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SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: SECOND DEPARTMENT

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MAPLE MEDICAL, LLP,

Respondent-Plaintiff,

Appellate Division
Index No. 2019-09157

- against -

Supreme Court
Index No. 51103/2019

JOSEPH SCOTT,

Appellant-Defendant

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NOTICE OF MOTION

PLEASE TAKE NOTICE that, upon the annexed Statement in Support of Motion for Leave to Appeal, upon the briefs and record filed in the Appellate Division, Second Department on the prior appeal in this action, and upon all papers and prior proceedings in this action, the undersigned will move this court at the courthouse of the Appellate Division Second Department, 45 Monroe Place, Brooklyn, New York, on January 11, 2020, at 10:00 a.m., or as soon thereafter as counsel can be heard, for an order pursuant to CPLR 5602(a)(1) granting Plaintiff-Respondent Maple Medical, LLP leave to appeal to the Court of Appeals from the order of the Appellate Division, Second Department entered December 11, 2020 which unanimously reversed the order and judgment of the Supreme Court, Westchester County (Ecker, J.) granting summary judgment in favor of Plaintiff Respondent Maple Medical, LLP and declaring that Defendant-

Appellant be awarded the case consideration from Medical Liability Mutual Insurance Company and/or such other and further relief as this Court may deem proper in the premises.

PLEASE TAKE FURTHER NOTICE, that opposition papers, if any, must be filed with the Clerk's office on or before the return date.

Dated: White Plains, New York
December 22, 2020

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SUPREME COURT OF THE STATE OF NEW YORK
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MAPLE MEDICAL, LLP,

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AFFIRMATION IN SUPPORT OF MOTION FOR
LEAVE TO APPEAL TO THE COURT OF APPEALS

Carl L. Finger, Esq., an attorney duly admitted to practice before the Courts of the State of New York, hereby affirms as follows:

1. I am the attorney for the Respondent-Plaintiff in this matter and as such I am fully familiar with the facts and circumstances of this matter. I make this affirmation in support of Respondent-Plaintiff's motion for an order pursuant to CPLR 5602(a)(1) granting Plaintiff-Respondent Maple Medical, LLP leave to appeal to the Court of Appeals from the order of the Appellate Division, Second Department entered December 11, 2020 which unanimously reversed the order and judgment of the Supreme Court, Westchester County (Ecker, J.) granting summary judgment in favor of Plaintiff Respondent Maple Medical, LLP and declaring that Defendant-Appellant be awarded the case consideration from Medical Liability Mutual Insurance Company and/or such other

and further relief as this Court may deem proper in the premises.

2. The Statement of Facts set forth in the Memorandum of Law in Support of this motion are hereby adopted by reference with the same force and effect as if set forth herein.

3. Attached hereto are the following exhibits:

Exhibit A	Opinion and Order of the Appellate Division, Second Department
Exhibit B	Decision and Order of the Supreme Court, County of Westchester, Ecker, J
Exhibit C	Order of the Court of Appeals Granting Leave to Appeal in the Matter of *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338, 340, 126 N.Y.S.3d 532, 534, leave to appeal granted, 35 N.Y.3d 918 (2020)

Wherefore, Respondent-Appellant respectfully prays for an order pursuant to CPLR 5602(a)(1) granting Plaintiff-Respondent Maple Medical, LLP leave to appeal to the Court of Appeals from the order of the Appellate Division, Second Department entered December 11, 2020 which unanimously reversed the order and judgment of the Supreme Court, Westchester County (Ecker, J.) granting summary judgment in favor of Plaintiff Respondent Maple Medical, LLP and declaring that Defendant-Appellant be awarded the case consideration from Medical Liability Mutual Insurance Company and/or such other and further relief as this Court may deem proper in the premises.

Dated: White Plains, New York
December 22, 2020

Carl L. Finger
Finger & Finger, A Professional Corporation
Attorneys for Respondent-Plaintiff
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FILED: APPELLATE DIVISION - 2ND DEPT 12/09/2020 04:20 PM 2019-09157
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Supreme Court of the State of New York
Appellate Division: Second Judicial Department

D64774
R/htr

_____AD3d_____ Argued - October 13, 2020

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

2019-09157 OPINION & ORDER

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

(Index No. 51103/19)

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

Nolan Heller Kauffman, LLP, Albany, NY (Justin A. Heller and Brendan J. Carosi of counsel), for appellant.

Finger & Finger, White Plains, NY (Carl L. Finger of counsel), for respondent.

SCHEINKMAN, P.J. In 2018, the defendant Medical Liability Mutual Insurance Company (hereinafter MLMIC) was converted from a mutual insurance company to a

stock insurance company. The question presented on this appeal is whether the cash consideration paid as part of the conversion belongs to a physician who was a policyholder of a medical malpractice insurance policy issued by MLMIC or to the medical practice that employed the physician and paid the premiums on the policy. The Departments of the Appellate Division have divided on this question. We agree with our colleagues in the Third and Fourth Departments that the funds belong to the physician-policyholder and respectfully do not agree with our colleagues in the First Department that the funds should be paid over to the medical practice-employer.

RELEVANT FACTS

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

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

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

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

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

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

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

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

equitable share of each policyholder in the mutual insurer is determined by the ratio which the net premiums (gross premiums less return premiums and dividends paid) properly and timely paid by the policyholder over the three-year period bear to the total net premiums received by the mutual insurer from all eligible policyholders (*see id.*).

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

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

On September 6, 2018, DFS issued a decision approving the demutualization and plan of conversion (*Matter of Medical Liab. Mut. Ins. Co. [National Indem. Co.]*, https://www.dfs.ny.gov/system/files/documents/2019/01/mlmic_decision_20180906.pdf [NY St Dept of Fin Servs, Sept. 6, 2018, Vullo, Supt.] [hereinafter DFS Op]). In its decision, DFS noted

that there was a dispute as to whether the cash consideration should be paid to policyholders or to the medical groups and hospitals who paid premiums on behalf of policyholders. DFS stated that section 7307(e) of the Insurance Law refers to "policyholder," who might or might not be the person who paid the premium (DFS Op at 23). DFS also observed that section 7307(e) recognizes the possibility that policyholders may have assigned their legal rights to others. Rather than deny or delay demutualization because of this dispute, the plan set forth an objection procedure for the resolution of disputes related to which party is entitled to the cash consideration. Under this procedure, the cash consideration attributable to each claim in dispute would be held in escrow until the claim is resolved by agreement or by a nonappealable order of an arbitration panel or court with proper jurisdiction. DFS determined that this objection procedure was a "reasonable framework" for resolving disputes between policyholders and entities claiming to be policy administrators (DFS Op at 23) .

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

PROCEDURAL HISTORY

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

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

separately answered the complaint and asserted counterclaims for judgments declaring that they were the parties entitled to the cash consideration.

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

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

In this case, the Supreme Court held that it was bound by stare decisis to apply the precedent established by *Schaffer* in the absence of a contrary ruling from this Court or the Court of Appeals (*see Maple Med. LLP v Scott*, 64 Misc 3d at 912). Since *Schaffer* involved identical facts and an identical legal issue, the court applied *Schaffer*, finding that, in any event, "the conclusions drawn in the First Department's decision [were] persuasive" (*Maple Med. LLP v Scott*, 64 Misc 3d at 912). Consequently, the court denied Scott's motion, granted Maple Medical's cross motion, declared that Maple Medical was "entitled to the receipt from the escrow agent currently holding [the] funds due it . . . plus accrued interest," and directed the escrow agent to pay the funds within fifteen days of service of the order with notice of entry upon the escrow agent (*id.* at 913).

In the other five cases, the Supreme Court relying on its rationale in *Scott*, declared

that Maple Medical, not the defendant physicians, was entitled to the cash contribution and directed that the escrow agent release the funds to Maple Medical (*Maple Med. LLP v Youkeles*, 64 Misc 3d 1213[A], 2019 NY Slip Op 51131[U] [Sup Ct, Westchester County]; *Maple Med. LLP v Arevalo*, 64 Misc 3d 1213[A], 2019 NY Slip Op 51127[U] [Sup Ct, Westchester County]; *Maple Med. LLP v Goldenberg*, 64 Misc 3d 1213[A], 2019 NY Slip Op 51128[U] [Sup Ct, Westchester County]; *Maple Med. LLP v Sundaram*, 64 Misc 3d 1213[A], 2019 NY Slip Op 51130[U] [Sup Ct, Westchester County]; *Maple Med. LLP v Mutic*, 64 Misc 3d 1213[A], 2019 NY Slip Op 51129[U] [Sup Ct, Westchester County].

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

LEGAL ANALYSIS

I. Stare Decisis

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

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

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

The Appellate Division is a single state-wide court divided into departments for administrative convenience (*see Mountain View Coach Lines v Storms*, 102 AD2d 663, 664). While the Supreme Court is bound to apply the law as promulgated by the Appellate Division in its own department, where the issue has not been addressed within that department, the Supreme Court is obligated to follow the precedent set by the Appellate Division of another department until its home department or the Court of Appeals pronounces a contrary rule (*see Phelps v Phelps*, 128 AD3d 1545, 1547; *D'Alessandro v Carro*, 123 AD3d 1, 6; *Mountain View Coach Lines v Storms*, 102 AD2d at 664). In applying an Appellate Division precedent, it is not open to the Supreme Court to consider whether the precedent was correctly established—that is a matter that may be considered by another department or by the Court of Appeals. Thus, regardless of whether the Supreme Court agreed with the analysis provided by the First Department in reaching its conclusion in *Schaffer*, the Supreme Court was bound to apply it, in the absence of a contrary precedent from another department or from the Court of Appeals. It is only where two departments have issued conflicting rulings on a point of law that a trial court, situated in neither and whose department has not spoken, may follow the holding that it deems to comport most closely with the law (*see* Siegel & Connors, NY Prac § 449 at 860 [6th ed], citing *Darko v New York City Tr. Auth.*, 13 Misc 3d 203, 206 [Sup Ct, Bronx County]). Thus, putting aside the happenstance that the Supreme Court here expressed its agreement with the views announced by the First Department in *Schaffer*, the Supreme Court appropriately concluded that it was bound to follow what was then the only extant binding appellate precedent.[1] The niceties of the procedural distinctions between the cases and the precise arguments raised do not give the Supreme Court a basis for disregarding an on-point ruling of a department of the Appellate Division.

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[1]We note that the Supreme Court, in another case decided subsequently, determined to follow the position of the First Department, rather than the view of the Third and Fourth Departments (*see Healthcare Radiology & Diagnostic Sys., PLLC v Goldman*, ___ Misc 3d ___, 2020 NY Slip Op 20306 [Sup Ct, Westchester County]). The First Department's view was also followed, and the view of the Third and Fourth Department not, in *Wyckoff Heights Med. Ctr. v Monroe* (2020 NY Slip Op 32580[U] [Sup Ct, Kings County]).

These considerations, however, do not apply to this Court. While we should accept the decisions of the other departments as persuasive, we are free to reach a contrary result (*see State of New York Mtge. Agency v Braun*, 182 AD3d 63, 75; *Weaver v State of New York*, 91 AD3d 758, 761; *Mountain View Coach Lines v Storms*, 102 AD2d at 665). With respect to the issue presently before us, after the Supreme Court rendered its determination, the Third and Fourth Departments addressed the same exact issue and each has reached a result contrary to that of the First Department.

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

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

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

employee there was entitled to the cash consideration, that court, like the Supreme Court in this case, found that it was constrained to follow *Schaffer* (*see Shoback v Broome Obstetrics & Gynecology, P.C.*, 184 AD3d 1000). In *Shoback*, the Third Department, like us, concurred that the Supreme Court was bound by *Schaffer*; however, the Third Department expressed its disagreement with *Schaffer* and declined to follow it (*see Shoback v Broome Obstetrics & Gynecology, P.C.*, 184 AD3d 1000).

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

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

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

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

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

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

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

clear and unambiguous.

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

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

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

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

"Q5. Who is eligible to receive consideration in connection with the Proposed Transaction?

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

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

In its decision approving the plan of conversion, DFS considered "a written comment asserting that the group of policyholders eligible to be paid shares of the purchase price should be changed or that the purchase price should be allocated differently" (DFS Op at 22 [internal quotation marks omitted]). DFS, however, rejected the argument, opining that "Insurance Law § 7307(e)(3) explicitly defines those policyholders who are eligible to receive the purchase price consideration based on the three-year period of eligible policies" (*id.* at 23 [internal quotation marks omitted]).

DFS also did not accept the contention, which had been advanced by Maple Medical, that the person that paid the premium is thereby entitled to the proceeds of the sale. "The Superintendent finds that this is not determinative because [Insurance Law § 7307(e)(3)] refers to the 'policyholder,' which might or might not be the person who paid the premiums" (*id.* at 23 [internal quotation marks omitted]). However, DFS, when discussing the dispute resolution process, noted that the Insurance Law "also recognize[d] that such policyholders may have assigned such legal right to other persons. Therefore, the Plan appropriately includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to payment in a given case" (*id.* [internal quotation marks omitted]).

In *Schoch* and in *Maple-Gate Anesthesiologists, P.C.*, the Third and Fourth Departments, respectively, considering the language of the Insurance Law, the plan of conversion,

and the DFS decision, determined that the employee physicians, not the employer practice groups, were entitled to the cash consideration (*see Schoch v Lake Champlain OB-GYN, P.C.*, 184 AD3d at 343-344; *Maple-Gate Anesthesiologists, P.C. v Nasrin*, 182 AD3d at 985). Both courts were unpersuaded by the argument that the employee physician's designation of his or her employer as policy administrator entitled the policy administrator to the cash consideration. In *Schoch*, the Third Department held that the practice group's "designation as policy administrator gave it no greater right to the cash consideration, and plaintiff did not explicitly assign that right to defendant and declined to do so" (*Schoch v Lake Champlain OB-GYN, P.C.*, 184 AD3d at 342). "Although the conversion plan gives a policy administrator the right to object if it believes that it has a legal right to the cash consideration, the right to object carries no rights, in and of itself, to the consideration, and the objector must prove its claimed legal right thereto," which the employer practice group failed to do in that case (*id.*). Similarly, the Fourth Department in *Maple-Gate Anesthesiologists, P.C.*, opined that the plan of conversion stated the cash contribution would be made to the policyholder unless he or she affirmatively designated a policy administrator to receive it on his or her behalf (*see Maple-Gate Anesthesiologists, P.C. v Nasrin*, 182 AD3d at 985). In that case, the physician employees "were the policyholders of the relevant MLMIC policies and . . ., although [the physician employees] had assigned some of their rights as policyholders to plaintiff [employer] as Policy Administrator, they had not designated plaintiff to receive demutualization payments" (*id.*).

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

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

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

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

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

The Third Department reasoned that "[t]he first quoted sentence of this statute [Insurance Law § 7307] explains who is entitled to receive the consideration, whereas the second quoted sentence explains how the consideration for each eligible person is to be calculated" (*Schoch v Lake Champlain OB-GYN, P.C.*, 184 AD3d at 342). Thus, it determined that the language "such policyholder has properly and timely paid to the insurer" "pertains to how the considerations are calculated, rather than to whom they must be paid. The reference to 'policyholder' immediately preceding the word 'paid'—the latter of which is the word that [the employer] focuses on—supports our interpretation" (*id.* at 342-343 [internal quotation marks omitted], citing *Columbia Mem. Hosp. v Hinds*, 65 Misc 3d 1205[A], 2019 NY Slip Op 51508[U], *4 [Sup Ct, Columbia County], *affd* ___ AD3d ___, 2020 NY Slip Op 06329). Further, the Third Department noted that

> "DFS's decision, in addressing similar comments raised by a different medical employer, concluded that an employer is not entitled to the consideration merely based on its payment of the premiums on an insurance policy, because the same provision refers to 'policyholder,' which may or may not be the person who paid the premium"

(*Schoch v Lake Champlain OB-GYN, P.C.*, 184 AD3d at 343, citing *Maple-Gate Anesthesiologists, P.C. v Nasrin*, 63 Misc 3d 703, 709 [Sup Ct, Erie County], *affd* 182 AD3d 984 ["The formula takes into account the amount of premiums paid. No distinction is made between a policyholder who pays the premium out of his (or her) own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. Insurance Law § 7307 does not confer an ownership interest . . . to anyone other than the policyholder"]).

As the Third Department held,

> "DFS explained in its decision that Insurance Law § 7307 defines the policyholders eligible to receive cash considerations but recognizes that they may have assigned such legal rights to others; that is why MLMIC's conversion plan includes a procedure for objections and holding considerations in escrow pending resolution of any disputes"

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

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

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

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

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

III. Unjust Enrichment

Maple Medical argues that Scott, as well as the other physicians, will be unjustly enriched if they receive the cash consideration because it was Maple Medical who paid all of the premiums under the policies. In response, Scott and the others contend that, under their employment agreements with the plaintiff, they agreed to devote their professional services to Maple Medical in

exchange for which Maple Medical agreed to provide them with compensation and various benefits, including payment of their malpractice insurance. Scott and the other physicians assert that, in exchange for the benefits Maple Medical paid to and for them, Maple Medical received the services from them that it bargained for and cannot predicate an unjust enrichment claim upon the premiums paid in consideration for the services provided.

To establish a cause of action for unjust enrichment, "[a] plaintiff must show 'that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered'" (*Mandarin Trading Ltd. v Wildenstein*, 16 NY3d 173, 182, quoting *Citibank, N.A. v Walker*, 12 AD3d 480, 481 [internal quotation marks omitted]; *see GFRE, Inc. v U.S. Bank, N.A.*, 130 AD3d 569, 570). "The essential inquiry in any action for unjust enrichment . . . is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered" (*Paramount Film Distrib. Corp. v State of New York*, 30 NY2d 415, 421).

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

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

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

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

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

In setting forth its conclusion that awarding the physician the proceeds of the

demutualization would result in unjust enrichment, the First Department cited two federal court cases: *Ruocco v Bateman, Eichler, Hill, Richards, Inc.* (903 F2d 1232, 1238 [9th Cir 1990] [hereinafter *Ruocco*]) and *Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund* (2005 WL 525427, *4, *8, 2005 US Dist LEXIS 42877, *10-11, *21-22 [ND Ill, Mar. 4, 2005, No. 02 C 3115] [hereinafter *Chicago Truck Drivers*]).

In *Ruocco*, the defendant, a stock brokerage and financial consulting firm, offered its employees group long term disability insurance through Union Mutual Insurance Company (*see Ruocco v Bateman, Eichler, Hill, Richards, Inc.*, 903 F2d at 1234). The Union Mutual policy was paid for by the employees participating in the plan and the defendant deducted premiums from their pay (*see id.*). In 1986, Union Mutual notified the defendant that it intended to convert from a mutual insurance company to a wholly-owned subsidiary of a publicly-owned stock corporation called UNUM (*see id.* at 1235). Under Maine law, where Union Mutual was incorporated, the conversion could take place only upon distribution to each policyholder of a pro rata share of the retained surplus which the converting company had acquired while it was operating as a mutual insurance company (*see id.*). Union Mutual notified the defendant that the returned surplus would take the form of shares of UNUM stock and warrants to purchase additional shares of UNUM stock (*see id.*). The defendant decided to exercise the warrants and paid the sum of $609,336 to buy 25,755 shares of UNUM stock, which were sold by the defendant for a profit of $104,913.30 (*see id.*). The defendant also received a distribution of UNUM shares in 1988, which it sold for $524,510.01, making the total profit it received from the sale of shares $629,423.31 (*see id.*).

The plaintiff commenced an action in the United States District Court for the Central District of California (hereinafter the California District Court) claiming that the defendant's decision to retain the UNUM distribution violated the Employee Retirement Income and Security Act of 1974 (29 USC § 1001 *et seq.* [hereinafter ERISA]), California Commercial Code section 8315 (since repealed), and the Racketeer Influenced and Corrupt Organizations Act (18 USC § 1961 *et seq.* [hereinafter RICO]) (*see Ruocco v Bateman, Eichler, Hill, Richards, Inc.*, 903 F2d at 1235). The California District Court granted summary judgment to the plaintiff on the ERISA and California Commercial Code claims, finding that the plan was an "employee welfare benefit plan" as defined by ERISA, that defendants were "fiduciaries" of the plan, that the plaintiff was a

"participant" in the plan, and that the surplus dividend was an "asset of the plan" (*id.* [internal quotation marks omitted]). The California District Court found that "the balance of equities" weighed in favor of the plan participants because they paid for the plan and the funds would not benefit them if distributed to the defendants (*id.*). The United States Court of Appeals for the Ninth Circuit affirmed on the "balance of equities" issues, stating, "[w]e agree with the [California] district court that the balance of equities weighs in favor of the plaintiff class" (*id.* at 1238).

In *Chicago Truck Drivers*, the plaintiff sought a declaratory judgment against the defendant pension fund and the defendant labor union to the effect that the demutualization compensation paid for four employee-benefit plans of Principal Financial Group (hereinafter Principal) was a plan asset and should revert to the participants of the plans (*see Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund*, 2005 WL 525427, *1, 2005 US Dist LEXIS 42877, *1-2). Principal adopted its plan for demutualization in 2001 (*see Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund*, 2005 WL 525427, *1, 2005 US Dist LEXIS 42877, *2). In *Chicago Truck Drivers*, the issues before the United States District Court for the Northern District of Illinois (hereinafter the Illinois District Court) were whether the demutualization compensation was an asset of the employee benefit plans, and, if so, whether the compensation reverted to the participants of the plan or to the employers (*see Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund*, 2005 WL 525427, *1, 2005 US Dist LEXIS 42877, *3). The Illinois District Court determined that, under ERISA and guidance from the Department of Labor advisory opinions, because the contributions to a 401(k) plan were made entirely by the employees, outside of minor administrative costs, the demutualization compensation attributable to the 401(k) plan should revert to the employees (*see Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund*, 2005 WL 525427, *3-4, 2005 US Dist LEXIS 42877, *11, *22). However, as to the other three employee-benefit plans, the Illinois District Court found that the demutualization

compensation attributable to a severance plan must be used to offset future employer contributions and that the demutualization compensation attributable to an in-house pension plan and a life insurance plan reverted to the employers (*see Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund*, 2005 WL 525427, *8, 2005 US Dist LEXIS 42877, *19, *21-23).

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

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

As we have already observed, the essential inquiry for unjust enrichment is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered. In undertaking this inquiry, we must look to see if a benefit has been conferred upon the defendant under mistake of fact or law, if the benefit remains with the defendant, if there has been a change of position by the defendant, and whether the defendant's conduct was tortious or fraudulent (*see Paramount Film Distrib. Corp. v State of New York*, 30 NY2d at 421; *see also Mandarin Trading Ltd. v Wildenstein*, 16 NY3d at 182). To prevail, the proponent of the cause of

action must establish that it conferred a benefit on the other party and that the other party will retain that benefit without adequately compensating the first party therefor (*see Beaman v Awaye Realty Mgt., LLC*, 176 AD3d 1025; *MT Prop., Inc. v Ira Weinstein & Larry Weinstein, LLC*, 50 AD3d 751, 752).

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

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

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

485). We find the Third Department's analysis very persuasive:

> "Had [the medical group] selected a different company to provide malpractice insurance to cover [the employee], [the medical group] would have met its contractual obligation to provide and pay for that insurance while [the employee] would have received the benefit of such coverage. Under those circumstances, neither party would receive a cash consideration. Thus, the demutualization proceeds were unexpected and will be a windfall to whichever party receives them. The fact that one party will receive these benefits does not mean that such party has unjustly enriched itself at the other's expense (*see Goel v Ramachandran*, 111 AD3d [783,] 791), i.e., that it 'is in possession of money or property that rightly belongs to another' (*Clifford R. Gray, Inc. v. LeChase Constr. Servs., LLC,* 31 AD3d at 988)"

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

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

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

IV. *The Escrow Provision*

Finally, Scott and the other physicians argue that the Supreme Court's orders directing the escrow agent to release the funds to Maple Medical violated the escrow procedure set forth in the plan of conversion and the terms of the parties' stipulation. We agree. The plan of conversion states, "[i]f MLMIC receives a properly filed objection, the allocated Cash Consideration will be held in escrow by the Conversion Agent until MLMIC receives joint written instructions . . . as to how the allocation is to be distributed, or a *non-appealable order* of an arbitration panel or court with proper jurisdiction ordering payment of the allocation" (emphasis added). The stipulations the plaintiff entered into with Scott, and each of the other physicians, likewise provided that "MLMIC shall hold the funds in escrow pending a further stipulation of the parties or a final non-appealable order or judgment of the Court." Here, the court's orders underlying the instant and related appeals (*see Maple Medical LLP v Youkeles*, __ AD3d ___ [decided herewith]; *Maple Medical LLP v Arevalo*, __ AD3d ___ [decided herewith]; *Maple Medical LLP v Goldenberg*, __ AD3d ___

[decided herewith]; *Maple Medical LLP v Sundaram*, __ AD3d ___ [decided herewith]; *Maple Medical LLP v Mutic*, __ AD3d ___ [decided herewith]) were appealable and, accordingly, the funds should have been held in escrow pending the outcome of these appeals.

V. Conclusion

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

DILLON, DUFFY and CONNOLLY, JJ., concur.

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

ENTER:

Aprilanne Agostino
Clerk of the Court

B

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, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

MAPLE MEDICAL LLP,

Plaintiff,

-against-

JOSEPH SCOTT, D.O. [1] and MEDICAL LIABILITY MUTUAL INSURANCE COMPANY [2],

Defendants.

Index No. 51103/2019

DECISION/ORDER/JUDGMENT

Motion Seqs. 1, 2
Submitted: 5/15/19

ECKER, J.

The following papers were read on the motion of defendant JOSEPH SCOTT, D.O.("Scott") [Mot. Seq. 1], made pursuant to CPLR 3212, for an order granting summary judgment on the counterclaim for a declaratory judgment against plaintiff MAPLE MEDICAL LLP ("plaintiff"), and the cross-motion of plaintiff [Mot. Seq. 2], made pursuant to CPLR 3212, for an order granting summary judgment on the complaint as against Scott:

PAPERS

Notice of Motion, Affirmation, Exhibits A-H, Affidavit, Exhibits A-D and Memorandum of Law
Notice of Cross-Motion, Affirmation, Affidavit, Exhibits A-R, Memorandum of Law in Support and in Opposition, and Exhibits E-K
Affidavit in Reply and in Opposition to Cross-Motion, Exhibits I-M, and Memorandum of Law in Opposition to Cross-Motion and in Support of Motion
Memorandum of Law in Further Support of Cross-Motion

Upon the foregoing papers, the court determines as follows:

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

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

This lawsuit is one of six litigations[3] before this court that involve plaintiff, as the employer partnership, and individual physicians, as plaintiff's employees. The parties in the separate actions are all represented by the same law firms.

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

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

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

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

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

Each of the parties now moves for summary judgment on its claims, in essence seeking a declaration of which party is entitled to the Payment. The court will accept all

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

papers submitted in this action for its review, notwithstanding Scott's argument that plaintiff did not follow proper procedure. There is no prejudice demonstrated, and this court strongly believes in the resolution of disputes upon the merits.

The court finds that the recent decision of the Appellate Division, First Department in *Matter of Schaffer, Schonholz & Drossman, LLP v Title* (171 AD3d 465) ("the *Matter of Schaffer*"), decided April 4, 2019, is dispositive of the issues raised in this matter. Applying the principles set forth in the *Matter of Scaffer* decision to the facts presented, the court holds that plaintiff is therefore entitled to the distribution of the sales proceeds of MLMIC.

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

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

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

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

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

Where an issue has not been addressed within an Appellate Department, the Supreme Court is bound by the doctrine of *stare decisis* to apply precedent established in another Department, either until a contrary rule is established by the Appellate Division in its own Department or by the Court of Appeals. *Phelps v Phelps*, 128 AD3d 1545 [4th Dept

2015]; *D'Alessandro v Carro*, 123 AD3d 1[4th Dept 2015]; *see Mountain View Coach Lines v Storms,* 102 AD2d 663, 664–665 [2d Dept 1984]. As such, in light of the identical facts and legal question presented here and in the *Matter of Schaffer*, the decision in the *Matter of Schaffer* is binding on this court. *See Mountain View Coach Lines v Storms, supra*. Applying the holding from the *Matter of Schaffer* to the facts presented here, the court determines that the Payment is appropriately awarded to plaintiff.

In any event, the court finds that the conclusions drawn in the First Department's decision are persuasive, and that a similar holding in this action based on the principles of unjust enrichment is warranted. Simply put, awarding Scott the cash proceeds of MLMIC's demutualization would result in his unjust enrichment. *See Matter of Schaffer, Schonholz & Drossman, LLP v Title, supra; see Paramount Film Distrib. Corp. v State,* 30 NY2d 415 [1972].

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

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

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

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

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

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

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

Dated: White Plains, New York
July 5 , 2019

ENTER

HON. LAWRENCE H. ECKER, J.S.C.

Appearances:
All parties appearing via NYSCEF

C

State of New York
Court of Appeals

Decided and Entered on the
twenty-third day of November, 2020

Present, Hon. Janet DiFiore, *Chief Judge, **presiding***.

Mo. No. 2020-521
Kim E. Schoch,
Respondent,
v.
Lake Champlain OB-GYN, P.C.,
Appellant.

Appellant having moved for leave to appeal to the Court of Appeals in the above cause;

Upon the papers filed and due deliberation, it is

ORDERED, that the motion is granted.

John P. Asiello
Clerk of the Court

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION : SECOND DEPARTMENT AD2 DOCKET. 2019-09157

MAPLE MEDICAL, LLP,

Respondent-Plaintiff,

-against-

JOSEPH SCOTT, M.D.,

Appellant-Defendant,

And

Medical Liability Mutual Insurance Company,

Defendant.

MOTION FOR LEAVE TO COURT OF APPEALS

Finger & Finger, A Professional Corporation
158 Grand Street
White Plains, New York 10601
Tel: (914) 949-0308
Fax: (914) 949-3608

To:

Signature:________________________________ **Rule 130-1.1-a**
Carl L. Finger, Esq.

SERVICE OF A COPY OF THE WITHIN IS HEREBY ADMITTED

DATED: ______________________________

______**NOTICE OF ENTRY: PLEASE TAKE NOTICE THAT THE WITHIN IS A TRUE COPY OF THE JUDGMENT / ORDER DULY ENTERED IN THE OFFICE OF THE CLERK OF THE WITHIN NAMED COURT ON**

____ NOTICE OF SETTLEMENT: PLEASE TAKE NOTICE THAT AN ORDER / JUDGMENT OF WHICH THE WITHIN IS A TRUE COPY WILL BE PRESENTED FOR SETTLEMENT TO THE HON. ROBERT DIBELLA, ONE OF THE JUSTICES OF THE WITHIN COURT, AT THE SUPREME COURT, COUNTY OF WESTCHESTER ON ________________________________ at 9:30 a.m.

Dated: White Plains, New York
December 22, 2020

Finger & Finger, A Professional Corporation
Attorneys for Respondent-Plaintiff
158 Grand Street
White Plains, New York 10601
Tel: (914) 949-0308
Fax: (914) 949-3608

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: SECOND DEPARTMENT

---X

MAPLE MEDICAL, LLP,

Respondent-Plaintiff,

Appellate Division
Index No. 2019-09157

- against -

Supreme Court
Index No. 51103/2019

JOSEPH SCOTT,

Appellant-Defendant

---X

MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR LEAVE TO APPEAL TO THE COURT OF APPEALS

Carl L. Finger
Finger & Finger, A Professional Corporation
Attorneys for Respondent-Plaintiff
158 Grand Street
White Plains, NY 10601
(914) 949-0308

I. PRELIMINARY STATEMENT

In October 2018, Medical Liability Mutual Insurance Company ("MLMIC") converted from a mutual insurance company into a stock corporation in what was the first demutualization of a mutual insurance company in New York's history. This application for leave to appeal requests that this Court resolve a split among the Appellate Division departments as to who is entitled to share in the $2.502 billion in proceeds from this unprecedented demutualization pursuant to the procedures set forth in Insurance Law § 7307(e)(3) and the MLMIC Plan of Conversion approved by the Department of Financial Services. Numerous courts have issued conflicting decisions, and a split exists among the First, Third, Fourth and now Second Departments of the Appellate Division as to whether the demutualization proceeds should go to the named insured on the MLMIC policy or to the insured's employer that purchased and bargained for the policy and paid all of the premiums.

Plaintiff-Respondent Maple Medical, LLP ("Maple") seeks leave to appeal from the Opinion and Order of the Appellate Division, Second Department dated and entered December 11, 2020 reversing the order and judgment of the Supreme Court, Westchester County (Ecker, J.) which granted summary judgment in favor of Maple Medical, LLP declaring it to be entitled to receive the cash consideration from the MLMIC demutualization. The Second Department order further granted summary judgment to Defendant-Appellant Joseph Scott ("Defendant") and declared that

Defendant is solely entitled to said cash consideration.

II. JURISDICTIONAL SHOWING PURSUANT TO RULE 500.22(b)(3)

The Appellate Division Second Department has jurisdiction over the instant motion and proposed appeal under CPLR 5602(a)(1) because (1) the action originated in Supreme Court, (2) the December 11, 2020 order appealed from is not appealable as a matter of right, and (3) the order appealed from is a final determination as defined in CPRL § 5611 whereby it disposes of all the issues in the action.

III. DISCLOSURE STATEMENT PURSUANT

Plaintiff-Respondent Maple is not a publicly held company. It has no parents, subsidiaries or affiliates.

IV. PROCEDURAL HISTORY OF THE CASE AND TIMELINESS OF THE MOTION

Maple commenced this action by filing and service of a Summons and Complaint. Defendant served an Answer with Counterclaims. Defendant moved for summary judgment and Maple Cross-Moved for Summary Judgment. No discovery occurred in the action. The parties' motions for summary judgment sought a declaratory judgment as to who was entitled to the cash proceeds from the demutualization of MLMIC. By Decision and Judgment dated July 5, 2019, the Supreme Court (Ecker, J.) granted summary judgment in favor of Plaintiff-Respondent. The Supreme Court ruled on both grounds of *stare decisis* based on the Appellate Division, First Department's ruling in *Schaffer, Schonholz & Drossman, LLP v Title*, 171 AD3d 465 [1st Dept 2019] and based on the merits of the claims. By Opinion and Order dated and entered December 11, 2020, the Appellate Division, Second Department unanimously reversed the judgment of the Supreme Court, granted summary judgment to Defendant and declared that Defendant is solely entitled to the MLMIC demutualization proceeds. (Ex. A). Notice of entry of said order was served via NYSCEF on December 11, 2020. (Ex. B). Defendant-Appellant moves herein for leave to appeal within thirty (30) days of the entry and service of the order of the Appellate Division. Accordingly, the instant motion is timely.

V. QUESTIONS PRESENTED

Q1. Is an employer who purchased a MLMIC policy of insurance that insured an employee entitled to a distribution of the demutualization proceeds, i.e., "Cash Consideration," as a matter of law and equity where the employer selected and bargained for the policy, paid the policy premiums, received the dividends, received the policy refunds and administered the policy?

A. The Appellate Division, Second Department answered No.

Q2. Would awarding Plaintiff-Respondent the Cash Consideration where Plaintiff did not bargain for the demutualization proceeds or pay any premiums on the policy result in Plaintiff's unjust enrichment?

A. The Appellate Division, Second Department answered No.

Q3. Is Defendant solely entitled to all of the Cash Consideration and prejudgment interest commencing with the placement of the Cash Consideration into escrow?

A. The Appellate Division, Second Department answered Yes.

Q4. Should this matter be remanded to the lower court for discovery on Defendant-Appellant's affirmative defenses and counterclaims?

A. The Appellate Division, Second Department did not reach this issue.

VI. STATEMENT OF FACTS

The facts in this case are largely undisputed. Appellant Joseph Scott M. D. ("Dr. Scott") is a licensed physician employed by Maple pursuant to a written employment agreement. (R. 212-20, 238-42). As part of Dr. Scott's employment agreement, Maple agreed to pay for professional medical malpractice insurance coverage for Dr. Scott, at no cost to her. (R. 212-20, 238-42) Although Maple procured and paid for the policies, medical malpractice insurance cannot be written as a group policy and must name individual insureds on the policies. As a result, individual physicians including Dr. Richard Frimer, a partner in Maple's practice are named on the policies instead of Maple. (R. 238-39)

In July 2016, MLMIC applied to the New York Department of Financial Services ("DFS") to convert from a mutual insurance company to a stock insurance company. MLMIC announced the sale of the company to Berkshire Hathaway by email dated July 18, 2016, which stated in pertinent part:

> [T]he person or entity that paid the premium will be considered as the owner of the eligible policy" and that "each owner of an eligible policy will be entitled to receive in cash a proportionate share of all of the cash consideration...

(R. 288-90, "Email Announcement").

Thereafter, MLMIC continued to release information pertaining to the transaction reiterating that "<u>the person or entity that paid the premium will be considered as the owner of the eligible policy</u>" and that "<u>each owner of an eligible policy will be entitled to receive in cash a proportionate share of all of</u>

the cash consideration paid.". (R. 291-93, "Newsletter"). MLMIC further prepared a Plan of Conversion dated June 15, 2018 (hereinafter "Plan") (R. 63-160). However, contrary to the foregoing pronouncements and the understanding of all involved, the Plan, for the first time, indicated that the person or entity that paid the premium would not be considered as the owner of the eligible policy. In short, the Plan defined "Policyholder" as "*the person(s) identified on the declarations page of such Policy as the insured.*" (Definitions, "Eligible Policyholder" R. 68). Thus, by this definition, the party that paid the premium would not be entitled to receive a proportionate share of all the cash consideration paid from the demutualization. This sudden and sea change in the definition of policyholder, owner of the policy, and party who would be entitled to the cash consideration, came almost two years after the initial announcement. Equally momentous is that the Plan also changed the party that would be entitled to vote on the whether to approve the plan of demutualization and the sale, only weeks before the vote whether to approve the sale and demutualization. (Definitions, "Eligible Policyholder" R. 68)

The revisions set forth in the labyrinthine Plan provided that cash consideration would be paid to policyholders/members in exchange for the extinguishment of the policyholder membership interests. Pursuant to the Plan, "Each Eligible Policyholder (or it's designee) shall receive a cash payment in an amount equal to the applicable conversion." (R. 77, § 8.2 (a)). An "eligible policyholder" was the person designated as the insured, while a "designee" meant employers or policy administrators, "designated by

Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders." (R. 68, § 2.1 "Designees") According to the Plan, in the absence of an explicit designation from the policyholder/member, the policy administrator would not receive cash consideration.

In short, the revised definitions of the Policyholder and Eligible Policyholder in the Plan would not be the party that paid the premium as originally disclosed in the Email and the Newsletter. The prior disclosures never indicated that the Policy Administrator was or would be a substantive designation or, more importantly, that the failure of the party acting as Policy Administrator but not having been formally designated Policy Administrator would have any substantive impact.

Shortly after the Plan a Notice of Public Hearing was published (R. 123, "Notice") The Notice stated that eligible policyholders would be eligible to receive the cash consideration but did not clearly indicate who would be considered an eligible policyholder. It also stated that "an eligible policyholder may designate another party (such as a policy administrator or employer) to receive that policyholder's share of the cash consideration by timely completing and returning to MLMIC a designation form to be provided by MLMIC." (R. 222) The Notice of Public Hearing further stated that "previous appointments of designees by policyholders for certain purposes (such as submitting premium payments or receiving dividends on the policyholder's behalf) are not valid for this purpose."

The Public Hearing was held on August 23, 2018 (R. 171-72). The problem wrought by the Plan's revision to who is a "policyholder" was aired at the public hearing by multiple policy administrators who testified about how the Plan denied the entities justly and long-believed entitled to the cash distributions – that is the groups like Maple that obtained the policies and paid the premiums. (R. 183-85, 243)

New York Insurance Law § 7307 codifies a plan of conversion to be enacted when a demutualization occurs. The conversion plan must be presented to and approved by the Superintendent of the New York State Department of Financial Services ("DFS"). The statute further sets forth the calculation of how demutualizing companies should distribute compensation corresponding to equitable share associated with each policy:

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

N.Y. INS. LAW § 7307(e)(3) (emphasis added).

Insurance Law § 7307(e)(3) is seemingly straightforward in directing that the proceeds of a demutualization be distributed to "policyholders" based on the amount of premiums "such policyholder" has paid. Under a typical group policy, the employer pays the premiums and is the listed policyholder removing all doubt as to which party would be the recipient of

the proceeds of demutualization. However, medical malpractice insurance cannot be written as a group policy, necessitating the naming of individual physicians on the policy.

On September 6, 2018, the DFS issued a Decision approving the demutualization of MLMIC. (R. 162-89) Recognizing that disputes might arise concerning the proper beneficiary of the cash consideration for a particular policy, the Plan set forth a procedure whereby objections could be filed with MLMIC, which would in turn trigger an escrow of the relevant cash consideration until the dispute was resolved either by agreement of the parties or by a judicial ruling. (R. 184-86) However, throughout the decision the DFS misconstrues the express language of § 7307(e)(3) by failing to hold that the policyholders, are the parties that paid the premiums on the policy of insurance, *i.e.* the medical practice. By classifying the insured physicians as the "policyholders" contrary to all of the prior declarations and policy, and contrary to the statutory language that requires, *inter alia,* calculation of the distribution ***such policyholder has properly and timely paid*** *to the insurer on insurance policies in effect*, the DFS decision stood to unjustly enrich the physicians and deprive the medical practices of their due proceeds as well as disenfranchising them from voting on whether to approve the demutualization.

In order to remove any doubt as to its entitlement to the Cash Consideration, Maple filed the underlying action against 6 of its employee

physicians.[1]

VII. THE QUESTIONS PRESENTED MERITS REVIEW BY THE COURT

A. A Split Exists Among the Departments of the Appellate Division

A split exists among the First, Third, Fourth and now Second Departments of the Appellate Division as to whether the MLMIC demutualization proceeds should be distributed to (i) an employer who selected and purchased the policy and paid the premiums or (ii) an employee who is the named insured.

In *Matter of Schaffer, Schonholz & Drossman LLP v Title* (171 AD3d 465 [1st Dept 2019]), the First Department ruled that a medical practice group, who was the Policy Administrator and paid all of the policy premiums, was entitled to the cash proceeds from the demutualization of MLMIC. The *Schaffer* court held that to award the cash proceeds to the named insured physician who never paid any policy premiums would constitute unjust enrichment:

> 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

[1] In addition to the underlying matter, *Maple Med. LLP v. Scott*, 2019-09157 (Index No. 51103/2019 Sup. Ct. Westchester Cty. Jul. 5, 2019), the following cases were filed and decided: *Maple Med. LLP v. Sundaram*, 2019-09161 (Index. No. 51107/2019 Sup. Ct. Westchester Cty. July 5, 2019); *Maple Med. LLP v. Mutic*, 2019-09162 (Index No. 51108/2019 Sup. Ct. Westchester Cty. Jul. 5, 2019); *Maple Med. LLP v. Goldenberg*, 2019-09160 (Index. No. 51105/2019 Sup. Ct. Westchester Cty. Jul. 5, 2019); *Maple Med. LLP v. Youkeles*, 2019-09158 (Index No. 51109/2019 Sup. Ct. Westchester Cty. Jul. 5, 2019); *Maple Med. LLP v. Arevalo*, 2019-09159 (Index No. 51106/2019 Sup. Ct. Westchester Cty. Jul. 5, 2019) (collectively the "Six Actions").

> costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds. Awarding respondent the cash proceeds of MLMIC's demutualization would result in her unjust enrichment

171 AD3d at 465.

In support of its ruling, the First Department cited federal caselaw precedent on the distribution of insurance demutualization proceeds among employers and employees (*see id.*).

Subsequently, in *Maple-Gate Anesthesiologists, PC. v Nasrin* (182 AD3d 984 [4th Dept 2020]), the Fourth Department split with the First Department and ruled that an employer who paid all of the policy premiums had no "legal or equitable right of ownership to the demutualization proceeds" (*id.* at 842). The Fourth Department's decision did not cite or discuss any caselaw precedent involving the demutualization of insurance companies.

In the case of *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338, 340, 126 N.Y.S.3d 532, 534, leave to appeal granted, 35 N.Y.3d 918 (2020), the Third Department split with the First Department and joined the Fourth Department in ruling that the demutualization proceeds were not bargained for by either party, constituted an unexpected windfall, and that Defendant Lake Champlain failed to establish a claim of unjust enrichment. The Third Department further awarded Plaintiff Schoch the entire Cash Consideration in the amount of $74,747.03 with no credit to Defendant for its payment of $25,710 in premiums. (R.225 ¶22, R. 233). The Third Department also awarded Plaintiff pre-judgment interest on the demutualization proceeds

despite Plaintiff's sole cause of action being one for declaratory relief, an equitable remedy, and despite the parties submitting a joint Active Dispute Resolution Notice to MLMIC requesting that the money be maintained in escrow to permit the dispute to be resolved by the courts.

The Court of Appeals granted Lake Champlain Ob-Gyn, P.C. leave to appeal to the Court of Appeals on November 23, 2020.

B. Other Jurisdictions Apply Principles of Equity and Fairness to Allocate Demutualization Proceeds to Employers and/or Employees Based on Their Share of Premiums Paid—Which is Consistent with New York Insurance Law §7307(e)

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. The proper standard of review to determine whether a party has an equitable claim to share in the proceeds —which is also consistent with the process laid out in New York Insurance Law § 7307(e)—is to calculate the amount of premiums that the employer/employee paid. This is the majority view of courts throughout the nation in considering the demutualization of insurers providing employee disability insurance, health insurance, 401k retirement benefits, etc. (*see Ruocco v Bateman, Eichler, Hill, Richards, Inc.*, 903 F2d 1232, 1238 [9th Cir 1990], *cert denied*, 498 US 899 [1990] [holding that the "balance of equities" weighed in favor of distributing the demutualization proceeds to the employees who paid the disability insurance policy premiums]; *Chicago Truck Drivers, Helpers & Warehouse Workers Union*

[Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper and Warehouse Workers Union [Ind.] Pension Fund, 2005 WL 525427, *4, 8 [ND Ill, Mar. 4, 2005] [holding employees who fully funded 401(k) plan were entitled to demutualization proceeds rather than the employer who would receive an "undeserved windfall"]; *see also Mell v Anthem, Inc.*, 688 F3d 280 [6th Cir 2002], quoting *Mell v Anthem, Inc.*, 2010 WL 796751, at *10 [SD Ohio Mar. 3, 2010] [affirming district court's finding that employees were not the owners of health insurance policy subject to demutualization "because as employees and retirees [the employees] 'had nothing to do with the choice of insurance carrier, nor with its governance, and they received what they bargained with the [the employer] to get: insurance coverage'"]; *Greathouse v E. Liverpool*, 159 OhioApp3d 251, 257 [Ohio Ct App 2004] [holding that "[a]s a benefit of his employment, the city provided appellant with health insurance—nothing more. Appellant cannot contend that he somehow owned the policy and was entitled to the [demutualization] stock proceeds."]; *Town of N. Haven v N. Haven Educ. Association*, 2004 WL 113524, at *2 [Conn Super Ct, No. CV030474463, Jan. 5, 2004] [commenting in application to stay arbitration of dispute concerning medical insurer's demutualization and distribution of stock that "[f]airness dictates that the teachers should share in the proceeds received by the Town to the extent that the amount of the premiums paid by them bears to the total amount of the premiums paid by the Town upon which the total stock distribution was based"]).

As illustrated by the above cases, distribution of the MLMIC Cash Consideration should be determined by the parties' respective share of the premiums that they paid. This rule is consistent with New York Insurance Law § 7307(e)(3), which provides:

> [t]he equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the insurer on insurance policies . . . .

N.Y. Insurance Law § 7307(e).

The rule is also consistent with principles of equity and fairness, and particularly applicable to the facts here. While sometimes termed a "windfall", this unexpected windfall would not have arisen without Maple specifically selecting and bargaining for a MLMIC policy, paying all of the premiums, and assuming all of the financial risk associated with the policy.

C. The Demutualization Cases Relied Upon by Plaintiff-Respondent and the Third Department are Inapposite

In the *Schoch v. Lake Champlain Ob-Gyn, P.C.*, 184 A.D.3d 338, 340, 126 N.Y.S.3d 532, 534, leave to appeal granted, 35 N.Y.3d 918 (2020), and in this case, the employee relied below on *Dorrance v United States* (809 F3d 479 [9th Cir 2015]) which is a tax case. Unlike the MLMIC conversion, in *Dorrance,* the demutualization proceeds were shares of stock that were not valued based on the payment of policy premiums (*see id.* at 497 ["Thus, the value at demutualization was not derived from something paid for by the [policyholder]"). Here, in contrast, the value of the MLMIC Cash Consideration is directly based on the amount of premiums paid during the

three-year period preceding the plan of conversion. (§2.1 "Eligibility Period", §8.2). Moreover, the Ninth Circuit, which decided *Dorrance*, has also held that where the distribution of demutualization proceeds is based on premium payments, that "the balancing of equities weighed in favor of the plan participants because the premiums for the plan were paid by the participants and because...'[the other party] paid nothing'" (*Ruocco v Bateman, Eichler, Hill, Richards, Inc.*, 903 F2d at 1238).

Similarly, Defendant's reliance on *Bank of New York v Janowich* (470 F3d 264, 274 [6th Cir 2006]) was misplaced. First, *Bank of New York* involved annuity contracts that were purchased after the termination of an employer funded employee benefit plan. The annuities were purchased from benefits that were already due the employees. The employer had no interest in the annuity contracts, and thus no right to the demutualization proceeds (*see id.* at 271). Here, in contrast, the MLMIC policy is the subject of the demutualization. Second, the demutualization plan in *Bank of New York* was silent as to any rights of the employer. In contrast, the MLMIC Plan of Conversion and DFS Decision approving the Plan expressly acknowledge that the. employer policy administrator who paid the premiums, rather than the named insured, may be entitled to the demutualization proceeds, depending "on the facts and circumstances of the parties' relationship and applicable law...." (R.151).

D. Insurance Law § 7307(e)(3) Did Not Contemplate the Demutualization of a Medical Malpractice Liability Insurer.

MLMIC is the first mutual medical malpractice insurer to demutualize in New York. In New York, medical malpractice insurance generally cannot be written as a group policy (*see Urgent Medical Care, PLLC v Amedure*, 64 Misc 3d 1216[A], 2019 NY Slip Op 51188[U] [Sup Ct, Greene County 2019]).[2] As recognized during the DFS hearing on the MLMIC conversion, in a group policy the employer would be the policyholder notwithstanding the individual named insureds being covered by the policy.[3] But for this anomaly, Defendant would lack standing to challenge the distribution of the Cash Consideration, and Maple would receive a return on its investment of selecting and bargaining for the MLMIC policy, paying all premiums, and assuming all financial risk associated with the same.

E. Neither the New York Insurance Law nor the MLMIC Plan of Conversion Defines Who is a "Policyholder" Entitled to the Distribution of the MLMIC Demutualization Proceeds

The New York Insurance Law does not define "policyholder" under

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[2] "Both Insurance Law § 3435 and Regulation 135 (11 NYCRR 153) permit the issuance of group property/casualty insurance only with respect to public and not-for-profit insureds. Thus, under New York law with the limited exception of a risk retention group authorized under Federal law, group property/casualty insurance for physician groups may not be written in New York (*see* Office of General Counsel, Department of Financial Services, *New York Medical Professional Liability Insurance* [June 4, 2008] OGC Op No 08-06-02, available at https://www.dfs.ny.gov/insurance/ogc2008/rg080602.htm); *Urgent Medical Care PLLC v Amedure*, 64 Misc 3d 1216[A], 2019 NY Slip Op 51188[U] [Sup Ct, Greene County 2019] [citation in original].

[3] *See* Public Hearing in the Matter of Medical Liability Mutual Insurance Company), August 23, 2018, Transcript at p. 170, last accessed on July 13, 2020, available at https://www.dfs.ny.gov/system/files/documents/2019/01/mlmic_transcript_20180823.pdf.

Insurance Law § 7307(e) or provide that the "policyholder" is necessarily entitled to a distribution of the MLMIC demutualization proceeds. Rather, Section 7307(e) provides the process for determining the amount of demutualization consideration that shall be paid in exchange for a policyholder's equitable share in the mutual insurer and specifies that such consideration shall be payable to "each person who had a policy of insurance in effect at any time during the three-year period immediately preceding the [demutualization]."

Notably, Section 7307(e) uses the term "policyholder" when referring to the manner and method of calculating the equitable share in the mutual insurer from which the amount of consideration is to be calculated. However, when referencing who is entitled to receive the consideration in exchange for the policyholder's equitable share, the statute more broadly states that the consideration is payable to "each person who had a policy of insurance in effect at any time during the three-year period immediately preceding the [demutualization]." This guidance is consistent with the DFS Decision that "[t]he determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided by agreement of the parties or by an arbitrator or court." Defendant argues in conclusory fashion that Defendant is a "policyholder" and thus entitled to receive the cash consideration by virtue of Defendant's status as a "member" of MLMIC pursuant to Insurance Law § 1211. Maple in turn submits that it is entitled to the cash consideration because it "had a

policy in effect" during the relevant time period, selected and purchased that policy, was the Policy Administrator or de facto Policy Administrator on the policy, paid all the premiums on the policy, and the policy and its endorsements were issued to it.

Insurance Law § 1211 upon which Defendant relies does not mention demutualization and does not address, let alone create, any right of a "policyholder" or "named insured" or "member" to demutualization proceeds. As discussed in Point VII.B. above, such nominal designations are not determinative in balancing the parties' legal and equitable rights, but the Second Department essentially found them determinative. Defendant, however, argues that under the DFS Decision approving the MLMIC Plan of Conversion, the policy's "named insured" is automatically entitled to the demutualization proceeds absent an assignment of said proceeds to the Policy Administrator. Contrary to the Appellate Division rulings, the DFS Decision did not limit a Policy Administrator's right under the Plan's dispute resolution process to assert its legal and equitable ownership interest in the Cash Consideration. To the contrary, the DFS's Decision approving the Plan acknowledged that:

> If a Policy Administrator ... has not been specifically designated to receive the Cash Consideration allocated to an Eligible Policyholder, but nevertheless believes that it has a legal right to receive such Cash Consideration, such Policy Administrator ... may send MLMIC [an objection and] ... The allocated Cash Consideration will be held in escrow ... until MLMIC receives joint written instructions from the Eligible Policyholder and the Policy Administrator ... as to how the allocation is to be distributed, or a non-appealable

> order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the Policy Administrator or ... or the Eligible Policyholder.

The DFS was well-aware of the instant dispute that spawned litigation premiums and claimed a right to the cash consideration.[4] Instead, the DFS held:

> Nor does the definition of Policy Administrator under the particular facts or applicable law represent the Department's view that anyone that falls within this definition is (or is not) entitled, under the particular facts or applicable law, to receipt of the cash consideration. The determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided by agreement of the parties or by an arbitrator or court.
>
> . . . .
>
> The Department, while making clear that the parties to these disputes maintain all legal rights to pursue their claims, encourages all parties involved in the Objection Procedure to resolve their differences in a prompt, fair and equitable manner.

Thus the agency's deliberate decision not to adjudicate the legal merit of the competing claims demonstrates why this dispute warrants review by this Court and just as importantly, why the merits of the claims to the proceeds, such as unjust enrichment required resolution not by the agency

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[4] As noted by one commentator, the DFS "punted on the question of who would be paid. During public comment, both the physicians who were in many cases the nominal policyholders and the practices, hospitals, and others that acted as policy administrators and paid the premiums raised their hands as prospective payees. DFS did not decide the issue; rather, it left it to be determined through dispute resolution processes, including mediation, arbitration, and court proceedings" (Daniel J. Hurteau, *New questions arise following the latest ruling on MLMIC distributions*, Litigation and Insurance Alert [May 4, 2020],available at https://www.nixonpeabody.com/en/ideas/articles/2020/05/04/new-questions-arise-following-the- latest-ruling-on-mlmic-distributions; *see also* Daniel J. Hurteau, *New questions arise following the latest ruling on MLMIC distributions*, NYLJ, May 29, 2020, available at https://www.law.com/newyorklawjournal/2020/05/29/new-questions-arise-following-the-latest- ruling-on-mlmic-distributions/).

but on a case by case basis through Court or similar applicable dispute resolution mechanism.

F. This Court Should Recognize the Equitable Remedy of Unjust Enrichment for Disputes Between New York State Employers and Their Employees Who Receive Unexpected Insurance Demutualization Windfalls

Maple submits that this Court should recognize the remedy of unjust enrichment under New York law for employers and employees who paid premiums and claim a right to receive unexpected insurance demutualization windfalls that were not bargained for by the parties. Recognition of this equitable claim would align New York with the standard of review in other jurisdictions (*see* Point VII.B *supra*), and be in harmony with New York law, as discussed below.

"The essential inquiry in any action for unjust enrichment . . . is whether it is against equity and good conscience to permit [one party] to retain what is sought to be recovered" (*Mandarin Trading Ltd. v Wildenstein*, 16 NY3d 173, 182 [2011] [internal quotation marks and citation omitted]). Notably, "a party may be legally entitled to a benefit through a contract but still equitably owe those funds to another (*see Simonds v Simonds*, 45 NY2d at 239; see also Restatement [Third] Restitution and Unjust Enrichment § 26, Illustration 11)." *Urgent Medical Care, PLLC v Amedure*, 64 Misc 3d 1216(A), 2019 N.Y. Slip. Op. 51188(U) [Sup Ct, Greene County 2019]. Maple is not required to show that Defendant committed a

"wrongful act" to establish unjust enrichment (*see Simonds v Simonds*, 45 NY2d 233, 242 [1978] ["Unjust enrichment, however, does not require the performance of any wrongful act by the one enriched"]). As recognized by this Court, "[i]nnocent parties may frequently be unjustly enriched" (*id.* at 242 [holding former wife had equitable right to benefits under former husband's life insurance policies]).

Nor does mutual mistake by the parties does not preclude unjust enrichment. Similarly, proof of tortious or fraudulent conduct is not required to recover for unjust enrichment (*see e.g., Castellotti v Free*, 138 AD3d 198, 207-08 [1st Dept 2016] ["Here, the complaint's allegations show that [defendant] was enriched at [plaintiff's] expense because [plaintiff] paid the estate taxes and insurance premiums, despite [defendant] being the sole beneficiary of the will, and that it would be against equity and good conscience to allow [defendant] to retain that windfall"]).

Here, Maple selected and bargained for the policy, paid all policy premiums, and assumed all financial risk associated with the policy. Yet, the Second Department ruled that Defendant was entitled to the entire demutualization "windfall," which Defendant did not bargain for, and allocated no portion of the surplus cash consideration for reimbursement of the premiums paid by Maple.

It is respectfully submitted that the First Department in *Schaffer* correctly applied the law of unjust enrichment consistent with the New York law and the standard of review applied by other jurisdictions in allocating

insurance demutualization proceeds among employers and employees.

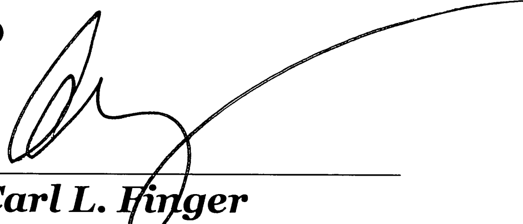
Alternatively, the Second Department should have remanded this case to Supreme Court for further discovery on the parties' claims and defenses, including Maple's defenses and claims for unjust enrichment, breach of contract, and breach of the implied covenant of good faith and fair dealing.

VIII. CONCLUSION

For the reasons above, Maple respectfully requests that this Court grant leave to appeal the Opinion and Order of the Appellate Division and award such other and further relief as it deems just and proper.

Dated: White Plains, New York

December 22, 2020



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