APL-2020-00169, APL-2021-00001, APL-2021-00045, APL-2021-00046, APL-2021-00047, APL-2021-00048, APL-2021-00049, APL-2021-00050
Saratoga County Clerk's Index No. 20184228, Columbia County Clerk's Index No. 14064/19, Westchester County Index Nos. 51103/19, 51105/19, 51106/19, 51107/19, 51108/19, 51109/19
Appellate Division, Third Department Case Nos. 529615, 530190
Appellate Division, First Department Case Nos. 2019-09157, 2019-09158, 2019-09159, 2019-09160, 2019-09161, 2019-09162

Court of Appeals

of the

State of New York

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

Plaintiff-Respondent,

– against –

LAKE CHAMPLAIN OB-GYN, P.C.,

Defendant-Appellant.

(For Continuation of Caption See Inside Cover)

BRIEF FOR *AMICI CURIAE* JAMES D. SULLIVAN, M.D., CHARLES CONTE, M.D., MANSOUR BEG, M.D., ALAN KADISON, M.D., JOHN RICCI, M.D. AND RAZA ZAIDI, M.D. IN SUPPORT OF RESPONDENTS

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THE COLUMBIA MEMORIAL HOSPITAL,

Plaintiff-Appellant,

– against –

MARCEL E. HINDS, M.D.,

Defendant-Respondent.

MAPLE MEDICAL LLP,

Plaintiff-Appellant,

– against –

JOSEPH SCOTT, M.D.,

Defendant-Respondent,

– and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

MAPLE MEDICAL LLP,

Plaintiff-Appellant,

– against –

DIANA GOLDENBERG, M.D.,

Defendant-Respondent,

– and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

MAPLE MEDICAL LLP,

Plaintiff-Appellant,

– against –

DIANA AREVALO, M.D.,

Defendant-Respondent,

– and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

MAPLE MEDICAL LLP,

Plaintiff-Appellant,

– against –

NINA SUNDARAM, M.D.,

Defendant-Respondent,

– and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

MAPLE MEDICAL LLP,

Plaintiff-Appellant,

– against –

MARIO MUTIC, M.D.,

Defendant-Respondent,

– and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

MAPLE MEDICAL LLP,

Plaintiff-Appellant,

– against –

LISA H. YOUKELES, M.D.,

Defendant-Respondent,

– and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

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INTEREST OF AMICI CURIAE

The *Amici Curiae* are six oncological surgeons (the "Surgeons") who were long-time policyholders of the Medical Liability Mutual Insurance Company ("MLMIC"). Currently, the Surgeons are in litigation in the First Department against Northwell Health, Inc. ("the Hospital") over the proceeds from MLMIC's demutualization. The Surgeons' case is titled *Sullivan v. Medical Liability Mutual Insurance Company*, No. 2019-0552 (the "*Sullivan* Case"), and was orally argued before a First Department panel on February 3, 2021.

At oral argument, the First Department justices indicated that they would hold the *Sullivan* Case in abeyance in anticipation of this Court's decisions in the above-captioned cases, so as to be guided by this Court. Thus, the Surgeons have a direct and substantial interest in these proceedings.

The Surgeons believe this *amici curiae* brief is necessary for two reasons. *First*, the parties in the above-captioned cases do not address crucial aspects of the law governing demutualization: the notice and voting requirements in Insurance Law § 7307. The notice and voting requirements logically prove that the Legislature intended that the policyholders – and no one else – be protected and compensated. A plan of demutualization cannot come into effect unless (1) the *policyholders* are sent copies of the plan, with an explanation of how

demutualization will affect them, Ins. Law § 7307(f)(g), and (2) the *policyholders* vote by supermajority in favor of the plan, Ins. Law § 7307(j).

By ensuring that the policyholders have the information necessary to understand how demutualization will affect them, and by giving policyholders the ultimate authority to approve or disapprove demutualization, the Legislature ensured that the policyholders' interests would be protected. The statute makes no sense unless the policyholder who is informed about, and votes on, the fairness of the demutualization compensation is the same policyholder who is entitled to receive the compensation.

Second, the parties in the above-captioned cases are only a tiny sampling (eight policyholders and three employers) of the many MLMIC litigants in New York State – and this sampling is not representative of all litigants. For instance, in the above-captioned cases, the employers, rather than the policyholders, chose and administered the MLMIC policies. In addition, there is no mention of the policyholders' casting ballots in the dispositive vote on demutualization. One of the employers' briefs even characterizes the policyholders as "nominal" policyholders.

By contrast, the Surgeons, and presumably many other policyholders, specifically chose MLMIC as their insurer, and negotiated for their employer to pay the premiums. Moreover, the Surgeons, and presumably many other

policyholders, were hands-on administrators of their MLMIC policies. (Their employer paid the insurance premiums, but was not the Surgeons' agent.)

Most significantly, the Surgeons, and no doubt many other policyholders, played a crucial role in demutualization. In reliance on MLMIC's written representations, regarding the specific amounts of monetary compensation that they would receive, the eligible Surgeons cast votes in favor of demutualization. Without the policyholders' votes, there would have been no demutualization, and no proceeds to be disputed on this appeal. Thus, the Surgeons, and no doubt other policyholders, could never be labeled "nominal" policyholders.

This Court's decisions will affect not only the above-captioned parties, but also many other parties whose cases are in negotiation, arbitration, and litigation in lower courts, and whose cases are factually distinct. A fair decision should consider all of the interests and equities at stake.

FACTUAL BACKGROUND

The Surgeons' case is illustrative of a factual permutation that should be considered by this Court, and demonstrates that the MLMIC disputes do not follow a single pattern. The Surgeons' employer did not select the MLMIC insurance, and did not control or manage the coverage. Rather, the Surgeons themselves chose their MLMIC policies, and managed their own coverage.

The Surgeons originally practiced medicine in an independent partnership with one another. Before they became Hospital employees, they negotiated with the Hospital over salaries, duties, and malpractice insurance. A key bargaining point was that each of the Surgeons would continue to choose and maintain his own, individual, MLMIC malpractice policy, with the Hospital paying the premiums. (*See* Exhibit A hereto, Affirmation of James D. Sullivan, M.D., ¶¶ 2-12)[1]

The Surgeons did not want to relinquish their long-held MLMIC policies because of the superiority of MLMIC coverage. MLMIC was a mutual insurance company, created by and for New York doctors (and owned by its policyholders). Thus, MLMIC policies were designed with particular features and advantages, permitting policyholders to choose their own counsel and to approve or disapprove settlements. The Hospital's group insurance lacked such advantages.[2]

As a result of negotiation, the Hospital agreed to pay the premiums for the Surgeons' MLMIC coverage. The Hospital's payments were a unique, bargained-for feature of the Surgeons' contracts, not extended to other Hospital employees.

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[1] Each surgeon submitted a similar affidavit to the trial court, and these documents are part of the Record before the First Department. Likewise, the other documents annexed to this brief are part of the Record in the *Sullivan* Case.

[2] The Hospital was self-insured, with a group malpractice policy that covered all of its medical personnel. Thus, from the Hospital's point of view, there was no need to purchase separate insurance for the Surgeons, and paying for MLMIC was a superfluous expense. (*See* Exhibit B hereto, Hospital memo.)

Thereafter, the Surgeons renewed and individually administered their MLMIC policies. Each surgeon appointed himself the "Policy Administrator" of his policy. The Hospital never obtained any rights with respect to the Surgeons' policies, and was never the Surgeons' agent. MLMIC sent invoices and other correspondence directly to the Surgeons, not to the Hospital.

When, in late July 2016, MLMIC announced its intention to demutualize, MLMIC directly notified the Surgeons, sending each surgeon a copy of the demutualization plan and information about exactly how much compensation the surgeon could expect to receive in exchange for his equity share if the demutualization plan were approved. In doing so, MLMIC was complying with the statutory requirement that "prompt notice shall be given by the mutual insurer to all persons who become policyholders . . . of the pendency of a proposed conversion *and of the effect hereof on them*," Ins. Law § 7307(f) (emphasis added). (*See* Exhibit C hereto, sample MLMIC communication regarding monetary compensation that a surgeon could expect to receive, and Exhibit A ¶ 16.)

New York law also requires that *policyholders* be given notice of a public hearing on the plan, "accompanied by a copy of the plan of conversion," and "any comment the superintendent [of insurance] considers necessary for the adequate information of the *policyholders*," Ins. Law § 7307(g) (emphasis added). The law

instructs the Superintendent of Insurance to consider the *policyholders*' "best interests," among other factors, in evaluating the demutualization plan, Ins. Law § 7307(h)(i). Here, the Superintendent approved the MLMIC demutualization plan.

Subsequently, in compliance with Insurance Law § 7307(i), MLMIC sent the Surgeons written notice of the impending vote to be held on the demutualization plan. After consulting with one another, the Surgeons decided that MLMIC's proposed monetary compensation was fair, and they decided to support demutualization. The eligible Surgeons then exercised their proxies in favor of MLMIC's demutualization plan.[3] In voting for demutualization, they relied on their statutory rights and on MLMIC's representations regarding what their compensation would be. (*See* Exhibit D hereto, sample proxy, executed by one of the Surgeons.)

At least two-thirds of the MLMIC policyholders voted in favor of demutualization. This satisfied the statutory requirement in New York Insurance Law § 7307(j), and the plan went into effect.

[3] Not all of the Surgeons were eligible to vote in 2018 because some policies had expired shortly before the cut-off date for voting set forth in § 7307(i) ("the day preceding the date of adoption of the resolution" by the insurer's board of directors).
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Later, over the Surgeons' opposition, a trial court held that the Hospital was entitled to the compensation that the Surgeons had relied on. Citing *Schaffer, Schonholtz & Drossman LLP v. Title*, 171 A.D.3d 465 (1st Dep't 2019), the trial court stated that, as a matter of law, compensation must be awarded to the Hospital because to do otherwise would be "unjust enrichment" for the Surgeons. (*See* Exhibit E hereto, trial court decision in the *Sullivan* Case.)

On appeal, a First Department panel indicated orally that it would be guided by this Court's decisions in the above-captioned cases.

ARGUMENT

I. The Notice and Voting Provisions of New York Insurance Law Demonstrate that the Legislature Intended the Policyholders, and No One Else, to Benefit from the Demutualization of a Casualty Insurance Company

The statutory scheme governing demutualization of New York insurance companies, set forth in Insurance Law § 7307, is consistent and clear. It leaves no room for debate.

After the board of directors of a property or casualty mutual insurance company decides to demutualize, it must "promptly" notify each policyholder "of the pendency of a proposed conversion and of the effect hereof on them," Ins. Law § 7307(f). No other party need be noticed and informed – only the policyholders.

The statute also provides for an independent appraisal of the insurance company, supervised by the Superintendent of Insurance, § 7307(b),(c),(d),and

sets forth what a demutualization plan "shall include," § 7307(e). The mandatory elements of a demutualization plan include a provision for "exchanging the equitable share of each eligible mutual policyholder for securities or other consideration," in that the policyholders "shall be entitled to receive in exchange for such equitable share . . . consideration payable in voting common shares of the insurance or other consideration or both," § 7307(e)(3).

In addition, the statute requires a public hearing, with notice mailed to all policyholders, "accompanied by a copy of the plan of conversion," along with "any comment the superintendent [of insurance] considers necessary for the adequate information of the policyholders," Ins. Law § 7307(g). The statute mandates that, in deciding whether or not to approve the plan, the Superintendent of Insurance must consider, together with other factors, the "best interests" of the policyholders, Ins. Law § 7307(h)(i).

Finally, if after the public hearing the Superintendent of Insurance approves the plan, the statute provides that, before demutualization can occur, the plan "shall be submitted to a vote of the policyholders." Each policyholder must be personally given, or mailed, with at least 30 days' notice, information regarding how to exercise his or her vote, along with a summary of the plan or a second copy of the plan, Ins. Law § 7307(i). "The votes of two-thirds of all the votes cast" is required before the plan can go into effect, § 7307(j).

Thus, the statute ensures that the policyholders have the information necessary to understand how demutualization will affect them. And the statute gives policyholders the ultimate authority to approve or disapprove demutualization.

By placing this knowledge and authority in the hands of the policyholders, the statute ensures that a demutualizing insurance company will consider the policyholders' interests. If the policyholders know or believe that they will not be adequately compensated for their membership interests, they will be motivated to vote against demutualization, and no demutualization will occur. The statute forces an insurance company that wants to demutualize to be fair to its policyholders. Even if the Superintendent of Insurance approves the company's demutualization plan, the plan cannot take effect unless and until the policyholders overwhelmingly approve it. The statute makes no provision for voting by anyone other than the policyholders.

Some employers argue that the word "policyholder" should be interpreted to include any third party who pays the premiums. But the notice and voting provisions of § 7307 demonstrate the fallacy of this argument. It would be illogical to vest a policyholder with the power to decide the fairness of a third party's compensation. (No third party was permitted to vote, nor do the employers

claim that they voted. Moreover, being a "policy administrator" did not confer any right under the statute.[4])

In the case of MLMIC, if the voting MLMIC policyholders had believed that they would *not* be compensated as promised, because the compensation would go to their employers, it is unlikely that these policyholders would have voted overwhelmingly in favor of the plan. Certainly, the eligible Surgeons would not have done so. To the contrary, they would have been motivated to vote against demutualization, rather than give up their membership interests and receive nothing in return.

Thus, the notice and voting provisions are strong, logical proof that the Legislature intended the policyholders, and no one else, to be assured of and receive the compensation in a demutualization. Otherwise, there would be no point in sending the policyholders a copy of the demutualization plan, informing them of what the effect would be on them, and placing the decision to demutualize squarely in their hands.

Some employers have argued that to compensate the policyholders would be unfair, because the employers paid insurance premiums. These employers urge the Court to disregard the statutory language and clear evidence of the Legislature's

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[4] Significantly, MLMIC's definition of a "policy administrator" is a person or organization *designated by the policyholder* to administer the insurance policy *on the policyholder's behalf*. *See* Plan of Conversion of Medical Liability Mutual Insurance Company," Article 2, Definitions (as adopted on May 31, 2018).

intent. But the Court should not override the Legislature's considered determinations.

Demutualization was foreseeable. There was always a possibility that a mutual insurance company would seek to demutualize. Almost forty years ago, the Legislature foresaw this possibility, and articulated exactly what the results should be, and what precise procedures should be followed. Section 7307 was carefully drafted to ensure that the policyholders – and only the policyholders – would be protected and compensated when demutualization occurred.

At the time that the statute was last amended, in 1984, it was commonplace for doctors and nurses to be employed by hospitals, unions, medical groups, and HMOs, and for employers to provide malpractice insurance for their medical personnel. Had the Legislature intended for employers to be compensated in a demutualization, simply because employers usually paid for their employees' malpractice insurance, the Legislature could easily have provided for this result. It is significant that the Legislature did not do so.[5]

In short, if the Appellants have an argument, it is with the Legislature, not with the Respondents. To deny compensation to the policyholders would not only

[5] Medical employers have long been on notice that compensation would go to their employees, the policyholders, if demutualization of MLMIC occurred.

violate the policyholders' reasonable expectations and reliance; it would violate the statutory scheme and ignore the Legislature's obvious intention.

II. Where Policyholders Chose, Bargained for, and Administered their MLMIC Policies, and Voted for Demutualization in Reliance on MLMIC's Representations and New York law, the Policyholders Alone Have an Equitable Claim to Compensation

The appeals before this Court, initiated by employers, display a particular fact pattern. In all of these cases, the employers chose the insurer; the employers paid the insurer; and the employers required the policyholders to accept this insurance. In most of the cases, the employers required the policyholders to designate the employer as agent, with unlimited discretion. Thus, the employers, not the policyholders, dealt with and corresponded with the insurance company.

The parties do not even mention voting. Therefore, it is not clear whether or not the policyholders in these cases exercised proxies in the crucial vote on demutualization – or, indeed, whether their employers even forwarded to the policyholders the correspondence notifying them that a decision on demutualization was imminent, and that they had a right to vote.

But not all cases fit this pattern. For instance, in the Surgeons' case, the policyholders – not the employer – chose and applied for MLMIC insurance. There was bargaining specifically for the MLMIC insurance, as part of the policyholders' compensation, and the policyholders at all times did the work of administering their own policies. Moreover, in the Surgeons' case, and

presumably many other cases, the eligible policyholders exercised their proxies in favor of demutualization.

Such policyholders have strong equitable claims to compensation. These policyholders maintained the relationship with MLMIC, did the work associated with MLMIC membership, and voted in reliance on MLMIC's representations regarding the specific monetary compensation that they would receive. They believed their rights were as MLMIC (and New York law) described. It would be unfair to deprive such policyholders of compensation based on after-asserted claims by employers who did not vote and took no actions in reliance on MLMIC's promises.

Had these policyholders believed that they would *not* be compensated in the demutualization process, because the promised compensation would actually go to their employers, these policyholders would have had no incentive to vote in favor of demutualization. To the contrary, they would have been motivated to vote against demutualization, because they would be giving up their membership interests and receiving nothing in return. In all likelihood, demutualization would not have occurred.

By contrast, the employers in these cases have no equitable claim to compensation. The employers agreed to pay the MLMIC premiums, but they did

so for a reason: to obtain the services of their employees. The employers then continued to pay the premiums because they were contractually obligated to do so.

The employers apparently did not anticipate MLMIC's demutualization, which made the MLMIC policies more valuable. But this factor is irrelevant. Consider, by analogy, the case of a prospective executive who negotiates with her future employer. Her future company agrees to help her relocate by making a down payment on a house and/or helping with her mortgage payments. Later, unexpectedly, the house increases in value. But the house still belongs to the executive – the company has no claim to it. The company agreed to help the executive purchase the house to induce her to accept employment by the company.

The MLMIC cases are analogous. The MLMIC policies turned out to be more valuable than was anticipated – but this did not confer a right on the employers. The policies still belonged to the policyholders.

III. The *Schaffer* Case, Finding Unjust Enrichment, Should be Limited to its Facts or Overruled

This Court has instructed that to find a defendant unjustly enriched, a court must perceive "an equitable obligation running from the defendant to the plaintiff." *Corsello v. Verizon New York, Inc.*, 18 N.Y.3d 777, 790 (2012). "Unjust enrichment . . . contemplates an obligation imposed by equity to prevent injustice, in the absence of an actual agreement." *Georgia Malone & Co. v. Rieder*, 19 N.Y.3d 511, 516 (2012) (internal quotation marks omitted). The essential elements

of an unjust enrichment claim are: (1) the other party was enriched; (2) at the claimant's expense; and (3) "it is against equity and good conscience to permit the other party to retain what is sought to be recovered." *Id*.

Thus, for an unjust enrichment claim to lie, it is not enough that someone benefited – the benefit must have been unjust. In addition, there must be no "actual agreement" regarding the subject matter. *Georgia Malone*, 19 N.Y.3d at 516; *see also Connaughton v. Chipotle Mexican Grill, Inc.*, 135 A.D.3d 535, 540 (1st Dep't 2016), *aff'd,* 29 N.Y.3d 137 (2017).

In the *Sullivan* Case and many other cases, the policyholders did not incur an "equitable obligation" by virtue of their employers' payments pursuant to contract. Nor did the employers suffer any "loss" within the meaning of unjust enrichment jurisprudence. In a review of New York appellate cases, we have not identified a single appellate decision that found unjust enrichment on facts comparable to the facts in such cases.

The *Schaffer* decision is not to the contrary. In *Schaffer*, 171 A.D.3d at 465, the First Department skipped a step. The First Department did not discuss the impact of New York Insurance Law § 7307. Rather, the court decided for the employer on purely equitable grounds. The *Schaffer* employer had chosen, administered, and controlled the MLMIC policy, and there was no indication that the *Schaffer* employee had voted in favor of demutualization or relied on

MLMIC's assurances or on her rights under Insurance Law § 7307. (*See* Exhibit F hereto, the *Schaffer* parties' joint "Submitted Facts" ¶¶ 6, 12.)

Thus, the only similarity between *Schaffer* and cases like the Surgeons' case is that the employer paid malpractice premiums. To the extent that *Schaffer* is good law, *Schaffer* is not on point for the Surgeons and similar policyholders.

The *Amici Curiae* respectfully urge that, if the Court applies equitable principles, the Court directly address the *Schaffer* case, and distinguish between the policyholder in *Schaffer* and policyholders like the Surgeons. The holding in *Schaffe*r can be limited to its facts or, in the alternative, interpreted to mean that policyholders are *never* entitled to compensation if an employer paid their insurance premiums. If given the latter interpretation, *Schaffer* should be overruled.

CONCLUSION

For the foregoing reasons, the *Amici Curiae* respectfully request that this Court

(1) Affirm the judgments below in favor of the policyholders, on statutory grounds; and

(2) If addressing equitable claims, hold that each of the MLMIC cases should be decided on its facts, and distinguish the *Amici Curiae* and

similarly situated policyholders, whose equitable claims are strong, from the policyholder in *Schaffer*.

Dated: September 9, 2021
New York, New York

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CERTIFICATION PURSUANT TO 22 N.Y.C.R.R. Part 500.23(a)(4)

Elizabeth F. Bernhardt, an attorney duly admitted and licensed to practice before the courts of the State of New York, certifies, pursuant to 22 N.Y.C.R.R. Part 500.23(a)(4), that:

(a) No party's counsel contributed content to the foregoing brief or participated in the preparation of the brief in any other manner;

(b) No party or party's counsel contributed money that was intended to fund preparation or submission of the brief; and

(c) No person or entity contributed money that was intended to fund preparation or submission of the brief.

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CERTIFICATE OF COMPLIANCE

Elizabeth F. Bernhardt, an attorney duly admitted and licensed to practice before the courts of the State of New York, certifies, pursuant to 22 N.Y.C.R.R. Parts 500.1(j), 500.13(c) and 500.23(a), as follows:

The foregoing brief was prepared on a computer using Microsoft Word. A proportionally spaced typeface was used, as follows:

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Exhibit A

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

James D. Sullivan, M.D., Charles Conte, M.D., Mansoor Beg, M.D., Alan Kadison, M.D., John Ricci, M.D., Raza Zaidi, M.D., and Mitchell Levine, M.D.

Plaintiffs,

-against-

Medical Liability Mutual Insurance Company and Northwell Health, Inc.

Defendants.

Index No. 656121/2018

Affidavit of
James D. Sullivan, M.D.

STATE OF NEW YORK)
) ss:
COUNTY OF NEW YORK)

JAMES D. SULLIVAN, M.D., a physician duly licensed to practice medicine in the State of New York having been duly sworn, states under the penalty of perjury that:

1. I am a Plaintiff in the above captioned action and have personal knowledge of the facts referred to herein. I submit this Affidavit in support of Plaintiffs' cross motion for summary judgment pursuant to CPLR § 3212 and 3001 against Defendant Northwell Health, Inc. and for the related relief requested in the accompanying Notice of Cross Motion for Summary Judgment.

2. In 1993, while in private practice as a principal of North Shore Surgical Oncology Group and about 14 years prior to my employment with Northwell, I purchased a medical malpractice insurance policy from MLMIC, which I remained covered under for nearly 24 years.

3. As a MLMIC Policyholder, I also owned a Membership Interest in MLMIC by purchasing an insurance policy from MLMIC, in addition to malpractice insurance coverage.

4. On or about June 12, 2007, I entered into an employment relationship with Northwell, whereby I negotiated and executed an employment agreement agreeing to provide services to Northwell in exchange for compensation and benefits.

5. The offer of employment was part of a larger transaction between North Shore Oncology Group, P.C. and Northwell. This transaction was a bargained-for exchange, the terms of which Dr. Conte, Beg and I negotiated with Northwell. After negotiations, the terms of the transaction included a loan from Northwell to Drs. Conte, Beg and myself for $110,000 each, totaling $330,000. A portion of the loan was forgiven for each year in which Drs. Conte, Beg and I worked for Northwell, with the entire loan being forgiven after eight years. Northwell also took over the lease agreement between North Shore Oncology Group and the landlord to the medical facility rented by North Shore Oncology Group. As part of this transaction, I negotiated my employment agreement with Northwell, which included maintaining my own malpractice insurance. Northwell agreed to pay the malpractice insurance premiums on my behalf. Northwell received any revenue generated for professional services provided on behalf of Northwell, outside Northwell as a private physician or for maintaining a private practice or from royalty income.

6. Under the bargained-for terms of my 2007 employment agreement with Northwell (a copy of which is annexed to the Affidavit of Zisin-Laor at Exhibit 6 (NYSECF Doc. No. 45)) one of the benefits to be provided to me in exchange for my services as a physician was Northwell's payment of my medical malpractice insurance premiums.

7. One relevant provision contained in the employment agreement is found at Section 7(f) and provides that "NSUH [Northwell] agreed to provide you with medical malpractice insurance and directors' and officers' liability insurance . . . . With respect to

medical malpractice insurance . . . you shall continue your current malpractice coverage through the Group and NSUH [Northwell] shall pay such premiums directly to your insurer. You agree not to unreasonably withhold your consent to settle any claims which arise during or as a result of your activities while employed by NSUH [Northwell]." (Ex. 6 to Affidavit of Zisin-Laor at Section 7(f).)

8. The terms of my employment agreement with Northwell required that I maintain my own malpractice insurance but did not specify which insurance carrier I was to choose. I chose to continue to receive medical malpractice insurance coverage under my MLMIC policy, and in the course of negotiating the employment agreement, Northwell agreed it would be responsible for paying the premiums on that policy.

9. The bargained-for terms of my employment agreement did not permit Northwell to cancel my MLMIC policy without my consent. (*See* Ex. 6 to Affidavit of Zisin-Laor at § 7(f).)

10. The bargained-for terms of my employment agreement also did not permit Northwell to settle any claims without my consent while I was covered by MLMIC. MLMIC communicated directly with me regarding settlement of any claims.

11. I remained the sole policyholder, the sole insured, and the sole policy administrator with respect to my MLMIC policy.

12. Since 2013, Northwell has attempted to persuade me to cancel my MLMIC policy to join Northwell's professional liability program on numerous occasions. For a number of years, I refused to cancel my MLMIC policy to join Northwell's own insurance program in part because I wanted to maintain control over settlement of any claims.

13. Years later, after renegotiating terms of my employment agreement, I agreed to amend my employment agreement and obtain medical malpractice insurance coverage through Northwell's professional liability program. I canceled my MLMIC policy and did not renew it after 2016.

14. Until announcement of the sale and demutualization of MLMIC, at no time throughout my employment relationship with Northwell were there any discussions related to my membership interest in MLMIC or the disposition of any proceeds which might come as a result of a potential demutualization.

15. At no time did I assign my Membership Interest to Northwell.

16. MLMIC has calculated my allocation of the cash consideration to be $629,482.38.

17. On or about December 8, 2017, Northwell sent a letter to me regarding the anticipated sale and demutualization of MLMIC and stated, "[s]ince Northwell paid for your individual professional liability policy during the Relevant Time Period but MLMIC will be paying the cash entitlement to you as the policyholder, you must assign such money to Northwell within **10** days from receipt of the funds from MLMIC." (Emphasis in original). A true and correct copy of Northwell's December 17, 2017 letter is attached herein as **Exhibit 1**.

18. On or about June 29, 2018, MLMIC mailed notices addressed to all Policyholders, which stated in relevant part: "Eligible policyholders are owners of policies issued by MLMIC that were in effect at any time from July 15, 2013 until July 14, 2016 . . . . **If there is a preference to have such distributions paid to a policy administrator as a matter of convenience or as a result of contractual obligations between you and your policy administrator, please execute the enclosed consent form** . . . ." (Emphasis in original).

19. Based on numerous things, including my longstanding ownership of the policy, the fact that payment of the MLMIC premiums was a bargained-for benefit of my employment, and my understanding of the MLMIC demutualization, I did not execute any assignment for my allocable share of the Cash Consideration to Northwell.

20. In August 2018, I was copied on an e-mail notice sent by Northwell to MLMIC, objecting to the payment of the cash consideration to me and requesting that money be placed in escrow.

21. MLMIC replied to Northwell's e-mail, informing Northwell that its objection had been denied because a valid policy administrator designation was not submitted by me, the eligible policyholder.

22. On or about September 24, 2018, I received a letter from MLMIC informing that Northwell had submitted an objection to the disbursement of my allocable share of the cash consideration to me and thus, that share is being held in escrow.

23. On October 12, 2018, I, along with Plaintiffs Conte, Beg, Kadison, Ricci, and Zaidi, through our attorneys, wrote a letter to Northwell requesting that Northwell withdraw its improper objections.

24. Also on October 12, 2018, I, along with Plaintiffs Conte, Beg, Kadison, Ricci, and Zaidi, through our attorneys, wrote to MLMLIC stating that Northwell's objections were improper because it was not a designated Policy Administrator and MLMIC should not have accepted the objections. Plaintiffs requested MLMIC overrule the objections and disburse the funds held in escrow to the insureds. MLMIC has not responded to this request.

25. On December 10, 2018, this action was commenced.

James D. Sullivan, M.D.

Sworn to me on this 3 day of October 2019

Christina Quinn
Notary Public

CHRISTINA QUINN
Notary Public - State of New York
No. 01QU6128126
Qualified In Nassau County
My Commission Expires 06/06/2021

Exhibit B

MEMO

To: Berthe Erisnor AVP, Ambulatory Services
Emily Kao RPh, VP, Surgery Service Line

Cc: Dorothy Feldman, Vice President, Chief Risk Officer

From: Hadar Zisin Laor
Director of Risk Services

RE: Employed physicians with individual policies

Date: November 20, 2013

All employed physicians are covered under the Health System's professional liability program for work preformed within the scope of their employment. Excluding LHH, the professional liability program contains a primary layer of coverage through a commercial carrier called Physicians Reciprocal Insurers (PRI), and multiple excess layers serve as excess insurers/ reinsurance companies. It is an occurrence based policy, and therefore if a physician leaves his employment with the System, he will be covered if a claim is filed for work preformed while employed if it was within his scope of employment.

There are several employed physicians with individual medical malpractice policies that PAANS has been paying for in addition to the Health System medical malpractice program, some are covered through MLMIC and PRI and others are covered through the NSLIJ RRG. The Health system has maintained these individual policies either due to the physicians request, or because it was perceived less costly to maintain the policy than purchase a tail. In reality it is much more expensive to maintain these individual policies and as a result these physicians are covered both under the Health System for work preformed within the scope of employment, and under their individual policies. If a claim arises with the scope of employment of the physician, both policies respond and pro-rate the expenses. The insurance policies do not stack to provide greater coverage, and each policy only pays a share of the claim reducing the value of the premium paid.

Since we created the tail program we would like to tail out these policies and greatly reduce the spend on tail coverage, but need PAANS to facilitate the process with the physicians. If we can utilize the tail program we are estimating that the tail of each policy will cost roughly $10,000.

Please note that in order to provide coverage through the tail program the physician must provide a complete application and supporting documents, must pass underwriting and be approved by Risk.

Additional information that is required in order to be considered for the program:

1. Confirmation of hire date and that once employed, the physician did not work in a private setting.

ATTORNEY-CLIENT PRIVILEGED

The Physicians with individual policies that we have on file include:

Physician Name	Hospital	Dept Name	FTE	2013 Annual Premium (based on information from PAANS)	Tail premium
nonresponsive					
Sullivan,James D	Manhasset	Surgery-Oncology	37.5	[redacted]	[redacted]
Kadison,Alan	Manhasset	Surgery-Oncology	37.5		
Beg,Mansoor H	Manhasset	Surgery-Oncology	37.5		
Ricci,John L	Manhasset	Surgery-Oncology	37.5		
Conte,Charles C	Manhasset	Surgery-Oncology	37.5		
Zaidi,Raza	Manhasset	Surgery-Oncology	37.5		
nonresponsive					

Exhibit C

-----Original Message-----
From: correspondence
To: jimmyboy3rd
Sent: Wed, Jun 27, 2018 4:11 pm
Subject: Your Estimated Allocation of Cash Consideration

Dear James Dennis Sullivan, MD,

In response to your request, attached please find our estimate of your allocable share of the cash consideration payable by National Indemnity Company if the acquisition of MLMIC is completed, the manner in which your share is calculated and to whom it will be distributable (to you and/or a Designee(s) and/or to escrow) based on MLMIC's records as of the date hereof. Please note that if you have not appointed a Designee to receive your allocable share but do so in the future, then any amounts specified on the attached as payable to you will instead be payable to such Designee.

Please do not reply to this email; this address is not monitored. Please address any questions to 1-888-998-7871.

Thank you,
MLMIC

MLMIC
Medical Liability Mutual Insurance Company

Estimated Cash Consideration

Policyholder Name	Reference #
James Dennis Sullivan, MD	MP0428046

Policy #	Policyholder Name	Policy Administrator	Eligible Start Date **	Eligible End Date **	Eligible Premium	Estimated Allocation of Cash Consideration	Distribution
3373412	James Dennis Sullivan, MD	James Dennis Sullivan, MD	07/15/2013	01/01/2016	327,731.79	629,482.38	James Dennis Sullivan, MD
				Grand Total:	327,731.79	629,482.38	

** Dates start and end at 12:01am

The amount allocable to a particular Eligible Policyholder will be based on a formula, being Eligible Premium divided by Total Eligible Premium ($1.303 billion), with the resulting factor then multiplied by the Cash Consideration ($2.502 billion).

The Eligible Premium for the Policyholder named above is: $327,731.79. The Total Eligible Premium is $1,303,000,000. Divide $327,731.79 by $1,303,000,000 and the resulting factor is .0002515917. The Cash Consideration is $2,502,000,000. Multiply the Cash Consideration of $2,502,000,000 by the resulting factor of .0002515917 and the estimated allocation of the Cash Consideration for the Policyholder named above is $629,482.38.

As of the date hereof, our records indicate that the allocable share of Cash Consideration will be distributable as itemized in the above column labeled Distribution.

Exhibit D

MLMIC

Medical Liability Mutual Insurance Company

IMPORTANT SPECIAL MEETING INFORMATION

008887

SIGN, DATE AND VOTE ON THE REVERSE SIDE

X0000108278

RAZA ZAIDI
5 SHADETREE LANE
ROSLYN HEIGHTS NY 11577-2502

VOTING OPTIONS

1. **MAIL** your signed and voted proxy card back in the postage paid envelope provided.

2. **IN PERSON** at MLMIC's home office, Two Park Avenue, Room 2500, New York, New York 10016, beginning at 10 a.m., Eastern Time.

PROXY CARD
MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
Two Park Avenue, Room 2500
New York, New York 10016

Policyholder Vote
On Proposal to Approve Plan of Conversion
From a Mutual to a Stock Company
September 14, 2018

The undersigned (a "Record Date Policyholder"), was a policyholder of Medical Liability Mutual Insurance Company ("MLMIC") on July 14, 2016 and is entitled to vote at a special meeting of policyholders to consider a proposal to approve the Plan of Conversion adopted by the Board of Directors of MLMIC on May 31, 2018 (the "Plan") that includes an Amendment and Restatement of MLMIC's Charter (the "Amended Charter").

This special meeting is scheduled to be held on September 14, 2018 at MLMIC's home office at Two Park Avenue, Room 2500, New York, New York 10016, beginning at 10:00 a.m., Eastern Time.

The Plan by its terms, including the Amended Charter, if adopted, will **only** be effective upon the closing of the purchase by National Indemnity Company of all of the issued and outstanding shares of common stock of MLMIC, under the Amended and Restated Acquisition Agreement, dated February 23, 2018, between MLMIC and National Indemnity Company (the "Acquisition").

The undersigned hereby casts his/her vote as indicated on the back of this proxy card with respect to approval of the Plan, including the Amended Charter.

X0000108278 IND RAZA ZAIDI

1 U P X MLMMTG2

The Board of Directors recommends you vote "YES" for the proposal to approve the Plan, subject to the closing of the Acquisition. This vote has an important impact on your rights as a policyholder and we encourage you to read the Policyholder Information Statement before casting your vote. Please vote by placing an "X" in one of the boxes on this proxy card, printing your name, and signing and dating the bottom of the proxy card. Then return this proxy card in the postage-paid envelope provided. An unmarked proxy card will be voted as a YES.

You can also vote in person at the policyholder meeting scheduled to be held on September 14, 2018 at MLMIC's home office at Two Park Avenue, Room 2500, New York, New York 10016, beginning at 10:00 a.m., Eastern Time.

IT IS IMPORTANT THAT YOU VOTE AS PROMPTLY AS PRACTICABLE. TO BE COUNTED, YOUR PROXY CARD MUST BE RECEIVED NO LATER THAN 10:00 A.M. EASTERN TIME ON THE DAY OF THE POLICYHOLDER MEETING.

If you have any questions, call MLMIC toll free at 1-888-919-2636. Representatives are available to assist you Monday through Friday 9 a.m. to 4 p.m., Eastern Time until September 13, 2018.

☒ YES, I vote FOR the proposal to approve the Plan, subject to the closing of the Acquisition.

☐ NO, I vote AGAINST the proposal to approve the Plan.

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned, a Record Date Policyholder of MLMIC, entitled to vote on the proposal to approve the Plan, revoking previous proxies relating to his or her eligible policy, hereby appoints John W. Lombardo, M.D., President of MLMIC and Richard M. Peer, M.D., Vice President & Secretary of MLMIC or any one or more of them, the attorneys and agents of the undersigned, with full power of substitution, to vote for and on behalf of the undersigned, at a special meeting of MLMIC policyholders scheduled to be held on September 14, 2018 at MLMIC's home office and at any adjournment or adjournments thereof, and on and with respect to which the undersigned is entitled to vote or act, upon the matters noted above.

EVERY PROPERLY SIGNED AND RETURNED PROXY CARD WILL BE VOTED ACCORDING TO THE BOX SELECTED ABOVE. IF YOU SIGN AND SUBMIT THIS PROXY CARD BUT DO NOT MAKE A SELECTION, YOU WILL BE DEEMED TO HAVE SELECTED THE FIRST BOX "YES, I VOTE FOR THE PROPOSAL TO APPROVE THE PLAN, SUBJECT TO THE CLOSING OF THE ACQUISITION."

All powers may be exercised by a majority of said proxies or said substitutes voting or acting, or, if only one votes and acts, then by that one.

Raza Zaidi

Printed name of policyholder
or authorized representative of policyholder
(Required for all proxy cards)

Signature of policyholder
or authorized representative of policyholder
(Required for all proxy cards)

July 22, 2018
Date

Exhibit E

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

----------X

INDEX NO. 656121/2018

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

MOTION DATE _____

Plaintiffs,

MOTION SEQ. NO. 001

- v -

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

DECISION, ORDER, AND JUDGMENT ON MOTION

Defendants.

----------X

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

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

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

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

Background

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

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

The Instant Motion

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

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

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

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

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

Plaintiffs' Third Cause of Action

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

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

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

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

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

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

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

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

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

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

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

Defendant Northwell's First Counterclaim

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

Plaintiffs' Fourth Cause of Action

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

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

Defendant Northwell's Second Counterclaim

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

Accordingly, it is hereby,

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

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

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

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

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

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

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

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

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

12/2/19
DATE

BARRY R. OSTRAGER, J.S.C.

BARRY R. OSTRAGER
JSC

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

Exhibit F

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

SCHAFFER, SCHONHOLZ & DROSSMAN, LLP,

Plaintiff,

-against-

RACHEL S. TITLE, M.D.,

Defendant.

Index No. _____/2018

SUBMITTED FACTS PURSUANT TO CPLR 3222

Pursuant to CPLR 3222, Schaffer, Schonholz & Drossman, LLP and Dr. Rachel S. Title (together, the "Parties"), by their respective undersigned attorneys, for the purposes of this action and submission, hereby agree upon the following facts upon which the controversy between them depends and respectfully submit that controversy to the Supreme Court of the State of New York, Appellate Division, First Department, for decision:

PARTIES

1. Plaintiff, Schaffer, Schonholz & Drossman, LLP ("SS&D") is a private practice radiology group with its principal office at 488 Madison Avenue, New York, NY 10022.

2. Defendant, Dr. Rachel S. Title, is an individual who resides at 115 East 87th Street, New York, NY 10128.

JURISDICTION AND VENUE

3. Jurisdiction in this action is based on CPLR 301 and CPRL 3222.

4. Pursuant to CPLR 503, venue for this action would be proper in the County of New York because Plaintiff's principal office is located, and Dr. Title is a resident, in this county. Pursuant to CPLR 3222(b)(3), this submission of controversy is being submitted to the Supreme Court of the State of New York, Appellate Division, First Department.

STATEMENT OF AGREED-UPON FACTS

5. Dr. Title was an employee of SS&D from 2011 to 2015.

6. Pursuant to Dr. Title's Offer of Employment from SS&D, dated December 8, 2010 and which Dr. Title accepted and executed by signature dated December 10, 2010 (attached hereto as Exhibit 1, the "Offer Letter"), Dr. Title was required to submit a completed professional liability insurance policy application to Medical Liability Mutual Insurance Company ("MLMIC") and to name SS&D as the Policy Administrator. (*See id.* ¶ 3.) Pursuant to Paragraph 3 of the Offer Letter, title "Professional Insurance and Licensing Matters," SS&D was responsible for paying all premiums during the duration of Defendant's employment with SS&D. (*See id.*) There was never any discussion between SS&D and Dr. Title about choice of insurer.

7. Under Paragraph 2 of the Offer Letter, titled "Compensation, Vacation and Benefits," Dr. Title agreed to be compensated at a rate of $225,000 per year, and any days that she worked in excess of a three day work schedule were

to be compensated at a daily rate of $1,442.30. (*Id.* ¶ 2.) Further, under Paragraph 2 of the Offer Letter, Dr. Title was entitled to paid vacation and sick days, group health insurance coverage for her and her family, short-term and long-term disability insurance, participation in a 401(k) plan, and registration fees associated with one professional conference per year, membership dues in accredited medical societies in her specialty and New York State medical license fees. (*Id.*)

8. In the Offer Letter, which Dr. Title signed, she also acknowledged and agreed that the compensation specified and agreed to under the terms of the Offer Letter "shall satisfy and discharge in full all claims [she] may have against [SS&D] for compensation for [her] services." (*Id.* ¶ 5.)

9. On November 22, 2010, Dr. Title completed and executed the MLMIC professional liability insurance policy application, naming SS&D as the Policy Administrator (attached hereto as Exhibit 2).

10. On or around January 4, 2011, MLMIC issued an insurance policy (the "Insurance Policy," attached hereto as Exhibit 3.)

11. The Insurance Policy identified Dr. Title as the insured and SS&D as the Policy Administrator. (*See id.*, Declarations Page.)

12. The Insurance Policy package included a letter from MLMIC to Dr. Title, dated January 4, 2011, informing her that "you have been added onto the

professional liability insurance policy issued to Schaffer, Schonholz & Drossman, LLP." (*Id.*, Jan. 4, 2011 Letter from MLMIC to Dr. R. Title.) The letter also stated that:

> Our records indicate that you have designated Schaffer, Schonholz & Drossman, LLP as your Policy Administrator. As such, Schaffer, Schonholz & Drossman, LLP has the right to pay the premium and receive return premiums, including dividends, when due. Your Policy Administrator also has the right to make changes to your policy as well as cancel it.

(*Id.*)

13. SS&D paid in full all annual premiums for the MLMIC Insurance Policy for the entire duration of Dr. Title's employment with SS&D. Dr. Title did not pay any of the annual premiums or any of the other costs related to the Insurance Policy.

14. A document prepared by SS&D, titled "Annual Compensation and Performance Review RACHEL TITLE, MD January 31, 2013" (attached hereto as Exhibit 4) shows "Total Compensation" in the amount of $321,689 and a breakdown of that number as consisting of the following: "Base Salary" in the amount of $230,000; "Merit Bonus" in the amount of $7,500; "Health Insurance" in the amount of $28,437 and "Malpractice Insurance + Excess" in the amount of $55,752. The "Excess" refers to excess insurance coverage over and above the Insurance Policy coverage.

15. In 2015, Dr. Title's employment with SS&D was terminated and SS&D cancelled the Insurance Policy.

16. In June 2018, MLMIC provided notification that it planned to convert from a mutual insurance company owned by its members to a stock insurance company (the "MLMIC Notification," attached hereto as Exhibit 5).

17. The MLMIC Notification explained that as a result of this "conversion," "Eligible Policyholders, or their Designees" will collectively receive "consideration for the extinguishment of their Policyholder Membership Rights." (*Id.*, Plan of Conversion of Medical Liability Mutual Insurance Company at 1.)

18. The Plan of Conversion, at Page 2 states: "Eligible Policyholder" means "[t]he Policyholder of an Eligible Policy. For Eligible Policies that identify multiple insureds, each Person so identified on the declarations page of such Policy shall be an Eligible Policyholder. Each such Eligible Policyholder that is a Record Date Policyholder shall be entitled to vote at the Special Meeting. In addition, each such Eligible Policyholder shall be entitled to an allocation of the Cash Consideration based on the Eligible Premium with respect to such Eligible Policyholder as set for in the definition of Eligible Premium". The Plan of Conversion further states, at Page 4: "Policyholder" means, "[w]ith respect to any Policy, the Person(s) identified on the declarations page of such Policy as the insured."

19. The total Cash Consideration is $2.502 billion. (*Id.* at 2.) The amount of Cash Consideration paid on each eligible policy is based on the share of premiums properly and timely paid on that policy. (*Id.*)

20. The MLMIC Notification also provides an objection process for a "Policy Administrator," who believes that it, rather than the insured "has a legal right to receive [the] Cash Consideration." (*Id.*, June 22, 2018 Medical Liability Mutual Insurance Company, Policyholder Information Statement at 8.) The notification provides in relevant part:

> A14. If a Policy Administrator or EPLIP Employer[1] has not been specifically designated to receive the Cash Consideration allocated to an Eligible Policyholder, but nevertheless believes it has a legal right to receive such Cash Consideration, the Policy Administrator or EPLIP Employer may send MLMIC a letter (return receipt requested) or an e-mail (preferably an e-mail) at the address set forth in A11 that sets forth such position, along with a statement to the effect that it has provided a copy of such letter or e-mail to the applicable Eligible Policyholders, at any time prior to the date of the Superintendent's public hearing. ...
>
> ...
>
> A15. If MLMIC receives an objection properly filed as set forth in A14, the allocated Cash Consideration will be held in escrow by the Conversion Agent until MLMIC receives joint written instructions from the Eligible Policyholder and the Policy Administrator or EPLIP

[1] The references in the Plan of Conversion to "Employee Professional Liability Insurance Policy" and "EPLIP Employer" are inapplicable to this matter.

> Employer as to how the allocation is to be distributed, or a non-appealable order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the Policy Administrator or EPLIP Employer or the Eligible Policyholder.

(*Id.*)

21. By a letter from MLMIC to Dr. Title, dated June 29, 2018, with a copy to SS&D (attached hereto as Exhibit 6), MLMIC informed the Parties that the amount of Cash Consideration with respect to the Insurance Policy is $127,848.62 (the "Disputed Amount"). The letter attached a consent form (the "Authorization") to be signed by Dr. Title for the payment to be made to SS&D. (*See id.*)

22. By letters dated July 19, July 27 and August 10, 2018, SS&D requested that Dr. Title execute the Authorization. Dr. Title has not done so.

23. Under the terms of the Offer Letter, Dr. Title "agree[d] to execute any and all forms and documents as may be requested by [SS&D] so that [SS&D] may bill and collect from patients and third party payers, including Medicare, for services you render on behalf of [SS&D]." (Exhibit 1, Offer Letter ¶ 5.)

24. On August 12, 2018, SS&D received a response letter from Dr. Title's attorney, stating that Dr. Title is entitled to the Disputed Amount.

25. On August 16, 2018, pursuant to MLMIC's objection procedures discussed above, SS&D provided the MLMIC comptroller with its objection letter

and supporting documents (the "Objection"). SS&D also provided Dr. Title's undersigned attorney with a copy of the objection letter and supporting documents.

26. In response to SS&D's Objection, MLMIC has placed the Disputed Amount in escrow.

CONTROVERSY PRESENTED

27. The Parties respectfully ask that the Court:

a. issue a declaratory judgment determining whether SS&D or Dr. Title is entitled to the Disputed Amount and any interest accrued on the Disputed Amount which may be paid by MLMIC while held in escrow;

b. issue an order instructing the non-prevailing party to execute and provide the necessary documentation such as joint written instructions to MLMIC, to facilitate the transfer of the Disputed Amount and accrued interest, if any, from the insurer to the prevailing party; and

c. enter judgment for such other and further relief as the Court deems equitable and just.

28. The controversy presented is real and the submission is made in good faith by the Parties for the purpose of determining the rights of the Parties as to the Disputed Amount.

Dated: New York, New York
~~October __, 2018~~
November 1, 2018

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Rachel S. Title, MD

Acknowledgment by a Person Within New York State (RPL § 309-a)

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

On the 30th day of October in the year 2018 before me, the ~~undersigned~~ Above Signed, personally appeared Richard Schaffer, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Richard Schaffer MD.

(signature and office of individual taking acknowledgment)

DWAYNE L JACKSON
Notary Public - State of New York
NO. 01JA6271502
Qualified in Kings County
My Commission Expires Nov 5, 2020

Acknowledgment by a Person Within New York State (RPL § 309-a)

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

On the 18th day of October in the year 2018 before me, the undersigned, personally appeared Rachel S. Title, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

(signature and office of individual taking acknowledgment)

RICHARD A. KLASS
Notary Public, State of New York
No. 02KL5005992
Qualified in Kings County
Commission Expires 12/21/18

STATE OF NEW YORK)		**AFFIDAVIT OF SERVICE**
)	ss.:	**BY OVERNIGHT FEDERAL**
COUNTY OF NEW YORK)		**EXPRESS NEXT DAY AIR**

I, Tyrone Heath, 2179 Washington Avenue, Apt. 19, Bronx, New York 10457, being duly sworn, depose and say that deponent is not a party to the action, is over 18 years of age and resides at the address shown above or at

On October 13, 2021

deponent served the within: **Brief for Amici Curiae James D. Sullivan, M.D., Charles Conte, M.D., Mansour Beg, M.D., Alan Kadison, M.D., John Ricci, M.D. And Raza Zaidi, M.D. In Support of Respondents**

upon:

See attached Service List

the address(es) designated by said attorney(s) for that purpose by depositing **2** true copy(ies) of same, enclosed in a properly addressed wrapper in an Overnight Next Day Air Federal Express Official Depository, under the exclusive custody and care of Federal Express, within the State of New York.

Sworn to before me on October 13, 2021

Mariana Braylovskiy

MARIANA BRAYLOVSKIY
Notary Public State of New York
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Qualified in Richmond County
Commission Expires March 30, 2022

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