To be argued by:
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APL No. APL-2020-00169
Appellate Division, Third Department Docket No. 529615
Saratoga County Clerk's Index No. 20184228

Court of Appeals

of the

State of New York

KIM E. SCHOCH, CNM, OB/GYN NP,

Plaintiff-Respondent,

– against –

LAKE CHAMPLAIN OB-GYN, P.C.,

Defendant-Appellant.

REPLY BRIEF FOR DEFENDANT-APPELLANT LAKE CHAMPLAIN OB-GYN, P.C.

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CORPORATE DISCLOSURE STATEMENT

Defendant-Appellant Lake Champlain OB-GYN, P.C. ("Lake Champlain") submits this Corporate Disclosure pursuant to 22 NYCRR 500.1(f) and states that it is not a publicly held company, and has no parents, affiliates, or subsidiaries.

POINT I

RESPONDENT'S CONTENTION THAT THE INSURANCE LAW PERMITS EACH PLAN OF CONVERSION TO ADOPT ITS OWN DEFINITION OF POLICYHOLDER IS ENTIRELY CONTRARY TO THE INTENT OF THE STATUTE AND BELIED BY ITS PLAIN LANGUAGE

As Appellant explained in its opening brief, the Appellate Division erred in utilizing the definitions of terms contained in the Plan of Conversion for purposes of determining how those terms were intended to have been interpreted by the Legislature in the Insurance Law. In opposition, Respondent now argues that the lower court was correct in interpreting the statutory language of § 7307, including the crucial term "policyholder", by merely relying upon the definition of "Policyholder" that MLMIC elected to include in its Plan of Conversion. In seeking to support this contention, Respondent suggests that the Legislature intended to "defer" to an insurance company's Plan of Conversion, effectively allowing each converting insurance company to decide for itself what the statutory term "policyholder" means as used in § 7307. Resp. Brief, at 14 (arguing that the Plan and § 7307 share an "interdependence" and that "the Plan is not a non-statutory, non-

legislative, extrinsic document . . . but rather a critical component of the framework of § 7307”).

This proposed interpretation is clearly unsupported, unworkable, and, if accepted, would constitute an unconstitutional delegation of legislative authority to private companies (see Fink v Cole, 302 NY 216, 225 [1951] [holding that delegation of Legislative power to a private corporation was “patently an unconstitutional relinquishment of legislative power in violation of section 1 of article III of the [State Constitution]”). Respondent argues that its extraordinary interpretation is backed up by the requirement in § 7307 (e)(3) that any Plan of Conversion that the Superintendent authorizes an insurance company to submit must include, among other things, “the manner and basis of exchanging the equitable share of each eligible mutual policyholder.” Thus, in Respondent’s view, this demonstrates that the statute itself may be interpreted by reference to the terminology and definitions included in an insurance company’s Plan of Conversion (see Resp. Brief, at Point I).

However, Respondent does not cite, and the statute does not contain, anything that would support even a logical inference, let alone clear indication, that the Legislature intended for its legislation to be interpreted based upon the definitions espoused in a private insurance company’s Plan of Conversion. The dubiousness of Respondent’s contention that the Plan of Conversion should determine the definition

of a § 7307 "policyholder" is further evidenced by the fact that the term "policyholder" is used in the statute when setting forth steps in the demutualization process that are required to take place before a Plan of Conversion is even prepared (if indeed one ever is) (see Insurance Law § 7307 [4] [b] [requiring that, *prior to* submitting a Plan of Conversion, an insurer must adopt a resolution specifying, *inter alia*, "the manner in which the conversion is expected to benefit policyholders" and allowing Superintendent to deny permission to submit a Plan of Conversion if the proposed conversion is contrary to law, not in the best interests of the "policyholders", or where the mutual insurer would not have a specified surplus to "policyholders"]). Thus, Respondent's contention would produce the unreasonable and illogical result that the term "policyholder" under § 7307 would either lack a definition unless a Plan of Conversion was ultimately approved, or that the term would be susceptible to differing definitions depending upon what stage of the demutualization process was under consideration. Under such interpretation, the term would lack any clear definition unless and until a Plan of Conversion was submitted by an insurance company. This simply cannot have been the intention of a rational legislature. Rather, the statutory meaning of the term "policyholder" as used in § 7307, which is essential to the resolution of this appeal, should be determined based upon settled and codified rules of statutory interpretation (see App. Brief, at Point I).

POINT II

THE DEPARTMENT OF FINANCIAL SERVICES DECISION DID NOT, AND COULD NOT, DETERMINE WHICH PARTY WAS ENTITLED TO THE CASH CONSIDERATION AS A MATTER OF LAW AND EXPRESSLY RECOGNIZED THIS FACT

Respondent would not merely seek to confer legislative authority on MLMIC, but also attempts to confer the Department of Financial Services (DFS) with the judicial power of adjudicating cases and controversies turning on the interpretation of a statute. Notably, the DFS Decision itself plainly and repeatedly states that it serves no such purpose, and that neither DFS nor the Plan conclusively determine the parties' legal right to the cash consideration. (R.151). Rather, the approval of the Plan merely authorizes a default system for distributing the proceeds of the demutualization and establishes an Objection Procedure designed to serve as just one of several possible methods for parties to resolve disputes over their legal entitlement to the cash consideration. (R.87,91,171).

Respondent contorts and selectively cites language contained in the DFS's responses to public comments in an effort to suggest that the DFS Decision fully "resolved" the question of which parties were entitled to the cash consideration as a matter of law. It plainly did not. In fact, the DFS Decision clearly contemplated that neither the Plan nor the decision itself was even capable of doing so. For instance, in finding that approving the Plan was in the best interests of policyholders, the DFS Decision explicitly recognized that Insurance Law § 7307(e)(3), and not the

Plan or the DFS Decision, determines who should qualify as a policyholder eligible to receive the cash consideration as a matter of law. As stated by the Decision:

> The Superintendent also concludes that the transaction is in the best interests of policyholders of MLMIC . . . Although Insurance Law § 7307(e)(3) determines those policyholders who are eligible to receive the transaction consideration, the Superintendent concludes that the transaction is in the best interests of all MLMIC policyholders.

R.140-41.

Moreover, the DFS Decision made abundantly clear that such disputes were to be expected even after the Plan and its Objection Procedure were approved because of the inability of either to provide a binding interpretation of the Insurance Law. The Decision endorsed the Objection Procedure contained in the Plan as being but one "reasonable framework" to resolve disputes between "*certain* policyholders and entities that claim to be Policy Administrators." R.151 [emphasis added]. Notably, however, DFS took pains to emphasize that the Objection Procedure in the Plan required that both parties *voluntarily* agreed to submit the dispute and even then would not limit their legal rights to seek redress from the courts. R.151 (noting that the submission of disputes to an ADR Specialist as part of the Objection Procedure must be "voluntary" and that doing so "does not limit any person's legal rights" unless all parties agreed to be bound). The Decision further emphasized that "[i]mportantly, the Objection Procedure does not, in any way, impact any person's rights to resolve their dispute in any forum of their choosing or as required by

contract or law." R.149.

Finally, Ms. Schoch claims that Appellant is engaged in a "veiled attempt to collaterally attack the DFS Decision" and "should not be permitted to litigate on this appeal issues that were resolved by the DFS Decision" (Resp. Brief, at 24-25). Notably, however, it was Ms. Schoch that commenced the underlying action seeking to obtain a judicial declaration of her right to the cash consideration. Nevertheless, she posits in self-serving fashion that the court should entertain only *her* arguments for legal entitlement to the cash consideration, while Appellant's should be disregarded as a "veiled attempt to collaterally attack the DFS Decision." It bears repeating that the DFS Decision was not a court decision and explicitly stated that it was not an adjudication of any person's legal right to the cash consideration and did not preclude any party from asserting a legal right to the cash consideration in a forum of their choosing. Accordingly, notwithstanding Respondent's undue emphasis on the DFS Decision, it is effectively irrelevant to the resolution of the dispositive legal questions at issue in this appeal, and namely, the legislature's intended definition of "policyholder" in § 7307.

Appellant's statutory interpretation argument is neither veiled nor an attempt to collaterally attack the DFS Decision. Respondent apparently takes issue with Appellant's contention that the meaning of "policyholder" in § 7307 should be resolved through settled, codified principles of statutory construction. The case

principally relied upon by Respondent to claim that Appellant's arguments constitute an impermissible collateral attack is both inapposite and clearly non-binding on this Court. In Grossman v Akker (2016 NY Slip Op 31551[U]), Supreme Court, New York County considered circumstances starkly different from those at issue here involving multiple defendants seeking to simultaneously assert claims arising from the demutualization of a mutual life insurance company[1] under § 7312 through both a plenary class action and an Article 78. The *Grossman* causes of action alleged that DFS approved the Plan notwithstanding the alleged failure of the insurance company to comply with two procedural requirements required prior to approval of the Plan. In dismissing the action, the court found that both requirements alleged to have been lacking had in fact been expressly considered by DFS in a detailed analysis and found to have been sufficiently complied with. Thus, the court reasoned that permitting the plenary action to stand would allow the plaintiffs' to collaterally attack the DFS decision through the guise of a plenary action.

Notably, however, Respondent's analysis of *Grossman* fails to cite to the portion of the decision that most clearly distinguishes that case from the facts at issue here. In the paragraph immediately following that quoted by Respondent, the court further held that:

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[1] The instant case concerns the demutualization of a mutual property/casualty insurance company under § 7307.

> The collateral attack doctrine is limited, however, to the extent that where a claim challenges the sufficiency of a plan approved by the Superintendent... the preclusive effect of the Superintendent's decision is necessarily limited by the scope of the Superintendent's review. Thus, a plaintiff cannot be precluded from litigating an issue upon which the Superintendent did not pass.

<u>Grossman v Akker</u>, 2016 N.Y. Slip Op. 31551[U], 10 [N.Y. Sup Ct, New York County 2016].

As set forth above, the DFS Decision expressly and properly declined to pass on the question of which parties were legally entitled to the cash consideration under § 7307. Accordingly, the *Grossman* decision provides no support for Respondent's collateral attack theory because the DFS Decision did not pass upon the persons who may be able to establish entitlement to the cash consideration under § 7307 and, accordingly, Appellant is not precluded from litigating that issue.

POINT III

APPELLANT'S STATUTORY INTERPRETATION ARGUMENTS WERE RAISED BELOW AND, IN ANY EVENT, CONCERN PURE QUESTIONS OF LAW AND STATUTORY INTERPRETATION THAT DO NOT HINGE UPON RECORD EVIDENCE

Respondent incorrectly asserts that Appellant did not raise a statutory entitlement to the cash consideration below and that its argument that the definition of "policyholder" found in Insurance Law § 501 should be applied pursuant to settled rules of statutory construction is unpreserved and cannot be considered by this Court. These claims are wholly without merit.

As an initial matter, Appellant did, in fact, raise its statutory entitlement to the cash consideration in the courts below, contrary to Respondents' claim (see Schoch v Lake Champlain Ob-Gyn, P.C., 184 AD3d 338, 341 [3d Dept 2020], lv to appeal granted, 35 NY3d 918 [2020] ["Plaintiff contends that, *pursuant to statute*, the conversion plan, DFS's decision approving the plan and under the common law, she is entitled to the cash consideration because she was the policyholder with a membership interest in MLMIC. Defendant argues that *these same sources* entitle it to receive the cash consideration because it paid the premiums and had control over the policy."] [emphasis added]; see also R. 226, 285).

Regardless, "[a]lthough the doctrine of preservation generally precludes appellate review of matters that are raised for the first time on appeal, it is well settled that pure questions of law or statutory interpretation may be considered because their resolution does not hinge on the record evidence" (Chambers v Old Stone Hill Rd Assocs., 303 AD2d 536, 538 [2d Dept 2003], affd 1 NY3d 424 [2004]; see Matter of Richardson v Fiedler Roofing, Inc., 67 NY2d 246, 250 [1986] ["The argument raises solely a question of statutory interpretation, however, which we may address even though it was not presented below"]).

POINT IV

SECTION § 3420(j)(2) IS NOT INTENDED TO PROVIDE A DEFINITION FOR THE TERM "POLICYHOLDER"

Respondent also alleges that the term "Policyholder" is also defined elsewhere in the Insurance Law besides § 501 in the property/casualty insurance context. In this regard, she cites only to Insurance Law § 3420(j)(2). Presumably this argument is meant to suggest that the Court need not apply the § 501 definition of "policyholder" to § 7307, but rather could also ostensibly adopt the definition contained in § 3420(j)(2).

However, Insurance law § 3420(j)(2) clearly is not intended to provide a definition for the term "policyholder", but rather, to provide a restriction on the definition of that term in order to achieve the purposes of a highly specific subsection. In this regard, the language of § 3420(j)(2) provides that:

> The term "policyholder" as used in [subsection j] shall be limited to an individual or individuals as defined by the terms of the policy, but shall not include corporate or other business entities or an individual who has or individuals who have in effect a workers' compensation policy which covers employees working in and about his or their residence.

Notably, § 3420(j) pertains solely to property insurance policies written for one, two, three, or four family, owner-occupied dwellings and requires them to include liability coverage for workers compensation obligations. Thus, unlike the definition of "policyholder" in § 501, which is clearly intended to be definitional in nature, § 3420(j)(2) is not intended to define the conditions that make a person or

entity a "policyholder." Instead, it is meant to exempt certain "policyholders" from specific requirements of that subsection to the extent that they already possess workers compensation insurance.

POINT V

NOTHING IN INSURANCE LAW § 501 PRECLUDES THIS COURT FROM UTILIZING THE § 501 DEFINITION OF "POLICYHOLDER" FOR PURPOSES OF INTERPRETING THE TERM "POLICYHOLDER" ELSEWHERE IN THE INSURANCE LAW

Respondents argue that Insurance Law § 501 expressly limits the definition of "Policyholder" contained therein to Article 5 pertaining to Certificates of Insurance. Indeed, § 501 begins with "For purposes of this Article" and Article 5 regulates Certificates of Insurance of property/casualty insurance policies. However, the language "for purposes of this Article" does not create any restriction on the definition therein being utilized by the Court elsewhere in the Insurance Law where appropriate in order to effect the Legislature's intent. Notably absent from § 501 is any language of limitation like that commonly found in other statutes, such as "for purposes of this Article *only*" or, as in § 3420 "the term 'policyholder' as used in this subsection *shall be limited to*" (see, e.g., Correction Law 40(3) [defining "Correctional Facility" and expressly stating that definition applies "for the purposes of this article only"]).

Moreover, § 502 of Article 5 provides that "[a] certificate of insurance shall not amend, extend, or alter the coverage provided by the insurance policy to which

the certificate of insurance makes reference." Thus, the Certificate of Insurance, as interpreted by reference to the definitions in § 501, is statutorily required to be co-extensive with the actual coverage provided by the policy. Accordingly, if under the Certificate of Insurance the "Policyholder" is determined by reference to the definition of "Policyholder" in § 501 (which it is) then the policy itself is also required to provide that same coverage pursuant to § 502 (2)(c). In other words, if the "Policyholder" under the Certificate of Insurance is the party that contracts with an insurer for property/casualty insurance, then the policy itself must also provide that such person is entitled to the rights of a "Policyholder." This serves to provide further support for utilizing the § 501 Definition in order to interpret the term "policyholder" in § 7307.

POINT VI

LAKE CHAMPLAIN'S EQUITABLE CLAIMS ARE NOT FORECLOSED BY INSURANCE LAW § 7307 OR NEW YORK COMMON LAW ON UNJUST ENRICHMENT

Even assuming arguendo that Respondent is solely entitled to the Cash Consideration under Insurance Law § 7307 (which she is not), Appellant's equitable claims are not foreclosed by the Insurance Law or New York common law on unjust enrichment. As recognized by this Court, a contractual right or legal title does not preclude a claim based in equity (see Simonds v Simonds, 45 NY2d 233, 239 [1978]; Robert M. Schneider, M.D., P.C. v Licciardi, 65 Misc 3d 254, 256 [Sup Ct 2019]

("[A] party may be legally entitled to a benefit through a contract but still equitably owe those funds to another."); Urgent Med. Care. PLLC v Amedure, 64 Misc.3d 1216A (Sup. Ct. Greene Co. 2019) ("[l]egal title does not end the inquiry").

As more fully briefed in Appellant's prior papers, "[t]he essential inquiry in any action for unjust enrichment or restitution is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered" (Paramount Film Distrib. Corp. v State, 30 NY2d 415, 421 [1972]). Respondent ignores this essential question. In fact, Ms. Schoch offers no fair explanation why she in good conscience should be the sole beneficiary of a benefit that she admittedly did not bargain for and which was an unexpected windfall. The only basis for Respondent's claim to the Cash Consideration is her interpretation of the DFS Decision and Insurance Law § 7307 (see Resp. Brief at p. 42). However, even the plain language of the statute provides that "[t]he equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums . . . such policyholder has properly and timely paid to the insurer . . . ." Insurance Law § 7307(e)(3). Respondent of course paid no premiums.

As cited by the First Department in *Schaffer*, other courts have decided the issue of entitlement to insurance demutualization proceeds among employers and employees pursuant to principles of equity and fairness (see Matter of Schaffer, Schonholz & Drossman LLP v Title, 171 A.D.3d 465 [1st Dept 2019]). The

overwhelming consensus of other jurisdictions is that demutualization proceeds should be equitably distributed in a ratio according to the amount of premiums paid by each party (see App. Brief at p. 33). Lake Champlain respectfully submits that the Court should recognize this majority view, which is also consistent with the plain language, legislative intent, and construction of the Insurance Law.

Respondent's argument that the cases cited by Appellant concern demutualization of insurers providing employee disability insurance, health insurance and 401k retirement benefits subject to other state laws or ERISA misses the point. In each case, the contracting parties did not bargain for the windfall and the court applied equitable principles to distribute the proceeds based on the premiums paid by the employer and/or employee.

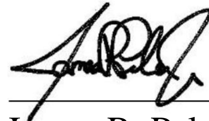
Alternatively, Appellant should equitably recoup the amount of premiums that it paid. Respondent's contention that such relief is unpreserved for review should be rejected. Lake Champlain clearly seeks to recover the premiums that it paid. Moreover, Lake Champlain requested that both the Supreme Court and Appellate Division alternatively remand its equitable counterclaims for discovery and further proceedings. R.287.

CONCLUSION

Accordingly, Defendant-Appellant Lake Champlain respectfully requests that this Court reverse the Opinion and Order of the Appellate Division, Third Department.

Dated: June 3, 2021
Albany, New York

DREYER BOYAJIAN LLP



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