:	12
Line spacing:	Double

Word Count. The total number of words in this brief, inclusive of point headings and footnotes and exclusive of pages containing the table of contents, table of citations, proof of service, certificate of compliance, statement of status of related litigation, corporate disclosure statement, statement of questions presented required by subsection (a), or any addendum containing material required by subsection 500.1(h), is 5,125.

APPENDIX A

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION – THIRD DEPARTMENT

----------X

THE COLUMBIA MEMORIAL HOSPITAL,

Appellant,

-against-

MARCEL E. HINDS, M.D.,

Respondent.

----------X

Case No.: 530190

NOTICE OF ENTRY

PLEASE TAKE NOTICE, that attached hereto is a true copy of the Memorandum and Order of the Appellate Division, Third Department, dated and entered in the above-captioned action in on the 5th day of November, 2020.

Dated: New Hyde Park, New York
November 5, 2020

WEISS ZARETT BROFMAN
SONNENKLAR & LEVY, P.C.
Attorneys for Respondent

By: _____

Seth A. Nadel, Esq.
3333 New Hyde Park Road, Suite 211
New Hyde Park, New York 11042
(516) 627-7000

TO: Garfunkel Wild, P.C.
Jason Hsi, Esq.
Attorneys for Appellant
111 Great Neck Road
Great Neck, New York 11021
(516) 393-2200
Via NYSCEF

State of New York
Supreme Court, Appellate Division
Third Judicial Department

Decided and Entered: November 5, 2020 530190

COLUMBIA MEMORIAL HOSPITAL,
Appellant,
v MEMORANDUM AND ORDER

MARCEL E. HINDS,
Respondent.

Calendar Date: September 16, 2020

Before: Garry, P.J., Egan Jr., Lynch, Mulvey and Reynolds Fitzgerald, JJ.

Garfunkel Wild, PC, Great Neck (Jason Hsi of counsel), for appellant.

Weiss Zarett Brofman Sonnenklar & Levy, PC, New Hyde Park (Seth A. Nadel of counsel), for respondent.

Egan Jr., J.

Appeal from an order of the Supreme Court (Zwack, J.), entered September 12, 2019 in Columbia County, which, among other things, granted defendant's motion to dismiss the complaint.

Defendant, an obstetrics/gynecology physician, was employed by plaintiff from August 2012 through August 2017. Pursuant to defendant's employment agreement with plaintiff, defendant was to be paid a base salary plus incentive compensation, and plaintiff was required to, as relevant here, procure, maintain and pay the premiums for a professional

liability insurance policy on defendant's behalf. Pursuant thereto, plaintiff procured a professional liability insurance policy from Medical Liability Mutual Insurance Company (hereinafter MLMIC) naming defendant as the sole policyholder and thereafter served as policy administrator, ensuring, among other things, that the premiums with respect thereto were paid throughout the duration of defendant's employment with plaintiff.

In 2016, it was announced that National Indemnity Company would be acquiring MLMIC and, as part of said transaction, MLMIC would be converted or "demutualized" from a mutual insurance company to a stock insurance company. In July 2016, in accord with Insurance Law § 7307 (e) (3), MLMIC applied to the Department of Financial Services for permission to file a plan of conversion, which provided, in relevant part, that eligible policyholders or their "designees," between July 2013 and July 2016, would receive cash consideration in exchange for the extinguishment of their policyholder membership interests. Pursuant to the controlling valuation formula, the amount of cash consideration to be paid with respect to the subject policy was $412,418.93 (hereinafter the MLMIC funds). Plaintiff, as policy administrator, subsequently made three separate requests to have defendant, as the sole policy holder, designate or assign his interest in the MLMIC funds to plaintiff; however, no such assignment was ever executed. Pursuant to the dispute resolution procedure provided for in the conversion plan, plaintiff objected to the distribution of the MLMIC funds to defendant and, in turn, MLMIC placed said funds in escrow pending resolution of the dispute.[1]

Plaintiff thereafter commenced this declaratory judgment action asserting that, as policy administrator, it is entitled to receive the MLMIC funds as it paid for the policy's premiums and controlled and/or administered the policy during the course of defendant's employment, and, pursuant to the parties'

[1] MLMIC ultimately received regulatory approval from the Department of Financial Services and policyholder approval for its plan to convert to a stock company, and MLMIC's demutualization was thereafter completed.

employment agreement, defendant was not entitled to any additional monies following his separation from employment. Plaintiff also asserted causes of action for unjust enrichment, money had and received and breach of the implied covenant of good faith and fair dealing. Defendant filed a pre-answer motion to dismiss the complaint, alleging that the complaint failed to state a cause of action (see CPLR 3211 [a] [7]) and that plaintiff's claims failed based upon documentary evidence (see CPLR 3211 [a] [1]). Supreme Court granted defendant's motion, declared that defendant was entitled to the MLMIC funds and dismissed plaintiff's complaint. Plaintiff appeals.

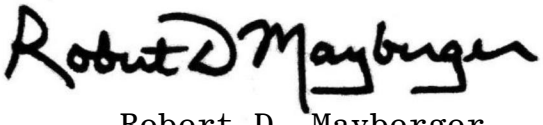
We affirm. As relevant here, Insurance Law § 7307 (e) (3) provides that, when a mutual insurance company converts to a stock insurance company, a plan of conversion "shall . . . provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the [conversion] resolution . . . 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." Even if we accept as true plaintiff's contention that it is entitled to payment of the MLMIC funds because it paid the premiums for the subject policy, which we must on a motion to dismiss (see NYAHSA Servs., Inc., Self-Ins. Trust v Recco Home Care Servs., Inc., 141 AD3d 792, 794 [2016]; SUS, Inc. v St. Paul Travelers Group, 75 AD3d 740, 741 [2010]), this Court recently concluded in Schoch v Lake Champlain OB-GYN, P.C. (184 AD3d 338, 342-344 [2020]) that entitlement to the MLMIC funds is not contingent on who paid the premiums for the subject policy. Rather, the sole policyholder, here, defendant, is entitled to receive said funds unless he or she executed an assignment of such rights to third party (see Insurance Law § 7307). Given the documentary evidence establishing that defendant was the named policyholder and specifically declined to execute any assignment of his right to receive the MLMIC funds, he was statutorily entitled to receive same (see Schoch v Lake Champlain OB-GYN, P.C., 184 AD3d at 342-343; Maple-Gate Anesthesiologists, P.C. v. Nasrin, 182 AD3d 984, 985 [2020]).

To the extent that plaintiff contends that this Court should follow precedent from another Department so as to grant it entitlement to the MLMIC funds (see Matter of Schaffer, Schonholz & Drossman, LLP v Title, 171 AD3d 465, 465 [1st Dept 2019]; see also Wyckoff Heights Med. Ctr. v Monroe, ___ Misc 3d ___, 2020 NY Slip Op 32580[U] [Sup Ct, Kings County 2020]), we disagree with the legal analysis contained therein and are not bound by that decision (see Shoback v Broome Obstetrics & Gynecology, P.C., 184 AD3d 1000, 1001 [2020]). Instead, for the reasons stated in Schoch v Lake Champlain OB-GYN, P.C. (184 AD3d at 343-344), decided together with Shoback v Broome Obstetrics & Gynecology, P.C. (184 AD3d at 1001-1002), we find that plaintiff failed to establish any legal or equitable right to distribution of the MLMIC funds and, as such, Supreme Court appropriately granted defendant's motion to dismiss the complaint.

Garry, P.J., Lynch, Mulvey and Reynolds Fitzgerald, JJ., concur.

ORDERED that the order is affirmed, with costs.

ENTER:



Robert D. Mayberger
Clerk of the Court

APPENDIX B

State of New York
Court of Appeals

Decided and Entered on the twenty-third day of November, 2020

Present, Hon. Janet DiFiore, *Chief Judge,* ***presiding.***

Mo. No. 2020-521
Kim E. Schoch,
Respondent,
v.
Lake Champlain OB-GYN, P.C.,
Appellant.

Appellant having moved for leave to appeal to the Court of Appeals in the above cause;

Upon the papers filed and due deliberation, it is

ORDERED, that the motion is granted.

John P. Asiello
Clerk of the Court

APPENDIX C

State of New York
Court of Appeals

Decided and Entered on the twenty-third day of November, 2020

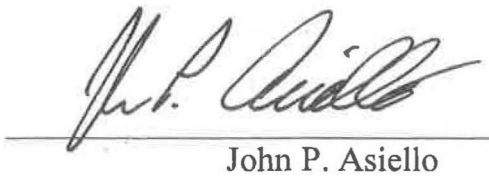
Present, Hon. Janet DiFiore, *Chief Judge, **presiding**.*

Mo. No. 2020-639
Kim E. Schoch,
Respondent,
v.
Lake Champlain OB-GYN, P.C.,
Appellant.

Samaritan Medical Center, et al. having moved for leave to appear amici curiae on the motion for leave to appeal herein;

Upon the papers filed and due deliberation, it is

ORDERED, that the motion is granted and the brief is accepted as filed.



John P. Asiello
Clerk of the Court

APPENDIX D

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JUSTIN A. HELLER, ESQ.
Direct Dial: (518) 432-3118
Email: jheller@nhkllp.com

November 30, 2020

John P. Asiello, Esq., Chief Clerk
New York State Court of Appeals
20 Eagle Street
Albany, New York 12207

Re: Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.
Appeal No. APL-2020-00169

Dear Mr. Asiello:

We represent Respondent Kim E. Schoch in the above-referenced matter. The Court granted Appellant's Motion for Leave to Appeal on November 23, 2020. We are writing to request that the Court consider this appeal under the alternative procedure described in Section 500.11 of the Court's Rules of Practice, on the basis of narrow issues of law not of overriding or State-wide importance, and other appropriate factors discussed below.

This appeal concerns a narrow question of law as to who is entitled to the cash consideration paid in exchange for a Medical Liability Mutual Insurance Company ("MLMIC") policyholder's membership interest: (i) the employee (here, Respondent) who became a MLMIC policyholder—and thereby acquired a membership interest—as part of the bargained-for exchange of consideration under the parties' employment agreement; or (ii) the employer (here, Appellant), which paid its employee's MLMIC premiums pursuant to, and in exchange for their employee's services under, the employment agreement?

A split currently exists between the Third and Fourth Departments, on the one hand, and the First Department, on the other, as to who is entitled to the MLMIC cash consideration.[1]

In the within case, *Schoch v. Lake Champlain OB-GYN, P.C.* (184 A.D.3d 338 [3d Dep't 2020]), the Third Department relied upon the statutory framework of the New York Insurance Law, MLMIC's Plan of Conversion, the Decision of the New York State Department of Financial Services ("DFS") approving the Plan, the plain terms of Respondent's employment agreement, and controlling unjust enrichment law, for its holding that, (a) as policyholder, Respondent was solely entitled to her share of the cash consideration, and (b) Appellant had no legal or equitable claim to the funds.[2] The Third Department's holding was consistent with the Fourth Department's decision in *Maple-Gate Anesthesiologists, P.C. v. Nasrin* (182 A.D.3d 984 [4th Dep't 2020]), which held that under the Insurance Law and Plan of Conversion, payment of the cash consideration was "required to be made to those policyholders who had coverage during the relevant period," and not to the employer, which "as a matter of law . . . had no legal or equitable right of ownership to the demutualization payments." *Id.* at 985.

In contrast, in *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't 2019), the First Department—hearing the case in the first instance, on submitted facts, pursuant to CPLR 3222—"summarily held, without any analysis," that awarding the MLMIC cash consideration to the employee-policyholder would constitute unjust enrichment. *Schoch*, 184 A.D.3d at 347-48. Significantly, the First Department reached its determination in reliance upon inapposite ERISA case law and without discussing or citing the New York Insurance Law, the Plan of Conversion, the DFS Decision, the parties' employment agreement, or New York unjust enrichment law—all of which, for the reasons explained in *Schoch* and *Maple-Gate*, require that the cash consideration be paid to the employee-policyholders.

---

[1] On October 13, 2020, the Second Department heard oral argument in an appeal of another case involving a dispute over MLMIC consideration: *Maple Medical LLP v. Scott*, 64 Misc. 3d 909, 912 (Sup. Ct. Westchester Cty. 2019) (Appellate Division No. 2019-09157).

[2] *See also Shoback v. Broome Obstetrics & Gynecology, P.C.*, 184 A.D.3d 1000, 1001-02 (3d Dep't 2020); *Columbia Memorial Hospital v. Hinds*, 2020 N.Y. App. Div. LEXIS 6521 (3d Dep't Nov. 5, 2020).

The issue as to entitlement to MLMIC demutualization consideration is narrow and generally not of State-wide importance beyond disputes between MLMIC policyholders and their employers. However, MLMIC's demutualization has caused scores of lawsuits throughout New York State between MLMIC polocyholders and employers, and the current split in authority between the Departments has led (and will continue to lead) to inconsistent outcomes at the trial court level and an ongoing influx of appeals to the Appellate Division. As an example of the breadth of similar MLMIC lawsuits, our law firm alone represents MLMIC policyholders in over 50 pending trial court cases and over 20 pending appeals. Upon information and belief, there are a great many more cases pending throughout the State.

Review under the alternative procedure described in Rule 500.11 would expedite resolution of the issues common to all MLMIC litigation, which, in turn, would reduce the burden on the trial courts and the Appellate Division, as well as the time and expense for litigants in resolving their disputes, resulting from the current split of authority.

Accordingly, we respectfully request that the Court review this appeal under the alternative procedure described in Rule 500.11.

Thank you for your consideration.

Respectfully submitted,

NOLAN HELLER KAUFFMAN LLP

Justin A. Heller

JAH/pdm

Cc:
James R. Peluso, Esq.
Alan J. Pierce, Esq.

DREYER·BOYAJIAN
ATTORNEYS AT LAW

December 3, 2020

John P. Asiello, Esq., Chief Clerk
New York State Court of Appeals
20 Eagle Street
Albany, NY 12207

Re: Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB-GYN, P.C.
Appeal No. APL-2020-00169

Dear Mr. Asiello:

The undersigned represents the Appellant-Defendant ("Appellant") Lake Champlain OB-GYN, P.C. in the above-referenced matter. Enclosed for filing is an original and one copy of Appellant's Preliminary Appeal Statement, together with proof of service.

Please also accept this letter in opposition to the November 30, 2020 letter application of Respondent-Plaintiff ("Respondent") requesting that the Court forego normal briefing and argument procedures in this appeal in favor of the alternative, expedited review procedure set forth in 22 NYCRR 500.11. The complex and impactful legal dispute now before the Court on this appeal should not be decided under the alternative, expedited review procedure. This appeal does not involve narrow issues of law lacking statewide importance, nor is this an appeal that can be disposed of on the basis of a limited scope of review, new binding precedent, or unpreserved errors of law (see 22 NYCRR 500.11 [b] [listing grounds upon which the Court may review selected appeals by an alternative procedure]).

Contrary to Respondent's suggestion, this appeal involves numerous legal issues that will have an immense statewide impact, both immediately and for years to come. The Court's decision here will resolve a split amongst the First, Third, and Fourth Appellate Divisions, effectively decide the outcome of hundreds, if not thousands, of legal disputes throughout the state, and settle the question of the proper beneficiaries of over $2.5 billion in cash consideration arising out of the first demutualization of a medical malpractice mutual insurance company in this state's history. In deciding this appeal, the Court will be called upon to interpret and

analyze key provisions of the New York State Insurance Law, in particular whether insurance demutualization proceeds should be distributed among employers and employees to (i) the party or parties who paid the premiums, or (ii) the party who paid no premiums but was the named insured. In this regard, the decision will stand as important precedent that will guide courts in applying the Insurance Law for years to come, not only in the context of a mutual insurance company demutualization (see N.Y. Insurance Law § 7307), but also in cases turning on the interpretation of other similar provisions of the Insurance Law (see generally N.Y. Insurance Law §§ 7301 et seq. [governing conversion, reconversion, and reorganization of a diverse range of insurance company entity types]).

This Court will also be presented with the opportunity to clarify and further define the law of unjust enrichment and the circumstances in which a party may rely upon that commonly utilized cause of action. Notably, consistent with the First Department's decision in *Matter of Schaffer, Schonholz & Drossman LLP v Title* (171 AD3d 465 [1st Dept 2019]), other courts have decided the issue of entitlement to insurance demutualization proceeds among employers and employees pursuant to principles of equity and fairness. The proper standard of review to determine whether a party has an equitable claim to share in such proceeds—which is also consistent with the process laid out in New York Insurance Law § 7307(e)—is to calculate the amount of premiums that the employer/employee paid. This is the majority view of courts throughout the nation in considering the demutualization of insurers providing employee disability insurance, health insurance, 401k retirement benefits, etc. (*see* cases cited in Appellant's Motion for Leave to Appeal dated July 15, 2020 at p. 12) Accordingly, it is submitted that this Court should not constrain itself and the parties under an expedited, alternative briefing procedure when determining an appeal of this nature involving complex and impactful legal questions that will have a profound impact throughout the state.

Moreover, full and complete briefing is necessary given the numerous non-party stakeholders that will seek to be heard through this appeal. A thorough consideration of the legal questions raised in this appeal is equally as crucial to these stakeholders and they should therefore be given a full opportunity to participate and brief any additional law or arguments that might otherwise escape the Court's consideration. In this regard, Appellant's counsel has already been in communication with several third parties that intend to seek amicus curiae status or consolidation of their pending appeals with the instant appeal. The alternative, expedited briefing procedure proposed by Respondent would inhibit both the Court and any intervening third parties by precluding a full presentation of the additional

arguments they will seek to raise, such as how certain contractual terms or courses of conduct at issue in their cases may influence the legal analysis.

In closing, it is respectfully submitted that the Court should follow its usual and customary procedures for perfecting appeals rather than implementing the alternative, expedited procedure sought by the Respondent. It should be noted that, despite prevailing in the Third Department below, Respondent's counsel argued *in support* of this Court granting leave to appeal, citing "the breadth of litigation throughout New York State relating to MLMIC's demutualization, and the continued inconsistent holdings among the Appellate Division departments and the trial courts therein[.]" (Affirmation of Justin Heller, Esq. in Response to Defendant-Appellant's Motion for Leave to Appeal dated July 31, 2020, at ¶ "10"). With the Court having now accepted Respondent's suggestion that this case warranted review, she now attempts to downplay its statewide importance in an effort to justify alternative, expedited review. However, for the same reasons initially cited by both Appellant and Respondent in support of granting leave, and for the additional reasons set forth by Appellant herein, it is respectfully submitted that this appeal is not suitable for alternative review under 22 NYCRR 500.11 and this Court should proceed under its usual and customary procedures for perfecting and hearing appeals.

Thank you for your attention to this matter.

Respectfully,

DREYER BOYAJIAN LLP

James R. Peluso
jpeluso@dblawny.com

Enc.

cc: Justin A. Heller, Esq.
Alan J. Pierce, Esq.

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FILE NO.: 06253.1260

December 4, 2020

By FedEx

Mr. John P. Asiello, Esq., Chief Clerk
New York State Court of Appeals
20 Eagle Street
New York, NY 12207

Re: *The Columbia Memorial Hospital v. Marcel Hinds, M.D.*
Third Department Docket No. 530190

Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB/GYN, PC
Appeal No. APL-2020-00169

Dear Mr. Asiello:

We represent Columbia Memorial Hospital ("Hospital").

We write to inform the Court that the Hospital is filing a motion today seeking leave to appeal a Third Department decision involving the sale and demutualization of Medical Liability Mutual Insurance Company ("MLMIC").[1] Because the Hospital's appeal involves the exact same MLMIC-related issues as a currently pending appeal, *Kim E. Schoch, CNM, OB/GYN NP v. Lake Champlain OB/GYN, PC*, Appeal No. APL-2020-00169 (the "*Schoch* Appeal"),[2] the Hospital's motion will also seek to consolidate the two appeals.

We have recently learned that Respondent Kim E. Schoch has requested the Court's application of the Rule 500.11 alternative procedures for an expedited resolution in the *Schoch* Appeal. Although the Hospital has not technically made an appearance yet in connection with the *Schoch* Appeal, the Hospital respectfully submits this letter opposing that request to the extent that it might affect the procedural relief sought in the Hospital's anticipated motion to consolidate, particularly with regard to the timing and alignment of simultaneous submissions. Furthermore, the Hospital opposes that request because the MLMIC issue, which involves

[1] An informal copy of the Hospital's motion (without the accompanying documents) is attached for informational purposes.
[2] Leave to appeal in the *Schoch* Appeal was recently granted on November 23, 2020.

matters of statewide importance and will undoubtedly affect the distribution of hundreds of millions of dollars to healthcare providers across New York, requires a full set of briefs and argument that should not be curtailed just for the sake of expediency. The fact that there are numerous lawsuits and appeals pending only serves to highlight the importance of a full and complete set of arguments. The Hospital does not believe that the alternative procedures are warranted under the circumstances.

Thank you for your consideration. Should you have any questions, feel free to contact me at anytime.

Respectfully submitted,

Jason Hsi

cc: Rachel M. MacVean, Chief Motion Clerk
Seth Nadel, Esq.
James Peluso, Esq.
Justin Heller, Esq.
Alan Pierce, Esq.
Andrew Zwerling, Esq.

APPENDIX E

171 A.D.3d 465, 96 N.Y.S.3d 526
(Mem), 2019 N.Y. Slip Op. 02617

***1** In the Matter of Schaffer, Schonholz & Drossman, LLP, Petitioner,

v

Rachel S. Title, M.D., Respondent.

Supreme Court, Appellate Division,
First Department, New York
1602015/18, 8892
April 4, 2019

CITE TITLE AS: Matter of Schaffer, Schonholz & Drossman, LLP v Title

HEADNOTE

Insurance
Liability Insurance
Cash Proceeds from Demutualization of Insurance Company

Hughes Hubbard & Reed LLP, New York (Amina Hassan of counsel), for petitioner.

Richard A. Klass, Brooklyn, for respondent.

Upon facts submitted to this Court pursuant to CPLR 3222 (b) (3), it is declared that petitioner is entitled to the cash proceeds resulting from the demutualization of nonparty Medical Liability Mutual Insurance Company (MLMIC). The Clerk of Supreme Court, New York County is directed to enter judgment awarding petitioner said cash proceeds, including interest accrued while the proceeds were in escrow.

Although 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 (*see Ruocco v Bateman, Eichler, Hill, Richards, Inc.*, 903 F2d 1232, 1238 [9th Cir 1990], *cert denied* 498 US 899 [1990]; *Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund*, 2005 WL 525427, *4, *8, 2005 US Dist LEXIS 42877, *10-11, *21-22 [ND Ill, Mar. 4, 2005, No. 02 C 3115]). Concur—Sweeny, J.P., Manzanet-Daniels, Kern, Oing, Singh, JJ.

APPENDIX F

New York Official Reports

182 A.D.3d 984, 122 N.Y.S.3d 840, 2020 N.Y. Slip Op. 02389

**1 Maple-Gate Anesthesiologists, P.C., Appellant,

v

Deixy Nasrin et al., Respondents.

Supreme Court, Appellate Division, Fourth Department, New York
19, 19-00612
April 24, 2020

CITE TITLE AS: Maple-Gate Anesthesiologists, P.C. v Nasrin

HEADNOTE

Contracts
Quasi Contracts
No Equitable Right of Ownership to Demutualization Payments

Barclay Damon LLP, Buffalo (Robert J. Portin of counsel), for plaintiff-appellant.
Hurwitz & Fine, P.C., Buffalo (Amber E. Storr of counsel), for defendants-respondents.

Appeal from an order of the Supreme Court, Erie County (Frank A. Sedita, III, J.), entered March 22, 2019. The order granted the motion of defendants to dismiss the complaint.

It is hereby ordered that the order so appealed from is unanimously affirmed without costs.

Memorandum: Plaintiff commenced this action against defendants, its former employees, alleging that it is entitled to certain proceeds paid to defendants by the Medical Liability Mutual Insurance Company (MLMIC) has a result of MLMIC's conversion from a mutual insurance company to a stock insurance company (demutualization). Pursuant to defendants' employment contracts, plaintiff agreed to provide to defendants the annual premiums for their professional liability insurance as part of their compensation packages. Plaintiff purchased professional liability insurance for defendants and all of its employees through MLMIC. Each defendant was named as the "insured" or "policyholder" on his or her MLMIC policy, and plaintiff was formally designated by defendants as the "Policy Administrator." Defendants assigned certain policyholder rights to plaintiff as the Policy Administrator, namely, the right to receive any dividends and return premiums, and also assigned certain policyholder duties, namely, the duty to pay all premiums.

In 2018, after defendants had left their employment with plaintiff, MLMIC made certain demutualization payments to defendants because of their status as former policyholders. When defendants refused plaintiff's request to pay it 50% of those payments, plaintiff commenced this action, asserting causes of action for conversion and unjust enrichment and alleging that it was the rightful recipient of the demutualization payments. Thereafter, defendants moved to dismiss the complaint pursuant to, inter alia, CPLR 3211 (a) (1). Supreme Court granted the motion, and we affirm.

***985** "On a motion to dismiss pursuant to CPLR 3211, pleadings are to be liberally construed . . . The court is to accept the facts as alleged in the [pleading] as true . . . [and] accord [the proponent of the pleading] the benefit of every possible favorable inference" (*Baumann Realtors, Inc. v First Columbia Century-30, LLC*, 113 AD3d 1091, 1092 [4th Dept 2014] [internal quotation marks omitted]). "A motion to dismiss pursuant to CPLR 3211 (a) (1) will be granted if the documentary evidence resolves all factual issues as a matter of law, and conclusively disposes of the [plaintiff's] claim[s]" (*Lots 4 Less Stores, Inc. v Integrated Props., Inc.*, 152 AD3d 1181, 1182 [4th Dept 2017] [internal quotation marks omitted]).

Here, contrary to plaintiff's contention, the court properly granted the motion because the documentary evidence established as a matter of law that plaintiff had no legal or equitable right of ownership to the demutualization payments (*see LaBarte v Seneca Resources Corp.*, 285 AD2d 974, 976 [4th Dept 2001]; *Di Siena v Di Siena*, 266 AD2d 673, 674 [3d Dept 1999]; *see generally Mandarin Trading Ltd. v Wildenstein*, 16 NY3d 173, 182 [2011]; *Colavito v New York Organ Donor Network, Inc.*, 8 NY3d 43, 49-50 [2006]). Insurance Law § 7307 (e) (3) provides that, when a mutual insurance company converts to a stock insurance company, the plan of conversion: "shall . . . 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 [seeking approval of the conversion] 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." In support of their motion, defendants submitted the MLMIC plan of conversion (plan), which, in accordance with that provision of the Insurance Law, provided that cash distributions were required to be made to those policyholders who had coverage during the relevant period prior to demutualization in exchange for the "extinguishment of their Policyholder Membership Interests." The plan stated that the cash distribution would be made to the policyholder unless he or she "affirmatively designated a Policy Administrator . . . to receive such amount on [his or her] behalf." Additional documentary evidence demonstrated that defendants were the policyholders of the relevant MLMIC policies and that, although defendants had assigned some of their rights as policyholders to plaintiff as Policy Administrator, they had not designated plaintiff to receive demutualization payments. Even assuming, arguendo, that plaintiff could be entitled to the demutualization payments without the ***986** express designation contemplated by the plan, we conclude that plaintiff has not alleged any facts or circumstances from which it could be established that it was entitled to any such payments. The mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments (*cf. Matter of Schaffer, Schonholz & Drossman, LLP v Title*, 171 AD3d 465, 465 [1st Dept 2019]). Present—Whalen, P.J., Centra, Lindley, Troutman and Winslow, JJ. **[Prior Case History: 63 Misc 3d 703.]**

APPENDIX G

New York Official Reports

184 A.D.3d 338, 126 N.Y.S.3d 532, 2020 N.Y. Slip Op. 03444

**1 Kim E. Schoch, Appellant,

v

Lake Champlain OB-GYN, P.C., Respondent.

Supreme Court, Appellate Division, Third Department, New York
529615
June 18, 2020

CITE TITLE AS: Schoch v Lake Champlain OB-GYN, P.C.

SUMMARY

Appeal from a judgment of the Supreme Court, Saratoga County (Ann C. Crowell, J.), entered June 17, 2019. The judgment, among other things, issued a declaration in defendant's favor.

Schoch v Lake Champlain OB-GYN, P.C., 64 Misc 3d 1215(A), 2019 NY Slip Op 51176(U), reversed.

HEADNOTES

Insurance
Liability Insurance
Distribution of Cash Proceeds from Demutualization of Professional Liability Insurance Company—Conversion Plan in Accordance with Insurance Law

(1) Plaintiff medical professional, who was listed as the sole insured on a malpractice policy obtained by her employer, defendant professional corporation, in satisfaction of the parties' employment agreement, was entitled to the cash consideration distributed as a result of the demutualization of the issuing professional liability insurance company, even though defendant paid the premiums and had control over the policy. In accordance with Insurance Law § 7307 (e) (3), the insurance company's plan to convert to a stock insurance company provided that anyone who was a policyholder during the relevant time period would receive a cash consideration in exchange for the extinguishment of his or her policyholder membership interest. As the named insured on the policy, plaintiff was the policyholder with a membership interest. While the conversion plan provided that consideration was payable to eligible policyholders or their designees, designee was defined to mean someone who a policyholder specifically designated to receive the proceeds from demutualization. Plaintiff did not sign a special consent form distributed by the insurance company to policyholders that would designate someone else (i.e., defendant) to receive her share of the cash consideration. While she did sign a form designating defendant as the policy administrator, thereby appointing defendant as her agent and giving defendant the right to, among other things, make changes to the policy and receive dividends, an ordinary designation as policy administrator did not convey the right to receive the cash consideration. Furthermore, the language in Insurance Law § 7307 (e) (3) stating that the amount of the cash consideration is based partly on the amount of premiums that "such policyholder has properly and timely paid to the insurer" pertains to how the considerations are calculated, rather than to whom they must be paid. It did not entitle defendant to the consideration merely based on its payment of premiums.

Insurance
Liability Insurance
Distribution of Cash Proceeds from Demutualization of Professional Liability Insurance Company—Unjust Enrichment

(2) In an action seeking a declaration that plaintiff medical professional, who was listed as the sole insured on a malpractice policy obtained by her *339 employer, defendant professional corporation, in satisfaction of the parties' employment agreement, was entitled to the cash consideration distributed as a result of the demutualization of the issuing professional liability insurance company, defendant, which paid the premiums and had control over the policy as the designated policy administrator, failed to meet its burden to establish its affirmative defense and counterclaim alleging unjust enrichment. Neither party bargained for the demutualization proceeds, and neither actually paid for them, because membership interests in a mutual insurance company are not paid for by policy premiums; such rights are acquired at no cost, but rather as an incident of the structure of

mutual insurance policies, through operation of law and the company's charter and bylaws. Thus, the demutualization proceeds were unexpected and would be a windfall to whichever party received them. The fact that one party would receive those benefits did not mean that such party had unjustly enriched itself at the other's expense, i.e., that it was in possession of money or property that rightly belongs to another. The benefit of the cash consideration would be paid to plaintiff based on Insurance Law § 7307 (e) (3) and the insurance company's conversion plan—a correct reading of the law, rather than a mistake. No factual mistake existed, other than the parties' mutual failure to consider the potential for demutualization when negotiating their employment agreement. Furthermore, both parties benefitted from defendant's fulfillment of its contractual obligation to provide malpractice insurance and pay for the premiums, inasmuch as the insurance provided coverage to protect the liability interests of plaintiff both individually and as an employee of defendant. Neither party changed its position based on demutualization and plaintiff's conduct was neither tortious nor fraudulent.

RESEARCH REFERENCES

Am Jur 2d Insurance §§ 69, 81.

Couch on Insurance (3d ed) §§ 39:44, 39:45.

McKinney's, Insurance Law § 7307 (e) (3).

NY Jur 2d Insurance §§ 5, 320.

ANNOTATION REFERENCE

See ALR Index under Insurance.

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APPEARANCES OF COUNSEL

Nolan Heller Kaufman LLP, Albany (*Justin A. Heller* of counsel), for appellant.
Dreyer Boyajian LLP, Albany (*James R. Peluso* of counsel), for respondent.

***340 OPINION OF THE COURT**

Mulvey, J.

Appeal from a judgment of the Supreme Court (Crowell, J.), entered June 17, 2019 in Saratoga County, which, among other things, issued a declaration in defendant's favor.

Plaintiff, a certified nurse midwife and obstetrics/gynecology nurse practitioner, was employed by defendant from June 2007 to at least June 2014.[1] One of the terms of the parties' employment agreement required defendant to maintain and pay the premiums for a professional liability insurance policy. Defendant satisfied that term by obtaining from Medical Liability Mutual Insurance Company (hereinafter MLMIC) a malpractice policy that listed plaintiff as the sole insured. Plaintiff signed a form designating defendant as the policy administrator of the MLMIC policy, thereby appointing defendant as her agent and giving defendant the right to, among other things, make changes to the policy and receive dividends. Defendant paid all the premiums on the MLMIC policy covering plaintiff.

In July 2016, MLMIC applied to the Department of Financial Services (hereinafter DFS) for permission to file a plan to convert from a mutual insurance company to a stock insurance company. In accordance with Insurance Law § 7307 (e) (3), MLMIC's conversion plan provided that anyone who was a MLMIC policyholder from July 2013 to July 2016 would receive a cash consideration in exchange for the extinguishment of his or her policyholder membership interest. Plaintiff did not sign a special consent form distributed by MLMIC to policyholders that would designate someone else (i.e., defendant) to receive her share of the cash consideration. Pursuant to a provision in the conversion plan, defendant objected to the distribution of the cash consideration—in the amount of $74,747.03—to plaintiff, and MLMIC placed the disputed cash consideration in escrow pending resolution of the dispute. Eventually, DFS approved the conversion plan, MLMIC's members voted in favor of it and MLMIC completed the demutualization.

Thereafter, plaintiff commenced this declaratory judgment action asserting that, as the policyholder with a membership interest in MLMIC and absent an assignment of her membership interest to defendant, she is entitled to receive the cash consideration. Defendant raised affirmative defenses and ***341** counterclaims asserting, among other things, unjust enrichment and requested a declaration that the cash

consideration must be distributed to defendant. After joinder of issue, plaintiff moved and defendant cross-moved for summary judgment. Supreme Court, concluding that it was bound by a recent First Department decision (*Matter of Schaffer, Schonholz & Drossman, LLP v Title*, 171 AD3d 465 [2019]), denied plaintiff's motion, granted defendant's cross motion and declared that defendant was entitled to a judgment awarding it the cash consideration, on the basis that plaintiff would be unjustly enriched if she received the money. Plaintiff appeals.

(1) Plaintiff contends that, pursuant to statute, the conversion plan, DFS's decision approving the plan and under the common law, she is entitled to the cash consideration because she was the policyholder with a membership interest in MLMIC. Defendant argues that these same sources entitle it to receive the cash consideration because it paid the premiums and had control over the policy. Alternatively, defendant argues that plaintiff would be unjustly enriched if she were to receive the cash consideration.

Before the conversion, MLMIC was a mutual insurance company, meaning that it was owned by, maintained and operated for the benefit of its members. By statute, "[e]very policyholder shall be a member of such corporation" (Insurance Law § 1211 [a]). Accordingly, policyholders have a dual relationship with a mutual insurance company, in that they have both a membership interest (e.g., the right to vote and receive dividends) and contractual rights (i.e., the obligations of the insurance company under the policy) (*see Dorrance v United States*, 809 F3d 479, 482 [9th Cir 2015]; *Bank of N.Y. v Janowick*, 470 F3d 264, 267 [6th Cir 2006], *cert denied* 552 US 825 [2007]; 17 Steven Plitt et al., Couch on Insurance 3d § 39:37 [1995]; *see also* Insurance Law § 1211 [a]).

By statute, a plan for conversion from a mutual insurance company to a stock insurance company

> "shall . . . provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding [a specified date] 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 ***342** 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 [those] three years . . . bears to the total net premiums received by the mutual insurer from such eligible policyholders" (Insurance Law § 7307 [e] [3]).

The first quoted sentence of this statute explains who is entitled to receive the consideration, whereas the second quoted sentence explains how the consideration for each eligible person is to be calculated. Consideration is owed to anyone who had a policy of insurance in effect during the relevant time period. Under MLMIC's conversion plan, the consideration is payable to eligible policyholders or their designees. Designee is defined to mean someone who a policyholder specifically designated to receive the proceeds from demutualization; an ordinary designation as policy administrator does not convey the right to receive the cash consideration. The conversion plan defines member of the corporation as a policyholder, which is further defined as the person identified on the policy's declarations page as the insured. Plaintiff was the named insured on the relevant MLMIC policy. Hence, per the relevant statute and the conversion plan's definitions, plaintiff was entitled to the cash consideration (*see Maple-Gate Anesthesiologists, P.C. v Nasrin*, 182 AD3d 984, 985 [2020]).

Defendant's designation as policy administrator gave it no greater right to the cash consideration, and plaintiff did not explicitly assign that right to defendant and declined to do so (*see Maple-Gate Anesthesiologists, P.C. v Nasrin*, 63 Misc 3d 703, 709 [Sup Ct, Erie County 2019], *affd* 182 AD3d 984 [2020]). Although the conversion plan gives a policy administrator the right to object if it believes that it has a legal right to the cash consideration, the right to object carries no rights, in and of itself, to the consideration, and the objector must prove its claimed legal right thereto. Defendant has failed to provide any proof in that regard, as it has not demonstrated that plaintiff assigned it that right through a designation form or contractual arrangement.

Instead, defendant relies on its payment of premiums, as well as language in the conversion plan, DFS's decision approving the plan, and the statute stating that the amount of the cash consideration is based partly on the amount of premiums that "such policyholder has properly and timely paid ***343** to the insurer" (Insurance Law § 7307 [e] [3]).[2] However, as noted above, this language pertains to how the considerations are calculated, rather than to whom they must be paid. The reference to "policyholder" immediately preceding the word "paid"—the latter of which is the word that defendant focuses on—supports our interpretation (*see Columbia Mem. Hosp. v*

Hinds, 65 Misc 3d 1205[A], 2019 NY Slip Op 51508[U], *4 [Sup Ct, Columbia County 2019]). Indeed, DFS's decision, in addressing similar comments raised by a different medical employer, concluded that an employer is not entitled to the consideration merely based on its payment of the premiums on an insurance policy, because the same provision refers to "policyholder," which may or may not be the person who paid the premium (*see Maple-Gate Anesthesiologists, P.C. v Nasrin*, 63 Misc 3d at 709 ["No distinction is made between a policyholder who pays the premium out of his (or her) own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. Insurance Law § 7307 does not confer an ownership interest . . . to anyone other than the policyholder"]). DFS explained in its decision that Insurance Law § 7307 defines the policyholders eligible to receive cash considerations but recognizes that they may have assigned such legal rights to others; that is why MLMIC's conversion plan includes a procedure for objections and holding considerations in escrow pending resolution of any disputes (*see id.* [noting that DFS's decision "tied eligibility for the objection and escrow process to when the policyholder had, in fact, assigned the right to cash consideration to another person or entity"]). According to DFS, the determination of who is entitled to the cash in these situations depends on the facts and circumstances of the parties' relationship and the applicable law. Defendant attempts to take this last portion of DFS's decision out of context, as if all determinations of the proper payee are based on the parties' relationship. However, that only applies if an objector raises a legitimate assertion that it is entitled to the consideration based on an assignment from the policyholder (*see id.*), which does not exist here. Accordingly, pursuant to ***344** the language of the statute, the conversion plan and DFS's decision, MLMIC should pay the cash consideration to plaintiff.

Having 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 (*see Urgent Med. Care, PLLC v Amedure*, 64 Misc 3d 1216[A], 2019 NY Slip Op 51188[U], *7 [Sup Ct, Greene County 2019] [noting that an employee who was a policyholder had "legal title to the proceeds" of MLMIC's demutualization, but requiring further proceedings based on possible unjust enrichment]). To recover under a theory of unjust enrichment, defendant must show (1) that plaintiff was enriched, (2) at defendant's expense, and (3) that it is against equity and good conscience to permit plaintiff to retain what is sought to be recovered by defendant (*see Mandarin Trading Ltd. v Wildenstein*, 16 NY3d 173, 182 [2011]; *New York State Workers' Compensation Bd. v Program Risk Mgt., Inc.*, 150 AD3d 1589, 1594 [2017]). "The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another" (*Clifford R. Gray, Inc. v LeChase Constr. Servs., LLC*, 31 AD3d 983, 988 [2006] [citations omitted]). "Generally, courts will look to see if a benefit has been conferred on the [plaintiff] under mistake of fact or law, if the benefit still remains with the [plaintiff], if there has been otherwise a change of position by the [plaintiff], and whether the [plaintiff's] conduct was tortious or fraudulent" (*Paramount Film Distrib. Corp. v State of New York*, 30 NY2d 415, 421 [1972] [citation omitted], *cert denied* 414 US 829 [1973]; *accord Goel v Ramachandran*, 111 AD3d 783, 791 [2013]; *Clark v Daby*, 300 AD2d 732, 732 [2002], *lv denied* 100 NY2d 503 [2003]). An allegation that the other party "received benefits, standing alone, is insufficient to establish a cause of action to recover damages for unjust enrichment" (*Goel v Ramachandran*, 111 AD3d at 791 [internal quotation marks and citations omitted]).

Here, the parties' employment agreement provided that plaintiff would perform professional services for defendant. In exchange, defendant would pay her a stated salary and provide specified benefits including, as relevant here, obtaining and paying the premiums for professional liability insurance covering plaintiff. The record indicates that defendant purchased, controlled and maintained such a policy from MLMIC in ***345** plaintiff's favor. Defendant was the policy administrator, selected the coverage and terms, and was responsible for all financial aspects of the policy. Notably, defendant paid annual premiums of approximately $25,710; plaintiff paid nothing toward the premiums and those amounts were not counted as income to plaintiff. Defendant received from MLMIC dividends, premium reductions and the return of premiums when the policy was canceled upon plaintiff leaving defendant's employ, all without any objection by plaintiff.

Defendant contends that it would be unjust for plaintiff to receive the cash consideration because defendant paid all the premiums on the MLMIC policy upon which the consideration is based. Plaintiff argues that she was the policyholder and the employment agreement provided the insurance policy as an employment benefit, so she is entitled to the cash consideration for her membership in MLMIC based on that policy. Although "[a] party may not recover

in unjust enrichment where the parties have entered into a contract that governs the subject matter" (*Pappas v Tzolis*, 20 NY3d 228, 234 [2012] [internal quotation marks, ellipsis and citation omitted]), the parties' employment agreement did not specifically address demutualization proceeds (*see Sergeants Benevolent Assn. Annuity Fund v Renck*, 19 AD3d 107, 112 [2005]). The lack of discussion in the contract on this topic is understandable, inasmuch as "no rights to demutualization proceeds arise until the demutualization is announced, absent a clear earlier agreement" (*Bank of N.Y. v Janowick*, 470 F3d at 274), and MLMIC's demutualization was unexpected, as it was the first for a professional liability insurance company in this state.

(2) Defendant asserts that the cash consideration would be a windfall to plaintiff. While true, the converse is also true; the consideration would be a windfall to defendant if defendant were to receive it. "Demutualization has been referred to as a 'windfall' in some cases because it is often unclear if parties knew the ownership stake even existed prior to the demutualization plan" (*Urgent Med. Care, PLLC v Amedure*, 2019 NY Slip Op 51188[U], *4 [citations omitted]; *see Columbia Mem. Hosp. v Hinds*, 2019 NY Slip Op 51508 [U] *5). The reality is that neither party here bargained for the demutualization proceeds. Moreover, neither party actually paid for them, because membership interests in a mutual insurance company are not paid for by policy premiums; such rights are "acquired . . . at no cost, but rather as an incident of the structure of ***346** mutual insurance policies," through operation of law and the company's charter and bylaws (*Dorrance v United States*, 809 F3d at 485; *see Columbia Mem. Hosp. v Hinds*, 2019 NY Slip Op 51508[U] *5).[3] Had defendant selected a different company to provide malpractice insurance to cover plaintiff, defendant would have met its contractual obligation to provide and pay for that insurance while plaintiff would have received the benefit of such coverage. Under those circumstances, neither party would receive a cash consideration. Thus, the demutualization proceeds were unexpected and will be a windfall to whichever party receives them. The fact that one party will receive these benefits does not mean that such party has unjustly enriched itself at the other's expense (*see Goel v Ramachandran*, 111 AD3d at 791), i.e., that it "is in possession of money or property that rightly belongs to another" (*Clifford R. Gray, Inc. v LeChase Constr. Servs., LLC*, 31 AD3d at 988).

Looking at the circumstances that the Court of Appeals listed for courts to consider when evaluating a claim of unjust enrichment (*see Paramount Film Distrib. Corp. v State of New York*, 30 NY2d at 421), the benefit of the cash consideration would be paid to plaintiff based on the statute and the conversion plan—a correct reading of the law, rather than a mistake. No factual mistake exists, other than the parties' mutual failure to consider the potential for demutualization when negotiating their employment agreement. Furthermore, both parties benefitted from defendant's fulfillment of its contractual obligation to provide malpractice insurance and pay for the premiums, inasmuch as the insurance provided coverage to protect the liability interests of plaintiff both individually and as an employee of defendant.[4] Neither party changed its position based on demutualization and plaintiff's conduct was neither tortious nor fraudulent. Hence, we conclude that defendant failed to meet its burden to establish its affirmative defense and counterclaim alleging unjust enrichment. Based on our analysis, we decline to follow *Matter of Schaffer, Schonholz & Drossman, LLP v Title* (171 AD3d 465 [2019], *supra*), which ***347** summarily held, without any analysis, that awarding an employee a cash consideration related to MLMIC's demutualization would constitute unjust enrichment where the employer had paid the policy premiums (*id.* at 465; *compare Maple-Gate Anesthesiologists, P.C. v Nasrin*, 182 AD3d at 985-986 [dismissing action by employer alleging unjust enrichment and conversion of demutualization proceeds by employees]). Accordingly, plaintiff was entitled to a declaratory judgment entitling her to receive the cash consideration from MLMIC's demutualization.

Garry, P.J., Egan Jr., Devine and Colangelo, JJ., concur.

Ordered that the judgment is reversed, on the law, with costs, defendant's cross motion denied, plaintiff's motion granted, and it is declared that plaintiff is solely entitled to the $74,747.03 cash consideration from Medical Liability Mutual Insurance Company's demutualization, plus interest for the time the proceeds were in escrow, and defendant's claim thereto is invalid.

Footnotes

1 Although defendant asserts that it employed plaintiff through February 2015, the precise dates of employment are unimportant for our purposes.

2 Defendant also relies on a 2016 MLMIC newsletter article discussing the proposed demutualization. The article states that, "[i]n most cases, the person or entity that paid the premium will be considered as the owner of the eligible policy," who is entitled to the cash consideration. This informal opinion, provided two years before the conversion, should not be relied upon because it is contradicted by later, formal information provided in the conversion plan and other documents.

3 "These rights are not transferable and upon termination of a policy, the policyholder receives nothing for any membership rights" (*Dorrance v United States*, 809 F3d at 485). These rights apparently have a monetary value only if the mutual insurance company demutualizes or liquidates while solvent (*see id.* at 486).

4 Defendant received protection from the policy because, as plaintiff's employer, defendant may also be named in a malpractice complaint based on plaintiff's actions.

APPENDIX H

2020 WL 4561195 (N.Y.Sup.), 2020 N.Y. Slip Op. 32580(U) (Trial Order)
Supreme Court of New York.
Kings County

**1 WYCKOFF HEIGHTS MEDICAL CENTER, Plaintiff,

v.

LEONORA MONROE & MLMIC INSURANCE COMPANY, Defendant.

No. 526139/18.
August 7, 2020.

Decision and Order

Present: Hon. Leon Ruchelsman.

August 7, 2020

**1 The defendant Dr. Leonora Monroe has moved pursuant to CPLR § 2221 seeking to reargue a decision and order dated February 13, 2020 which denied her motion, essentially, seeking the cash compensation pursuant to a conversion of the insurance company that provided professional liability insurance from a mutual insurance company to a stock company. The facts were adequately presented in the prior order and need not be recited again. In the prior decision the court based its holding denying the compensation to the defendant on three distinct factors. First, the only Appellate Division decision at the time, Schaffer, Schonholz & Drossman, LLP v. Title, 171 AD3d 465, 96 NYS3d 526 [1st Dept., 2019] and numerous lower court decisions all universally held the entity that paid the premiums was entitled to the compensation and not the individual such as the defendant in this case. Second, the court concluded the insurance premiums were not part of the defendant's compensation package and thus the compensation payment was not "hers" to receive. Third, the court explained that no party contemplated the possibility or **2 probability of such payments when the employment agreement was negotiated and entered into by the parties thus the defendant had no right to such payments.

Upon reargument, the defendant argues that a recent decision, Maple-Gate Anesthesiologists P.C. v. Nasrin, 182 AD3d 984, 122 NYS3d 840 [4th Dept., 2020] held the policyholder was entitled to the compensation and that consequently since the defendant is the policyholder the court should grant reargument and upon such reargument grant defendant's motion seeking summary judgement.

Conclusions of Law

A motion to reargue must be based upon the fact the court overlooked or misapprehended fact or law or for some other reason mistakenly arrived at in its earlier decision (Deutsche Bank National Trust Co., v. Russo, 170 AD3d 952, 96 NYS2d 617 [2d Dept., 2019]).

The recent Maple-Gate decision (supra) held that pursuant to Insurance Law § 7307(e)(3) the employee is the policyholder of the insurance policy and that therefore regardless of whether the institution pays the premiums the employee is entitled to the compensation following the demutualization.

There is no dispute that the employee, the defendant in this case is the policyholder. Indeed, the term policyholder is **3 defined "with respect to any Policy, the Person(s) identified on the declarations page of such Policy as the insured" (see, Plan

of Conversion, Article 2.1 "Policyholder"). The declarations page identifies Dr. Monroe as the insured, thus she is clearly the policyholder.

However, there is no dispute she did not make any premium payments and that all premium payments were made by the plaintiff. Insurance Law § 7307(e)(3) relied upon in Maple-Gate (supra) provides that "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" (id). While a plain reading of the statute forecloses any compensation due a policyholder who never paid any premiums, cases in the malpractice insurance context have interpreted that sentence to require the cash compensation be directed to the policyholder even though "such policyholder" did not make the payments. Thus, in Maple-Gate v. Anesthesiologists P.C. v. Nasrin, 63 Misc3d 703, 96 NYS3d 837 [Supreme Court Erie County 2019] the court explained that "no distinction is made between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an **4 employee compensation package. Insurance Law § 7307 does not confer an ownership interest in the stock or to the to the [sic] cash consideration to anyone other than the policyholder" (id). The Third Department adopted this approach and held the language of Insurance Law § 7307(e)(3) demands the policyholder receive the cash compensation even if such policyholder did not pay the premiums. The court in Schoch v. Lake Champlain Ob-Gyn, P.C., ___ AD3d ___, ___ NYS3d ___, 2020 WL 3271606 [3rd Dept., 2020]) explained the language in the statute which purports to require payment by the policyholder so that a ratio can be determined really only "pertains to how the considerations are calculated, rather than to whom they must be paid" (id) eliding the precise language of the statute. The Third Department relied upon Maple-Gate, (supra) and expressly declined to follow Schaffer, (supra). Thus, there can be no dispute there is a clear split in the departments concerning this issue. Schaffer (supra) based its holding on the fact it would be unjust to award the cash compensation to a party that did not make any of the premium payments. Maple-Gate (supra) and Schoch (supra) based their identical holdings on an interpretation of Insurance Law § 7307 that awards the cash compensation to the employee even though such employee did not make any of the premium payments. Consequently, a fresh analysis could prove helpful.

*2 It is clear that Insurance Law § 7307 did not contemplate a **5 demutualization plan and accompanying cash compensation payment where the policyholder did not pay the premiums herself (see, Demutualization of New York Domestic Property/ Casualty Insurers, New York State Bar Journal September/October 1998 by Peter Lencsis). Indeed, there can be no dispute that if such policyholder paid the premiums then of course such policyholder would be entitled to the cash compensation. This litigation arises only because the premiums were paid by the plaintiff on behalf of the defendant. In truth, the defendant's only legal claim to the cash compensation is an adherence to her designation as the 'policyholder' and all the rights that flow from that designation. However, a policyholder only maintains an entitlement to the cash compensation if the policyholder paid the premiums (Insurance Law § 7307). The arguments espoused in Maple-Gate (supra) and Schoch (supra) 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. Further, the demutualization plan itself contemplated competing claims by the institution that paid the premiums and the employee that received its benefits and established a dispute resolution mechanism to resolve such conflicts, acknowledging the tension created in this context. Thus, the plan explained that "in the event that a Policy Administrator or EPLIP Employer believes that it has a legal **6 right to receive any Cash Consideration allocated to an Eligible Policyholder, it may file an objection with MLMIC at any time prior to the date of the Superintendent's public hearing in accordance with the provisions set forth in Schedule I, and such objection will be resolved in accordance with such provisions" (§ 6.3(f) of the Plan of Conversion). Schedule I provided that in case such dispute arises the cash compensation will be placed in escrow until resolved. 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. The defendant argues in Reply that there can be no doubt and therefore no dispute that defendant is solely and legally entitled to the cash compensation based strictly upon the language of Insurance Law § 7307. The defendant argues that "in light of the specific statutory directive requiring that the Cash Consideration be paid to the policyholder, there is no rule of construction that would provide an implied right in equity to Plaintiff, which would inevitably directly contradict this statutory provision. There is no room for an interpretation that would engraft onto the statute a contrary result - even a result which might otherwise appear to be equitable or even sensible" (Affirmation in Reply ¶9). However, there can be no possible reason to create a dispute resolution forum if there can

be nothing to dispute. Thus, clearly, notwithstanding **7 Insurance Law § 7307 a court must conduct an independent analysis of the competing claims to the cash compensation.

Moreover, the decision of the Department of Financial Services dated September 6, 2018 likewise acknowledged the anomaly of a 'policyholder' who has not paid the premiums, conceding that such policyholder "might or might not be the person who paid the premiums" (see, Department of Financial Services decision, page 23). The Department of Financial Services decision correctly understood the statutory tension and explained that "Insurance Law § 7307(e)(3) defines the policyholders eligible to be paid their proportional shares of the purchase price, but also recognizes that such policyholders may have assigned such legal right to other persons. Therefore, the Plan appropriately includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to the payment in a given case" (id). Significantly, the Department of Financial Services decision did not limit any disputes only to cases of assignments, where again, there can be little basis for disagreement. Rather, the Department of Financial Services decision noted that "in order for a person to trigger the escrow, there must be evidence of a designation by the policyholder of that person to act as a Policy Administrator, which means to be designated by the policyholder as 'the agent of [the] Insured[] ... for the paying **8 of Premium, requesting changes in the policy, including cancellation thereof, and for receiving dividends and any return Premiums when due' " (id at 24). The plaintiff in this case had the sole authority to pay the premiums, request changes and had the sole right to receive dividends and to receive a return of the premiums. The Department of Financial Services decision contemplated the right of the plaintiff to present claims for the cash compensation. This reality was rejected by Maple-Gate (supra) and Schoch (supra) which held no such claims are possible sine the policyholder is entitled to the cash compensation regardless of who paid the premiums. Indeed, the defendant argues those decisions "explicitly rejected the theory that paying premiums or performing other administrative duties with respect to a policy is sufficient to establish an equitable claim" (Affirmation in Reply, ¶10). While that is certainly true there are clearly alternative approaches to the broader meaning of 'policyholder' especially where the policyholder did not pay the premiums. The Department of Financial Services decision certainly understood that competing claims rightly exist.

Moreover, the Department of Financial Services decision acknowledged that resolution of this issue could not be solved by simply resorting to the language of Insurance Law § 7307 to the exclusion of all other evidence since, as noted, that would not really resolve any actual conflict at all. Thus, without **9 resolving the tension the Department of Financial Services decision merely concluded that "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" (id). Thus, the difficulty of this issue was readily apparent throughout the entire demutualization process with no resolution suggested other than by arbitration or court. Clearly, this court cannot decide the tension by mere interpretation or parsing of Insurance Law § 7307. In fact, Insurance Law § 7307 proves unhelpful in this context as noted above. Therefore, the court must decide the issue only considering the specific facts of this case as well as the applicable law in reaching a determination. To the extent Maple-Gate (supra) and Schoch (supra) reached a different result, this court is not bound by those decisions (Schaffer, supra).

*3 As explained, the sole basis for the defendant's claim to the cash compensation is that she happens to be the policyholder of the insurance contract and thus has a superior legal and equitable claim to the cash compensation over the hospital. However, she did not bargain for such policy, she did not negotiate any of its terms and of course she did not pay the premiums. Indeed, she had no say whatsoever in the procuring of the insurance contract or the parameters and scope of such **10 contract and can therefore more accurately be termed a passive policyholder. More importantly, the insurance contract was not part of the defendant's compensation package. These factors are precisely the factors the Department of Financial Services decision contemplated must be examined to determine who is entitled to the cash compensation. This does not mean that an employee policyholder can never vindicate her claims to the cash compensation. The case of Columbia Memorial Hospital v. Hinds, 65 Misc3d 1205(A), 118 NYS3d 368 [Supreme Court Columbia County 2019] is instructive. In that case the court held the evidence clearly demonstrated that the insurance premiums were part of the physicians compensation package and thus the employee was entitled to the cash compensation. The defendant argues that whether or not the employee compensation package included the malpractice insurance is not relevant to this analysis because in any event the insurance payments were clearly a 'benefit' of compensation. While that is undoubtedly true the issue is not whether a benefit was conferred upon Dr. Monroe, the issue is

whether it was a component of her compensation package which conferred rights to her thereby. Since the insurance was not part of her compensation agreement she maintains no rights in the insurance and consequently no rights in the cash compensation.

The defendant points out that both Maple-Gate (supra) and Schoch (supra) held there were no questions the doctors in **11 question had the legal right to the cash compensation. However, as noted those decisions cannot really be squared with the holding reached in Schaffer (supra) which held that to the contrary, the hospital had the legal right to the cash compensation for the reasons enumerated. To be sure, Maple-Gate (supra) and Schoch (supra) have placed an undue dependence on the word 'policyholder' found in Insurance Law § 7307, where the precise facts of this case do not easily fit within that statutory context at all.

Moreover, it would unjust to award the cash compensation to the defendant who never paid for the premiums at any time during her employment. That truism further undermines any reliance upon Insurance Law § 7307 because awarding the cash compensation to her violates the express provision of the statute that requires the "policyholder has properly and timely paid" the premiums. Highlighting the word 'policyholder' to the exclusion of the requirement such policyholder pay the premiums impermissibly elevates one phrase of the statute over another. By the same token ignoring the phrase 'policyholder' suffers the same infirmity. Thus, resolution of this case can only be decided by resorting to legal principles that stand beyond the language of the statute. Those principles lead to the inescapable conclusion that the defendant is not entitled to the cash compensation.

Therefore, based on the foregoing, the motion seeking **12 reargument is denied.

So ordered.

DATED: August 7, 2020

Brooklyn N.Y.

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<<signature>>

Hon. Leon Ruchelsman

JSC

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