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.

REPLY BRIEF FOR PLAINTIFF-APPELLANT

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INTRODUCTION

One of the critical centerpieces of the lower court's September 3, 2019 Decision and Order ("Decision"), which granted Respondent Marcel E. Hinds, M.D.'s ("Respondent") motion to dismiss, was an explicit finding that Respondent paid for the premiums of his malpractice insurance through deductions to his salary. Based on that factual determination, and the absence of an assignment of rights, the lower court held that Petitioner Columbia Memorial Hospital (the "Hospital" or "Petitioner") could not claim any right to the $412,418.93 in demutualization proceeds ("MLMIC Funds") currently held by Medical Liability Mutual Insurance Company. In doing so, the lower court factually distinguished the First Department's seminal case, *Schaffer, Schonholtz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't 2019) ("*Schaffer*"), which had awarded the MLMIC monies to the employer who had paid the premiums based on an unjust enrichment claim.

In its appellate brief, the Hospital established multiple reasons why the lower court was wrong to conclude that Respondent had paid the premiums, especially on a CPLR 3211(a)(1) motion to dismiss. The only documentary evidence introduced – Respondent's Employment Agreement – did not establish that Respondent actually paid for his premiums; rather, the Employment Agreement only established a formula for a potential payment by Respondent

depending on the Hospital's actual operating expenses and certain thresholds of productivity. However, none of the Hospital's actual financial statements in any of the 2013 to 2016 years had been introduced into evidence. And, even if thresholds had been met, Respondent would have only partially paid for the malpractice insurance premiums under the Employment Agreement, thus preserving at least a partial entitlement to the MLMIC Funds under an unjust enrichment theory. In essence, the Employment Agreement did not conclusively establish a defense to the Hospital's claims so as to warrant dismissal at this juncture.

In his opposition brief, Respondent entirely avoids the Court's erroneous factual determination, and mischaracterizes the Decision as not even based on this factual finding at all. Respondent clearly seeks to distance himself from the Court's determination, as any possible retort on appeal would have only highlighted the existence of material issues of fact that were improperly resolved by the lower court on a motion to dismiss.

Instead, Respondent's brief focuses exclusively on legal grounds in the hopes of independently propping up the Decision as a matter of law. To that end, Respondent asserts that the Court correctly found that the Insurance Law, MLMIC's Plan of Conversion, and the New York State Department of Financial Services' ("DFS") Decision (the "DFS Decision") are fully dispositive of the

parties' rights as a matter of law, and that the policyholders (*i.e.* the individual providers) automatically get the MLMIC Funds unless an assignment is given. While this conclusive interpretation has potential support from the Fourth Department's recent decision in *Maple-Gate Anesthesiologists v. Nasrin*, 2020 WL 1966900 (4th Dep't 2020) ("*Maple-Gate*"), the Hospital respectfully submits that this Court's independent analysis will find that the language found in those authorities are not determinative as a matter of law. Indeed, neither MLMIC nor DFS, to whom this Court should defer to as the administrative agency with expertise, thought fit to interpret Insurance Law in such a conclusive manner. DFS even made it explicit that resolution of this issue was to be decided by either agreement of the parties or an arbitrator or court.

Moreover, even assuming Respondent's interpretation of the Insurance Law is correct – although it is not – the issue of whether the Hospital should ultimately be entitled to the MLMIC Funds still remains as between the private parties. In other words, the Hospital still possesses equitable claims against Respondent, even if MLMIC were to distribute the funds to Respondent, because: (1) the Insurance Law only governs the initial distribution of the funds to those on record (*i.e.* the policyholders or assignees), and is more akin to a ministerial act needed for demutualization than it is as an ultimate determination of entitlement or ownership between the parties; (2) DFS explicitly states that formal titles are not dispositive

of entitlement between employers/employees; and (3) under *Schaffer* and its progeny, unjust enrichment may still be controlling as between the private parties, where the facts and circumstances may warrant such a finding.

Respondent will likely also rely on *Maple-Gate* for the holding that payment alone is not sufficient to establish unjust enrichment as a matter of law. Such reliance on *Maple-Gate* to distinguish *Schaffer*, however, is misplaced where the Fourth Department's legal analysis is entirely non-existent on the law of unjust enrichment. Ironically, even if the *Maple-Gate* court disagreed with *Schaffer* on unjust enrichment, at least the *Schaffer* court cited cases to support its finding; *Maple-Gate*'s decision, on the other hand, was inexplicably silent and thus unpersuasive. Moving forward, it will be up to this Court (or the Court of Appeals) to reconcile the conflicting opinions.

Regardless, at this pre-answer juncture, the lower court pre-maturely dismissed the Hospital's unjust enrichment claim without ascertaining the full facts and circumstances. This is particularly true where the facts had been erroneously resolved based on the limited documentary evidence at hand. For the same reasons, it was pre-mature for the Hospital's alternative claims for money had and received, or under the contract, to have been dismissed so readily.

Accordingly, the Court should respectfully reverse the lower court's Decision and reinstate the Hospital's complaint.

ARGUMENT

POINT I

RESPONDENT EFFECTIVELY CONCEDES THAT THE LOWER COURT MADE AN IMPROPER FACTUAL DETERMINATION BY MISCHARACTERIZING THE DECISION TO AVOID IT ALTOGETHER

Respondent blatantly mischaracterizes the lower court's Decision by twisting it to say that the Hospital's claims were dismissed based solely on Insurance Law § 7307. *See* Opp. Br., at pp.19-23. Respondent apparently hopes that this Court will ignore the lower court's strongly contested finding that Respondent paid the premiums, a "fact" which served as the foundation for its determination and for distinguishing any equitable claims under *Schaffer*. By taking this approach, Respondent purposefully avoids the need to respond to the lower court's erroneous factual determination, which would have only served to highlight the material issues of fact at hand that were improperly resolved on a motion to dismiss. That gaping silence speaks volumes.

A. The Decision Was Predicated On Factual Findings

The lower court's dismissal of the equitable claims was clearly predicated on a factual finding that the Hospital did not pay for the malpractice insurance

premiums. It could not have been any more explicit in the Decision, which provides in relevant part:

> 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**.
>
> Nor has the plaintiff demonstrated that the defendant has been unjustly enriched. Unjust enrichment, also known as an action for money had or received, or implied contract…, arises when a plaintiff demonstrates "that (1) the other party was enriched, (2) at (the plaintiff'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.... **Given that the plaintiff received the defendant's services in exchange for compensation – which was reduced by the cost of the premium payments made on the defendant's behalf by the plaintiff** – there is simply no merit to the plaintiff's claim of unjust enrichment.

(R. 12-13) (emphasis added)

Moreover, the lower court's factual determination allowed it to distinguish *Schaffer*, which would have otherwise applied under the *stare decisis* doctrine. The lower court held that "[t]he 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 the**

defendant Nasrin in *Maple-Gate Anesthesiologists*… the defendant's insurance premiums were paid in lieu of compensation." (R. 14) (emphasis added)

In sum, the lower court explicitly found that the Hospital could not sustain an unjust enrichment claim under *Schaffer* where Respondent (and not the Hospital) paid for the premiums through deductions to his incentive compensation. As set forth in the Hospital's appellate brief, that decision was incorrectly derived from the Employment Agreement alone.

Notably, the Hospital's interpretation of the Decision was recently confirmed by another court, which opined that the lower court made a factual determination that was dispositive of the case. In *NRAD Med. Assoc., P.C. v. Kim,* Index No. 617351/2018 (Sup. Ct. Nassau Co. Oct. 28, 2019), the Honorable Timothy Driscoll, J.S.C., of the Supreme Court, Nassau County, summarized the Decision as follows:

> 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.

Id., at 22.

Therefore, the lower court not only made a factual determination, but it used that substantive determination as a platform to disregard controlling precedent found in *Schaffer* and progeny that would have otherwise applied.

B. Respondent Has Not Contested The Lower Court's Erroneous Findings

By asserting that the Decision was not based on improper findings of fact, and avoiding any analysis whatsoever, Respondent fails to dispute the substantial errors which the Hospital pointed out in its appellate brief. Indeed, Respondent fails to present any argument in opposition to the Hospital's assertion that the lower court improperly made factual determinations in finding that the Respondent effectively paid the premiums for the MLMIC policy. (App. Br., at pp.23-31) Such a tactic is not surprising, as any possible response would have only served to highlight the existence of material issues of fact that were improperly resolved by the lower court on a motion to dismiss.

Accordingly, and for the reasons set forth in the Hospital's moving brief, the lower court erred when it dismissed the Complaint.

POINT II

RESPONDENT'S ATTEMPT TO SET ASIDE *SCHAFFER* IS UNAVAILING BECAUSE THE INSURANCE LAW AND GOVERNING AUTHORITIES ARE NOT DISPOSITIVE PER SE

Although the lower court declined to apply the *stare decisis* doctrine based on what it believed to be distinguishable facts from *Schaffer*, Respondent attempts to have this Court set aside *Schaffer* altogether as having "no precedential value." (Opp. Br., at p.35) Rejecting *Schaffer* entirely is necessary under Respondent's logic, because if the lower court is found to have made an erroneous finding of fact, which is what Respondent appears to concede (*see supra*, Point I), the Hospital should have at least survived the dismissal standard with an equitable cause of action for unjust enrichment under *Schaffer*.

Respondent attempts to nullify *Shaffer*'s precedential value by arguing (or, more aptly, speculating) that the First Department did not consider Insurance Law § 7307, the DFS Decision, or any "relevant" sections of the Plan of Conversion and, as a result, *Schaffer* represents an "erroneous interpretation of the law" that allegedly conflicts with those authorities. In doing so, Respondent will presumably rely on the Fourth Department's recent decision in *Maple-Gate* for support.

As demonstrated below, should this Court independently examine the applicable authorities, including the superficial analysis in *Maple-Gate*, it will find

that the Insurance Law and the governing authorities are not dispositive per se of the rights as between the parties themselves. As demonstrated in Point III, *infra*, even if the Insurance Law dictated a release of the MLMIC Funds to the policyholder, equity still provides a claim for relief by the Hospital against Respondents (outside the purview of the Insurance Law), and it is up to the courts to determine the parties' equitable rights based on the specific facts and circumstances at hand. Accordingly, *Schaffer* remains not just a valid source of authority, but also a well-reasoned and consistent approach to deciding which of the parties is ultimately entitled to MLMIC Funds.

A. Neither Insurance Law § 7307, the Plan of Conversion, nor the DFS Decision Are Fully Dispositive of the Claims at Issue

Respondent asserts that the Insurance Law § 7307, the Plan of Conversion, and the DFS Decision are fully dispositive of the issues, and require payment of the MLMIC Funds to Respondent, as the formal policyholder, regardless of who paid the premiums, because he never assigned his rights to the funds.

As discussed at length in the Hospital's opening brief, such a definitive interpretation is not supported by these authorities, and the vast majority of courts have found that entitlement to the MLMIC Funds remains an open-ended question that depends on the specific factual circumstances. (App. Br., at pp. 46-51).

Indeed, even the trial court acknowledged that a potential unjust enrichment claim exists, notwithstanding the applicable laws and regulations governing demutualization, if the facts warrant such an equitable claim. (R. 12-13)

1. Respondent Erroneously Asserts That Policyholders Are Entitled To The MLMIC Funds Under The Insurance Law

Respondent first claims that Insurance Law § 7307 unambiguously awards proceeds from an insurance company's demutualization to its policyholders. However, the Insurance Law is neither clear nor definitive on the issue, particularly when read in conjunction with the Conversion Plan and the DFS Decision.

To be sure, the Insurance Law does not award demutualization proceeds to policyholders who did not pay any policy premiums. While the trial court, the Fourth Department in *Maple-Gate*, and Respondent all cite to one particular sentence found in Insurance Law Section 7307(e)(3),[1] they all omit consideration

[1] Insurance Law Section 7307(e)(3) provides in pertinent part:

> The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution described in subsection (b) hereof shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both. The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) **such policyholder has properly and timely paid** to the insurer on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors

of the sentence that follows, which provides that the "equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) **such policyholder has properly and timely paid to the insurer**…." N.Y. INS. LAW § 7307(e)(3) (emphasis added). If this language is applied literally in situations where a policyholder's employer paid for the policy premiums (such as in *Maple-Gate*, *Schaffer*, and the present case), neither party would be entitled to any MLMIC Funds.

Given this patent ambiguity in the Insurance Law that defies a literal application, and the unintended windfall that would be realized by a policyholder who did not pay any premiums, the Court is left to ascertain the parties' respective rights by examining MLMIC's Conversion Plan and DFS Decision. Indeed, as Respondent admits, the Insurance Law states that the terms of the demutualization will be governed by the Conversion Plan, as further implemented by DFS's orders. In this case, those documents explicitly leave the issue of entitlement for the courts to decide based on the specific facts and circumstances of each case. *See* Insurance Law § 7307(e); App. Br., at pp.47-49; Point II (A)(2), *infra*.

> under subsection (b) hereof bears to the total net premiums received by the mutual insurer **from such eligible policyholders**.

(emphasis added)

2. The Conversion Plan And The DFS Decision Clearly Acknowledge That Entitlement To The MLMIC Funds Depends On The Factual Circumstances Of Each Provider

Despite Respondent's strained arguments to the contrary, the Plan of Conversion and DFS Decision explicitly confirm that the Insurance Law alone is not dispositive of which party is entitled to the MLMIC Funds. Specifically, these documents do not summarily award the MLMIC Funds to policyholders/assignees, but rather state that, if there is an ongoing dispute over entitlement to the MLMIC Funds, courts must resolve it based on the facts and circumstances of each case.

Respondent relies on the strict definitions of "Eligible Policyholder," "Policy Administrators," "Policyholders," and "Policy Membership Interest," in conjunction with the following language in the Plan of Conversion, to argue that only policyholders are entitled to the demutualization proceeds:

> …the amount distributable to each Eligible Policyholder shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has affirmatively designated a Policy Administrator or EPLIP Employer to receive such amount on its behalf, in which case such amount shall be distributed to such Designee.

(R.57)

However, the Conversion Plan explicitly acknowledges that formal titles and definitions do not definitively determine a party's right to the demutualization funds, and other parties may be entitled to those funds. (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 likewise confirms that it is not formal titles and definitions that determine entitlement to the demutualization proceeds, but rather the facts and circumstances of each case: "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)[2]

Read together, the Plan of Conversion (R. 63), DFS Decision (R. 98-125), and DFS Order, (R. 126-129) establish an objection and dispute resolution process whereby those parties who believe they are entitled to the demutualization funds under the Plan of Conversion, regardless of their formal title, are free to assert their claims in court or through an alternative dispute resolution process while MLMIC holds the demutualization proceeds in escrow. Such an elaborate and explicit

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[2] Respondent also repeatedly emphasizes that DFS states that its statutory mission is to make sure the Plan of Conversion "is in the best interest of the policyholders and the public." (Opp. Br., at 15-16). However, this language is entirely in keeping with the fact that both policyholder *and anyone else* may have a right to receive the demutualization funds depending on the specific facts of each case.

process would be entirely meaningless if, as Respondent claims, only formal policyholders and their assignees are entitled to the funds. *See generally Duflo Spray-Chem., Inc. v. Jorling*, 153 A.D.2d 244, 247 (3d Dep't 1990).

In light of the actual language found in the Plan of Conversion and DFS Decision, Respondent's insistence that policyholders should automatically receive the demutualization funds is simply not supportable. Instead, these authorities left that ultimate determination to the courts, which must examine the factual circumstances of each parties' specific relationship. *See Sullivan v. Northwell Health, Inc.*, Index No. 656121/2018 (Sup. Ct. N.Y. Co. Dec. 2, 2019) (finding that the Insurance Law does not dictate entitlement to the MLMIC Funds, and that the Plan of Conversion and DFS Decision specifically leave that determination to the courts). This is exactly what the First Department did in *Schaffer* when it found that employers that paid for the MLMIC policy premiums are entitled to the MLMIC Funds under an equitable theory of unjust enrichment.

3. DFS's Interpretation Of Insurance Law § 7307 Should Be Afforded Deference

Should the Court find the need for guidance on interpreting the Insurance Law, it need not look any further than DFS's orders. Indeed, it is well-established that "[w]here the interpretation of a statute involves specialized knowledge and understanding of underlying operational practices or entails an evaluation of

factual data and inferences to be drawn therefrom, the courts should defer to the administrative agency's interpretation unless irrational or unreasonable… [however, where] the question is one of pure statutory interpretation dependent only on accurate apprehension of legislative intent, there is little basis to rely on any special competence or expertise of the administrative agency and its interpretive regulations are therefore to be accorded much less weight." *Matter of KSLM-Columbus Apartments, Inc. v. New York State Div. of Hous. and Community Renewal*, 5 N.Y.3d 303, 312 (2005) (quotation omitted); *Putnam Northern Westchester Board of Cooperative Educational Services v. Mills*, 46 A.D.3d 1062, 1063(3d Dep't 2007).

Respondent himself recognizes the significance of DFS's input, as he relies on a passage from the DFS Decision that he claims supports his interpretation of the Insurance Law. Specifically, this section of the DFS Decision notes that certain "medical groups and hospitals" submitted comments during the Plan approval process that "contend[ed] that the cash consideration should be paid to them in the circumstances where they paid the premiums on behalf of policyholders and/or acted as policy administrators." (R. 120) Respondent claims that DFS "specifically considered and rejected" this suggestion. (Resp. Br. at 25).

However, Respondent grossly misrepresents DFS's response to these comments. Instead of rejecting the suggestion that entities that paid policy premiums are entitled to demutualization proceeds, DFS merely points out that the Conversion Plan establishes an objection procedure which "provides a reasonable framework for the resolution of disputes between certain policyholders and entities that claim to be Policy Administrators" that "does not, in any way, impact any person's rights to resolve the dispute in any forum of their choosing or as required by contract or law."[3] (R. 120)

Thus, DFS has consistently reiterated that the facts and circumstances of each case would determine entitlement, and that it would need to be adjudicated in a separate forum. (R.120, 122) Under these circumstances, the Court should defer to DFS's interpretation of the open-ended nature of the Insurance Law.

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[3] Respondent also tries to support his mischaracterization of the DFS Decision using the Supreme Court, Westchester County's decision in *Maple Medical LLP v. New York State Department of Financial Services*, Index No. 65929/2018 (Sup. Ct. Westchester Cnty. Dec. 28, 2018), in which the court dismissed an Article 78 petition challenging the definition of "policyholder" that DFS used in its decision. As Respondent readily admits, the court dismissed the *Maple Medical* petition on procedural grounds and never addressed its merits. The minimal and superficial discussion that it includes regarding whether DFS used the proper definition of "policyholder" is merely dicta, and fails to acknowledge other pertinent language in the DFS Decision. Accordingly, *Maple Medical* has no precedential weight here.

POINT III

THE HOSPITAL'S EQUITABLE CLAIMS SURVIVE EVEN IF DISTRIBUTION IS MADE TO RESPONDENT

Even assuming the governing authorities mandate payment to be made only to the record policyholder or assignee, the Hospital still has the right to demand payment directly from Respondent if the facts and circumstances support an unjust enrichment claim. Indeed, once the MLMIC Funds are released to Respondent, the governing authorities overseeing demutualization and distribution of the MLMIC Funds become irrelevant. At that point, as between an employer and employee, their respective rights are purely a matter of contract law or, if there is no governing contract, based on equity under the specific facts and circumstances of each case.

A. Even If Insurance Law § 7307 Allowed For Policyholders To Receive The MLMIC Funds In The First Instance, This Ministerial Distribution Is Irrelevant To Which Party Is Ultimately Entitled To The Funds

Even if Insurance Law § 7307 provided for policyholders to initially receive the cash consideration from the demutualizing insurer – which it does not – the distribution allowed for in the statute is only ministerial and does not dictate which party is ultimately entitled to possess the funds.

Notably, the Insurance Law makes no mention of actual "ownership" of the demutualization funds themselves, and only refers to the policyholder's entitlement to receive the funds in exchange for their shares. *See generally* N.Y. INS. LAW § 7307. In other words, the statutory language only provides for the distribution of the funds to the most easily identifiable parties: the record policyholders or their designated assignees. This default procedure simplifies the process for demutualizing companies like MLMIC from having to make hundreds and thousands of potentially complex factual determinations, and leaves it to the parties to reach a determination through some other forum.

In the absence of any statutorily-defined ownership right, courts are thus free to examine the parties' equitable rights. This, of course, is exactly what the First Department did in *Schaffer* and what the lower court recognized below (but misapplied based on the erroneously determined facts).

B. <u>The DFS Decision Supports This Distinction</u>

As noted above, DFS confirmed that formal titles and definitions do not determine entitlement to the demutualization proceeds, but rather, the facts and circumstances of each case. DFS stated 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)

Interpreting this provision, the court in *Sullivan v. Northwell Health, Inc.* held that the Plan of Conversion, as approved by DFS, "specifically provided that the facts of individual cases would dictate entitlement to the proceeds and established an objection procedure… that the ultimate legal right to the Cash Consideration, if disputed, would be decided by a court." The *Sullivan* court further noted that DFS confirmed this process for determining entitlement to the funds in its January 2019 Order, in which it made clear that a party's status as a "policy administrator" or "designee" are irrelevant to the issue of entitlement, as "nothing in the [Plan of Conversion] determines the *underlying legal rights* of the parties to the Cash Consideration." *See Sullivan*, Index No. 656121/2018 at 5 (emphasis in original); *see also* (R. 126-129)

C. Given *Maple-Gate*'s Unexplained Departure From *Schaffer*, This Court Should Not Blindly Follow Suit

In the *Maple-Gate* decision, the Fourth Department disagreed with *Schaffer* on the grounds that the employer's payment of premiums could not form the predicate for an unjust enrichment claim. *See Maple-Gate*, 2020 WL 1966900, at *2. While the Fourth Department could have certainly elaborated on that point with supporting case law, particularly since it was overriding another Appellate

Division decision, the Fourth Department inexplicably chose not to do so. The Court is thus left with little persuasive authority from the Fourth Department on this issue. Accordingly, this Court should not feel bound to blindly accept such a conclusory holding devoid of legal rationale.

POINT IV

THE HOSPITAL PROPERLY ASSERTED EQUITABLE CLAIMS FOR THE MLMIC FUNDS

Respondent argues that the lower court properly dismissed the Hospital's equitable claims because: 1) courts may not apply equity when there is an applicable legal remedy, and 2) the Hospital failed to plead the requisite elements of unjust enrichment. However, these arguments are based entirely on misinterpretations of the law.

A. Courts Are Free To Award The MLMIC Demutualization Proceeds Based On Equitable Theories

In support of his first argument, Respondent cites to cases that allegedly stand for the proposition that law precludes equity when there is unambiguous statute that addresses the relevant issue. *See, e.g.*, *Golub v. New York State Tax Appeals Tribunal*, 116 A.D.3d 1261, 1262 (3d Dep't 2014). However, this argument presupposes a favorable finding under his interpretation of the Insurance Law § 7307. As described extensively in Point II and Point III, *supra*, and in the

Hospital's opening brief (App. Br., at pp.46-53), Insurance Law § 7307 does not unambiguously dictate entitlement to the demutualization funds in this situation. Instead, this determination is left to the court system by the Plan of Conversion and the DFS Decision.

In any event, even if, *arguendo*, Respondent was entitled to the MLMIC Funds under Insurance Law § 7307, legal title does not preclude claims based on equity. *See Simonds v. Simonds,* 45 N.Y.2d 233, 239 (1978) ("Equity arose to soften the impact of legal formalisms; to evolve formalisms narrowing the broad scope of equity is to defeat its essential purpose"); *Castellotti v. Free*, 138 A.D.3d 198, 207 (1st Dep't 2016); *Urgent Medical Care PLLC v. Amedure*, 64 Misc.3d 1216(A) (Sup. Ct. Greene Co. July 12, 2019).

B. The Hospital Sufficiently Pled Equitable Claims For Unjust Enrichment and Money Had And Received

Respondent contends that the Hospital's equitable claims were defective as a matter of law, and therefore properly dismissed. Specifically, he argues that Respondent would not be enriched at the Hospital's expense, and any such enrichment would not be unjust. Respondent is mistaken on both accounts.

Should Respondent keep the MLMIC Funds that are currently held in escrow, he will undoubtedly have been enriched at the Hospital's expense.

Accepting the Hospital's allegations as true, as the lower court was required to do for purposes of the motion, the Hospital paid the entirety of the premiums for the policy upon which the MLMIC Funds were based and performed all of the administrative functions associated with the policy. (R. 21) In sharp contrast, Respondent paid nothing for the policy (including by way of any deductions to his compensation) and did nothing to manage it. (R. 21) To award Respondent, and not the Hospital, with the MLMIC Funds under these circumstances would be unjust.

Again, this is what the First Department determined in *Schaffer*. In accordance with the terms of the Plan of Conversion and DFS Decision, the First Department examined the specific facts and circumstances of that case, and, applying the equitable theory of unjust enrichment, determined that the employer that paid the MLMIC policy premiums, and not the policyholder-physician, should receive the demutualization funds. *See Schaffer*, 171 A.D.3d at 465.

Since this matter involves materially identical facts to those in *Schaffer*, the Hospital's equitable claims for unjust enrichment and money had and received are properly asserted. The lower court improperly dismissed those claims.

C. Ownership Is Not A Necessary Element Of A Claim For Unjust Enrichment

Respondent also falsely asserts that a party must plead an "ownership" right to the disputed monies when asserting a claim for unjust enrichment.

In support of this assertion, Respondent relies exclusively on the lower court's decision in the *Maple-Gate* case. *See Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc. 3d 703, 709 (Erie County Sup. Ct. Mar. 22, 2019). There, the court erroneously grafted an "ownership" element onto its unjust enrichment test. *See* 2019 WL 1321102, *3. However, "ownership" is not an element of the unjust enrichment test, which requires only 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). (quotations omitted). Nowhere in this flexible standard is there a requirement that the property must have been previously owned by the plaintiff.

To be sure, the authority that the *Maple-Gate* court relied on for the ownership requirement, *Roslyn Union Free School District v. Barkan*, does not stand for the outlier proposition that legal ownership is a required element of unjust enrichment. 71 A.D.3d 660 (2d Dep't 2010). In its analysis, the *Roslyn* court improperly conflated its discussions of unjust enrichment, accounting, and

constructive trust claims, stating that all three claims "require a plaintiff to set forth… that the defendant possessed property or assets of the plaintiff." *Id*. at 661. However, the primary authority on which the *Roslyn* court relies, *Cruz v. McAneney*, does not state that ownership is a required element of unjust enrichment. 31 A.D.3d 54 (2d Dep't 2006). Rather, the *Cruz* decision only holds that legal title is an essential element of a *constructive trust* claim. *Id*. at 58-59. It does not say that plaintiffs must demonstrate ownership when claiming unjust enrichment. Accordingly, the Supreme Court in *Maple-Gate*, having relied on faulty authority, incorrectly required its plaintiff to demonstrate ownership. No such showing is required when pleading a cause of action for unjust enrichment.

POINT V

THE HOSPITAL PROPERLY ASSERTED A CLAIM FOR BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING

Respondent also argues that the lower court properly dismissed the Hospital's claim for breach of the implied covenant of good faith and fair dealing, which was based on Respondent's refusal to assign the MLMIC Funds to the Hospital. (Resp. Br., at p.42) Specifically, section 11(b) of the Employment Agreement limits Respondent's compensation upon the termination of his employment to compensation that accrued before the date of his termination. (R. 36) Respondent argues that the lower court's dismissal of this claim was correct

because: (1) this section does not apply to the MLMIC Funds, as they are distributed by a third party – MLMIC – and therefore not "compensation," (2) this section only applies in the event that Respondent is terminated for cause, (3) there was never a meeting of the minds on the issue of demutualization proceeds, and (4) the contract should be interpreted in light of the applicable law at the time it was executed, *i.e.* Insurance Law § 7307. Each of these arguments fails to justify the lower court's erroneous decision.

Respondent's first argument is flawed in that he fails to recognize that the Hospital's claim is brought pursuant to the implied covenant of good faith and fair dealing. 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 contract, but nonetheless seeks to procure the MLMIC Funds which belong to the Hospital. Should he obtain the funds, the Respondent will have effectively procured additional compensation at the Hospital's expense as a result of his employment, depriving the Hospital of its

bargained-for right to no-longer have to compensate Respondent 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.

Respondent's second argument is equally flawed, as he misreads Section 11(b) of the Employment Agreement. Specifically, this section only applies "[u]pon the termination of this Agreement for any of the foregoing causes." (R.36) "Foregoing causes" includes those listed in Section 11(a) as well as those in the un-numbered language at the beginning of Section 11 that allows for termination of the agreement by either party without written notice. (R.35) Respondent terminated the agreement in accordance with the "cause" in the unnumbered language. Therefore, Respondent is bound by the terms of Section 11(b), which he has breached by refusing to assign the MLMIC Funds to the Hospital.

Respondent's third argument also fails, as there was a meeting of the minds between the parties regarding the MLMIC Funds. While Section 11(b) may not specifically reference the MLMIC Funds, it prohibits Respondent from receiving any additional compensation from the Hospital once his employment was terminated. The parties clearly intended this provision to be a broad catch-all prohibiting the Respondent from procuring additional money from the Hospital.

Therefore, there was a meeting of the minds between the parties regarding entitlement to the MLMIC Funds.[4]

Lastly, it is of no consequence that Insurance Law § 7307 was in effect at the time the parties executed the Employment Agreement. As established in Point II above, and in Point IV of the Hospital's opening brief, Insurance Law § 7307 does not entitle any one party to receive the MLMIC Funds. Therefore, this statute does not negate the Hospital's contractual right to the MLMIC Funds.

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

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[4] Should the Court find that the parties' intent remains ambiguous, this would constitute an issue of fact necessitating a trial. *See Hertz v Rozzi*, 148 A.D.2d 535, 537 (2d Dep't 1989), *aff'd,* 74 N.Y.2d 702 (1989).

CONCLUSION

For the reasons set forth above, the Hospital respectfully asks that this Court reverse the lower court's 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
June 18, 2020

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By: _____

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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: June 18, 2020

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ADDENDUM

FILED: WESTCHESTER COUNTY CLERK 01/02/2019 04:34 PM INDEX NO. 65929/2018
NYSCEF DOC. NO. 59 RECEIVED NYSCEF: 01/02/2019

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

----------X

MAPLE MEDICAL LLP, RICHARD FRIMER, M.D., ANDREW GOLDSTEIN, M.D., JOANNE TAMBURRI, M.D., AND WILLIAM ZAROWITZ, M.D.,

DECISION, ORDER & JUDGMENT

Petitioner,

Index No. 65929/2018

-against-

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, MARIA T. VULLO, SUPERINTENDENT OF THE DEPARTMENT OF FINANCIAL SERVICES,

Respondents,

For a judgment, pursuant to Article 78 of the Civil Practice Law and Rules.

----------X

SCHWARTZ, J.

Petitioners commenced this hybrid CPLR Article 78 proceeding and declaratory judgment action seeking an order and judgment (1) reversing, annulling, vacating and setting aside the Decision of the Superintendent of the Department of Financial Services dated September 6, 2018, and/or (2) declaring that the parties that paid the premiums on the polices of insurance for the identified period are the policy holders of the policies issued by Medical Liability Insurance Company, and/or (3) declaring that the parties that paid the premiums on these policies are the parties entitled to receive any payment due upon demutualization. The respondents oppose.

The Court has considered the following papers: the e-filed documents numbered 1-23, 31-48, and 51-57.

Upon the foregoing papers, the petition is disposed of as follows:

Petitioner MAPLE MEDICAL LLP is a multispecialty medical practice in White Plains, New York. As gleaned from the papers, on or about July 15, 2016, Medical Liability Mutual Insurance Company ("MLMIC") announced that it would seek to convert from a domestic mutual property/casual insurance company into a domestic stock property/casualty insurance company and, pursuant to Insurance Law § 7307, filed an application with the respondents for permission to convert. Pursuant to the conversion plan and an acquisition agreement, MLMIC would convert, and, in exchange, the eligible policyholders would receive cash consideration for their interest in MLMIC, rather than stock, which would instead be sold to National Indemnity Company. Policyholders' cash payments would be calculated based upon the pro-rata share of net premiums paid on

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eligible policies. The conversion plan defines a policyholder as a person or persons identified on the declaration page of the policy as the insured.

Respondents ordered an examination of MLMIC pursuant to Insurance Law § 7307(b)(3) and after a duly-noticed public hearing, amendments to the acquisition agreement and examination report, the Department approved the conversion plan provided the plan was submitted to a vote by the record date policyholders and, upon approval, the acquisition closed by September 30, 2018, or any agreed upon extended date (*see* Decision, Doc No. 23). On September 13, 2018, the record date policyholders approved the plan and the acquisition by National Indemnity Company's of MLMIC's shares closed on October 1, 2018. As of October 30, 2018, over $2.3 billion has been paid out to eligible policyholders.

On September 28, 2018, the petitioner commenced the instant proceeding and action. Petitioners do not argue that the determination approving demutualization and sale of MLMIC was arbitrary and capricious, irrational, or in violation of proper procedure. Rather, the petitioners argue that the definition of a policyholder in the conversion plan is erroneous because it is contrary to the Insurance Law's definition of a policy holder. Petitioners contend that, in effect, Insurance Law § 7307 requires policyholders be defined under the conversion plan as the parties who actually paid the premiums and not the doctors who are insured under the policies. Since Petitioners paid for and procured medical liability insurance from MLMIC for employees of their practice, Petitioners argue they, not the doctors they paid to insure, should have been deemed the policyholders and thus recipients of cash payments under the conversion plan.

Respondents argue as affirmative defenses that, *inter alia*, the petition must be dismissed as moot and the petitioners failed to name necessary parties. Respondents also contend that, nevertheless, the determination was not contrary to the Insurance Law, arbitrary and capricious, nor irrational, and should be upheld.

Relevant Law

An administrative determination "must be upheld if it has support in the record, a reasonable basis in law, and is not arbitrary or capricious" (*Paloma Homes, Inc. v Petrone*, 10 AD3d 612, 613 [2d Dept 2004]).

"As the power of a court to declare the law only arises out of, and is limited to, determining the rights of persons which are actually controverted in a particular case, courts generally may not pass on academic, hypothetical, moot, or otherwise abstract questions…Thus, courts ordinarily may not consider questions that have become moot by passage of time or change in circumstances…When a determination would have no practical effect on the parties, the matter is moot and the court generally has no jurisdiction to decide the matter" (*Berger v Prospect Park Residence, LLC*, 166 AD3d 937 [2d Dept 2018] [internal citations omitted]; *see also State Farm Mut. Auto. Ins. Co. v TIG Ins. Co.*, 62 AD3d 859, 860 [2d Dept 2009]).

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"A party whose interest may be adversely effected by a potential judgment must be made a party in a CPLR article 78 proceeding" (*Karmel v White Plains Common Council*, 284 AD2d 464, 465 [2d Dept 2001]; *see also Feder v Town of Islip Zoning Bd. of Appeals*, 114 AD3d 782 [2nd Dept 2014] and CPLR 1001[a]). Where a necessary party has not been timely joined and does not voluntarily appear or participate in the proceeding, the Supreme Court must deny the petition and dismiss the proceeding. (*see Karmel v White Plains Common Council*, 284 AD2d 464, 465 [2d Dept 2001; *Artrip v Inc. Vil. of Piermont*, 267 AD2d 457, 457 [2d Dept 1999]).

Discussion

Since the filling of the petition, it is not disputed that demutualization has occurred and that over $2.3 billion in cash payments have been distributed to policyholders pursuant to the determination of the Department and the conversion plan. In light of the foregoing and petitioners' failure to seek injunctive relief from this Court to preserve the status quo before demutualization and distribution of cash payments, I find the petition is moot and must be dismissed (*see Berger* at 937; *see also Weeks Woodlands Ass'n, Inc. v Dormitory Auth. of State, 95 AD3d 747 [1st Dept 2012], affd, 20 NY3d 919 [2012]*).

If the petition were not moot, it would still be dismissed for failure to name necessary parties. The policyholders who received cash payments were not made parties to this proceeding, and it cannot be disputed they would be adversely effected by a potential judgment declaring them not entitled to those payments in whole or in part (*see Karmel* at 465). Moreover, of those policyholders who are entitled to receive cash payments under the plan, it is not in dispute some of them are doctors employed by the petitioners' very own medical practice (*see* Doc. No. 4). Yet, the petitioners did not join those doctors in this proceeding and action.

Even if the Court were to reach the merits of the petition, the Court would not annul the respondents' determination. The Court's review of the parties' submissions, including the record, reveals that the respondents properly considered and weighed the relevant criteria and that the determination had a rational basis. Furthermore, the record does not reveal that the respondents acted illegally or arbitrarily and capriciously. Given these circumstances, the Court would not disturb the respondents' determination. Accordingly, it is

ORDERED and ADJUGED that the petition is dismissed in its entirety.

This decision constitutes the order and judgment of the Court.

Dated: White Plains, New York
December 28, 2018

HON. LARRY J. SCHWARTZ, A.J.S.C.

3

January 2nd 2019

FILED: WESTCHESTER COUNTY CLERK 01/02/2019 04:34 PM INDEX NO. 65929/2018
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TO: All parties by e-filing.

182 A.D.3d 984
Supreme Court, Appellate Division,
Fourth Department, New York.

MAPLE–GATE ANESTHESIOLOGISTS, P.C., Plaintiff–appellant,
v.
Deixy NASRIN and Douglas Brundin, Defendants–respondents.

CA 19–00612
|
19
|
Entered: April 24, 2020

Synopsis

Background: Anesthesiologist employer brought action against its former employees for conversion and unjust enrichment, alleging it was entitled to certain demutualization payments to employees by medical liability insurer after insurer converted from a mutual insurance company to a stock insurance company. The Supreme Court, Erie County, Frank A. Sedita, J., granted employees' motion to dismiss. Employer appealed.

[Holding:] The Supreme Court, Appellate Division held that documentary evidence established as a matter of law that employer had no legal or equitable right of ownership to demutualization payments.

Affirmed.

West Headnotes (2)

[1] Pretrial Procedure Sufficiency and effect

A motion to dismiss pursuant to rule governing dismissal when a defense is founded upon documentary evidence will be granted if the documentary evidence resolves all factual issues as a matter of law, and conclusively disposes of the plaintiff's claims. N.Y. CPLR § 3211(a)(1).

[2] Insurance Conversions or reorganizations

Documentary evidence established as a matter of law that anesthesiologist employer had no legal or equitable right of ownership to demutualization payments made to former employees after medical liability insurer converted from a mutual insurance company to a stock insurance company, where employees submitted insurer plan of conversion that provided that cash distributions were required to be made to those policyholders who had coverage during the relevant period prior to demutualization in exchange for extinguishment of their policyholder membership Interests, and plan stated that cash distribution would be made to policyholder unless he or she affirmatively designated a policy administrator to receive such amount on his or her behalf, which employees did not do. N.Y. CPLR § 3211(a)(1); N.Y. Insurance Law § 7307(e)(3).

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

Attorneys and Law Firms

BARCLAY DAMON LLP, BUFFALO (ROBERT J. PORTIN OF COUNSEL), FOR PLAINTIFF–APPELLANT.

HURWITZ & FINE, P.C., BUFFALO (AMBER E. STORR OF COUNSEL), FOR DEFENDANTS–RESPONDENTS.

PRESENT: WHALEN, P.J., CENTRA, LINDLEY, TROUTMAN, AND WINSLOW, JJ.

MEMORANDUM AND ORDER

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

Memorandum: Plaintiff commenced this action against defendants, its former employees, alleging that it is entitled to certain proceeds paid to defendants by the Medical Liability Mutual Insurance Company (MLMIC) as a result

of MLMIC's conversion from a mutual insurance company to a stock insurance company (demutualization). Pursuant to defendants' employment contracts, plaintiff agreed to provide to defendants the annual premiums for their professional liability insurance as part of their compensation packages. Plaintiff purchased professional liability insurance for defendants and all of its employees through MLMIC. Each defendant was named as the "insured" or "policyholder" on his or her MLMIC policy, and plaintiff was formally designated by defendants as the "Policy Administrator." Defendants assigned certain policyholder rights to plaintiff as the Policy Administrator, namely, the right to receive any dividends and return premiums, and also assigned certain policyholder duties, namely, the duty to pay all premiums.

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

***842** **[1]** "On a motion to dismiss pursuant to CPLR 3211, pleadings are to be liberally construed ... The court is to accept the facts as alleged in the [pleading] as true ... [and] accord [the proponent of the pleading] the benefit of every possible favorable inference" (*Baumann Realtors, Inc. v First Columbia Century–30, LLC,* 113 A.D.3d 1091, 1092, 978 N.Y.S.2d 563 [4th Dept. 2014] [internal quotation marks omitted]). "A motion to dismiss pursuant to CPLR 3211(a)(1) will be granted if the documentary evidence resolves all factual issues as a matter of law, and conclusively disposes of the [plaintiff's] claim[s]" (*Lots 4 Less Stores, Inc. v. Integrated Props., Inc.,* 152 A.D.3d 1181, 1182, 59 N.Y.S.3d 628 [4th Dept. 2017] [internal quotation marks omitted]).

[2] Here, contrary to plaintiff's contention, the court properly granted the motion because the documentary evidence established as a matter of law that plaintiff had no legal or equitable right of ownership to the demutualization payments (*see La Barte v. Seneca Resources Corp.,* 285 A.D.2d 974, 976, 728 N.Y.S.2d 618 [4th Dept. 2001]; *Di Siena v. Di Siena,* 266 A.D.2d 673, 674, 698 N.Y.S.2d 93 [3d Dept. 1999]; *see generally Mandarin Trading Ltd. v Wildenstein,* 16 N.Y.3d 173, 182, 919 N.Y.S.2d 465, 944 N.E.2d 1104 [2011]; *Colavito v New York Organ Donor Network, Inc.,* 8 N.Y.3d 43, 49–50, 827 N.Y.S.2d 96, 860 N.E.2d 713 [2006]). Insurance Law § 7307(e)(3) provides that, when a mutual insurance company converts to a stock insurance company, the plan of conversion: "shall ... provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution [seeking approval of the conversion] shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both." In support of their motion, defendants submitted the MLMIC plan of conversion (plan), which, in accordance with that provision of the Insurance Law, provided that cash distributions were required to be made to those policyholders who had coverage during the relevant period prior to demutualization in exchange for the "extinguishment of their Policyholder Membership Interests." The plan stated that the cash distribution would be made to the policyholder unless he or she "affirmatively designated a Policy Administrator ... to receive such amount on [his or her] behalf." Additional documentary evidence demonstrated that defendants were the policyholders of the relevant MLMIC policies and that, although defendants had assigned some of their rights as policyholders to plaintiff as Policy Administrator, they had not designated plaintiff to receive demutualization payments. Even assuming, arguendo, that plaintiff could be entitled to the demutualization payments without the express designation contemplated by the plan, we conclude that plaintiff has not alleged any facts or circumstances from which it could be established that it was entitled to any such payments. The mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments (*cf. Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 A.D.3d 465, 465, 96 N.Y.S.3d 526 [1st Dept. 2019]).

All Citations

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

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

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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.

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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**

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.

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

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

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

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

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

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

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

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

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,

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

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

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.

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

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.

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

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).

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).

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.

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

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

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.

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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
(The decision is referenced in
the New York Supplement.)
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

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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), 117 N.Y.S.3d 459 (Table), 2019 WL 3331795, 2019 N.Y. Slip Op. 51188(U)