Court of Appeals
of the
State of New York

THE COLUMBIA MEMORIAL HOSPITAL,

Plaintiff-Appellant,

- against -

MARCEL E. HINDS, M.D.,

Defendant-Respondent.

OPPOSITION TO MOTION FOR LEAVE TO APPEAL AND TO CONSOLIDATE

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PRELIMINARY STATEMENT

Respondent Marcel E. Hinds, M.D. ("Dr. Hinds") respectfully makes this submission in opposition to the motion ("Motion") of Appellant The Columbia Memorial Hospital ("Hospital"), seeking leave to appeal the Third Department's affirmance of an order by the Supreme Court, Columbia County, which dismissed the Hospital's complaint in its entirety and awarded the proceeds from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC") to Dr. Hinds. Additionally, the Hospital seeks to consolidate its contemplated appeal with the pending case of *Kim E. Schoch, CNM v. Lake Champlain OB-GYN, P.C.*, Case No. APL-2020-0169 ("Schoch Appeal").

Initially, Dr. Hinds disputes that the split of authority in the Appellate Divisions necessitates review of the Third Department's determination by the Court of Appeals in the case at bar. At present, as set out in Plaintiff's Motion, the Third and Fourth Departments have properly analyzed the governing authorities and determined that an employer has no claim to a policyholder's share of the MLMIC demutualization proceeds ("Cash Consideration") absent an express assignment of that right by the policyholder, irrespective of whether the employer paid the policyholder's insurance premiums.

Additionally, on December 9, 2020 and subsequent to the Hospital's submission of this Motion, the Second Department has finally issued a decision

likewise concluding that a policyholder is solely entitled to the Cash Consideration. A copy of the Second Department's comprehensive decision in the case of *Maple Medical, LLP, v. Scott*, 2020 WL 7233649 (2d Dep't 2020) is appended hereto for the Court's consideration at **Appendix A**. In sum, three of the four Departments are now in accord.

Meanwhile, there are appeals pending that will give the First Department its first opportunity to limit or overrule its prior holding in favor of the policyholder's employer – rendered in an expedited proceeding on stipulated facts pursuant to CPLR 3222 – to its facts and likewise determine that the governing authorities require a determination in favor of the policyholder. *See Schaffer, Schonholz & Drossman v. Title*, 171 A.D.3d 465, 96 N.Y.S.3d 526 (1st Dep't 2019).

However, even if the Court of Appeals determines that its review is warranted, there no reason to consolidate this appeal with the Schoch Appeal. By the Hospital's own admission, the instant case involves a determination of the exact same legal issues the Court of Appeals already plans to address in *Schoch*. This being the case, we respectfully submit that it would be a needless expenditure of judicial resources for the Court of Appeals to consolidate these cases only to engender multiple duplicative briefings and arguments on the same issues.

Furthermore, there are numerous other pending appeals arising from the MLMIC demutualization which may be decided prior to the disposition of the

Schoch Appeal. Rather than continually consolidating these cases and necessitating even more needless briefings, it would be more logical to stay determination on further motions for leave so the Court of Appeals may render an expeditious determination in the Schoch Appeal. This will both preserve the rights of prospective appellants, such as the Hospital, and alleviate needless complexity in determining what is ultimately a simple issue of the proper interpretation of relevant statutory and regulatory authority related to the MLMIC demutualization.

QUESTIONS PRESENTED

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

The Second, Third and Fourth Departments properly determined that it does not. The First Department did not address this question, as the summary proceedings in *Schaffer* made no reference to Insurance Law § 7307, nor relevant provisions of the Plan of Conversion.

2. May the Hospital stake a claim the Cash Consideration under a theory of unjust enrichment based on its payment of insurance premiums, despite both Dr. Hinds and the Hospital having received the full benefit of their bargain under the parties' employment agreements, which contained no provision giving the Hospital the right to demutualization proceeds arising from Dr. Hinds' solely-owned policy?

The Third Department properly determined that the Hospital was not entitled to the proceeds, and that receipt of the Cash Consideration would be a windfall to either party where both the policyholder and the employer received all they were due under the parties' employment arrangement. The Second and Fourth Departments are in accord. The First Department summarily concluded otherwise, stating that an

employer was entitled to the demutualization proceeds under a theory of unjust enrichment based on stipulated facts and an incomplete record.

3. Did the Supreme Court make an improper factual finding that Dr. Hinds had paid for his malpractice premiums through deductions to his compensation, creating an issue of fact which rendered dismissal premature?

No, the Supreme Court properly determined that the only relevant facts under the applicable law were: (1) Dr. Hinds' identity as sole policyholder and (2) that Dr. Hinds had not assigned or designated the Hospital as the recipient of his share of the Cash Consideration. The Third Department did not directly address the issue of which party paid Dr. Hinds' MLMIC premiums, as the identity of which party paid the premiums is irrelevant for the purpose of this dispute.

STATEMENT OF UNDISPUTED FACTS

Dr. Hinds was employed by the Hospital from 2006 through August 2017 [R.133-34][1], as an OB-GYN physician under a written Employment Agreement [R.140-48]. The Employment Agreement set forth Dr. Hinds' compensation and benefits and required the Hospital to "maintain an individual occurrence-based medical malpractice insurance policy" on his behalf [R.143]. In other words, the Hospital agreed to provide Dr. Hinds with a malpractice insurance policy as part of his compensation in consideration for his professional services.

In accordance with its obligations under the Employment Agreement, the Hospital chose to provide Dr. Hinds with a malpractice insurance policy through MLMIC [R.165], for which Dr. Hinds was the named policyholder and owner [R.149]. Notably, the Employment Agreement was silent as to the disposition of any demutualization proceeds, should they ever arise.

In mid- to late-2018, MLMIC announced its intention to be sold to National Indemnity Company – a subsidiary of Berkshire Hathaway – and demutualize, meaning that MLMIC would be converted from a mutual insurance company owned by its policyholders to a stock insurance company owned by conventional shareholders [R.47].

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

In connection with MLMIC's proposed sale and demutualization, policyholders such as Dr. Hinds became eligible to receive compensation in exchange for the sale of their ownership interests in MLMIC [R.47]. Prior to its demutualization, MLMIC was a mutual insurance company, "organized, maintained and operated for the benefit of its members as a non-stock corporation." Insurance Law § 1211(a). Every MLMIC policyholder – including Dr. Hinds – was a member of MLMIC and had an ownership interest in the company. *Id.*

Importantly, a policyholder's ownership interest is not "bought" through payment of insurance premiums, but rather arises by operation of law fundamental to the structure of a mutual insurer. *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338 (3d Dep't 2020) (*citing Dorrance v. United States*, 809 F.3d 479, 482 [9th Cir. 2015]); *accord Maple Med., LLP, v. Scott*, 2020 WL 7233649, at *9 (2d Dep't 2020).

The requirements for demutualization of an insurer are set forth in the New York Insurance Law, and the governing terms and methodology of demutualization are set forth in a "plan of conversion," requiring approval by both a majority of MLMIC's policyholders and the New York State Department of Financial Services ("DFS"). Insurance Law § 7307(d).

In a demutualization, is the plan of conversion which governs and defines the rights of the parties and members. Insurance Law § 7307(d)-(e); *See Bank of New*

York v. Janowick, 470 F.3d 264, 266 (6th Cir. 2006) (demutualization plan defines rights to proceeds when mutual insurer demutualizes); *Praxair, Inc. v. Union Carbide Corp.*, 2008 WL 222321 *2 (D. Conn. Jan. 25, 2008) (plan sets forth allocation principals for distributing demutualization proceeds).

Insurance Law § 7307(e)(3) expressly sets forth the requirements for a plan of conversion promulgated by an insurer before a demutualization may take place. The statute provides, in pertinent part, the following: "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… shall be entitled to receive… consideration…" *Id.*

According to the mandates of the Insurance Law, the MLMIC Plan of Conversion, adopted by resolution of MLMIC's Board of Directors on May 31, 2018, incorporated the above-quoted language of the Insurance Law. The Plan also provided that the conversion "will provide Eligible Policyholders, or their Designees, with Cash Consideration… The amounts allocated to Eligible Policyholders shall vary according to the premiums properly and timely paid under their Eligible Policies." *Plan*, Art. 1 (emphasis added).

The September 6, 2018 decision issued by the DFS, which granted approval of MLMIC's sale and conversion, likewise confirms that it is Insurance Law §

7307(e)(3) that "explicitly defines those policyholders who are eligible to receive the purchase price consideration." *Id.*

As part of its approval process, DFS solicited oral testimony and written public comments from interested parties in MLMIC's demutualization. Many commenters were hospitals like the Hospital that believed they – rather than the policyholders – should be paid the Cash Consideration.

One such commenter referred to the language of Insurance Law § 7307(e)(3), arguing that the statute based the amount of cash consideration on premiums "properly and timely paid to an insurer," and that an who employer paid the MLMIC premiums, rather than the policyholder, should receive the Cash Consideration. *DFS Decision*, p. 23.

DFS rejected this interpretation of the Insurance Law. *Id.; Maple Med., LLP, v. Scott*, 2020 WL 7233649, at *9 (2d Dep't 2020) ("DFS considered, and rejected, this precise argument in its decision"); *see also GHVHS Medical Group, P.C. v. Cornell*, 2020 N.Y. Slip Op. 20104 (Sup. Ct. Orange Co. 2020) ("A close reading of the [DFS Decision] reveals that Plaintiff's claims were considered during the [MLMIC] demutualization process, but they did not change the language of what constitutes an 'eligible policyholder', even though [plaintiff] and others made objections at the public hearing").

The Insurance Law provides for no payment of Cash Consideration to anyone except the eligible policyholder and is unambiguous in this regard. *See* Insurance Law § 7307(e)(3); *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc.3d 703 (Sup. Ct. Erie Co. 2019) ("Insurance Law § 7307 does not confer an ownership interest in stock or to cash consideration to anyone except the policyholder"); *Maple Medical*, at *7 ("the statute is precise and it is clear and unambiguous").

Subsequent to adoption of the DFS Decision, a vote of the policyholders was held to determine whether to approve the Plan, which would clear the way for the ultimate sale and demutualization of MLMIC. As with other policyholders, Dr. Hinds had the right to vote. Ninety-five percent of the policyholders voted to approve the Plan.

The proper recipients of Cash Consideration are explicitly identified in the Plan, which provides that "[the] amount distributable to each Eligible Policyholder shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has *affirmatively designated* a Policy Administrator or EPLIP Employer to receive such amount on its behalf, in which case such amount shall be distributed to such Designee." *Plan*, Art. 6. (emphasis added).

The Plan defines "Designees" as "Policy Administrators and EPLIP [Employee Professional Liability Insurance Policy] Employers, in each case, to the extent designated by Eligible Policyholders to receive the portion of the Cash

Consideration allocated to such Eligible Policyholders." *Plan*, Art. 2. (emphasis added).

Accordingly, under the Plan, the only instance Cash Consideration is payable to anyone other than the eligible policyholder is where the eligible policyholder had executed an assignment in that party's favor or otherwise expressly designated another party to receive payment in the policyholder's stead.

There is no dispute that Dr. Hinds was the legal owner of his MLMIC Policy throughout the relevant three-year eligibility period, and he never assigned or otherwise designated the Hospital to receive his share of the Cash Consideration. After learning of MLMIC's impending demutualization, the Hospital demanded that Dr. Hinds designate the Hospital as recipient of the Cash Consideration claiming it paid his premiums and was the policy administrator [R.150-62]. Dr. Hinds refused to assign his rights to the Hospital [R.25, 134-36].

Following Dr. Hinds' refusal, the Hospital commenced this action [R.17-30]. Dr. Hinds moved to dismiss the Complaint under CPLR 3211(a)(1) and (a)(7) based on controlling legal authorities and lack of any contractual entitlement to the Cash Consideration [R.163-178]. Following extensive briefing, the Supreme Court determined that Dr. Hinds was entitled to the Cash Consideration as a matter of law, and dismissed the Hospital's complaint [R.5-16]. The Third Department affirmed, citing its lengthy and well-reasoned decision in *Schoch*.

LEGAL ARGUMENT

I. THE COURT OF APPEALS SHOULD DENY OR, IN THE ALTERNATIVE, STAY THE HOSPITAL'S MOTION

A. The weight of authority supports the Third Department's Decision, which need not be reviewed by the Court of Appeals

Dr. Hinds does not disagree that the issues involving MLMIC's demutualization have presented courts with a novel issue of law: whether an employer who paid a policyholder's premiums in consideration of the policyholder's professional services has any right to demutualization proceeds where the employer never bargained for such a right and otherwise received everything it was entitled under the parties' employment arrangement.

Dr. Hinds likewise does not dispute the apparent split in authority between the Second, Third and Fourth Departments, on one hand, and the First Department, on the other.

However, the split in authorities related to the MLMIC demutualization is of an unusual nature, in that it finds its genesis with *Schaffer*, an early case submitted directly to the First Department as a court of first impression under CPLR 3222. *Schaffer* was decided before almost every other MLMIC case. Accordingly, by virtue of its procedural posture, *Schaffer* was the only appellate precedent for over a year before any other case found its way to the Appellate Division.

The first court to decide the question was the Supreme Court, Erie County, in *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc.3d 703, 96 N.Y.S.3d 837 (Sup. Ct. Erie Co. 2019), *aff'd*, 182 A.D.3d 984, 122 N.Y.S.3d 840 (4th Dep't). In a lengthy and well-reasoned opinion granting the policyholder's motion to dismiss the employer's complaint, the court properly concluded that unambiguous statutory language foreclosed the possibility that the employer had any interest in MLMIC or any right to Cash Consideration in the absence of an assignment of that right, regardless of whether the employer paid the insurance premiums.

One week later, the First Department decided *Schaffer.* A review of submissions in *Schaffer* shows that the parties omitted certain undisputed material facts, made no mention of Insurance Law § 7307, and misleadingly referred to (but did not attach) a letter which allegedly informed the defendant-physician that she had been added onto the employers' professional liability insurance policy, giving the misleading impression that the defendant-physician's employer (rather than the physician) somehow had an ownership interest of the policy [R.202-203].

Inexplicably, in her legal brief [R.226-238], the respondent-physician in *Schaffer* failed to make any reference to Insurance Law §7307 – which indisputably controls demutualization – or to cite to any relevant sections of the Plan. In its reply, the petitioner-medical practice did not disclose or even hint at the statutory and regulatory scheme governing demutualization under the Insurance Law and the Plan

[R.238-256]. The medical practice even went so far as to title one section of its reply, "The Opposition Identifies No New York Law that Would Entitle Dr. Title to the Cash Consideration," conspicuously avoiding reference to Insurance Law §7307 [R.244].

Based on these omissions and the limited facts and legal arguments presented, the First Department summarily decided – by way of a four-sentence analysis – that the medical practice was entitled to the policyholder's money based on unjust enrichment [R.190-191]. Neither the parties' briefs nor the First Department's decision referenced any relevant provisions of the Plan, and neither Insurance Law §7307 nor the DFS Decision were mentioned once in the entire proceeding.

Indeed, *Schaffer* cited no New York law, but only two out-of-jurisdiction federal cases: *Ruocco v. Bateman, Eichler, Hill, Richards, Inc.,* 903 F.2d 1232 (9th Cir. 1990) and *Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Brotherhood. of Teamsters*, 2005 U.S. Dist. LEXIS 42877 (N.D. Ill. 2005).

Both cases addressed esoteric questions involving whether demutualization proceeds constituted "plan assets" under ERISA federal benefits law; a question which has no relevance to the instant dispute. *Maple Medical*, at *12 ("[The employer's] unjust enrichment claim must be analyzed under New York's common

law principles of unjust enrichment. The federal ERISA authorities [cited in *Schaffer*] are of no assistance in this regard").

Following *Schaffer*, the Hospital and other similarly-situated employers ceased squarely arguing the law and instead uniformly contended – notwithstanding its dearth of analysis– that *Schaffer* was binding on all lower courts in New York as the only Appellate Division precedent addressing MLMIC's demutualization.

For the most part, lower courts agreed, deeming it necessary to follow *Schaffer*, resulting in a number of lower court decisions in favor of employers in disputes over the Cash Consideration. The vast majority of Supreme Court decisions following *Schaffer* came about simply because no other MLMIC case had reached the Appellate Division.

In a rare exception, however, the Supreme Court in the instant case disagreed, held in favor of Dr. Hinds, and pointedly noted with respect to *Schaffer* that "courts are free to correct prior erroneous interpretations of the law [R.10]."

It took more than a year after *Schaffer* was decided for any other Appellate Division court to consider a MLMIC dispute. That court was the Fourth Department in *Maple-Gate.* The Fourth Department declined to follow the reasoning in *Schaffer*, and held that the Supreme Court properly granted the policyholder's motion to dismiss because the documentary evidence, consisting of the policy declaration pages showing the defendant as lawful policyholder, "established as a matter of law

that the plaintiff [employer] had no legal or equitable right of ownership to the demutualization payments." *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 182 A.D.3d 984 (4th Dept 2020).

Shortly thereafter, the Third Department followed suit, in *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338 (3d Dep't 2020) and *Shoback v. Broome Obstetrics & Gynecology, P.C.*, 184 A.D.3d 1000 (3d Dep't 2020). Employing the same comprehensive and thoughtful analysis as the Fourth Department, the Third Department likewise held that in the absence of an assignment, the policyholders were entitled to the Cash Consideration as a matter of law.

Following those decisions, the Supreme Court's determination in the instant case was affirmed by the Third Department under the same principles.

On December 9, 2020, five days before the date of this submission, the Second Department issued its long-awaited decision in *Maple Medical LLP v. Joseph Scott M.D.*, 2020 WL 7233649 (2d Dep't 2020), and five related appeals. In accord with the determinations of the Third and Fourth Departments, the Second Department systematically rejected each of the arguments advanced by the employer, reversed the decision of the Westchester County Supreme Court which had previously determined it was bound to follow *Schaffer*, and held that the policyholder-physicians were entitled to the Cash Consideration as a matter of law.

The first MLMIC appeals in the First Department are pending. With the benefit of available precedent and a new wealth of cases articulating the relevant authorities in this dispute, it is not unreasonable to predict that the First Department will re-analyze the issue, and either limit *Schaffer* to its holding or expressly overrule it.

It also bears mentioning that the Hospital mischaracterizes the dispositions of lower court cases in the Second Department as "uniformly [following] *Schaffer*," when this is demonstrably incorrect. *See, e.g.*, *GHVHS Medical Group, P.C. v. Cornell*, 2020 N.Y. Slip Op. 20104 (Sup. Ct. Orange Co. 2020); *AdvantageCare Physicians, P.C. v. Bitter*, Case No. 152327/2020, NYSCEF Doc. 97 (Sup Ct. New York County 2020); *Flushing Radiation Oncology Services, PLLC v. Kang*, 2020 WL 6386996 (Sup. Ct. Queens County 2020); *Healthcare Radiology and Diagnostic Systems, PLLC v. Goldman*¸ 2020 WL 6859513 (Sup. Ct. Westchester County 2020).

Regardless, in light of the Second Department's decision in *Maple Medical*, all contrary lower court decisions in the Second Department which might ostensibly support the Hospital's position have now been abrogated.

B. There is no meaningful distinction between the legal issues in this case and those of the Schoch Appeal

The relevant facts in the instant case and the Schoch Appeal are identical, as are the legal issues in contention. Both cases involve medical professionals who were MLMIC policyholders. In both cases the respective employers contend they

are entitled to the Cash Consideration because they paid the insurance premiums. In neither case did the policyholder assign or otherwise designate his employer to receive the Cash Consideration. Both employers served as policy administrators for the respective MLMIC policies and objected to the disbursement of Cash Consideration. Finally, both employers principally allege unjust enrichment as grounds for claiming entitlement to the Cash Consideration, despite never bargaining for the right to receive it.

Any factual distinctions between the two cases are immaterial, though the Hospital attempts to argue otherwise in its Motion. Specifically, in the instant case, Dr. Hinds' employment agreement contained a unique provision which provided that if Dr. Hinds were entitled to incentive compensation, MLMIC premiums paid by the Hospital on his behalf would offset and reduce any incentive compensation he might earn [R.141].

On appeal to the Third Department the Hospital contended that dismissal was premature because the Supreme Court improperly found, as a matter of law, that Dr. Hinds actually paid the premiums by a deduction to his employment compensation. Thus, the Hospital mischaracterized the Supreme Court's decision as holding that Dr. Hinds was entitled to the Cash Consideration *because he paid the premiums*.

The Hospital raises this same argument again on the instant Motion, contending there is a meaningful factual distinction between this case and the Schoch

Appeal which needs to be addressed by the Court of Appeals. However, as previously established, entitlement to the Cash Consideration turns on two simple inquiries: (1) the identity of the policyholder; and (2) whether the policyholder ever assigned his right to the Cash Consideration to his employer. *Who* paid any portion of the policyholder's MLMIC insurance premiums is irrelevant.

Set forth in proper context, the Supreme Court held as follows:

> *The statute* [Insurance Law §7307(e) *repeatedly refers to those eligible for cash consideration as the 'policyholder. It is important to note that '[n]o 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 employee compensation package. Insurance Law 7307 does not confer an ownership interest...on anyone other than the policyholder.*"
>
> Here, the defendant is clearly the policyholder, and the plaintiff the policy administrator. The documentary evidence — the Employment Agreement — establishes that the insurance premiums were deducted before the defendant received any incentive pay. That is, the defendant was to receive incentive pay, 65% of the amount by which his revenue exceeded the expenses paid by the hospital, and one [of] the expenses being his medical malpractice insurance. Stated differently, *the defendant would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance. Further, under the plain language of the Insurance Law, the cash consideration cannot be given to the plaintiff unless the defendant signs the agreement to do so. Here, the defendant has not signed such an agreement, and given the circumstances of this case — the Employment Agreement which required him to*

> *pay the cost of his malpractice premiums by way of his salary incentives — does not have to agree to do so*.
>
> The plaintiff's entire argument, as framed by the complaint, focuses on the bare and incorrect assertion that the hospital paid the policy premiums *and that equity, not ownership, dictates that it should be the recipient of the cash contribution*. However viewed, this assertion is belied by the terms of the Employment Agreement, whereby the defendant's incentive compensation is reduced by the policy premiums. On this record, equity does not dictate that the plaintiff should be compensated.

[R.11-12] (emphasis added) (internal citations omitted).

The Supreme Court did not, in any way, make a factual finding that Dr. Hinds paid the MLMIC premiums through reductions in his compensation. Rather, the Supreme Court correctly determined that Dr. Hinds was the policyholder legally entitled to Cash Consideration, and that the Cash Consideration could not be given to the Hospital unless Dr. Hinds signed an agreement to do so.

Nowhere in the decision did the Supreme Court find that Dr. Hinds paid the premiums, or that he was entitled to the Cash Consideration *on that basis*. What the decision actually stated was that applicable law governed demutualization and payment of the Cash Consideration; that *equity* did not supersede the law; and that even assuming that equity could be a factor, it would not serve to gift the Hospital the Cash Consideration where the parties' contract placed the onus of paying premiums on Dr. Hinds, and *not* on the Hospital.

As the Supreme Court and Third Department clearly understood, the issue of which party paid the premiums is a red herring. The *sole* dispositive question in this case is whether Dr. Hinds, as the policyholder eligible to receive demutualization proceeds from the sale of his mutual ownership interest in MLMIC, ever *assigned* his legal right to the Cash Consideration to the Hospital. Since no such assignment was ever made, the Hospital had no right to the Cash Consideration as a matter of law.

While this issue was not squarely addressed by the Third Department, this was neither an oversight nor an error. As the Third Department rightly determined, "[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 a third-party." *Columbia Mem'l Hosp. v. Hinds*, 2020 WL 6493499, at *2 (3d Dep't 2020). Accordingly, the Third Department had no reason to inquire into which party paid the premiums, because it is irrelevant as a matter of law. The facts of Dr. Hinds' status as sole policyholder and his refusal to execute an assignment were themselves fatal to the Hospital's claims, just as they were to the employers in *Schoch, Shoback, Maple-Gate* and *Maple-Medical*.

C. The Hospital's motion should be denied or, in the alternative, stayed

Based on the dispositions in the Second, Third and Fourth Departments, and the pending appeals in the First Department, it is likely the Appellate Division will reach a consensus on this issue without the need for intervention by the Court of Appeals. Accordingly, we do not believe review of our case by the Court of Appeals is warranted.

That being said, we recognize that the Court of Appeals has already granted leave in the Schoch Appeal, and thus it is not feasible at this point to contend that review is not merited, or that an ultimate determination on the MLMIC issue by this Court should not be made. However, in light of the Court's pending review of the Schoch Appeal, there is no specific reason that *our case* merits review as distinct from any of dozens, if not hundreds, of other essentially identical disputes regarding the MLMIC demutualization proceeds.

In the interest of judicial economy and prompt resolution of the overarching issues by the Court of Appeals, we respectfully submit that determination of this Motion should be stayed pending the outcome in the Schoch Appeal. If the Court of Appeals agrees with the determinations of the Second, Third and Fourth Departments, leave may be denied accordingly, without resulting prejudice to the rights of either party.

II. THERE IS NO REASON TO CONSOLIDATE THIS CASE WITH THE SCHOCH APPEAL, AS THE LEGAL ISSUES IN BOTH APPEALS ARE IDENTICAL AND IT SERVES ONLY TO COMPLICATE THE PENDING APPEAL IN SCHOCH

The Hospital seeks to consolidate this appeal with the Schoch Appeal for the stated purpose of "simultaneous briefings and oral arguments." The basis for the Hospital's request is that "there is an identity of issues and facts that are before this Court on this appeal and the Schoch Appeal."

There is no benefit to consolidating this proceeding with the Schoch Appeal. As explicitly stated by the Hospital, and as set forth above, the parties in both cases are identically situated and the operative issues in both cases are likewise the same. The only result from a consolidation of these cases would be to increase the number of briefs and oral arguments this Court will be made to consider on the same legal issues.

Additionally, the Second Department, just days prior to this submission, has simultaneously decided six appeals in favor of policyholders in *Maple Medical*, which could very well precipitate additional motions for leave by the employer in *those* cases. Rather than opening the door to continued consolidation of these cases as they arrive at the Court's doorstep, the Court should stay determination on this Motion until it decides the Schoch Appeal, which will be dispositive in most, if not all cases involving the MLMIC demutualization proceeds.

CONCLUSION

Based on the foregoing, Dr. Hinds respectfully requests this Court deny the Hospital's motion for leave to appeal. In the alternative, Dr. Hinds requests that this Court decline the Hospital's request to consolidate and stay determination of this Motion pending a disposition in the pending case of *Kim E. Schoch, CNM v. Lake Champlain OB-GYN, P.C.*, Case No. APL-2020-0169.

Dated: December 11, 2020

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Appendix A

2020 WL 7233649
Only the Westlaw citation is currently available.
Supreme Court, Appellate Division,
Second Department, New York.

Maple Medical, LLP, respondent,
v.
Joseph Scott, etc., appellant, et al., defendant.

2019–09157 (Index No. 51103/19)
|
December 09, 2020

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ALAN D. SCHEINKMAN, P.J. MARK C. DILLON COLLEEN D. DUFFY FRANCESCA E. CONNOLLY, JJ.

Argued—October 13, 2020

OPINION & ORDER

***1** APPEAL by the defendant Joseph Scott, in an action, inter alia, for a declaratory judgment and to recover damages for unjust enrichment, from an order and judgment (one paper) of the Supreme Court (Lawrence H. Ecker, J.), dated July 5, 2019, and entered in Westchester County. The order and judgment, insofar as appealed from, denied that branch of that defendant's motion which was for summary judgment on his counterclaim for a judgment declaring that he is entitled to receive certain funds in the amount of $128,148, granted that branch of the plaintiff's cross motion which was for summary judgment declaring that it is entitled to receive those funds, declared that the plaintiff is entitled to receive the subject funds, and directed the escrow agent to release the funds to the plaintiff.

SCHEINKMAN, P.J. In 2018, the defendant Medical Liability Mutual Insurance Company (hereinafter **MLMIC**) was converted from a mutual insurance company to a stock insurance company. The question presented on this appeal is whether the cash consideration paid as part of the conversion belongs to a physician who was a policyholder of a medical malpractice insurance policy issued by **MLMIC** or to the medical practice that employed the physician and paid the premiums on the policy. The Departments of the Appellate Division have divided on this question. We agree with our colleagues in the Third and Fourth Departments that the funds belong to the physician-policyholder and respectfully do not agree with our colleagues in the First Department that the funds should be paid over to the medical practice-employer.

RELEVANT FACTS

Prior to the conversion which precipitated this dispute, **MLMIC** was a mutual insurance company. Pursuant to Insurance Law § 1211(a), mutual insurance companies are organized, maintained, and operated for the benefit of their members and "[e]very policyholder [in a mutual insurance company] shall be a member of such corporation." As members, policyholders "receive both membership interests (e.g., the right to elect directors and the right to receive a proportionate share of the company if it liquidates) and contract rights (i.e., the obligations of the insurance company under the policy)" (*Bank of New York v. Janowick,* 470 F3d 264, 267 [6th Cir]).

The defendant Joseph Scott was a physician employed by the plaintiff, Maple Medical, LLP (hereinafter Maple Medical), a medical practice in White Plains, pursuant to the provisions of an employment agreement dated February 29, 2012. In exchange for Scott's services, Maple Medical agreed to pay him a base salary and additional compensation and also agreed to pay certain expenses and fringe benefits on his behalf. Among these expenses and fringe benefits were payment of medical insurance premiums for Scott and his family, and Scott's medical license and registration fees, his continuing professional education expenses, his cellular telephone and pager costs, and the premiums on an occurrence type professional liability insurance policy with specified coverage minimums.

***2** Maple Medical also employed five other physicians, Lisa H. Youkeles, Diana Arevalo, Diana Goldenberg, Nina Sundaram, and Mario Mutic. The employment agreements for these physicians also required Maple Medical to pay the premiums for their professional liability insurance policies.

Scott and the other five physicians each obtained medical malpractice insurance policies from **MLMIC**. Under these policies, each of the physicians was the sole insured and the

sole policyholder. Scott, as well as Arevalo, Goldenberg, and Sundaram, executed a form designating Maple Medical as "Policy Administrator," making Maple Medical the "agent" "for the paying of Premium, requesting changes in the policy, including cancellation thereof, and for receiving dividends and any return Premiums when due." Youkeles and Mutic did not designate Maple Medical as Policy Administrator for their policies.

In 2015, the Berkshire Hathaway Group (hereinafter Berkshire Hathaway) approached **MLMIC** about a possible acquisition of **MLMIC** by the Medical Protective Company (hereinafter MPC), an affiliate of Berkshire Hathaway. **MLMIC's** executive committee chose not to pursue that acquisition, but Berkshire Hathaway revised its expression of interest to propose National Indemnity Company (hereinafter NICO) as the purchaser instead of MPC, among other concessions. **MLMIC's** executive committee voted to pursue the revised expression of interest, and subsequently, its board of directors also voted to pursue the revised expression of interest "as being in the best long-term interest of **MLMIC's** Policyholders."

On July 15, 2016, **MLMIC** announced the proposed transaction publicly, and on July 16, 2016, it applied to the Superintendent of the New York Department of Financial Services (hereinafter DFS) for permission to convert **MLMIC** to a stock insurance company. In its initial email announcement of the proposed conversion and subsequent newsletter, **MLMIC** stated that, "[o]nce the transaction is finalized, each owner of an eligible policy will be entitled to receive in cash a proportionate share of all of the cash consideration paid by [NICO]. In most cases, the person or entity that paid the premium will be considered as the owner of the eligible policy."

Insurance Law § 7307 governs the conversion process from a mutual insurance company into a stock insurance company. The statute requires the insurer to apply to the Superintendent of DFS, pursuant to a corporate resolution, for permission to convert (*see* Insurance Law § 7307[b]). Once such permission is obtained, the parties to the proposed transaction must prepare a plan of conversion for approval by the Superintendent (*see* Insurance Law § 7307[d], [e]). The conversion plan must provide for the exchange of the equitable share of each eligible mutual policyholder for securities or other consideration provided by the stock corporation into which the mutual insurer is to be converted. The statute states that "each person who had a policy of insurance in effect at any time during the three year period" immediately preceding the adoption of the resolution "shall be entitled to receive" the consideration (Insurance Law § 7307[e][3]). The equitable share of each policyholder in the mutual insurer is determined by the ratio which the net premiums (gross premiums less return premiums and dividends paid) properly and timely paid by the policyholder over the three-year period bear to the total net premiums received by the mutual insurer from all eligible policyholders (*see id.*).

***3** In conformity with the statute, the plan of conversion for **MLMIC** provided that, as a result of **MLMIC's** demutualization, "the Eligible Policyholders, or their Designees, will receive Cash Consideration in consideration for the extinguishment of their Policyholder Membership Interests." The Policyholder Information Statement defined "Eligible Policyholder" as the holder of "[a]ny Policy that was In Effect at any time from July 15, 2013 ... through the Record Date (July 14, 2016)." It defined "designees" as "Policy Administrators ... to the extent designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders." Scott, as well as the other five physicians, declined Maple Medical's requests to be designated to receive the cash consideration.

DFS held a public hearing on the proposed plan of conversion on August 23, 2018. Richard B. Frimer, Maple Medical's managing partner, attended the hearing and expressed opposition to the concept of distributing the payout to employees who never directly contributed any funds toward their premiums. Frimer argued that many third parties, such as medical groups and hospitals, paid medical malpractice premiums attributable to employees and it was illogical to refund premiums to individual policyholders who themselves had not paid the premiums. According to Frimer, "the equities lie with the payments upon demutualization going to the party or parties that pay the premium." In response to questions from the Superintendent of DFS, Frimer acknowledged that Maple Medical had paid the premiums for employees who had not designated Maple Medical as policy administrator. Frimer expounded that Maple Medical would receive a renewal bill and pay it promptly regardless of whether the form indicated that Maple Medical was the policy administrator. Frimer conceded that the policyholders are the individual physicians. He also stated that dividends paid by **MLMIC** would be used to reduce the amount of the premiums.

On September 6, 2018, DFS issued a decision approving the demutualization and plan of conversion (*Matter of Medical Liab. Mut. Ins. Co. [National Indem. Co.],* https://www.dfs.ny.gov/system/files/documents/2019/01/**mlmic**_decision_20180906.pdf [NY St Dept of Fin Servs, Sept. 6, 2018, Vullo, Supt.] [hereinafter DFS Op]). In its decision, DFS noted that there was a dispute as to whether the cash consideration should be paid to policyholders or to the medical groups and hospitals who paid premiums on behalf of policyholders. DFS stated that section 7307(e) of the Insurance Law refers to "policyholder," who might or might not be the person who paid the premium (DFS Op at 23). DFS also observed that section 7307(e) recognizes the possibility that policyholders may have assigned their legal rights to others. Rather than deny or delay demutualization because of this dispute, the plan set forth an objection procedure for the resolution of disputes related to which party is entitled to the cash consideration. Under this procedure, the cash consideration attributable to each claim in dispute would be held in escrow until the claim is resolved by agreement or by a nonappealable order of an arbitration panel or court with proper jurisdiction. DFS determined that this objection procedure was a "reasonable framework" for resolving disputes between policyholders and entities claiming to be policy administrators (DFS Op at 23).

Maple Medical challenged the DFS decision by commencing a hybrid proceeding pursuant to CPLR article 78 and declaratory judgment action. On December 28, 2018, the Supreme Court dismissed the petition, determining that it was moot because the demutualization had occurred and more than $2.3 billion in cash payments had been distributed to policyholders pursuant to the DFS decision and the conversion plan (*see Maple Medical LLP v New York State Dept. of Fin. Servs.,.* Sup Ct, Westchester County, Dec. 28, 2018, Schwartz, J., index No.65929/2018). The court further determined that, in any event, the DFS decision had a rational basis and was not arbitrary and capricious (*see id.*).

***4** PROCEDURAL HISTORY

In January 2019, Maple Medical commenced six separate actions in the Supreme Court, Westchester County, seeking to establish its entitlement to recover the payments due under the conversion plan on account of the **MLMIC** policies held by Scott and the other five physicians. The parties then entered into stipulations that "**MLMIC** shall hold the funds in escrow pending a further stipulation of the parties or a final non-appealable order or judgment of the Court."

In its complaints, Maple Medical asserted causes of action against each physician and **MLMIC** for judgments declaring that it was entitled to the cash consideration, to recover damages for breach of contract, to direct **MLMIC** to release the applicable funds from escrow to Maple Medical in accordance with Insurance Law § 7307, and for unjust enrichment. Each physician separately answered the complaint and asserted counterclaims for judgments declaring that they were the parties entitled to the cash consideration.

In the cases involving Scott, Goldenberg, and Sundaram, those defendants separately moved for summary judgment on their respective counterclaims and for summary judgment dismissing the respective complaints insofar as asserted against each of them. In those cases, Maple Medical opposed the separate motions of those defendants and cross-moved for summary judgment on the respective complaints. In the cases involving Youkeles, Arevalo, and Mutic, Maple Medical moved for summary judgment on the complaints asserted against each of those defendants. In those cases, the defendants opposed Maple Medical's motions and separately cross-moved for summary judgment on their respective counterclaims and for summary judgment dismissing the respective complaints insofar as asserted against each of them.

In the present case, involving Scott, the Supreme Court (Lawrence H. Ecker, J.) addressed "the same single legal issue" at "the heart of all of the actions"—"whether the physician employee or the employer partnership is entitled to a distribution payment made by" **MLMIC** (*Maple Med. LLP v. Scott,* 64 Misc.3d 909, 910 [Sup Ct, Westchester County]). At the time the court decided the matter, there was only one appellate decision on point—that of the Appellate Division, First Department, in *Matter of Schaffer, Schonholz & Drossman, LLP v Title* (171 AD3d 465 [hereinafter *Schaffer*]). *Schaffer* held that the employer practice group was entitled to the payout based upon a theory of unjust enrichment (*see Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d at 465; *Maple Med. LLP v. Scott,* 64 Misc.3d at 912).

In this case, the Supreme Court held that it was bound by stare decisis to apply the precedent established by *Schaffer* in the absence of a contrary ruling from this Court or the Court of Appeals (*see Maple Med. LLP v. Scott,* 64 Misc.3d at 912). Since *Schaffer* involved identical facts and an identical legal

issue, the court applied *Schaffer,* finding that, in any event, "the conclusions drawn in the First Department's decision [were] persuasive" (*Maple Med. LLP v. Scott,* 64 Misc.3d at 912). Consequently, the court denied Scott's motion, granted Maple Medical's cross motion, declared that Maple Medical was "entitled to the receipt from the escrow agent currently holding [the] funds due it ... plus accrued interest," and directed the escrow agent to pay the funds within fifteen days of service of the order with notice of entry upon the escrow agent (*id.* at 913).

***5** In the other five cases, the Supreme Court relying on its rationale in *Scott,* declared that Maple Medical, not the defendant physicians, was entitled to the cash contribution and directed that the escrow agent release the funds to Maple Medical (*Maple Med. LLP v. Youkeles,* 64 Misc.3d 1213[A], 2019 N.Y. Slip Op 51131[U] [Sup Ct, Westchester County]; *Maple Med. LLP v. Arevalo,* 64 Misc.3d 1213[A], 2019 N.Y. Slip Op 51127[U] [Sup Ct, Westchester County]; *Maple Med. LLP v. Goldenberg,* 64 Misc.3d 1213[A], 2019 N.Y. Slip Op 51128[U] [Sup Ct, Westchester County]; *Maple Med. LLP v. Sundaram,* 64 Misc.3d 1213[A], 2019 N.Y. Slip Op 51130[U] [Sup Ct, Westchester County]; *Maple Med. LLP v. Mutic,* 64 Misc.3d 1213[A], 2019 N.Y. Slip Op 51129[U] [Sup Ct, Westchester County].

Scott appeals and the other defendants each separately appeal. While the six appeals have been prosecuted on separate records and separate briefs, the appeals were argued together. This opinion addresses the issues tendered for our consideration and the other appeals are resolved by separate orders issued in reliance upon the views expressed herein.

LEGAL ANALYSIS

I. Stare Decisis

In their respective briefs, Maple Medical and Scott debate whether the Supreme Court appropriately concluded that it was bound to follow the First Department's decision in *Schaffer.* Scott, in particular, contends that the Supreme Court was not bound by *Schaffer* because *Schaffer* 's holding conflicts with prior decisions of this Court and the Court of Appeals and was erroneously decided. Scott also contends that *Schaffer* was not binding because of its distinct procedural posture and because the physician in that case did not raise the specific arguments raised by Scott here.

In *Schaffer,* the parties submitted facts to the First Department pursuant to CPLR 3222(b)(3), requesting a declaratory judgment as to whether the employer practice group or employee physician was entitled to the cash consideration and an order to facilitate transfer of the cash consideration to the prevailing party (*see Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d at 465). Scott points out that in *Schaffer,* the **MLMIC** policy was issued to the employer, and the employee physician had only been added onto the employer's policy. Scott also contends that, while the physician in *Schaffer* argued that the plan of conversion made clear that she was entitled to the cash consideration because she was the policyholder and did not designate the group to receive the funds, she did not raise arguments under Insurance Law § 7307, as Scott does here.

While the parties' contentions about stare decisis have largely been overtaken by subsequent developments, we think it important to correct the misperception inherent in Scott's argument.

The Appellate Division is a single state-wide court divided into departments for administrative convenience (*see Mountain View Coach Lines v Storms,* 102 A.D.2d 663, 664). While the Supreme Court is bound to apply the law as promulgated by the Appellate Division in its own department, where the issue has not been addressed within that department, the Supreme Court is obligated to follow the precedent set by the Appellate Division of another department until its home department or the Court of Appeals pronounces a contrary rule (*see Phelps v. Phelps,* 128 AD3d 1545, 1547; *D'Alessandro v. Carro,* 123 AD3d 1, 6; *Mountain View Coach Lines v. Storms,* 102 A.D.2d at 664). In applying an Appellate Division precedent, it is not open to the Supreme Court to consider whether the precedent was correctly established—that is a matter that may be considered by another department or by the Court of Appeals. Thus, regardless of whether the Supreme Court agreed with the analysis provided by the First Department in reaching its conclusion in *Schaffer,* the Supreme Court was bound to apply it, in the absence of a contrary precedent from another department or from the Court of Appeals. It is only where two departments have issued conflicting rulings on a point of law that a trial court, situated in neither and whose department has not spoken, may follow the holding that it deems to comport most closely with the law (*see* Siegel & Connors, N.Y. Prac § 449 at 860 [6th ed], citing *Darko v. New York City Tr. Auth.,* 13 Misc.3d 203, 206 [Sup Ct, Bronx County]). Thus, putting aside the happenstance that the Supreme Court here expressed its agreement with the views announced by the First

Department in *Schaffer,* the Supreme Court appropriately concluded that it was bound to follow what was then the only extant binding appellate precedent.[1] The niceties of the procedural distinctions between the cases and the precise arguments raised do not give the Supreme Court a basis for disregarding an on-point ruling of a department of the Appellate Division.

***6** These considerations, however, do not apply to this Court. While we should accept the decisions of the other departments as persuasive, we are free to reach a contrary result (*see State of New York Mtge. Agency v Braun,* 182 AD3d 63, 75; *Weaver v. State of New York,* 91 AD3d 758, 761; *Mountain View Coach Lines v. Storms,* 102 A.D.2d at 665). With respect to the issue presently before us, after the Supreme Court rendered its determination, the Third and Fourth Departments addressed the same exact issue and each has reached a result contrary to that of the First Department.

In *Maple–Gate Anesthesiologists, P.C. v Nasrin* (182 AD3d 984 [hereinafter *Maple–Gate Anesthesiologists, P.C.*]), the Appellate Division, Fourth Department, in a memorandum decision, held that, pursuant to Insurance Law § 7307(e)(3), the defendant employees were entitled to the **MLMIC** demutualization payments as the policyholders of the **MLMIC** professional liability policy, notwithstanding that the plaintiff medical group had paid the insurance premiums. The Fourth Department stated that, although the defendant employees had assigned some of their rights as policyholders to their employer, they had not designated the employer to receive the demutualization payments. The Fourth Department further stated that "[t]he mere fact that [the employer] paid the annual premiums on the policies on [the employees'] behalf does not entitle it to the demutualization payments (*cf. Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d 465, 465)" (*Maple–Gate Anesthesiologists, P.C. v Nasrin,* 182 AD3d at 986). The "*cf.*" citation to *Schaffer* reflects the Fourth Department's awareness of that decision as well as its disagreement with it.

Shortly thereafter, in *Schoch v. Lake Champlain OB–GYN, P.C.* (184 AD3d 338, *lv granted* 35 NY3d 918 [hereinafter *Schoch*]), the Third Department, in an opinion by Justice Robert C. Mulvey, held that the plaintiff, a certified nurse midwife and obstetrics/gynecology nurse practitioner, was entitled to the cash consideration from the **MLMIC** conversion, even though her employer, the defendant medical group, had paid the premiums on the professional liability policy as required by an employment agreement. Contemporaneously, the Third Department applied its *Schoch* ruling to reverse the denial of summary judgment to the plaintiff employee in *Shoback v Broome Obstetrics & Gynecology, P.C.* (184 AD3d 1000 [hereinafter *Shoback*]).[2] In *Shoback,* while the Supreme Court in the order on appeal had stated its inclination to agree that the plaintiff employee there was entitled to the cash consideration, that court, like the Supreme Court in this case, found that it was constrained to follow *Schaffer* (*see Shoback v Broome Obstetrics & Gynecology, P.C.,* 184 AD3d 1000). In *Shoback,* the Third Department, like us, concurred that the Supreme Court was bound by *Schaffer;* however, the Third Department expressed its disagreement with *Schaffer* and declined to follow it (*see Shoback v Broome Obstetrics & Gynecology, P.C.,* 184 AD3d 1000).

Given the division of opinion among the departments of the Appellate Division, we must decide, subject to ultimate determination by the Court of Appeals,[3] what the appropriate rule of law ought to be for this Department, giving due weight to the views expressed by our colleagues in the other departments. Of necessity here, our view will align with at least one department and will depart from that of at least one department.

7 II. The Policyholder is Entitled to the Proceeds of the **MLMIC Demutualization*

The plain language of Insurance Law § 7307, the plan of conversion, and the DFS decision make clear that the policyholder is entitled to the consideration paid in connection with the **MLMIC** demutualization.

Until 2018, **MLMIC** was a mutual insurance company. It was then converted into a stock insurance company. The conversion was governed by the detailed provisions of the Insurance Law. Section 7307(e)(3) of that statute provides that, when a mutual insurance company demutualizes, the plan of conversion shall include "[t]he manner and basis of exchanging the equitable share of *each eligible mutual policyholder* for securities or other consideration, or both, of the stock corporation into which the mutual insurer

is to be converted and the disposition of any unclaimed shares" (emphasis added). The statute specifically requires that the plan of conversion

> "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 ... 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"

(*id.* [emphasis added]). As the Third Department explained in *Schoch* (184 AD3d at 342), that portion of the statute "explains who is entitled to receive the consideration," which is "anyone who had a policy of insurance in effect during the relevant time period." The statute is precise and it is clear and unambiguous.

In conformity with the statute, the **MLMIC** plan of conversion also makes clear that the policyholders are the ones entitled to the cash consideration unless there has been a specific designation to an identified policy administrator. The preamble to the plan of conversion states that "*the Eligible Policyholders, or their Designees,* will receive Cash Consideration in consideration for the extinguishment of their Policyholder Membership Interests" (emphasis added). Ensuing articles of the plan consistently reflect that the payments belong to the policyholders in the absence of an express designation to a policy administrator.

Article 1 of the plan of conversion states that the "amounts allocated to *Eligible Policyholders* shall vary according to the premiums properly and timely paid under their Eligible Policies, and *shall be payable to Eligible Policyholders, or their Designees,* as described in Article 8 of this Plan of Conversion, in respect of the extinguishment of all Policyholder Membership Interests" (emphasis added). "Eligible Policyholder" is defined in the **MLMIC** Policyholder Information Statement as the "[t]he Policyholder of an Eligible Policy," which is defined as "[a]ny Policy that was In Effect at any time from July 15, 2013 ... through the Record Date (July 14, 2016)." The definition of Eligible Policyholder states that "each such Eligible Policyholder shall be entitled to an allocation of the Cash Consideration." "Designee" is defined as "Policy Administrators ... to the extent designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders."

***8** Article 6, Section 6.3(f) of the plan of conversion states: "The amount distributable to each Eligible Policyholder *shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has affirmatively designated a Policy Administrator* or EPLIP Employer *to receive such amount on its behalf,* in which case such amount shall be distributed to such Designee" emphasis added). Article 8, Section 8.2(a), titled, "Allocation of Cash Consideration for the Eligible Policyholders," states, "*Each Eligible Policyholder (or its Designee*) shall receive a cash payment in an amount equal to the applicable Conversion Payment" (emphasis added).

The **MLMIC** Policyholder Information Statement and the Notice to Policyholders also made clear that the policyholder was entitled to the cash consideration unless he or she affirmatively designated, in writing, a policy administrator to receive the funds. The Policyholder Information Statement contained the following Question and Answer:

> "Q5. Who is eligible to receive consideration in connection with the Proposed Transaction?
>
> "A5. Each *Policyholder of an Eligible Policy* will be eligible to receive a share of the Cash Consideration. Owners of such Policies are referred to as Eligible Policyholders in this policyholder information statement. The amount distributable to Eligible Policyholders shall be paid directly to each Eligible Policyholder *unless such Eligible Policyholder has affirmatively designated in writing (using a designation form to be provided by **MLMIC**) a Policy Administrator* or EPLIP Employer to receive such amount on its behalf ..." (emphasis added).

Similarly, **MLMIC's** notice for policyholders of its planned conversion to a stock insurance company stated: "In connection with the Conversion, it has been determined that the current policy administrator designations on file with **MLMIC** *do not extend to the distribution of the cash amounts allocated to eligible policyholders* ... In order for cash amounts to be distributed to policy administrators, eligible policyholders must appoint their policy administrators to receive such distributions" (emphasis added).

In its decision approving the plan of conversion, DFS considered "a written comment asserting that the group of policyholders eligible to be paid shares of the purchase price should be changed or that the purchase price should be allocated differently" (DFS Op at 22 [internal quotation marks omitted]). DFS, however, rejected the argument,

opining that "Insurance Law § 7307(e)(3) explicitly defines those policyholders who are eligible to receive the purchase price consideration based on the three-year period of eligible policies" (*id.* at 23 [internal quotation marks omitted]).

DFS also did not accept the contention, which had been advanced by Maple Medical, that the person that paid the premium is thereby entitled to the proceeds of the sale. "The Superintendent finds that this is not determinative because [Insurance Law § 7307(e)(3)] refers to the 'policyholder,' which might or might not be the person who paid the premiums" (*id.* at 23 [internal quotation marks omitted]). However, DFS, when discussing the dispute resolution process, noted that the Insurance Law "also recognize[d] 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 payment in a given case" (*id.* [internal quotation marks omitted]).

***9** In *Schoch* and in *Maple–Gate Anesthesiologists, P.C.,* the Third and Fourth Departments, respectively, considering the language of the Insurance Law, the plan of conversion, and the DFS decision, determined that the employee physicians, not the employer practice groups, were entitled to the cash consideration (*see* *Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 343–344; *Maple–Gate Anesthesiologists, P.C. v Nasrin,* 182 AD3d at 985). Both courts were unpersuaded by the argument that the employee physician's designation of his or her employer as policy administrator entitled the policy administrator to the cash consideration. In *Schoch,* the Third Department held that the practice group'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" (*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 342). "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," which the employer practice group failed to do in that case (*id.*). Similarly, the Fourth Department in *Maple–Gate Anesthesiologists, P.C.,* opined that the plan of conversion stated the cash contribution would be made to the policyholder unless he or she affirmatively designated a policy administrator to receive it on his or her behalf (*see* *Maple–Gate Anesthesiologists, P.C. v Nasrin,* 182 AD3d at 985). In that case, the physician employees "were the policyholders of the relevant **MLMIC** policies and ..., although [the physician employees] had assigned some of their rights as policyholders to plaintiff [employer] as Policy Administrator, they had not designated plaintiff to receive demutualization payments" (*id.*).

Here, it is undisputed that Scott (as well as the other physicians) did not specifically designate Maple Medical to receive the demutualization payments and that, in the cases of Youkeles and Mutic, Maple Medical was never designated policy administrator at all.

Maple Medical argues that there is a provision of Insurance Law § 7307 by which its payment of the premiums entitled it to the cash consideration. Maple Medical points to the portion of the statute which states:

> "The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) *such policyholder has properly and timely paid to the insurer* on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors under subsection (b) hereof bears to the total net premiums received by the mutual insurer from such eligible policyholders"

(Insurance Law § 7307[e][3] [emphasis added])

DFS considered, and rejected, this precise argument in its decision, finding that the matter of who paid the premium "is not determinative because [Insurance Law § 7307(e)(3)] refers to the 'policyholder,' which might or might not be the person who paid the premiums" (DFS Op at 23 [internal quotation marks omitted]). This argument was also found unavailing by the Third Department in *Schoch.*

The Third Department reasoned that "[t]he first quoted sentence of this statute [Insurance Law § 7307] 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" (*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 342). Thus, it determined that the language "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. The reference to 'policyholder'

immediately preceding the word 'paid'—the latter of which is the word that [the employer] focuses on—supports our interpretation" (*id.* at 342–343 [internal quotation marks omitted], citing *Columbia Mem. Hosp. v. Hinds,* 65 Misc.3d 1205[A], 2019 N.Y. Slip Op 51508[U], *4 [Sup Ct, Columbia County], *affd* ___ AD3d ___, 2020 N.Y. Slip Op 06329). Further, the Third Department noted that

> "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"

***10** (*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 343, citing *Maple–Gate Anesthesiologists, P.C. v Nasrin,* 63 Misc.3d 703, 709 [Sup Ct, Erie County], *affd* 182 AD3d 984 ["The formula takes into account the amount of premiums paid. 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"]).

As the Third Department held,

> "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"

(*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 343).

> "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. [The employer] attempts to take [the] last portion of DFS's decision [regarding the objection procedure] out of context, as if all determinations of the proper payee are based on the parties' relationship. However, that only applies if an objector raises a legitimate assertion that it is entitled to the consideration based on an assignment from the policyholder, which does not exist here. Accordingly, pursuant to the language of the statute, the conversion plan and DFS's decision, **MLMIC** should pay the cash consideration to [the employee physician]"

(*id.* at 343–344 [citation omitted]).

Here, like in *Schoch* and *Maple–Gate Anesthesiologists, P.C.,* there is no dispute that, while some of the physicians employed by Maple Medical assigned to their employer some rights as policy administrator, none of the physicians designated Maple Medical to receive the cash consideration. We agree with the Third and Fourth Departments that Insurance Law § 7307 makes clear that the policyholder is entitled to the consideration, and that the references to the amount of premiums paid applies only to calculation of the *amount* of consideration. Thus, the defendants are "legally entitled to receive the cash consideration" (*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 344). Accordingly, in accordance with the controlling statute, the plan of conversion, and the DFS decision, Scott, and the other Maple Medical physicians, are entitled to the cash consideration (*see id.* at 342–344; *Maple–Gate Anesthesiologists, P.C. v Nasrin,* 182 AD3d at 985–986).

In reaching this conclusion, we also note that the First Department in *Schaffer* did not express any contrary views as to the import of the statute, the conversion plan, and the DFS approval decision. Rather, the First Department's determination to award the cash consideration to the employer medical group was predicated entirely upon the theory of unjust enrichment, a theory to which we now turn (*see Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d at 465).

III. Unjust Enrichment

Maple Medical argues that Scott, as well as the other physicians, will be unjustly enriched if they receive the cash consideration because it was Maple Medical who paid all of the premiums under the policies. In response, Scott and the others contend that, under their employment agreements with the plaintiff, they agreed to devote their professional services to Maple Medical in exchange for which Maple Medical agreed to provide them with compensation and various benefits, including payment of their malpractice insurance. Scott and the other physicians assert that, in exchange for the benefits Maple Medical paid to and for them, Maple Medical received the services from them that it bargained for

and cannot predicate an unjust enrichment claim upon the premiums paid in consideration for the services provided.

***11** To establish a cause of action for unjust enrichment, "[a] plaintiff must show 'that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered' " (*Mandarin Trading Ltd. v. Wildenstein,* 16 NY3d 173, 182, quoting *Citibank, N.A. v. Walker,* 12 AD3d 480, 481 [internal quotation marks omitted]; *see GFRE, Inc. v. U.S. Bank, N.A.,* 130 AD3d 569, 570). "The essential inquiry in any action for unjust enrichment ... is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered" (*Paramount Film Distrib. Corp. v State of New York,* 30 N.Y.2d 415, 421).

> "Generally, courts will look to see if a benefit has been conferred on the defendant under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the defendant, and whether the defendant's conduct was tortious or fraudulent"

(*id.*). " 'The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another' " (*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 344, quoting *Clifford R. Gray, Inc. v LeChase Constr. Servs., LLC,* 31 AD3d 983, 988).

In *Schaffer,* the First Department held that although the physician employee

> "was named as the insured on the relevant **MLMIC** professional liability insurance policy, [the employer practice group] purchased the policy and paid all the premiums on it. [The employee] 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 [the employee] the cash proceeds of **MLMIC's** demutualization would result in her unjust enrichment"

(*Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d at 465). Significantly, as the defendants argue, as the Third Department noted in *Schoch,* and as we have observed above, the First Department did not discuss the Insurance Law, the plan of conversion, or the DFS decision in its memorandum decision.

In setting forth its conclusion that awarding the physician the proceeds of the demutualization would result in unjust enrichment, the First Department cited two federal court cases: *Ruocco v Bateman, Eichler, Hill, Richards, Inc.* (903 F.2d 1232, 1238 [9th Cir1990] [hereinafter *Ruocco*]) and *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 U.S. Dist LEXIS 42877, *10–11, *21–22 [ND Ill, Mar. 4, 2005, No. 02 C 3115] [hereinafter *Chicago Truck Drivers*]).

In *Ruocco,* the defendant, a stock brokerage and financial consulting firm, offered its employees group long term disability insurance through Union Mutual Insurance Company (*see Ruocco v Bateman, Eichler, Hill, Richards, Inc.,* 903 F.2d at 1234). The Union Mutual policy was paid for by the employees participating in the plan and the defendant deducted premiums from their pay (*see id.*). In 1986, Union Mutual notified the defendant that it intended to convert from a mutual insurance company to a wholly-owned subsidiary of a publicly-owned stock corporation called UNUM (*see id.* at 1235). Under Maine law, where Union Mutual was incorporated, the conversion could take place only upon distribution to each policyholder of a pro rata share of the retained surplus which the converting company had acquired while it was operating as a mutual insurance company (*see id.*). Union Mutual notified the defendant that the returned surplus would take the form of shares of UNUM stock and warrants to purchase additional shares of UNUM stock (*see id.*). The defendant decided to exercise the warrants and paid the sum of $609,336 to buy 25,755 shares of UNUM stock, which were sold by the defendant for a profit of $104,913.30 (*see id.*). The defendant also received a distribution of UNUM shares in 1988, which it sold for $524,510.01, making the total profit it received from the sale of shares $629,423.31 (*see id.*).

***12** The plaintiff commenced an action in the United States District Court for the Central District of California (hereinafter the California District Court) claiming that the defendant's decision to retain the UNUM distribution violated the Employee Retirement Income and Security Act of 1974 (29 USC § 1001 *et seq.* [hereinafter ERISA]), California Commercial Code section 8315 (since repealed), and the Racketeer Influenced and Corrupt

Organizations Act (18 USC § 1961 *et seq.* [hereinafter RICO]) (*see* *Ruocco v Bateman, Eichler, Hill, Richards, Inc.*, 903 F.2d at 1235). The California District Court granted summary judgment to the plaintiff on the ERISA and California Commercial Code claims, finding that the plan was an "employee welfare benefit plan" as defined by ERISA, that defendants were "fiduciaries" of the plan, that the plaintiff was a "participant" in the plan, and that the surplus dividend was an "asset of the plan" (*id.* [internal quotation marks omitted]). The California District Court found that "the balance of equities" weighed in favor of the plan participants because they paid for the plan and the funds would not benefit them if distributed to the defendants (*id.*). The United States Court of Appeals for the Ninth Circuit affirmed on the "balance of equities" issues, stating, "[w]e agree with the [California] district court that the balance of equities weighs in favor of the plaintiff class" (*id.* at 1238).

In *Chicago Truck Drivers,* the plaintiff sought a declaratory judgment against the defendant pension fund and the defendant labor union to the effect that the demutualization compensation paid for four employee-benefit plans of Principal Financial Group (hereinafter Principal) was a plan asset and should revert to the participants of the plans (*see* *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, *1, 2005 U.S. Dist LEXIS 42877, *1–2). Principal adopted its plan for demutualization in 2001 (*see* *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, *1, 2005 U.S. Dist LEXIS 42877, *2). In *Chicago Truck Drivers,* the issues before the United States District Court for the Northern District of Illinois (hereinafter the Illinois District Court) were whether the demutualization compensation was an asset of the employee benefit plans, and, if so, whether the compensation reverted to the participants of the plan or to the employers (*see* *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, *1, 2005 U.S. Dist LEXIS 42877, *3). The Illinois District Court determined that, under ERISA and guidance from the Department of Labor advisory opinions, because the contributions to a 401(k) plan were made entirely by the employees, outside of minor administrative costs, the demutualization compensation attributable to the 401(k) plan should revert to the employees (*see* *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, *3–4, 2005 U.S. Dist LEXIS 42877, *11, *22). However, as to the other three employee-benefit plans, the Illinois District Court found that the demutualization compensation attributable to a severance plan must be used to offset future employer contributions and that the demutualization compensation attributable to an in-house pension plan and a life insurance plan reverted to the employers (*see* *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, *8, 2005 U.S. Dist LEXIS 42877, *19, *21–23).

We do not agree with our colleagues in the First Department that the principles found in *Ruocco* and *Chicago Truck Drivers* should apply here. Those cases involved employee benefit plans subject to ERISA and, as a result, ERISA and federal law principles governed. In contrast, Maple Medical has presented a cause of action against Scott, as well as against its other physician employees, founded on unjust enrichment, a cause of action grounded in state law principles. The essence of Maple Medical's unjust enrichment claim is an effort to use the principles of unjust enrichment to overcome the medical professionals' entitlement to the proceeds of demutualization, which entitlement derives from this State's Insurance Law. We therefore conclude that the unjust enrichment claim must be analyzed under New York's common law principles of unjust enrichment. The federal ERISA authorities are of no assistance in this regard.

***13** We note, as the Third Department did in *Schoch,* that recovery in unjust enrichment is not available where the parties have a contract which governs the subject matter (*see* *Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 345, citing *Pappas v. Tzolis,* 20 NY3d 228, 234). While the parties here had an employment agreement, their contract does not provide for who would be entitled to demutualization proceeds, an absence which is hardly surprising since, until the **MLMIC** conversion, there had never been a demutualization of a professional liability insurance company

in this state (*see* *Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 345).

As we have already observed, the essential inquiry for unjust enrichment is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered. In undertaking this inquiry, we must look to see if a benefit has been conferred upon the defendant under mistake of fact or law, if the benefit remains with the defendant, if there has been a change of position by the defendant, and whether the defendant's conduct was tortious or fraudulent (*see* *Paramount Film Distrib. Corp. v State of New York,* 30 N.Y.2d at 421; *see also* *Mandarin Trading Ltd. v Wildenstein,* 16 NY3d at 182). To prevail, the proponent of the cause of action must establish that it conferred a benefit on the other party and that the other party will retain that benefit without adequately compensating the first party therefor (*see* *Beaman v. Awaye Realty Mgt., LLC,* 176 AD3d 1025; *MT Prop., Inc. v Ira Weinstein & Larry Weinstein, LLC,* 50 AD3d 751, 752).

Applying these principles here, Maple Medical has not proven, and cannot prove, a cause of action for unjust enrichment. It has not provided the benefits in question to its employee-physicians—those benefits are provided by the plan of conversion and, ultimately, by the acquiring entity. At most, Maple Medical provided malpractice insurance premium payments, surely a benefit, but a benefit of the employment contracts between Maple Medical and its physician-employees for which the physician-employees paid valuable consideration in the form of their labor. Since the physicians provided their services to Maple Medical in exchange for the benefits paid to them, or for them, under the employment agreements, it simply cannot be said that the employees have not already adequately compensated Maple Medical for the benefits paid. The payment of the medical malpractice insurance premiums was not a gratuitous act; it was part of the bargained-for consideration for the employment services that the physicians provided to the medical group. Moreover, the medical group itself benefitted from the payment of premiums for the malpractice policies to the extent that they covered the group's vicarious liability for the acts of its employees.

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

The thrust of Maple Medical's argument is that Scott and the other physicians are receiving a windfall as the result of the demutualization of **MLMIC**. However, as our colleagues in the Third Department have written, the reality is that the consideration would equally be a windfall to Maple Medical if it were to receive it. Neither party bargained for it and neither party can be said to have paid for it. Membership interests in a mutual insurance company are not paid for by the premiums; rather, such rights are acquired, at no cost, as an incident of the structure of the mutual insurance policy, through operation of law and the company's charter and bylaws (*see* *Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 345–346, citing *Dorrance v. United States,* 809 F3d 479, 485). We find the Third Department's analysis very persuasive:

> ***14** "Had [the medical group] selected a different company to provide malpractice insurance to cover [the employee], [the medical group] would have met its contractual obligation to provide and pay for that insurance while [the employee] 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 [783,] 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)"

(*Schoch v Lake Champlain OB–GYN, P.C.,* 184 AD3d at 346).

The Fourth Department reached a similar conclusion in *Maple–Gate Anesthesiologists, P.C.,* where it held that "[t]he mere fact that [the employer practice group] paid the annual premiums on the policies on [the employees'] behalf does not entitle it to the demutualization payments" (*Maple–Gate Anesthesiologists, P.C. v Nasrin,* 182 AD3d at 986).

We therefore conclude that Maple Medical has no cognizable unjust enrichment cause of action against Scott or any of the other physicians.

IV. The Escrow Provision

Finally, Scott and the other physicians argue that the Supreme Court's orders directing the escrow agent to release the funds to Maple Medical violated the escrow procedure set forth in the plan of conversion and the terms of the parties' stipulation. We agree. The plan of conversion states, "[i]f **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 ... 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" (emphasis added). The stipulations the plaintiff entered into with Scott, and each of the other physicians, likewise provided that "**MLMIC** shall hold the funds in escrow pending a further stipulation of the parties or a final non-appealable order or judgment of the Court." Here, the court's orders underlying the instant and related appeals (*see Maple Medical LLP v. Youkeles,* __ AD3d ___ [decided herewith]; *Maple Medical LLP v. Arevalo,* __ AD3d ___ [decided herewith]; *Maple Medical LLP v. Goldenberg,* __ AD3d ___ [decided herewith]; *Maple Medical LLP v. Sundaram,* __ AD3d ___ [decided herewith]; *Maple Medical LLP v. Mutic,* __ AD3d ___ [decided herewith]) were appealable and, accordingly, the funds should have been held in escrow pending the outcome of these appeals.

V. Conclusion

Accordingly, the order and judgment is reversed insofar as appealed from, that branch of the motion of the defendant Joseph Scott which was for summary judgment on his counterclaim for a judgment declaring that he is entitled to receive certain funds in the amount of $128,148 is granted, and that branch of the plaintiff's cross motion which was for a judgment declaring that it is entitled to receive those funds is denied. Since this is an action for, inter alia, a declaratory judgment, the matter is remitted to the Supreme Court, Westchester County, for the entry of a judgment, among other things, declaring that the defendant Joseph Scott is entitled to receive the subject funds in the principal amount of $128,148 and directing that such funds be released to the defendant 30 days after service of this opinion and order with notice of entry, provided that in the event Maple Medical timely moves for leave to appeal to the Court of Appeals, the funds shall remain in escrow pending a determination of such motion and, if such motion is granted, pending a determination of that appeal.

***15** DILLON, DUFFY and CONNOLLY, JJ., concur.

ORDERED that the order and judgment is reversed insofar as appealed from, on the law, with costs, that branch of the motion of the defendant Joseph Scott which was for summary judgment on his counterclaim for a judgment declaring that he is entitled to receive certain funds in the amount of $128,148 is granted, that branch of the plaintiff's cross motion which was for a judgment declaring that it is entitled to receive those funds is denied, and the matter is remitted to the Supreme Court, Westchester County, for the entry of a judgment, inter alia, declaring that the defendant Joseph Scott is entitled to receive the subject funds in the principal amount of $128,148 and directing the release of the funds to that defendant 30 days after service of this opinion and order with notice of entry, provided that in the event the plaintiff timely moves for leave to appeal to the Court of Appeals, the funds shall remain in escrow pending a determination of such motion and, if such motion is granted, pending a determination of that appeal.

ENTER:

Aprilanne Agostino

Clerk of the Court

All Citations

--- N.Y.S.3d ----, 2020 WL 7233649

Footnotes

1 We note that the Supreme Court, in another case decided subsequently, determined to follow the position of the First Department, rather than the view of the Third and Fourth Departments (*see Healthcare Radiology & Diagnostic Sys., PLLC v Goldman,* ___ Misc.3d ___, 2020 N.Y. Slip Op 20306 [Sup Ct, Westchester County]

). The First Department's view was also followed, and the view of the Third and Fourth Department not, in *Wyckoff Heights Med. Ctr. v. Monroe* (2020 N.Y. Slip Op 32580[U] [Sup Ct, Kings County]).

2 The Third Department also applied *Schoch* in *Columbia Mem. Hosp. v. Hinds* (___ AD3d ___, 2020 N.Y. Slip Op 06329 [3d Dept]).

3 Such a determination may be forthcoming as the Court has granted leave to appeal in *Schoch.*

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
)
COUNTY OF WESTCHESTER)

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

That on the 11th day of December, 2020 deponent served the within:

Opposition to Motion for Leave to Appeal

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

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Sworn to before me this
11th day of December, 2020

Eric R. Larke
Notary Public, State of New York
No. 01LA5067236
Qualified in Westchester County
Commission Expires March 5, 2023

Brian R. Landy, Jr.

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