To be Argued by:
SETH A. NADEL
(*Time Requested: 15 Minutes*)

Supreme Court of the State of New York
Appellate Division – Third Department

Case No.: 530190

THE COLUMBIA MEMORIAL HOSPITAL,

Plaintiff-Appellant,

- against -

MARCEL E. HINDS, M.D.,

Defendant-Respondent.

BRIEF FOR DEFENDANT-RESPONDENT

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(914) 948-2240

TABLE OF CONTENTS

Page No.

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

Other Authorities

PRELIMINARY STATEMENT

Respondent Marcel E. Hinds, M.D. ("Dr. Hinds") respectfully submits this brief in opposition to the appeal of Appellant The Columbia Memorial Hospital ("Hospital"), seeking reversal of the Order of the Supreme Court, Columbia County, dated September 3, 2019. The Order dismissed the Hospital's complaint in its entirety under Rule 3211(a)(1) and (a)(7) of the Civil Practice Law and Rules ("CPLR"), and awarded the proceeds from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC") to Dr. Hinds.

Under a written employment contract ("Employment Agreement"), the Hospital agreed to procure for Dr. Hinds a medical-malpractice insurance policy in partial consideration for providing his work, labor and services to the Hospital as an OB-GYN physician. The Hospital obtained the policy from MLMIC, which was a mutual insurance company owned by its physician-policyholders. When MLMIC was subsequently demutualized and sold, Dr. Hinds – as an owner of the company – became eligible to receive cash consideration ("Cash Consideration") in exchange for his ownership interest. Despite having never bargained for the rights to demutualization proceeds in the event such proceeds became available, and having agreed to provide the policy as part of Dr. Hinds' employee compensation, the Hospital sued Dr. Hinds, claiming it was entitled to the Cash Consideration. The

Supreme Court dismissed the Hospital's claims, finding that the Hospital had no right to the proceeds as a matter of law.

A straightforward analysis the of controlling legal authorities governing demutualization and the undisputed facts and documentary evidence presented in this case demonstrate that the Supreme Court's decision was the correct one. The demutualization of a mutual insurance company is a highly regulated process, subject to the New York Insurance Law ("Insurance Law"), a plan of conversion promulgated by MLMIC and approved by the policyholders ("Plan"), and approval of the Plan by the New York State Department of Financial Services ("DFS") to ensure that the Plan followed the Insurance Law and was in the best interest of MLMIC's *policyholders*.

In connection with the demutualization and under the Insurance Law, eligible policyholders – including Dr. Hinds – were statutorily entitled to receive Cash Consideration in consideration for their respective membership interest in MLMIC. The *only* exception to this statutory entitlement was if the policyholder *affirmatively* assigned the right to receive the cash consideration to a third party. It is undisputed and dispositive of this appeal that neither the Employment Agreement nor any subsequent document was ever executed by Dr. Hinds assigning the Cash Consideration to the Hospital. The Hospital's own Verified Complaint

("Complaint") flatly admits that the Hospital demanded that Dr. Hinds assign his rights to the Cash Consideration, and that he refused.

Despite Dr. Hinds' clear legal entitlement to the Cash Consideration, the Hospital falls back on a litany of arguments in an effort to circumvent controlling law and the express terms of the Employment Agreement. As explained below, all of the Hospital's arguments were thoroughly considered and properly rejected by the Supreme Court. For instance, the Hospital argues that it should receive the Cash Consideration because it was the "policy administrator" of Dr. Hinds' MLMIC policy, and it received dividends and refunds from MLMIC in connection therewith. However, the only rights the Hospital had as policy administrator were to carry out limited clerical functions on the policyholder's behalf. The Hospital's status as policy administrator had nothing to do with the Cash Consideration and did not vest the Hospital with any ownership in Dr. Hinds' MLMIC policy or Cash Consideration. The Hospital's alternative argument that its payment of premiums entitles it to the Cash Consideration is likewise unavailing. The Hospital specifically agreed to pay premiums to induce Dr. Hinds to work for the Hospital in the first place, and under the Employment Agreement the premiums were factored into Dr. Hinds' incentive compensation.

The plain language of the Employment Agreement coupled with the Hospital's own admissions in its Complaint reveals that the Hospital never bargained

for demutualization proceeds, and there is no language in the Employment Agreement which might even arguably apply to this dispute. Only now, having realized the inherent value of the MLMIC policy the Hospital agreed to provide to Dr. Hinds, does the Hospital entreat the Court to read a provision into the Employment Agreement to secure a benefit which it never anticipated nor bargained for.

The Hospital further contends that the Supreme Court "improperly resolved numerous factual issues," the existence of which, in the Hospital's estimation, should have precluded a pre-answer dismissal. However, the so-called "factual issue" upon which the Hospital relies – whether deductions were made from Dr. Hinds' incentive compensation to cover the cost of his MLMIC premiums – is immaterial. The relevant facts are uncontested: Dr. Hinds was the policyholder and never assigned his rights to the Cash Consideration to the Hospital. Whether and to what extent any party paid the MLMIC premiums is irrelevant as a matter of law.

In the absence of any articulable legal or contractual right to the contrary, Dr. Hinds is legally entitled to the Cash Consideration. As the Hospital has stated no claim under any cause of action, the Supreme Court's decision should be affirmed.

QUESTION PRESENTED

1. Does the Hospital which employed Dr. Hinds have any right to the Cash Consideration allocated to him under the Insurance Law, Plan, DFS Decision, and DFS Order, even taking as true that the Hospital paid Dr. Hinds' medical-malpractice-insurance premiums as part of his compensation and served as policy administrator? The Supreme court answered this question in the negative, and dismissed the Hospital's Complaint.

STATEMENT OF UNDISPUTED FACTS

The material facts are undisputed and justify dismissal of the Hospital's action, on the law, under CPLR Rule 3211(a)(1) and (a)(7).

Dr. Hinds was employed by the Hospital from 2006 through August 2017 [R.133-34][1], as an OB-GYN physician under a written Employment Agreement [R.140-48], effective as of August 2012. The Employment Agreement set forth Dr. Hinds' compensation and benefits and reflected the Hospital's agreement to "maintain an individual occurrence-based medical malpractice insurance policy" on his behalf through an insurance carrier "as the Hospital [deemed] reasonable and appropriate" [R.143]. In other words, the Hospital agreed to provide Dr. Hinds with a malpractice insurance policy as part of the compensation paid to Dr. Hinds for his professional services.

The Employment Agreement expressly provides for a base salary, and incentive compensation based on several factors. Among the factors for computing Dr. Hinds' incentive compensation was MLMIC premiums. The relevant language of the Employment Agreement is as follows:

> (b) *Incentive Compensation*: The amount equal to the annual professional component net revenue, which for purposes of this Agreement shall mean the amount actually collected by the Hospital in a given contract fiscal year from billing the professional component of any services provided by you, regardless of office location,

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

> ("Hinds Revenue"), shall be calculated quarterly for your review and *shall be reconciled each contract fiscal year against the expenses directly attributable to your employment hereunder* ("Hinds Expenses")…
>
> If in a given fiscal year the Service Revenue is in excess of the Service Expenses, the Hospital shall pay you additional compensation ("Incentive Compensation") from those Service Revenues in an amount equal to sixty-five percent (65%) of the amount *equal to the difference of (a) the Hinds Revenue and (b) the Hinds Expenses*, assuming such difference is a positive number.
>
> The Hinds Expenses, and the expenses for each of the Physicians in the Service shall be calculated as follows in any given fiscal year:
>
> | | | |
> |---|---|---|
> | 1. | Base Salary | $ |
> | 2. | Actual Cost of Benefits | $ |
> | 3. | Malpractice Premium | $ |
> | 4. | Office and Staff Overhead Figure | $_____ |
>
> Total Amount to be exceeded per annum to earn Incentive Compensation in accordance with this Section 3(b) $

[R.141] (emphasis added). To the extent that Dr. Hinds was entitled to incentive compensation based on the volume of patient services he provided, that compensation was to be reduced in proportion to the cost of his malpractice premiums and overhead costs.

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

demutualization proceeds, should they ever arise. The Hospital, for its part, was identified on Dr. Hinds' insurance policy declaration page as Policy Administrator [R.149], which provided that the Hospital was the "agent of [the Insured] for the paying of premiums, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return premiums when due [R.180]." Nothing in the policy administrator designation makes reference to a policy administrator's right to demutualization proceeds [R.180].

In mid- to late-2018, MLMIC announced its intention to be sold to National Indemnity Company – a subsidiary of Berkshire Hathaway – and demutualize, meaning it would be converted from a mutual insurance company owned by its policyholders to a stock insurance company owned by conventional shareholders [R.47]. In connection with MLMIC's proposed sale and demutualization, policyholders such as Dr. Hinds became eligible to receive compensation in exchange for the sale of their ownership interests in MLMIC [R.47].

After learning of MLMIC's impending demutualization and payment of Cash Consideration, the Hospital demanded that Dr. Hinds designate the Hospital as recipient of the Cash Consideration because the Hospital had paid the premiums and was the policy administrator [R.150-62]. Despite threats of litigation, Dr. Hinds refused to assign his rights to the Hospital [R.25, 134-36].

Following Dr. Hinds' refusal, the Hospital commenced this action attempting to claim the Cash Consideration [R.17-30]. The Hospital's Complaint asserted four causes of action: (1) a declaratory judgment that the Hospital was legally entitled to the Cash Consideration; (2) a claim for unjust enrichment if Dr. Hinds were to receive the Cash Consideration; (3) an equitable claim for money had and received; and (4) a breach of the implied duty of good faith and fair dealing by Dr. Hinds asserting that the Hospital was entitled to the Cash Consideration under the Employment Agreement [R.18-30].

In lieu of answering, Dr. Hinds moved to dismiss the Complaint under CPLR 3211(a)(1) and (a)(7) upon the grounds that controlling legal authorities and lack of any contractual entitlement to the Cash Consideration foreclosed any claim to the money [R.163-178]. Following extensive briefing by the parties, the Supreme Court issued a comprehensive written decision, determining that Dr. Hinds was entitled to the Cash Consideration as a matter of law, and granting Dr. Hinds' motion to dismiss in its entirety [R.5-16].

LEGAL ARGUMENT

I. POLICYHOLDERS OF A MUTUAL INSURANCE COMPANY ARE ENTITLED TO DEMUTUALIZATION PROCEEDS AS A MATTER OF LAW

A. The Insurance Law clearly provides that the policyholders in a mutual insurer, and no others, are is entitled to cash consideration resulting from a demutualization and sale.

Prior to its demutualization, MLMIC was a mutual insurance company "organized, maintained and operated for the benefit of its members as a non-stock corporation." Insurance Law §1211(a). Members in a mutual insurance company acquire their membership and ownership rights not through payment of premiums to the insurer, but by operation of law incident to the coverage they receive under their policies. *Dorrance v. United States*, 809 F.3d 479, 485 (9th Cir. 2015). Every MLMIC policyholder – including Dr. Hinds – was a member of MLMIC and had an *ownership* and management interest in the company. Insurance Law §1211(a).

The requirements for demutualization of a mutual insurer are set forth in Insurance Law §7307, and the terms and procedures of the demutualization are set forth in a "plan of conversion" duly promulgated by a majority of MLMIC's policyholders, and approved by DFS. Insurance Law §7307(d). It is the plan of conversion which governs and defines the rights of the parties and members in a demutualization. Insurance Law §7307(d)-(e); *See Bank of New York v. Janowick*, 470 F.3d 264, 266 (6th Cir. 2006) (demutualization plan defines rights to proceeds);

Praxair, Inc. v. Union Carbide Corp., 2008 WL 222321 *2 (D. Conn. Jan. 25, 2008) (plan sets forth allocation principals for distributing demutualization proceeds).

Insurance Law §7307(e)(3) expressly sets forth the requirements for a plan of conversion, and plainly specifies who is entitled to the proceeds from the sale of a mutual insurer. The Insurance Law states, in pertinent part: "The plan [of conversion] 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." Insurance Law §7307(e)(3) (emphasis added). Nothing in the statute provides that anyone except the "person who had a policy of insurance" is entitled to receive consideration upon demutualization and sale.

B. The MLMIC Plan of Conversion confirms that policyholders are statutorily entitled to demutualization proceeds, the only exception being where the policyholder affirmatively assigned those rights to another.

"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 [R.100-01]."

Insurance Law §7307(c) and (d) provide that before granting or denying permission to submit a plan of conversion, DFS must appoint an appraiser to report

on the insurer's value, taking into consideration its assets and liabilities and any other factors bearing on value. After receiving these reports, DFS may grant or deny permission to submit a plan of conversion.

Insurance Law §7307(e)(3) provides that a conversion plan must include the manner and basis of exchanging the equitable shares of each eligible *policyholder* for the stock of the converted insurer or other consideration. The statutory scheme, followed by the Plan, recognizes the right of *policyholders* to the cash consideration, and is central to determining the instant case.

Under the Insurance Law, on May 22, 2018, DFS granted MLMIC permission to file an application to approve the Plan [R.52]. The Plan was adopted by MLMIC's board on May 31, 2018 and was submitted to DFS for consideration on June 15, 2018 [R.98]. The Plan proposed MLMIC's conversion to a stock corporation, and the sale of the newly-authorized MLMIC shares to National Indemnity Company in accordance with an Acquisition Agreement, dated February 23, 2018 [R.47].

Mirroring the language of the Insurance Law, the Plan clearly identifies *policyholders* as those whose rights are affected [R.47-48]. The Plan defines Cash Consideration as an amount equal to $2,502,000,000.00 [R.48], and represents that the Cash Consideration allocable and paid to *Eligible Policyholders* will constitute adequate consideration paid for MLMIC [R.54]. Article 2 of the Plan clearly

delineates definitions of "eligible policyholders," "policy administrators," "policyholders," and "policyholder membership interest" as follows:

> '*Eligible Policyholder*' means the Policyholder of an Eligible Policy. For Eligible Policies that identify multiple insureds, each Person so identified on the declarations page of such Policy shall be an Eligible Policyholder. Each such Eligible Policyholder that is a Record Date Policyholder shall be entitled to vote at the Special Meeting. In addition, each such Eligible Policyholder shall be entitled to an allocation of the Cash Consideration based on the Eligible Premium with respect to such Eligible Policyholder as set forth in the definition of Eligible Premium.
>
> * * *
>
> '*Policy Administrator*' means a Person designated on the declarations page of the applicable Policy or otherwise as the administrator of the Policy on behalf of the applicable Policyholder, or any successor to such Person. For the avoidance of doubt, such Person may be an organization, a professional practice group or a third party.
>
> * * *
>
> '*Policyholder*' means, with respect to any Policy, the Person(s) identified on the declarations page of such Policy as the insured. For Policies that identify multiple insureds, each Person so identified on the declarations page of such Policy shall be a Policyholder. For the avoidance of doubt, no Person(s) identified as an additional insured under any Policy shall be considered a Policyholder with respect to such Policy.
>
> * * *
>
> '*Policyholder Membership Interests*' means, with respect to MLMIC, the interests of Members arising under the

> New York Insurance Law and under the charter, bylaws and Policies of MLMIC prior to the Conversion, including the right to vote, the right to participate in any distribution of surplus, earnings and profits of MLMIC (including dividends), and the right to participate in meetings of members. 'Policyholder Membership Interests' do not include insurance coverages provided under the Policies.

[R.49-51] (emphasis in original).

In accordance with the Insurance Law, the Plan provided that the conversion *will provide Eligible Policyholders, or their Designees, with Cash Consideration*. The amounts allocated to Eligible Policyholders vary according to the *premiums properly and timely paid under their Eligible Policies* [R.48].

Finally, the Plan identified the only circumstance where someone other than the policyholder can receive Cash Consideration: "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] (emphasis added). *Designees*, under the Plan, were defined as "Policy Administrators and EPLIP Employers, in each case, *to the extent designated by Eligible Policyholders* to receive the portion of the Cash Consideration allocated to such Eligible Policyholders" [R.49] (emphasis added)."

D. The DFS Decision confirms that the Insurance Law is controlling, and approves the Plan.

To effect a demutualization, Insurance Law §7307(b) requires a mutual insurer, by and through its board of directors, to apply to DFS for leave to convert to a stock insurer. The application must be made pursuant to a resolution adopted by the board of directors, "specifying the reasons for and the purposes of the proposed conversion, *and the manner in which the conversion is expected to benefit policyholders and the public*." Insurance Law §7307(b) (emphasis added). Under Insurance Law §7307(h)(1), the mutual insurer must actually demonstrate to DFS, among other things, the benefit to *policyholders* and the public.

Upon receipt of MLMIC's proposed plan, and as part of the statutorily-mandated approval process in Insurance Law §7307, DFS solicited oral testimony and written public comments from interested parties and held a public hearing. Insurance Law §7307(h)(1) requires that upon conclusion of the public hearing, DFS shall either approve the conversion plan as submitted, refuse to approve it, or request modification before approval.

Once approved the conversion plan is submitted to a vote of the *policyholders*. Insurance Law §7307(i). The votes of two-thirds of all votes cast by *policyholders* are necessary to adopt the plan. Insurance Law §7307(j).

In June and July 2018, DFS published notice of a public hearing in various daily newspapers and sent notice to policyholders whose rights would be affected

by the demutualization [R.107-108]. DFS held the public hearing on August 23, 2018, after publishing notice in the New York Register and on DFS' website [R.107]. Excluding DFS personnel, 64 individuals attended the public hearing and eight interested individuals asked to speak at the hearing [R.108].

Following the hearing, the DFS Decision, rendered on September 6, 2018, approved the Plan [R.98-125]. The DFS Decision thoroughly outlines the procedural requirements for demutualization as codified in Insurance Law §7307, and acknowledges DFS's authority under Insurance Law §7307(h)(1) to approve the Plan if it "is not inconsistent with law, is fair and equitable, and is in the best interest of the *policyholders* and the public [R.109 (emphasis added)]." DFS determined that Insurance Law parameters were met [R.109], and that the purchase price was negotiated at arm's length and was fair and equitable [R.110].

The DFS Decision also addressed certain public comments, mainly from hospitals and other employers of physicians who believed that they – rather than the policyholders – should receive the Cash Consideration [R.118-119]. Relevant here, one such commenter raised an argument (also made by the Hospital) referring to the language of Insurance Law §7307(e)(3), noting that the statute based the amount of cash consideration on premiums "properly and timely paid to an insurer." *Id.* Therefore, the commenter argued, if an employer paid the MLMIC premiums, the employer should be entitled to the Cash Consideration [R.120]. *DFS rejected this*

argument, citing the Insurance Law, and finding that a third party's payment of premiums "is not determinative because [Insurance Law §7307(e)] refers to 'policyholder,' which may or may not be the person who paid the premiums [R.120]."

Most importantly, the DFS Decision confirmed that "*Insurance Law §7307(e)(3) explicitly defines those policyholders who are eligible to receive the purchase price consideration*" [R. 120 (emphasis added)], and confirmed the *one and only* instance when cash consideration may be paid to someone other than the policyholder:

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

[R.120 (emphasis added)].

Following the demutualization and an initial spate of objections by various employers, including the Hospital [R.25], the DFS Decision was followed by an "Order Pursuant to the Superintendent's Decision Dated September 6, 2018" ("DFS Order"), dated January 14, 2019 [R.126-29]. The DFS Order, at footnote 1, cites Insurance Law §7307(e)(3), which defines eligible policyholders as persons who had

policies in effect during the three-years preceding MLMIC's resolution to demutualize [R.126].

Consistent with the Plan and DFS Decision, the DFS Order acknowledges that cash consideration is payable to eligible policyholders, "except that such Eligible Policyholders could assign their legal rights to such consideration to other persons" [R.126-27]. The DFS Order is otherwise consistent with the Plan and DFS Decision. Neither the Insurance Law, the Plan, nor the DFS Decision granted any ownership interest in MLMIC or rights to cash consideration to a policy administrator or any other third party, *absent an assignment by the policyholder*.

Based on the foregoing legislative enactments, the Plan and DFS's findings, the present dispute may thus be resolved by answering two simple questions: (1) who was the policyholder; and (2) did the policyholder ever assign the Cash Consideration to a third party?

The uncontested facts and documentary evidence presented to the Supreme Court demonstrated, as a matter of law, that Dr. Hinds was the policyholder and a mutual owner of MLMIC [R.149], and that he never made an assignment to or otherwise designated the Hospital to receive the Cash Consideration [R.25].

Accordingly, and as further argued below, the Supreme Court's determination that Dr. Hinds is legally entitled to the Cash Consideration was correct and should be affirmed.

II. THE SUPREME COURT PROPERLY DETERMINED THAT DR. HINDS WAS LEGALLY ENTITLED TO THE CASH CONSIDERATION

A. The Supreme Court properly decided this dispute in the context of governing authorities, and determined that Dr. Hinds was entitled to the Cash Consideration, as a matter of law.

The Supreme Court determined that Dr. Hinds was entitled to the Cash Consideration, as a matter of law, and was thus entitled to dismissal of the Complaint and declaratory judgment in his favor [R.15-16]. In so finding, the Supreme Court's analysis followed the plain language of the governing authorities, most notably Insurance Law §7307 and the Plan. Specifically, the Supreme Court confirmed that under the Insurance Law, only a *policyholder* (such as Dr. Hinds) was legally entitled to demutualization proceeds [R.11], and that Dr. Hinds had not assigned his rights to the Cash Consideration to the Hospital [R.12].

The Supreme Court likewise rejected the Hospital's arguments that it was entitled to the Cash Consideration as policy administrator, holding that the cash consideration did not represent a refund of premiums, but rather was the purchase price for Dr. Hinds' ownership interest in MLMIC [R.14].

B. There are no outstanding issues of material fact and the Supreme Court properly applied the standard for determining a motion to dismiss.

The Employment Agreement provided that if Dr. Hinds were entitled to incentive compensation, MLMIC premiums paid by the Hospital on his behalf would

offset and reduce any incentive compensation he might earn [R.141]. The Hospital contends that dismissal was premature because the Supreme Court improperly "found, as a matter of law, that [Dr. Hinds] actually paid the premiums by a deduction to his employment compensation" [App. Brief, at 23]. The Hospital thus mischaracterizes the Supreme Court's decision as holding that Dr. Hinds was entitled to the Cash Consideration *because he paid the premiums*.

Viewed in light of the actual text of the decision, the Hospital's characterization of the Supreme Court's holding is misinformed at best, and disingenuous at worst. Set forth in proper context, the Supreme Court held as follows:

> Insurance Law 7307 governs the process by which MLMIC was converted from a mutual insurance company into a stock insurance company. Insurance Law 7307 (e) (3) provides in pertinent part that "each person who had a policy of insurance in effect at any time during the three year period immediately proceeding the date of the adoption of the resolution shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting shares of the insurer or other consideration, or both." *The statute repeatedly refers to those eligible for cash consideration as the "policyholder." It is important to note that "[n]o distinction is made between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. Insurance Law 7307 does not confer an ownership interest...on anyone other than the policyholder*." (*Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc 3d 703, 709 [Sup Ct, Erie County, 2019]).

> Here, the defendant is clearly the policyholder, and the plaintiff the policy administrator. The documentary evidence — the Employment Agreement — establishes that the insurance premiums were deducted before the defendant received any incentive pay. That is, the defendant was to receive incentive pay, 65% of the amount by which his revenue exceeded the expenses paid by the hospital, and one [of] the expenses being his medical malpractice insurance. Stated differently, *the defendant would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance*. *Further, under the plain language of the Insurance Law, the cash consideration cannot be given to the plaintiff unless the defendant signs the agreement to do so. Here, the defendant has not signed such an agreement, and given the circumstances of this case — the Employment Agreement which required him to pay the cost of his malpractice premiums by way of his salary incentives — does not have to agree to do so*.
>
> The plaintiff's entire argument, as framed by the complaint, focuses on the bare and incorrect assertion that the hospital paid the policy premiums *and that equity, not ownership, dictates that it should be the recipient of the cash contribution*. However viewed, this assertion is belied by the terms of the Employment Agreement, whereby the defendant's incentive compensation is reduced by the policy premiums. On this record, equity does not dictate that the plaintiff should be compensated.

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

As is clear from its decision, the Supreme Court did not, in any way, make a factual finding that Dr. Hinds paid the premiums through reductions in his compensation. Rather, the Supreme Court correctly determined that Dr. Hinds was the policyholder legally entitled to Cash Consideration, and that the Cash

Consideration could not be given to the Hospital unless Dr. Hinds signed an agreement to do so.

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

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

Beyond this, the Hospital attempts to tease out what it perceives as ambiguities in the Insurance Law, Plan, and DFS Decision, essentially contending that the governing law says something other than what it says: that Dr. Hinds is entitled to the Cash Consideration absent an assignment. Rather, according to the

Hospital, the entitlement to the Cash Consideration "depends on the factual circumstances of each physician" and the Supreme Court was required to "consider the factual circumstances and not the formal designations" before deciding which party was so entitled [App. Brief, at 47].

The Hospital's argument that the Supreme Court was required to "consider the factual circumstances of the parties' specific relationship" falls flat. The relevant and material factual circumstances are based on uncontested facts and dispositive documentary evidence, which includes the Employment Agreement specifically setting forth the parties' contracted rights and obligations. There is nothing of substance yet to be established. Despite the Hospital's vague allusions to an evaluation of the facts and circumstances which it claims should have taken place in the Supreme Court, it does not even specify what facts, if proven, remain to be discovered which could entitle the Hospital to the Cash Consideration. The Hospital has offered nothing sufficient to survive a motion to dismiss.

C. The Hospital proffers no cogent grounds for reversal under relevant law.

"Where the terms of a statute are clear and unambiguous, 'the court should construe it so as to give effect to the plain meaning of the words used…" *Lubov v. Welikson*, 21 Misc. 3d 896, 900–01, 865 N.Y.S.2d 510 (Sup. Ct. 2008) (internal citations omitted). *The Court's objective is to discern and apply the will of the*

Legislature, "not the court's own perception of what might be equitable." Sutka v. Conners, 73 N.Y.2d 395, 403, 538 N.E.2d 1012 (1989).

In accordance with this basic maxim, the lower court employed a straightforward analysis of the underlying authorities. By contrast, the Hospital cherry-picks and misquotes language from the Insurance Law, Plan and DFS Decision to obfuscate the fact that the law clearly confers a right to demutualization proceeds on a *policyholder*, in the absence of an affirmative assignment.

The Hospital argues that under the Plan, "a Designee may be legally entitled to the Cash Consideration even if it has not been 'specifically designated'" [App. Brief, at 47]. However, the Hospital has not alleged that the Cash Consideration was, in fact, designated to the Hospital – either "specifically" or otherwise. To the contrary, the Hospital *admitted* in its Complaint that "Defendant has refused to comply with the Hospital's request that the MLMIC Funds be turned over to the Hospital [R. 25]." The Hospital cannot argue that Dr. Hinds somehow designated it to receive the Cash Consideration while at the same time admitting that he refused to do so.

The Hospital also mischaracterizes the DFS Decision as stating that Insurance Law §7307 is *not* determinative of who receives the Cash Consideration. However, the quoted language of the DFS Decision confirms that the only exception is where

a policyholder assigned his rights to demutualization proceeds to a third party [R.120], which the Hospital admits Dr. Hinds did not do [R. 25].

Next, the Hospital turns its attention to Insurance Law §7307. As previously mentioned, Insurance Law §7307 confers the right to demutualization proceeds to one party: *the eligible policyholder*. Nothing in the statute suggests that anyone else is entitled to demutualization proceeds under any circumstance, regardless of who paid the premiums, or acted as policy administrator, or otherwise.

In support of its position that the Insurance Law does *not* conclusively deem Dr. Hinds the proper recipient of the Cash Consideration, the Hospital cites language in the statute referring to premiums "properly and timely paid to the insurer," and implies that if Dr. Hinds did not "pay" such amounts, he should not be entitled to the Cash Consideration. This position was specifically considered and rejected by DFS prior to rendering the DFS Decision, the question having been raised by numerous hospitals and medical practices similarly situated to the Hospital at the public hearing [R. 120].

Following DFS's approval of the Plan, Maple Medical – one of the employers that urged the rejected interpretation of Insurance Law §7307(e)(3) – commenced an Article 78 proceeding against DFS in the Supreme Court, Westchester County, arguing that DFS's interpretation of Insurance Law §7307(e)(3) was erroneous, and that the *employer* should have been determined to be the policyholder to whom the

demutualization proceeds should be paid. Maple Medical's petition was dismissed on procedural grounds, but the Supreme Court noted that even if the merits had been reached, it would not have annulled DFS's interpretation of the Insurance Law. *Maple Medical LLP v. New York State Department of Financial Services*, Index No. 65929/2018, NYSCEF Doc. 59 at 3 (Sup. Ct. Westchester Co. 2018) (record revealed that DFS properly considered and weighed relevant criteria and that determination had rational basis).

Paradoxically, the Hospital agrees that "the statute is silent on the ultimate entitlement to MLMIC Funds as between an employee as named policyholder and an employer who paid the premiums" (App. Brief, at 51). This is precisely the point. Under the Statutes Law, "[a] *court cannot by interpretation supply in a statute a provision which it is reasonable to assume the Legislature intended intentionally to omit, and the failure of the Legislature to include a matter within the scope of an act may be construed as an indication that its exclusion was intended*." NY Statutes § 74 (emphasis added). See NY Statutes § 73 ("the courts… do not sit in review of the discretion of the Legislature or determine the expediency, wisdom, or propriety of its action on matters within its powers").

Here, the New York Legislature clearly intended that eligible *policyholders* receive demutualization proceeds. The Hospital's interpretation of Insurance Law §7307 finds no support in its text, and the Hospital's attempts to judicially overrule

the Legislature and read comprehensive provisions into the statute to support entitlement to the Cash Consideration are unavailing.

D. The Supreme Court's reliance on *Maple-Gate Anesthesiologists v. Nasrin* was proper, and courts which have substantively analyzed the controlling law have likewise concluded that the policyholder is solely entitled to the MLMIC funds.

When the Supreme Court decided this case, there were two prior decisions in New York addressing the question of which party was legally entitled to MLMIC demutualization proceeds. The first was *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc. 3d 703 (Sup. Ct. Erie Co. 2019), decided by the Erie County Supreme Court following its thorough analysis of the governing law.[2]

In *Maple-Gate,* the plaintiff-employer sued two medical practitioners following their receipt of MLMIC proceeds, asserting a right to the cash consideration based on conversion and unjust enrichment. *Id.* at 704. In all material respects, the legal questions in *Maple-Gate* are identical to those raised in the instant dispute, including allegations by the plaintiff-practice that it was entitled to the MLMIC proceeds because it paid the premiums, served as the policy administrator, and was entitled to the funds under a theory of unjust enrichment. *Id* at 706.

[2] The second decision was *Schaffer, Schonholz & Drossman v. Title*, 171 A.D.3d 465, 96 N.Y.S. 526 (1st Dep't 2019), a summary proceeding submitted to the First Department as a court of first impression pursuant to CPLR Rule 3222. Owing to its outsized influence on disputes related to the MLMIC demutualization, the limited value of *Schaffer* as precedent, on which the lower court was fully briefed, is addressed in greater detail in Section IV, *infra*.

The court in *Maple-Gate* fully analyzed and rejected each argument proffered by the plaintiff as to why it should be entitled to MLMIC demutualization proceeds, granted the policyholders' motion to dismiss, and affirmed that the policyholders were entitled to MLMIC demutualization proceeds as a matter of law. *Id.* at 709-710. Faced with the same legal issues – and *Maple-Gate* being the only case which had substantively analyzed those issues up to that point – the Supreme Court below reached the same conclusion, following the analysis in *Maple-Gate* as a guide [R.15].

The Hospital contends that the Supreme Court's reliance on *Maple-Gate* was erroneous. However, other than asserting that *Maple-Gate* was wrong to render a decision contrary to its own arguments, the Hospital offers little to justify reversal of the Supreme Court's decision. The Hospital tries to differentiate the arguments advanced by the employer in *Maple-Gate* from its own by claiming that the employer in *Maple-Gate* had argued that it was the true "owner" of the policy, while the Hospital does not (App. Brief, at 52). However, regardless of the words used in framing their respective causes of action, the claims asserted by the *Maple-Gate* employer were *exactly* the same as the Hospital's: that it paid the premiums and served as the policy administrator, and should, therefore, be equitably entitled to the Cash Consideration.

The Hospital also attempts to paint *Maple-Gate* as being factually distinct from the instant case, but the only factual distinction is that the Hospital availed itself of the escrow procedure put in place by MLMIC to hold the money pending the outcome of this dispute, while the plaintiff in *Maple-Gate* did not [App. Brief, at 53]. However, as admitted in the Hospital's own Brief and plainly set forth in the DFS Decision, "the release of escrow shall have no substantive effect on the parties' positions with respect to who is entitled to the payment under the relevant law [R. 122]." The Hospital therefore has no stronger argument for having initially objected than did the employer in *Maple-Gate*.

Nor is *Maple-Gate* an isolated decision. In *Shoback v. Broome Obstetrics and Gynecology, P.C.*, Index No. EFCA2018003334, NYCEF Doc. 45 at 4 (Sup. Ct. Broome Co. 2019), in response to an employer's identical argument that it paid the premiums and was thus entitled to the demutualization proceeds, the Broome County Supreme Court stated:

> The language of the Plan is clear and unambiguous, and as such must be accorded the plain meaning of its terms. *Goldman v. Emerald Green Prop. Owner's Assn., Inc.*, 116 AD3d 1279, 1280 (2014). According to those terms, [the policyholder] is entitled to the money.
>
> Defendant's argument – that it paid the premiums and as such is entitled to the funds, is unpersuasive. Policyholders in a mutual insurance company acquire two separate types of rights – contractual rights and membership rights. The contractual rights are paid for by the premiums, and pay for the cost of the insurance itself. 'The premiums paid

> covered the rights under the insurance contract, not any membership rights… premium payments go toward the actual cost of the insurance benefits provided. *Dorrance v. U.S.*, 809 F3d 479, 485.
>
> Here, the [medical practice] paid the premiums as part of its obligation under the Employment Agreement with [the physician]. She provided services and in turn [the practice] was confident that she was covered (and hence it was covered) in terms of malpractice insurance.

Id.[3]

In January 2020, the Orange County Supreme Court granted summary judgment in favor of four MLMIC policyholders in four separate cases[4]: *GHVHS Medical Group, P.C. v. Cornell*, Index #EF001610/2019, NYSCEF Doc. 47 (Sup. Ct. Orange Co. 2020), *GHVHS Medical Group, P.C. v. Arthurs*, Index #EF001609/2019, NYSCEF Doc. 42 (Sup. Ct. Orange Co. 2020), *GHVHS Medical Group, P.C. v. Sidorski-Nutt*, Index #EF001620/2019, NYSCEF Doc. 46 (Sup. Ct. Orange Co. 2020) and *GHVHS Medical Group, P.C. v. Allegro-Skinner*, Index #EF001608/2019, NYSCEF Doc. 32 (Sup. Ct. Orange Co. 2020).

In those cases, as in *Maple-Gate*, the Supreme Court considered and summarily rejected the same arguments advanced by the Hospital here, and

[3] In *Shoback*, as set forth in the Hospital's brief, despite finding that the policyholder-physician's argument was the correct interpretation of the law, the court denied her motion to dismiss, on the basis that *Schaffer* was *stare decisis* – until the Third Department decides otherwise. As discussed in *Point IV*, *supra*, the Hospital's argument that *Schaffer* is binding in the instant proceeding was considered and rejected by the Supreme Court below.

determined that since policyholders were the rightful recipients of the money under the law, and that employers had not been assigned nor bargained for demutualization proceeds, the policyholders were entitled to judgment in their favor.

The court even went a step further, stating that "*to rule that the [employers] should receive the money in every case would unjustly enrich the [employers] who never bargained for this windfall*." *Cornell*, NYSCEF Doc. No. 47, p. 8 (emphasis added). This analysis is on point here, where the Hospital asserts rights to the Cash Consideration despite having never anticipated or bargained for such a right when it procured a MLMIC policy for Dr. Hinds in partial consideration of his employment.

Overall, it is abundantly clear that the Insurance Law and the Plan represent the controlling law in this dispute, and unambiguously confer the right to the Cash Consideration to Dr. Hinds. Thus, the Hospital has proffered no legitimate legal basis under the law for reversal of the Supreme Court's decision.

III. THE HOSPITAL'S ARGUMENTS THAT IT IS ENTITLED TO THE CASH CONSIDERATION BECAUSE IT WAS DR. HINDS' POLICY ADMINISTRATOR ARE WITHOUT MERIT

The Hospital alternatively makes several references in its Brief to how its past receipt of "premium refunds," "rebates," or "dividends," (App. Brief, at 11, 33 and 44), *ipso facto*, should entitle it to the Cash Consideration. The Hospital, however, conspicuously omits any mention of the circumstances under which it received such payments. In reality, the Hospital's receipt of premium refunds or dividends were merely a clerical function of its role as *policy administrator* and have no bearing on the disposition of the Cash Consideration to be paid for Dr. Hinds' ownership interest in MLMIC.

For context, the MLMIC policy administrator designation form states as follows:

> The policy administrator is the *agent* of all Insureds herein for the paying of premiums, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return premiums when due.

[R.180 (emphasis added)].

Despite the language of the policy administrator designation which clearly delineates its obligations thereunder, the Hospital insinuates that the Cash Consideration should be paid to the Hospital as a *dividend* or *return premium*. This position is misguided for several reasons. First, the Cash Consideration is not a dividend or return premium. The plain terms of Insurance Law §7307(e)(3), when

setting forth how to calculate a policyholder's equitable share in the demutualized insurer, provide that the net premium payment (for the purposes of determining the Cash Consideration) shall consist of "*gross premiums less return premiums and dividends paid…*" *Id.* In other words, the statute itself draws a firm distinction between the Cash Consideration on the one hand, and dividends or return premiums on the other.

Second, the plain language of the policy administrator designation form, as quoted above, provides that the policy administrator is the *agent* of the insured for paying premiums and receiving dividends and return premiums. "An agency relationship results from a manifestation of consent by one entity to another that the agent shall act on the principal's behalf and subject to the principal's control." *Quik Park W. 57, LLC v. Bridgewater Operating Corp.*, 148 A.D.3d 444, 445, 49 N.Y.S.3d 112, 114 (1st Dep't 2017). In other words, merely being the policy administrator, the Hospital is not entitled to receive and retain any such funds for its own benefit, but rather holds those funds as a fiduciary for its principal – Dr. Hinds. *See* Restatement Third, *Agency* § 1.01.

Overall, despite the Hospital's attempt to shoehorn the MLMIC demutualization funds into the definition of a "dividend," "refund" or "rebate," the Hospital's status as policy administrator conferred no right to the Cash Consideration. Dr. Hinds' position on this issue is supported wholesale by the

decision in *Maple-Gate*, and the law. In conducting its own analysis, the *Maple-Gate* court rejected the plaintiff's identical argument that the Cash Consideration was a "dividend" or "return premium," stated as follows:

> 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.

Id. The *Maple Gate* court likewise rejected the plaintiff's allegation that it was entitled to the MLMIC proceeds based on the fact that it had served as the policy administrator:

> Being designated as the policy administrator did not make the plaintiff a policyholder, did not make the plaintiff a member of MLMIC and did not entitle the plaintiff to the cash consideration.

Id.; *see also GHVHS v Cornell,* at 5 ("nowhere in [the policy administrator] form does it mention proceeds of demutualization").

In sum, the Hospital's policy administrator designation has nothing to do with the Cash Consideration, the Hospital's attempts to argue that the Cash Consideration should be payable it to as a "dividend" or "refunds" are meritless.

IV. THE FIRST DEPARTMENT'S DECISION IN *SCHAFFER* HAS NO PRECEDENTIAL VALUE TO THIS COURT.

The Hospital's principle reliance in its opposition to Dr. Hinds' motion to dismiss rested on *Schaffer, Schonholz & Drossman v. Title*, 171 A.D.3d 465, 96 N.Y.S. 526 (1st Dep't 2019), where the First Department held that equity dictated that the proceeds from the MLMIC demutualization be paid to the medical practice that employed the policyholder and paid her MLMIC premiums. Below, the Hospital strenuously argued that *Schaffer* was *stare decisis*, a proposition the lower court properly rejected. On appeal, the Hospital again relies heavily on *Schaffer*.

A. *Schaffer* addressed none of the legal questions relevant to this appeal.

Schaffer was an expedited proceeding submitted *directly* to the First Department on stipulated facts pursuant to CPLR Rule 3222 with no lower court proceedings [R.200]. A review of the submitted facts[5] reveals that the parties in *Schaffer* evidently elected to omit certain undisputed material facts, made no mention of the Insurance Law, and misleadingly referred to (but did not attach) a letter which allegedly informed the defendant-physician that she had been added onto the employers' professional liability insurance policy, giving the misleading impression that the defendant-physician's employer (rather than the physician) somehow had an ownership interest of the policy [R.202-203].

[5] The stipulated facts and parties' submissions in *Schaffer* were provided to the Supreme Court in support of Dr. Hinds' motion to dismiss [R.200-257].

Inexplicably, in her legal brief [R.226-238], the respondent-physician in *Schaffer* failed to make any reference to Insurance Law §7307 – which indisputably controls demutualization – or to cite to any relevant sections of the Plan. In its reply, evidently taking advantage of the respondent-physician's failure to make the relevant legal arguments, the plaintiff-medical practice did not disclose to the First Department or even hint at the existence of the statutory and regulatory scheme governing demutualization under the Insurance Law and the Plan [R.238-256]. The medical practice even went so far as to title one section of its reply, "The Opposition Identifies No New York Law that Would Entitle Dr. Title to the Cash Consideration," conspicuously avoiding reference to Insurance Law §7307 [R.244].

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

In awarding the MLMIC proceeds to the medical practice, *Schaffer* cited to no New York law, only two out-of-jurisdiction federal cases: *Ruocco v. Bateman, Eichler, Hill, Richards, Inc.* (903 F.2d 1232 (9th Cir. 1990) and *Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710,*

Int'l Brotherhood. of Teamsters, 2005 U.S. Dist. LEXIS 42877 (N.D. Ill. 2005). Both cases involved esoteric questions of whether demutualization proceeds constituted "plan assets" under ERISA federal benefits law; a question which has no relevance to the instant dispute.

B. <u>*Schaffer* makes no sense in the context of the relevant law.</u>

The holding in *Schaffer* states in its entirety:

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

Schaffer, Schonholz & Drossman v. Title, 171 A.D.3d 465, 96 N.Y.S. 526 (1st Dep't 2019) (citations omitted).

Schaffer makes no reference to the Insurance Law, the Plan, or the DFS determinations. The decision does not, on its face, even acknowledge that the respondent was the *policyholder* (merely referring to her as the *insured*), or evidence any awareness of the significance of the respondent's status as policyholder under the Insurance Law. The decision makes no reference to whether or by what manner the policyholder might have assigned the proceeds to the employer, or that an

assignment was mandatory under the Insurance Law and Plan before demutualization proceeds could be paid to anyone other than the policyholder.

Instead, *Schaffer* relied only on the stipulated facts, and simply stated that the respondent-physician did not "bargain for the benefit of the demutualization proceeds," a proposition which the Hospital maintains should support its own entitlement to the Cash Consideration. *Id.* However, the Hospital's argument is completely illogical in light of the governing law. The right to demutualization proceeds under the Insurance Law and Plan vests solely in a policyholder, absent an assignment of that right.

The idea that policyholders are required to separately *bargain* for a right already conferred to them by statute is absurd and cannot be reconciled against the authorities which actually govern this dispute. Simply put, the *Schaffer* decision has no basis in – and indeed directly contradicts – applicable law.

C. The lower courts have felt compelled to follow *Schaffer* as *stare decisis.*

As a matter of judicial logistics, the parties in *Schaffer* submitted their dispute to the First Department in late-2018, before almost any other MLMIC-related litigation had been commenced and before any substantive disputes regarding the MLMIC proceeds (save for *Maple-Gate*) had been adjudicated. Despite *Schaffer's* unusual procedural posture, absence of substantive legal arguments or determinations, and lack of any analysis of relevant law, *Schaffer* was decided at the

appellate level far in advance of the many lawsuits being litigated on the Supreme Court level throughout New York.

Despite the clear limitations of *Schaffer*, other lower courts have understandably felt constrained to follow its determination in the absence of any other appellate precedent [App. Brief, at 35-41]. Expecting the same flawed and unjust result in the court below, the Hospital urged the Supreme Court to pay unquestioning adherence to *Schaffer*, hoping the court would refrain from an independent reasoned analysis of the underlying legal authorities. The Supreme Court rejected this notion, thoughtfully analyzed the dispute in the context of the governing authorities and pointedly noted, with respect to *Schaffer*, that "courts are free to correct prior erroneous interpretations of the law [R.10]."

V. THE HOSPITAL HAS STATED NO COGNIZABLE CLAIM UNDER THE EMPLOYMENT AGREEMENT.

A. The Employment Agreement does not support the Hospital's entitlement to the Cash Consideration.

As it did in the Supreme Court, the Hospital argues a contractual entitlement to the Cash Consideration, but opts to frame that claim as a breach of the implied covenant of good faith and fair dealing. "For a complaint to state a cause of action alleging breach of an implied covenant of good faith and fair dealing, the plaintiff must allege facts which tend to show that the defendant sought to prevent performance of the contract or to withhold its benefits from the plaintiff." *Aventine Inv. Mgmt., Inc. v. Canadian Imperial Bank of Commerce*, 265 A.D.2d 513, 514 (2d Dep't 1999).

"The rule [of the implied covenant] is grounded in many cases that in every contract there is an implied undertaking on the part of each party that he will not intentionally and purposely do anything to prevent the other party from carrying out the agreement on his part." *Grad v. Roberts*, 14 N.Y.2d 70, 75, 198 N.E.2d 26, 28 (1964) (internal citations omitted); *Kirke La Shelle Co. v. Paul Armstrong Co.*, 263 N.Y. 79, 87, 188 N.E. 163, 167 (1933) (neither party shall do anything to destroy or injure the right of the other party to receive fruits of contract); *1357 Tarrytown Rd. Auto, LLC v. Granite Properties, LLC*, 142 A.D.3d 976, 977 (2d Dep't 2016); *ABN AMRO Bank, N.V. v. MBIA Inc.*, 17 N.Y.3d 208, 228 (2011).

The language relied upon by the Hospital to support what it claims to be a contractual entitlement is found in Section 11 of the Employment Agreement. Section 11(a) provides that Dr. Hinds' employment would automatically terminate upon the happening of certain events, including revocation of his medical license, conviction of a felony, and termination of medical-staff privileges, among others [R.35-36]. In other words, this was the section of the Employment Agreement which allowed the Hospital to terminate Dr. Hinds' employment for cause.

Section 11(b) of the Employment Agreement, immediately following for-cause termination, states that "upon the termination of this Agreement for any of the foregoing causes, you shall only be entitled to receive the accrued but unpaid Base Salary, and Incentive Compensation, owed to you as of the date of your termination [R.36]." This provision simply states the uncontroversial proposition that if Dr. Hinds had been terminated for cause, the Hospital would not have had to continue paying him a salary after firing him. This is the only contractual provision relied upon by the Hospital in support of its contention that Dr. Hinds' Employment Agreement somehow entitles the Hospital to the Cash Consideration.

From its tortured interpretation of this provision, the Hospital synthesizes the conclusion that "Defendant agreed that he would not be entitled to receive any further monies arising from his employment relationship except for any accrued but unpaid compensation [R.28]," and that "[implicit] within that provision is an

agreement that Defendant would not attempt to obtain any additional compensation from third parties that would otherwise be due to the Hospital [R.28]."

This is simply not what the Employment Agreement says. Initially, the Hospital's argument that this language pertains to the Cash Consideration (money being paid by a third-party in exchange for Dr. Hinds' ownership interest) is illogical, as Cash Consideration is not "compensation" paid by the Hospital; it is the purchase price for Dr. Hinds' mutual interest paid to him by MLMIC.

Moreover, even granting the Hospital the very generous assumption that this provision *might* pertain to the Cash Consideration, the Hospital's breach-of-contract claim is undermined by two conflicting allegations its own Complaint. First, the Hospital admits that the sole provision it relies upon could only apply if Dr. Hinds was terminated for cause [R.20]. Second, the Hospital admits Dr. Hinds resigned (i.e. was *not* terminated for cause) on August 2, 2017 [R.22]. Thus, assuming for the sake of argument that this provision even *could* relate to the Cash Consideration, it would be of no effect here.

It is well-established that "*a cause of action for breach of the implied covenant of good faith and fair dealing … may not be used as a substitute for a nonviable claim of breach of contract*." *Sheth v. New York Life Ins. Co.*, 273 A.D.2d 72, 73, 709 N.Y.S.2d 74, 75 (1st Dep't 2000). In light of the plain inapplicability of the provisions it relies on, what the Hospital is essentially requesting is that the Court

rewrite the Employment Agreement to include terms upon which the parties never agreed, but which would conveniently entitle the Hospital to the Cash Consideration. There is simply no language in the Employment Agreement to support this *post-hoc* argument. It is well-established that courts will not read supplemental or inconsistent provisions into a contract long after both parties have rendered full performance. *Himmelberger v. 40-50 Brighton First Rd. Apartments Corp.*, 94 A.D.3d 817, 819, 943 N.Y.S.2d 118, 120 (2d Dep't 2012) (court cannot under guise of interpretation rewrite parties' contract to impose additional terms); *Reiss v. Fin. Performance Corp.*, 97 N.Y.2d 195, 199, 764 N.E.2d 958, 961 (2001) (courts may not by construction add or excise terms nor distort meaning of those used and thereby make new contract for parties under guise of interpretation).

B. The Supreme Court correctly determined that none of the Hospital's rights under the Employment Agreement were compromised.

The Supreme Court stated that "[in] all likelihood neither party appreciated that a windfall could occur as a result of the MLMIC sale, because, quite simply, they did not appreciate the value of an ownership stake prior to the demutualization plan… It cannot be therefore said that this cash contribution was negotiated or bargained for, but is simply rather an operation of law, and therefore no one's interest in the actual contract was compromised [R.13-14]."

The Hospital takes umbrage with the Supreme Court's conclusions and characterizes the parties' intent as an unresolved question of fact precluding

dismissal [App. Brief, at 20]. However, the Hospital never even alleged in the Complaint that there was any meeting of the minds on the issue of demutualization proceeds. Nor can the Hospital overcome the well-settled point that the parties' intent is to be discerned from the four corners of the document itself. *GHVHS Medical Services, P.C. v. Cornell*, Index #EF00161/2019, NYSCEF Doc. No. 47, p. 6 (Sup. Ct. Orange Co. 2020) (finding no contractual terms applicable to demutualization and granting summary judgment awarding MLMIC proceeds to physician-policyholder). If the Hospital wished to have a right to demutualization proceeds, nothing stopped it from bargaining for them in the Employment Agreement when the parties negotiated the contract. It cannot now ask this Court to rewrite the Employment Agreement to rectify its failure eight years after the fact.

Undermining the Hospital's position further, the Court of Appeals in *Dolman v. United States Trust Co. of New York*, 2 N.Y.2d 110, 116 (1956), stated that "unless a contract provides otherwise, the law in force at the time the agreement is entered into becomes as much a part of the agreement as though it were expressed or referred to therein, for it is presumed that the parties had such law in contemplation when the contract was made and the contract will be construed in the light of such law." *Id.* Under the *Dolman* Rule, when parties enter into a contract, courts will interpret the contract consistently with corresponding law. *Id.* at 214, 849. Contracting parties are presumed to have in mind all existing laws relating thereto, or the subject matter

thereof. Such laws enter into, define, and determine the contract. *See Sullivan County Harness Racing Association, Inc. v. City of Schenectady Off-Track Betting Commission*, 76 Misc.2d 558, 561 (Sup.Ct. Sullivan Co. 1973). The Hospital cannot claim ignorance of the law as an excuse for its failure to bargain for demutualization payments when negotiating the terms of the Employment Agreement.

Finally, the Hospital argues that under *Schaffer*, it is not its own failure but *Dr. Hinds'* failure to specifically bargain for the Cash Consideration. As discussed in *Point IV, supra*, the nonsensical proposition espoused in *Schaffer* that a lawful policyholder is required to bargain for rights *already conferred by law* is contrary to controlling authority and common sense.

The Hospital has no claim for breach of the implied covenant of good faith and fair dealing. Even taking the allegations in the Complaint as true, the Hospital cannot establish any *right* under the Employment Agreement that Dr. Hinds' might have injured. Thus, the Supreme Court's dismissal of the cause of action for breach of the implied covenant of good faith and fair dealing was proper and should be affirmed.

VI. THE HOSPITAL HAS NOT STATED AN EQUITABLE CLAIM, AND CANNOT USE EQUITY TO CIRCUMVENT THE CLEAR TERMS OF THE INSURANCE LAW AND THE PLAN.

A. The Hospital cannot circumvent a statutory entitlement by asserting equitable claims.

Apparently recognizing that its claim is not supported by statute, the Plan, the DFS determinations, or the Employment Agreement, the Hospital relies on equity to intervene and award it the Cash Consideration. Indeed, the basic thrust of the Hospital's argument is that this Court may disregard an express statutory mandate whenever adherence to the statute might be unfair.

This is a legally untenable proposition. As set forth by the Court of Appeals: "In interpreting statutes, which are the enactments of a coequal branch of government and an expression of the public policy of this State, we are of course bound to implement the will of the Legislature; statutes are to be applied as they are written or interpreted to effectuate the legislative intention." *Niesig v. Team I*, 76 N.Y.2d 363, 369, 558 N.E.2d 1030 (1990). *See Bordell v. Gen. Elec. Co.*, 208 A.D.2d 219, 221 (3d Dep't 1995).

"It is not the duty of courts to disregard the plain words of a statute, even in favor of what may be termed an 'equitable construction,' in order to extend it to some supposed policy not included in the act." Tompkins v. Hunter, 149 N.Y. 117, 123, 43 N.E. 532, 534 (1896) (internal citations omitted).

In *Golub v. New York State Tax Appeals Tribunal*, 116 A.D.3d 1261, 984 N.Y.S.2d 454 (3d Dep't 2014), the Third Department confirmed that under long settled principles of statutory interpretation, a court may not essentially rewrite an unambiguous statutory provision by ignoring explicit language, no matter how equitable the result may appear. 116 A.D.3d, at 1262, 984 N.Y.S.2d, at 456. *See Constellation Nuclear Power Plants LLC v. Tax Appeals Tribunal*, 131 A.D.3d 185, 193, 14 N.Y.S.3d 538, 545 (3d Dep't 2015).

This principle is universally recognized. As stated by the United States Supreme Court in *Guidry v. Sheet Metal Workers National Pension Fund*, 493 U.S. 365, 376, 110 S.Ct. 680, 687, 107 L.Ed.2d 282 (1990), "courts should be loath to announce equitable exceptions to legislative requirements or prohibitions that are unqualified by the statutory text." *Id.* A statute "should not be supplemented by extratextual remedies, such as common-law doctrines… " *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 497, 119 S.Ct. 755, 764, 142 L.Ed.2d 881 (1999), *citing*, *Guidry, supra*.

Identification of any remedies must be left to the Legislature. *See In re Merco Joint Venture LLC*, 2002 WL 32063450*3 (Bankr. Ct. E.D.N.Y. 2002); *see also National Railroad Passenger Corp. v. National Association of Railroad Passengers*, 414 U.S. 453, 457, 94 S.Ct. 690, 693, 38 L.Ed.2 646 (1974) (when legislation

expressly provides particular remedy, court should not expand statute's coverage to subsume other remedies).

It is well settled that when parties – especially sophisticated business people – enter into a contract, courts will enforce the contract as written and will not interpret a contract as impliedly stating something the parties did not include, thereby making a new or better contract. *Vermont Teddy Bear Co., Inc. v. 538 Madison Realty Co.*, 1 N.Y.3d 470, 807 N.E.2d 876, 775 N.Y.S.2d 765 (2004). As briefed to the Supreme Court and herein, the Hospital could have bargained for a *contractual* right to the Cash Consideration when it negotiated the Employment Agreement, yet it failed to do so.

In light of these facts and controlling authority, the Hospital may not look to equity to create a right where none exists.

B. <u>The Hospital failed to state a claim for unjust enrichment.</u>

"The essential inquiry in any action for unjust enrichment… is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered." *Paramount Film Distribution Corp. v. State of New York*, 30 N.Y.2d 415, 421 (1972), *rearg. den.*, 31 N.Y.2d 709 (1972). Thus, to prevail on a claim for unjust enrichment, a plaintiff must show "that (1) the other party was enriched, (2) at that party's expense, and (3) that 'it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered.'"

Citibank, N.A. v. Walker, 12 A.D.3d 480, 481, 787 N.Y.S.2d 48, 49 (2d Dept. 2004) (*citing, Paramount, supra*).

In support of its unjust-enrichment claims as well as its analogous cause of action for money had and received, the Hospital references the following allegations in its Complaint: (1) the Hospital selected the policy and made all the premium payments [R. 19, 21]; (2) the hospital was the policy administrator [R. 21]; (3) the Hospital's entitlement to the funds is supported by the fact that it was the beneficiary of rebates or refunds under Dr. Hinds' MLMIC policy [R. 21]; and (4) Dr. Hinds was never intended to be eligible for further monies beyond those specified in the Employment Agreement [R. 20, 36].

As thoroughly addressed herein, none of these allegations are a sufficient basis for surviving a motion to dismiss. Neither the Hospital's selection of the policy nor any payment of premiums gives it any right to the Cash Consideration, which belongs to Dr. Hinds. *See Points I and II, supra*. The Hospital's status as policy administrator and its receipt of refunds or rebates in that capacity likewise has no bearing on the disposition of the Cash Consideration. *See Point III, supra*. Finally, the plain terms of the Employment Agreement and lack of any reference to demutualization proceeds therein foreclose the existence of any contractual right to the Cash Consideration. *See Point V, supra*.

Even leaving all other considerations aside and disregarding the fact that all legal and statutory authority supports Dr. Hinds' entitlement to the Cash Consideration, it is axiomatic that to establish a claim for unjust enrichment, it is necessary to demonstrate that the defendant had been *unjustly enriched at the plaintiff's expense*. *E.J. Brooks Co. v. Cambridge Sec. Seals*, 31 N.Y.3d 441 (2018). In the instant matter, there can be no unjust enrichment as a matter of law, because Dr. Hinds has not been enriched *at the Hospital's expense*. The Hospital remitted premiums and served as policy administrator for Dr. Hinds' malpractice insurance policy as an inducement for his work, labor and services. In exchange for this promise, the Hospital received a skilled OB/GYN physician insured by a malpractice policy, and the right to bill and collect for his professional services. In other words, the Hospital received *exactly what it bargained for*.

As articulated by the court in *Maple-Gate*, "an unjust enrichment claim presupposes that the plaintiff has an ownership interest in the property or benefit it seeks to recover from the defendant… " M*aple-Gate*, *supra*, at 841 (*citing, Roslyn Union Free Sch. Dist. v. Barkan*, 71 A.D.3d 660, 896 N.Y.S.2d 406 (2010)). With respect to unjust enrichment, the court also clarified that "[the] doctrine is a narrow one and is not a catchall cause of action to be used when others fail." *Id.* (*citing, E.J. Brooks Co.*, *supra*, at 445).

It is also important to note that "[enrichment] alone will not suffice to invoke the remedial powers of a court of equity. Critical is that under the circumstances and as between the two parties to the transaction the enrichment be *unjust*." *McGrath v. Hilding*, 41 N.Y.2d 625, 629, 363 N.E.2d 328, 331 (1977) (emphasis added). The mere fact that one's activities bestowed a benefit on another is insufficient to establish an unjust-enrichment claim. Generally, courts will look to see if a benefit has been conferred 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. *Clark v. Daby*, 300 A.D.2d 732, 732, 751 N.Y.S.2d 622, 623–24 (3d Dep't 2002).

Here, the mere fact that Dr. Hinds is entitled to the cash consideration arising out of his ownership in MLMIC, the Insurance Law, Plan and DFS Decision, does not equate to enrichment which is *unjust*. *Shoback v. Broome Obstetrics and Gynecology, P.C.*, Index No. EFCA2018003334, NYCEF Doc. 45 at 5 (Sup. Ct. Broome Co. 2019) ("fact that [MLMIC proceeds are] a windfall does not, per se, render it illicit or unjust"). There was no mistake of law or fact at the time the parties entered into or fulfilled the terms of Dr. Hinds' employment contract; and the Hospital was aware that it was procuring an individual malpractice policy for Dr. Hinds of which he would be policyholder and owner. Furthermore, Dr. Hinds'

conduct with respect to the MLMIC funds has been neither tortious nor fraudulent. He merely asserts a right to that which is unequivocally his under applicable law.

Both parties have received the full benefit of their bargained-for exchange in which the Hospital agreed to pay the premiums to MLMIC and Dr. Hinds agreed to work for the Hospital. Any knee-jerk notions of "unfairness" by the Hospital in light of the benefit Dr. Hinds will realize as a result of the demutualization are not actionable. As stated aptly by the Supreme Court when analyzing this exact issue: "*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.13] (emphasis added).

C. The Hospital's cause of action for money had and received was properly dismissed

For the same reasons its unjust enrichment claim is without merit, the Hospital's Third Cause of Action for money had and received must also fail. The elements of a cause of action for money had and received are: (1) receipt of money *belonging to the plaintiff*; (2) the recipient benefited from that money; and (3) equity and good conscience will not permit the receipt to keep the money. *Torrance Const., Inc. v. Jaques*, 127 A.D.3d 1261, 1263, 8 N.Y.S.3d 441, 445 (3d Dep't 2015).

Courts in the Third Department draw no distinction between unjust enrichment and other quasi-contractual claims such as money had and received. *See*

Matter of Witbeck, 245 A.D.2d 848, 666 N.Y.S.2d 315 (3d Dep't 1997); *see also J.C. Penney Corp. v. Carousel Center Co., L.P.*, 635 F.Supp.2d 126 (N.D.N.Y. 2008), at n.1. The Hospital's claims for unjust enrichment and money had and received were likewise treated as analogous by the Supreme Court [R.12-13].

As with its cause of action for unjust enrichment, the Hospital's claim for money had and received is based on the unsupportable premise that the Hospital has an ownership interest in the Cash Consideration. As already detailed at length, the Hospital has no such interest. This is true regardless of whether it selected the policy, paid the premiums, or served as the policy administrator.

The Hospital's cause of action for money had and received was thus properly dismissed by the Supreme Court, and the Supreme Court's determination should be affirmed.

CONCLUSION

Insurance Law §7307(e)(3), the Plan, and the legal determinations of DFS all provide that demutualization proceeds are payable to an eligible *policyholder*, and no other party, absent a designation of those rights. The Hospital's own admissions in the Complaint establish that Dr. Hinds made no such designation. The Employment Contract, by its plain terms, vests no right in the Hospital to the Cash Consideration, and the Hospital's equitable claims consist of nothing more than a request that the Court rewrite controlling law and the parties' agreement for the Hospital to receive the Cash Consideration without having bargained for it.

In the clear absence of any statutory or contractual right to the Cash Consideration, the allegations in the Complaint – essentially amounting to the unsupportable assertion that both the governing law and the language of the contract are unfair – are an inadequate foundation upon which to maintain this action. The pertinent facts are undisputed and prove conclusively and as a matter of law that Dr. Hinds is entitled to retain the proceeds from the sale of his mutual ownership interest in MLMIC. Thus, even taking all the allegations in the Complaint as true, the Hospital has stated no claim.

Based on the foregoing, Dr. Hinds respectfully requests that the Supreme Court's holding be affirmed.

Dated: March 5, 2020

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APPELLATE DIVISION – THIRD DEPARTMENT
PRINTING SPECIFICATIONS STATEMENT

I hereby certify pursuant to 22 N.Y.C.R.R. Section 1250.8(j) that the forgoing brief was prepared on a computer using Microsoft Word.

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

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Addendum

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

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]).

"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

TO: All parties by e-filing.

At a term of the IAS Part of the Supreme Court of the State of New York, held in and for the County of Orange located at 285 Main Street, Goshen, New York 10924 on the 6th day of January, 2020.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

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

GHVHS MEDICAL GROUP, P.C.,

PLAINTIFF,

-AGAINST-

LORRAIN ALLEGRO-SKINNER; MEDICAL LIABILITY MUTUAL INSURANCE COMPANY; and COMPUTERSHARE TRUST COMPANY,

DEFENDANTS.

DECISION AND ORDER
Index No. EF001608-2019
Motion Date: 9/6/19
Motion Seq. #1 & #2

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 22 were read on Plaintiff's motion for partial summary judgment on its first and eighth causes of action, or in the alternative, on its fifth and eighth causes of action, and a dismissal of Allegro-Skinner's counterclaim(seq. #1); and on Defendant Allegro-Skinners cross-motion(seq. #2) for a declaration that she is the owner and policy-holder of the medical malpractice policy held by MLMIC and entitled to the escrow money being held by Computershare in the amount of $39,325.00;

Notice of Motion/Affirmation of Mitchell Berns, Esq./Exhibits A - G/Affidavit of Joseph Anesi/Exhibits A - F/Memorandum of Law/Supplemental Affidavit of Joseph Anesi ..... 1 - 18
Notice of Cross-Motion/Affidavit of Lorraine Allegro-Skinner/Memorandum of Law in Opposition to motion and in Support of Cross-motion ..... 19 - 21
Memorandum of Law in Opposition to Cross-motion /Affirmation in Opposition to Cross-motion of Matthew Schenker, Esq. 22

This action is in essence, one for a declaratory judgment to determine who should receive the windfall profit created when the medical malpractice insurer, MLMIC, converted from a mutual insurance company to a publically traded one. This process is called 'demutualization' and is heavily regulated by the New York State Department of Insurance. This is the fourth case of this nature where this Court has considered similar arguments and rendered a declaratory opinion. In all prior cases, this Court found that the employment contract was silent as to who

should receive the proceeds, and that Defendant/Doctors would not be unjustly enriched by receiving the proceeds of this sale.[1]

The facts in this case are similar to the prior cases decided by this Court. Here, Plaintiff/Provider and the Defendant/Doctor entered into an extensive written employment contract on or about March 13, 2014 which was effective on or about June 2, 2014. (See "Agreement, Exhibit A). The Physician was employed by the Provider until February 26, 2016. The employment contract included a base salary of $200,000 per year, and the agreement that the Provider would pay all the medical malpractice premiums of the Doctor as part of employment. As part of the negotiation, the Plaintiff had the discretion to choose the insurer and the Doctor was required to cooperate by applying to that insurer for medical malpractice insurance. There is no dispute that the Doctor agreed to allow the Plaintiff to be the 'administrator' of the insurance policy and a form was signed by the Doctor permitting that to occur. This form was created by the insurance company MLMIC, and presented to the Doctor by the Plaintiff. The form gives limited power to the Plaintiff to pay the premiums and receive dividends to offset the cost of the policy, but it does not affect the status of policy holder/member in any way. Plaintiff has submitted no proof that the unexpected demutualization was discussed or addressed between the parties in any way when the employment contract was negotiated and signed. Accordingly, under the terms of the contract, Plaintiff has no right to the proceeds.

Looking at the contract provisions of MLMIC, it is clear that the Doctor is a member of the mutual insurance company. Article II, Section One defines members as policy holders, and Dr. Allegro-Skinner is the policy holder. Plaintiff points to an e-mail letter from MLMIC to its members regarding the sale of the company dated July 18, 2016 which states that "...In most

[1]See *GHVHS v. Arthurs, et al* Index No. EF001609-2019; *GHVHS v. Cornell, et al* Index No. EF001610-2019; *GHVHS v. Sidorski-Nutt*, et al Index No. EF001620-2019.

cases, the person or entity that paid the premium will be considered as the owner of the eligible policy...", this letter is mere rhetoric as the terms of the sale had to be approved by the Department of Insurance after public hearings. Although the Providers voiced objections at the public hearing, the term actually placed into the approved plan was 'policy holder' or its 'assignee', not the person who paid the premium. Therefore, once again, a plain reading of the approved Plan for demutualization requires the Doctor to be recipient of the funds unless the doctor assigns their right to the provider.

Plaintiff also argues that Defendant/Doctor would be unjustly enriched by allowing them to receive all the profits. This Court disagrees. When the contract was written, neither party imagined that the insurance company they chose would be sold and distribute thousands of dollars to policy holders. The terms of the contract indicate that Plaintiff agreed to pay the premiums as well as receive dividends to help offset the cost of the policy. This was recognized by both parties as part of the compensation due to the Doctor. Both parties received the benefit from these terms as both parties needed the malpractice insurance to protect themselves.

When considering the law of unjust enrichment, Plaintiff must prove "...the defendants were enriched, at the plaintiff's expense, and that it is against equity and good conscience to permit the defendants to retain what is sought to be recovered (citing *Old Republic Natl. Tit. Ins. Co. v. Luft*, 52 A.D.3d 491, 859 N.Y.S.2d 261). " 'The essence of unjust enrichment is that one party has received money or a benefit at the expense of another' " (*Goldman v. Simon Prop. Group, Inc.*, 58 A.D.3d 208, 220, 869 N.Y.S.2d 125, quoting *City of Syracuse v. R.A.C. Holding*, 258 A.D.2d 905, 906, 685 N.Y.S.2d 381)." *County of Nassau v Expedia, Inc.*, 120 AD3d 1178, 1180 [2d Dept 2014]. In this case, Plaintiff has not met this burden, and Defendant will not be enriched at the expense of another. In fact, quite the opposite is true. Aside from the fact that

Plaintiff is requesting thousands of unexpected dollars from each doctor who was a policy holder, the facts here are akin to those cases involving the voluntary payment doctrine. This doctrine, " ...bars recovery of payments voluntarily made with full knowledge of the facts, and in the absence of fraud or mistake of material fact or law" *(citing Dillon v. U–A Columbia Cablevision of Westchester,* 100 N.Y.2d 525, 526, 760 N.Y.S.2d 726, 790 N.E.2d 1155; and *Gimbel Bros. v. Brook Shopping Ctrs., Inc.*, 118 A.D.2d 532, 535–536, 499 N.Y.S.2d 435)." *Wells Fargo Bank, N.A. v Burke*, 155 AD3d 668, 671 [2d Dept 2017]. Plaintiff voluntarily paid the premiums of the Defendants malpractice insurance knowing that they would only, at best, be reimbursed by the amount of dividends. It was in Plaintiff's best interest to ensure the payment of the medical malpractice and paying these premiums was not a result of fraud or mistake. Accordingly, Plaintiff has failed to show that Defendant would be unjustly enriched.

Therefore, upon a reading of all the papers submitted herein, it is hereby

ORDERED, ADJUDGED and DECREED that plaintiffs' motion, made pursuant to CPLR §3212, for an order granting Plaintiff summary judgment on the first and eighth causes of action in the complaint for a declaratory judgment as against all defendants is denied; and it is further

ORDERED, ADJUDGED and DECREED that plaintiffs' motion for an order granting summary judgment on the fifth and eighth causes of action in the complaint as against all defendants is denied; and it is further

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

ORDERED, ADJUDGED and DECREED that Defendant, Lorraine Allegro-Skinner, MD's motion and counterclaim for a declaratory judgment in her favor, is granted. This Court

declares that the "eligible policy holder" is Lorraine Allegro-Skinner, and she is entitled to the escrowed amount of $39,325.00 as her share of the sale and demutualization of MLMIC as determined by the Plan which was approved by the Department of Insurance, and it is further

ORDERED, ADJUDGED and DECREED that Defendants, MLMIC and Computershare Trust Co., NA shall pay to Defendant, Lorraine Allegro-Skinner the amount of $39,325.00 within fifteen (15) days of the service of this Order, with Notice of Entry, upon the escrow agent.

The foregoing constitutes the Decision and Order of the Court.

Dated: January 6, 2020
Goshen, New York

Enter,

Hon. Maria S. Vazquez-Doles, J.S.C.

To: Counsel of record via NYSCEF.

At a term of the IAS Part of the Supreme Court of the State of New York, held in and for the County of Orange located at 285 Main Street, Goshen, New York 10924 on the 7th day of October, 2019.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

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

GHVHS MEDICAL GROUP, P.C.,

PLAINTIFF,

-AGAINST-

GILLY ARTHURS, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A.,

DEFENDANTS.

DECISION AND ORDER
Index No. EF001609-2019
Motion date: 8/2/19
Motion #2

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 15 were read on Plaintiff's motion for partial summary judgment on the first and eighth causes of action, or in the alternative its fifth and eighth causes of action;

Notice of Motion/Affirmation of Mitchell Berns Esq./Exhibits A - F/
Affidavit of Joseph Anesi/Exhibits A - E/Memorandum of Law ..... 1 - 15

Plaintiff commenced this action to determine its right to receive monies from the sale and demutualization of Defendant Medical Liability Mutual Insurance Company, (hereinafter MLMIC). MLMIC demutualized the insurance company with the approval of the NYS Department of Insurance, and sold their company to Berkshire Hathaway. As part of the plan which was approved by the NYS Department of Insurance, each "Eligible Policyholder" or its "Designee" were to receive a payment reflecting its pro rata share of the cash consideration, allocated according to the amount of the premium paid on the policy. In this case, Gilly Arthurs was the "eligible policy holder" entitled to receive approximately $4,744.00. The money is currently being held in escrow by Computershare. Plaintiff alleges that they are entitled to the money as they have paid all the premiums on behalf of Arthurs, have been the administrator of

the medical malpractice insurance policy and the sole recipient of any dividends.[1] Plaintiff further alleges that many other doctors and nurse practioners agreed to assign their rights to Plaintiff, but Arthurs refused because of a dispute about money owed on her final paycheck. Plaintiff seeks relief of a declaratory judgment which finds Plaintiff is the rightful recipient of the funds as they have paid all the premiums for the insurance policy, without contributions from Arthurs. Plaintiff argues in the alternative that Arthurs will be unjustly enriched if she is declared to be the recipient.

Defendant, Gilly Arthurs, has not filed a response to this motion sequence number 2, but in her pro-se response to motion sequence number 1, she states that Plaintiff owes her money for accrued time and has refused to pay because she breached the employment contract. The letter also indicates that she would assign her rights if Plaintiff paid her the $9,887.50 which she alleges is owed from leave accrual.

Defendant, MLMIC and Computershare have not filed any opposition papers to this motion either.

DISCUSSION:

The pertinent undisputed facts in the case show that an employment contract was signed between Plaintiff and Arthurs in May of 2016. The employment contract specifically stated that Plaintiff "...will maintain professional liability insurance on behalf of each party at its sole cost and expense." (Employment Contract Pg 5). The contract is silent as to demutualization and acquisition with future profits. The plan for demutualization and acquisition was approved by the NYS Department of Insurance on September 6, 2018, thus the parties were unaware that this future event would occur when they signed the employment contract.

[1]Although Plaintiff makes this claim regarding dividends, there is no evidence submitted to support that dividends were actually distributed by MLMIC prior to the sale and demutualiztion.

Since the written contract between the parties does not specifically address the issue of who should receive the profits of the sale, the Court is faced with the question of who is the proper recipient of those funds. Plaintiff argues that they should receive the profits as they were the 'administrators" of the policy and that it would be inequitable to allow Defendant Arthurs to be unjustly enriched when she did not pay for or administer the malpractice insurance.

Under a plain reading of the insurance law, which addresses reorganization of a mutual insurer, Arthurs is clearly the policy holder. New York Insurance Law §7312 states in part, "Policyholder" means a person, as determined by the records of a mutual life insurer, who is deemed to be the "policyholder" of a policy or annuity contract...". Gilly Arthurs is the named policyholder. The Plan which was approved by the Department of Insurance, allows for the policyholder to assign its rights to the profit. In this case, Arthurs refused to assign her rights, thus a plain reading of the contract and law would result in Arthurs receiving any profit from the demutualization and acquisition.

However, Plaintiff argues that this result would be unjust as they have paid the cost of the policy since the inception and have been noted as the policy administrator. To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered ". *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018] (citing *Goel v. Ramachandran*, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428, quoting *Paramount Film Distrib. Corp. v. State of New York*, 30 N.Y.2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695)."). 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. (citations omitted)". *Betz v Blatt,* 160 AD3d 696,

701 [2d Dept 2018]. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law if the benefit remains with Defendant as neither party was even aware of this benefit at the time the employment contract was signed. The benefit still remains with the Defendant as the Department of Insurance considered Plaintiff's claims during the demutualization process and did not change the language of what constitutes an "eligible policyholder", when Plaintiff and others made objections at the public hearing.

Accordingly, upon a review of the foregoing papers, and case law addressing this issue around the State of New York, and considering the specific facts of this case, it is hereby

ORDERED, ADJUDGED and DECREED that Plaintiff's motion for partial summary judgment on the first and eighth causes of action is denied. This Court declares that the "eligible policy holder" is Gilly Arthurs and she is entitled to $4,774.00 as her share of the sale and demutualization as determined by the Plan. The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits, but Defendant, Arthurs chose not to do so. The employment contract required Plaintiff to pay all the premiums of the medical malpractice insurance held by MLMIC, but it did not bargain in the agreement for who should receive any monies which might flow should there be a demutualization and sale, and it is further

ORDERED, ADJUDGED and DECREED that Plaintiff's motion for a finding of unjust enrichment is also denied. There has been no unjust enrichment because Plaintiff agreed to pay the premiums as part of the employment agreement offered to Dr. Arthurs. "To prevail on a claim of unjust enrichment, a party must show that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered" (citing *Goel v. Ramachandran*, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428 [internal quotation marks omitted])." *FoxStone Group, LLC v Calvary*

Pentecostal Church, Inc., 173 AD3d 978, 981 [2d Dept 2019]. While Dr. Arthurs may be enriched by receiving this profit, she is not being enriched at the expense of the Plaintiff. Plaintiff fully expected to pay all the insurance premiums, without repayment, as part of the compensation to Defendant, when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit paid to the policyholders. Therefore Defendant's enrichment is not at Plaintiff's expense, but rather an unforeseen benefit of the bargain, and it is further

ORDERED that Defendants, MLMIC and Computershare take all steps necessary to transfer the payment now being held in escrow, to Gilly Arthurs within 30 days of the posting of this notice to NYSCEF.

Counsel is directed to serve Defendants with a copy of this Order within 30 days of the date of this decision.

The foregoing constitutes the Decision and Order of the Court.

Dated: October 7, 2019
Goshen, New York

ENTER,

Hon. Maria S. Vazquez-Doles, J.S.C.

To: Counsel of record via NYSCEF.

Gilly Arthurs, NP
29 Grandview Terrace
Chester, New York 10918

At a term of the IAS Part of the Supreme Court of the State of New York, held in and for the County of Orange, at 285 Main Street, Goshen, New York 10924 on the 6 day of January, 2020.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

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

GHVHS MEDICAL GROUP, P.C. and ORANGE REGIONAL MEDICAL CENTER,

Plaintiffs,

-AGAINST-

DAVID CORNELL, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A.

Defendants.

DECISION AND ORDER
INDEX #EF001610/2019
Motion date: 09/05/19
Motion Seq.#1

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 18 were read on plaintiffs' motion for summary judgment on their first and eighth causes of action or, in the alternative, on their fifth and eighth causes of action against the defendants and dismissing defendant, David Cornell's counterclaim:

Notice of Motion/Berns Affidavit/Exhibits A - G/Anesi Affidavits/
Exhibits A-F/Memorandum of Law ..... 1 - 7
Gitomer Affirmation in Opposition/Cornell Affidavit/Exhibits 1-2/
Memorandum of Law ..... 8 - 11
DeLaHoz Affirmation in Response/Exhibit 1 ..... 12, 13
Craw Affidavit in Response/Exhibit A 14, 15
Reply Affirmation/Exhibit A/ Memorandum of Law ..... 16 - 18

In this action, the single legal issue is whether the physician employee, defendant, David Cornell, or the employer, Orange Regional Medical Center together with GHVHS Medical Group, P.C., (the "Provider") is entitled to a distribution payment made by Medical Liability Mutual Insurance Company ("MLMIC"). MLMIC is a medical malpractice insurance company that issued a policy covering Cornell that was paid for as part of the employment contract, by the Provider as his employer. The parties seek, in essence, a declaratory judgment resolving this one

central issue.

GHVHS Medical Group, P.C. (the "P.C.") is affiliated with two not-for-profit hospitals, one of which is plaintiff, Orange Regional Medical Center ("ORMC") located in Orange County, New York. ORMC is an acute care hospital licensed to operate 383 beds in Middletown, New York. Pursuant to the employment agreement effective October 22, 2013, between Cornell as employee and ORMC as employer, Cornell served as Medical Director for ORMC's trauma program. The Agreement was later assigned to the PC on December 1, 2014. Cornell was employed by the PC until September 10, 2015. The Agreement details Cornell's compensation and other party obligations. It specifies that the employer is to provide medical malpractice coverage to the Physician at the employer's expense (Agreement at ¶5). There is no dispute that Plaintiff/Provider was designated by Cornell to serve as his agent for the purpose of administering the policy, the coverages, the reporting requirements, and the payment of the premium.

The policy insuring Cornell was issued by MLMIC. At the time the insurance policy was issued, MLMIC was a mutual insurance company owned by its policyholders, one of whom was Cornell. Thereafter, MLMIC negotiated a sale of its business to a subsidiary of Berkshire-Hathaway, which formed a stock company, and paid MLMIC $2.5 Billion for the MLMIC assets. This demutualization plan ("the Plan") was approved by the New York State Department of Financial Services pursuant to Insurance Law §7307. The Plan includes the methodology for the pro rata distribution of the proceeds of the sale to parties in interest. As for Cornell's policy, the amount for the distribution allotted to the policy is $197,539.89 ("the Payment" - $181,104.82 related to Cornell's employment with ORMC and $16,435.07 related to

his employment with the PC. The question presented here is whether Cornell or plaintiffs are entitled to the Payment.

Defendants, MLMIC and Computershare respond to the instant motion without taking a position as to the merits. MLMIC admits that on October 4, 2018, due to a 'misclassification', MLMIC issued the allocable share of cash consideration related to Cornell's employment with ORMC in the amount of $181,104.82 directly to Cornell. Thus, based upon the disagreement of the parties, only a portion of the Payment is being held in the MLMIC escrow account pending resolution of the dispute. The escrow amount is $16,435.07. MLMIC sent a letter to Cornell on January 7, 2019 demanding return of the distributed cash consideration, but despite such demand, Cornell has not returned the funds.

The Amended complaint asserts eight causes of action including; *inter alia*, declaratory judgment; breach of contract and unjust enrichment. The answer of Cornell includes a counterclaim for declaratory judgment in his favor. Plaintiffs now move for summary judgment, in essence seeking a declaration that they are entitled to the Payment.

Plaintiffs ask the Court to follow the recent decision of the Appellate Division, First Department in *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465 (the "Matter of Schaffer"), decided April 4, 2019. Plaintiffs argue that it is dispositive of the issues raised in this matter.

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

A review of the facts in the *Matter of Schaffer* reveals that the litigation, like this action, involved a physician named as insured on a MLMIC policy. The doctor's employer, similar to the Provider, purchased the policy and paid all of the premiums and costs related to the policy. Like Cornell, the doctor acknowledged that she did not pay any of the premiums or any of the other costs related to the policy. Further, like Cornell, the doctor designated her employer as the 'Policy Administrator'. Plaintiff argues that as policy administrator, they had the right to receive return premiums, including dividends when due. Both doctors acknowledged that she did not bargain for the benefit of the demutualization proceeds, but then neither did the hospital/provider. Under the facts of *Schaffer*, the court held that: "Awarding [the doctor] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment (citations omitted)." Similar to the *Matter of Schaffer*, the named employer here purchased and paid all of the premiums on the medical professional insurance policy covering the physician who now seeks the distribution payment based on the policy.

In the instant case, Defendant/Cornell attempts to distinguish the facts from the facts in the *Matter of Schaffer* alleging that he specifically bargained for the right to obtain and receive his own MLMIC professional liability insurance policy and all benefits that flowed from such policy including the right to any demutualization proceeds. Cornell acknowledges that he agreed to designate Plaintiff as a "policy administrator' but that designation said nothing about demutualization proceeds. Cornell submits the policy administrator change form in support of this argument. This form states in part, "*The Policy Administrator is the agent of all insureds herein for the paying of the premium, requesting changes in the policy, including cancellation thereof and receiving dividends and any return premiums when due. By designating a Policy*

Administrator each insured gives us permission to release information about each such Insured, your practice or any other information that we may have to such Policy Administrator." Nowhere in this form does it mention proceeds of demutualization.

In support of his claim to have bargained for the benefit of the Payment, Cornell submits an affidavit in which he acknowledges the Employment Agreement which requires that the Provider provide the physician with malpractice "coverage", from a company of the Providers choice, including self-insured plans. There was no requirement that the physician be provided with a policy from a mutual insurer featuring ownership benefits. Cornell further argues that this medical coverage was an employment incentive- "...was part of my compensation..."(Cornell Aff'd ¶9), and that this contract was carefully negotiated with his attorney. Cornell makes no allegation that the Agreement is ambiguous in any way and does not allege that demutualization was discussed at all, simply that neither party anticipated the demutualization event.

Cornell further argues that the First Department's decision in the *Matter of Schaffer* is not binding on this court as this case was filed in the Second Department. Cornell further contends that, in any event, the First Department's determination based on the principles of unjust enrichment was in error because the issue was not properly argued to the appellate court.

While it is true that courts are bound by the doctrine of *stare decisis,* to apply precedent established in another Department until a contrary rule is established by the Appellate Division in its own Department or by the Court of Appeals, (see *Phelps v. Phelps*, 128 A.D.3d 1545 [4th Dept. 2015]; *D'Alessandro v. Carro*, 123 A.D.3d 1 [4th Dept. 2015]; *see Mountain View Coach Lines v. Storms*, 102 A.D.2d 663, 664–665 [2d Dept. 1984],) caution must be applied in some cases. (See *People v Hobson*, 39 NY2d 479, 489-90 [1976], which recognized that conclusory

assertions should be carefully scrutinized.) In this instance, the First Department's two paragraph decision summarily concludes that it would be an unjust enrichment to award the proceeds to the doctor.

In the facts of this case, the parties agreed upon an extensive employment contract. It is clear from the terms of the contract that the cost of medical malpractice insurance would be additional compensation for the doctor as it was being paid by the Provider. Neither party anticipated or bargained for the demutualization, and there are no terms in the contract which suggest how the profits should be disbursed. Applying the clear law of contracts to the case at bar, two contract principals are present in this case. First "... a contract is to be construed in accordance with the parties' intent, which is generally discerned from the four corners of the document itself. Consequently, 'a written agreement that is complete, clear and unambiguous on its face must be enforced according to the plain meaning of its terms' " (citing *MHR Capital Partners LP v. Presstek, Inc.*, 12 N.Y.3d 640, 645, 884 N.Y.S.2d 211, 912 N.E.2d 43, quoting *Greenfield v. Philles Records*, 98 N.Y.2d 562, 569, 750 N.Y.S.2d 565, 780 N.E.2d 166)." *Legum v Russo*, 133 AD3d 638, 639 [2d Dept 2015]. Moreover, this Court is mindful of the fact that "...courts may not by construction add or excise terms, nor distort the meaning of those used and thereby 'make a new contract for the parties under the guise of interpreting the writing.' (citing *Heller v. Pope*, 250 N. Y. 132, 135; *Friedman v. Handelman*, 300 N. Y. 188, 194.)" *Morlee Sales Corp. v Manufacturers Tr. Co.*, 9 NY2d 16, 19-20 [1961]. Applying this law to this employment contract, there are no terms which address proceeds of demutualization.

A review of the Superintendent's Decision approving the demutualization plan orders that the proceeds shall go to the " eligible policyholders", or their "assignees" unless an objection is

timely filed, in which case the proceeds are to be held in escrow until the dispute is resolved. Insurance Law §7307(e)(3) defines the group of persons who are eligible to receive the proceeds of demutualiztion as "Eligible Policyholders". There is no dispute that Dr. Cornell is the 'eligible policyholder'. This definition does not differentiate between who pays the premiums and who does not. In fact, because every situation/employment contract is different, a process was set up to put disputed funds in escrow until the dispute is resolved by the courts or arbitration. In the instant case, Dr. Cornell, the eligible policy holder, chose not assign the proceeds to the Provider and is contesting their right to the same.

To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered ". *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018] (citing *Goel v. Ramachandran*, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428, quoting *Paramount Film Distrib. Corp. v. State of New York*, 30 N.Y.2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695)."). 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. (citations omitted)". *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018]. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed. A close reading of the Department of Insurance decision reveals that Plaintiff's claims were considered during the demutualization process, but they did not change the language of what constitutes an "eligible policyholder", even though Plaintiff and others made objections at the public hearing.

Accordingly there is no unjust enrichment if the Defendant/doctor receives the money in this case.

In rendering this decision, the Court has considered its prior ruling in the case of GHVHS MEDICAL GROUP, P.C. v. GILLY ARTHURS, et al under Orange County Index No. EF001609-2019 wherein this Court found that the rightful owner of those funds was the policy holder, Gilly Arthurs. Although the Second Department has not addressed one of these cases thus far, many similar cases have been filed in Orange County. To rule that the Providers should receive the money in every case would unjustly enrich the Providers who never bargained for this windfall. Furthermore, it may open the flood gates to every type of profession which negotiated the payment of malpractice insurance as part of the employment contract. This Court believes the issue is fact specific, and turns on the language of each individual contract of employment. Plaintiff argues the catchall phrase of 'unjust enrichment' to support a finding that this windfall profit should go to them. However, factually no one knew that this company would be demutualized and there were no contract terms addressing the situation. This Court finds that when a contract fails to state the terms specifically, a ruling must be against the drafter of the contract, which in this case is the provider. (See for example, *Mejia v Trustees of Net Realty Holding Tr.*, 304 AD2d 627, 628 [2d Dept 2003]).

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

ORDERED, ADJUDGED and DECREED that plaintiffs' motion, made pursuant to CPLR §3212, for an order granting Plaintiff summary judgment on the first and eighth causes of

action in the complaint for a declaratory judgment as against all defendants is denied; and it is further

ORDERED, ADJUDGED and DECREED that plaintiffs' motion for an order granting summary judgment on the fifth and eighth causes of action in the complaint as against all defendants is denied. There has been no unjust enrichment because Plaintiff agreed to pay the premiums as part of the employment agreement offered to Dr. Cornell. While Dr. Cornell may be enriched by receiving this profit, he is not being enriched at the expense of the Plaintiff. Plaintiff fully expected to pay all the insurance premiums, without repayment, as part of the compensation to Defendant, when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit paid to the policyholders. Therefore Defendant's enrichment is not at Plaintiff's expense, but rather an unforeseen benefit of the bargain, and it is further

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

ORDERED, ADJUDGED and DECREED that Defendant, David Cornell's counterclaim for a declaratory judgment in his favor, is granted. This Court declares that the "eligible policy holder" is David Cornell and he is entitled to both the $181,104.82, already disbursed, as the amount of the ORMC payment, and the escrowed amount of $16,435.07 as the amount of the PC payment, as his share of the sale and demutualization as determined by the Plan. The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits, but Defendant, Cornell chose not to do so. The employment contract required Plaintiff to pay all the premiums of the medical malpractice insurance held by MLMIC, but it did not bargain in the agreement for who should receive any monies which might flow should there

be a demutualization and sale, and it is further

ORDERED, ADJUDGED AND DECLARED that Defendant, David Cornell is entitled to the receipt from the escrow agent currently holding funds due it in the amount of $16,435.07 plus accrued interest, if any, as to said amount representing the pro rata amount assigned to the account of DAVID CORNELL, which amount shall be paid to Defendant, David Cornell, within fifteen (15) days of the service of this Order, with Notice of Entry, upon the escrow agent; and it is further

ORDERED, ADJUDGED and DECREED that upon compliance with this Order, namely payment of the amounts due defendant, the action shall be dismissed with prejudice.

The foregoing constitutes the Decision and Order of this Court.

Dated: January 6th, 2019
Goshen, New York

ENTER:

HON. MARIA S. VAZQUEZ-DOLES, J.S.C.

TO: Counsel via NYSCEF

At a term of the IAS Part of the Supreme Court of the State of New York, held in and for the County of Orange located at 285 Main Street, Goshen, New York 10924 on the 6th day of January, 2020.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

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

GHVHS MEDICAL GROUP, P.C.,

PLAINTIFF,

-AGAINST-

LORI SIDORSKI-NUTT; MEDICAL LIABILITY MUTUAL NSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A.,

DEFENDANTS.

DECISION AND ORDER
Index No. EF001620-2019
Motion Date: 9/6/19
Motion Seq. #1

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 31 were read on Plaintiff's motion for partial summary judgment on the first and eighth causes of action, or in the alternative its fifth and eighth causes of action, and to dismiss Defendants' counterclaims;

Notice of Motion/Affirmation of Mitchell Berns Esq./Exhibits A - G/
Affidavit of Joseph Anesi/Exhibits A - F/Memorandum of Law ..... 1 - 17
Affirmation in Opposition of Justin Heller, Esq./Exhibits A - F/Memorandum
of Law/Affidavit of Lori Sidorski-Nutt/Exhibits A - D ..... 17 - 30
Memorandum of Law in Reply 31

Plaintiff commenced this action to determine its right to receive monies from the sale and demutualization of Defendant *Medical Liability Mutual Insurance Company*, (hereinafter MLMIC). MLMIC demutualized the insurance company with the approval of the NYS Department of Insurance, and sold their company to Berkshire Hathaway. As part of the plan which was approved by the NYS Department of Insurance, each "Eligible Policyholder" or its "Designee" were to receive a payment reflecting its pro rata share of the cash consideration, allocated according to the amount of the premium paid on the policy. If there was a dispute over who the cash consideration should be paid to, the monies were to be deposited in an escrow account until a determination was made by a court or arbitrator. In this case, Defendant Nurse Practioner, Lori Sidorski-Nutt is an eligible policy holder entitled to a cash consideration of

$14,315.61. Dr. Sidorski-Nutt did not assign her cash contribution to anyone and the money was deposited in an escrow account with Defendant, Computershare Trust Company.

Plaintiff now moves for partial summary judgment seeking a declaration that they should receive the cash consideration of $14,316 which is being held for the policy holder, Defendant Sidorski-Nutt. Plaintiff argues that they are the designated "policy administrator" who purchased and paid all the premiums on the malpractice insurance policy for Dr. Sidorski-Nutt, from April 2014 through October , 2016. Plaintiff further argues that they administered the policy and received the benefits of ownership as they were credited with dividends to pay down premiums. (See Memo of Law pg 8). Plaintiff argues that this Court should follow the First Department case of *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't April 4, 2019), which held that the doctor would be unjustly enriched should they be the recipient of the cash considerations.

Dr. Sidorski-Nutt opposes this motion and argues that she should be the recipient of those funds for several reasons. First, under the terms of her Employment Agreement, Plaintiff agreed to pay all the premiums of her malpractice insurance in addition to her salary and in exchange for her professional services. She argues that the contract is silent as to how to distribute funds upon demutualization. Secondly, she argues that the funds in dispute are the Cash Consideration payable to her for the extinguishment of her *Membership Interest* as a policy holder in MLMIC, and are not fees for my professional services rendered to Plaintiff's patients, as addressed in the employment contract. Finally, Dr. Sidorski-Nutt argues that the form which designates Plaintiff as the 'policy administrator' merely makes Plaintiff an agent for the paying of premiums, requesting changes in the policy, and for receiving dividends and any return premiums when due. She argues that the form does not change her ownership status as the policy holder, and she

should receive the cash consideration.

Upon all the papers and proceedings held herein, and a consideration of the cases around the State of New York, this Court finds and declares that Lori Sidorski-Nutt is the 'policy holder' who is entitled to the cash consideration of demutualization in the amount of $14,315.61.

The MLMIC's Plan of Conversion provided that the "Eligible Policy Holders" or their "Designees", would receive their portion of the cash consideration for the extinguishment of their policy holder membership interests. In this case, the Defendant policy holder did not designate Plaintiff as its designee to receive this cash consideration, nor did the parties bargain for this event in their employment agreement.

Moreover, this Court finds that there will be no unjust enrichment if Dr. Sidorski-Nutt receives this cash contribution. To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered ". *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018] (citing *Goel v. Ramachandran*, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428, quoting *Paramount Film Distrib. Corp. v. State of New York*, 30 N.Y.2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695)."). 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. (citations omitted)". *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018]. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed. Finally, the Court finds that Plaintiff has already received the benefit of the bargain from the dividends which reduced the premiums the Plaintiff paid before MLMIC converted.

Accordingly, it is hereby

ORDERED, ADJUDGED and DECREED that plaintiffs' motion, made pursuant to CPLR §3212, for an order granting Plaintiff summary judgment on the first and eighth causes of action in the complaint for a declaratory judgment as against all defendants is denied; and it is further

ORDERED, ADJUDGED and DECREED that plaintiffs' motion for an order granting summary judgment on the fifth and eighth causes of action in the complaint as against all defendants is denied; and it is further

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

ORDERED, ADJUDGED and DECREED that Defendant, Lori Sidorski-utt's counterclaim for a declaratory judgment in her favor, is granted. This Court declares that the "eligible policy holder" is Lori Sidorski-Nutt's, and she is entitled to the escrowed amount of $14,315.61 as her share of the sale and demutualization of MLMIC as determined by the Plan which was approved by the Department of Insurance, and it is further

ORDERED, ADJUDGED and DECREED that Defendants, MLMIC and Computershare Trust Co., NA shall pay to Defendant, LORI SIDORSKI-NUTT the amount of $14,315.61 within fifteen (15) days of the service of this Order, with Notice of Entry, upon the escrow agent.

The foregoing constitutes the Decision and Order of the Court.

Dated: January 6, 2020
Goshen, New York

Enter,

Hon. Maria S. Vazquez-Doles, J.S.C.

To: Counsel of record via NYSCEF.

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

PRESENT: HON. MOLLY REYNOLDS FITZGERALD
JUSTICE PRESIDING

STATE OF NEW YORK
SUPREME COURT : COUNTY OF BROOME

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

Plaintiff,

DECISION AND ORDER

-against-

Index No.: EFCA2018003334

BROOME OBSTETRICS AND GYNECOLOGY, P.C,

Defendant.

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

FACTS

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

Defendant provided a policy through Medical Liability Mutual Insurance Company,

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

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

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

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

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

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

LEGAL ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: September 10, 2019

HON. MOLLY REYNOLDS FITZGERALD
SUPREME COURT JUSTICE

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