To be Argued by:
JASON HSI
(Time Requested: 15 Minutes)

New York Supreme Court

Appellate Division—Third Department

THE COLUMBIA MEMORIAL HOSPITAL,

Case No.: 530190

Plaintiff-Appellant,

– against –

MARCEL E. HINDS, M.D.,

Defendant-Respondent.

BRIEF FOR PLAINTIFF-APPELLANT

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INTRODUCTION

Petitioner Columbia Memorial Hospital (the "Hospital" or "Petitioner") submits this brief in support of its appeal from the Decision and Order of the Supreme Court, Columbia County, dated September 3, 2019 ("Decision"). The Decision granted Respondent Marcel E. Hinds, M.D.'s ("Respondent") motion to dismiss the Hospital's claims, pursuant to CPLR §§ 3211(a)(1) and (a)(7), and found as a matter of law that Respondent alone was entitled to receive $412,418.93 (the "MLMIC Funds") from non-party Medical Liability Mutual Insurance Company ("MLMIC"), which is currently holding such amounts in escrow pending a final determination of the parties' dispute. As set forth below, because the Decision improperly resolved numerous factual issues on a pre-answer motion to dismiss on the basis of inconclusive documents and misinterpreted the applicable laws, the Decision should be reversed and the Hospital's complaint ("Complaint") reinstated.

By way of background, MLMIC was a mutual insurance company that issued medical malpractice policies to health care providers in New York. Respondent was one of numerous providers at the Hospital who received malpractice coverage through MLMIC in connection with their employment. In 2016, MLMIC announced that it was being acquired and that MLMIC would be

converted or "demutualized" from a mutual insurance company to a stock insurance company. In connection with the demutualization, it was determined that the physician policyholders or their administrative designees (which were typically the employers, such as the Hospital) would receive payments based on the amount of premiums paid for any malpractice policies issued between July 2013 and July 2016. Recognizing that disputes might arise between providers and employers concerning the proper beneficiary of the cash consideration for a particular policy, MLMIC's Plan of Conversion (the "Conversion Plan") set forth a procedure whereby objections could be filed with MLMIC, which would in turn trigger an escrow of the relevant cash consideration until the dispute was resolved either by settlement or upon the final ruling of an arbiter or court.

After lodging its objections with MLMIC, the Hospital commenced the underlying action seeking to establish its entitlement to the MLMIC Funds. The Hospital asserted, among other claims, a cause of action for declaratory judgment finding that Respondent, a former employee, would be unjustly enriched if he were to receive the MLMIC Funds because the Hospital paid for the annual malpractice insurance premiums for his policies between 2013 and 2016 (collectively, the "Policy"). The Hospital also alleged that Respondent's failure to assign the MLMIC Funds to the Hospital constituted a breach of the implied covenant of good faith and fair dealing inherent in his employment agreement, dated August 1,

2012 (the "Employment Agreement"), because he had already received all compensation due to him in connection with his prior employment.

Notwithstanding the Hospital's allegation that it alone paid for Respondent's malpractice premiums – an allegation that the lower court was required to accept as true for purposes of the motion – the lower court erroneously accepted Respondent's conclusory contention that he had actually paid for the malpractice premiums each policy year by way of a deduction to his incentive compensation. This argument was based upon language from the Employment Agreement.

In arguing before the lower court that he paid the MLMIC premiums, Respondent simply relied on an incentive compensation formula in the Employment Agreement. The Employment Agreement stated that, in addition to his base salary, Respondent was entitled to incentive compensation when the revenue the Hospital actually received from his professional services exceeded the expenses attendant to his employment, including his base salary, the actual costs of his benefits, the malpractice premiums, and office and staff overhead costs. Even if that threshold was reached, however, Respondent was only entitled to 65% of the amount of that excess figure.

However, because that formula merely spoke of the potential for incentive compensation, and did not support a finding that Respondent actually paid for his

malpractice premiums out of his incentive compensation, the Employment Agreement did not conclusively establish Respondent's defense as a matter of law and therefore did not constitute proper documentary evidence sufficient to warrant dismissal under the strict standards imposed by CPLR § 3211(a)(1) for motions to dismiss based on documentary evidence. Compounding this manifest error was the lower court's erroneous reliance on Respondent's affidavit, which case law uniformly holds cannot be used in support of a motion pursuant to CPLR § 3211(a)(1).

Moreover, in positing the conclusory assertion that he actually paid the malpractice premiums, Respondent did not allege, let alone prove:

- Whether the revenue he and his unit produced during the relevant time frame would have entitled him to any incentive compensation but for the malpractice premiums.

- What the Hospital's actual expenses were during the relevant time, a critical factor in assessing Respondent's entitlement to incentive compensation.

Despite the fact that such factual issues are not a proper subject of inquiry in resolving a pre-answer motion to dismiss and that Respondent never furnished the lower court with any such facts, the lower court accepted at face value Respondent's conclusory allegation that he had actually paid for the malpractice

premiums through his incentive compensation. This factual finding was patently erroneous and thus requires reversal of the dismissal order.

Based on the same erroneous findings, the lower court then dismissed the Hospital's alternative claims for unjust enrichment, money had and received, and breach of the implied covenant of good faith and fair dealing. Such claims are supported by sufficient allegations, and were only dismissed because of the lower court's improper resolution of the facts.

In order to further justify its erroneous determination, the lower court distinguished this matter from the seminal First Department case of *Schaffer, Schonholtz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't 2019) ("*Schaffer*") and the numerous courts that have followed it, including the Supreme Courts in New York County, Westchester County, Nassau County, Saratoga County, Suffolk County, Greene County, Warren County, and Broome County. These courts have all held that, at a minimum, there are viable claims for declaratory judgment based upon unjust enrichment principles where the employer alleges that it paid for the premiums, and the employer/employee did not bargain for the specific disposition of the MLMIC Funds in any employment agreement. The lower court instead opted to follow an Erie County Supreme Court decision that predated *Schaffer* to find that Respondent was entitled to the MLMIC Funds,

particularly given its (erroneous) finding that Respondent had allegedly paid for the premiums by way of his incentive compensation. As established herein, the Erie County decision should not be followed here in light of the underlying factual determination that was erroneous.

Finally, the lower court also relied heavily on Insurance Law § 7307, which it interpreted to preclude payment of the MLMIC Funds to a policy administrator "unless the defendant [policyholder] signs the agreement to do so." In parsing out one phrase, the lower court plainly ignored MLMIC's Conversion Plan and the orders from the New York State Department of Financial Services ("DFS"). Both MLMIC and DFS explicitly recognized that entitlement to the MLMIC Funds depended on the factual circumstances of each case, and that the formal designations of a "policyholder," "policy administrator," or "designees," or the absence of a formal assignment of the cash consideration, were not conclusive per se as to any party's entitlement to the MLMIC Funds.

Accordingly, the Court should respectfully reverse the Decision and reinstate the Complaint.

QUESTIONS PRESENTED

1. Whether the lower court improperly granted Respondent's motion to dismiss, pursuant to CPLR § 3211(a)(1) & (a)(7), based solely on the parties' Employment Agreement and Insurance Law § 7307?

The lower court improperly granted Respondent's motion to dismiss because the documentary evidence – the Employment Agreement – did not conclusively establish a defense as a matter of law. The Employment Agreement merely set forth a formula to calculate potential incentive compensation that included malpractice premiums as just one of several factors. However, it did not establish that Respondent actually paid for the malpractice premiums, directly or indirectly, through his incentive compensation in each of the three policy years between 2013 and 2016. Because of this gaping evidentiary hole, the lower court should have denied Respondent's motion.

Furthermore, Insurance Law § 7307 does not unequivocally establish that the policyholders alone are entitled to the cash consideration absent a formal assignment. Recognizing this open issue, both MLMIC and DFS have explicitly stated that the ultimate entitlement to the cash consideration is fact-dependent on each physician's employment circumstances.

2. Whether the lower court improperly dismissed the Hospital's claim for unjust enrichment?

Relying on the same unfounded assumption that Respondent actually paid for the malpractice premiums, the lower court erroneously concluded, as a matter of law, that Respondent could not have been unjustly enriched if he had paid for the malpractice premiums himself. Because this remains an open issue that requires discovery, the lower court improperly dismissed the Hospital's claim for unjust enrichment.

3. Whether the lower court improperly dismissed the Hospital's claim for breach of the implied covenant of good faith and fair dealing?

The lower court improperly dismissed the implied covenant claim by assuming facts not in evidence. Specifically, the lower court assumed that neither party contemplated the consequences of MLMIC's sale, and that as a result, neither party's interest was compromised so as to implicate the implied covenant of good faith and fair dealing. However, such assumptions regarding the parties' intent were erroneous, where the Hospital maintained a catch-all interest in any funds arising from the employment. In any event, such factual determinations should not have been made on a motion to dismiss.

STATEMENT OF FACTS

A. Respondent's 2012 Employment Agreement

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

The Hospital compensated Respondent for his services with a $300,000 "Base Salary," incentive compensation, and on-call compensation, as well as various benefits, including health, disability and life insurance, retirement benefits, vacation time, and time/reimbursement for other allowed activities and expenses. Pursuant to Section 9 of the Employment Agreement, the Hospital purchased "an individual occurrence-based medical malpractice insurance policy in the minimum amounts required for all members of the Medical Staff of the Hospital" for Respondent, and chose MLMIC for that policy. (R. 20; 35)

Upon the termination of the Employment Agreement for cause, Respondent agreed that he would "only be entitled to receive the accrued but unpaid Base Salary, and Incentive Compensation, owed to you as of the date of your termination." (R. 20; 36)

B. The Incentive Compensation Formula

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

> (b) Incentive Compensation: The amount equal to the annual professional component net revenue, which for purposes of this Agreement shall mean the amount actually collected by the Hospital in a given contract fiscal year from billing the professional component of any services provided by you, regardless of office location, ("Hinds Revenue"), shall be calculated quarterly for your review and shall be reconciled each contract fiscal year against the expenses directly attributable to your employment hereunder ("Hinds Expenses").
>
> If in a given fiscal quarter, 50% of the Hinds Revenue exceeds $75,000, you will receive additional compensation ("Incentive Compensation") for the amount exceeding $75,000 up to a total of $5000 per quarter. The Quarterly incentive, if achieved, will be paid May (for 1st qtr), August (for 2nd qtr), November (for 3rd qtr), February (for 4th qtr).
>
> If in a given fiscal year the Service Revenue[1] is in excess of the Service Expenses, the Hospital shall pay you additional compensation ("Incentive Compensation") from those Service Revenues in an amount equal to sixty-five percent (65%) of the amount equal to the difference of (a) the Hinds Revenue and (b) the Hinds Expenses, assuming such difference is a positive number. The Hinds Expenses, and the expenses for each of the Physicians in the Service shall be calculated as follows in any given fiscal year:

---

[1] While the Employment Agreement does not explicitly define the terms "Service Revenue" and "Service Expenses," these terms refer to the revenue and expenses, respectively, of the Hospital's "OB/GYN Service," which is defined on the first page of the agreement as the division of the Hospital devoted to providing OB/GYN care.

1.	Base Salary	$
2.	Actual cost of benefits	$
3.	Malpractice premium	$
4.	Office and staff overhead figure	$
	Total amount to be exceeded per annum to earn Incentive Compensation in accordance with this Section 3(b)	$

(R. 33)

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

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

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

Respondent never took any steps to administer, manage, or otherwise oversee the Policy. Furthermore, Respondent never inquired as to the status of the policy, renewals of the policy, or the costs of the policy, or objected when the Hospital received any dividends or rebates in connection with the policy. (R. 21)

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

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

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

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

E. Recent Events Involving MLMIC's Demutualization

MLMIC historically was a mutual insurance company subject to the supervision, and rules and regulations, of DFS. (R. 22)

Sometime in or about 2016, MLMIC announced that NICO, a subsidiary of Berkshire Hathaway, would be acquiring MLMIC and that, as part of that transaction, MLMIC would be converted or "demutualized" from a mutual insurance company to a stock insurance company. Under New York Insurance Law § 7307, demutualizations are governed by a plan of conversion, which must be approved by the Superintendent of DFS. Such plans of conversion must set forth the "manner and basis of exchanging the equitable share of each eligible mutual policyholder for securities or other consideration, or both, of the stock corporation into which the mutual insurer is to be converted." (R. 22)

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

On July 15, 2018, the Board of Directors of MLMIC adopted a Plan of Conversion that governed the proposed demutualization, subject to DFS approval and a vote of eligible policyholders (the "Conversion Plan"). (R. 44-97) In connection with that transaction, certain cash consideration in an amount

calculated to be 1.9 times the sum of premiums timely paid during the payout period, which was defined as the period between July 15, 2013 and July 14, 2016, was to be paid to eligible policyholders or their "Designees." (R. 23; 58)

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

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

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

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

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

(R. 63) (emphasis added)

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

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

On January 14, 2019, DFS issued a follow-up order concerning the MLMIC Funds and set forth a few deadlines for the parties to advise their respective

tribunals and/or MLMIC of the on-going dispute and resolution status ("DFS Order"). (R. 25; 126-129) To those that do not advise MLMIC of any active dispute resolution processes, DFS authorized MLMIC to release the MLMIC Funds to the policyholder upon the expiration of the stated deadline. However, in the event that MLMIC released the remaining escrowed funds to policyholders, the DFS Decision reiterated that "the release of the escrow shall have no substantive effect on the parties' positions with respect to who is entitled to the payment under the relevant law." (R. 38; 122)

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

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

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

PROCEDURAL HISTORY

A. The Complaint

The Hospital commenced this action by the filing of a Summons and Complaint on February 20, 2019. (R. 17-31)

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

B. Respondent's Motion to Dismiss

Rather than answer the Verified Complaint, Respondent moved to dismiss, pursuant to CPLR §§ 3211(a)(1) and (7). Respondent submitted a factual affidavit from Dr. Hinds, an affirmation of Seth E. Nadel, Dr. Hinds' attorney, agreements and correspondence between the parties and MLMIC, and certain documents from MLMIC. (R. 130-182) Respondent did not submit any documentary evidence regarding the actual operating figures for the calculation of his incentive compensation, nor did Respondent submit any evidence that he actually paid his malpractice premiums through his incentive compensation or otherwise.

C. The Lower Court's Decision

In granting Respondent's motion to dismiss, the lower court made one critical factual determination that erroneously permeated the entire Decision: that Respondent alone paid for the malpractice premiums for the Policy. The lower court summarized this point, stating:

> 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. 12)

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

By finding that Respondent actually paid for the malpractice premiums, the lower court dismissed the Hospital's claim for declaratory judgment, which was based on principles of unjust enrichment, and the unjust enrichment claim itself, because it found no enrichment at the Hospital's expense.

The lower court found support for its determination in Insurance Law § 7307. The lower court strictly interpreted the statute to require payment to the policyholder/owner absent an assignment. (R. 11) Notably, the lower court ignored both the Conversion Plan and DFS' Decision, which provided for the objection procedures, in its determination.

The lower court also dismissed the claim for breach of the implied covenant of good faith and fair dealing because it was apparently able to divine the parties' intent regarding the MLMIC proceeds. It stated, without any evidentiary support or findings, that "in all likelihood neither party appreciated that a windfall could occur as a result of the MLMIC sale, because, quite simply, they did not appreciate the meaning and the value of an ownership stake prior to the demutualization plan." (R. 13)

THE APPLICABLE LEGAL STANDARDS OF REVIEW FOR MOTIONS TO DISMISS

On a motion to dismiss pursuant to CPLR § 3211, "the court must afford the pleadings a liberal construction, take the allegations of the complaint as true and provide plaintiff the benefit of every possible inference." *EBC I, Inc. v Goldman, Sachs & Co.*, 5 N.Y.3d 11, 19 (2005); *see Goshen v. Mutual Life Ins. Co. of N.Y.*, 98 N.Y.2d 314, 326 (2002); *see also Graves v. Stanclift, Ludemann, Mcmorris & Silvestri, P.C.*, 174 A.D.3d 1086 (3d Dep't 2019); *Piller v. Tribeca Dev. Group LLC*, 156 A.D.3d 1257, 1261 (3d Dep't 2017). "Whether a plaintiff can ultimately establish its allegations is not part of the calculus in determining a motion to dismiss." *EBC I, Inc.*, 5 N.Y.3d at 19.

When the movant relies specifically on CPLR § 3211(a)(1), dismissal is warranted only if the documentary evidence submitted "utterly refutes plaintiff's factual allegations, conclusively establishing a defense as a matter of law." *Koziatek v. SJB Dev. Inc*., 172 A.D.3d 1486 (3d Dep't 2019). *See Ganje v. Yusuf*, 133 A.D.3d 954, 956 (3d Dep't 2015) (quoting *Goshen v. Mut. Life Ins. Co. of New York*, 98 N.Y.2d 314, 326 (2002)); *see also Goldman v. Metro. Life Ins. Co.*, 5 N.Y.3d 561, 571 (2005) ("where documentary evidence submitted conclusively establishes a defense to the asserted claims as a matter of law"). To qualify as documentary evidence, the evidence must be unambiguous and of undisputed

authenticity. *Koziatek v. SJB Dev. Inc*., 172 A.D.3d 1486 (3d Dep't 2019). Particularly relevant here, affidavits and affirmations do not constitute the type of "documentary evidence" considered in support of a motion to dismiss pursuant to CPLR § 3211(a)(1). *Lopes v. Bain*, 82 A.D.3d 1553, 1554 (3d Dep't 2011); *Crepin v. Fogarty*, 59 A.D.3d 837, 838 (3d Dep't 2009) ("[A]ffidavits submitted by a defendant do not constitute documentary evidence upon which a proponent of dismissal can rely."). The only valid purpose for which an affidavit may be submitted on a motion to dismiss is "for the important (but limited) purpose of authenticating the 'documentary evidence.'" *See* Higgit, Practice Commentary, McKinney's Cons Laws of NY, CPLR § 3211.

Respondent also moved to dismiss for failure to state a cause of action under CPLR § 3211(a)(7). On such a motion to dismiss, the Court must determine whether the proponent of the pleading has a cause of action, not whether the proponent has stated one. *Guggenheimer v. Ginzburg*, 43 N.Y.2d 268, 275 (1977); *Scheffield v. Vestal Parkway Plaza, LLC*, 102 A.D.3d 992, 993 (3d Dep't 2013). Then, as with all motions under CPLR § 3211, the Court must "accept the facts as alleged in the complaint as true, accord plaintiffs the benefit of every possible favorable inference, and determine only whether the facts as alleged fit… within any cognizable legal theory." *Leon v. Martinez*, 84 N.Y.2d 83, 87-88 (1994).

ARGUMENT

POINT I

THE DECISION SHOULD BE REVERSED BECAUSE THE DOCUMENTARY EVIDENCE DID NOT CONCLUSIVELY RESOLVE FACTUAL ISSUES AND DISPOSE OF THE HOSPITAL'S CLAIMS

The fundamental starting point for the Hospital's appeal lies in the Court's proper understanding of the Employment Agreement and how incentive compensation is determined and calculated. As established below, Section 3(b) of the Employment Agreement – the only "documentary evidence" relied upon – only sets forth a formula for determining potential incentive compensation based on actual operating figures, such as revenue and expenses. Because there is no evidence of the Hospital's actual operating figures, however, the Court should not have found, as a matter of law, that Respondent actually paid the premiums by a deduction to his incentive compensation.

The lower court's Decision was thus fundamentally flawed because it failed to properly apply the standard for motions to dismiss under CPLR § 3211(a)(1). Specifically, the Employment Agreement did not conclusively establish that the Respondent paid his own malpractice insurance premiums so as to refute the Hospital's allegations that the Hospital had paid the premiums in the course of Respondent's employment. (R. 12; 33) Rather, the formula in the Employment

Agreement merely gave rise to the possibility of this occurrence depending upon facts that were never provided by Respondent and that could not have served as the basis for dismissal under CPLR § 3211(a)(7). Because this error permeated the entire Decision, this Court should reverse the Decision and reinstate the Complaint.

A. The Employment Agreement's Formula For Calculating Incentive Compensation Is Contingent Upon Actual Operating Figures

Under Section 3(b) of the Employment Agreement, there are two periods of potential incentive compensation that Respondent was entitled to earn: quarterly and annually. [2]

---

[2] Section 3(b) of the Employment Agreement provides, in relevant part:

> If in a given fiscal quarter, 50% of the Hinds Revenue exceeds $75,000, you will receive additional compensation ("Incentive Compensation") for the amount exceeding $75,000 up to a total of $5000 per quarter….
>
> If in a given fiscal year the Service Revenue is in excess of the Service Expenses, the Hospital shall pay you additional compensation ("Incentive Compensation") from those Service Revenues in an amount equal to sixty-five percent (65%) of the amount equal to the difference of (a) the Hinds Revenue and (b) the Hinds Expenses, assuming such difference is a positive number. The Hinds Expenses, and the expenses for each of the Physicians in the Service shall be calculated as follows in any given fiscal year:
>
> | | | |
> |---|---|---|
> | 1. | Base Salary | $ |
> | 2. | Actual cost of benefits | $ |
> | 3. | Malpractice premium | $ |
> | 4. | Office and staff overhead figure | $ |
> | | | _____ |
> | | Total amount to be exceeded per annum to earn Incentive Compensation in accordance with this Section 3(b) | $_____ |
>
> (R. 33)

First, for each fiscal quarter, Respondent was entitled to receive up to $5,000 if the actual revenues collected by the Hospital for Respondent's work exceeded a threshold of $150,000. (R. 33) Once Respondent's collected revenues exceeded $160,000, he was entitled to the full $5,000.

Second, for each fiscal year, Respondent was entitled to receive up to 65% of the amount that the Hinds Revenue exceeded the Hinds Expenses, assuming that the Service Revenue (after subtracting the four categories of Service Expenses) were sufficient to pay for the 65% figure. (R. 33)

Thus, while the Hospital was willing to reward Respondent up to five times each year for his productivity, there was no guarantee of incentive compensation (as compared to his base salary set forth in Section 3(a)) if, for example, productivity or collections were too low. Rather, it all depended on the actual operating figures of the Hospital, which had yet to be determined. Indeed, the figures for each category of expenses are purposefully left blank to reflect the methodology for future calculations with hard numbers. (R. 33)

Moreover, Respondent was not penalized with any loss of his base salary if his productivity was poor each quarter and/or the Service lost money. Thus, for instance, if Respondent generated only $25,000 per quarter in "Hinds Revenue" for the Hospital in a given year, Respondent would still get his $300,000 Base Salary,

nothing for incentive compensation, and the Hospital would be fully responsible for the payment of Respondent's salary, benefits, administrative costs, and malpractice insurance premiums in their entirety.

At the other end of the factual spectrum, if Respondent generated $1 million in annual revenue, and his annual expenses were only half that amount, Respondent would receive 65% of $500,000 as additional incentive compensation, or $325,000, assuming the Service Revenues also exceeded the Service Expenses by that same amount.

In sum, the Employment Agreement, by itself, merely establishes a formula for determining potential incentive compensation; it does not support a conclusive determination that Respondent actually paid for his malpractice premiums. As established below, the lower court erroneously made numerous factual assumptions about the Hospital's actual operating figures for each policy year in question.

B. The Lower Court Made Numerous Assumptions About the Hospital's Actual Operating Figures

In order for the lower court to have concluded that Respondent actually paid for the malpractice premiums, the lower court must have made broad assumptions of facts regarding the Hospital's actual revenues and expenses. The most apparent

facts that the lower court presumed were that Respondent and the OB-GYN Service actually generated substantial revenues for the Hospital, and that such revenues exceeded the Hospital's actual expenses. On a more granular level, because the MLMIC Funds were comprised of payments from three separate policy years, the lower court must have also assumed that the Hospital's revenues exceeded its expenses for each and every year between 2013 and 2016. Lastly, the lower court must have assumed that incentive compensation was actually calculated in the way specified by the Employment Agreement.

As the Court will readily find, there was no documentary evidence in the record regarding the Hospital's actual revenues, the actual cost of benefits afforded Respondent, or the share of his expenses relating to administrative overhead. Nor was there any evidence that the compensation was actually calculated each policy year in accordance with the Employment Agreement. The only thing that the lower court cited to was the Employment Agreement, which was literally blank as to any future operating figures. This was plainly erroneous.

Even worse, the lower court made such assumptions in the face of the Hospital's allegations – which should have been accepted as true – that the Hospital alone paid the malpractice premiums for Respondent. (R. 12; 19; 21; 26) To the extent that the lower court relied on Respondent's affidavit, which claimed

that he paid for the premiums,[3] that was reversible error as well. To reiterate (*see* p.21-22, *supra*) "[i]n order for evidence to qualify as 'documentary,' it must be unambiguous, authentic, and undeniable." *Magee-Boyle v. Reliastar Life Ins. Co. of New York*, 173 A.D.3d 1157 (2d Dep't 2019). "[L]etters, emails, and affidavits fail to meet the requirements for documentary evidence" that can be considered in support of a motion to dismiss pursuant to CPLR § 3211(a)(1). *Magee-Boyle v. Reliastar Life Ins. Co. of New York*, *supra*; *Lopes*, 82 A.D.3d at 1554; *Art & Fashion Grp. Corp. v. Cyclops Prod., Inc.*, 120 A.D.3d 436, 438, 992 N.Y.S.2d 7, 10 (1st Dep't 2014); *Tsimerman v. Janoff*, 40 A.D.3d 242, 242 (1st Dep't 2007); *Fontanetta v. John Doe*, 73 A.D.3d 78, 85-86 (N.Y. App. Div. 2010) ("[A]ffidavits are not documentary evidence").

Thus, absent documentary evidence of the kind acceptable under CPLR § 3211(a)(1) to refute the Hospital's allegation that the Hospital paid for the malpractice premiums, the lower court committed reversible error.

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[3] Respondent submitted an affidavit to establish a number of factual assertions, including allegations that his incentive compensation was reduced in an amount equal to the Policy premiums and that the Hospital attempted to manipulate Defendant into assigning the MLMIC Funds. (R. 132-139) Reliance on affidavit proof at this stage was improper. In any event, since all of these factual disputes "do no more that assert the inaccuracy of plaintiffs' allegations," they should be disregarded entirely. *Art & Fashion Grp. Corp.*, 120 A.D.3d at 438.

C. Premiums As An Expense Factor Does Not Equate To A Payment By Respondent Only

Moreover, even if Respondent and the Hospital's OB-GYN Service had generated sufficient revenues to cover their respective expenses, thereby entitling Respondent to an incentive compensation payment, the lower court should not have found that Respondent alone paid for the malpractice premiums. The lower court essentially found that because it was possible that Respondent had indirectly paid for some of the malpractice premiums, he therefore must have paid for the entirety of that expense. However, there are at least two problems with this conclusion.

First, Section 3(b) of the Employment Agreement provides for an incentive compensation payment "in an amount equal to sixty-five percent (65%) of the amount equal to the difference of (a) the Hinds Revenue and (b) the Hinds Expenses," which includes "Malpractice premiums." (R. 33) Thus, assuming that Respondent was entitled to receive incentive compensation in any given year, Respondent's incentive compensation was only reduced by 65 cents for each dollar that the Hospital spent for Respondent's premiums. This means that, hypothetically, the Respondent indirectly only paid for 65% of the premiums, with the remaining 35% of the costs being paid by the Hospital.

Second, the lower court's reasoning is conceptually flawed because, under its interpretation, if Respondent was allegedly paying for his malpractice premiums, he was also paying for the other expenses included in the "Hinds Expense" calculation, such as his own Base Salary, benefits, and other office overhead. Taken the lower court's logic to the extreme, Respondent is paying the Hospital to work for the Hospital. This makes no sense.

In other words, the fact that there was a threshold to Respondent receiving incentive compensation (that happened to be based on the Hospital's actual expenses), does not mean that the Respondent was actually paying for those costs out of his own pocket. Rather, it simply means that the Hospital was willing to reward a productive employee by sharing its net profits via incentive compensation.

In light of the foregoing, the Employment Agreement cannot support the Decision as a matter of law.

POINT II

THE HOSPITAL STATED A CLAIM FOR DECLARATORY JUDGMENT UNDER *SCHAFFER* AND RECENT PROGENY

In light of the lower court's improper resolution of facts regarding the Employment Agreement and the alleged indirect payment of premiums through

deductions to Respondent's incentive compensation, the Hospital has stated a viable claim for declaratory judgment based on unjust enrichment principles under the First Department's decision in *Schaffer, Schonholtz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't 2019), and recent progeny throughout New York.

A. The Hospital Stated A Viable Declaratory Judgment Claim Based On Equitable Principles Of Unjust Enrichment

Pursuant to CPLR § 3001, "[t]he supreme court may render a declaratory judgment having the effect of a final judgment as to the rights and other legal relations of the parties to a justiciable controversy whether or not further relief is or could be claimed." A declaratory judgment action requires "the existence of a bona fide justiciable controversy, defined as a real dispute between adverse parties, involving substantial legal interests for which a declaration of rights will have some practical effect." *Salvador v. Town of Queensbury*, 162 A.D.3d 1359, 1360 (3d Dep't 2018) (quotations omitted).

To prevail on a claim of unjust enrichment, "a party must show that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered." *Mandarin Trading Ltd. v. Wildenstein*, 16 N.Y.3d 173, 182 (2011). "The essential inquiry in any action for unjust enrichment or restitution is whether it is against equity and good conscience to permit the defendant to retain what is

sought to be recovered." *Paramount Film Distrib. Corp. v. State of New York*, 30 N.Y.2d 415, 421 (1972). Notably, unjust enrichment does not require a showing that the party enriched committed a wrongful act. *See Hornett v. Leather*, 145 A.D.2d 814, 816 (3d Dep't 1988).

Here, the parties are embroiled in a bona fide dispute. Both parties seek to obtain the MLMIC Funds currently held in escrow by MLMIC. The Hospital asserts that it is entitled to the funds under the facts and circumstances surrounding the parties' employment relationship, and that it would be unjust or inequitable if Respondent walked away with monies that arose from the Policy that the Hospital alone purchased in the course of the parties' employment relationship; which the Hospital administered on Respondent's behalf; and where the Hospital has always been the beneficiary of any rebates or refunds under the Policy. Thus, Respondent would be unjustly enriched were he to receive the funds. Furthermore, because Respondent disputes entitlement to the MLMIC Funds on various factual grounds and MLMIC is holding the funds in escrow pending a determination, there is an actual controversy that requires resolution by a court.

B. ***Schaffer*** **Supports The Viability Of The Hospital's Claims**

In *Schaffer*, the First Department held that an employer who paid all policy premiums to MLMIC is entitled to the demutualization funds, even if the employee

is the named policyholder, on the grounds of unjust enrichment. Specifically, in *Schaffer*, the court held that:

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

171 A.D.3d 465.

Here, the Hospital has alleged each of the elements cited by the First Department. Although Respondent was named as the insured on the Policy, the Hospital has alleged that it purchased the policy and paid all premiums on it. (R. 19; 21; 26) Respondent did not pay any premiums or other costs, nor did he bargain for the benefit of the demutualization proceeds. (R. 19; 21; 26; 32-40).

Although the lower court attempts to distinguish *Schaffer* on the grounds that Respondent indirectly paid the premiums through deductions to his incentive compensation, it relied on assumptions – rather than any documentary evidence – to establish that Respondent actually paid the premiums. As explained in Point I above, there is no evidence regarding the Hospital's actual operating revenues and expenses attributable to Respondent's practice.

Thus, because the Hospital has pled viable claims under *Schaffer*, the Hospital's claims should not have been dismissed.

C. The Supreme Courts in Westchester, Saratoga, Suffolk, Greene, New York, Nassau, Broome, Warren, and Queens Counties Have All Followed *Schaffer*

There have been multiple courts that have followed *Schaffer*, while *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc. 3d 703, 709 (Erie County Sup. Ct. Mar. 22, 2019) ("*Maple-Gate*"), which pre-dated *Schaffer*, has been largely set aside. *See* Point IV(c), *infra*. Indeed, the Supreme Courts in Westchester, Saratoga, Suffolk, Greene, New York, Nassau, Broome, and Warren counties have all followed *Schaffer* in one manner or another (whether denying motions to dismiss, or granting motions for summary judgment in favor of the employers who paid the premiums).

The Supreme Court, Westchester County, recently issued an omnibus decision resolving six litigations before it, holding that the decision in *Schaffer* is controlling precedent, and that its reasoning was persuasive and warranted. In *Maple Medical, LLP v. Scott*, Index No. 51103/2019, 2019 WL 3070676 (Sup. Ct. Westchester Co. July 7, 2019), the court held that *Schaffer* "is dispositive of the issues raised in this matter," noting:

> [t]he parties here serve in the same roles as the parties in *Matter of Schaffer*, and, in fact, MLMIL [sic] is the relevant insurance company in both actions. Like in the *Matter of Schaffer*, the named employer here purchased and paid all of the premiums on the medical professional insurance policy covering the physician who now seeks the distribution payment based on the policy. In addition [the physician], like the doctor in *Matter of Schaffer*, does not claim to have bargained for the benefit of the Payment.

Id. at *2. The court also stated that "the conclusions drawn in the First Department's decision are persuasive, and…a similar holding in this action based on the principles of unjust enrichment is warranted." *Id*. at *3.

Schaffer was again found to be determinative by the Supreme Court in Saratoga County, which held that "the First Department found as a matter of law that an award of the MLMIC proceeds to the named insured doctor would result in her unjust enrichment." *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 64 Misc.3d 1215(A), *2 (Sup. Ct. Saratoga County 2019). The court found that "[t]he significant facts relied upon by the First Department are not distinguishable from the significant facts in this case," and granted summary judgment to the employer. *Id*.

In *Urgent Medical Care PLLC v. Amedure*, 64 Misc.3d 1216(A) (Sup. Ct. Greene Co. July 12, 2019), a case which the lower court even cited, the Greene County Supreme Court denied the defendant's motion to dismiss. It found that the

practice stated an equitable claim for unjust enrichment, notwithstanding the physician's legal title to the proceeds because "[l]egal title does not end the inquiry."

In *John T. Mather Memorial Hosp. of Port Jefferson, New York, Inc. v. Fadel*, Index No. 624734/2018 (Sup. Ct. Suffolk Co. Aug. 21, 2019), the court granted the hospital's motion for summary judgment because the facts were "indistinguishable from" those in *Schaffer* and "concurr[ed] with the First Department's conclusion… [that] awarding defendant [employee] the demutualization proceeds would result in her unjust enrichment." *Id.* at 2.

In *Mid-Manhattan Physician Services, P.C. v. Dworkin*, Index No. 656478/2018 (Sup. Ct. New York Co. Sept. 3, 2019), the Supreme Court of New York relied on *Schaffer* and awarded disputed MLMIC funds to an employer that paid the premiums for the policy in question. In particular, the court also found that Section 8.2(a) of the Conversion Plan[4] would be rendered "meaningless" were the court to award the MLMIC funds to a physician who did not pay the policy premiums. *Id*.

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[4] Section 8.2(a)(i) of the Conversion Plan also provides: "For Eligible Policies that identify multiple insureds, the Eligible Premium with respect to each Eligible Policyholder under such Eligible Policy means the sum of the net premiums . . . properly and timely paid and allocable to such Eligible Policyholder under the Eligible Policy." (R. 59)

The Nassau County Supreme Court also granted summary judgment in favor of the employer in a decision, dated October 7, 2019. *See Long Island Radiology Associates, P.C. v. Koshy et al*., Index No. 600195/2019 (Sup. Ct. Nassau Co. Oct. 7, 2019). Contrary to the lower court's Decision here, the Nassau County Supreme Court found that the employer's payment of malpractice premiums as a benefit for the physicians did not result in a finding that the physician indirectly paid for the premiums through his compensation plan.

Next, the Broome County Supreme Court followed *Schaffer* when denying the motion for summary judgment by the plaintiff certified nurse midwife in a Decision and Order, dated September 10, 2019. *See Shoback, CNM v. Broome Obstetrics and Gynecology, P.C.*, Index No. EFCA2018003334 (Sup. Ct. Broome Co. Sept. 10, 2019). In doing so, the *Shoback* Court explicitly set aside its "academic" opinion on the Conversion Plan, which it generally believed to have been more favorable to the practitioner, and adopted the *Schaffer* holding which it believed to be binding on the issue.

In *Women's Care in Obstetrics and Gynecology, P.C. v. Herrick et al.*, 2019 N.Y. Slip Op. 51776(U), 2019 WL 5691879 (Sup. Ct. Warren Co. Nov. 4, 2019), the Warren County Supreme Court issued a Decision and Order denying the defendants certified nurse midwives' motion for summary judgment. Notably, the

Women's Care Court properly decided the issues on the facts presented (*i.e*. who paid the premium), rather than simply on a conceptual analysis of the Conversion Plan or Insurance Law, and determined that, because the facts of *Schaffer* were on point, *Schaffer* was binding.

Next, in *Zilkha Radiology, P.C. v. Schulze*, Index No. 622517/2018 (Sup. Ct. Suffolk Co. Nov. 1, 2019), the Supreme Court of Suffolk County awarded MLMIC cash consideration to a radiology practice that paid the premiums for its physician-policyholder's MLMIC policy. While the premium payments were a negotiated "benefit" in the physician's employment contract, the court nonetheless found that the physician never bargained for the demutualization proceeds specifically. *Id*. at *2. Therefore, in light of the practice's premium payments, the court found the "essential facts" to be "indistinguishable" from those in *Schaffer*, and awarded the cash consideration to the radiology practice.

In both *NRAD Med. Assoc., P.C. v. Kim*, Index No. 617351/2018 (Sup. Ct. Nassau Co. Oct. 28, 2019) and *Benoit v. Jamaica Anesthesiologist, P.C.*, Index No. 615476/2018 (Sup. Ct. Nassau Co. Nov. 26, 2019), the Supreme Court of Nassau County again found in favor of medical practices that paid the premiums for their employees' MLMIC coverage as a benefit of their employment. The court recognized that *Schaffer* is binding on all New York state trial courts. *See NRAD*,

Index No. 617351/2018, at *23; *Benoit*, Index No. 615476/2018, at *13. Accordingly, it denied the employee-plaintiffs' motions for summary judgment and awarded the cash consideration to the practices which paid the policy premiums. *See NRAD*, Index No. 617351/2018, at *23-25; *Benoit*, Index No. 615476/2018, at *12-14.

In *Sullivan v. Northwell Health, Inc.*, Index No. 656121/2018 (Sup. Ct. N.Y. Co. Dec. 2, 2019), the Supreme Court of New York County again followed *Schaffer* and awarded the disputed cash consideration to a hospital which had paid the premiums for its employees' policies. In reaching its holding, the Court rejected a number of the employee-policyholders' arguments. First, the employees attempted to distinguish their case from the facts in *Schaffer* on the grounds that they had procured their MLMIC policies before commencing their employment with the hospital. *Id.* at *4. The court disagreed with this argument, finding that this was a distinction without a difference so long as the hospital had paid for the policies during the policyholders' employment. *Id.*

Next, the employees in *Sullivan* argued that since they bargained for their insurance coverage and the ability to retain their MLMIC policies while employed by the hospital, they had therefore bargained for the demutualization proceeds in satisfaction of *Schaffer*. *Id.* The court rejected this argument as well, finding that

although the employees had bargained for those provisions of their employment agreements, the agreements never addressed entitled to the demutualization proceeds specifically. *Id*.

Schaffer was again recognized to be controlling precedent in *Episcopal Health Services v. Henry*, Index No. 707615 (Sup. Ct. Queens Co. Dec. 10, 2019), in which the Supreme Court of Queens County denied a physician policyholder's motion to dismiss his former employer's complaint for cash consideration from the MLMIC demutualization. Relying on *Schaffer*, the court found that the plaintiff-employer had properly pled its causes of action for unjust enrichment, money had and received, and the implied covenant of good faith and fair dealing by alleging that it had paid the entirety of the premiums for the MLMIC policy in question and that the parties' employment agreement did not address entitlement to demutualization proceeds. *Id*. at *2-3.

Most recently, in *Brauer v. Dr. R. G. Geronemus, M.D., P.C.*, Index No. 70720/2018 (Sup. Ct. Westchester Co. Dec. 19, 2019), the Supreme Court of Westchester County again found that a medical practice that paid the MLMIC policy premiums was entitled to the disputed funds. Specifically, the court followed *Schaffer*, finding that the practice both paid the premiums and the parties did not bargain for the demutualization proceeds. *Id*. at *2-3. The court also held

that the practice was entitled to the funds because it was the policy administrator. *Id*. at *3.

The foregoing decisions from nine Supreme Courts throughout New York collectively illustrate the broad acceptance of *Schaffer* and its application to cases similar to this one. This Court should likewise follow suit and find, at a minimum, that the Hospital has stated a viable claim for the MLMIC Funds belonging to the Hospital.

POINT III

THE LOWER COURT ERRONEOUSLY DISMISSED THE HOSPITAL'S CLAIMS FOR MONEY HAD AND RECEIVED AND BREACH OF THE IMPLIED COVENANT

Based on the same facts, the Hospital sufficiently pled claims of unjust enrichment, money had and received, and breach of the implied covenant of good faith and fair dealing. This is particularly so given that the lower court was required to accept the allegations in the Complaint as true and provide the Hospital the benefit of every possible inference, where the documentary evidence was not conclusive as to the counter-facts stated by Respondent.

A. The Hospital Stated Viable Claims For Unjust Enrichment and Money Had And Received

Similar to the elements of an unjust enrichment claim (*see* Point II(a), *supra*), the essential elements of a cause of action for money had and received are: (1) the defendant received money belonging to the plaintiff, (2) the defendant benefitted from receipt of the money, and (3) under principles of equity and good conscience, the defendant should not be permitted to keep the money. *See In re Estate of Moak*, 92 A.D.3d 1040, 1044 (3d Dep't 2012); *see also Marini v. Adamo*, 995 F. Supp. 2d 155, 206 (E.D.N.Y. 2014), *aff'd*, 644 F. App'x 33 (2d Cir. 2016).

As alleged in the Complaint (R. 17-31), the allegations of which must be accepted as true on this motion, the Hospital selected the Policy and made all of the associated premium payments. (R. 19; 21) Furthermore, the Hospital was the designated policy administrator. (R. 21) The Hospital's entitlement to the funds is further supported by the fact that it was always the beneficiary of any rebates or refunds under the Policy. (R. 21) Finally, Defendant was never intended to be eligible for any further monies beyond those specified in the Employment Agreement, and he has long since received the entirety of that compensation. (R. 19; 20; 36)

B. The Money Had And Received Claim Should Survive For The Same Reasons As The Unjust Enrichment Claim

The Hospital's money had and received claim survives for the same reasons as its unjust enrichment claim. As the Appellate Division has stated, "[a] cause of action for money had and received is similar to a cause of action to recover damages for unjust enrichment, the essence of which is that one party has received money or a benefit at the expense of another." *Gargano v. Morey*, 165 A.D.3d 889, 891 (2018). Accordingly, for the reasons set forth in Point II above regarding the Hospital's unjust enrichment claim, if the Respondent were to receive moneys that the Hospital has a right to receive, it has a valid claim for money had and received.

C. The Hospital Is Contractually Entitled To The MLMIC Funds

Under New York Law, "all contracts imply a covenant of good faith and fair dealing in the course of performance… This covenant embraces a pledge that 'neither party shall do anything which shall have the effect of destroying or injuring the right of the other party to receive the fruits of the contract.'" *511 W. 232nd Owners Corp. v. Jennifer Realty Co.*, 98 N.Y.2d 144, 153 (2002) (quoting *Kirke La Shelle Co. v. Paul Armstrong Co.*, 263 N.Y. 79 (1933)).

Here, under Section 11(b), Respondent agreed not to receive any additional compensation for the services he provided under the Employment Agreement. (R. 36) Nonetheless, he seeks to obtain further compensation for his services in the form of the MLMIC Funds, to which the Hospital has both a legal and equitable right. Should he obtain the funds, Respondent will have effectively procured additional compensation from the Hospital, and in doing so, deprived the Hospital of its bargained-for right not to owe Respondent any further sums for his services. It is of no consequence that the funds would have been technically paid by third-party MLMIC – the loss to the Hospital is the same, regardless of the payor.

The lower court's dismissal of the Hospital's alternative breach of the implied covenant claim was erroneous at this juncture. The lower court reasoned that, because neither party appreciated the windfall derived from the demutualization and neither party bargained for the cash consideration, no party's interest in the Employment Agreement was compromised in any way. (R. 13)

There are at least two problems with the lower court's holding. First, the parties' intent is typically a question of fact that should not be resolved at this stage. *See Hertz v Rozzi*, 148 A.D.2d 535, 537 (2d Dep't 1989), *aff'd*, 74 N.Y.2d 702 (1989). Although it is true that the Employment Agreement did not reference the MLMIC demutualization, the Hospital cited to Section 11(b) to assert its

interest in the MLMIC Funds. As noted above, this catch-all provision encompasses the MLMIC Funds here.

Second, even assuming that the parties did not bargain for the MLMIC Funds, the failure to bargain for the cash consideration weighs in favor of the employer under *Schaffer*. *See supra*, Point II(B).

Thus, the lower court's dismissal of the Complaint should be reversed, and the Complaint reinstated with all causes of action.

POINT IV

THE LOWER COURT MISINTERPRETED INSURANCE LAW § 7307 TO REQUIRE PAYMENT TO POLICYHOLDERS, AND PLACED UNDUE RELIANCE ON *MAPLE-GATE*

In reaching its erroneous determination that Respondent was entitled to the MLMIC Funds, the lower court relied on the Erie County Supreme Court's interpretation of Insurance Law § 7307 in *Maple-Gate*. However, as in *Maple-Gate*, the lower court misconstrued the scope of Insurance Law § 7307 when it ignored MLMIC's Conversion Plan, the DFS Decision, and DFS's Order, all of which explicitly acknowledged the need to look beyond formalities, and to examine the factual circumstances of the parties' relationship.

A. The Lower Court Ignored the Conversion Plan, The DFS Decision, And The DFS's Order, All Of Which Acknowledge That Entitlement To The MLMIC Funds Depends On The Factual Circumstances Of Each Physician

While there is no dispute that Respondent is the formal policyholder and the Hospital is the policy administrator, such formal designations are not dispositive of the ultimate issue of entitlement as between the parties. *See Urgent Med. Care, PLLC v. Amedure*, 64 Misc. 3d 1216(A) (Sup. Ct. Greene Co. 2019) ("[l]egal title does not end the inquiry"). Indeed, MLMIC's Conversion Plan, the DFS Decision, and the DFS's Order, which the lower court ignored, have explicitly acknowledged that entitlement to the MLMIC Funds depends on the factual circumstances and not the formal designations.

Under the Conversion Plan, the MLMIC Funds are to be paid either to Eligible Policyholders or their "Designees." (R. 58) "Designees" are defined as, *inter alia*, Policy Administrators "to the extent designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policy holder." (R. 49) The Plan itself does not define or limit the manner in which an Eligible Policyholder may "designate" a Policy Administrator as a "Designee" to receive the Cash Consideration. Rather, as the Objection Procedure indicates, a Designee may be legally entitled to the Cash Consideration even if it has not been "specifically designated." (R. 63) ("If a Policy Administrator or

EPLIP Employer has not been specifically designated to receive the Cash Consideration allocated to an Eligible Policyholder, but nevertheless believes that it has a legal right to receive such Cash Consideration," such person may file an objection and submit the dispute for court or arbitral resolution.).

The DFS Decision expressly states that Insurance Law § 7307(e)(3) "is not determinative" of who is to receive the Cash Consideration, noting that:

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

(R. 120) (emphasis added)

The DFS Decision also does not rule on or in any way limit the manner in which a Policy Administrator can become a "Designee" entitled to receive the Cash Consideration:

> [N]othing in the escrow arrangement is intended to shift the burden of proof or persuasion on the underlying issue. Nor does the definition of Policy Administrator represent the Department's view that anyone that falls within this definition is (or is not) entitled, under the particular facts or applicable law, to receipt of the cash consideration. The determination of who is entitled to the cash consideration depends on the facts and

> circumstances of the parties' relationship and applicable law, to be decided either by agreement of the parties or by an arbitrator or court.

(R.122)

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

In short, and contrary to the decision of the lower court, the governing Conversion Plan, DFS Decision, and DFS Order, all acknowledge that the dispute is not resolved by the statute, which is examined further below. The DFS Superintendent expressly declined to rule on the question at issue in this case, and left that determination to the courts, which must examine the factual circumstances of each parties' specific relationship.

B. New York Insurance Law § 7307 Merely Governs the Procedure for Demutualization, And Leaves Open The Issue of Entitlement

The lower court's interpretation of Insurance Law § 7307 was flawed because it failed to account for certain key provisions regarding payment of the premiums.

To be sure, Insurance Law § 7307 describes the formula for determining the amount of consideration to be paid out for each policy based on a ratio of the premiums paid for the policies and describes the time period and set of eligible policyholders for which the formula applies. In particular, under Section 7307(e)(3), the amount of consideration due to an eligible policyholder is calculated based on "the net premiums . . . 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)."

While this subsection dictates how to calculate the amount of cash consideration, it simply assumes that the policyholder is the person who paid the premiums and does not specify to whom the cash consideration must be paid when someone other than the policyholder has paid the premiums. Indeed, were the Court to rely literally on subsection (e)(3) to determine who is entitled to the cash consideration, it would lead to absurd results in this case, because the amount of premiums that "such policyholder [i.e., Respondent] properly and timely paid to" MLMIC here is zero. Again, the Hospital has alleged that Respondent did not "properly and timely [pay]" any premium to MLMIC, nor did MLMIC "receive" any premiums from Respondent. Instead, it was the Hospital that made payments to MLMIC.

Again, DFS did not make any ruling on the meaning of that statutory provision. Rather, as the DFS' Decision recognized, the specific facts of each particular case will dictate entitlement to the proceeds:

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

(R. 120)

In short, although the default situation contemplated by the statute is the circumstance where the policyholder has paid the premiums and, therefore, is the recipient of the cash consideration, the statute is silent on the ultimate entitlement to MLMIC Funds as between an employee named as policyholder and an employer who paid the premiums.

C. The Erie County Supreme Court's Decision in *Maple-Gate* Is Inapplicable and Should Not Be Followed Here

Rather than follow the First Department's decision in *Schaffer*, the lower court instead relied on an Erie County Supreme Court decision, *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc. 3d 703, 709 (Erie County Sup. Ct. Mar. 22, 2019), which placed great emphasis on a policyholder's ownership interest in

the Policy. Such reliance was misplaced, however, as *Maple-Gate* is distinguishable and, in any event, not controlling law.

The *Maple-Gate* court rejected an argument (not raised in this case) that the employer-medical practice was the true "owner" of the MLMIC policy at issue, entitling it to the MLMIC Funds. Relying on Insurance Law § 7307, the *Maple-Gate* court found that the statute "does not confer an ownership interest in the stock or to the cash consideration to anyone other than the policyholder."

However, just because Respondent is the formal owner of the Policy does not mean that he is ultimately entitled to the MLMIC Funds. Rather, as specified by the Conversion Plan, DFS Decision, and DFS Order, the appropriate analysis requires a further examination of the legal and equitable relationship between the parties. Applying that analysis, the First Department in *Schaffer* determined that, in the absence of a contract on point, principles of unjust enrichment required that the MLMIC Funds be paid to the employer who paid the premiums. *Schaffer*, 171 A.D.3d at 465. Subsequent courts have likewise followed suit, with Warren County's latest decision from early November 2019 confirming the analysis. *See Women's Care in Obstetrics and Gynecology, P.C. v. Herrick, supra.*

To the extent the *Maple-Gate* decision rested on the premise 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," 63 Misc. 3d at 709, that premise was directly overruled by *Schaffer* and the subsequent Supreme Court cases, *supra*.

Moreover, *Maple-Gate* is factually distinguishable. The court in *Maple-Gate* placed great significance on the fact that the employer-medical practice had not availed itself of the objection and escrow procedure under the Conversion Plan, inferring that the practice had never believed it was entitled to the cash consideration and had perhaps waived any right to it. *See id*. at 709 ("As it appears the defendants never had designated the plaintiff to receive the cash consideration, it is no wonder that the plaintiff did not avail itself of the objection and escrow process"). Here, in contrast, the Hospital, as the Policy Administrator, timely objected to distribution of the MLMIC Funds to Respondent and did not waive any rights or entitlement to the MLMIC Funds. (R. 25) And, as noted above, Respondent has not established from the documentary evidence that Respondent actually paid for the malpractice premiums.

Accordingly, this Court should not follow *Maple-Gate*'s analysis, but instead construe Insurance Law § 7307 within the explanatory context of the Conversion Plan, DFS Decision, and DFS Order, which plainly defer entitlement issues to the Court to examine the underlying factual circumstances.

CONCLUSION

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

Dated: Great Neck, New York
January 7, 2020

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APPELLATE DIVISION – THIRD DEPARTMENT
PRINTING SPECIFICATIONS STATEMENT

I hereby certify pursuant to 22 NYCRR 1250.8(j) that the foregoing brief was prepared on a computer using Microsoft Word.

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Dated: January 7, 2020

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Addendum of Unreported Cases

ADD-1

SUPREME COURT-STATE OF NEW YORK
SHORT FORM ORDER
Present:

HON. TIMOTHY S. DRISCOLL
Justice Supreme Court

----------x

VLADIMIR BENOIT, MD, MARIAN DUMITRU, MD, FREGENS DUVALSAINT, MD, AHMED ELSHERYIE, MD, CRAIG PASSMORE, MD, MARIEANGE JEAN-MICHEL, CRNA, and ROSALIND BOYCE, CRNA,

Plaintiffs,

-against-

JAMAICA ANESTHESIOLOGIST, P.C. d/b/a JAMAICA ANESTHESIA ASSOCIATES, PC and MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendants.

----------x

TRIAL/IAS PART: 10

NASSAU COUNTY

Index No: 615476-18
Motion Seq. Nos. 2 and 3
Submission Date: 10/7/19

Papers Read on these Motions:

Pls. Memo of Law in Support.....x
Pls. Aff. in Support with Exhibits.....x
Def. Memo of Law in Opp. and in Support of Cross Motion.....x
Def. Aff. and Affm. in Opp. and in Support with Exhibits.....x
Pls. Memo of Law in Opp. and Reply.....x
Pls. Affm. in Opp. and Reply with Exhibit.....x

This matter is before the court on the motion filed by plaintiffs Vladimir Benoit, MD, Marian Dumitru, MD, Fregens Duvalsaint, MD, Ahmed Elsheryie, MD, Craig Passmore, MD, Marieange Jean-Michel, CRNA, and Rosalind Boyce, CRNA (collectively, "Plaintiffs"), and the cross-motion filed by defendant Jamaica Anesthesiologist, P.C. d/b/a Jamaica Anesthesia Associates, PC ("Jamaica Anesthesia"). For the following reasons, Plaintiffs' motion is denied and Defendants' cross-motion is granted in part and denied in part.

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BACKGROUND

A. Relief Sought

Plaintiffs move for an Order, pursuant to CPLR §§ 3212 and 3001, granting summary judgment in their favor as follows: 1) declaring they are entitled to their allocable share of the cash consideration derived from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC") with respect to insurance policies that they own, 2) directing MLMIC to immediately release all funds held in escrow to the Plaintiffs, and 3) dismissing Jamaica Anesthesia's counterclaim. Jamaica Anesthesia cross-moves for an Order, pursuant to CPLR § 3212, granting summary judgment. MLMIC takes no position on the pending motions.

B. Parties' History

Plaintiffs' Complaint, *see* Elsheryie Aff. at Exh. A, alleges as follows:

Plaintiffs are either anesthesiologists or certified registered nurse anesthetists who worked at Jamaica Hospital Center ("Jamaica Hospital") at various times from July 15, 2013, through July 14, 2016. Jamaica Hospital did not directly employ Plaintiffs and instead created a pass-through entity, Jamaica Anesthesia, which entered into employment contracts with each of the Plaintiffs to perform comprehensive anesthesia services at Jamaica Hospital and its outpatient departments. Jamaica Anesthesia is a for-profit corporation that provides all anesthesia services at Jamaica Hospital.

Plaintiffs' employment agreements with Jamaica Anesthesia contained similar language stating that: "[i]n consideration of the Attending rendering professional services on a full-time basis, the Corporation shall procure and maintain a professional liability policy with limits in the amount of $1,300,000 per occurrence and $3,900,000 in aggregate per annum for the Attending. However, the Attending is responsible for the timely submissions of applications and premium payment notices." Compl. ¶ 26. Plaintiffs' employment agreements included the insurance as a fringe benefit and their benefits plan entitled them to medical health insurance, dental health insurance, life insurance, continuing medical education, disability insurance and malpractice insurance. These agreements do not provide Jamaica Anesthesia with any rights as to monies resulting from the demutualization of their medical malpractice insurance company.

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Plaintiffs were each insured through a policy procured from MLMIC. Jamaica Anesthesia designated each Plaintiff as the policy holder with respect to his or her policy. Until September 14, 2018, MLMIC was organized as a mutual insurance company to be owned and operated for the benefit of its policyholders. In or around July 2016, MLMIC announced that it entered into an agreement to be acquired by National Indemnity Company ("NICO") with the acquisition conditioned on MLMIC first being converted from a mutual insurance company to a stock insurance company.

The demutualization or conversion process is highly regulated and governed by New York Insurance Law, which provides that a plan of conversion is the document governing a demutualization. A plan of conversion (the "Plan") was unanimously adopted by MLMIC's Board of Directors on May 31, 2018, and revised on June 15, 2018. *See* Compl. at Exh. A. The Plan provides for the conversion of MLMIC from a mutual insurance company into a stock insurance company, and then the subsequent purchase of the newly authorized stock by NICO. As a result of the conversion, rather than each policyholder's membership interest being converted into equity in the new insurance company, each policyholder is entitled to the allocable portion of the proceeds of the sale in exchange for the extinguishment of their policyholder membership interest (the "Cash Consideration").

Pursuant to New York Insurance Law, each person who had an insurance policy with MLMIC in effect at any time during the three-year period preceding the MLMIC Board's adoption of a resolution on July 15, 2016, approving the transaction ("Eligible Policyholders") is entitled to receive the Cash Consideration. Thus, the eligibility period was from July 15, 2013, through July 14, 2016. The Plan defines Eligible Policyholders as "the Policyholder of an Eligible Policy. For Eligible Policies that identify multiple insureds, each Person so identified on the declarations page of such Policy shall be an Eligible Policyholder . . ." Compl. ¶ 35. Plaintiffs are Eligible Policyholders and each are the only individual identified as the insured on the declaration page of their respective policies.

New York Insurance Law also requires that the Superintendent of Financial Services conduct a public hearing regarding the Plan and that the Plan be submitted to the Policyholders for a vote at a Special Meeting. On September 6, 2018, the Superintendent of Financial Services

issued a decision approving the Plan (the "DFS Decision"). *See* Compl. at Exh. B. On September 14, 2018, the Special Meeting was held and the policyholders voted to approve the Plan.

The Plan sets forth a procedure for disputes by Policy Administrators that believe they have a legal right to receive the Cash Consideration. Particularly, the Policy Administrator may send MLMIC a letter or e-mail setting forth its position, along with a statement that it provided a copy of the letter or e-mail to the applicable Eligible Policyholders prior to the Superintendent's public hearing. If MLMIC receives a properly filed objection, the allocated Cash Consideration will be held in escrow until MLMIC receives joint written instructions from the Eligible Policyholder and the Policy Administrator as to how the allocation is to be distributed, or a non-appealable order of an arbitration panel or court directs payment of the allocation to the Policy Administrator.

In certain instances, Jamaica Anesthesia designated itself as the Policy Administrator. On August 20, 2018, Jamaica Anesthesia filed separate objections to the distribution of each of the Plaintiffs' monies without any legal basis for such entitlement. Jamaica Anesthesia claims that it should be entitled to receive the Cash Consideration paid to the Eligible Policyholders because it paid the premiums to MLMIC for each policy. However, nothing in the law or the Plan provides that an entity that paid the premiums is automatically entitled to Cash Consideration. Additionally, there is no agreement that provides Jamaica Anesthesia with the legal right to the Cash Consideration, and Plaintiffs have complied with the obligations in their employment agreements, which only require that Plaintiffs return any premium refund. Jamaica Anesthesia has attempted to pressure Plaintiffs into signing away their money, but Plaintiffs have refused to do so.

On November 15, 2018, Plaintiffs commenced this action seeking a declaration that each Plaintiff is entitled to their allocable share of the Cash Consideration, Jamaica Anesthesia has no rights to any of the funds being held in escrow by MLMIC, and MLMIC must immediately release all funds held in escrow to the Plaintiffs.

On March 22, 2019, Jamaica Anesthesia filed an Answer and Counterclaims. *See* Elsheryie Aff. at Exh. L. Jamaica Anesthesia alleges, in relevant part, that between July 2013

and July 2016, each of the Plaintiffs were employed by Jamaica Anesthesia pursuant to a written employment agreement.[1] Under their employment agreements, each Plaintiff agreed to provide healthcare services to patients of Jamaica Anesthesia's affiliated hospital. In return, the agreements entitled each Plaintiff to receive a salary and certain other defined incentive-based monetary compensation. The Employment Agreements provided that such salary and incentive compensation were the only compensation to which Plaintiffs were entitled. Additionally, Jamaica Anesthesia agreed to provide and pay the premiums for professional liability insurance coverage for Plaintiffs. The Employment Agreements expressly provided that Jamaica Anesthesia was entitled to any return of monies from the professional liability insurer, stating: "[Plaintiff] assigns to [Jamaica Anesthesia] all of [Plaintiff]'s rights, title, and interest, if any, in any refund premium which might otherwise be made directly to the [Plaintiff]." Ans. at p. 11, ¶ 18. Jamaica Anesthesia handled all aspects of administration of the Policies and also paid premiums for the Policies. Plaintiffs paid nothing for the Policies, and did little or nothing to administer coverage, renew the policies, or otherwise deal with MLMIC with respect to the Policies.

Jamaica Anesthesia was named as the Policy Administrator on the declarations page of the Policies for the relevant period and performed all of the functions and obligations of a Policy Administrator. Plaintiffs designated Jamaica Anesthesia to receive the Cash Consideration by expressly agreeing in their Employment Agreements to assign any premiums returned in connection with the Policies to Jamaica Anesthesia. Plaintiffs, in the course of their performance under the Employment Agreements, confirmed the agreement to these terms by, *inter alia*, acquiescing in Jamaica Anesthesia's collection and retention of returned premiums, credits and dividends received in connection with the Policies.

Jamaica Anesthesia requested that each Plaintiff execute an MLMIC Consent form and, subsequently, requested that they each execute an MLMIC Assignment form. Plaintiffs have

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[1]In her affidavit, Antoinetta Morisco, MD, Jamaica Anesthesia's President, concedes that based on a review of Jamaica Anesthesia's records, Benoit and Duvalsaint did not sign employment agreements. Dr. Morisco alleges that Jamaica Anesthesia nevertheless compensated all Plaintiffs and procured, paid for, and administered their MLMIC Policies. Morisco Aff. ¶ 8.

refused to execute those forms. Additionally, on August 22, 2018, Jamaica Anesthesia submitted to MLMIC, pursuant to Schedule I of the Plan, objections to the distributions of Cash Consideration to the Plaintiffs. Jamaica Anesthesia simultaneously sent copies of the objections to Plaintiffs. As a result of the objections, MLMIC, as Stakeholder, has acknowledged that it or the Conversion Agent is holding the Cash Consideration in escrow. To date, despite repeated requests, Plaintiff have refused to execute the MLMIC-approved form of assignment or consent and, through counsel, have expressly asserted their entitlement to the Cash Consideration.

Jamaica Anesthesia asserts the following counterclaims: 1) declaratory judgment of breach of contract seeking a declaration that distribution of the Cash Consideration to Plaintiffs would constitute a breach of each Plaintiff's obligations under their Employment Agreements with Jamaica Anesthesia, and that Jamaica Anesthesia is entitled to receive the Cash Consideration associated with the Policies; and 2) declaratory judgment of unjust enrichment seeking a declaration that distribution of the Cash Consideration to Plaintiffs would constitute unjust enrichment, and that Jamaica Anesthesia is entitled to receive the Cash Consideration associated with the Policies.

On both counterclaims, Jamaica Anesthesia seeks 1) injunctive relief requiring MLMIC to direct the Conversion Agent (as defined in the Plan) to disburse the Cash Consideration to Jamaica Anesthesia and not to Plaintiffs, or 2) alternatively, an award of damages in favor of Jamaica Anesthesia and against Plaintiffs in an amount no less than the Cash Consideration distributed in connection with the Policy. Jamaica Anesthesia also requests an injunction requiring MLMIC to hold the Cash Consideration in escrow pending a non-appealable order in this action or a joint instruction by Jamaica Anesthesia and Plaintiffs directing disposition of the Cash Consideration.

C. The Parties' Positions

Plaintiffs allege that they are entitled to summary judgment on their claims because 1) it is undisputed that under the Plan, each of the Plaintiffs is an eligible policyholder, and absent any agreement or designation assigning Plaintiffs' rights, each of the Plaintiffs is entitled to the Cash Consideration, 2) it is undisputed that none of the Plaintiffs signed any written consent or

assignment to Jamaica Anesthesia, and 3) Jamaica Anesthesia had no membership interests in MLMIC and was simply the Policy Administrator or Agent for Plaintiffs' policies.

Plaintiffs further contend that Jamaica Anesthesia's counterclaims should be dismissed, as they are inconsistent with New York Insurance Law, the Plan, and the DFS Decision, all of which state that Plaintiffs or eligible policyholders are entitled to the Cash Consideration. Jamaica Anesthesia fails to identify any provision of the employment agreements expressly requiring Plaintiffs to designate Jamaica Anesthesia as the recipient of the Cash Consideration such that any distribution of the Cash Consideration to Plaintiffs would constitute a breach of contract. Jamaica Anesthesia's breach of contract claim incorrectly focuses on language in the employment agreements requiring the return of any refund premiums. The Cash Consideration, however, is a payment for the extinguishment of Plaintiffs' policyholder membership interest and not a return of premiums paid. There is no obligation in the Employment Agreements for Plaintiffs to assign the Cash Consideration to Jamaica Anesthesia, and contrary to Jamaica Anesthesia's contention, there is nothing in Plaintiffs' conduct that approaches a waiver.

Plaintiffs aver that it is undisputed that the Employment Agreements govern the obligations with respect to the MLMIC Policies, and the existence of a valid contract precludes Jamaica Anesthesia from recovery under an unjust enrichment claim. Even assuming, *arguendo*, that Jamaica Anesthesia's claim is not precluded, it fails because Plaintiffs were not unjustly enriched. The parties negotiated the benefits and obligations under the Employment Agreements, and absent from those obligations is an obligation for Plaintiffs to assign the Cash Consideration in the event of MLMIC's demutualization. Thus, Jamaica Anesthesia cannot claim that Plaintiffs did nothing in exchange for the Cash Consideration or were unjustly enriched, as the Policies and their benefits were obtained in consideration for the medical services provided by Plaintiffs.

Jamaica Anesthesia argues that it is entitled to summary judgment on its unjust enrichment claim. The facts of this case are materially identical to those in *Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dept. 2019), which is binding on all trial courts as the only New York State Appellate Division case to rule on the issue presented here. In *Schaffer*, the First Department held that where the employer paid the MLMIC insurance premiums for the policy covering the physician-employee, awarding the employee the cash

proceeds of MLMIC's demutualization would result in her unjust enrichment. Plaintiffs, having received the insurance coverage they bargained for at no cost to themselves and at the expense of Jamaica Anesthesia, should not receive a windfall in the form of the Cash Consideration. Additionally, Jamaica Anesthesia's unjust enrichment claim is not barred by the existence of the Employment Agreements. Jamaica Anesthesia is entitled to argue in the alternative, and if the Court finds that the Employment Agreements are silent on the parties' rights to the Cash Consideration, summary judgment must be granted in Jamaica Anesthesia's favor on the unjust enrichment claim.

Jamaica Anesthesia contends that the only discernible difference between this action and *Schaffer* is the provision in the Employment Agreements that "[t]he Attending assigns to the Corporation all of the Attending's rights, title, and interest, if any, in any refund premium which might otherwise be made directly to Attending." *See* Morisco Aff. at Exh. 1. This provision suffices to designate Jamaica Anesthesia as the recipient of the Cash Consideration as contemplated in the Plan. Jamaica Anesthesia's interpretation is consistent with the Employment Agreement provision stating that "all revenues" associated with Plaintiffs' services "belong to" Jamaica Anesthesia, and further reflects the parties' agreement that Plaintiffs agreed to limit their compensation solely to the salary and benefits expressly outlined in the Employment Agreements. Additionally, Plaintiffs' suggestion that Jamaica Anesthesia considers Plaintiffs' conduct to be a waiver of their alleged rights to the Cash Consideration is incorrect, as Jamaica Anesthesia contends that there was no need for a waiver because Plaintiffs already assigned any rights they had in the Cash Consideration pursuant to their Employment Agreements. Plaintiffs' course of conduct in continually permitting Jamaica Anesthesia to collect any dividends, credits, and returned premiums for the Policies is evidence not of a waiver, but of their ongoing recognition that those monies belonged to Jamaica Anesthesia.

Jamaica Anesthesia further argues that if the Court finds that the Employment Agreements are silent on the issue of entitlement to Cash Consideration, the Court is bound to follow *Schaffer*. Moreover, the Insurance Law, the Plan of Conversion, and the DFS Decision do not determine allocation of the Cash Consideration but, instead, require an examination of the relationship between the parties. Thus, Jamaica Anesthesia's relationship to Plaintiffs as their

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employer and the party that paid all of the premiums for the Policies requires that Jamaica Anesthesia receive the Cash Consideration under principles of unjust enrichment or, alternatively, under the Employment Agreements.

On reply and in opposition to Defendants' cross motion, Plaintiffs argue that they are entitled to the Cash Consideration under New York Insurance Law and the Plan of Conversion as approved by the DFS Decision, which govern the appropriate recipient entitled to the Cash Consideration. Plaintiffs further contend that it is clear that the Superintendent contemplated the central issue raised by Jamaica Anesthesia in the instant matter and found that the policyholders were entitled to the Cash Consideration. Since this issue was addressed by the Superintendent, if Jamaica Anesthesia wanted to challenge her determination, it had to do so in an Article 78 proceeding, and Jamaica Anesthesia should not be permitted to proceed under a plenary action by way of an unjust enrichment claim to challenge the DFS Decision.

Plaintiffs aver that the facts of *Schaffer* are inapposite to the facts of this matter. Here, the Employment Agreements address the terms and conditions under which the parties are governed with respect to the administration and handling of the Policies. Jamaica Anesthesia decided not to include additional language requiring that the Plaintiffs return the Cash Consideration in the event of MLMIC's demutualization. Additionally, in *Schaffer*, the issue decided by the Court was limited to the controversy presented by the agreed-upon facts, and the parties did not address the DFS Decision or mention the statute governing demutualizations, all of which provide the basis for why Plaintiffs in this action as policyholders and owners are entitled to the monies. Thus, *Schaffer* instead narrowly reviewed the agreed-upon facts in the context of a traditional unjust enrichment claim, and *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc.3d 703 (Sup. Ct. Erie Cty. Mar. 22, 2019), remains the relevant decision specifically addressing Plaintiffs' statutory entitlement under the demutualization and applicable law. Further, in this case, each of the contracts provide that the insurance is a benefit to each of the Plaintifs and limits Jamaica Anesthesia's rights to funds to premium refunds. In *Schaffer*, there was no such contract, as that case involved an offer letter which, among the benefits described, did not include the medical malpractice policy.

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Finally, Plaintiffs argue that Jamaica Anesthesia's breach of contract claim fails as a matter of law, as the Employment Agreements are unambiguous and only require that Plaintiffs return any refund premiums. Jamaica Anesthesia does not argue that the Employment Agreements are ambiguous on their face and instead asks the Court to look beyond the four corners of the agreements and incorporate terms and obligations not required by the agreements.

The Court heard oral argument on the parties' motions on October 7, 2019. Counsel for the moving parties filed correspondence alerting the Court to recent relevant decisions both prior and subsequent to oral argument.

RULING OF THE COURT

A. Motion for Summary Judgment

On a motion for summary judgment, the moving party must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact. *Nomura Asset Capital Corp. v. Cadwalader, Wickersham & Taft LLP*, 26 N.Y.3d 40, 49 (2015), quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 (1986). If the moving party produces the requisite evidence, the burden then shifts to the non-moving party to establish the existence of material issues of fact which require a trial of the action. *Nomura Asset Capital Corp.*, 26 N.Y.3d at 49, quoting *Alvarez*, 68 N.Y.2d at 324. Viewing the evidence in the light most favorable to the non-moving party, if the non-moving party, nonetheless, fails to establish a material triable issue of fact, summary judgment for the movant is appropriate. *Nomura Asset Capital Corp.*, 26 N.Y.3d at 49, quoting *Ortiz v. Varsity Holdings, LLC*, 18 N.Y.3d 335, 339 (2011).

B. Contract and Quasi-Contract Principles

The elements of a breach of contract claim are "the existence of a contract, the plaintiff's performance pursuant to the contract, the defendant's breach of its contractual obligations, and damages resulting from the breach." *El-Nahal v. FA Management, Inc.*, 126 A.D.3d 667, 668 (2d Dept. 2015) citing, *inter alia*, *Dee v. Rakower*, 112 A.D.3d 204, 208-209 (2d Dept. 2013). A contract is ambiguous where its terms are "reasonably susceptible of more than one interpretation." *Obstfeld v. Thermo Niton Analyzers, LLC*, 112 A.D.3d 895, 897 (2d Dept. 2013), quoting *Chimart Assoc. v. Paul*, 66 N.Y.2d 570, 573 (1986). Whether a contract is

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ambiguous is a question of law, and where a contract is, in fact, ambiguous, the court may consider extrinsic evidence to determine the parties' intent. *Obstfeld*, 112 A.D.3d at 897.

To state a claim for unjust enrichment, the plaintiff must demonstrate "1) the defendant was enriched, 2) at the plaintiff's expense, and 3) that it is against equity and good conscience to permit the defendant to retain what is sought to be recovered." *Mobarak v. Mowad*, 117 A.D.3d 998, 1001 (2d Dept. 2014). Unjust enrichment claims are equitable in nature and, thus, are only appropriate where a valid and enforceable contract does not cover the dispute at issue. *First Class Concrete Corp. v. Rosenblum*, 167 A.D.3d 989, 990 (2d Dept. 2018).

C. *Schaffer* and its Progeny

On April 4, 2019, the First Department rendered a decision in the *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465, 465 (1st Dept. 2019), and determined, upon stipulated facts submitted to the Court pursuant to CPLR § 3222(b)(3), that the employer[2] was entitled to the cash proceeds resulting from the demutualization of MLMIC. The Court concluded that 1) while the physician was named as the insured on the subject MLMIC professional liability insurance policy, the petitioner purchased the policy and paid all of the premiums on it, 2) the physician did not deny that she did not pay any of the annual premiums or any of the other costs related to the policy, and 3) the physician did not bargain for the benefit of the demutualization proceeds. *Id.* The Court held that "[a]warding the [physician] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment." *Id.*

In the wake of *Schaffer*, a number of trial courts have considered disputes arising out of the demutualization of MLMIC and, in particular, the issue of whether the employer or employee is entitled to the demutualization proceeds. The vast majority of trial courts have relied upon *Schaffer* in concluding that the premium-paying employer is entitled to the demutualization proceeds. *See Long Island Radiology Assocs., P.C. v. Koshy*, Index No. 600195-19 (Sup. Ct. Nassau Cty. Oct. 8, 2019) (Libert, J.); *Shoback v. Broome Obstetrics and Gynecology*, Index No. EFCA2018003334 (Sup. Ct. Broome Cty. Sept. 10, 2019); *Mid-Manhattan Physician Servs.*,

[2]The Submitted Facts Pursuant to CPLR 3222 filed in connection with *Schaffer*, *see* Kramer Affm. at Exh. 5, clarify that the respondent-physician was employed by the petitioner-private practice radiology group.

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P.C. v. Dworkin, Index No. 656478-18, 2019 WL 4261348 (Sup. Ct. N.Y. Cty. Sept. 4, 2019); *John T. Maher Memorial Hospital of Port Jefferson, New York, Inc. v. Fadel*, Index No. 624734-18 (Sup. Ct. Suffolk Cty. Aug. 21, 2019); *Maple Medical LLP v. Scott*, 64 Misc.3d 909 (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Mutic*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Goldenberg*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Arevalo*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Sundaram*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Youkeles*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 64 Misc.3d 1215(A) (Sup. Ct. Saratoga Cty. Jun. 7, 2019).

The opposite result was reached, however, in *Columbia Memorial Hospital v. Hinds*, 65 Misc.3d 1205(A) (Sup. Ct. Columbia Cty. Sept. 3, 2019). There, the Columbia County Supreme Court granted the physician's motion seeking 1) dismissal of the hospital's claims regarding the demutualization proceeds, and 2) an Order declaring that the physician was entitled to the demutualization proceeds. The *Hinds* Court held, in relevant part, that *Schaffer* was not controlling because the facts differed insofar as the physician's insurance premiums were paid in lieu of compensation. Particularly, the physician's employment agreement provided that he would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance.

D. Application of the Principles to the Instant Action

Plaintiffs' motion for summary judgment is denied. Contrary to Plaintiffs' contentions, *Schaffer* – the only Appellate Division to date addressing a dispute regarding the MLMIC Cash Consideration proceeds– is controlling unless and until this issue is addressed by the Court of Appeals or Second Department. *See Mountain View Coach Lines v. Storms*, 102 A.D.2d 663, 664-65 (2d Dept. 1984) ("[t]he Appellate Division is a single State-wide court divided into departments for administrative convenience and, therefore, the doctrine of *stare decisis* requires trial courts in this department to follow precedents set by the Appellate Division of another department until the Court of Appeals or this court pronounces a contrary rule"). *Schaffer* clearly held that because the physician did not pay any of the costs related to the policy and did not

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bargain for the benefit of the demutualization proceeds, the physician would be unjustly enriched by an award of the demutualization proceeds. Here, Plaintiffs undisputedly did not pay any of the costs related to the Policies and their receipt of malpractice insurance as an alleged benefit does not render *Schaffer* factually distinguishable. Indeed, this conclusion is consistent with the Court's determination in *NRAD Medical Associates, P.C. v. Kim*, Index No. 617351-18 (Sup. Ct. Nassau Cty. Oct. 28, 2019), which also involved a dispute between a medical practice and its employees regarding MLMIC's demutualization proceeds. Further, this matter is not analogous to the persuasive authority of *Hinds*, where the subject employment agreement provided that the physician would not receive incentive pay until the revenue generated by his services exceeded the amount of his malpractice insurance. To the extent that Plaintiffs rely on *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc.3d 703 (Sup. Ct. Erie Cty. Mar. 22, 2019), the Court respectfully declines to follow *Nasrin*, which was determined prior to *Schaffer*.

Jamaica Anesthesia's motion for summary judgment is granted in part and denied in part. Summary judgment is denied as to Jamaica Anesthesia's counterclaim for declaratory judgment of breach of contract. The Employment Agreements do not address entitlement to the Cash Consideration resulting from the demutualization of MLMIC, an issue which the parties clearly did not anticipate when they entered into the agreements. In particular, the provision in the Employment Agreements that any premiums returned in connection with the Policies shall be assigned to Jamaica Anesthesia is unambiguous and does not translate into a contractual entitlement to the Cash Consideration. Thus, a distribution of the Cash Consideration to Plaintiffs would not constitute a breach of contract.

Summary judgment, however, is granted to Jamaica Anesthesia as to Plaintiffs' claim and Jamaica Anesthesia's second counterclaim for declaratory judgment of unjust enrichment. For the reasons set forth above in its discussion of Plaintiffs' claims, the Court concludes that given Jamaica Anesthesia's undisputed payment of the costs related to the Policies, a distribution of the Cash Consideration to Plaintiffs would constitute unjust enrichment. Accordingly, Jamaica Anesthesia is entitled to its requested declaration that distribution of the Cash Consideration to Plaintiffs would constitute unjust enrichment, and that Jamaica Anesthesia is entitled to receive

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the Cash Consideration associated with the Policies. MLMIC shall direct the Conversion Agent (as defined in the Plan) to disburse the Cash Consideration to Jamaica Anesthesia.

CONCLUSION

Plaintiffs' motion is denied. Jamaica Anesthesia's motion is granted in part and denied in part. Jamaica Anesthesia is awarded summary judgment in its favor on Plaintiffs' claim and on its second counterclaim for declaratory judgment of unjust enrichment.

MLMIC shall direct the Conversion Agent (as defined in the Plan) to disburse the Cash Consideration to Jamaica Anesthesia.

Settle judgment on ten (10) days notice.

All matters not decided herein are hereby denied.

This constitutes the decision and order of the Court.

DATED: Mineola, NY
November 26, 2019

ENTER

HON. TIMOTHY S. DRISCOLL
J.S.C.

X X X

ENTERED
DEC 02 2019
NASSAU COUNTY
COUNTY CLERK'S OFFICE

FILED: WESTCHESTER COUNTY CLERK 12/20/2019 09:35 AM INDEX NO. 70720/2018
NYSCEF DOC. NO. 67 RECEIVED NYSCEF: 12/20/2019

To commence the statutory time period for appeals as of right (CPLR 5513 [a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER
PRESENT: HON. WILLIAM J. GIACOMO, J.S.C.

---x

JEREMY A. BRAUER, M.D.,

Plaintiff,

Index No. 70720/2018

– against –

Sequence No. 1 & 2

DR. R. G, GERONEMUS, M.D., P.C. and MLMIC INSURANCE COMPANY f/k/a MEDICAL LIABILITY MUTUAL INSURANCE CORPORATION,

Defendants.

DECISION & ORDER

---x

In an action for a judgment declaring that the plaintiff is entitled to distribution payments made by the defendant Medical Liability Mutual Insurance Company (1) the defendant Dr. R. G, Geronemus, M.D., P.C. moves for summary judgment dismissing the complaint, pursuant to CPLR 3212 (motion sequence #1); and (2) the plaintiff cross-moves for summary judgment pursuant to CPLR 3212 on the complaint and to dismiss the counterclaims (motion sequence #2):

Papers Considered

1. Notice of Motion/Affirmation of Kevin G. Donoghue, Esq./Exhibits A-L/Affirmation of Roy G. Geronemus, M.D./Exhibit A;
2. Notice of Cross Motion/Affidavit of Jeremy A. Brauer, M.D./Exhibits A-H/Affirmation of Caroline P. Wallitt, Esq./Exhibits I-J;
3. Reply Affirmation of Kevin G. Donoghue, Esq./Exhibit A;
4. Reply Memorandum of Law.

Factual and Procedural Background

The plaintiff, Jeremy A. Brauer, M.D., was employed by defendant Dr. R. G. Geronemus, M.D., P.C. (hereinafter referred to as the P.C.) between July 11, 2013, and August 2017. Pursuant to the terms of Dr. Brauer's employment agreement, he was to maintain medical malpractice insurance which was paid for by the P.C.

The defendant Medical Liability Mutual Insurance Company ("MLMIC") issued a medical malpractice insurance policy identifying Dr. Brauer as the policyholder and the P.C. as the policy administrator. It is undisputed that the P.C. paid the policy premiums during Dr. Brauer's employment tenure.

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In July 2016, MLMIC applied to the New York State Department of Financial Services for permission to file a plan to convert from a mutual insurance company to a stock insurance company. As a result of the plan of conversion, MLMIC's policyholders were to receive cash consideration for the extinguishment of their policyholder membership interests. The conversion payment for Dr. Brauer's policy is $139,914.95. MLMIC is holding the payment in escrow.

Dr. Brauer commenced this action against the P.C. and MLMIC. The complaint seeks a judgment declaring that Dr. Brauer is entitled to distribution of the conversion payment, that the P.C. has no right to the conversion payment, and that MLMIC shall release the conversion payment to Dr. Brauer.

The P.C. joined issue and counter claimed for a judgment declaring that it is entitled to the conversion payments and that MLMIC turn over the funds to the P.C.

The P.C. moves for summary judgment dismissing the complaint. The P.C. argues that this Court is bound, by stare decisis, to follow the only Appellate Court decision on this issue from the First Department in *Schaffer, Schonholz & Drossman, LLP v. Title*, 171 AD3d 465 [1st Dept 2019]). In addition, the P.C. submits an affidavit of its president, Roy G. Geronemus, M.D. Dr. Geronemus attests that all of the practice's employees received medical malpractice insurance through MLMIC. The practice paid the entirety of the premiums for the policy insuring Dr. Brauer. The practice performed all the functions and maintained the policy for Dr. Brauer including corresponding with MLMIC and taking responsibility for any claims issues.

Dr. Brauer argues that he is entitled to the conversion payment from the MMLIC membership interest. Dr. Brauer points to the MLMIC information statement, dated June 29, 2018, stating that in order for the cash payments to be made to the policy administrator, i.e. the P.C., Dr. Brauer must appoint his policy administrator to receive the distribution. Dr. Brauer attests that he has not executed the consent form.

Discussion

In *Matter of Schaffer, Schonholz & Drossman, LLP v Title*, 171 AD3d 465, the First Department declared that the petitioner former employer was entitled to the cash proceeds resulting from the demutualization of MLMIC. The Court held that although the respondent, Dr. Title, was named as the insured on the MLMIC professional liability insurance policy, the employer purchased the policy and paid all the premiums. Dr. Title did not deny that she did not pay any of the annual premiums or any of the other costs related to the policy or bargain for the benefit of the demutualization proceeds. The Court held that awarding Dr. Title the cash proceeds of MLMIC's demutualization would result in her unjust enrichment.

As in *Schaffer*, here, Dr. Brauer is the named insured on the MLMIC policy and the P.C. is the policy administrator. The policy was purchased by the P.C. and the P.C. paid all the premiums. Moreover, the employment agreement between plaintiff and Dr. Brauer

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is silent as to demutualization and therefore, Dr. Brauer did not bargain for the benefit of the demutualization proceeds.

Stare decisis requires this Court to follow precedent set by the Appellate Division of another department until the Court of Appeals or the Second Department pronounces a contrary rule (*see Mtn. View Coach Lines, Inc. v Storms*, 102 AD2d 663, 664 [2d Dept 1984]). In fact, in six actions involving an employer and individual physicians with the same set of facts as *Schaffer*, the Supreme Court, Westchester County (Ecker, J.), relying upon *Schaffer*, declared that the employer was entitled to receipt of the cash considerations (*see Maple Med. LLP v Scott*, 2019 NY Slop Op 29210, et al.).

Furthermore, the P.C. demonstrated entitlement to summary judgment by establishing, as a matter of law, that it acted as the policy administrator by choosing the insurer, paying the annual premiums, and communicating with the insurer. In opposition, Dr. Brauer failed to raise a triable issue of fact.

The parties remaining contentions have been considered by the Court and are found to be without merit.

Accordingly, it is

ORDERED that the motion of the defendant Dr. R. G. Geronemus, M.D., P.C. for summary judgment pursuant to CPLR 3212 is GRANTED (motion sequence #1); and it is further

ORDERED that the plaintiff's cross motion for summary judgment on the complaint and to dismiss the cross claims, pursuant to CPLR 3212, is DENIED (motion sequence #2); and it is further

ORDERED ADJUDGED AND DECLARED that the defendant Dr. R. G. Geronemus, M.D., P.C. is entitled to the conversion payment from Medical Liability Mutual Insurance Company associated with the professional liability policy of insurance to Jeremy A. Brauer, M.D., in the amount of $139,914.95, which amount shall be paid to defendant Dr. R. G. Geronemus, M.D., P.C. within **twenty days** of service of this order with notice of entry; and it is further

ORDERED that upon payment of the amount due to Dr. R. G. Geronemus, M.D., P.C., in connection herewith, the action is dismissed.

Dated: White Plains, New York
December 19, 2019

HON. WILLIAM J. GIACOMO, J.S.C.

H: ALPHABETICAL MASTER LIST-WESTCHESTER/Brauer v. Dr. R.G. Geronemus, M.D.

FILED: QUEENS COUNTY CLERK 12/19/2019 11:16 AM INDEX NO. 707615/2019
NYSCEF DOC. NO. 39 RECEIVED NYSCEF: 12/19/2019

SHORT FORM ORDER

NEW YORK STATE SUPREME COURT - QUEENS COUNTY

Present: Honorable Leonard Livote IAS TERM, PART 33
Acting Supreme Court Justice

----------X:

EPISCOPAL HEALTH SERVICES, INC., d/b/a ST JOHN'S EPISCOPAL HOSPITAL,

Plaintiff,

-- against --

JAMES HENRY, M.D.,

Defendants.

----------X

Index No: 707615/19

Motion Date: 9/10/19

Seq. No: 1

The following papers numbered 1 to 8 read on this motion by Defendant for an Order to Dismiss.

	PAPERS NUMBERED
Notice of Motion, Affirmation, Affidavits and Exhibits.....	1 - 4
Affidavit in Opposition.....	5 - 6
Reply Affirmations, Affidavits and Exhibits.....	7 - 8

Upon the foregoing papers, the motion is denied.

Plaintiff purchased a medical malpractice insurance policy from MLMIC in 1997. Subsequently, in 2001 defendant became employed part-time by the plaintiff-Hospital as an orthopedic surgeon pursuant to the terms of an employment agreement, which was later renegotiated and renewed in 2011. As part of the consideration to be paid to defendant in exchange for his willingness to provide services for the Hospital, the Hospital agreed to pay 75% of defendant's MLMIC insurance premiums during the relevant period.

In late-2018, by a vote of its policyholders (including Plaintiff), MLMIC was sold to National Indemnity Company, a subsidiary of Berkshire-Hathaway, and "demutualized" - meaning it was converted from a mutual insurance company owned by its policyholders to a stock insurance company owned by conventional shareholders. As part of that transaction, Plaintiff received the Cash Consideration in exchange for his mutual

ownership interest in MLMIC. Upon learning of the payment of the Cash Consideration to Plaintiff , the Hospital demanded that Dr. Henry remit the funds to the Hospital, to which Plaintiff refused on multiple occasions.

Subsequently, the Hospital commenced the instant litigation in an attempt to obtain the Cash Consideration paid to Plaintiff as a former mutual owner of MLMIC. Plaintiff moves to dismiss.

"On a motion to dismiss the complaint pursuant to CPLR 3211(a)(7) for failure to state a cause of action, the court must afford the pleading a liberal construction, accept all facts as alleged in the pleading to be true, accord the plaintiff the benefit of every possible inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (*Rabos v. R & R Bagels & Bakery, Inc.*, 100 AD3d 849, 2012 N.Y. Slip Op 07974, 2012 WL 5870676 [2nd Dept 2012]).

To grant a motion to dismiss due to "a defense that is founded upon documentary evidence" pursuant to CPLR §3211(a)(1), the evidence in question must "utterly refute the plaintiff's allegations and establish a defense as a matter of law." (See, *Goshen v. Mutual Life Ins. Co.*, 98 NY2d 314,[2002]). "To be considered 'documentary,' evidence must be unambiguous and of undisputed authenticity" (*Fontanetta v Doe*, 73 AD3d 78, 86 [2d Dept 2010]).

The complaint alleges 3 causes of action. The first cause of action is for unjust enrichment. "The elements of unjust enrichment are that the defendants were enriched, at the plaintiff's expense, and that it is against equity and good conscience to permit the defendants to retain what is sought to be recovered" (*County of Nassau v Expedia, Inc.*, 120 AD3d 1178, 1180 [2d Dept 2014]). Under the facts alleged, plaintiff has stated a claim for unjust enrichment (*see, Schaffer, Schonholz & Drossman, LLP v Tit.*, 171 AD3d 465 [1st Dept 2019]).

The second cause of action alleges money had and received. The elements of a cause of action for money had and received are: (1) that the defendant received money belonging to the plaintiff: (2) that the defendant benefitted from that money; and (3) that equity and good conscience will not permit the defendant to keep the money (*Torrance Const., Inc. v. Jaques*, 127 A.D.3d 1261, 1263 [3d Dep't 2015]). This claim is merely the unjust enrichment claim stated in a different manner. Accordingly, plaintiff has stated a claim for monies had and received.

The third cause of action alleges that the defendant

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breached the implied covenant of good faith and fair dealing contained in the contract. "The implied covenant of good faith and fair dealing is breached when a party acts in a manner that would deprive the other party of the right to receive the benefits of their agreement" (*1357 Tarrytown Rd. Auto, LLC v Granite Properties, LLC*, 142 AD3d 976, 977 [2d Dept 2016]).

Where a contract is ambiguous or incomplete, extrinsic and parol evidence is admissible (*see, R/S Assoc. v New York Job Dev. Auth.*, 98 NY2d 29, 33 [2002]). In the instant case, the contract does not address what the parties expectations were in the event of a demutualization. Thus, extrinsic evidence is admissible and dismissal would be premature.

Accordingly, the motion is denied.

This constitutes the Order of the Court.

Dated: December 10, 2019

.....
Leonard Livote, A.J.S.C.

FILED: SUFFOLK COUNTY CLERK 08/22/2019 04:03 PM INDEX NO. 624734/2018
NYSCEF DOC. NO. 76 RECEIVED NYSCEF: 08/22/2019

Short Form Order

Index No. 624734/2018

SUPREME COURT – STATE OF NEW YORK
PART 55 - SUFFOLK COUNTY

PRESENT:
Hon. George Nolan
Justice Supreme Court

x

JOHN T. MATHER MEMORIAL HOSPITAL OF PORT JEFFERSON, NEW YORK, INC.,

Plaintiff,

-against-

DINA ABI FADEL,

Defendant.

x

Mot. Seq. No. #001 - MG CASEDISP
Mot. Seq. No. #002 - MD
Orig. Return Date: 04/12/2019
Mot. Submit Date: 08/15/2019

PLAINTIFF'S ATTORNEY
KIRKLAND & ELLIS LLP
601 Lexington Avenue
New York, NY 10022

DEFENDANT'S ATTORNEY
BAUMAN & KUKAJ
120 E. 37th Street
New York, NY 10016

Upon the e-filed documents numbered 07 through 39 and 42 through 62 (motion sequence nos. 001 and 002), and upon due deliberation and consideration by the Court of the foregoing papers, it is hereby determined as follows:

Plaintiff, John T. Mather Memorial Hospital of Port Jefferson, New York, Inc. ("Mather Hospital") moves, and defendant Dina Abi Fadel ("Fadel") cross moves, pursuant to CPLR 3212 and 3001, each seeking an order granting summary judgment and a declaration of their ownership right to certain cash proceeds resulting from the demutualization of the Medical Liability Mutual Insurance Company ("MLMIC").

Mather Hospital is a non-profit community teaching hospital located in Port Jefferson, New York. For many years, Mather Hospital provided its physician employees with medical malpractice insurance coverage under policies it purchased from MLMIC. Defendant Fadel is a physician who worked for Mather Hospital between August, 2015 and June, 2017. When Fadel began her employment, Mather Hospital added her to its MLMIC medical malpractice insurance policy. It is undisputed that Mather Hospital paid all of the premiums and costs related to the policy while the defendant was employed by the hospital. The defendant states in an affidavit attached to her moving papers that she took certain affirmative actions to qualify for the medical malpractice coverage, but she does not assert that she bargained with Mather Hospital for the demutualization proceeds that are in dispute in this action.

FILED: SUFFOLK COUNTY CLERK 08/22/2019 04:03 PM INDEX NO. 624734/2018
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At the time the defendant began her employment with Mather Hospital, MLMIC was a mutual insurance company owned by its policyholders. However, between 2016 and October 1, 2018, MLMIC negotiated and completed the sale of its business to the National Indemnity Company ("NICO"), a subsidiary of Berkshire Hathaway, which formed a stock company and paid $2.5 billion for MLMIC's assets. The New York State Department of Financial Services approved a conversion or "demutualization" plan which provided a methodology for the pro-rata distribution of the sale proceeds to eligible policyholders. While the conversion plan approved by the New York State Department of Financial Services defined "eligible policyholder" as the named insured and not the entity which paid the premiums, the plan also included an objection and escrow procedure for the resolution of disputes for those persons and entities disputing whether a policyholder was entitled to the payment.

The amount of demutualization consideration allocable to the defendant's insurance coverage is $55,774.68. Mather Hospital objected to the payment of this sum to the defendant and these monies are currently being held in escrow pending the resolution of this dispute.

The facts in this case are indistinguishable from those presented in the recent Appellate Division decision, ***Matter of Schaffer, Schonholz & Drossman v. Title***, 171 AD3d 465, 96 NYS3d 96 [1st Dept 2019]. As in the instant action, ***Matter of Schaffer*** involved a physician named as an insured on a MLMIC policy. The doctor's employer purchased the policy and paid all of the premiums and costs related to the policy. As in this case, the doctor in ***Matter of Schaffer*** *(id.)* did not bargain for the demutualization proceeds. Based on these facts, the Appellate Division, First Department, concluded that awarding the doctor the cash proceeds resulting from the demutualization of MLMIC would result in her unjust enrichment.

This court concurs with the First Department's conclusion in ***Matter of Schaffer*** *(id.)*. "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." (***Mandarin Trading Ltd v W. Ivenstein***, 16 NY3d 173, 919 NYS2d 465 [2011], *quoting* ***Paramount Film Distrib. Corp. v State of New York***, 30 NY2d 415, 421, 334 NYS2d 388 [1972]. Under the facts of this case, awarding defendant Fadel the demutualization proceeds would result in her unjust enrichment. Accordingly, it is

ORDERED that the motion of plaintiff John T. Mather Memorial Hospital of Port Jefferson, New York, Inc., made pursuant to CPLR 3212 and 3101, for an order granting summary judgment in its favor and for declaratory judgment against defendant Dina Abi Fadel, is granted; and it is further

ORDERED that the motion of defendant Dina Abi Fadel, made pursuant to CPLR 3212 and 3101, for an order granting summary judgment in favor of the defendant and for declaratory judgment against the plaintiff John T. Mather Memorial Hospital of Port Jefferson, New York, Inc., is denied and the defendant's counterclaim is dismissed; and it is further

FILED: SUFFOLK COUNTY CLERK 08/22/2019 04:03 PM INDEX NO. 624734/2018
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ORDERED, ADJUDGED and DECREED that plaintiff John T. Mather Memorial Hospital of Port Jefferson, New York, Inc., is entitled to the receipt of funds in the amount of $55,774.68, currently held in escrow, plus accrued interest, said amount representing the pro-rata amount assigned to the account of defendant Dina Abi Fadel; and it is further

ORDERED that the Clerk of the Court enter judgment in favor of John T. Mather Memorial Hospital of Port Jefferson, New York., Inc., in the amount of $55,774.68, plus accrued interest, if any, from October 1, 2018 to the date of judgment.

The foregoing constitutes the decision and Order of the Court.

ENTER

Date: August 21, 2019
Riverhead, New York

HON. GEORGE NOLAN, J.S.C.

__X__ FINAL DISPOSITION **____ NON-FINAL DISPOSITION**

ADD-24

FILED: NASSAU COUNTY CLERK 10/09/2019 04:51 PM INDEX NO. 600195/2019
NYSCEF DOC. NO. 127 RECEIVED NYSCEF: 10/09/2019

SUPREME COURT - STATE OF NEW YORK

PRESENT: HON. JACK L. LIBERT,
Justice.

TRIAL PART 23
NASSAU COUNTY

LONG ISLAND RADIOLOGY ASSOCIATES, P.C.

Plaintiff,

-against-

MOTION # 02, 04, 05
INDEX # 600195/19
MOTION SUBMITTED:
AUGUST 2, 2019
md, md, mg

XXX

ABEY KOSHY, ALICIA A. CAMBRIA, AMARYLLIS MENDEZ, ANGELA T. LAINO, ANGELA RAMOS, ARON NAFISI, BASIL J. OSABU, BENJAMIN A. GOBIOFF, BIND KEERIKATTE, BRIGITTE M. GEFFKEN-KELLY, CARLOS A. MONTILLA, CARMEN H. SANTOS, CHRISTINA L. WEEDON, CHRISTINA PALMIERO-WILLIAMS, CYNTHIA BRITO, DANIEL E. BEYDA, DEBORAH A. ASDAHL, DENNIS R. ROSSI, ELVIRA E. ERDAIDE, GEORGE H. CONNELL, GERALD SCHULZE, GEORGINA PEACHEY, HADASSAH HOFFMAN-BROWNSTEIN, HAMIDE CENAJ, IGOR CHER, IRINA MURATOVA, JAMIE L. ESPOSITO, JAMES M. LODOLCE, JASON W. SISK, JASON WILSON, JEFFREY JONES, JENNIFER E. D'AMBROSIO, JESSICA A. BOXER, JONATHAN OLIVERI, JOSE F. VALERIANO, KATIE L. O'SULLIVAN, KHALID U. KHAN, KRISTEN PERDICHIZZI, LANCE S. LEFKOWITZ, LISA G. LEE, MARGARET J. USURIELLO, MARILYN MADRID, MARINA TAMARKINA, MARTHA S. MORALES, MELISSA SPENCER, MICHAEL KLUKO, MILAGROS A. TLATOA, MIRA SHPIGELMAN, NILKA E. SANTANA, NORMA Y. ARCE, OLIVER PRATT, PASHA TORKAMANI, RON PANDOLFINI, SAMUEL M. ISSAC-REJIAH, SCOTT A. MCNALLY, STACY HONOVICH, SUZANNE CARLTON, THIERRY DUVIVIER, TINAMARIE P. THADAL, AND VICTORIA L. BEYDA,

Defendants.

The following papers having been read on this motion:

Notice of Motion/Order to Show Cause.....1, 2
Cross Motion/Answering Affidavits.....3, 4, 5, 6
Reply Affidavits.....7, 8, 9

FILED: NASSAU COUNTY CLERK 10/09/2019 04:51 PM INDEX NO. 600195/2019
NYSCEF DOC. NO. 127 RECEIVED NYSCEF: 10/09/2019

Pursuant to CPLR 3211 defendant Gerald Schulze moves for summary judgment dismissing the complaint against him and granting the declaratory relief sought in his counterclaims (Motion Seq. # 2); defendants Daniel E. Beyda and Victoria L. Beyda also move for dismissal of the complaint and summary judgment on their counterclaims (Motion Seq. # 4); plaintiff moves for summary judgment granting the relief sought in the complaint and dismissing the counterclaims of Schulze and the Beyda defendants (Motion Seq. # 5]).

Plaintiff owns and operates a radiological medical practice. Schulze is a former physician employee. The Beyda defendants were originally shareholders of plaintiff, but subsequently relinquished their shareholdings and became employees. Plaintiff provided malpractice insurance for each of the moving defendants through Medical Liability Mutual Insurance Company, which was a mutual company. As part of an approved demutualization plan, MLMIC agreed to a dividend payment[1] to policyholders of record, subject to a court determination as to whether that is the party equitably entitled to the proceeds. Plaintiff asserted in the instant action that it is entitled to the dividend distribution, having paid all the premiums and maintained the policies.

Defendant Schulze

At all relevant times Schulze was employed by plaintiff under the terms of an employment contract dated July 1, 2011. The compensation of Schulze was fixed on an annual basis (¶ Third, Schulze Affidavit). In addition to the annual compensation plaintiff agreed to pay certain expenses that Schulze would incur in connection his employment including the cost of malpractice insurance (Exhibit B, ¶ Fourth, Schulze Affidavit). These premium payments were not deducted from the compensation that Schulze received from plaintiff. Essentially they were in lieu of reimbursement

[1]The dividends are calculated based upon the premiums paid (Insurance Law §7307).

FILED: NASSAU COUNTY CLERK 10/09/2019 04:51 PM INDEX NO. 600195/2019
NYSCEF DOC. NO. 127 RECEIVED NYSCEF: 10/09/2019

to him for expenses he would have otherwise incurred. It is undisputed that plaintiff duly paid the insurance premiums throughout the course of Schulze's employment.

In the *Matter of Schaffer, Schonholz & Drossman, LLP v Title* (171 A.D.3d 465, 96 N.Y.S.3d 526 [1st Dept. 2019]) the court held:

> Although respondent was named as the insured on the relevant MLMIC professional liability insurance policy, petitioner purchased the policy and paid all the premiums on it. Respondent does not deny that she did not pay any of the annual premiums or any of the other costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds.

In the case at bar plaintiff paid the premiums at its own expense. Schulze received the benefit of his bargain having been relieved of the obligation to pay those premiums. Like the respondent in *Schaffer* (*supra*) Schulze would be unjustly enriched if he received the dividend based upon premiums that plaintiff paid.

The Beyda Defendants

With respect to their tenure as employees of plaintiff the Beyda defendants would be unjustly enriched in the same fashion as Schulze if allowed to collect the policy dividends. With respect to the period of time that they were shareholders, the Beyda defendants argue that the premiums paid were paid out of corporate funds which would otherwise have been distributed to them (presumably in *pari passu* to the respective ownership interests of all shareholders). Since "their equity interest contributed to the payment of MLMIC premiums" they claim to be entitled to the dividends.

Under general principles of corporate law, a shareholder and the corporation are separate entities. Even if they were not separate entities the position of the Beydas is contrary to reason. If the corporation distributed to shareholders the funds used to pay for the malpractice insurance, the

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Beyda defendants would not have had the insurance; unless they paid for it themselves in which event they would not have the distributed funds.

Conclusion

Plaintiff is entitled to the cash proceeds resulting from the demutualization of nonparty MLMIC. The motions of moving defendants (Motion Seq. # 2 and #4) are denied. Plaintiff's motion for summary judgment (Motion Seq. #5) is granted and the counterclaims are dismissed.

ORDERED and decreed, it is hereby declared that plaintiff is entitled to the proceeds of the MLMIC distribution; and it is further

ORDERED that MLMIC shall pay the cash proceeds in escrow together with interest accrued to plaintiff.

ORDERED, that any relief not specifically granted is denied.

Submit judgment.

ENTER

DATED: October 7, 2019

HON. JACK L. LIBERT
J. S. C.

ENTERED
OCT 09 2019
NASSAU COUNTY
COUNTY CLERK'S OFFICE

64 Misc.3d 909
Supreme Court, Westchester County, New York.

MAPLE MEDICAL LLP, Plaintiff,
v.
Joseph SCOTT, D.O. and Medical Liability Mutual Insurance Company, Defendants.

51103/2019

Decided on July 7, 2019

Synopsis

Background: Employer partnership brought complaint against employee physician seeking declaratory judgment as to who was entitled to distribution payment made by medical malpractice mutual insurance company, which issued policy covering employee physician that was paid for by employer partnership, pursuant to demutualization plan approved following sale of company to a subsidiary, which formed a stock company. Employee physician moved for summary judgment, and employer partnership cross-moved for summary judgment.

[Holding:] The Supreme Court, Westchester County, Lawrence H. Ecker, J., held that awarding proceeds to employee physician would result in employee's unjust enrichment.

Motion denied and cross-motion granted.

West Headnotes (2)

[1] Courts
Decisions of co-ordinate courts of same state

Where an issue has not been addressed within an Appellate Department, the trial court is bound by the doctrine of stare decisis to apply precedent established in another Department, either until a contrary rule is established by the Appellate Division in its own Department or by the Court of Appeals.

1 Cases that cite this headnote

[2] Implied and Constructive Contracts
Consideration or Purpose for Which Money Was Received

Awarding proceeds of stock sale of medical malpractice mutual insurance company's business to employee physician, rather than to employer partnership, would result in employee's unjust enrichment, despite employee being named as insured on policy, where employer purchased policy and paid all premiums and costs related to policy, and employee acknowledged that he did not bargain for benefit of demutualization proceeds.

1 Cases that cite this headnote

Attorneys and Law Firms

****824** Finger & Finger, Attorney for plaintiff, 158 Grand Street, White Plains, NY 10601

Nolan Heller Kauffman, LLP, Attorneys for defendants, 80 State Street, 11th Floor, Albany NY 12207

Rivkan Rakler LLP, Attorney for Defendants 926 Rxr Plaza Uniondale NY 1156

Opinion

Lawrence H. Ecker, J.

***910** Motion of defendant Joseph Scott, D.O.[1] (mot sequence No. 1), made pursuant to CPLR 3212, for an order granting summary judgment on the counterclaim for a declaratory judgment against plaintiff Maple Medical LLP, and cross motion of plaintiff (mot sequence No. 2), made pursuant to CPLR 3212, for an order granting summary judgment on the complaint as against Scott.

The court determines as follows:

This lawsuit is one of six litigations[2] before this court that involve plaintiff, as the employer partnership, and individual physicians, as plaintiff's employees. The parties in the separate actions are all represented by the same law firms.

At the heart of all of the actions is the same single legal issue: whether the physician employee or the employer partnership is entitled to a distribution payment made by Medical Liability Mutual Insurance Company ("MLMIC").[3] MLMIC is a medical ****825** malpractice insurance company that issued policies covering the employee physicians that were paid for by plaintiff as their employer. The parties in all six litigations seek, in essence, a declaratory judgment resolving this one central issue. As such, the court's finding herein will govern and resolve the pending motions in the other five actions.

Plaintiff is a limited liability partnership that operates a multispecialty medical practice in White Plains NY Pursuant to the employment agreement between Scott as employee and plaintiff as employer, Scott performed medical services for plaintiff. As part of Scott's employment compensation package, plaintiff paid the malpractice insurance premiums for coverage for Scott. Plaintiff was designated by Scott to serve as his agent for the purpose of administering the policy, the coverages, the reporting requirements, and the payment of the premium.

The policy insuring Scott was issued by MLMIC. At the time of that the insurance policy was issued, MLMIC was a mutual insurance ***911** company owned by its policyholders, one of whom was Scott.

Thereafter, MLMIC negotiated a sale of its business to a subsidiary of Berkshire-Hathaway, which formed a stock company, and paid MLMIC $2.5 Billion for the MLMIC assets. This demutualization plan ("the Plan") was approved by the New York State Department of Financial Services pursuant to Insurance Law § 7307. The Plan includes the methodology for the *pro rata* distribution of the proceeds of the sale to parties in interest. As for Scott's policy, the amount for the distribution allotted to the policy is $128,148 ("the Payment"). The question presented in this action is whether Scott or plaintiff is entitled to the Payment. Based upon the disagreement of the parties, the Payment is in escrow pending resolution of the dispute.

The complaint asserts four causes of action: declaratory judgment; breach of contract-covenant of good faith and fair dealing; Insurance Law § 7307; and unjust enrichment. The answer includes a counterclaim for declaratory judgment.

Each of the parties now moves for summary judgment on its claims, in essence seeking a declaration of which party is entitled to the Payment. The court will accept all papers submitted in this action for its review, notwithstanding Scott's argument that plaintiff did not follow proper procedure. There is no prejudice demonstrated, and this court strongly believes in the resolution of disputes upon the merits.

The court finds that the recent decision of the Appellate Division, First Department in *Matter of Schaffer, Schonholz & Drossman, LLP v. Title,* 171 A.D.3d 465, 96 N.Y.S.3d 526 ("the *Matter of Schaffer*"), decided April 4, 2019, is dispositive of the issues raised in this matter. Applying the principles set forth in the *Matter of Scaffer* decision to the facts presented, the court holds that plaintiff is therefore entitled to the distribution of the sales proceeds of MLMIC.

In the *Matter of Schaffer*, the parties, pursuant to CPLR 3222(b)(2), filed directly with the Appellate Court a statement of stipulated facts, together with their briefs. The statement of facts includes a section entitled "Controversy Presented ... Issue a declaratory judgment determining whether SS & D or Dr. Title is entitled to the disputed amount..."

A review of the facts in the *Matter of Schaffer* reveals that the litigation, like this action, involved a physician named as insured on a MLMIC policy. The doctor's employer, similar to ***912** plaintiff, purchased the policy and paid all of the premiums and costs related to the policy. Like Scott, the doctor acknowledged that she did not bargain for the benefit of the demutualization proceeds. Under the facts, the court held that:

> "Awarding [the doctor] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment (citations omitted)."

****826** Of note, Scott does not try to distinguish the facts in this case from the facts in the *Matter of Schaffer*. The parties here serve in the same roles as the parties in *Matter of Schaffer*, and, in fact, MLMIL is the relevant insurance company in both actions. Like in the *Matter of Schaffer*, the named employer here purchased and paid all of the premiums on the medical professional insurance policy covering the physician who now seeks the distribution payment based on the policy. In addition Scott, like the doctor in *Matter of Schaffer*, does not claim to have bargained for the benefit of the Payment. Hence, the issues before the Court in the *Matter of Schaffer* are identical to the issues before this court, namely whether the employee physician, whose MLMIC

premiums were paid by the employer, is entitled to the *pro rata* distribution of the stock sale proceeds.

Acknowledging that the facts are identical in the two actions, Scott argues that the First Department's decision in the *Matter of Schaffer* is not binding on this court. Scott further contends that, in any event, the First Department's determination based on the principles of unjust enrichment was in error because the issue was not properly argued to the appellate court.

[1] [2] Where an issue has not been addressed within an Appellate Department, the Supreme Court is bound by the doctrine of *stare decisis* to apply precedent established in another Department, either until a contrary rule is established by the Appellate Division in its own Department or by the Court of Appeals. *Phelps v. Phelps*, 128 A.D.3d 1545, 9 N.Y.S.3d 519 [4th Dept. 2015]; *D'Alessandro v. Carro*, 123 A.D.3d 1, 992 N.Y.S.2d 520 [4th Dept. 2015]; *see Mountain View Coach Lines v. Storms*, 102 A.D.2d 663, 664–665, 476 N.Y.S.2d 918 [2d Dept. 1984]. As such, in light of the identical facts and legal question presented here and in the *Matter of Schaffer*, the decision in the *Matter of Schaffer* is binding on this court. *See Mountain View Coach Lines v. Storms*, *supra*. Applying the holding from the *Matter of Schaffer* to the facts presented here, the court determines that the Payment is appropriately awarded to plaintiff.

In any event, the court finds that the conclusions drawn in the First Department's decision are persuasive, and that a ***913** similar holding in this action based on the principles of unjust enrichment is warranted. Simply put, awarding Scott the cash proceeds of MLMIC's demutualization would result in his unjust enrichment. *See Matter of Schaffer, Schonholz & Drossman, LLP v. Title, supra; see Paramount Film Distrib. Corp. v. State,* 30 N.Y.2d 415, 334 N.Y.S.2d 388, 285 N.E.2d 695 [1972].

The court has considered the additional contentions of the parties not specifically addressed herein. To the extent any relief requested by either party was not addressed by the court, it is hereby denied. Accordingly, it is hereby

ORDERED that the motion of defendant JOSEPH SCOTT, D.O. [Mot. Seq. 1], made pursuant to CPLR 3212, for an order granting summary judgment on the counterclaim for a declaratory judgment against plaintiff MAPLE MEDICAL LLP is denied; and it is further

ORDERED that the cross-motion of plaintiff MAPLE MEDICAL LLP [Mot. Seq. 2], made pursuant to CPLR 3212, for an order granting summary judgment on the first cause of action in the complaint for a declaratory judgment as against defendant JOSEPH SCOTT, D.O., is granted; and it is further

ORDERED that the second, third and fourth causes of action in the complaint are dismissed as moot; and it is further

ORDERED, ADJUDGED AND DECLARED that plaintiff MAPLE MEDICAL LLP is entitled to the receipt from the escrow agent currently holding funds due it in the amount of $128,148. plus accrued interest, if any, as to said amount representing the *pro rata* amount assigned to the account of JOSEPH SCOTT, D.O., which said amount shall be paid to plaintiff MAPLE MEDICAL LLP within fifteen ****827** (15) days of the service of this Order, with Notice of Entry, upon the Escrow Agent; and it is further

ORDERED that upon compliance with this Order, namely payment of the amounts due plaintiff MAPLE MEDICAL LLP by defendant MEDICAL LIABILITY MUTUAL INSURANCE COMPANY, the action shall be dismissed with prejudice.

The foregoing constitutes the Decision/Order/Judgment of the court.

All Citations

64 Misc.3d 909, 105 N.Y.S.3d 823, 2019 N.Y. Slip Op. 29210

Footnotes

1 Defendant points out that he is a doctor of osteopathy and not a doctor of medicine.

2 The other actions are *Maple Medical, LLP v Goldenberg*, 51105/2019; *Maple Medical LLP v Arevalo*, 51106/2019; *Maple Medical, LLP v Sundaram*, 51107/2019; *Maple Medical LLP v Mutic*, 51108/2019; *Maple Medical, LLP v Youkeles*, 51109/2019.

3 Medical Liability Mutual Insurance Company (MLMIC) is the escrow agent holding the relevant funds in escrow. MLMIC does not submit any papers relative to these motions. In its answer (NY St Cts Elec Filing [NYSCEF] Doc No. 14), it generally denied the allegations in the complaint and asserts affirmative defenses.

End of Document

KeyCite Yellow Flag - Negative Treatment
Distinguished by Women's Care in Obstetrics and Gynecology, P.C. v. Herrick, N.Y.Sup., November 4, 2019

63 Misc.3d 703
Supreme Court, Erie County, New York.

MAPLE-GATE
ANESTHESIOLOGISTS, P.C., Plaintiff
v.
Deixry NASRIN and Douglas Brundin, Defendants

818104/2018

Decided on March 22, 2019

Synopsis

Background: Employer, a medical practice, brought unjust enrichment and conversion action against employees, for whom employer had paid professional liability insurance premiums as employment benefit, after employees failed to transfer to employer cash consideration they received from liability insurer as result of insurer's extinguishment of employees' membership interests, alleging that consideration rightfully belonged to employer because it had paid insurance premiums. Employees filed motion to dismiss.

[Holding:] The Supreme Court, Erie County, Frank A. Sedita III, J., held that employer was not entitled to cash consideration granted to employees.

Motion granted.

West Headnotes (8)

[1] **Pretrial Procedure**
Availability of relief under any state of facts provable

Pretrial Procedure
Construction of pleadings

Pretrial Procedure
Presumptions and burden of proof

The trial court, when considering a motion for summary dismissal of complaint, must accept the facts as alleged in the complaint as true, accord the plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory. N.Y. CPLR § 3211.

1 Cases that cite this headnote

[2] **Pretrial Procedure**
Matters considered in general

Pretrial Procedure
Sufficiency and effect

Allegations in a complaint consisting of bare legal conclusions, as well as claims flatly contradicted by documentary evidence, are not entitled to consideration by trial court; such a complaint should be dismissed when the documentary evidence conclusively refutes its allegations. N.Y. CPLR § 3211.

1 Cases that cite this headnote

[3] **Conversion and Civil Theft**
Assertion of ownership or control in general

An actionable conversion takes place when someone, intentionally and without authority, assumes or exercises control over personal property belonging to someone else, interfering with that person's right of possession.

[4] **Conversion and Civil Theft**
Assertion of ownership or control in general

Conversion and Civil Theft
Title and Right to Possession of Plaintiff

The key elements of conversion are (1) the plaintiff's possessory right or interest in the property and (2) the defendant's dominion over the property or interference with it, in derogation of the plaintiff's rights.

[5] **Implied and Constructive Contracts**
Unjust enrichment

The key elements of unjust enrichment are (1) that the defendants were enriched (2) at the plaintiff's expense and (3) that it is against equity

and good conscience to permit the defendants to retain what is sought to be recovered.

1 Cases that cite this headnote

[6] **Implied and Constructive Contracts**
⇦ Unjust enrichment

The doctrine of unjust enrichment is a narrow one and is not a catchall cause of action to be used when others fail.

[7] **Implied and Constructive Contracts**
⇦ Unjust enrichment

Mere enrichment is not enough to warrant liability under theory of unjust enrichment and an allegation that the defendants received benefits, standing alone, is insufficient to establish the cause of action; critical is that the enrichment be unjust.

[8] **Insurance**
⇦ Conversions or reorganizations

Employer, a medical practice, was not entitled to receive cash consideration granted to employees, for whom employer paid professional liability insurance premiums, after professional liability insurer extinguished employees' membership interests; although employer was policy administrator, it was not policyholder, when employees signed up for insurer's policies, they acquired membership interests in insurer, and upon insurer's demutualization were thus entitled to receive consideration in exchange for equitable shares in insurer, and employees did not designate employer to receive cash consideration granted to them. N.Y. Insurance Law §§ 1211(a), 7307, 7307(e)(3).

2 Cases that cite this headnote

Attorneys and Law Firms

****838** BARCLAY DAMON, LLP, Attorneys for Plaintiff, Robert J. Portin and Michael E. Ferdman, Buffalo, of Counsel

HURWITZ & FINE, P.C., Attorneys for Defendant, Amber Storr and Andrea Schillaci, Buffalo, of Counsel

Opinion

Frank A. Sedita III, J.

***704** The plaintiff is suing the defendants for unjust enrichment and conversion. Before the court is the defendants' pre-Answer motion to dismiss the lawsuit.

The plaintiff is a medical practice. It provides anesthesia services to hospitals and ambulatory surgical centers in Western New York. These facilities require the plaintiff's physicians and Certified Registered Nurse Anesthetists to maintain professional liability insurance.

The defendants are Certified Registered Nurse Anesthetists. Defendant Deixry Nasrin was employed by the plaintiff from March 13, 2012 to April 28, 2017. Defendant Douglas Brundin was employed by the plaintiff from January 1, 2010 to January 6, 2016. Article 3 (c)(ii) of their employment agreements provided that the plaintiff would pay professional liability insurance premiums as an "employment benefit for and on behalf of" the employee. That insurance was secured through the Medical Liability Mutual Insurance Company (MLMIC). The defendants were named as the insured under their individual MLMIC policies. They consequently became policyholders and members of MLMIC.

MLMIC and the defendants entered into a "MLMIC Policy Administrator — Designation &/or Change" agreement, by which the defendants designated the plaintiff as their agent and policy administrator. According its terms, "The Policy Administrator is the agent of all Insureds herein for the paying of premium, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return premiums when due."

Neither the employment agreement nor the MLMIC Policy Administrator — Designation &/or Change agreement contained language indicating that the defendants ****839** waived, transferred or assigned their ownership interest in the policy to someone else.

The MLMIC Board of Directors approved a proposed transaction by which MLMIC would demutualize, convert to a stock ***705** insurance company, and be acquired by the National Indemnity Company (NICO) for $ 2.502 billion. The

MLMIC Board later adopted a plan of conversion, whereby cash consideration would be paid to policyholders/members in exchange for the extinguishment of the policyholder membership interests. Pursuant to § 8.2(a) of the Plan of Conversion (the Plan), "Each Eligible Policyholder (or it's designee) shall receive a cash payment in an amount equal to the applicable conversion." Pursuant to § 2.1 of the Plan, an "eligible policyholder" was the person designated as the insured, while a "designee" meant employers or policy administrators, "designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders." The Plan did not provide for the policy administrator to receive cash consideration absent such a designation from the policyholder/member.

The New York Superintendent of Financial Services held a public hearing and approved the Plan. In her September 6, 2018 decision (DFS Decision), the Superintendent wrote: "MLMIC's eligible policyholders will receive cash consideration. Insurance Law § 7307(e)(3) expressly defines those persons who are entitled to receive the proceeds of the Demutualization as each person who had a policy in effect during the three-year period preceding the MLMIC Board's adoption of the resolution (the 'Eligible Policyholders') and explicitly provides that each Eligible Policyholder's equitable share of the purchase price shall be determined based on the amount of the net premiums paid on eligible policies" (DFS Decision, p.4).

The DFS Decision also acknowledged testimony and written comments from medical groups. Nearly identical to the plaintiff's contentions in this case, the medical groups had argued that the cash consideration belonged to them because they had paid the premiums on behalf of the policyholders and/or had acted as the policy administrators. Addressing these arguments, the Superintendent of Financial Services wrote: "Insurance Law § 7307(e)(3) defines the policyholders eligible to be paid their proportional shares of the purchase price, but also recognizes that such policyholders may have assigned such legal right to other persons. Therefore, the plan appropriately ***706** includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to the payment in a given case." Such a claim would be, "decided either by agreement of the parties or by an arbitrator [which must be voluntary] or court" (DFS Decision, p.25).

The plaintiff did not make a claim, or otherwise avail itself of the objection and escrow procedure. MLMIC paid $ 18,532.60 to defendant Nasrin and $ 15,546.95 to defendant Brundin on October 4, 2018. Plaintiff's counsel corresponded to both defendants on the very same day. He threatened the defendants with legal action and demanded that they, "execute an [enclosed] Assignment Agreement transferring your right to the cash consideration to the practice."

Much of the foregoing detail is alleged in the plaintiff's complaint. It additionally alleges, inter alia, that the money received by the defendants is "unwarranted" and "rightly belongs to Maple-Gate" (¶ 29-32); that "it is against equity and good conscience" for defendants to have kept these ****840** benefits because the plaintiff paid the premiums (¶ 40); that the defendants were "unjustly enriched" (¶ 41); that the, "cash consideration that Defendants received is Maple-Gate's property" (¶ 45); and, that "by failing and refusing to remit the Benefit that each Defendant received, each Defendant has converted Maple-Gate's property" (¶ 48).

The defendants filed their motion to dismiss, in lieu of an Answer, on January 6, 2019. Pursuant to CPLR 3211(a)(7), the defendants allege that the complaint fails to state a cause of action. Pursuant to CPLR 3211(a)(1), the defendants also allege that the documentary evidence conclusively establishes that the plaintiff does not have a cause of action. The plaintiff's opposition papers were filed on February 8, 2019. Oral arguments were heard by the court on February 20, 2019.

In support of their motion to dismiss, the defendants principally contend that they were the lawful policyholders and thus possessed an actual and exclusive ownership interest in the cash consideration.

In opposition, the plaintiff principally contends that it is entitled to the cash consideration because it had a virtual ownership interest in the cash consideration; i.e. being designated as the policy administrator, paying the premiums and using any refunds to reduce overall business costs, "vested ***707** the Practice w/ virtually all incidents of ownership in the policies" (Plaintiff's Memorandum of Law, p.5). The plaintiff also contends that the Plan and the DFS Decision, "control everything in the case and take precedence over everything in the case" and that, "both expressly recognize the practice's claims to the proceeds and expressly or implicitly, at least, refute the claim that the defendants have to those proceeds as a matter of law" (Transcript of Motions Argument, p.11).

[1] [2] CPLR 3211 authorizes the summary dismissal of a complaint. The court, when considering such a motion, must accept the facts as alleged in the complaint as true, accord the plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory. *Leon v. Martinez,* 84 N.Y.2d 83, 88, 614 N.Y.S.2d 972, 638 N.E.2d 511; *Murnane Building Contractors, LLC v. Cameron Hill Construction, LLC,* 159 A.D.3d 1602, 1603, 73 N.Y.S.3d 848. A cause of action cannot, however, be predicated on mere conclusory statements unsupported by factual allegations. *Bratge v. Simons,* 167 A.D.3d 1458, 91 N.Y.S.3d 630; *Miller v. Allstate Indemnity Co.*, 132 A.D.3d 1306, 17 N.Y.S.3d 240. Allegations consisting of bare legal conclusions, as well as claims flatly contradicted by documentary evidence, are not entitled to consideration. *Maas v. Cornell University,* 94 N.Y.2d 87, 91, 699 N.Y.S.2d 716, 721 N.E.2d 966; *Attallah v. Milbank, Hadley, and McCloy, LLP* 168 A.D.3d 1026, 93 N.Y.S.3d 353. Such a complaint should be dismissed when the documentary evidence conclusively refutes its allegations. *Dominski v. Frank Williams & Son, LLC,* 46 A.D.3d 1443, 848 N.Y.S.2d 791 (*also see, Liberty Affordable Housing Inc. v. Maple Court Apartments,* 125 A.D.3d 85, 998 N.Y.S.2d 543).

[3] [4] The complaint's allegations are made in support of two causes of action, namely, conversion and unjust enrichment. An actionable conversion takes place when someone, intentionally and without authority, assumes or exercises control over personal property belonging to someone else, interfering with that person's right of possession. *Reeves v. Giannotta,* 130 A.D.3d 1444, 12 N.Y.S.3d 736. The key elements of conversion are (1) the plaintiff's possessory right or interest in the property and (2) ****841** the defendants dominion over the property or interference with it, in derogation of the plaintiff's rights. *Palermo v. Taccone,* 79 A.D.3d 1616, 1619-1620, 913 N.Y.S.2d 859.

[5] [6] [7] Like conversion, an unjust enrichment claim presupposes that the plaintiff has an ownership interest in the property or benefit it seeks to recover from the defendants (*see, 28 NY Practice,* ***708** *Contract Law* § 4:14; *Roslyn Union Free School District v. Barkan*, 71 A.D.3d 660, 661, 896 N.Y.S.2d 406). The key elements of unjust enrichment are (1) that the defendants were enriched (2) at the plaintiff's expense and (3) that it is against equity and good conscience to permit the defendants to retain what is sought to be recovered. The doctrine is a narrow one and is not a catchall cause of action to be used when others fail. *E.J. Brooks Company v. Cambridge Security Seals,* 31 N.Y.3d 441, 455, 105 N.E.3d 301. Mere enrichment is not enough to warrant liability and an allegation that the defendants received benefits, standing alone, is insufficient to establish the cause of action. Critical is that the enrichment be unjust (*see, Goel v. Ramachandran,* 111 A.D.3d 783, 791, 975 N.Y.S.2d 428).

[8] It is undisputed that the plaintiff received refunds, like returned dividends and premiums, while it was the policy administrator and MLMIC was the insurer. The benefit at issue in this matter is the cash consideration. Unlike a refund, the cash consideration was clearly intended to be in exchange for the extinguishment of the defendants' membership interest in MLMIC.

It is important to note that MLMIC was a mutual insurance company. Generally speaking, a mutual insurance company is a cooperative enterprise in which the policyholders constitute the members for whose benefit the company is organized, maintained, and operated (68 NY Jur. 2d Insurance § 179). In this regard, Insurance Law § 1211(a), provides in part, that: "Every domestic mutual insurance corporation shall be organized, maintained and operated for the benefit of its members as a non-stock corporation. Every policyholder shall be a member of such corporation." Thus, when the defendants, at the plaintiff's behest, signed up for professional liability policies issued by MLMIC, they acquired certain rights and benefits, including membership in MLMIC.

It is also important to take note of the demutualization process by which MLMIC was converted from a mutual insurance company into a stock insurance company acquired by NICO. § 7307 of the Insurance Law governs this process. Insurance Law § 7307(e)(3), in relevant part, provides 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, ***709** consideration payable in voting common shares of the insurer or other consideration, or both." The statute goes on to repeatedly refer to the eligible recipient as the policyholder and sets forth a formula regarding how to calculate the amount of consideration the policyholder would receive as a result of demutualization. The formula takes-into-account the amount of premiums paid. No distinction is made between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. Insurance Law

§ 7307 does not confer an ownership interest in the stock or to the to the cash consideration to anyone other than the policyholder.

Being designated as the policy administrator did not make the plaintiff a policyholder, did not make the plaintiff a member ****842** of MLMIC and did not entitle the plaintiff to the cash consideration. More was required. Under the Plan, the policyholder was required to designate someone as being entitled to the cash consideration before that person or entity was entitled to that benefit. The DFS Decision reiterated that it was the policyholder who was entitled to the cash consideration; recognized that such policyholders "may have assigned such legal right to other persons" (DFS Decision, p.25); and, tied eligibility for the objection and escrow process to when the policyholder had, in fact, assigned the right to cash consideration to another person or entity. It appears certain that such a designation or assignment never took place in this case. More to the point, the plaintiff does not allege that such a designation or assignment ever took place. This alone is fatal to the plaintiff's claim that it is entitled to the cash consideration.

As it appears the defendants never had designated the plaintiff to receive the cash consideration, it is no wonder that the plaintiff did not avail itself of the objection and escrow process. The plaintiffs instead demanded that the defendants, "execute an assignment agreement transferring your right to the cash consideration to the Practice." Such an explicit recognition of the defendant's *right* to the cash consideration undermines the claim that the they unlawfully converted it to themselves or that they were unjustly enriched. The transfer demand is also an implicit acknowledgement that the defendants had never designated the plaintiff to receive the cash consideration.

The controlling statutes and the documentary evidence conclusively demonstrate that the defendants had an actual ***710** and exclusive ownership interest in the cash consideration. Allegations to the effect that the plaintiff had a legally cognizable ownership interest in the cash consideration is flatly contradicted by the same statutes and evidence. Allegations to the effect that the defendants windfall was unwarranted, or that the defendants converted to themselves that which rightly belonged to the plaintiff, or that the defendants were unjustly enriched, or that it is against equity and good conscience for the defendants to keep their money, are nothing more than bare legal conclusions. Accordingly, the defendants' motion to dismiss the Complaint, pursuant to CPLR 3211(a)(1) and CPLR 3211(a)(7), is GRANTED.

The foregoing shall constitute the decision and order of this court.

All Citations

63 Misc.3d 703, 96 N.Y.S.3d 837, 2019 N.Y. Slip Op. 29075

End of Document

INDEX NO. 656478/2018
NYSCEF DOC. NO. 116 RECEIVED NYSCEF: 09/04/2019

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. DEBRA A. JAMES** **PART** **IAS MOTION 59EFM**

Justice

----------X

MID-MANHATTAN PHYSICIAN SERVICES, P.C.,

Plaintiff,

- v -

MELISSA DWORKIN and MEDICAL LIABILITY MUTUAL INSURANCE COMPANY

Defendant.

----------X

INDEX NO. 656478/2018

MOTION DATE 08/22/2019

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115

were read on this motion to/for SUMMARY JUDGMENT(AFTER JOINDER).

ORDER

Upon the foregoing documents, it is

ORDERED that the motion of defendant Melissa Dworkin that seeks summary judgment on her counterclaim for a declaratory judgment against plaintiff and her cross claim for declaratory judgment against defendant-stakeholder Medical Liability Mutual Insurance Company is denied; and it is further

ORDERED that the cross motion for a summary declaratory judgment in favor of plaintiff against defendant Dworkin on the first cause of action is granted; and it is further

ORDERED that branch of plaintiff's cross motion for summary judgment on the second, third, fourth, and fifth causes of action

is denied and upon a search of the record pursuant to CPLR 3212 (b), such causes of action are dismissed; and it is further

ADJUDGED and DECLARED that plaintiff is entitled to receive the funds held by defendant Medical Liability Mutual Insurance Company; and it is further

ORDERED that defendant Medical Liability Mutual Insurance Company and/or its Conversion Coordinator and/or its current escrow agent is directed to release or turn-over the funds directly to plaintiff Mid-Manhattan Physician Services, P.C.; and it is further

ORDERED that the branch of plaintiff's motion that seeks summary judgment dismissing the counterclaims interposed by defendant Dworkin is granted to the extent that the second, third, and fourth such claims are dismissed.

DECISION

Defendant Dworkin's reading of section 8.2(a) of the Plan of Conversion would render meaningless the sentence:

> "For Eligible Policies that identify multiple insureds, the Eligible Premium with respect to each Eligible Policyholder under such Eligible Policy means the sum of the net premiums . . . properly and timely paid and allocable to such Eligible Policyholder under the Eligible Policy."

See also Matter of Schaffer, Schonholz & Drossman, LP v Title, 171 AD3d 465 (1st Dept. 2019).

9/3/2019
DATE

DEBRA A. JAMES, J.S.C.

CHECK ONE:	[X]	CASE DISPOSED		[ ]	NON-FINAL DISPOSITION		
	[ ]	GRANTED	[X] DENIED	[ ]	GRANTED IN PART	[ ]	OTHER
APPLICATION:	[ ]	SETTLE ORDER		[ ]	SUBMIT ORDER		
CHECK IF APPROPRIATE:	[ ]	INCLUDES TRANSFER/REASSIGN		[ ]	FIDUCIARY APPOINTMENT	[ ]	REFERENCE

ADD-40

FILED: NASSAU COUNTY CLERK 10/30/2019 02:07 PM INDEX NO. 617351/2018
NYSCEF DOC. NO. 211 RECEIVED NYSCEF: 10/30/2019

SUPREME COURT-STATE OF NEW YORK
SHORT FORM ORDER
Present:

HON. TIMOTHY S. DRISCOLL
Justice Supreme Court

----------x

NRAD MEDICAL ASSOCIATES, P.C.,

Plaintiff,

-against-

ALICE Y. KIM, CYLON W. BELL, DANIEL F. SETTLE, DAVID M. KAPLAN, JAMES M. KESSLER, LAWRENCE B. TENA, PATRICIA J. ROCHE, SANDRA A. RUSSO, SHYAMALI SAHA and YEKATERINA BULKIN,

Defendants.

----------x

TRIAL/IAS PART: 10

NASSAU COUNTY

Index No: 617351-18
Motion Seq. Nos. 1, 2, 3, 4, 5
Submission Date: 9/6/19

Papers Read on these Motions:

- **Settle and Roche Statement of Material Facts.....x**
- **Settle and Roche Affs. and Affm. with Exhibits.....x**
- **Settle and Roche Memo of Law.....x**
- **Kim and Kaplan Statement of Material Facts with Exhibits.....x**
- **Kim and Kaplan Affs. and Affm. with Exhibits .....x**
- **Kim and Kaplan Memo of Law.....x**
- **Pl. Aff. and Affm. in Opp. and Support of First Cross Mot. with Exhibits.....x**
- **Pl. Memo of Law in Opp. and Support of First Cross Mot.....x**
- **Pl. Resp. to Statement of Material Facts.....x**
- **Kessler Affm. with Exhibits.....x**
- **Kessler Memo of Law.....x**
- **Settle and Roche Affm. in Opp. and Reply with Exhibits.....x**
- **Settle and Roche Resp. to Pl. Statement of Material Facts.....x**
- **Settle and Roche Memo of Law in Opp. and Reply.....x**
- **Kim and Kaplan Resp. to Pl. Statement of Material Facts.....x**
- **Kim and Kaplan Affs. in Opp. and Reply with Exhibits.....x**
- **Kim and Kaplan Memo of Law in Opp. and Reply.....x**
- **Pl. Affm. in Opp. and in Support of Sec. Cross Mot. with Exhibits.....x**
- **Kessler Affm. in Opp. and Reply with Exhibits.....x**
- **Kessler Memo of Law in Opp. and Reply.....x**
- **Pl. Affm in Reply with Exhibits.....x**
- **Pl. Memo of Law in Reply .....x**

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Pl. Supplemental Memo of Law in Reply with Exhibits.....x
Settle and Roche Supplemental Memo of Law.....x
Kessler Supplemental Memo of Law.....x
Kim and Kaplan Supplemental Memo of Law.....x

This matter is before the court on the pending motions filed by 1) defendants Daniel F. Settle ("Settle") and Patricia J. Roche ("Roche"), 2) defendants Alice Y. Kim ("Kim") and David M. Kaplan ("Kaplan"), 3) Plaintiff NRAD Medical Associates P.C. ("Plaintiff" or "NRAD"), and 4) defendant James M. Kessler ("Kessler").

For the following reasons, the motions filed by Defendants are denied as to Plaintiff's first claim and granted as to Plaintiff's remaining claims pursuant to CPLR § 3211. The cross-motions filed by Plaintiff are granted to the extent that Plaintiff is awarded summary judgment on its first claim against defendants Settle, Roche, Kim, Kaplan, and Kessler (collectively, the "Moving Defendants"), and denied in all other respects.

The remaining parties are reminded of the conference scheduled for November 26, 2019 at 11:00 a.m.

BACKGROUND

A. Relief Requested

Settle and Roche move for an Order: 1) pursuant to CPLR § 3211(a), dismissing the Complaint, and 2) alternatively, pursuant to CPLR § 3212, granting Defendants summary judgment and dismissing the Complaint. Settle and Roche's motion is filed on the Court's docket at Motion Sequence 1.

Kim and Kaplan move for an Order 1) dismissing the Complaint pursuant to CPLR § 3211(a)(5), as it may not be maintained because the claims have been released by virtue of a General Release, 2) dismissing the Complaint pursuant to CPLR § 3211(a)(7), or in the alternative, 3) for summary judgment dismissing the Complaint pursuant to CPLR § 3212. Kim and Kaplan's motion is filed on the Court's docket at Motion Sequence 2.

NRAD opposes the motions filed by Settle and Roche, and Kim and Kaplan, and cross-moves against Kim, Kaplan, Settle, and Roche for summary judgment on its first and third causes of action for declaratory judgment and unjust enrichment. NRAD's cross-motion (the "First Cross-Motion") is filed on the Court's docket at Motion Sequence 3.

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Kessler moves for an Order, pursuant to CPLR § 3211, dismissing the Complaint. Kessler's motion is filed on the Court's docket at Motion Sequence 4.

NRAD opposes Kessler's motion and cross-moves against Kessler for summary judgment on its first and third causes of action for declaratory judgment and unjust enrichment. NRAD's cross-motion (the "Second Cross-Motion") is filed on the Court's docket at Motion Sequence 5.

Defendants Cylon W. Bell ("Bell"), Lawrence B. Tena ("Tena"), Sandra A. Russo ("Russo"), Shyamali Saha ("Saha"), and Yekaterina Bulkin ("Bulkin" and collectively, the "Non-Moving Defendants") take no position on the pending motions.

B. The Parties' History

The Complaint alleges as follows:

NRAD is a professional corporation organized under the laws of the State of New York with its principal place of business in Garden City, New York. NRAD is engaged in the practice of medicine as an integrated multi-specialty practice. Defendants are medical professionals specializing in radiology or other medical specialties. Medical Liability Mutual Insurance Company ("MLMIC") is one of the largest medical professional liability insurers in the United States, and the largest in the State of New York.

At all relevant times, Defendants were salaried employees of Plaintiff. Pursuant to their employee relationship and/or employment agreements, while Defendants remained employed with Plaintiff, Plaintiff paid for liability insurance issued by MLMIC covering Defendants' medical services rendered for and on Plaintiff's behalf, as salaried employees. Plaintiff specifically paid the MLMIC insurance policy premiums necessary to maintain reasonable and appropriate per-incident and aggregate insurance limits for malpractice claims against Defendants, arising from Defendants' professional medical services rendered as Plaintiff's salaried employees. Plaintiff paid the aforesaid premiums to MLMIC at all relevant times, including during portions of the period of July 15, 2013 through July 14, 2016. Plaintiff paid 100% of the malpractice premiums for Defendants' liability insurance while Defendants were employed by Plaintiff. Plaintiff was exclusively responsible for managing and maintaining the subject policies and received all related dividends and return premiums from MLMIC, without

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objection from any of the Defendants at any time. Defendants knew, accepted, and acquiesced in Plaintiff's exercise of unfettered control and dominion over the subject MLMIC policies.

On or about May 31 and June 16, 2018, the Board of Directors of MLMIC adopted and revised a Plan of Conversion subsequently approved by the New York Superintendent of Financial Services, providing for the acquisition, demutualization, and privatization of MLMIC (the "Plan of Conversion"). The Plan of Conversion provides for 1) the demutualization of MLMIC from a mutual insurance company into a stock insurance company, and 2) the acquisition of MLMIC by National Indemnity Company ("NICO"), a subsidiary of Berkshire Hathaway, Inc.

The Plan of Conversion provides for the issuance of distributions in the name of each eligible policyholder, concurrent with the termination of his or her policyholder membership. According to the Plan of Conversion, distributions paid to eligible policyholders are based on the following formula: 1) eligible policy premiums (which are identified under the Plan as the net premiums – *i.e.* gross premiums less return premiums and dividends – properly and timely paid during the eligible policy period of July 15, 2013 through July 14, 2016) paid on each policy, 2) divided by the total eligible premium for all eligible policyholders ($1.303 billion), and 3) multiplied by the total cash consideration paid by NICO ($2.502 billion). The projected distributions for each policy are estimated to equal approximately 1.9 times the eligible policy premiums paid for each individual policy.

Plaintiff believes that, pursuant to Section 7307 of the New York Insurance Law, the Plan of Conversion was formally approved by at least two-thirds of all votes cast by Record Date Policyholders (as defined within the Plan) present in person or by proxy at the special MLMIC Shareholder meeting held on September 14, 2018. On or about October 1, 2018, MLMIC announced the completion of its demutualization from a mutual insurance company into a stock insurance company, and the acquisition by NICO. MLMIC has adopted and implemented procedures to effectuate the Plan of Conversion, pursuant to which each individual policyholder is afforded the opportunity to confirm his or her consent to receipt of the demutualization distribution by the Policy Administrator identified on his or her MLMIC policy. Plaintiff is the

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designated Policy Administrator listed on the MLMIC policies that Plaintiff purchased covering claims against Defendants.

In or about July 2018, Plaintiff reasonably requested that Defendants faithfully execute the necessary MLMIC consent form to ensure Plaintiff's rightful receipt and recovery of the MLMIC distribution. Defendants have unreasonably refused and declined to execute the MLMIC consent. Plaintiff has repeatedly demanded in writing that Defendants sign and submit the MLMIC consent and other documentation to ensure Plaintiff's recovery of the MLMIC distribution in question.

In or about August 2018, Plaintiff submitted an objection via email to the MLMIC Conversion Coordinator, requesting that MLMIC hold in escrow all distribution proceeds arising from MLMIC coverage purchased covering claims against Defendants. Defendants continue to disavow any obligation owed to Plaintiff relating or arising from Plaintiff's faithful payment of the MLMIC policy premiums covering Defendants' medical services rendered while working as salaried employees.

Plaintiff asserts the following causes of action: 1) declaratory judgment that Plaintiff is entitled to the distribution proceeds at issue herein, and directing the MLMIC Conversion Agent to disburse to Plaintiff all escrowed proceeds relating to liability insurance covering Defendants, 2) breach of the covenant of good faith and fair dealing based on Defendants' alleged attempt to realize gains that their employment agreements implicitly deny and to deprive Plaintiff of the fruits of its bargain, 3) unjust enrichment, 4) breach of fiduciary duty based on Defendants' refusal to return the MLMIC distribution proceeds to Plaintiff, and 5) a preliminary and permanent injunction, including but not limited to an order restraining and enjoining Defendants from recovering the distributions in question, and from transferring, encumbering, or expending any part thereof.

C. The Parties' Affidavits

1. Settle Affidavit

Settle affirms that he is a radiologist and worked for NRAD between September 30, 2013, and December 2014, pursuant to a written employment agreement. In connection with his employment with NRAD, Settle applied for and maintained medical malpractice insurance with

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MLMIC. Settle's MLMIC policy allowed him to designate a Policy Administrator as his agent for purposes of administration of the policy, and Settle designated NRAD. Settle's Binder for Professional Liability Insurance with MLMIC, demonstrates that Settle is the insured policyholder and NRAD has only been designated as the Policy Administrator. All documentation relating to the policy was sent to Settle through the Policy Administrator, and Settle did not assign his rights to the proceeds of the demutualization of MLMIC to NRAD or any other entity.

2. Roche Affidavit

Roche affirms that she is a radiologist and worked for NRAD between October 1, 2013, and August 28, 2014, pursuant to a written employment agreement. In connection with her employment with NRAD, Roche applied for and maintained medical malpractice insurance with MLMIC. Roche's MLMIC policy allowed her to designate a Policy Administrator as her agent for purposes of administration of the policy, and Roche designated NRAD. All documentation relating to the policy was sent to Roche through the Policy Administrator, and Roche did not assign her rights to the proceeds of the demutualization of MLMIC to NRAD or any other entity.

3. Kaplan Affidavit

Kaplan affirms, in relevant part, that he is a radiologist and acquired a one-quarter share of NRAD in July 2002. Over the years, NRAD amended its controlling shareholders agreements, and Kaplan was a party to NRAD's 4th Amended and Restated Shareholders' Agreement dated January 1, 2010, as amended by resolutions adopted on December 18, 2012, June 13, 2013, and November 19, 2013. As a shareholder of NRAD, Kaplan was also a party to employment agreements which were modified over the years. NRAD and Kaplan were parties to a Second Amended and Restated Physician Employment Agreement ("Kaplan Shareholder Employment Agreement") dated as of January 1, 2010. Pursuant to the Kaplan Shareholder Employment Agreement, NRAD agreed to 1) pay Kaplan compensation, including full-time basic salary and fringe benefits, which included malpractice coverage, and 2) NRAD paid the cost of Kaplan's Physicians and Surgeons Professional Liability Insurance to MLMIC until the policy was terminated at the end of 2013. In late 2013, Kaplan's liability insurance MLMIC was discontinued in favor of a lower cost insurer, MedPro Group ("MedPro"). The switch to MedPro

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occurred at the end of 2013 or early 2014, and thereafter, NRAD paid the costs of Kaplan's Liability Insurance to MedPro.

At or prior to 2012, NRAD's revenue began to significantly decline as referring physicians aligned themselves with competitor hospitals or other medical organizations and stopped referring patients to NRAD. Additionally, the reimbursement rates paid to NRAD from third-party payors significantly decreased. The falling revenues resulted in internal dissension between the controlling shareholders of NRAD and the Associate Shareholders, who owned fractional interests of the common shares of NRAD.

On October 5, 2012, NRAD's Directors sent a Notice of Meeting of the Shareholders to the Associate Shareholders giving notice of an October 16, 2012 shareholders meeting at which time proposed resolutions would be presented and voted on to amend the 2010 Shareholders' Agreement to impose a reduction in the full-time annual compensation of the Associate Shareholders that was disproportionate to the reduction in full-time total annual compensation of the full share owners. Kaplan and other Associate Shareholders filed a lawsuit titled *Ehrenpreis v. NRAD Medical Associates, P.C.*, Nassau County Index No. 13006-12 (the "First Action"), requesting money damages and equitable relief relating to a subsequent December 2012 Resolution and the proposed October 2012 resolution, which was never voted upon by the NRAD shareholders. A June 2013 resolution by NRAD's controlling board members designed to further disenfranchise the Associate Shareholders resulted in the filing of an action titled *Kaplan v. NRAD Medical Associates, P.C.*, Nassau County Index No. 8019-13 (the "Second Action").

As a result of the legal and economic disputes with NRAD's Board, seventeen Associate Shareholders, including Kaplan, sold their rights under the Shareholder's Agreement back to NRAD, either voluntarily or as required by NRAD as part of the settlement of the First Action and Second Action. Ten Associate Shareholders entered into shareholder redemption agreements effective in 2013, and seven Associate Shareholders entered into redemption agreements effective in 2014. NRAD was left with eight remaining shareholders.

Pursuant to an Agreement and Stipulation of Settlement entered February 26, 2014 ("Kaplan Settlement Agreement"), NRAD and Kaplan resolved all disputed matters as of that

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date, including all claims relating to the Resolutions, the First Action, and the Second Action. Pursuant to the terms of the Kaplan Settlement Agreement, Kaplan surrendered his ownership interests in NRAD effective February 2, 2014, in consideration of a stock redemption agreement from NRAD in which NRAD agreed to pay Kaplan a redemption price of $425,000 acknowledged by a promissory note from NRAD which provided for sixty equal consecutive monthly installments of principal plus interest. Kaplan simultaneously entered into a new Physician Employment Agreement with NRAD commencing on March 1, 2014. The Kaplan Settlement Agreement also contained a mutual exchange of general releases, and released Kaplan from any claim NRAD had, whether known or unknown, from the beginning of time through and including February 26, 2014. As of the date of the Kaplan Settlement Agreement, Kaplan no longer had liability insurance from MLMIC or any rights as a policyholder of MLMIC to receive future dividends. Any right Kaplan then had to receive cash consideration in a future demutualization of MLMIC was fixed as of the date of the termination of his MLMIC Policy, which occurred prior to the execution of the Kaplan Settlement Agreement.

After the Kaplan Settlement Agreement and the execution of Kaplan's 2014 employment agreement, NRAD paid the cost of Kaplan's liability insurance to MedPro. During the period of time that Kaplan maintained his professional liability coverage with MLMIC, NRAD requested that Kaplan execute a form titled Administrator-Designation &/or Change (the "Policy Administrator Designation") in order to facilitate their day-to-day administration and payment of his Liability Insurance. As Policy Administrator, NRAD was acting as an agent on Kaplan's behalf. At no time did his designation of NRAD as Policy Administrator grant NRAD a contract or property right in his beneficial ownership interest in the MLMIC policy.

As an MLMIC policyholder, Kaplan owned membership rights, including the right to participate in any distribution of surplus and earnings and profits of MLMIC, the right to vote, and the right to participate in meetings of members. MLMIC issued dividends to its policyholders, and it is Kaplan's understanding from the Policy Administrator Designation that those dividends were applied by MLMIC as a credit to the invoice on his policy as an offset to the base rate being charged by MLMIC. As Kaplan's MLMIC policy was terminated no later

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than February 2014, he was not entitled to the 5% dividend for 2014, but had been entitled to the 3% dividend issued in 2013.

On March 31, 2015, Kaplan entered into an employment agreement with NYU Langone Medical Center with the commencement date of June 1, 2015. In and after April 2015, Kaplan was no longer employed by NRAD and there was no further contractual relationship other than NRAD's continuing obligations in connection with the 2014 redemption agreement and promissory note delivered in connection with the Kaplan Settlement Agreement.

On July 7, 2015, NRAD filed a Petition for relief under Chapter 11 of the Bankruptcy Code with the United States District Court for the Eastern District of New York, Case No. 15-72898 (the "Bankruptcy Action"). NRAD's filings in the Bankruptcy Action establish that NRAD never claimed or asserted any interest in any component of the MLMIC policy. Despite public notice of MLMIC's Plan of Conversion from at least July 2016, NRAD never scheduled the Policy Administrator Designation as an executory contract or sought to include the potential demutualization distributions as an asset on its bankruptcy schedules, the Plan of Reorganization, the Disclosure Statements, or the First and Second Amendments to the Plan that were subsequently approved by the Bankruptcy Court on June 6, 2017.

NRAD never scheduled or sought to include Kaplan's MLMIC policy as an asset of its Bankruptcy estate, never identified its alleged right to receive dividends or returned premiums from MLMIC for the malpractice liability insurance as an asset of the Bankruptcy estate, and never scheduled the Policy Administrator Designation as an executionary contract. In fact, NRAD commenced adversary proceedings against Kaplan in May 2016 seeking, among other things, to avoid and recover payments made to Kaplan prior to the petition date. Notices in July 2016 put the medical community on notice that MLMIC would be demutualized well before NRAD filed its First Amended Plan of Reorganization and Disclosure Statement on February 23, 2017. NRAD never sought to amend any of its schedules of assets to include any potential demutualization proceeds as assets of its Bankruptcy Estate.

In late 2016 and early 2017, NRAD, the Creditors Committee, and counsel to the former shareholders of NRAD (including Kaplan) engaged in lengthy negotiations regarding the terms of a consensual Chapter 11 Plan. In these negotiations, NRAD's counsel did not reference or assert

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that NRAD had any interest in any component of Kaplan's MLMIC policy or the potential demutualization proceeds. As a result of these negotiations, NRAD, the Creditors Committee, the remaining shareholders, and the former shareholders, including Kaplan, agreed to a Plan Support Agreement. The Plan Support Agreement provided, among other terms to be contained in the proposed First Amended Plan of Reorganization, that the parties would support a Plan that provided for the treatment of various classes of claims and interests as provided for in the Plan, and the adversary proceedings against the Former Shareholders would be dismissed in exchange for releases by the Debtor of all asserted and possible claims against the Former Shareholders. The Bankruptcy Court approved the Plan in an Order entered on June 6, 2017 ("Order Confirming Plan").

NRAD has twice released Kaplan from any claims, first in February 2014, and later in the Bankruptcy Action. Thus, NRAD has no standing to assert its claims against Kaplan. Moreover, NRAD is equitably estopped from asserting any claim to the demutualization proceeds. NRAD was required to identify all potential assets and all executory contracts in its bankruptcy schedules but failed to schedule any claim to potential demutualization proceeds or any element of Kaplan's MLMIC policy.

On November 11, 2018, Kaplan received an unsigned email not attributable to any individual from NRAD Medical Associates, P.C., attaching a document titled "Assignment and Joint Payment Instructions," and instructing him that it was an administrative requirement and he should execute the document, have it notarized, and return it to the sender. Kaplan never executed the document, and the fact that NRAD needs Kaplan to execute a valid assignment of his demutualization cash consideration is an acknowledgment by NRAD that he never assigned any right or interest in them, and that NRAD has no rights to those proceeds under Kaplan's prior Policy Administrator Designation, which did not survive bankruptcy.

4. Kim Affidavit

In her affidavit, Kim attests to many of the same facts as Kaplan. Kim affirms, in relevant part, that she is a radiologist and in July 2006, acquired a one-quarter share of NRAD. Kim was a party to NRAD's 4th Amended and Restated Shareholders' Agreement dated January 1, 2010, as amended by resolutions adopted on December 18, 2012, June 13, 2013, and

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November 19, 2013. Kim was also a party to employment agreements which were modified over the years. NRAD and Kim were parties to a Second Amended and Restated Physician Employment Agreement dated as of January 1, 2010, in which NRAD agreed to pay Kim full-time basic salary and fringe benefits, which included malpractice insurance coverage. Pursuant to the employment agreement, NRAD paid the cost of Kim's Physicians and Surgeons Professional Liability Insurance to MLMIC, until the policy was terminated at the end of 2013 to change to MedPro. Thereafter, NRAD paid the costs of Kim's liability insurance to MedPro.

Kim was a party to the First Action and Second Action. Pursuant to an Agreement and Stipulation of Settlement entered February 26, 2014 ("Kim Settlement Agreement"), Kim surrendered her ownership interest in NRAD effective February 2, 2014 in consideration of a stock redemption agreement from NRAD in which NRAD agreed to pay her a redemption price of $425,000, acknowledged by a promissory note from NRAD which provided for sixty equal consecutive monthly installments of principal plus interest. Kim simultaneously entered into a new Physician Employment Agreement with NRAD commencing on March 1, 2014. The Kim Settlement Agreement contains a mutual exchange of general releases between NRAD and Kim, and released Kim from any claim NRAD had, whether known or unknown, from the beginning of time through and including February 26, 2014. Any right Kim had to receive cash consideration in a future demutualization of MLMIC was fixed as of the date of the termination of her MLMIC Policy, which occurred prior to the execution of the Kim Settlement Agreement on February 26, 2014. After the Kim Settlement Agreement and the execution of her 2014 employment agreement, NRAD paid the cost of Kim's liability insurance to MedPro.

Prior to the end of 2013, when Kim maintained her professional liability coverage with MLMIC, NRAD requested that she execute the Policy Administrator Designation to facilitate their day-to-day administration and payment of her liability insurance. As Policy Administrator, NRAD was acting as an agent on Kim's behalf and at no time did her designation of NRAD as Policy Administrator grant NRAD a contract or property right in her beneficial ownership interest in the MLMIC policy.

As an MLMIC policyholder, Kim owned membership rights, including the right to participate in any distribution of surplus and earnings and profits of MLMIC, the right to vote,

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and the right to participate in meetings of members. MLMIC issued dividends to its policyholders, and it is Kim's understanding from the Policy Administrator Designation that those dividends were applied by MLMIC as a credit to the invoice on her policy as an offset to the base rate being charged by MLMIC. As Kim's MLMIC policy was terminated no later than February 2014, she was not entitled to the 5% dividend for 2014, but had been entitled to the 3% dividend issued in 2013.

On March 31, 2015, Kim entered into an employment agreement with NYU Langone Medical Center with the commencement date of June 1, 2015. In and after April 2015, Kim was no longer employed by NRAD and there was no further contractual relationship other than NRAD's continuing obligations in connection with the 2014 redemption agreement and promissory note delivered in connection with the Kim Settlement Agreement.

Multiple filings made by NRAD in the Bankruptcy Action state that Kim was not an employee of NRAD on or prior to the Petition Date, and NRAD never claimed or asserted any interest in any component of the liability policies. NRAD never scheduled or sought to include Kim's MLMIC policy as an asset of its Bankruptcy estate, never identified its alleged right to receive dividends or returned premiums from MLMIC for the malpractice liability insurance as an asset of the Bankruptcy estate, and NRAD never scheduled the Policy Administrator Designation as an executionary contract. In fact, NRAD commenced adversary proceedings against Kim in May 2016 seeking, among other things, to avoid and recover payments made to her prior to the Petition Date. Pursuant to the Order Confirming Plan entered on June 6, 2017, as a former shareholder, Kim has been released by NRAD from any and all claims arising out of its pre-petition affairs. Thus, NRAD has twice released Kim from any claims, first in February 2014, and later in bankruptcy. NRAD has unconditionally released Kim from any and all claims, known or unknown, and NRAD is equitably estopped from asserting any claim to the demutualization proceeds.

On November 11, 2018, Kim received an unsigned email not attributable to any individual from NRAD Medical Associates, P.C., attaching a document titled "Assignment and Joint Payment Instructions," and instructing her that it was an administrative requirement and she should execute the document, have it notarized, and return it to the sender. Kim never executed

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the document, and the fact that NRAD needs Kim to execute a valid assignment of her demutualization cash consideration is an acknowledgment by NRAD that she never assigned any right or interest in them and that it has no rights to those proceeds under her prior Policy Administrator Designation, which did not survive bankruptcy.

5. Lang Affidavit

Paul S. Lang ("Lang"), the President of NRAD, affirms that the essence of the employment agreements between Plaintiff and each of the defendants in this action (the "Employment Agreements"), was that Plaintiff would pay Defendants' salaries and, in exchange, Plaintiff would enjoy all financial benefits related to Defendants' association with Plaintiff's medical practice. Pursuant to the Employment Agreements, at all relevant times, while Defendants remained employed by Plaintiff, Plaintiff paid for liability insurance issued by MLMIC, covering Defendants' medical services rendered for and on Plaintiff's behalf, as salaried employees. NRAD paid 100% of the MLMIC malpractice premiums for Defendants' liability insurance. NRAD was also exclusively responsible for securing, managing, and maintaining the policies. NRAD is the designated Policy Administrator on the MLMIC policies because it was always NRAD's intention and actual practice to retain unfettered control over the MLMIC malpractice policies. The prospect of demutualization was never even a remote thought and, thus, Defendants never bargained to receive any payments related to the MLMIC policies.

Public information shows that on or about May 31 and June 16, 2018, the Board of Directors of MLMIC adopted and revised a Plan of Conversion subsequently approved by the New York Superintendent of Financial Services for the acquisition, demutualization, and privatization of MLMIC. It is Lang's understanding that prior to MLMIC's issuance of the Plan of Conversion, the financial ramifications of the subject demutualization for the policyholders were not publicly available. NRAD had no knowledge that the MLMIC demutualization would lead to payouts for each individual policy until May or June 2018, sometime after the Plan of Conversion was released, and NRAD had no way to know or even to speculate that Defendants would assert the position in 2018 that they are entitled to the MLMIC Proceeds. Defendants' claim was completely unforeseeable based on NRAD having paid 100% of the MLMIC premiums. To Lang's knowledge, MLMIC is currently holding all MLMIC Proceeds related to

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this dispute in escrow pending a determination by the Court. NRAD's money is frozen in escrow strictly because of Defendants' position and claims asserted in 2018.

On February 26, 2014, Plaintiff entered into settlement agreements with Kim and Kaplan to resolve certain shareholder disputes unrelated to this action (the "2014 Settlement Agreements"). The 2014 Settlement Agreements contain mutual general releases covering the claims and disputes between the parties existing as of February 26, 2014. The 2014 Settlement Agreements could not and did not relate to the demutualization proceeds at issue here, which did not exist at the time, and only came into existence in October 2018 following the MLMIC demutualization.

On July 7, 2015, NRAD filed for Chapter 11 bankruptcy. On July 21, 2015, NRAD filed its schedules with the Bankruptcy Court and filed amended bankruptcy schedules on August 6, 2015. The Bankruptcy Action was terminated on March 15, 2018. NRAD participated in the Bankruptcy Action in good faith and reported all assets, claims, contingent claims, and liabilities existing during the pendency of the proceeding, and did not omit any information required to be submitted to the Bankruptcy Court. NRAD did not possess the claims at issue in this action when the Bankruptcy Action was filed, as the unjust enrichment claim only first came into existence after the MLMIC Proceeds became available in October 2018, after Defendants unjustly sought to recover them, and after Defendants' actions required that the monies be frozen in escrow instead of being paid to NRAD.

The Reorganization Plan confirmed by the Bankruptcy Court did not address MLMIC or anything involving demutualization proceeds. All of the Defendants in this action had notice of the Bankruptcy Action and, in fact, Kim and Kaplan filed their own unrelated claims that were resolved through the Bankruptcy Action. None of the parties in this action, nor anyone else, filed any claim in the Bankruptcy Action related to insurance demutualization proceeds. The parties to the Bankruptcy Action did not intend to release, nor did they release, any potential future claims related to demutualization proceeds. While Plaintiff exchanged general mutual releases with Kim and Kaplan on February 26, 2014 and submitted the Reorganization Plan on April 6, 2017, there was no mention or negotiation of any aspects of the MLMIC demutualization.

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While Lang recently learned that the MLMIC demutualization was announced in July 2016, neither Lang nor anyone employed by Plaintiff has knowledge that there would be MLMIC Proceeds until sometime after the Plan of Conversion was first released to the public on May 31, 2018. Although the possibility of MLMIC's demutualization was announced in July 2016, almost all of the events necessary to complete the transaction took place in 2018. MLMIC did not receive any monies related to the demutualization until on or around October 1, 2018, thus, neither Plaintiff nor Defendants had any claim to the MLMIC Proceeds until around that time.

D. The Parties' Positions

Settle and Roche argue that this action should be dismissed based upon Plaintiff's lack of standing, as the failure to declare an asset in a bankruptcy proceeding precludes the debtor from later bringing a claim related to that asset. NRAD did not assert the MLMIC policies, dividends, or the purchase price of MLMIC ("Demutualization Proceeds") as assets or potential assets in the Bankruptcy Action, despite ample opportunity to do so, and is barred from bringing claims predicated upon the Demutualization Proceeds, which they were aware of since at least July 2016. The action should also be dismissed because the New York State Department of Financial Services ("DFS") Decision dated September 6, 2018 approving the demutualization of MLMIC and converting MLMIC to a stock insurance company, *see* Castelli Affm. at Exh. C, Policyholder Information Sheet, *see id.* at Exh. E, and Plan of Conversion, *see id.* at Exh. D, all specifically state that the Policyholders, if they constitute Eligible Policyholders, are to be the recipients of the Demutualization Proceeds. NRAD is not an Eligible Policyholder, and Roche and Settle did not waive or transfer their rights in favor of NRAD upon their designation of NRAD as the Policy Administrator. The plain language of the definition of Policy Administrator in the Plan of Conversion establishes that the Policy Administrator was only to be an agent for the Policyholder, and the mere designation of a Policy Administrator does not and did not constitute an assignment of Roche or Settle's rights to the Demutualization Proceeds.

Settle and Roche further contend that Plaintiff cannot maintain a claim for unjust enrichment. Plaintiff and Defendants had valid, enforceable contracts in the form of the Employment Agreements, and professional malpractice insurance was specifically negotiated as a benefit to both Roche and Settle. As NRAD is pursuing its breach of contract claim, it cannot

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bring an alternate claim for unjust enrichment. Further, Defendants received the benefit of professional malpractice insurance in exchange for working for NRAD, and NRAD could not have had any expectation of receiving compensation from Roche or Settle for the professional malpractice insurance, dividends, or the Demutualization Proceeds to which the doctors, as Eligible Policyholders, are entitled.

Kaplan and Kim argue that this action is barred by 1) the first general release contained in the 2014 Settlement Agreements, *see* Kim and Kaplan Statement of Material Facts at Exhs. A and E; 2) the second general release set forth in the Order Confirming Plan, *see id.* at Exh. Y at p. 13. Additionally, Plaintiff is judicially estopped from asserting its claims based on its failure to disclose the Employment Agreements and Policy Administrator Designation or its alleged claim to the Demutualization Proceeds in the Bankruptcy Action.

Kaplan and Kim further argue that New York Insurance Law § 7307 and the subject MLMIC documents entitle Defendants to the Demutualization Proceeds because they are Eligible Policyholders as mandated by statute and as defined by the MLMIC Policy Statement. The Employment Agreements provide that the payment of malpractice premiums were part of the compensation provided to Defendants, and Plaintiff's performance of the administrative function of paying these expenses does not elevate NRAD's status as agent to policy holder. Additionally, Plaintiff has no valid unjust enrichment claim because: 1) Defendants have not received any money and have not been enriched, and 2) the controlling contracts in this case preempt any unjust enrichment claim. As to the claim for breach of covenant of good faith and fair dealing, NRAD has not pled a contractual relationship that survived the Bankruptcy Action, and even if a contractual relationship was found to have survived, the subject agreements do not support NRAD's claims and the Court should not imply a term which the parties have failed to include. Plaintiff cannot establish any misconduct to support a breach of fiduciary duty claim, as Defendants are trying to retain their statutory, contractual, and possessory rights to the Demutualization Proceeds. The Demutualization Proceeds are being held in escrow by DFS pending a determination of NRAD's claims, and no injunction is merited if NRAD is not found to have a possessory right.

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Kessler largely echoes the arguments of his co-defendants and contends that the DFS Decision, Policyholder Information Sheet, and Plan of Conversion all state that the recipients of the Demutualization Proceeds are the Eligible Policyholders. Under the plain language of MLMIC's Plan of Conversion, Kessler is the Eligible Policyholder and NRAD is not an Eligible Policyholder but a Policy Administrator. The documents clearly establish that the policyholders did not waive or assign their rights to any proceeds under the policies – such as dividends or, in this case, Demutualization Proceeds – by designating a Policy Administrator. Kessler also contends that NRAD is estopped from asserting its claims due to its failure to disclose the Demutualization Proceeds in the Bankruptcy Action. Moreover, Plaintiff's claim for breach of the covenant of good faith and fair dealing must be dismissed as it has not pled a contractual relationship that survived its bankruptcy filing, and the claim for unjust enrichment cannot be sustained, as Kessler has not yet received any of the Demutualization Proceeds. Plaintiff also cannot establish a breach of fiduciary duty, as Kessler did not engage in any misconduct that damaged NRAD, and NRAD is not entitled to an injunction as they have no possessory rights to the Demutualization Proceeds.

Plaintiff contends[1] that it is undisputed that it paid 100% of the insurance premiums, and payment of the Demutualization Proceeds to an insured physician who did not pay the underlying premiums constitutes unjust enrichment. By refusing to cooperate with NRAD in filing the necessary paperwork to allow NRAD to recover the Demutualization Proceeds pursuant to the protocols established by MLMIC and DFS, Defendants have already directly benefitted at Plaintiff's expense insofar as the MLMIC Proceeds are in escrow poised for release to Defendants in the event that this Court rules in Defendants' favor. It is well-established that an indirect benefit is sufficient to support an unjust enrichment claim. Further, Plaintiff is not precluded from proceeding on both breach of contract and quasi-contract theories, as the Employment Agreements do not cover the disputed issue and do not so much as mention

[1]In its opposition to Kessler's motion and in support of its cross-motion for summary judgment against Kessler, Plaintiff directed the Court to the facts and arguments submitted in Plaintiff's cross-motion and opposition papers with respect to the motions filed by Settle and Roche, and Kim and Kaplan.

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MLMIC, let alone address which of the parties would be entitled to the proceeds in the event of a demutualization.

Plaintiff argues that its claims accrued in 2018 when Defendants, for the first time, wrongfully asserted their claim to the Demutualization Proceeds and blocked NRAD from recovering the funds. As a result, each of Defendants' arguments based on the 2014 Settlement Agreements, the 2015 bankruptcy filings, and the bankruptcy reorganization finalized in 2017 fails. Moreover, the Demutualization Proceeds did not exist until well after the Bankrupty Action was closed. To the extent Kim and Kaplan argue that Plaintiff's claims are barred based on two general releases from 2014 and 2017, these releases, by their terms and definition, did not apply to claims that did not accrue until October 2018 when Defendants first asserted their actionable claims to the Demutualization Proceeds. Distribution of the Demutualization Proceeds were only a remote possibility until the Plan of Conversion was issued in May 2018, and only became certain in October 2018 when MLMIC completed the demutualization process. Further, the doctrine of judicial estoppel is inapplicable, as there are no inconsistencies between NRAD's asset list filed in the Bankruptcy Action and its Complaint in this action, as NRAD had no MLMIC-related interest to list in 2015 or while its Bankruptcy Action was pending. Defendants' argument that Plaintiff was obligated to amend its 2015 bankruptcy schedules to reference hypothetical MLMIC Proceeds or to forecast Defendants' claim to future MLMIC demutualization proceeds is unsupported.

Plaintiff contends that Defendants are not entitled to summary judgment on their claims for breach of the implied covenant of good faith and fair dealing, and breach of fiduciary duty. The essence of the Employment Agreements was that Plaintiff would pay Defendants' salaries and in exchange, Plaintiff would enjoy all benefits related to Defendants' employment. Additionally, Defendants owed Plaintiff the duty of good faith and loyalty, and were obligated to cooperate with NRAD's recovery of any distribution related to the MLMIC policies for which Plaintiff paid.

On September 6, 2019, the Court held oral argument on the pending motions and granted the parties leave to file supplemental memoranda of law addressing recent case law. Plaintiff and the moving Defendants each filed supplemental memoranda of law, which primarily discuss the

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applicability of the *Matter of Schaffer, Schonholtz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dept. 2019), and its progeny to the instant matter. As discussed more fully below, the *Schaffer* Court held that the employer was entitled to the disputed MLMIC demutualization proceeds. Settle and Roche argue that the instant matter is distinguishable from *Schaffer* and its progeny because 1) malpractice insurance was part of the compensation and benefit package negotiated pursuant to the Employment Agreements, 2) the policies were in the doctors' names, rather than the doctors being added to the practice's policy, and 3) Defendants did not assign any rights or benefits. Kessler argues, *inter alia*, that the *Schaffer* decision is of limited precedential value because it was based upon stipulated facts pursuant to CPLR § 3222(b)(3), including the stipulated fact that the physician's malpractice insurance was not a benefit of her employment.

RULING OF THE COURT

A. Motion to Dismiss

A motion to dismiss pursuant to CPLR § 3211(a)(1) may only be granted where "the documentary evidence utterly refutes the plaintiff's factual allegations, thereby conclusively establishing a defense as a matter of law." *Karpovich v. City of N.Y.*, 162 A.D.3d 996, 997 (2d Dept. 2018), quoting *Mawere v. Landau*, 130 A.D.3d 986, 987 (2d Dept. 2015). Documentary evidence must be "unambiguous, authentic, and undeniable." *Karpovich*, 162 A.D.3d at 997, quoting *Granada Condominium III Ass'n v. Palomino*, 78 A.D.3d 996, 996-97 (2d Dept. 2010).

CPLR § 3211(a)(3) provides that a party may move to dismiss based on lack of legal capacity to sue. On a motion to dismiss based on lack of standing, the defendant bears the burden of establishing, *prima facie*, that the plaintiff lacks standing as a matter of law. *U.S. Bank N.A. v. Cohen*, 156 A.D.3d 844, 846 (2d Dept. 2017). "If, at the time of the commencement of a bankruptcy proceeding, the debtor either knew or should have known that he or she had a claim against a party, and failed to disclose that claim as an asset, he or she lacks capacity to sue on that claim since the claim became part of the estate in bankruptcy upon the commencement of the bankruptcy proceeding and the proceeds of any recovery on the claim could have been used to satisfy creditors' claims against the debtor." *R. Della Realty Corp. v. Block 6222 Constr. Corp.*, 65 A.D.3d 1323, 1323 (2d Dept. 2009), citing *Whelan v. Longo*, 7 N.Y.3d 821, 822 (2006).

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On a motion to dismiss pursuant to CPLR § 3211(a)(7), the court is required to "accept the facts as alleged in the complaint as true, accord the plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory." *Connaughton v. Chipotle Mexican Grill, Inc.*, 29 N.Y.3d 137, 141 (2017), quoting *Leon v. Martinez*, 84 N.Y.2d 83, 87-88 (1994). Dismissal is warranted where the non-movant "fails to assert facts in support of an element of the claim, or if the factual allegations and inferences to be drawn from them do not allow for an enforceable right of recovery." *Connaughton*, 29 N.Y.3d at 142.

B. Motion for Summary Judgment

On a motion for summary judgment, the moving party must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact. *Nomura Asset Capital Corp. v. Cadwalader, Wickersham & Taft LLP*, 26 N.Y.3d 40, 49 (2015), quoting *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 (1986). If the moving party produces the requisite evidence, the burden then shifts to the non-moving party to establish the existence of material issues of fact which require a trial of the action. *Nomura Asset Capital Corp.*, 26 N.Y.3d at 49, quoting *Alvarez*, 68 N.Y.2d at 324. Viewing the evidence in the light most favorable to the non-moving party, if the non-moving party, nonetheless, fails to establish a material triable issue of fact, summary judgment for the movant is appropriate. *Nomura Asset Capital Corp.*, 26 N.Y.3d at 49, quoting *Ortiz v. Varsity Holdings, LLC*, 18 N.Y.3d 335, 339 (2011).

C. Relevant Legal Principles

Every contract contains an implied covenant of good faith and fair dealing, "which encompasses any promise that a reasonable promisee would understand to be included." *Michaan v. Gazebo Hort., Inc.*, 117 A.D.3d 692, 693 (2d Dept. 2014). The covenant is breached when one party to the contract seeks to prevent its performance by, or to withhold its benefits from, the other party. *Id.* Nevertheless, the implied covenant of good faith and fair dealing cannot be broadly construed "to effectively nullify other express terms of the contract, or to create independent contractual rights." *Nat'l Union Fire Ins. Co. of Pittsburgh, P.A. v. Xerox Corp.*, 25 A.D.3d 309, 310 (1st Dept. 2006).

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To state a claim for unjust enrichment, the plaintiff must demonstrate "1) the defendant was enriched, 2) at the plaintiff's expense, and 3) that it is against equity and good conscience to permit the defendant to retain what is sought to be recovered." *Mobarak v. Mowad*, 117 A.D.3d 998, 1001 (2d Dept. 2014).

The elements of a claim for breach of fiduciary duty are: "1) the existence of a fiduciary relationship, 2) misconduct by the defendant, and 3) damages directly caused by the defendant's misconduct." *Armentano v. Paraco Gas Corp.*, 90 A.D.3d 683, 684 (2d Dept. 2011), quoting *Rut v. Young Adult Inst., Inc.*, 74 A.D.3d 776, 777 (2d Dept. 2010).

A permanent injunction requires "a violation of a right presently occurring, or threatened and imminent, that [the plaintiff] has no adequate remedy at law, that serious and irreparable harm will result absent the injunction, and that the equities are balanced in [the plaintiff's] favor." *Caruso v. Bumgarner*, 120 A.D.3d 1174, 1175 (2d Dept. 2014), quoting *Elow v. Svenningsen*, 58 A.D.3d 674, 675 (2d Dept. 2009).

D. *Schaffer* and its Progeny

On April 4, 2019, the First Department rendered a decision in the *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465, 465 (1st Dept. 2019), and determined, upon stipulated facts submitted to the Court pursuant to CPLR § 3222(b)(3), that the employer[2] was entitled to the cash proceeds resulting from the demutualization of MLMIC. The Court concluded that 1) while the physician was named as the insured on the subject MLMIC professional liability insurance policy, the petitioner purchased the policy and paid all of the premiums on it, 2) the physician did not deny that she did not pay any of the annual premiums or any of the other costs related to the policy, and 3) the physician did not bargain for the benefit of the demutualization proceeds. *Id.* The Court held that "[a]warding the [physician] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment." *Id.*

In the wake of *Schaffer*, a number of trial courts have considered disputes arising out of the demutualization of MLMIC and, in particular, the issue of whether the employer or employee

[2]The Submitted Facts Pursuant to CPLR 3222 filed in connection with *Schaffer*, *see* Castelli Reply Affm. at Exh. N, clarify that the respondent-physician was a radiologist employed by the petitioner-private practice radiology group.

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is entitled to the demutualization proceeds. The vast majority of trial courts have relied upon *Schaffer* in concluding that the premium-paying employer is entitled to the demutualization proceeds. *See Shoback v. Broome Obstetrics and Gynecology*, Index No. EFCA2018003334 (Sup. Ct. Broome Cty. Sept. 10, 2019), *see* Pl. Suppl. Memo of Law at Exh. 33; *Mid-Manhattan Physician Servs., P.C. v. Dworkin*, Index No. 656478-18, 2019 WL 4261348 (Sup. Ct. N.Y. Cty. Sept. 4, 2019); *John T. Maher Memorial Hospital of Port Jefferson, New York, Inc. v. Fadel*, Index No. 624734-18 (Sup. Ct. Suffolk Cty. Aug. 21, 2019), *see* Pl. Suppl. Memo of Law at Exh. 30; *Maple Medical LLP v. Scott*, 64 Misc.3d 909 (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Mutic*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Goldenberg*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Arevalo*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Sundaram*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Maple Medical LLP v. Youkeles*, 64 Misc.3d 1213(A) (Sup. Ct. Westchester Cty. Jul. 7, 2019); *Skoch v. Lake Champlain Ob-Gyn, P.C.*, 64 Misc.3d 1215(A) (Sup. Ct. Saratoga Cty. Jun. 7, 2019).

The opposite result was reached, however, in *Columbia Memorial Hospital v. Hinds*, 65 Misc.3d 1205(A) (Sup. Ct. Columbia Cty. Sept. 3, 2019). There, the Columbia County Supreme Court granted the physician's motion seeking 1) dismissal of the hospital's claims regarding the demutualization proceeds, and 2) an Order declaring that the physician was entitled to the demutualization proceeds. The *Hinds* Court held, in relevant part, that *Schaffer* was not controlling because the facts differed insofar as the physician's insurance premiums were paid in lieu of compensation. Particularly, the physician's employment agreement provided that he would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance.

E. Applicability of the Principles to the Instant Action

The parties' motions are granted in part and denied in part. Preliminarily, the Court concludes that Plaintiff possesses the capacity to bring the instant action notwithstanding its undisputed failure to disclose any claim with respect to the Demutualization Proceeds in the Bankruptcy Action. While the Moving Defendants allege that information regarding MLMIC's

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demutualization was publicly available as early as 2016, any claim as to the Demutualization Proceeds was purely hypothetical until the Plan of Conversion was adopted by the Board of Directors on May 31, 2018 and revised on June 15, 2018, *see* Castelli Affm. at Exh. D. Indeed, the Plan of Conversion was not approved by DFS until September 6, 2018. *See id.* at Exh. C. It is undisputed that the Order Confirming Plan in the Bankruptcy Action was issued on June 6, 2017, *see* Kim and Kaplan Statement of Material Facts at Exh. Y, and the Final Decree closing the Bankruptcy Action was filed on February 28, 2018, *see* Castelli Affm. at Exh. J. Thus, Plaintiff did not know or should have known of the instant claims during the pendency of the Bankruptcy Action. Similarly, the general releases set forth in 2014 Settlement Agreements, *see* Kim and Kaplan Statement of Material Facts at Exhs. A and E, predate the adoption of the Plan of Conversion by several years and accordingly, do not bar Plaintiff's claims against Kim and Kaplan.

Plaintiff's cross-motion for summary judgment is granted against the Moving Defendants as to that portion of its first claim for a declaratory judgment that it is entitled to the Demutualization Proceeds. Contrary to the Moving Defendants' contentions, *Schaffer* – the only Appellate Division to date addressing a dispute regarding MLMIC demutualization proceeds – is controlling unless and until this issue is addressed by the Court of Appeals or Second Department. *See Mountain View Coach Lines v. Storms*, 102 A.D.2d 663, 664-65 (2d Dept. 1984) ("[t]he Appellate Division is a single State-wide court divided into departments for administrative convenience and, therefore, the doctrine of *stare decisis* requires trial courts in this department to follow precedents set by the Appellate Division of another department until the Court of Appeals or this court pronounces a contrary rule"). The Court is not persuaded that the *Schaffer* parties' submission to stipulated facts – particularly, the stipulated fact that the subject policy was not a benefit of the physician's employment – renders it factually dissimilar from the instant matter. *Schaffer* clearly held that because the physician did not pay any of the costs related to the policy and did not bargain for the benefit of the demutualization proceeds, the physician would be unjustly enriched by an award of the demutualization proceeds. The Court reaches the same result here, where the Moving Defendants undisputedly did not pay any of the costs related to the subject policies and do not allege that they bargained for the benefit of the

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Demutualization Proceeds. Moreover, to the extent that *Hinds* is persuasive authority, the facts of the instant matter are in no way analogous to those in *Hinds*, where the subject employment agreement provided that the physician would not receive incentive pay until the revenue generated by his services exceeded the amount of his malpractice insurance.

The Court denies, without prejudice, that branch of Plaintiff's motion seeking summary judgment on the second portion of the Plaintiff's declaratory judgment claim that requests an order directing the MLMIC Conversion Agent to disburse to Plaintiff all escrowed proceeds relating to the Moving Defendants' liability insurance. MLMIC is not, at this time, a party to this action. Accordingly, Plaintiff must either file and serve a separate action against MLMIC, or seek to implead MLMIC in this action, before such relief is appropriate.

The Court grants the Moving Defendants' motions to dismiss the second through fifth causes of action for failure to state a claim. The notion that the implied covenant of good faith and fair dealing in the Employment Agreements encompassed an obligation on the part of Defendants to cooperate with Plaintiff's recovery of the Demutualization Proceeds is a quantum leap, as the parties clearly did not anticipate a dispute of this nature when they entered into the Employment Agreements. As to the third claim for unjust enrichment, it is undisputed that the Moving Defendants have not received the Demutualization Proceeds, which are being held in escrow. The Court strains to discern any benefit to the Moving Defendants, whether direct or indirect, from the Demutualization Proceeds being held in escrow and concludes that Plaintiff has failed to state a claim for unjust enrichment. As to the fourth claim for breach of fiduciary duty, Defendants' attempts to obtain the Demutualization Proceeds and/or failure to cooperate in Plaintiff's recovery of such proceeds does not constitute misconduct. Finally, Plaintiff has not stated a claim for injunctive relief in light of its failure to allege irreparable harm.

The Court notes that Plaintiff has not moved for summary judgment against the Non-Moving Defendants. While Tena has filed an Answer, the remaining Non-Moving Defendants have not appeared in this case. Plaintiff is directed to advised the Court at the next conference scheduled for November 26, 2019, whether and to what extent it intends to continue to litigate this matter against the Non-Moving Defendants.

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CONCLUSION

The parties' motions are granted in part and denied in part as follows. The motions filed by defendants Settle and Roche (Motion Sequence 1), Kim and Kaplan (Motion Sequence 2), and Kessler (Motion Sequence 4), are denied as to Plaintiff's first claim and granted as to Plaintiff's remaining claims pursuant to CPLR § 3211. The cross-motions filed by Plaintiff (Motion Sequences 3 and 5) are granted to the extent that Plaintiff is awarded summary judgment on its first claim against Settle, Roche, Kim, Kaplan, and Kessler, and denied in all other respects.

The remaining parties are reminded of the conference scheduled for November 26, 2019 at 11:00 a.m.

All matters not decided herein are hereby denied.

This constitutes the decision and order of the Court.

DATED: Mineola, NY
October 28, 2019

ENTER

HON. TIMOTHY S. DRISCOLL
J.S.C.

ENTERED
OCT 30 2019
NASSAU COUNTY
COUNTY CLERK'S OFFICE

64 Misc.3d 1215(A)
Unreported Disposition
NOTE: THIS OPINION WILL NOT APPEAR IN A PRINTED VOLUME. THE DISPOSITION WILL APPEAR IN THE REPORTER.
Supreme Court, New York,
Saratoga County.

Kim E. SCHOCH, CNM, Ob/Gyn NP, Plaintiff,
v.
LAKE CHAMPLAIN OB-GYN, P.C., Defendant.

2018-4228
|
Decided on June 7, 2019

Attorneys and Law Firms

Nolan, Heller Kaufman, LLP, Attorneys for Plaintiff, 80 State Street, 11th Floor, Albany, New York 12207

Dreyer Boyajian LaMarche Safarnko, Attorneys for Defendant, 75 Columbia Street, Albany, New York 12210

Opinion

Ann C. Crowell, J.

***1** The plaintiff, Kim E. Schoch, CNM, OB/GYN NP ("Schoch") requests an Order pursuant to CPLR § 3212 granting summary judgment declaring that Schoch is entitled to $74,747.03 in cash proceeds being held in escrow. The defendant, Lake Champlain OB-GYN, P.C. ("Lake Champlain") requests an Order pursuant to CPLR § 3212 granting summary judgment declaring that Lake Champlain is entitled to $74,747.03 in cash proceeds being held in escrow.

From June 18, 2007 to February 27, 2015, Schoch was employed by Lake Champlain as a Certified Nurse Midwife (CNM) pursuant to a written employment agreement. Lake Champlain purchased professional liability insurance for all of its physicians, certified nurse midwives and nurse practitioners, including Schoch, from Medical Liability Mutual Insurance Company ("**MLMIC**"). New York law does not permit Schoch to practice as a CNM unless she is in a collaborative relationship with enumerated medical practitioners or entities. See, Insurance Law § 6950 (1). Lake Champlain was able to purchase coverage for Schoch because of her collaborative relationship with Lake Champlain. Lake Champlain selected, bargained for, purchased, controlled and maintained the **MLMIC** policies for Schoch. Lake Champlain paid all of the premiums for the policies and received any policy dividends or premium reductions. Lake Champlain requested Schoch be listed as the "insured" on the applicable insurance policies that provided her individual coverage while practicing at Lake Champlain in the amount of 1 million/ 3 million dollars. The endorsements to the policy were issued to "Lake Champlain OB-GYN, P.C." Lake Champlain was named as the "Policy Administrator" on the policy. Upon Schoch's departure from the practice in February of 2015, Lake Champlain received the policy cancellation premium refund of $8,664.00. Schoch does not make any claim to the policy refund.

In 2018, **MLMIC** announced that it was converting from a mutual insurance company into a stock insurance company. As part of the conversion, **MLMIC** was required to distribute a "cash consideration" to policy holders/members to extinguish their membership interests in an amount calculated upon the premiums paid on the policies. The amount of cash consideration for the policies with Schoch listed as the named insured is $74,747.03.

Schoch's motion for summary judgment relies upon Justice Sedita's March 22, 2019 decision in *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc 3d 703 [Sup. Ct., Erie Cty. 2019]. Justice Sedita determined that Insurance Law § 7307(e) and the New York State Department of Financial Service's decision on the demutualization of **MLMIC** required that the cash consideration be paid to the "policyholder," named insured. Justice Sedita found that the practices' allegations of unjust enrichment to be nothing more than bare legal conclusions.

Lake Champlain's cross-motion for summary judgment relies upon the Appellate Division, First Department's decision, issued two and half weeks later on April 4, 2019, in *Schaffer, Schonholz & Drossman, LLP v. Title*, 171 AD3d 465 [1st Dept. 2019]. Upon facts submitted to the Appellate Division, First Department pursuant to CPLR § 3222(b)(3), the Court determined:

> ***2** "Although respondent was named as the insured on the relevant **MLMIC** professional liability insurance policy, petitioner purchased the policy and paid all the premiums on it. Respondent does not deny that she did not pay any of the annual premiums or any of the other costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds. Awarding respondent the cash

> proceeds of **MLMIC's** demutualization would result in her unjust enrichment." (citations omitted)

The doctrine of *stare decisis* provides that once a court has resolved a legal issue, it should not be re-examined each and every time it is presented. *Battle v. State*, 257 AD2d 745 [3d Dept. 1999] (internal citations omitted). Schoch discounts the Appellate Division, First Department's decision in *Schaffer, Schonholz & Drossman, LLP v. Title, supra* based upon its terseness and lack of detail. However terse, the First Department found as a matter of law that an award of the **MLMIC** proceeds to the named insured doctor would result in her unjust enrichment. The significant facts relied upon by the First Department are not distinguishable from the significant facts in this case. This Court is bound to follow the Appellate Division, First Department until such time as the Appellate Division, Third Department or the Court of Appeal issues a contrary decision. Based upon the doctrine of *stare decisis* Schoch's motion for summary judgment is denied. Lake Champlain's cross-motion for summary judgment is granted.

It is declared that judgment be entered awarding defendant Lake Champlain OB-GYN, P.C. the **MLMIC** proceeds in the amount of is $74,747.03, plus the interest accrued while the proceeds were in escrow, plus costs and disbursements. Any relief not specifically granted is denied. No costs are awarded to any party. This decision shall constitute the Judgment of the Court. The original Decision and Judgment shall be forwarded to the attorney for defendant Lake Champlain for filing and entry. The underlying papers will be filed by the Court.

All Citations

Slip Copy, 64 Misc.3d 1215(A), 2019 WL 3227444 (Table), 2019 N.Y. Slip Op. 51176(U)

End of Document

INDEX NO. EFCA2018003334
NYSCEF DOC. NO. 45 RECEIVED NYSCEF: 09/12/2019

At a Motion Term of the Supreme Court of the State of New York, held in and for the Sixth Judicial District, at the Broome County Courthouse, Binghamton, New York on the 28th day of June, 2019.

PRESENT: HON. MOLLY REYNOLDS FITZGERALD
JUSTICE PRESIDING

STATE OF NEW YORK
SUPREME COURT : COUNTY OF BROOME

JENNIFER M. SHOBACK, CNM, f/k/a JENNIFER M. DAVIDSON, CNM,

Plaintiff,

DECISION AND ORDER

-against-

Index No.: EFCA2018003334

BROOME OBSTETRICS AND GYNECOLOGY, P.C,

Defendant.

This declaratory action asks the court to answer the question: When a mutual liability insurance company demutualizes, who is entitled to the distribution payment - the employer, who has paid the premiums, or the employee who is the policyholder?

FACTS

Plaintiff, Jennifer Shoback, was employed by defendant, Broome Obstetrics, as a certified nurse midwife from July, 2015 - August, 2017. Her employment was pursuant to an Employment Agreement which provided the employer would maintain, at its expense, a policy of liability insurance on plaintiff's behalf.

Defendant provided a policy through Medical Liability Mutual Insurance Company,

then a mutual insurance company. Plaintiff was the policyholder and, so as to enable it to make the premium payments, named defendant as her policy administrator. There is no dispute that defendant made all premium payments.

In 2016 MLMIC applied to the New York State Department of Financial Services to file a Plan to convert from a mutual insurance company, a company owned by the policy holders, to a stock insurance company. Such a conversion must comply with the mandates of Insurance Law § 7307, which provides at the time of demutualization, the eligible policyholders of said company shall receive either a cash consideration and/or stock in exchange for the extinguishment of their equitable share of the company.

In this case, the mandates of § 7307 were assimilated into MLMIC's "Conversion Plan". Under New York Insurance Law, such a conversion is allowable only if the policy holders receive consideration for their equitable share. Here, MLMIC chose cash as the consideration. The total amount paid to MLMIC policy holders for the extinguishment of their membership interests would total $2.502 billion. In the case at bar, the disputed cash consideration is $49,273.59.

Plaintiff contends that the policy was provided to plaintiff as compensation for her services and that the cash consideration in question is a result of the extinguishment of a membership interest in the company. As the owner of the policy, and thus the membership interest, the cash consideration should come to her. Defendant argues that since it paid all the premiums on the policy, equity demands it receive the money and that plaintiff will be unjustly enriched if the funds go to her.

Plaintiff has moved for summary judgment, seeking an order from the court declaring that she is entitled to the demutualization distribution funds. In support of her

motion, plaintiff has submitted an attorney's affidavit with attachments, plaintiff's affidavit with attachments, including, inter alia, her employment agreement with defendant, and a memorandum of law in support of her motion. Defendant opposes the motion arguing that it is premature, and that plaintiff has failed to make a prima facie showing of entitlement to summary judgment. In support of its opposition, defendant has filed an attorney's affidavit with attachments including the affidavit of Marybeth Vanderpoole, Practice Manager of Broome Obstetrics and Gynecology, P.C., and a memorandum of law.

LEGAL ANALYSIS

The rights to the proceeds of a demutualization of a mutual insurance company are defined by the company's "Conversion Plan", *Bank of New York v Janowick*, 470 F3d 264, 274 (2012). The Plan in this case was approved by the New York State Department of Financial Services on September 6, 2018 and approved by the policyholders on September 14, 2018. It provided that the policyholders "or their designees" would receive cash for the extinguishment of their membership interests. The plan defines Policyholder as "the Person(s) identified on the declarations page of such Policy as the insured", and Eligible Policyholders as those *policyholders* that had a policy in effect between July 15, 2013 through July 14, 2016. It defines Policy Administrator as the person designated on the declarations page to administer the policy on behalf of the policyholder, and Designees as those 'Policy Administrators...*to the extent designated by the Eligible Policyholders* to receive the portion of the Cash Consideration allocated to such Eligible Policyholder'(emphasis added).

It is undisputed that plaintiff was the insured named on the declarations page, and as such the policyholder; and defendant was the policy administrator. To date, despite

repeated requests from defendant, plaintiff has not named defendant her designee.

The language of the Plan is clear and unambiguous, and as such must be accorded the plain meaning of its terms, *Goldman v Emerald Green Prop. Owner's Assn., Inc.*, 116 AD3d 1279 , 1280 (2014). According to those terms, plaintiff is entitled to the money.

Defendant's argument - that it paid the premiums and as such is entitled to the funds, is unpersuasive. Policyholders in a mutual insurance company acquire two separate types of rights - contractual rights and membership rights. The contractual rights are paid for by the premiums, and pay for the cost of the insurance itself. "The premiums paid covered the rights under the insurance contract, not any membership rights...premium payments go toward the actual cost of the insurance benefits provided", *Dorrance v U. S.*, 809 F3d 479, 485[1].

Here, the defendant paid the premiums as part of its obligation under the Employment Agreement with plaintiff. She provided services and in return defendant was confident that she was covered (and hence it was covered) in terms of malpractice insurance. This arrangement benefitted both parties.

The membership rights are acquired at "no cost", and are in fact, a benefit of being the policyholder, *Dorrance v United States*, at 485. They do not arise as a result of paying the premiums, but are intrinsic to the owner of the policy, the policyholder.

The bottom line is that the cash consideration that is generated as a result of demutualization is a "windfall", or "a pot of money no one expected or even envisioned", *Dorrance* at 486. Here, it was a result of a restructuring of a mutual insurance company

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[1] Defendant argues that Dorrance is not relevant as it is a tax case. While the facts may differ from the case at bar, the legal import of the case lies in its analysis of the demutualization process.

into a stock company. However, negative connotations aside, the fact that this is a "windfall" does not, per se, render it illicit or unjust. The court is certainly inclined to agree with the plain language of the Plan and the Insurance Law that in this case, plaintiff, the policyholder should be entitled to receive it.

However, all of the foregoing is academic in light of *Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d 465, an April, 2019 decision out of the 1st Department. The case involved the very issue before this court (in fact involving the same demutualization of MLMIC), who is entitled to the cash consideration. The Appellate Division found that the medical practice - the entity that had paid the premiums - was entitled to receive the funds and that any other result would unjustly enrich the individual practitioner. Despite a thorough search, the court has not discovered any third department cases that have ruled on this issue. "Where the issue has not been addressed within the Department, Supreme Court is bound by the doctrine of stare decisis to apply precedent established in another Department, either until a contrary rule is established by the Appellate Division in its own Department or by the Court of Appeals", *D'Alessandro v. Carro,* 123 AD3d 1, 6 (2014); *Tzolis v. Wolff*, 39 AD3d 138, 142 (2007); *Mountain View Coach Lines v Storms,* 102 AD2d 663, 664 (1984).

State trial courts must follow a higher court's existing precedent "even though they may disagree", *People v Rivera,* 5 NY3d 61 (2005).

Thus plaintiff's motion for summary judgment is denied. This constitutes the Decision and Order of the Court

Dated: September 10, 2019

HON. MOLLY REYNOLDS FITZGERALD
SUPREME COURT JUSTICE

cc: Justin A. Heller, Esq.
Jared R. Mack, Esq.
Judith E. Osburn, Broome County Chief Court Clerk

INDEX NO. 656121/2018
NYSCEF DOC. NO. 122 RECEIVED NYSCEF: 12/03/2019

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. BARRY R. OSTRAGER** **PART** **IAS MOTION 61EFM**

Justice

----------X

JAMES SULLIVAN, CHARLES CONTE, MANSOOR BEG, ALAN KADISON, JOHN RICCI, and RAZA ZAIDI,

Plaintiffs,

- v -

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and NORTHWELL HEALTH, INC.,

Defendants.

----------X

INDEX NO. 656121/2018

MOTION DATE

MOTION SEQ. NO. 001

DECISION, ORDER, AND JUDGMENT ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 90, 91, 92, 93, 94, 98, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 112, 113, 114, 115, 116, 117, 118, 119, 120

were read on this motion to/for SUMMARY JUDGMENT (AFTER JOINDER)

OSTRAGER, BARRY R., J.S.C.:

Before the Court is a motion for summary judgment by defendant Northwell Health, Inc. ("Northwell) and a cross-motion for summary judgment on Northwell's counterclaims by James Sullivan, M.D., Charles Conte, M.D., Mansoor Beg, M.D., Alan Kadison, M.D., John Ricci, M.D. and Raza Zaidi, M.D. ("Plaintiffs"). Defendant Medical Liability Mutual Insurance Company ("MLMIC") is not a party to either motion and has not submitted any papers.

Background

This case arises out of the demutualization of MLMIC and the distribution of cash consideration ("Cash Consideration") to policyholders in accordance with a plan approved by the New York State Department of Financial Services ("DFS"). Plaintiffs are each surgical oncologists who were insured by MLMIC during relevant portions of their employment with defendant Northwell, a public healthcare network. Plaintiffs and defendant Northwell each claim

entitlement to the Cash Consideration that MLMIC is distributing in connection with its demutualization. On September 14, 2018, DFS approved the demutualization plan (the "Approved Plan"). The Approved Plan contemplates that MLMIC will hold disputed demutualization proceeds in escrow pending resolution of any disputed claim to the Cash Consideration. For the reasons stated below, the Court finds that Northwell is entitled to the Cash Consideration currently held in escrow by MLMIC.

The Instant Motion

Defendant Northwell moves for summary judgment dismissing Plaintiffs' claims and declaring that Northwell is entitled to receive the Cash Consideration being held in escrow by MLMIC. Plaintiffs cross-move to dismiss Northwell's counterclaims and request that the Court deny defendant Northwell's motion for summary judgment in its entirety and declare that Plaintiffs are entitled to receive the Cash Consideration.

In their First Amended Complaint (NYSEF Doc. No. 67), Plaintiffs seek a declaratory judgment against Northwell, declaring that Plaintiffs are entitled to the approximately $4.688 million total share of the MLMIC Cash Consideration (Third Cause of Action). Plaintiffs also claim tortious interference with contract against Northwell for filing an objection to MLMIC's allocation of the Cash Consideration and thus causing the funds to be held in escrow pending legal resolution (Fourth Cause of Action).[1]

In its Answer and Counterclaims (NYSEF Doc. No. 68), defendant Northwell alleges that each Plaintiff's Employment Agreement implicitly required the doctor to designate Northwell as the designee for the purpose of receiving the Cash Consideration. As it is undisputed that no Plaintiff named Northwell as designee, defendant Northwell seeks a declaratory judgment that

[1] The First Two Causes of Action are asserted against defendant MLMIC, as discussed below.

receipt or retention of the Cash Consideration by Plaintiffs would constitute a material breach of the Employment Agreement. Additionally, defendant Northwell seeks a declaratory judgment that the distribution of the Cash Consideration to Plaintiffs would constitute unjust enrichment.

Plaintiffs' Third Cause of Action

Plaintiffs' motion for summary judgment on its Third Cause of Action against defendant Northwell seeking distribution of the Cash Consideration to Plaintiffs is denied.

The Court must follow the precedent set by the First Department in *Matter of Schaffer, Shonholz & Drossman, LLP v Title*, 171 A.D.3d 465 (1st Dep't 2019), which also dealt with the MLMIC demutualization. In *Schaffer*, the First Department held that: "Although [the individual professional] was named as the insured on the relevant MLMIC professional liability insurance policy, [the employer] purchased the policy and paid all the premiums on it ... [and the individual professional did not] bargain for the benefit of the demutualization proceeds." In other words, the First Department held that, absent a bargained-for agreement with respect to the Cash Consideration, the party who paid the premiums to MLMIC during the relevant period, even if not the insured, is entitled to the Cash Consideration.

This case is factually different from *Schaffer*, which was decided on stipulated facts, because, here, Plaintiffs specifically bargained to retain coverage with MLMIC, which had been Plaintiffs' insurer before Plaintiffs became affiliated with defendant Northwell. Nevertheless, it is undisputed that defendant Northwell paid Plaintiffs' insurance premiums for coverage by MLMIC during the relevant period, and the Court finds there was no bargained-for agreement with respect to the Cash Consideration. As such, Plaintiffs' motion for summary judgment on this cause of action must be denied.

Plaintiffs did distinguish the present facts from *Schaffer* by noting that in *Schaffer* the employer who had paid the insurance premiums had also procured and obtained the MLMIC policies, whereas here, it is undisputed that Plaintiffs had MLMIC policies before they began working for defendant Northwell. Additionally, Plaintiffs procured their own policies and kept these policies despite defendant Northwell's preference for another insurer. Nonetheless, the Court agrees with defendant Northwell that this is a distinction without a difference. The relevant inquiries under *Schaffer* are (1) who paid the premiums to MLMIC and (2) whether there was a bargained-for exchange *with respect to the Cash Consideration* from the demutualization process.

The Court finds that there was no bargained-for exchange with respect to the Cash Consideration. Plaintiffs do establish that their insurance coverage, and indeed their retention of MLMIC specifically, were bargained-for benefits of their overall employment agreements with defendant Northwell. However, Plaintiffs' Employment Agreements do not contain any provisions related to Cash Consideration from the MLMIC demutualization proceeds.

Additionally, the dispute among the parties regarding whether defendant Northwell properly served as a "policy administrator" is irrelevant. The Approved Plan states "the definition of Policy Administrator [does not] represent the Department's view that anyone that falls within this definition is (or is not) entitled, under the particular facts or applicable law, to receipt of the cash consideration." More importantly, the *Schaffer* court looked only at the two factors discussed above.

Plaintiffs further argue that the Court should not follow *Schaffer*, because the parties in that case did not raise, and thus the First Department did not consider, Plaintiffs' purported rights under New York Insurance Law Section 7307(e)(3).

The Court rejects the argument that Plaintiffs are entitled to the Cash Consideration under Insurance Law Section 7307(e)(3). Plaintiffs argue that because they are "policyholders" within the meaning of Section 7307, they are conclusively entitled to the Cash Consideration. However, this interpretation of Insurance Law Section 7307 is *contrary* to the First Department's decision in *Schaffer* by which this Court is bound. Although the First Department did not explicitly address this issue, there, as here, the "policyholder" (insured) was the employee-physician and nevertheless the First Department found that the employer, who had unquestionably paid the insurance premiums, was entitled to the Cash Consideration. *Schaffer*, 171 AD3d at 465.

The Court is also not persuaded by Plaintiffs' argument that DFS "affirmed" the decision to allocate the Cash Consideration to policyholders only. Plaintiffs cite to a public hearing held prior to Plan approval in August 2018 in which DFS purportedly rejected the proposition that employers who had paid insurance premiums were entitled to the Cash Consideration. (NYSCEF Doc. No. 53). However, the Approved Plan specifically provided that the facts of individual cases would dictate the entitlement to the proceeds and established an objection procedure – the one that defendant Northwell followed in this case (NYSCEF Doc. No. 54). As Northwell notes, the Approved Plan provides that the ultimate legal right to the Cash Consideration, if disputed, must be decided by a court (Approved Plan at 25, "[t]he determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided either by agreement of the parties or by an arbitrator or court.") Moreover, in January 2019, the Superintendent again clarified that regardless of the parties' status as "policy administrators" or "designees" and regardless even of whether the monies are paid out of escrow to one party or another, nothing in the Approved Plan determines the

underlying legal rights of the parties to the Cash Consideration, stating (at NYSCEF Doc. No. 55), that:

> The Superintendent continues to encourage all persons involved in disputes regarding the escrowed funds to resolve their differences in a prompt, fair, and equitable manner and reiterates that: (a) the parties maintain all legal rights to pursue their claims that they otherwise have absent the [DFS Approval] Decision and this Order; and (b) whether the funds are held in escrow has no effect on the respective legal rights of the parties to such funds.

Defendant Northwell's First Counterclaim

Likewise, the Court denies defendant Northwell's motion for summary judgment on its first counterclaim for a declaratory judgment that Plaintiffs breached their Employment Agreements. As discussed above, nothing in the Plaintiffs' Employment Agreements provides for the allocation of the Cash Consideration. Despite Northwell's counterclaim that Plaintiffs were implicitly required under their Employment Agreements to designate defendant Northwell as the designee of the Cash Consideration under the Approved Plan because the Employment Agreements required Plaintiffs to "assign" or "turn over" all fees or revenues generated by their practice of medicine to defendant Northwell, defendant Northwell admits, and the Court finds, that there is no contract provision expressly governing entitlement to the Cash Consideration, and the Employment Agreements are silent as to the demutualization proceeds.

Plaintiffs' Fourth Cause of Action

Plaintiffs' motion for summary judgment in their favor on their fourth cause of action for tortious interference with contract is denied. Assuming without deciding, for the purpose of this motion, that the Approved Plan constitutes a contract between MLMIC and Plaintiffs, the Court does not find that defendant Northwell tortiously interfered with that contract. Plaintiffs allege that by filing objections under the Approved Plan, with the intent that the Cash Consideration funds be held in escrow, Northwell tortiously interfered with Plaintiffs' contract with MLMIC.

The Court rejects this argument because it finds that defendant Northwell had legal justification to file such objections. The Approved Plan specifically proscribed the objection procedure, and defendant Northwell had a good faith basis, later substantiated by case law, to claim that it was entitled to the Cash Consideration because it had paid the insurance premiums to MLMIC during the relevant period.

Defendant Northwell's Second Counterclaim

Defendant Northwell's motion for summary judgment in its favor on its second counterclaim for a declaratory judgment of unjust enrichment is granted. Defendant Northwell alleged that if Plaintiffs were to receive and retain the Cash Consideration, they would be unjustly enriched. The Court finds under *Schaffer*, for the reasons discussed above, that Plaintiffs would be unjustly enriched were they to receive the Cash Consideration. *See Schaffer,* 171 AD3d at 465 (finding that "awarding [the insured] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment").

Accordingly, it is hereby,

ORDERED that Plaintiffs' motion for summary judgment on their third cause of action for a declaratory judgment that it is entitled to the Cash Consideration against Defendant Northwell is denied; and it is further

ADJUDGED and DECLARED that Plaintiffs are not entitled to the Cash Consideration from the MLMIC demutualization proceeds; and it is further

ADJUDGED and DECLARED that defendant Northwell is entitled to the Cash Consideration from the MLMIC demutualization proceeds; and it is further

ORDERED that Plaintiffs' motion for summary judgment on their fourth cause of action for tortious interference with contract against Defendant Northwell is denied; and it is further

ORDERED that defendant Northwell's motion for summary judgment on its first counterclaim against Plaintiffs for a declaratory judgment of breach of contract is denied; and it is further

ADJUDGED and DECLARED that Plaintiffs did not breach their Employment Agreements with defendant Northwell; and it is further

ORDERED that defendant Northwell's motion for summary judgment on its second counterclaim against Plaintiffs for a declaratory judgment of unjust enrichment is granted; and it is further

ADJUDGED AND DECLARED that Plaintiffs would be unjustly enriched if they were to receive the Cash Consideration from the MLMIC demutualization proceeds; and it is further

ORDERED that Defendant MLMIC may proceed to distribute the Cash Consideration consistent with the terms of this decision.

12/2/19
DATE

BARRY R. OSTRAGER, J.S.C.

BARRY R. OSTRAGER
JSC

CHECK ONE:	[X]	CASE DISPOSED		[ ]	NON-FINAL DISPOSITION		
	[ ]	GRANTED	[ ] DENIED	[X]	GRANTED IN PART	[ ]	OTHER
APPLICATION:	[ ]	SETTLE ORDER		[ ]	SUBMIT ORDER		
CHECK IF APPROPRIATE:	[ ]	INCLUDES TRANSFER/REASSIGN		[ ]	FIDUCIARY APPOINTMENT	[ ]	REFERENCE

64 Misc.3d 1216(A)
Unreported Disposition
NOTE: THIS OPINION WILL NOT APPEAR IN A PRINTED VOLUME. THE DISPOSITION WILL APPEAR IN THE REPORTER.
This opinion is uncorrected and will not be published in the printed Official Reports.
Supreme Court, New York, Greene County.

URGENT MEDICAL CARE, PLLC, Plaintiff,
v.
Amy J. Brueckner AMEDURE, Defendant.

19-0121
|
Decided on July 12, 2019

Attorneys and Law Firms

JOHN D. ASPLAND, JR., ESQ., FITZGERALD MORRIS BAKER FIRTH P.C., PO Box 2017, 68 Warren Street, Glens Falls, NY 12801, Attorney for Plaintiff

MICHAEL R. FRASCARELLI, ESQ., CATANIA, MAHON, MILLIGRAM & RIDER, PLLC, One Corwin Court, PO Box 1479, Newburgh, New York 12550, Attorney for Defendant

Opinion

Raymond J. Elliott, III, J.

*1 When a person lawfully receives a payment for an ownership interest that was created through payments made by another person, can a claim be stated, based in equity, for unjust enrichment? In short, that is the issue this motion requires the Court to resolve.

Defendant worked as a doctor in a practice owned by Plaintiff. Plaintiff paid Defendant's malpractice premiums. Due to the demutualization of a malpractice insurance provider, Defendant received a payment of nearly double the amount of three years' worth of premium payments for her ownership interest in that company. Plaintiff is suing Defendant alleging that Defendant has become unjustly enriched through receipt of these proceeds since Plaintiff paid the premiums throughout the relevant period and believes it has an equitable claim to the distribution. Before the Court is Defendant's Motion to Dismiss. Plaintiff has submitted an Amended Summons and Complaint correcting the previously erroneously named Plaintiff. Defendant does not contest the amendment; however, she elects to have her Motion applied to the new pleadings.

Motion to Dismiss

In determining a motion to dismiss a complaint, the court's role is ordinarily limited to determining whether the complaint states a cause of action (*see Frank v. Daimler Chrysler Corp.*, 292 AD2d 118, 121 [1st Dept 2002]). The court must "accept the facts as alleged in the complaint as true, accord plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (*Nonnon v. City of New York*, 9 NY3d 825, 874 [2007]). "The sole criterion on a motion to dismiss is whether the pleading states a cause of action, and if from its four corners factual allegations are discerned which taken together manifest any cognizable action at law, a motion for dismissal will fail" (*Harris v. IG Greenpoint Corp.*, 72 AD3d 608, 609 [1st Dept 2010]). "A motion [to dismiss] must be decided without regard to evidence submitted by defendants, unless that evidence 'conclusively establishes the falsity of an alleged fact' " (*ARB Upstate Communications LLC v. R.J. Reuter, L.L.C.*, 93 AD3d 929, 930 [3d Dept 2012], *citing Gray v. Schenectady City School Dist.*, 86 AD3d 771, 772 [3d Dept 2011]). "Whether the complaint will later survive a motion for summary judgment, or whether the plaintiff will ultimately be able to prove its claims, of course, plays no part in the determination of the motion to dismiss" (*Shaya B. Pacific, LLC v. Wilson, Elser, Moskowitz, Edelman & Dicker, LLP*, 38 AD3d 34, 38 [2nd Dept 2006], citing *EBC I, Inc. v. Goldman, Sachs & Co.*, 5 NY3d 11, 19 [2005]). Even were this Court to have doubts about the viability of the claim, the existence of potentially meritorious claims within the record, even if inartfully pleaded, requires denial of a motion to dismiss (*see Rovello v. Orofino Realty Co.*, 40 NY2d 633, 635 [1976]).

Unjust Enrichment

Although "unjust enrichment is not a catchall cause of action to be used when others fail" (*Corsello v. Verizon New York, Inc.*, 18 NY3d 777, 790 [2012]), the Court of Appeals has noted the broad equity jurisdiction of the Courts and our power to correct unjust enrichment, going so far as to cite Aristotle in this context, stating "[l]aw without principle is not law; law without justice is of limited value. Since adherence to principles of 'law' does not invariably produce justice,

equity is necessary" (*Simonds v. Simonds*, 45 NY2d 233, 239 [1978]). To recover under a theory of 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" (*New York State Workers' Compensation Bd. v. Program Risk Mgt., Inc.*, 150 AD3d 1589, 1594 [3d Dept 2017] [internal quotation marks, brackets and citations omitted]; *see Georgia Malone & Co., Inc. v. Rieder*, 19 NY3d 511, 516 [2012]).

***2** "The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another" (*Clifford R. Gray, Inc. v. LeChase Const. Servs., LLC*, 31 AD3d 983, 988 [3d Dept 2006]). This requirement of ownership is in the context of an equitable claim, not legal ownership rights; therefore, a party may be legally entitled to a benefit through a contract but still equitably owe those funds to another (*see Simonds v. Simonds*, 45 NY2d at 239; *see also* Restatement [Third] Restitution and Unjust Enrichment § 26, Illustration 11). " 'The essential inquiry in any action for unjust enrichment or restitution is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered' " (*Goel v. Ramachandran*, 111 AD3d 783, 791 [2013], *quoting Paramount Film Distrib. Corp. v. State of New York*, 30 NY2d 415, 421 [1972], *cert denied* 414 US 829 [1973]).

"[I]t is not prerequisite of unjust enrichment claim that one enriched commit wrongful or unlawful act" (*Mayer v. Bishop*, 158 AD2d 878, 878 [3d Dept 1990], *lv denied* 76 NY2d 704 [1990]). A claim for unjust enrichment "is undoubtedly equitable and depends upon broad considerations of equity and justice" (*Paramount Film Distrib. Corp. v. State of New York*, 30 NY2d at 421. "In determining whether this equitable remedy is warranted, a court should 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" (*Betz v. Blatt,* 160 AD3d 696, 701 [2d Dept 2018] [internal quotation marks and citations omitted]). Ultimately, "to determine whether there has indeed been unjust enrichment the inquiry must focus on the 'human setting involved', not merely upon the transaction in isolation" (*Mayer v. Bishop*, 158 AD2d at 880, quoting *McGrath v. Hilding*, 41 NY2d 625, 629 [1977]).

Statement of Facts

In 2018, Medical Liability Mutual Insurance Company (hereinafter **MLMIC**) approved a demutualization, resulting in a payment based on the ownership interest in the insurance policy at issue in this suit, which Plaintiff believes to be approximately $57,000 [Amended Complaint ¶ 19]. Defendant worked as a doctor for Plaintiff from 2009 until December 2018. Defendant swears she obtained a policy with **MLMIC** to provide malpractice coverage prior to her employment with Plaintiff [Defendant's Affidavit: ¶ 7]. Defendant states that not until 2011, when she ended her private practice, did Plaintiff assume responsibility for the **MLMIC** premiums [Defendant's Affidavit: ¶ 7-8]. Defendant asserts that she agreed to diminished compensation and the premium payments were "in lieu of" an increase in salary [Defendant's Affidavit: ¶ 8].

Plaintiff alleges that "[a]s a provider of health care services, Plaintiff's liability protection needs required all employees, providing health care services, to be covered by insurance" [Amended Complaint ¶ 4]. Therefore, "during the course of her employment and specifically for the period of July 15, 2013 through July 14, 2016, [Defendant] was covered with malpractice insurance by [Plaintiff]" [Plaintiff's Affidavit: ¶ 4]. Plaintiff alleges that "[d]espite the fact that [it] was maintaining the policy and making the premium payment directly to the insurer, through a clerical error, [Plaintiff] was mistakenly listed as the policy administrator" [Plaintiff's Affidavit: ¶ 6]. Further, Plaintiff asserts that "the premiums were simply an operating/overhead expense of [Plaintiff]" and not an employee benefit [Plaintiff's Affidavit: ¶ 7].

Demutualization

The New York Superintendent of Financial Services' September 6, 2018, decision (hereinafter DFS Decision) explains the nature of the demutualization and the ownership stake as follows:

> A mutual insurance company is owned by and operated for the benefit of its policyholders. A policyholder's ownership interest in a mutual company is known as a "membership interest." These membership interests provide policy holders with certain benefits, including the right to vote on matters submitted to a vote of members such as the election of directors, and the right to receive a distribution of profits earned by the mutual insurance company in the form of a dividend. Membership interests are not freely transferrable; they exist only in connection with a policyholder's ownership of a policy.

> When a demutualization occurs, membership interests in the mutual insurance company are converted to equity interests in the converted stock insurance company and eligible policyholders of the mutual insurance company thereby become shareholders of the converted stock insurance company. Under the Insurance Law, a plan of conversion is the operative document governing a demutualization, with such document subject to various procedural requirements and the Superintendent's approval. In the case of a property/casualty insurer such as **MLMIC**, such approval is subject to the standards set forth in Insurance Law § 7307 (h) (l) [DFS Decision p. 3-4].

Demutualization has been referred to as a "windfall" in some cases because it is often unclear if parties knew the ownership stake even existed prior to the demutualization plan (*see e.g. Bank of New York v. Janowick*, 470 F3d 264, 272 [6th Cir 2006] ["Here, it is clear that none of the parties expected to receive the demutualization proceeds, which will constitute a windfall to whoever receives them"]; *see also Ruocco v. Bateman, Eichler, Hill, Richards, Inc.*, 903 F2d 1232, 1238 [9th Cir 1990]; *Chicago Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union (Indep.) Pension Fund*, No. 02 C 3115, 2005 WL 525427, at *4 [ND Ill March 4, 2005]). Following the trend of demutualization in the life insurance industry one expert wrote, regarding property/casualty insurance as at issue here, that "[m]ost policyholders in such companies--including not only individuals but businesses, non-profit institutions, and municipalities--are undoubtedly unaware that they have substantial rights as owners which could be realized in the form of stock ownership, or in cash or otherwise, upon demutualization" (Peter M. Lencsis, *Demutualization of New York Domestic Property/casualty Insurers*, NY St BJ 42 [October 1998]).

MLMIC Demutualization

A recent Supreme Court case (Sedita III, J.) lays out the relevant history of this transaction:

> The **MLMIC** Board of Directors approved a proposed transaction by which **MLMIC** would demutualize, convert to a stock insurance company, and be acquired by the National Indemnity Company (NICO) for $ 2.502 billion. The **MLMIC** Board later adopted a plan of conversion, whereby cash consideration would be paid to policyholders/members in exchange for the extinguishment of the policyholder membership interests. Pursuant to § 8.2 (a) of the Plan of Conversion (the Plan), "Each Eligible Policyholder (or it's designee) shall receive a cash payment in an amount equal to the applicable conversion." Pursuant to § 2.1 of the Plan, an "eligible policyholder" was the person designated as the insured, while a "designee" meant employers or policy administrators, "designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders." The Plan did not provide for the policy administrator to receive cash consideration absent such a designation from the policyholder/member.
>
> ***4** The New York Superintendent of Financial Services held a public hearing and approved the Plan. In her September 6, 2018 decision (DFS Decision), the Superintendent wrote: "**MLMIC's** eligible policyholders will receive cash consideration. Insurance Law § 7307 (e) (3) expressly defines those persons who are entitled to receive the proceeds of the Demutualization as each person who had a policy in effect during the three-year period preceding the **MLMIC** Board's adoption of the resolution (the 'Eligible Policyholders') and explicitly provides that each Eligible Policyholder's equitable share of the purchase price shall be determined based on the amount of the net premiums paid on eligible policies" (DFS Decision, p.4).
>
> The DFS Decision also acknowledged testimony and written comments from medical groups. Nearly identical to the plaintiff's contentions in this case, the medical groups had argued that the cash consideration belonged to them because they had paid the premiums on behalf of the policyholders and/or had acted as the policy administrators. Addressing these arguments, the Superintendent of Financial Services wrote: "Insurance Law § 7307 (e) (3) defines the policyholders eligible to be paid their proportional shares of the purchase price, but also recognizes that such policyholders may have assigned such legal right to other persons. Therefore, the plan appropriately includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to the payment in a given case." Such a claim would be, "decided either by agreement of the parties or by an arbitrator or court" (DFS Decision, p.25).

(*Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc 3d 703, 704 [Sup Ct, Erie County 2019, Sedita III, J.]).

Ownership Interest: Policyholder vs. Policy Administrator

Both Insurance Law § 3435 and Regulation 135 (11 NYCRR 153) permit the issuance of group property/casualty insurance only with respect to public and not-for-profit insureds. Thus, under New York law with the limited exception of a risk retention group authorized under Federal law, group property/casualty insurance for physician groups may not be written in New York (*see* Office of General Counsel, Department of Financial Services, *New York Medical Professional Liability Insurance* [June 4, 2008] OGC Op No 08-06-02, available at https://www.dfs.ny.gov/insurance/ogco2008/rg080602.htm). Therefore, as a matter of course, medical malpractice insurance must generally be acquired for each provider rather than for a group. Thus, regardless for who paid the premium, the providers were the policyholders.

"A court may take judicial notice of matters of public record, such as an incontrovertible official document or other reliable documents, the existence and accuracy of which are not disputed, and information culled from public records" (10A Carmody-Wait 2d § 56:33; *see Matter of 60 Mkt. St. Assoc. v. Hartnett*, 153 AD2d 205, 208 n [3d Dept 1990], *affd* 76 NY2d 993 [1990]; *Matter of Sunhill Water Corp. v. Water Resources Commn.*, 32 AD2d 1006, 1008 [3d Dept 1969]). As both parties rely significantly on the demutualization process approved by the New York Superintendent of Financial Services, this Court finds it appropriate to take judicial notice of the entire record of the process as provided through the New York Superintendent of Financial Services (*see* Department of Financial Services, Public Hearings and Decisions: Medical Liability Mutual Insurance Company [**MLMIC**] Demutualization Plan of Conversion from Property and Casualty Mutual Insurance Company to Property and Casualty Stock Insurance Company, available at https://www.dfs.ny.gov/reports_and_publications/public_hearings [Last Accessed July 12, 2019]).

***5** Although the provider was the policyholder, **MLMIC's** counsel explained in written testimony that "a Policy Administrator is a Person designated by a Policyholder to act as administrator of the Policy for certain specified purposes. Designations are made on a form provided by **MLMIC** as part of the application process or at any point in time selected by the Policyholder. The form has been available on-line continuously throughout the Eligibility Period. Designations received as part of the application process are reflected on the declaration page of the applicable Policy. Policy Administrators can also be 'otherwise designated' by the submission of the prescribed form by the Policyholder following the issuance of the Policy. In such a case, the Policy Administrator would not be named on the declarations page of the Policy until the Policy is renewed, but an endorsement to the Policy would be issued in the interim" (Willkie Farr & Gallagher LLP, *Written Testimony at Public Hearing In the Matter of Medical Liability Mutual Insurance Company,* [August 28, 2018], available at https://www.dfs.ny.gov/docs/about/hearings/**mlmic**_08232018/willkie.pdf).

As part of the hearing process, several representatives for hospitals and other practices expressed concerns regarding the distribution of proceeds of the demutualization. **MLMIC's** Plan of Conversion (**MLMIC**, *Plan of Conversation of Medical Liability Mutual Insurance Company*, available at https://www.mlmic.com/wp-content/uploads/2018/09/**mlmic**_plan_of_conversion.pdf [June 15, 2018]), included "Schedule I: Objection Procedures." This procedure created a process for Policy Administrators to object to the distribution to the policyholder, causing the payment to be escrowed. The fact that the plan itself contemplated objections between policy administrators and policyholders creates, at least some, inference of acknowledge that these proceeds would be in dispute.

A significant point of contention exists regarding the nature of the policy administrator designation. Dr. Richard Frimer of Maple Medical LLP testified that his practice made all the premium payments "actually suffering sometimes to pay the premiums" (Department of Financial Services, Hearing Transcript, 124-134, [August 23, 2018], available at https://www.dfs.ny.gov/system/files/documents/2019/01/**mlmic**_transcript_20180823.pdf [hereinafter Hearing Transcript]). Frimer testified that despite **MLMIC's** estimate of 40 percent of policyholders having a different policy administrator, the common practice for many practices, including his own was for premiums to be paid on behalf of employees without designation [Hearing Transcript p.127-128]. Frimer also asserted that although the designation may have existed within the period at issue for calculating the proceeds, the designation has not always existed, thereby longtime employees could have a policy beginning before designation was even possible [Hearing Transcript p.131].

Frimer's testimony was further corroborated by one hospital system that went so far as book approximately $24 million in proceeds as part of their cash flow projection due to their belief that as the payor of the premiums, they were

entitled to the payment [Hearing Transcript p.156-176]. That testimony also noted the obstacle to group policies forcing the current conflict [Hearing Transcript p.170]. In response to this testimony, the Superintendent specifically noted that that "nothing in this procedure prevent anyone from exercising whatever legal rights they have" [Hearing Transcript p. 175].

These examples are emblematic of multiple oral and written testimonies that were provided to the Department of Financial Services regarding the claims of employers having paid the premiums to **MLMIC** and having acted as the owners of the policy, despite not being the policyholders or, in some cases, even declared as the policy administrator. Notably, **MLMIC's** counsel submitted written testimony that stated, "In all events [regarding declaration of a Policy Administrator] there must be an affirmative designation in writing on **MLMIC's** prescribed form. The mere acceptance of a policy application and premium on a Policy from a Person not designated by the Policyholder as a Policy Administrator does not confer the status of Policy Administrator on such Person" [Willkie Farr & Gallagher LLP, *Written Testimony*].

***6** The DFS Decision stated that "[t]he Objection Procedure provides a reasonable framework for the resolution of disputes between certain policyholders and entities that claim to be Policy Administrators. Importantly, the Objection Procedure does not, in any way, impact any person's rights to resolve their dispute in any forum of their choosing or as required by contract or law. Rather, the sole purpose of the Objection Procedure is to create a category of disputed claims for which the cash consideration attributable to such claims will be placed in an escrow and released by **MLMIC** upon one of two events: **MLMIC** either receives (a) 'joint written instructions from the Eligible Policyholder and the Policy Administrator... as to how the allocation is to be distributed,' or (b) 'a non-appealable order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the Policy Administrator... or the Eligible Policyholder' " (DFS Decision p.23).

First, the Court need not now resolve the dispute regarding what creates a policy administrator. Second, the Court does not, at this time, credit or give weight to the testimony provided at the hearing except to merely put context to the DFS Decision. Both the Superintendent's statement at the hearing and the decision's clear language stating that "the Objection Procedure does not, in any way, impact any person's rights to resolve their dispute in any forum of their choosing or as required by contract or law" clearly establish that the Department of Financial Services did not resolve the issues around equitable claims nor did they seek to in any way limit the ability of parties to bring these claims.

Precedent

There is a dearth of case law regarding demutualization of a property/casualty insurance company. Significantly, much of the case law that does exist is in the context of mutual life insurance and is driven by state law as well as the Federal Employee Retirement Income Security Act (hereinafter ERISA).

In *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, (*supra*), Supreme Court considered similar claims to those at issue here. The Court dismissed the complaint finding there was no claim of ownership and, therefore, no claim of unjust enrichment. Notably, in that case there were written employment agreements defining the relationship between the parties, which stated that "professional liability insurance premiums as an 'employment benefit for and on behalf of' the employee" (*Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc 3d at 704). Neither party claims such an agreement exists here.

The only Appellate Court decision regarding this issue is from the First Department in *Schaffer, Schonholz & Drossman, LLP v. Title* (171 AD3d 465, 465 [1st Dept 2019]). There, the Court ruled on stipulated facts that were submitted and relied on ERISA demutualization (*Id.*). The Court found that despite respondent being named as the policyholder, plaintiff had paid the premiums and all costs related to the policy and there was no record of bargaining for the benefit of demutualization proceeds, so [a]warding respondent the cash proceeds of **MLMIC's** demutualization would result in her unjust enrichment" (*Id.*) Here, the parties contest the nature of the understanding by which Plaintiff assumed payment of the premiums.

The Motion to Dismiss Must be Denied

In essence, an unjust enrichment claim accrues when one person has obtained money from the efforts of another person under such circumstances that, in fairness and good conscience, the money should not be retained (*see Miller v. Schloss*, 218 NY 400, 407 [1916]). In such circumstances, the law requires the enriched person to compensate the other person (*see Bradkin v. Leverton*, 26 NY2d 192, 196-197 [1970]). Such a claim is based not in legal title, but in equity (*see Simonds v. Simonds*, 45 NY2d at 239).

Here, viewing the Complaint in the light most favorable to Plaintiff and giving it all reasonable inferences, Plaintiff has stated a claim for unjust enrichment. Plaintiff paid the premiums. Plaintiff claims that, but for a mistake of fact, it would be the policy administrator, and it was its payments and efforts that created the proceeds from demutualization. Defendant vigorously disagrees and properly notes she has legal title to the proceeds. Legal title does not end the inquiry (*see Simonds v. Simonds*, 45 NY2d at 239; *Castellotti v. Free*, 138 AD3d 198, 207 [1st Dept 2016]). "In determining a motion to dismiss ..., the evidence must be accepted as true and given the benefit of every reasonable inference which may be drawn therefrom. The question of credibility is irrelevant, and should not be considered" (*Gonzalez v. Gonzalez*, 262 AD2d 281, 282, [2d Dept 1999]). Therefore, it is not currently before the Court to resolve whether Plaintiff's claims are true or even plausible, but only if they state a claim. Here, Plaintiff has clearly stated such a claim.

*7 According, it is

ORDERED, Defendant's Motion to Dismiss the Amended Complaint is **denied**.

This shall constitute the Decision, Order and Judgment of the court. This Decision, Order and Judgment is being returned to the attorney for Plaintiff. All original supporting documentation is being filed with the Greene County Clerk's Office. The signing of this Decision, Order and Judgment shall not constitute entry or filing under CPLR 2220. Counsel is not relieved from the applicable provision of that rule relating to filing, entry and notice of entry.

SO ORDERED AND ADJUDGED

Papers Considered:

1. Defendant's Notice of Motion to Dismiss dated March 28, 2019; Defendant's Affidavit in Support of the Motion to Dismiss sworn March 28, 2019; Attorney's Affirmation in Support of the Motion to Dismiss dated March 28, 2019; Defendant's Memorandum of Law in Support of the Motion to Dismiss dated March 28, 2019; Annexed Exhibits 1-8.

2. Plaintiff's Attorney Affirmation in Opposition to the Motion to Dismiss dated April 22, 2019; Plaintiff's Affidavit sworn April 19, 2019; Annexed Exhibit A.

3. Defendant's Reply Affirmation in Further Support of the Motion to Dismiss dated April 26, 2019; Annexed Exhibits 1-2.

All Citations

Slip Copy, 64 Misc.3d 1216(A), 2019 WL 3331795 (Table), 2019 N.Y. Slip Op. 51188(U)

End of Document

2019 WL 5691879
Unreported Disposition
NOTE: THIS OPINION WILL NOT APPEAR IN A PRINTED VOLUME. THE DISPOSITION WILL APPEAR IN THE REPORTER.
Supreme Court, New York,
Warren County.

WOMEN'S CARE IN OBSTETRICS AND GYNECOLOGY, P.C., Plaintiff,
v.
Allison HERRICK, Jennifer Kittell, Brittany Krotzer, Emily Scialabba, and Emily Yeast, Defendants.

EF2018-66053
|
Decided November 4, 2019

Attorneys and Law Firms

Drinker Biddle & Reath LLP, New York (Marsha J. Indych of counsel), for plaintiff.

Nolan & Heller, LLP, Albany (Justin A. Heller of counsel), for defendants.

Opinion

Robert J. Muller, J.

***1** Defendants are certified nurse midwives and former employees of plaintiff, an obstetrical and gynecological practice with a principal place of business in the City of Glens Falls, Warren County. Allison Herrick was employed by plaintiff from 2014 to 2016; Jennifer Kittell from 2012 to 2015; Brittany Krotzer from 2012 to 2015; Emily Scialabba from 2011 to 2014; and Emily Yeast from 2014 to 2016. Hospitals in this State will not grant privileges to midwives unless they have medical malpractice liability insurance coverage. To that end, plaintiff maintained such coverage for defendants during the course of their employment, with the "Policies, Procedures and Benefits Addendum" given to them at the time of hiring stating as follows:

> "[Certified nurse midwives'] malpractice insurance is paid by [plaintiff]. Malpractice insurance is placed with the same malpractice carrier and having the same claims coverage and terms as provided, from time to time, by [plaintiff] to other nurse midwives and nurse practitioners employed by [plaintiff]."

Plaintiff obtained policies for each defendant through Medical Liability Mutual Insurance Company (hereinafter **MLMIC**). Each defendant then signed a "Policy Administrator—Designation & /or Change" form designating plaintiff as the policy administrator, defined as "the agent of [the i]nsured for the paying of [the p]remium, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return [p]remiums when due." Defendants do not dispute that plaintiff paid all premiums relative to their respective policies.

In June 2018, **MLMIC** announced that it had been acquired by National Indemnity Company—a subsidiary of Berkshire Hathaway Inc.—and was being converted from a mutual insurance company to a stock insurance company. Under Insurance Law § 7303 (e) (3), when a mutual insurance company converts to a stock insurance company, the plan of conversion

> "shall ... provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution [seeking approval of the conversion] shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both."

To that end, **MLMIC's** plan of conversion required that cash distributions be made to all eligible policyholders. The amount of the distributions was calculated in accordance with Insurance Law § 7303 (e) (3), which further provides that

> "[t]he 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 ... to the total net premiums received by the mutual insurer from such eligible policyholders."

***2** Presumably in recognition of the fact that some eligible policyholders did not pay the premiums on their policies, **MLMIC's** plan of conversion provided a mechanism whereby policyholders could designate their policy administrators—or others—to receive the cash distributions in their place and stead. The plan of conversion further provided as follows:

> "In the event ... a [p]olicy [a]dministrator ... believes that it has a legal right to any [c]ash [c]onsideration allocated to an [e]ligible [p]olicyholder, it may file an objection with **MLMIC** at any time prior to the date of the ... public hearing [before the Department of Financial Services] and such objection will be resolved in accordance [with the procedures set forth in the plan]."

The objection procedures then provided that

> "[i]f **MLMIC** receive[s] a properly filed objection, the allocated [c]ash [c]onsideration will be held in escrow ... until **MLMIC** receives joint written instructions from the [e]ligible [p]olicyholder and the [p]olicy [a]dministrator ... as to how the allocation is to be distributed, or a non-appealable order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the [p]olicy [a]dministrator ... or the [e]ligible [p]olicyholder."

In July 2018, plaintiff notified defendants—all of whom are eligible policyholders—of their entitlement to cash distributions under **MLMIC's** conversion plan, with Herrick to receive $89,406.52, Kittell to receive $67,876.34, Krotzer to receive $89,317.62, Scialabba to receive $26,387.52, and Yeast to receive $95,589.41. Plaintiff further requested that defendants each execute a form designating plaintiff as the recipient of their distributions, since it was the administrator of their policies and paid all premiums relative thereto. According to plaintiff, defendants verbally agreed to execute these forms but failed to do so. In August 2018, plaintiff filed objections with **MLMIC** with respect to defendants' policies and the cash distributions were then placed in escrow. In September 2018, plaintiff received correspondence from counsel for defendants advising that his clients refused to designate plaintiff as the recipient of their respective cash distributions.

Plaintiff commenced this action in January 2019 for a declaratory judgment that it is entitled to defendants' cash distributions. Issue was then joined with defendants asserting counterclaims for a declaratory judgment that they are entitled to the distributions. No discovery has been exchanged. Presently before the Court is defendants' motion for summary judgment dismissing the complaint and granting the relief requested in the counterclaims.

Not surprisingly, there has already been a plethora of litigation on the very issue under consideration here—namely whether the policy administrator or the eligible policyholder is entitled to the cash distribution resulting from **MLMIC's** demutualization. The Court will begin its analysis with a discussion of these cases and then proceed with consideration of the motion.

The Supreme Court of Erie County (Sedita, J.) was the first to address the issue in *Maple-Gate Anethesiologists, P.C. v. Nasrin* (63 Misc 3d 703 [Sup Ct, Erie County 2019]) (hereinafter *Maple-Gate*), decided on March 22, 2019. In *Maple-Gate*, Supreme Court found that the eligible policyholders' "employment agreements provided that the [policy administrator] would pay professional liability insurance premiums as an 'employment benefit for and on behalf of' the [eligible policyholder]" (*id* at 704) and, as a result, the eligible policyholders—and not the policy administrator—were entitled to the cash distributions (*see id.* at 709-710).

***3** The Appellate Division, First Department then addressed the issue in *Matter of Schaffer, Schonholz & Drossman, LLP v. Title* (171 AD3d 465 [2019]) (hereinafter *Matter of Schaffer*) — decided on April 4, 2019 — "declar[ing] that [the policy administrator was] entitled to the cash proceeds resulting from the demutualization of [**MLMIC**]" (*id.*). In a brief decision, the First Department stated as follows:

> "Although [the eligible policyholder] was named as the insured on the relevant **MLMIC** professional liability insurance policy, [the policy administrator] purchased the policy and paid all the premiums on it. [The eligible policyholder] 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 eligible policyholder] the cash proceeds of **MLMIC's** demutualization would result in her unjust enrichment" (*id.* [citations omitted]).

On June 7, 2019, the Supreme Court of Saratoga County (Crowell, J.) addressed the issue in *Schoch v. Lake Champlain OB-GYN, P.C.* (64 Misc 3d 1215[A], 2019 NY Slip Op 51176[U] [Sup Ct, Saratoga County 2019]) (hereinafter *Schoch*), granting the policy administrator's motion for summary judgment for the relief requested in the complaint—namely a declaratory judgment that it was entitled to the eligible policyholder's cash distribution under **MLMIC's** plan of conversion. Supreme Court stated, in pertinent part:

> "The doctrine of stare decisis provides that once a court has resolved a legal issue, it should not be re-examined each and every time it is presented. [The eligible policyholder] discounts the Appellate Division, First Department's decision in [*Matter of Schaffer*] based upon its terseness and lack of detail. However terse, the First Department found as a matter of law that an award of the **MLMIC** proceeds to the named insured doctor would result in her unjust enrichment. The significant facts relied upon by the First Department are not distinguishable from the significant facts in this case. This Court is bound to follow the Appellate Division, First Department until such time as the Appellate Division, Third Department or the Court of Appeal issues a contrary decision" (*id.* at *2).[1]

The Supreme Court of Westchester County (Ecker, J.) next addressed the issue in *Maple Med. LLP v. Scott* (64 Misc 3d 909 [Sup Ct, Westchester County 2019] and five related cases, *Maple Med. LLP v. Arevalo* (64 Misc 3d 1213[A], 2019 NY Slip Op 51127[U] [Sup Ct, Westchester County 2019]), *Maple Med. LLP v. Goldenberg* (64 Misc 3d 1213[A], 2019 NY Slip Op 51128[U] [Sup Ct, Westchester County 2019]), *Maple Med. LLP v. Mutic* (64 Misc 3d 1213[A], 2019 NY Slip Op 51129[U] [Sup Ct, Westchester County 2019]), *Maple Med. LLP v. Sundaram* (64 Misc 3d 1213[A], 2019 NY Slip Op 51130[U] [Sup Ct, Westchester County 2019]), and *Maple Med. LLP v. Youkeles* (64 Misc 3d 1213[A], 2019 NY Slip Op 51131[U] [Sup Ct, Westchester County 2019]) (hereinafter collectively referred to as the *Maple Med.* cases)—all decided on July 7, 2019—finding that the policy administrator was entitled to the cash distributions and granting its motions for summary judgment. Just as in *Schoch*, Supreme Court concluded that "the recent decision of the Appellate Division, First Department in [*Matter of Schaffer* was] dispositive of the issues raised" (*Maple Med. LLP v. Scott*, 64 Misc 3d at 911; *see Maple Med. LLP v. Areval*, 2019 NY Slip Op 51127[U] at *1-2; *Maple Med. LLP v. Goldenberg*, 2019 NY Slip Op 51128[U] at *1-2; *Maple Med. LLP v. Mutic*, 2019 NY Slip Op 51129[U] at *1-2; *Maple Med. LLP v. Sundaram*, 2019 NY Slip Op 51130[U] at *1-2; *Maple Med. LLP v. Youkeles*, 2019 NY Slip Op 51131[U] at *1-2).

***4** The Supreme Court of Columbia County (Zwack, J.) then addressed the issue in *Columbia Mem. Hosp. v. Hinds* (65 Misc 3d 1205[A], 2019 NY Slip Op 51508[U] [Sup Ct, Columbia County 2019]) (hereinafter *Columbia Mem. Hosp.*)—decided on September 3, 2019—granting the eligible policyholder's motion to dismiss the complaint based upon a finding that he was entitled to the cash distribution as a matter of law. There, Supreme Court found that the eligible policyholder "actually paid the premiums, as the [policy administrator] deducted the amounts it paid for ... malpractice insurance from his incentive compensation" (*Columbia Mem. Hosp. v. Hinds*, 2019 NY Slip Op 51508[U] at * 2). Supreme Court thus distinguished *Matter of Schaffer*, stating as follows:

> "The doctrine of stare decisis clearly exists to provide guidance and consistent results in cases that share essentially the same facts. It does not apply where, as here, the facts are not the same. Here, like ... in [*Maple-Gate,*] the [eligible policy holder's] insurance premiums were paid in lieu of compensation ..." (*id.* at *3).

On September 4, 2019, the Supreme Court of New York County (James, J.) addressed the issue in *Mid-Manhattan Physicians Servs., PC v. Dworkin* (2019 WL 4261348 [Sup Ct, New York County 2019) (hereinafter *Mid-Manhattan Physicians*), granting the policy administrator's motion for summary judgment based upon a finding that it was entitled to the cash distribution. *Matter of Schaffer* was again cited in support of the determination (*see id.* at *1).

Finally, on September 10, 2019, the Supreme Court of Broome County (Reynolds Fitzgerald, J.) addressed the issue in *Shoback v. Broome Obstetrics and Gynecology, P.C.* (Sup Ct, Broome County, Sept. 10, 2019, Reynolds Fitzgerald, J., index No. EFCA201800334) (hereinafter *Shoback*). There, Supreme Court noted that it was "inclined to agree ... that ... plaintiff, the policy holder[,] should be entitled to receive [the cash distribution]" (*id.* at 5). With that said, it nonetheless denied plaintiff's motion for summary judgment based upon the contrary holding in *Matter of Schaffer*, finding that "trial courts must follow a higher court's existing precedent 'even though they may disagree' " (*id.* at 5, quoting *People v. Rivera*, 5 NY3d 61, 77 n 1 [2005, Ciparick, J., dissenting]).

Here, defendants contend that the facts of this case are akin to those before Supreme Court in *Maple-Gate* and *Columbia Mem. Hosp.* and, as such, they are entitled to summary judgment. In support of this contention, defendants have submitted a joint affidavit stating that "[u]nder the terms of [their] [e]mployment [a]greements with [plaintiff], one of the benefits to be provided ... in exchange for [their] services was the payment of [their] malpractice insurance premiums" Defendants further state as follows:

> "[The] employment relationship was simple: We provided midwifery services to [plaintiff's] patients under the terms of our [e]mployment [a]greements, which generated revenue for [plaintiff], and in return

> [plaintiff] paid us a salary and provided certain benefits (including payment of our malpractice insurance premiums). [Plaintiff's] attempt to obtain an additional benefit from our provision of services—one which we clearly did not agree to—should not be permitted."

In opposition, plaintiff contends that the facts of this matter are more akin to those before the First Department in *Matter of Schaffer* and—like Supreme Court in *Schoch*, the *Maple Med.* cases, *Mid-Manhattan Physicians* and *Shoback*—this Court is bound by that determination and must deny defendants' motion. To the extent that the decision in *Matter of Schaffer* is brief, plaintiff has submitted a copy of the stipulated facts submitted to the First Department in the case. These facts state, in pertinent part:

> ***5** "A document prepared by [the policy administrator], titled 'Annual Compensation and Performance Review [for the eligible policyholder]' ... shows 'Total Compensation' in the amount of $321,689 and a breakdown of that number as consisting of the following: 'Base Salary' in the amount of $230,000; 'Merit Bonus' in the amount of $7,500; 'Health Insurance' in the amount of $28,437 and 'Malpractice Insurance + Excess' in the amount of $55,752."

Under the circumstances, the Court finds that defendants' motion for summary judgment must be denied. The facts of this case are nearly identical to those before the First Department in *Matter of Schafer* and the Court is therefore bound by that decision (*see Mountain View Coach Lines v. Storms*, 102 AD2d 663, 664 [1984]; *Shoback v. Broome Obstetrics and Gynecology, P.C.*, Sup Ct, Broome County, index No. EFCA201800334, at 5; *Mid-Manhattan Physicians Servs., PC v. Dworkin*, 2019 WL 4261348 at * 1; *Maple Med. LLP v. Scott*, 64 Misc 3d at 911; *Maple Med. LLP v. Areval*, 2019 NY Slip Op 51127[U] at *1-2; *Maple Med. LLP v. Goldenberg*, 2019 NY Slip Op 51128[U] at *1-2; *Maple Med. LLP v. Mutic*, 2019 NY Slip Op 51129[U] at *1-2; *Maple Med. LLP v. Sundaram*, 2019 NY Slip Op 51130[U] at *1-2; *Maple Med. LLP v. Youkeles*, 2019 NY Slip Op 51131[U] at *1-2; *Schoch v. Lake Champlain OB-GYN, P.C.*, 2019 NY Slip Op 51176[U] at *2). If anything, the facts in *Matter of Schafer* are more damning to the eligible policyholder than the facts herein. There, the policy administrator listed the premium payment as part of the eligible policyholder's compensation in her Annual Compensation and Performance Review, thus suggesting that she in fact paid the premium. Here, there is nothing to suggest that the premium payment was considered part of defendants' compensation.

The Court further notes that *Maple-Gate* and *Columbia Mem. Hosp.* are not binding and, in any event, appear to be distinguishable. Notwithstanding defendants' contentions to the contrary, the record fails to demonstrate as a matter of law that the premium was paid by plaintiff as a benefit of defendants' employment, as Supreme Court found in *Maple-Gate*. Although the paragraph relative to the payment of premiums was contained within a form entitled "Policies, Procedures and Benefits," there is nothing in the paragraph itself to indicate that such payment was a benefit of employment—and to the extent this may be unclear, it constitutes a question of fact. Indeed, plaintiff's contention that the premium was paid to ensure that defendants had medical malpractice insurance and could obtain privileges at local hospitals is equally plausible. It must also be noted that the premium payment was never deducted from defendants' salaries, as was the case in *Columbia Mem. Hosp.*

Based upon the foregoing, defendants' motion for summary judgment is denied in its entirety. Counsel are hereby directed to appear for a preliminary conference on **November 21, 2019 at 11:00 A.M.** at the Warren County Courthouse in Lake George, New York. In lieu of an appearance, counsel may also complete a Preliminary Conference Stipulation and Order—which form is available online at https://www.nycourts.gov/LegacyPDFS/courts/4jd/mt-rules/muller-order.pdf—and submit the same to the Court at least 48 hours prior to the scheduled conference date.

Therefore, the Court having considered the Affirmation of Justin A. Heller, Esq. with exhibits attached thereto, dated January 25, 2019; Joint Affidavit of Allison Herrick, Jennifer Kittell, Brittany Krotzer, Emily Scialabba and Emily Yeast with exhibit attached thereto, sworn to January 22, 2019, January 22, 2019, January 24, 2019, January 22, 2019 and January 24, 2019, respectively; Memorandum of Law of Justin A. Heller, Esq., dated January 25, 2019; Affirmation of Martha J. Indych, Esq., dated February 15, 2019; Memorandum of Law of Martha J. Indych, Esq., dated February 15, 2019; Reply Memorandum of Law of Justin A. Heller, Esq., dated March 1, 2019; Correspondence of Justin A. Heller, Esq. with exhibit attached thereto, dated March 22, 2019; Correspondence of Marsha J. Indych, Esq. with exhibit attached thereto, dated April 17, 2019; Correspondence of Justin A. Heller, Esq., dated April 17, 2019; Supplemental Affirmation of Marsha J. Indych with exhibit attached thereto, dated May 6, 2019; Supplemental Memorandum of Law of Marsha J. Indych, Esq., dated May 6, 2019; Supplemental Affirmation of Justin A. Heller, Esq. with exhibits attached thereto, dated May 6, 2019; Supplemental Memorandum of Law of Justin A. Heller, Esq., dated May 6, 2019; Correspondence of Justin A.

Heller, Esq. with exhibit attached thereto, dated September 6, 2019; and Correspondence of Marsha J. Indych, Esq., dated October 28, 2019; and the Court having heard oral argument on October 24, 2019 with Marsha J. Indych, Esq. appearing on behalf of plaintiff and Justin A. Heller, Esq. appearing on behalf of defendants, it is hereby

***6** ORDERED that defendants' motion for summary judgment is denied in its entirety; and it is further

ORDERED that counsel shall appear for a preliminary conference on **November 21, 2019 at 11:00 A.M.** at the Warren County Courthouse in Lake George, New York or, in lieu of an appearance, complete a Preliminary Conference Stipulation and Order and submit the same to the Court at least 48 hours prior to the scheduled conference date; and it is further

ORDERED that any relief not specifically granted has nonetheless been considered and is denied.

The above constitutes the Decision and Order of this Court.

The original of this Decision and Order has been e-filed by the Court. Counsel for plaintiff is hereby directed serve a copy of the Decision and Order with notice of entry in accordance with CPLR 5513.

All Citations

Slip Copy, 2019 WL 5691879 (Table), 2019 N.Y. Slip Op. 51776(U)

Footnotes

1 The Court notes that, if the Second or Fourth Department were to issue a determination contrary to that of the First Department in *Matter of Schaffer*, then lower courts in the Third Department would be free to follow either Department unless and until the Third Department or Court of Appeals speaks on the issue (*see Matter of Daniel [Motor Veh. Acc. Indem. Corp.]*, 181 Misc 2d 941, 952 [Civ Ct, Bronx County 1999]; 1 Carmody Wait 2d § 2:342).

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Short Form Order Index No. 622517/2018

SUPREME COURT – STATE OF NEW YORK
PART 55 - SUFFOLK COUNTY

PRESENT:
Hon. George Nolan
Justice Supreme Court

ZILKHA RADIOLOGY, PC

Plaintiff,

-against-

GERALD SCHULZE

Defendant.

Mot. Seq. No. #001 - MD
Mot. Seq. No. #002 - MG Case Disp
Orig. Return Date: 05/17/2019
Mot. Submit Date: 10/10/2019

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Upon the e-filed documents numbered 07 through 54, and upon due deliberation and consideration by the Court of the foregoing papers, the motion and cross-motion (motion sequence nos. 001 and 002) are decided as follows.

Defendant, Gerald Schulze ('Schulze"), moves and plaintiff, Zilkha Radiology, P.C. ("Zilkha"), cross- moves, pursuant to CPLR 3212, each seeking an order granting summary judgment and a declaration of their right to certain cash proceeds resulting from the demutualization of the Medical Liability Mutual Insurance Company ("MLMIC").

This action is one of many arising from the aforementioned demutualization. MLMIC was a mutual insurance company owned by its policyholders. Between 2016 and October 1, 2018, MLMIC negotiated and completed the sale of its business to the National Indemnity Company ("NICO"), a subsidiary of Berkshire Hathaway, which formed a stock company and paid $2.5 billion for MLMIC's assets. The New York State Department of Financial Services approved a conversion or "demutualization" plan which provided a methodology for the pro-rata distribution of the sale proceeds to eligible policyholders. While the conversion plan approved by the New York State Department of Financial Services defined "eligible policyholder" as the named insured and not the entity which paid the premiums, the plan also included an objection and escrow procedure for the resolution of disputes for those persons and entities disputing whether a policyholder was entitled to the payment.

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The defendant Schulze is a physician who was employed by Zilkha from October 12, 2015 through February 12, 2016. In an affidavit attached to his moving papers the defendant states, *inter alia*,"[u]nder the terms of my employment agreement...one of the benefits to be provided to me in exchange for my services was the Plaintiff's payment of my medical malpractice insurance premiums...Consistent with the terms of my Employment Agreement, Plaintiff paid the insurance premiums to MLMIC with respect to my medical malpractice insurance coverage, and performed administrative duties with respect to my Policy, and received periodic refunds of premiums from MLMIC." Schulze does not assert that he bargained with Zilkha for the demutualization proceeds that are in dispute in this action.

The amount of demutualization consideration allocable to the defendant's insurance coverage is $40,124.29. Zilkha objected to the payment of this sum to the defendant. Schulze states in his affidavit that MLMIC is holding these monies pending the resolution of this dispute.

The essential facts in this case are indistinguishable from those presented in the recent Appellate Division decision, ***Matter of Schaffer, Schonholz & Drossman v. Title***, 171 AD3d 465, 96 NYS3d 526 [1st Dept 2019]. As in the instant action, ***Matter of Schaffer*** involved a physician named as an insured on a MLMIC policy. The doctor's employer purchased the policy and paid all of the premiums and costs related to the policy. As in this case, the doctor in ***Matter of Schaffer*** did not bargain for the demutualization proceeds. Based on these facts, the Appellate Division, First Department, concluded that awarding the doctor the cash proceeds resulting from the demutualization of MLMIC would result in her unjust enrichment.

This court agrees with the First Department's conclusion in ***Matter of Schaffer***. "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" (***Mandarin Trading Ltd v. W. Ivenstein***, 16 NY3d 173, 919 NYS2d 465 [2011], *quoting* ***Paramount Film Distrib. Corp. v. State of New York***, 30 NY2d 415, 334 NYS2d 388 [1972]). Under the facts of this case, awarding the proceeds to defendant Schulze would result in his unjust enrichment. Accordingly, it is

ORDERED that the motion (motion sequence no. 001) of defendant Gerald Schulze, made pursuant to CPLR 3212, for an order granting summary judgment in favor of the defendant and for declaratory judgment against the plaintiff Zilkha Radiology, P.C., is denied and the defendants counterclaim is dismissed; and it is further

ORDERED that the cross-motion (motion sequence no. 002) of plaintiff Zilkha Radiology, P.C. made pursuant to CPLR 3212, for an order granting summary judgment in its favor and for declaratory judgment against defendant Gerald Schulze, is granted; and it is further

ORDERED, ADJUDGED and DECREED that plaintiff Zilkha Radiology, P.C. is entitled to the receipt of funds in the amount of $40,124.79, plus accrued interest, if any, from October 1, 2018 to the date of judgment, said amount representing the pro-rata amount assigned to the MLMIC

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Medical Malpractice Policy, Policy Number NY-PZ-PO-3503042 (Named Insured - Gerald John Schulze) as a result MLMIC's demutualization.

The foregoing constitutes the decision and Order of the Court.

ENTER

Date: November 1, 2019
Riverhead, New York

HON. GEORGE NOLAN, J.S.C.

___X__ FINAL DISPOSITION ____ NON-FINAL DISPOSITION