To be argued by: Justin A. Heller
Time requested: 20 minutes

Court of Appeals of the
State of New York

MAPLE MEDICAL LLP,

Plaintiff-Appellant

- against -

JOSEPH SCOTT, M.D.,	APL-2021-00045
DIANA GOLDENBERG, M.D.,	APL-2021-00046
DIANA AREVALO, M.D.,	APL-2021-00047
NINA SUNDARAM, M.D.,	APL-2021-00048
MARIO MUTIC, M.D.,	APL-2021-00049
LISA H. YOUKELES, M.D.,	APL-2021-00050

Defendants-Respondents,

- and -

MEDICAL LIABILITY
MUTUAL INSURANCE COMPANY,

Defendant.

JOINT BRIEF FOR RESPONDENTS

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STATUS OF RELATED LITIGATION

There are currently two (2) other appeals before this Court to resolve the same narrow question of law stemming from the conversion of Medical Liability Mutual Insurance Company ("MLMIC") to a stock insurance company, and the resulting extinguishment of the Policyholders' Membership Interests: Who is entitled to the cash consideration paid in exchange for the extinguishment of a MLMIC Policyholder's Membership Interest—(i) the *insured/practitioner* (here, Respondents) who became a MLMIC Policyholder, and thereby acquired a Membership Interest, as part of the bargained-for exchange of consideration under his/her employment agreement; or (ii) the *employer/Policy Administrator* (here, Appellant), which paid the MLMIC premiums on the insured's behalf and in exchange for his/her services under the employment agreement?

The status of these two appeals are as follows:

- Kim E. Schoch v. Lake Champlain OB-GYN, P.C., 184 A.D.3d 338 (3d Dep't 2020), *lv granted*, 35 N.Y.3d 918 (2020): Appellant's brief was filed March 8, 2021, respondent's brief was filed May 12, 2021, and appellant's reply brief was filed June 4, 2021.
- Columbia Memorial Hospital v. Hinds, 188 A.D.3d 1336 (3d Dep't 2020), *lv granted*, 36 N.Y.3d 904 (2021): Appellant's brief was filed March 8, 2021, respondent's brief was filed May 7, 2021, and

appellant's reply brief was filed June 11, 2021.

Appellant claims (in the "Related Appeals" section of its Brief) that "several interested parties" have been granted *amicus curiae* relief. Respondents have not been served with any motions seeking to file an amicus brief on this appeal. In *Schoch*, the Court granted Samaritan Medical Center limited amicus curiae relief to submit papers in support of appellant's request for leave to appeal (not to submit a brief on the appeal). The docket for *Columbia Memorial Hospital* does not identify any amicus curiae parties.

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Did the Appellate Division, Second Department correctly hold that Defendants-Respondents were legally entitled to their respective shares of the Cash Consideration paid in exchange for the extinguishment of their Policyholder Membership Interests in Medical Liability Mutual Insurance Company ("MLMIC"), pursuant to New York Insurance Law (§7307[e][3]), the MLMIC Plan of Conversion, and the Decision of the New York State Department of Financial Services ("DFS") approving the MLMIC Plan?

   Answer: The court below correctly held that Defendants-Respondents were legally entitled to their respective shares of the MLMIC Cash Consideration pursuant to Insurance Law §7307(e)(3), the MLMIC Plan of Conversion and the DFS Decision approving the Plan.

2. Did the Appellate Division, Second Department correctly hold that Defendants-Respondents would not be unjustly enriched by receiving their respective shares of the Cash Consideration paid in exchange for the extinguishment of their MLMIC Policyholder Membership Interest?

   Answer: The court below correctly held that Defendants-Respondents would not be unjustly enriched by receiving their respective shares of the MLMIC Cash Consideration.

NATURE OF THE CASE

Defendants-Respondents Joseph Scott, M.D. ("Dr. Scott"), Diana Goldenberg, M.D. ("Dr. Goldenberg"), Diana Arevalo, M.D. ("Dr. Arevalo"), Nina Sundaram, M.D. ("Dr. Sundaram"), Mario Mutic, M.D. ("Dr. Mutic"), and Lisa H. Youkeles, M.D. ("Dr. Youkeles," and together with Drs. Scott, Goldenberg, Arevalo, Sundaram and Mutic, the "Respondents") respectfully submit this Joint Brief in response to the appeal of Plaintiff-Appellant Maple Medical LLP ("Appellant" or "Maple Medical") from the Opinion and Order in the *Scott* case (the "*Scott* Order" [Appdx.[1] 998-1019]) and the Decisions and Orders in the other five cases[2] of the Appellate Division, Second Department, which (i) reversed the Decisions/Orders/Judgments of the Westchester County Supreme Court, (ii) denied Appellant's motions for summary judgment, (iii) granted Respondents' cross-motions for summary judgment, and (iv) declared that Respondents were solely entitled to their respective shares of the MLMIC Cash Consideration (defined *infra*).

The question before the court below was straightforward. After MLMIC demutualized (thereby extinguishing its Policyholders' Membership Interests), who was entitled to the consideration paid in exchange for Respondents' Policyholder

[1] "Appdx." hereinafter refers to Respondents' Supplementary Appendix, which contains a substantial amount of the records below that Appellant omitted from its Record.

[2] The Decisions and Orders in *Goldenberg* (Appdx. 1021-22), *Arevalo* (Appdx. 1024-25), *Sundaram* (Appdx. 1027-28), *Mutic* (Appdx. 1030-31) and *Youkeles* (Appdx. 1033-34) relied on, and incorporated the reasoning in, the *Scott* Order.

Membership Interests: (i) *Respondents*, who became Policyholders—and thereby acquired Membership Interests—as part of the bargained-for exchange of consideration under their Employment Agreements; or (ii) *Appellant*, which paid Respondents' premiums on their behalf pursuant to the Employment Agreements (and as to Drs. Scott, Arevalo, Goldenberg and Sundaram, in its capacity as their Policy Administrator)? The answer to that question was manifest, compelled by the clear framework of the Insurance Law and Plan of Conversion, and the DFS Superintendent's unequivocal Decision approving the Plan.

In short, Insurance Law §7307(e)(3) and the Plan of Conversion mandated that as the Policyholders/Insureds, Respondents were entitled to the Consideration paid for their extinguished Membership Interests. The DFS decisively confirmed the Policyholders' legal right to the Consideration—with the limited exceptions being where their employer/Policy Administrator was expressly designated to receive or assigned the Consideration. Neither of those exceptions occurred here.

Faced with Respondents' clear entitlement to the Cash Consideration, Appellant proffers three spurious arguments in an unavailing attempt to manufacture an error in the *Scott* Order.

First, Appellant claims that the Second Department "misapplied the Insurance Law" by ignoring an "explicit distinction in the statute between 'receipt' and

'retention'" of the Cash Consideration (App. Brief,[3] 4-5). Insurance Law §7307 does not make any distinction—let alone an "explicit distinction"—between "receipt" and "retention" of the Consideration. As the Second Department emphasized below, Section 7307(e)(3) is "precise," "clear and unambiguous" that the person "'entitled to receive the consideration' . . . is 'anyone who had a policy of insurance in effect during the relevant time period.'" *Scott* Order, Appdx. 1007-08 (quoting *Schoch v. Lake Champlain OB-GYN, P.C.*, 184 A.D.3d 338, 342 [3d Dep't 2020]). Simply put, there is nothing in §7307 suggesting that consideration paid to the person who had a policy in effect (here, Respondents), in exchange for their membership interest, is to be remitted to and retained by a third party.

Second, Appellant argues that the Plan of Conversion and DFS Decision left the issue of statutory entitlement to the Consideration to the courts (App. Brief, 13-15). The Plan and DFS Decision could not have been clearer, however, as to who is entitled to receive the Consideration under §7307 —*the Eligible Policyholders* (here, Respondents) (*see* R.76 ¶6.3[f], 165 [para. 2]). As such, the Second Department correctly held below, "[t]he 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." *Scott* Order, Appdx. 1007.

[3] "App. Brief" hereinafter refers to Appellant's within Brief.

Third, Appellant attempts to revive the *same* argument that it unsuccessfully made to the DFS, to the Westchester County Supreme Court in its ensuing Article 78 proceeding,[4] and to the court below: The persons entitled to the Consideration under §7307 are those who made the premium payments, and not the insureds/employees on whose behalf the payments were made. As confirmed by the DFS Decision, and as held by the court below, Appellant's argument conflates the statutory language governing *how* the Consideration is to be calculated (by reference to premiums paid on the policy) with the provision governing *who* is to receive it (the Policyholder). *See Scott* Order, Appdx. 1012 ("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.").

Having no legal right to Respondents' shares of the Cash Consideration, Appellant posits that its service as Respondents' designated or "de facto" Policy Administrator and payment of their premiums entitled it to the Consideration on a theory of unjust enrichment. Appellant's argument entirely ignores that (a) a Policy Administrator is merely the Policyholder's agent, conferred with only limited rights established by MLMIC (none of which entitled it to the Consideration),

[4] *Matter of Maple Medical LLP, et al. v. New York State Dept. of Fin. Servs., et al.* Index No. 65929/2018 (Sup. Ct. Westchester Cty.) (*see* R.202-05).

(b) Appellant paid the premiums as an express term of the parties' Employment Agreements, and (c) Respondents provided the contractually agreed-upon consideration for those premium payments. Quite simply, Appellant was compensated for its payment of premiums and therefore cannot, as matter of established New York law, base an unjust enrichment claim on those premium payments. Moreover, as correctly held by the Second Department below, none of the other circumstances that courts consider when evaluating a claim of unjust enrichment militated in Appellant's favor. *See Scott* Order, Appdx. 1016-17.

Accordingly, for those and the other reasons herein, Respondents respectfully request that this Court affirm the *Scott* Order, and the Decisions and Orders in *Goldenberg*, *Arevalo*, *Sundaram*, *Mutic* and *Youkeles*, in their entirety.

COUNTERSTATEMENT OF FACTS, AND BACKGROUND OF MUTUAL INSURANCE COMPANY STRUCTURE

A. MLMIC was owned by its Members, the Policyholders.

Prior to its October 1, 2018 conversion to a stock insurance company, MLMIC was a mutual insurance company (R.66 [para. 1]). A mutual insurance company is owned by, and operated for the benefit of, its members, who are the policyholders of the company. *See* Insurance Law §1211(a).[5] Under MLMIC, the Policyholder was the person listed as the "insured" on the Declarations Page of the policy (R.70).

B. Respondents were each the sole insured under their respective MLMIC policy.

Respondents were employed as physicians with Appellant at various times during the period November 2005 to August 2017 (R.206 ¶2; Appdx. 205 ¶2, 454 ¶ 2, 668 ¶2, 822 ¶2, 949 ¶2). During their employment with Appellant, Respondents were each covered by MLMIC malpractice policies. (R.206 ¶3; Appdx. 205 ¶3, 454 ¶2, 668 ¶2, 822 ¶2, 949 ¶2). Respondents were the sole insureds—and thus the sole Policyholders—under their respective malpractice policies (R. 207 ¶4, 226; Appdx. 205-06 ¶4, 454-55 ¶¶2-3, 669 ¶4, 822-23 ¶¶2-3, 949-50 ¶¶2-3).

[5] *See also Methodist Hosp. of Brooklyn v. State Ins. Fund*, 64 N.Y.2d 365, 374 (1985) ("A mutual insurance company is organized and operated for the benefit of its policyholders who are by virtue of their policies members of the company.").

C. Policyholders had both contractual and membership rights.

Policyholders in a mutual insurance company have two distinct types of rights: (1) contractual rights; and (2) membership rights. *See Scott* Order, Appdx. 999 ("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).'" [quoting *Bank of N.Y. v. Janowick*, 470 F.3d 264, 267 (6th Cir. 2006)]).[6] Contractual rights are paid for by premiums and encompass the insurance benefits under the policy. *See Dorrance v. U.S.,* 809 F.3d 479, 485 (9th Cir. 2015).

Membership rights, on the other hand, "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." *Scott* Order, Appdx. 1017 (citing *Schoch*, 184 A.D.3d at 345-46 [quoting *Dorrance*, 809 F.3d at 485]). Membership rights include the right to participate in meetings of the members, to vote on company affairs, to receive excess annual premiums in the form of dividends,[7] and to receive consideration for the

[6] *See also Schoch*, 184 A.D.3d at 341 (Mutual insurance company policyholders have "both a membership interest (e.g., the right to vote and receive dividends) and contractual rights (i.e., the obligations of the insurance company under the policy).").

[7] A mutual insurance company "dividend" is not like a stock dividend of annual profits; it is an "adjustment" between the annual premium "estimated at the year's beginning . . . and the amount found actually to have been necessary in retrospect." *Kern v. John Hancock Mut. Life Ins. Co.*, 8 A.D.2d 256, 259 (1st Dep't 1959), *aff'd*, 8 N.Y.2d 833 (1960).

extinguishment of membership interests as part of a demutualization. *See* Insurance Law §1211, §7307(e)(3). MLMIC's membership interests were called "Policyholder Membership Interests" and, consistent with the foregoing, did not "include insurance coverages provided under the Policies" (R.70).

D. Certain of the Respondents designated Appellant to be their Policy Administrator with limited contractual and membership rights.

Under their Employment Agreements, one of the benefits that Appellant agreed to provide in exchange for Respondents' services was the payment of their malpractice premiums (R.213 ¶7[a]; Appdx. 211 ¶7, 463 ¶7, 690 ¶7[a], 831 ¶7, 960 ¶9). To effectuate payment of their MLMIC premiums, Drs. Scott, Arevalo, Goldenberg and Sundaram each signed a Policy Administrator - Designation and/or Change form ("PA Designation Form") designating Appellant as the "Policy Administrator" of their MLMIC policies (R.207 ¶4; Appdx. 205-06 ¶4, 455 ¶5, 669 ¶3).[8] The PA Designation Form (R.222; Appdx. 219, 470, 698) provided that the Policy Administrator would act as the "agent" of the insured and would be conferred only the following limited rights:

- Contractual Rights – "paying of Premium[s], requesting changes in the policy," "terminat[ing] coverage," and receiving "all legal notices"; and
- Membership Rights – receiving any "dividends" or "return Premiums."

[8] Drs. Mutic and Youkeles did not execute PA Designation Forms (*see infra*, subpoint F).

E. As Policy Administrator, Appellant exercised certain of the limited Administrator rights it had been granted.

Appellant acted as Policy Administrator for Drs. Scott, Arevalo, Goldenberg and Sundaram and exercised certain of the limited rights it had been conferred:

- Paying their premiums -- in accordance with its obligation under their Employment Agreements (R.239 ¶5[e]; Appdx. 237 ¶5[e], 441 ¶5[e], 717 ¶5[e], 809 ¶5[e], 937 ¶5[e]);
- Receiving "notices and correspondences" from MLMIC respecting the policies (*id.*, ¶5[i]); and
- Receiving the "dividends" (i.e., refunds of excess annual premiums) (*id.*, ¶5[g]).

F. Drs. Mutic and Youkeles did not designate Appellant as their Policy Administrator.

As Appellant's own documents show (R.287), Drs. Mutic and Youkeles did not execute PA Designation Forms in connection with their policies. As such, Drs. Mutic and Youkeles were the named Policy Administrators (Appdx. 828, 955-56). To the extent that Appellant performed administrative duties in connection with their policies, paid their premiums and received dividends (Appdx. 809-10 ¶5, 937-38 ¶5)—which Appellant posited made it "de facto" Policy Administrator (Appdx. 764 ¶27, 892 ¶27)—a Policy Administrator is the agent of the insured with limited contractual and membership rights (as set forth above).

G. MLMIC sought DFS' permission to demutualize and submitted a proposed Plan of Conversion.

Insurance Law §7307 ("§7307") sets forth a procedure for a mutual insurance company to convert to a stock insurance company—to wit, applying for the DFS Superintendent's permission to submit a proposed plan of conversion, and then submitting the plan to DFS. *See* §7307(b)-(e). MLMIC followed that procedure by applying for permission to submit a proposed plan (on July 16, 2016), receiving DFS' permission to submit a proposed plan (on May 22, 2018), and submitting the Plan of Conversion (the "Plan") (on June 15, 2018) (R.142, 171).

H. After holding a public hearing, DFS reviewed the Plan to ensure that it did not violate the Insurance Law, and approved it.

On August 23, 2018, in accordance with her obligations under §7307(g), the DFS Superintendent held a public hearing on the proposed Plan ("DFS Hearing") (R.171). Following the Hearing, the DFS Superintendent was required to review the Plan to ensure it "does not violate [the Insurance Law], is not inconsistent with law, is fair and equitable and is in the best interests of the policyholders and the public." §7307(h)(1). The Superintendent completed her review and issued a Decision dated September 6, 2018 (the "DFS Decision") approving the Plan (R.162-89).

I. MLMIC's Policyholders approved the Plan of Conversion.

The DFS Superintendent conditioned her approval on the Plan being submitted to a vote of MLMIC Policyholders (R.163 [para. 2 & n.1]). On September 14, 2018, the proposed Plan was submitted to a vote of all eligible Policyholders,

and two-thirds of those Policyholders approved the Plan (R.98-99, 137, 163).[9]

J. The Plan provided that Policyholder Membership Interests would be exchanged for Cash Consideration, which would be distributed to Eligible Policyholders or their Designees.

Insurance Law § 7307(e) provides that a plan of conversion shall include:

> "(3) The 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. The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution described in subsection (b) hereof shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both."

Rather than give Policyholders stock in the new company, the Plan provided that "Eligible Policyholders" (or their "Designees") would receive $2.502 billion in cash consideration ("Cash Consideration" or "Consideration") for the extinguishment of their Membership Interests (R.66 [para. 3], 77 ¶8.1). The Plan defined "Eligible Policyholders" as Policyholders during the period July 15, 2013 through July 14, 2016; "Policyholder" as the person identified on the policy as the insured; and "Designees" as Policy Administrators (or EPLIP Employers)[10] designated by Eligible Policyholders to receive the Consideration (R.68, 70).

[9] The conversion transaction closed on October 1, 2018 (R.203).

[10] Respondents' policies were not Employee Professional Liability Insurance Policies (EPLIP); thus, any reference in the Plan or DFS Decision to EPLIP Employers has been omitted herein.

K. Respondents were Eligible Policyholders.

Each Respondent had a MLMIC policy in effect during the above three-year period, and they were each the only person identified as the "insured" on their respective policies.[11] Thus, Respondents were Eligible Policyholders entitled to receive the Consideration under the Plan (R.70).

L. Respondents did not designate Appellant to receive the Cash Consideration.

The Plan stated that, "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 . . . to receive such amount on its behalf, in which case such amount shall be distributed to such Designee" (R.76 ¶6.3[f]). In its June 22, 2018 Policyholder Information Statement, MLMIC explained that such designation of a Policy Administrator must be made "in writing (using a designation form to be provided by MLMIC)" (R.131 ¶A.5). MLMIC subsequently clarified that prior Policy Administrator designations do not "extend to the distribution of the cash amounts allocated to eligible policyholders," and that the Policyholder would need to sign a specific Consent Form to designate its Administrator to receive the Consideration (R.207-08; Appdx. 473, 703).[12]

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[11] *See, supra*, subpoint B.

[12] *See also* "MLMIC Provides Clarification of Ability to Make Assignments of Cash Consideration"; MLMIC Blog, August 7, 2018, accessible at https://www.mlmic.com/blog/dentists/clarification-of-ability-to-make-assignments-of-cash-consideration (noting that in

Respondents did not sign the Consent Form required by MLMIC to make Appellant a "Designee" for receipt of the Cash Consideration (R.208 ¶8; Appdx. 207 ¶8, 456 ¶10, 670 ¶9, 824 ¶10, 951 ¶10). Appellant filed an objection with MLMIC to the distribution of the Consideration to Respondents (R.208 ¶9; Appdx. 207 ¶9, 456 ¶13, 670 ¶11, 824 ¶12, 952 ¶13), and the underlying disputes ensued (R.20; Appdx. 19, 393, 615, 761, 889).

addition to signed Consent Forms, MLMIC would honor "signed assignments" of Eligible Policyholders' "right to receive their allocable share of the cash consideration). Respondents did not execute assignments of their right to receive the Cash Consideration (R.45 ¶102, 207 ¶5; Appdx. 206 ¶5, 455 ¶7, 456 ¶12, 669 ¶6, 823 ¶7, 825 ¶13, 951 ¶7 & ¶12).

ARGUMENT

I. THE COURT BELOW CORRECTLY HELD THAT RESPONDENTS WERE LEGALLY ENTITLED TO THE CASH CONSIDERATION UNDER §7307, THE PLAN, AND THE DFS DECISION

The Second Department correctly held below that "[t]he 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." *Scott* Order, Appdx. 1007. In an unavailing attempt to contrive an error in the *Scott* Order and support its claim to the Cash Consideration, Appellant posits that §7307, the Plan and DFS Decision only mandate who initially "receives" the Consideration--not who is entitled to "retain" it (App. Brief, 4-5 & 12-13). Appellant's contention has no basis in the statute, flatly ignores the Plan and DFS Decision's unequivocal statements as to who is entitled to the Consideration under §7307 (*the Eligible Policyholders* [here, Respondents]), and is predicated on Appellant's limited rights as Respondents' designated or purported "de facto" Policy Administrator (none of which entitled it to the Consideration under §7307).

A. Insurance Law §7307(e)(3) is clear that the Cash Consideration is to be paid to the "person who had a policy of insurance in effect."

Section 7307(e)(3) provides that when a mutual insurance company converts to a stock insurance company, its plan of conversion shall include:

> "The 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. The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution [to seek approval of the conversion] shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both." (Emphasis added).

Contrary to Appellant's specious claim, §7307 does not make any distinction—let alone an "explicit distinction" (App. Brief, 5)—between "receipt" and "retention" of the Cash Consideration.[13] Section 7307(e)(3) is "precise," "clear and unambiguous" that the person "'entitled to receive the consideration' . . . is 'anyone who had a policy of insurance in effect during the relevant time period.'" *Scott* Order, Appdx. 1007-08 (quoting *Schoch*, 184 A.D.3d at 342). There is simply nothing in the statute suggesting that consideration paid to a person who had a policy in effect, in exchange for their membership interest, is to be retained by a third party.

B. MLMIC's Plan of Conversion provided that the Policyholders-Insureds were entitled to the Cash Consideration.

MLMIC's Plan of Conversion provided that the "Eligible Policyholder" was the "person who had a policy of insurance in effect," and was therefore entitled to

[13] Appellant's citation to landlord/tenant regulations respecting (a) the receipt and retention of payments under a lease with a purchase option pre-dating May 1, 1950 (9 NYCRR §2105.6), and (b) the collection of security deposits (9 NYCRR §2205.5 and §2525.4), is entirely unavailing. Neither provision has any bearing on Policyholders' entitlement to the Cash Consideration under Insurance Law §7307.

the Cash Consideration, under §7307(e)(3):

- "Eligible Policyholders, or their Designees, will receive Cash Consideration in consideration of the extinguishment of their Policyholder Membership Interest" (R.66 [para. 3]).
- "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 . . . to receive such amount on its behalf, in which case such amount shall be distributed to such Designee"[14] (R.76 ¶6.3[f]).
- "Each Eligible Policyholder (or its Designee) shall receive a cash payment in an amount equal to the applicable Conversion Payment" (R.77 ¶8.2).

See Scott Order, Appdx. 1008 ("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."); *Schoch*, 184 A.D.3d at 342 ("Consideration is owed to anyone who had a policy of insurance in effect during the relevant time period. Under MLMIC's conversion plan, the consideration is payable to eligible policyholders or their designees.").

The Plan defines "Eligible Policyholder" as the "Policyholder" under any policy in effect during the period July 15, 2013 to July 14, 2016 (R.68); and "Policyholder" as the person identified as "the insured" under the policy (R.70).[15]

[14] Respondents did not designate Appellant to receive the Consideration (R.208 ¶8; Appdx. 207 ¶8, 456 ¶10, 670 ¶9, 824 ¶10, 951 ¶10)

[15] The Plan's definition of Policyholder as the "insured" is consistent with New York case law,

As Appellant concedes,[16] Respondents were each listed as the sole "insured" under their respective MLMIC policies.[17] As such, Respondents were the "Policyholders" entitled to the Consideration under the Plan. *See Scott* Order, Appdx. 999-1000 ("Under these policies, each of the physicians was the sole insured and the sole policyholder.").

C. The DFS Superintendent did not leave the question of statutory entitlement to the courts.

While addressing the Plan's procedure for a Policy Administrator to object to the Policyholder's receipt of the Cash Consideration, the DFS Superintendent stated that "[t]he determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided either by agreement of the parties or by an arbitrator or court" (R.186). Through tortuous and erroneous reasoning, Appellant claims that the DFS' acknowledgement of the Plan's objection/escrow procedure, together with the above language, left the question of statutory entitlement to the Consideration to the courts (App. Brief, 13-15). Appellant's claim is belied, however, by the DFS Superintendent's discussion of Policyholders' rights under §7307(e)(3) and the limited availability of the

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which routinely identifies the policyholder as the insured. *See, e.g.*, *Allstate Ins. Co. v. Sullivan*, 230 A.D.2d 732, 732 (2d Dep't 1996); *Utica Fire Ins. Co. of Oneida County v. Gozdziak*, 198 A.D.2d 775, 775 (4th Dep't 1993); *Rhine v. N.Y. Life Ins. Co.*, 248 A.D. 120, 123 (1st Dep't 1936).

[16] *See* App. Brief, 1 (The physician/employee was "the named insured") & 3 (The "individual insureds [were] named as 'policyholders.'").

[17] *See* R. 207 ¶4, 226; Appdx. 205-06 ¶4, 454-55 ¶¶2-3, 669 ¶4, 822-23 ¶¶2-3, 949-50 ¶¶2-3).

MLMIC objection/escrow procedure:

> "Insurance Law § 7307(e)(3) defines the policyholders eligible to be paid their proportional shares of the purchase price, but also recognizes that such policyholders *may have assigned* such legal right to other persons. Therefore, the plan appropriately includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to the payment in a given case" (R.184 ¶4 [emphasis added]).

In short, the DFS Superintendent affirmed the Plan's inclusion of an objection procedure for an employer/Policy Administrator that was not designated to receive the Consideration (by way of MLMIC's Consent Form) but nevertheless claims to have been assigned a Policyholder's legal right to the Consideration. It was not, as Appellant advocates, carte blanche for courts to disregard the Insurance Law or Plan. *See Bank of N.Y.,* 470 F.3d at 274 (demutualization plan defines rights to proceeds).

Consistent with the foregoing, the Second Department explained in *Scott*:

> "'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 [*Schoch*]." Appdx. 1010 (quoting *Schoch*, 184 A.D.3d at 342 [emphasis added]).
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> * * *
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> "'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].'" Appdx. 1012 (quoting *Schoch*, 184 A.D.3d at 343-44 [emphasis added; alterations in original]).

See also Maple-Gate Anesthesiologists, P.C. v. Nasrin, 182 A.D.3d 984, 985 (4th Dep't 2020) ("*Maple-Gate*") ("although [employees] had assigned some of their rights as policyholders to [employer] as Policy Administrator, they had not designated [employer] to receive demutualization payments.")

In sum, DFS recognized that MLMIC's objection/escrow procedure is a mechanism for courts to determine whether the Consideration should be paid to an employer/Policy Administrator pursuant to an assignment or other contractual obligation. Its acknowledgement of this mechanism did not negate the approval of the Plan (and its definition of the Policyholders entitled to the Consideration under §7307), nor did it invite employers/Policy Administrators to challenge the DFS Decision or Plan under the guise of statutory interpretation or otherwise.[18]

[18] Further, contrary to Appellant's claim, DFS' statement that "the release of the escrow shall have no substantive effect on the parties' positions with respect to who is entitled to the payment under the relevant law" (R.186) does not support Appellant's strained receipt/retention argument. DFS was merely noting that if it were to direct MLMIC to release the Consideration from escrow prior to the resolution of all objections/disputes, then a Policyholder's receipt of the funds would not impact the parties' positions in that specific dispute (*see id.*). Moreover, MLMIC released Respondents' Cash Consideration from escrow and distributed it to Appellant pursuant to the Westchester County Supreme Court's Decisions/Orders/Judgments—not at DFS' direction.

D. Appellant's limited rights as Policy Administrator did not entitle it to the Cash Consideration.

To the extent Appellant's claimed legal entitlement to the Cash Consideration rests on its role as Respondents' designated or "de facto" Policy Administrator, a Policy Administrator is the "agent" of the Policyholder, conferred with only limited rights respecting the policy—"for the paying of premiums, requesting changes in the policy, including cancellation thereof, and for receiving dividends and any return Premiums when due" (R.222). None of those limited rights entitled Appellant to the Consideration.

1. Appellant's payment of premiums did not confer a right to the Cash Consideration.

A Policy Administrator, by definition, pays the policy's premiums; and despite payment, the Plan of Conversion does not permit Policy Administrators to receive the Consideration unless designated by the Policyholder. In short, if mere payment of premiums on behalf of a Policyholder conferred a right to the Consideration, the Plan would have said so. It did not. *See Bank of N.Y.*, 470 F.3d at 274 (Mutual insurer's demutualization plan defines rights to proceeds.).

Moreover, Appellant's contention that payment of premiums entitles it to the Consideration misunderstands the basic structure and operation of a mutual insurance company, which the Second Department described below:

> "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).'" *Scott* Order, Appdx. 999 (quoting *Bank of N.Y.*, 470 F.3d at 267).[19]

As the Second Department further explained, "[m]embership 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." *Scott* Order, Appdx. 1017 (citing *Schoch*, 184 A.D.3d at 345-46).

Simply put, the MLMIC premiums paid by Appellant were not paid for or allocated to Respondents' Policyholder Membership Interests. Thus, as confirmed by the court below, Appellant's payment of Respondents' premiums on their behalf did not entitle it to the Consideration under §7307. *See Scott* Order, Appdx. 1008-12. *See also Schoch*, 184 A.D.3d at 341-44; *Maple-Gate*, 182 A.D.3d at 986.

2. Appellant's receipt of dividends is entirely unrelated to Respondents' entitlement to the Cash Consideration.

A mutual insurer's dividend bears "no relation to a dividend upon stock . . . ." *Menin v. N.Y. Life Ins. Co.*, 188 Misc. 870, 871 (Sup. Ct. N.Y. Cty. 1941). Rather, a dividend in a mutual insurance company is a refund of the surplus annual premium. *Kern*, 8 A.D.2d at 259 (A mutual insurance company "dividend" is an "adjustment"

[19] *See also Schoch*, 184 A.D.3d at 341 (Policyholders have "a dual relationship with a mutual insurance company, in that they have both a membership interest (e.g., the right to vote and receive dividends) and contractual rights (i.e., the obligations of the insurance company under the policy).").

between the annual premium "estimated at the year's beginning . . . and the amount found actually to have been necessary in retrospect.").[20]

The MLMIC demutualization payout, on the other hand, represents cash consideration payable to Policyholders in exchange for the extinguishment of their Policyholder Membership Interests. *See Scott* Order, Appdx. 1008 (Cash Consideration was to be paid "'in consideration for the extinguishment of [the Eligible Policyholders'] Policyholder Membership Interests.'" [quoting Plan of Conversion, R.66]).[21] Accordingly, the Consideration is clearly not a dividend to which Appellant would have been entitled under the terms of the PA Designation Form. *See Columbia Mem. Hosp. v. Hinds*, 2019 NY Slip Op 51508(U), ¶5 (Sup. Ct. Columbia Cty. Sept. 3, 2019) ("This cash contribution, by law, is not a return to the hospital of any insurance premiums it paid on behalf of the defendant, it represents the policyholder's share in MLMIC."), *aff'd*, 188 A.D.3d 1337 (3d Dep't 2020); *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc. 3d 703, 708 (Sup. Ct. Erie Cty. 2019) ("Unlike a [premium] refund, the cash consideration was clearly intended to be in exchange for the extinguishment of the defendants' membership interest in MLMIC."), *aff'd*, 182 A.D.3d 984 (4th Dep't 2020).[22] As such,

[20] *See also Dorrance*, 809 F.3d at 481 (Surplus annual premiums are returned as dividends.).

[21] *See also Schoch*, 184 A.D.3d at 340 (Cash consideration was to be paid to Policyholders "in exchange for the extinguishment of his or her policyholder membership interest.").

[22] *See also Dorrance*, 809 F.3d at 486 (Consideration "received in exchange for the membership rights cannot be understood as a partial return on their past premium payments . . . .").

Appellant's receipt of dividends is entirely irrelevant to Respondents' entitlement to the Consideration.

3. MLMIC declared that a Policy Administrator's limited rights as the Policyholder's agent did not entitle it to the Consideration.

MLMIC repeatedly declared that a Policy Administrator may receive Cash Consideration only if the Policyholder expressly designates as such:

- Plan of Conversion: "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 . . . to receive such amount on its behalf, in which case such amount shall be distributed to such Designee" (R.76 ¶6.3[f]);

- 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 . . . to receive such amount on its behalf . . ." (R.131 ¶A.5; *see also* R.132-33 ¶A.12); and

- June 29, 2018 Notice: "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." (R.46 ¶108; Appdx. 473).

See Scott Order, Appdx. 1008-09 (citing the above provisions of the Plan, Policyholder Information Statement, and June 29, 2018 Notice). As the Third Department aptly noted in *Schoch*, "an ordinary designation as policy administrator does not convey the right to receive the cash consideration." 184 A.D.3d at 342. Rather, a Policy Administrator may receive the Consideration *only if* the

Policyholder "assigned it that right through a designation form or contractual arrangement" (*id.*)—neither of which occurred here.

In short, there is nothing about a Policy Administrator/agent's exercise of its limited rights that would entitle it to receive the proceeds of the Policyholder/principal's Membership Interest. If a Policy Administrator were entitled to the Cash Consideration by reason of its prior appointment, the Plan of Conversion would have provided so. It did not. Accordingly, an employer's "'designation as policy administrator gave it no greater right to the cash consideration.'" *Scott* Order, Appdx. 1010 (quoting *Schoch*, 184 A.D.3d at 342). *See also Maple-Gate*, 182 A.D.3d at 985 ("[A]lthough [the employees] had assigned some of their rights as policyholders to [their employer] as Policy Administrator, they had not designated [their employer] to receive demutualization payments.").

E. Respondents did not designate Appellant to receive, or assign their rights to, the Cash Consideration.

As set forth above, the Plan and DFS Decision make clear that the Cash Consideration is to be paid to the Policyholder in accordance with §7307(e)(3) unless the Policyholder has either: (a) specifically designated the Policy Administrator to receive the Consideration by signing MLMIC's Consent Form[23]; or (b) assigned

[23] *See Scott* Order, Appdx. 1001 ("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." [Emphasis added]); *Schoch*, 184 A.D.3d at 342 ("Under MLMIC's conversion plan, the consideration is payable to eligible

their right to the Consideration to the Policy Administrator.[24] Consequently, where there is no signed consent or assignment, "this alone is fatal to the [employer's] claim that it is entitled to the cash consideration." *Maple-Gate*, 63 Misc. 3d at 709.

Here, it is undisputed that Respondents did not sign the Consent Form, nor did Respondents assign their Membership Interests or rights to the Consideration to Appellant.[25] As such, Appellant's claimed entitlement to the Cash Consideration necessarily fails. *See Scott* Order, Appdx. 1012 ("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. . . . Accordingly, in accordance with the controlling statute, the plan of conversion, and the DFS decision, Scott, and the other Maple Medical physicians,

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policyholders or their designees. Designee is defined to mean someone who a policyholder specifically designated to receive the proceeds from demutualization; an ordinary designation as policy administrator does not convey the right to receive the cash consideration." [Emphasis added]). This specific designation is effected by the employee signing "a special consent form distributed by MLMIC to policyholders." *Schoch*, 184 A.D.3d at 340.

[24] *See Scott* Order, Appdx. 1009 ("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 receive the Cash Consideration] to other persons." [Emphasis added]); *Schoch*, 184 A.D.3d at 343 ("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 (*see* [*Maple-Gate*, 63 Misc. 3d at 709] [noting that DFS's decision 'tied eligibility for the objection and escrow process to when the policyholder had, in fact, assigned the right to cash consideration to another person or entity']).") [Emphasis added]).

[25] *See, supra*, Counterstatement of Facts, subpoint L.

are entitled to the cash consideration.").

See also Columbia Mem. Hosp. v. Hinds, 188 A.D.3d 1336, 1338-39 (3d Dep't 2020) (Rather, the sole policyholder, here, [employee], is entitled to receive said funds unless he or she executed an assignment of such rights to third party (*see* Insurance Law § 7307). Given the documentary evidence establishing that [employee] was the named policyholder and specifically declined to execute any assignment of his right to receive the MLMIC funds, he was statutorily entitled to receive same."); *Schoch*, 184 A.D.3d at 342 ("[Employer] has failed to provide any proof [of its claimed legal right to the Consideration], as it has not demonstrated that [employee] assigned it that right through a designation form or contractual arrangement."); *Maple-Gate*, 182 A.D.3d at 985 ("although [the employees] had assigned some of their rights as policyholders to plaintiff as Policy Administrator, they had not designated plaintiff to receive demutualization payments."); *GHVHS Med. Group, P.C. v. Cornell*, 2020 NY Slip Op 20104, ¶5 (N.Y. Sup. Ct. Orange Cty. Jan. 16, 2020) ("*Cornell*") ("The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits if they chose to do so, further illustrating that the rightful owner of the proceeds would be the Policy Holder, Dr. Cornell, and no one else. However, Defendant Dr. Cornell chose not to assign the proceeds; therefore he is entitled to the distribution . . . .").

II. APPELLANT'S MISCHARACTERIZATION OF §7307(e)(3) HAS NO BASIS IN THE PLAN, WAS REJECTED BY THE DFS, AND CONSTITUTES AN IMPERMISSIBLE COLLATERAL ATTACK

Faced with Respondents' clear entitlement to the Consideration in accordance with §7307, the Plan and the DFS Decision, Appellant attempts to revive the *same* argument that it unsuccessfully made to the DFS, to the Westchester County Supreme Court in its ensuing Article 78 proceeding,[26] and to the court below: The persons entitled to the Consideration under §7307 are those who made the premium payments, and not the insureds/employees on whose behalf the payments were made. Appellant's argument is based on its mischaracterization of § 7307(e)(3)'s formula for calculating Policyholders' shares of Consideration, is directly contrary to the Plan of Conversion and DFS Decision, and constitutes an impermissible collateral attack on the DFS Decision.

A. Appellant mischaracterizes §7307(e)(3)'s formula for calculating Policyholders' share of the Cash Consideration.

Appellant's contention that the party who paid the premiums is entitled to the Consideration under §7307(e)(3) is squarely based on Appellant's conflation of the statutory language governing *how* the Consideration is to be calculated (by reference to premiums paid on the policy) with the provision governing *who* is to receive it (the Policyholder):

[26] *Matter of Maple Medical LLP, et al. v. New York State Dept. of Fin. Servs., et al.* Index No. 65929/2018 (Sup. Ct. Westchester Cty.) (*see* R.202-05).

> "The plan [of conversion] shall include: . . . (3) The manner and basis of exchanging the equitable share of each eligible mutual policyholder for . . . consideration . . . The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period . . . shall be entitled to receive in exchange for such equitable share, . . . consideration payable in voting common shares of the insurer or other consideration, or both. *The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the insurer* on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors under subsection (b) hereof bears to the total net premiums received by the mutual insurer from such eligible policyholders . . . " (Emphasis added).

The italicized provision on which Appellant relies merely address *how* the amount of consideration is to be determined, not to whom it is payable. The underlined portion of §7307(e)(3) clearly describes to whom the Consideration is to be paid: "each person who had a policy of insurance in effect" (i.e., the Policyholder). *See Schoch*, 184 A.D.3d at 342 ("The first quoted sentence of this statute 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. Consideration is owed to anyone who had a policy of insurance in effect during the relevant time period."). The Second Department correctly held as such in the *Scott* Order: "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." (Appdx. 1012).

B. The Plan confirmed that an Eligible Policyholder's share of the Consideration is based in part on the premiums paid *on the policy*.

Further refuting Appellant's misreading of §7307(e)(3), the Plan stated that each "Eligible Policyholder shall be entitled to an allocation of the Cash Consideration based on the Eligible Premium with respect to such Eligible Policyholder" (R.68), and defined "Eligible Premium" as the net premiums "properly and timely paid on each Eligible Policy"[27] (R.78 [emphasis added]). In other words, MLMIC confirmed that a Policyholder's share of the Consideration does not turn on the amount of premiums they *personally paid*, but rather on the premiums paid on their policy.[28] As such, an employer/Policy Administrator's payment of its employee/Policyholder's premiums on their behalf has no bearing on the Policyholder's entitlement to the Consideration under §7307 or the Plan.

In a desperate attempt to support its strained position as to § 7307(e)(3), Appellant relies on a MLMIC email and newsletter from 2016—*two years b*efore the Plan of Conversion was adopted—positing that in most cases, the payor of the premiums will be considered the "owner" of policies (App. Brief, 6-7 [quoting

[27] *See also* MLMIC's Policyholder Information Statement, R.130, A1; R.131, A6 & A8 (repeating the Plan's reliance on the "Eligible Premium" [defined at R.127] to calculate the amount of Consideration payable to each Eligible Policyholder).

[28] *See also* Plan, R.67 ("The amounts allocated to Eligible Policyholders shall vary according to the premiums properly and timely paid under their Eligible Policies . . . ." [Emphasis added]).

R.288, R.297]). As Appellant concedes, MLMIC ultimately rejected that proposition in its Plan of Conversion. Specifically, the Plan (a) defined the "Members" (*i.e.*, the owners of the Policy under Insurance Law § 1211 [a]) as the Policyholders, and the Policyholders as the "insured" listed on the Policy (R. 69-70); and (b) defined "Eligible Premium" (the premiums on which the amount of Cash Consideration would be determined) as "with respect to *each Eligible Policyholder*, the sum of net premiums . . . properly and timely *paid on each Eligible Policy*." (R.68, R.78 [emphasis added]). In short, MLMIC recognized that under the Insurance Law, the Policyholder/Insured was entitled to the Consideration.

C. The DFS Superintendent correctly rejected that only the payor of premiums is entitled to the Cash Consideration under §7307(e)(3).

Having reviewed MLMIC's proposed Plan and held a public hearing thereon, the DFS Superintendent issued her Decision approving the Plan (R.162-89). In her Decision, the DFS Superintendent documented several medical groups and hospitals' contention that the Cash Consideration should be paid to them "where they paid the premiums on behalf of policyholders and/or acted as policy administrators" (R.184). In particular, she highlighted—and rejected—Appellant's within argument that §7307(e)(3)'s formula for calculating policyholders' shares of consideration foreclosed anyone but the actual payor of the premiums from receiving the consideration:

> "One commenter [Maple Medical] referred to the provision in Insurance Law § 7307(e) stating that in calculating each such person's equitable share one must factor in the amount 'such policyholder has properly and timely *paid* to the insurer on insurance policies in effect during the three years immediately preceding . . .' (emphasis added). The commenter suggested that this means that the person that paid the premium is automatically entitled to the proceeds of the sale. The Superintendent finds that this is not determinative because the same provision refers to the 'policyholder,' which might or might not be the person who paid the premiums" (R.184).

See Scott Order, Appdx. 1011 ("DFS considered, and rejected, [Maple Medical's] precise argument in its decision, finding that the matter of who paid the premium 'is not determinative . . . .'").

In other words, the DFS Superintendent correctly recognized that whether the premiums were paid by the Policyholders themselves, in the one instance, or on their behalf by their employers/Policy Administrators, in the other, has no relevance to whether the Policyholder is entitled to the Consideration under §7307(e)(3). As the DFS Superintendent unequivocally confirmed in her Decision:

- "Insurance Law § 7307(e)(3) expressly defines those persons who are entitled to receive the proceeds of the Demutualization as each person who had a policy 'in effect' during the three-year period preceding the MLMIC Board's adoption of the resolution (the 'Eligible Policyholders')"; and
- The operative component in calculating the Consideration is the "net premiums timely paid on that Eligible Policyholder's eligible policy"

(R.165 [emphasis added]).

D. Maple Medical commenced, *and lost*, an Article 78 proceeding challenging the DFS' approval of the Plan.

Following issuance of the DFS Decision, Maple Medical commenced an Article 78 proceeding (*Maple Med., LLP, et al. v. New York State Dept. of Fin. Servs.*, Index No. 65929/2018, Sup. Ct. Westchester County) to challenge the Plan of Conversion's definition of "Policyholder" by way of the DFS Decision. Maple Medical argued that §7307(e)(3) requires that "policyholders be defined under the conversion plan as the parties who actually paid the premiums and not the doctors who are insured under the policies" (R.203 [para. 2]). The Westchester County Supreme Court refused to disturb the DFS Decision, holding that the DFS Superintendent had a rational basis for approving the Plan, including its definition of Policyholders (and their entitlement to the Cash Consideration) (R.204 [para. 4]).

E. Appellant's collateral attack of the DFS Decision is impermissible.

Appellant argues that "by failing to properly reference the policyholder as the party that paid the premium, the DFS Decision arbitrarily overrides the statute by approving the Plan's definition of the Policyholder as the insured . . . . (App. Brief, 15). That is the same argument Maple Medical raised at the DFS Hearing and in its Article 78 proceeding. As the court aptly explained in *Grossman v. Akker*:

> "Under the collateral attack doctrine, a party is precluded from indirectly challenging the Superintendent's approval of a demutualization plan through a plenary action. In other words, because the Superintendent has exclusive jurisdiction to determine whether a plan complies with the statute, litigants may

> not use a plenary action as a means to achieve a different result, but rather, must avail themselves of CPLR Article 78."

2016 NY Slip Op 31551(U), ¶10 (Sup. Ct. N.Y. Cty. Aug. 8, 2016) (citing *Fiala v. Metropolitan Life Ins. Co.*, 6 A.D.3d 320 [1st Dep't 2004]; *Chatlos v. MONY Life Ins. Co.*, 298 A.D.2d 316 [1st Dep't 2002]). *See also ABN AMRO Bank, N.V. v. MBIA Inc.*, 17 N.Y.3d 208, 227 (2011) (recognizing the applicability of the collateral attack doctrine to the plenary lawsuit in *Fiala* [*supra*], where plaintiff challenged the "Superintendent's decision to approve a demutualization of an insurance company," "public hearings were held and plaintiff had notice and opportunity to be heard").

Here, Appellant is attempting to challenge the DFS Superintendent's determination that the Plan (including its definition of Policyholder) "does not violate the Insurance Law" (R.173[emphasis added]), and her unequivocal rejection of the claim that §7307(e)(3) conditions a person's entitlement to the Consideration on their out-of-pocket payment of the premiums. Simply put, Appellant should not be permitted to litigate on this appeal issues that were resolved by the DFS Decision. *See Grossman*, 2016 NY Slip Op 31551(U), ¶9 (dismissing amended complaint as an impermissible collateral attack because "[t]o sustain these causes of action would permit plaintiffs to relitigate, through a plenary action, issues that were previously decided by the Superintendent" in approving the demutualization plan); *Fiala*, 6 A.D.3d at 321 (affirming dismissal of claims respecting mutual life insurance company's demutualization as "impermissible collateral attacks on the

Superintendent's determination" approving the plan of conversion]).[29]

III. APPELLANT IS IMPROPERLY ATTEMPTING TO RE-WRITE THE INSURANCE LAW TO PERMIT GROUP MALPRACTICE POLICIES

Appellant admits (App. Brief, 6, 10) that New York does not permit group malpractice insurance policies, and policies must therefore be issued to the individual practitioners. *See* Insurance Law §3435; Regulation 135 (11 NYCRR §153.0) (permitting issuance of group property/casualty insurance only with respect to public and not-for-profit insureds). Yet, by arguing that it is the policyholder for employees such as Respondents, Appellant is improperly attempting to re-write the Insurance Law's prohibition of group malpractice insurance policies. The Court should not countenance Appellant's efforts to effect judicial legislation.

IV. THE SECOND DEPARTMENT CORRECTLY HELD THAT RESPONDENTS WOULD NOT BE UNJUSTLY ENRICHED BY RECEIVING THE CASH CONSIDERATION

Given Respondents' legal entitlement to the Cash Consideration, the next issue was whether they "would be unjustly enriched if [they] received the cash consideration as required by the statute and MLMIC's conversion plan." *Schoch*, 184 A.D.3d at 344. It is well-settled that the unjust enrichment "doctrine is a narrow one; it is 'not a catchall cause of action to be used when others fail.'" *E.J. Brooks Co. v. Cambridge Sec. Seals*, 31 N.Y.3d 441, 455 (2018). An allegation that a party

[29] *See also Brawer v. Johnson*, 231 A.D.2d 664, 664 (2d Dep't 1996) (affirming dismissal of all causes of action as "a collateral attack on the bank's conversion plan which was approved by the New York State Superintendent of Banks").

"'received benefits, standing alone, is insufficient to establish a cause of action to recover damages for unjust enrichment.' 'Critical is that under the circumstances and as between the two parties to the transaction the enrichment be unjust.'" *Goel v. Ramachandran*, 111 A.D.3d 783, 791 (2d Dep't 2013) (citations omitted).[30]

The typical unjust enrichment cases are those "in which the defendant, though guilty of no wrongdoing, has received money to which he or she is not entitled" (*E.J. Brooks Co.*, 31 N.Y.3d at 455)[31]; or those where a defendant enjoys a benefit bestowed by the plaintiff "'without adequately compensating plaintiff therefor.'" *Smith v. Chase Manhattan Bank, USA, N.A.*, 293 A.D.2d 598, 600 (2d Dep't 2002). Neither of the above situations applied to the case below.

A. Pursuant to the Insurance Law, Plan of Conversion and DFS Decision, Respondents are legally entitled to the Consideration.

As the court below held, Respondents are "'legally entitled'" to the Cash Consideration "in accordance with the controlling statute [§7307(e)(3)], the plan of conversion, and the DFS decision." *Scott* Order, Appdx. 1012 (quoting *Schoch*, 184 A.D.3d at 344). *See also Maple-Gate*, 182 A.D.3d at 985 (Under the Insurance Law and Plan, payment of the Cash Consideration was "required to be made to those

[30] *See also Clark v. Daby*, 300 A.D.2d 732, 732 (3d Dep't 2002) ("the mere fact that the plaintiff's activities bestowed a benefit on the defendant is insufficient to establish . . . unjust enrichment"), *appeal denied*, 100 N.Y.2d 503 (2003).

[31] *See also Schoch*, 184 A.D.3d at 344 ("'The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another.'" [quoting *Clifford R. Gray, Inc. v. LeChase Constr. Servs., LLC*, 31 A.D.3d 983, 988 (3d Dep't 2006)]).

policyholders who had coverage during the relevant period . . . .").

Appellant fails to explain--nor can it--how Respondents' receipt of money rightfully belonging to them under the Insurance Law, Plan and DFS Decision is unjust, improper or inequitable. *See A & A Assocs. v. Olympic Plumbing & Heating Corp.*, 306 A.D.2d 296, 297 (2d Dep't 2003) ("[N]o issue of fact was raised as to whether the respondents derived a benefit that belonged to plaintiff, which is necessary to sustain a cause of action based on unjust enrichment."), *appeal denied*, 1 N.Y.3d 503 (2003); *GHVHS Med. Group, P.C. v. Arthurs*, 2019 NY Slip Op 33988(U), 2019 N.Y. Misc. LEXIS 7166, *6 (Sup. Ct. Orange Cty. Oct. 7, 2019) ("[Employee's] enrichment is not at [her employer's] expense, but rather an unforeseen benefit of the bargain . . . ").[32]

Indeed, as the Second Department held below, "'[t]he 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, 975 N.Y.S.2d 428), 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).'" *Scott* Order, Appdx. 1018 (emphasis added) (quoting *Schoch*, 184 A.D.3d at 346).

[32] *See also CDR Creances S.A. v. Euro-Am. Lodging Corp.*, 40 A.D.3d 421, 422 (1st Dep't 2007) ("unjust enrichment cause of action was properly dismissed for failure to identify any improper benefit"); *Clifford R. Gray, Inc.*, 31 A.D.3d at 988 ("[P]laintiff asserts no facts suggesting that defendant is in possession of money or property belonging to plaintiff.").

Quite simply, Respondents' receipt of Cash Consideration rightly belonging to them cannot sustain a cause of action for unjust enrichment.[33]

B. Appellant paid Respondents' premiums as part of the bargained-for exchange of consideration under their Employment Agreements.

Appellant's unjust enrichment counterclaim admittedly stems from its payment of Respondents' MLMIC policy premiums.[34] However, under the Employment Agreements, Respondents agreed to devote their professional services to generating revenue for Appellant, in exchange for which Appellant agreed to, among other things, pay Respondents' malpractice insurance premiums. Appellant was therefore compensated for, and cannot base an unjust enrichment claim on, its payment of premiums. *See Scott* Order, Appdx. 1017 ("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

[33] Appellant's reliance on *State v. Barclays Bank of N.Y., N.A.* (76 N.Y.2d 533 [1990]) and *Simonds v. Simonds* (45 N.Y.2d 233 [1978]) is misplaced. In *Barclays Bank*, the Court held that plaintiff (like Appellant herein) "never acquired a property interest" in the subject funds and therefore could not have suffered the requisite loss to sustain an unjust enrichment claim. 76 N.Y.2d at 540-41. In *Simonds*, a husband caused his second wife to receive life insurance benefits that he had promised to his ex-wife under their separation agreement. The court held that the first wife had a vested equitable interest in the life insurance policy that arose from the separation agreement and was superior to the second wife's legal right to the proceeds as beneficiary. Here, by contrast, there was no contract from which Appellant obtained *any* interest in the Cash Consideration.

[34] *See* App. Brief, 2 (question presented is whether an employer that pays malpractice insurance premiums "can prevail on a claim for unjust enrichment").

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."); *Smith*, 293 A.D.2d at 600 (dismissal of unjust enrichment claim where there was "no allegation that the benefits received were less than what these purchasers bargained for"); *Fruchthandler v. Green*, 233 A.D.2d 214, 215 (1st Dep't 1996) (dismissing plaintiff's unjust enrichment claim because defendant provided consideration for the benefit plaintiff provided).[35]

Moreover, as the Second Department observed below, "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." *Scott* Order, 191 A.D.3d at 104. *See also Schoch*, 184 A.D.3d at 346 ("Furthermore, both parties benefitted from [Lake Champlain's] fulfillment of its contractual obligation to provide malpractice insurance and pay for the premiums, inasmuch as the insurance provided coverage to protect the liability interests of [employee] both individually and as an employee of [Lake Champlain]"). Thus, Appellant "received protection from the policy because, as [Respondents'] employer, [Appellant] may

[35] *See also GHVHS Med. Group, P.C. v. Sidorski-Nutt*, Index No. EF001620-2019, at 3 (Sup. Ct. Orange Cty. Jan. 6, 2020) (As a result of the Policyholder's services under the employment agreement, the employer had "already received the benefit of the bargain" and therefore could not sustain an unjust enrichment claim.).

also be named in a malpractice complaint based on [Respondents'] actions." *Schoch*, 184 A.D.3d at 346, n.4. The Second Department's analysis as to the parties' exchange of consideration was correct and supported summary judgment in Respondents' favor.

C. None of the additional factors that courts consider when evaluating an unjust enrichment claim warranted denial of Respondents' summary judgment motion.

Relying on *Paramount Film Distrib. Corp. v. State* (30 N.Y.2d 415 [1972]), the court below stated that when evaluating an unjust enrichment claim, "'courts will look to see if a benefit has been conferred on the [plaintiff] under mistake of fact or law, if the benefit still remains with the [plaintiff], if there has been otherwise a change of position by the [plaintiff], and whether the [plaintiff's] conduct was tortious or fraudulent.'" *Scott* Order, Appdx. 1013. The Second Department reviewed the above circumstances and found as follows:

- "No mistake of fact exists";
- "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 party changed its position"; and
- "There was no fraud or other tortious conduct."[36]

[36] Appellant's citation to *Alan B. Greenfield, M.D., P.C. v. Long Beach Imaging Holdings* (114 A.D.3d 888 [2d Dep't 2014]) is misplaced. *Greenfield* was a motion to dismiss case where defendant allegedly enriched itself at plaintiff's expense by wrongfully withholding plaintiff's files/records. Here, there are no allegations of wrongful conduct on Respondents' part.

Scott Order, Appdx. 1017.[37] *See also Schoch*, 184 A.D.3d at 346 ("[T]he benefit of the cash consideration would be paid to [the employee] based on the statute and the conversion plan — a correct reading of the law, rather than a mistake. No factual mistake exists, other than the parties' mutual failure to consider the potential for demutualization when negotiating their employment agreement. . . . Neither party changed its position based on demutualization and [employee's] conduct was neither tortious nor fraudulent.").

Based on its above analysis, the Second Department rightly held that Appellant had "no cognizable unjust enrichment cause of action" against any of the Respondents. *Scott* Order, Appdx. 1018. *See also Columbia Mem. Hosp.*, 188 A.D.3d at 1339 ("[F]or the reasons stated in *Schoch* . . . , we find that [employer] failed to establish any legal or equitable right to distribution of the MLMIC funds . . . ."); *Schoch*, 184 A.D.3d at 347 (Employee "was entitled to a declaratory judgment entitling her to receive the cash consideration from MLMIC's demutualization."); *Maple-Gate*, 182 A.D.3d at 985 ("as a matter of law . . . [employer] had no legal or equitable right of ownership to the [Consideration]."); *Cornell*, 2020 NY Slip Op 20104, ¶4 (Employee would not be unjustly enriched because "there are no

[37] *See also Schoch*, 184 A.D.3d at 346 ("[T]he benefit of the cash consideration would be paid to [the employee] based on the statute and the conversion plan — a correct reading of the law, rather than a mistake. No factual mistake exists, other than the parties' mutual failure to consider the potential for demutualization when negotiating their employment agreement. . . . Neither party changed its position based on demutualization and [employee's] conduct was neither tortious nor fraudulent.").

allegations of fraud or tortuous conduct. Moreover, there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed").[38]

Respondents respectfully submit that the Second Department's reasoning was sound, comports with established unjust enrichment precedent and should be affirmed in its entirety.

D. The First Department's decision in *Schaffer* has been rejected by the Second, Third and Fourth Departments, and should not be followed by this Court.

The First Department—hearing *Matter of Schaffer, Schonholz & Drossman, LLP v. Title* (171 A.D.3d 465 [1st Dep't 2019] ["*Schaffer*"]) in the first instance, on submitted facts, pursuant to CPLR 3222 —"summarily held, without any analysis, that awarding an employee a cash consideration related to MLMIC's demutualization would constitute unjust enrichment where the employer had paid the policy premiums." *Schoch*, 184 A.D.3d at 346-47. Indeed, the First Department reached its determination without discussing or citing the Insurance Law, the Plan, the DFS Decision, the parties' employment agreement, or New York unjust enrichment law—all of which, for the reasons explained above and in the *Scott*

[38] The facts alleged in support of the Appellant's unjust enrichment claim are materially identical to those alleged by the employers in *Columbia Mem. Hosp.* (188 A.D.3d at 1337), *Schoch* (184 A.D.3d at 340), *Maple-Gate* (182 A.D.3d at 984), and *Cornell* (2020 NY Slip Op 20104).

Order, require that the Consideration be paid to the Policyholders.[39]

Having engaged in a substantive analysis of the controlling statutory and documentary authority, together with the basic structure and operation of mutual insurance companies and controlling unjust enrichment law, the Second, Third and Fourth Departments correctly determined to decline to follow the First Department's holding in *Schaffer*. *See Scott* Order, Appdx. 1016; *Columbia Mem. Hosp.*, 188 A.D.3d at 1339; *Schoch*, 184 A.D.3d at 346-47; *Maple-Gate*, 182 A.D.3d at 986. Respondents respectfully submit that this Court should follow the reasoning of the Second, Third and Fourth Departments, and not that of the First Department.

E. Each of the cases Appellant cites is distinguishable or inapposite.

In support of its erroneous arguments, Appellant relies on several cases, each of which fails to establish its purported right to the Cash Consideration.

Appellant's citation to *Shah v. Exxis, Inc.* (138 A.D.3d 970 [2d Dep't 2016]) and *Mobarak v. Mowad* (117 A.D.3d 998 [2d Dep't 2014]) for the proposition that a defendant "may be unjustly enriched by the actions of a third party or 'others'" (App. Brief, 18-19) misses the mark. In those cases, plaintiffs conferred benefits on entities wholly owned by defendants. The courts held that while plaintiffs had conferred benefits on third parties, plaintiffs' allegations that defendants had thereby

[39] *See Scott* Order, Appdx. 1013 ("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.").

been enriched at plaintiffs' expense were sufficient to sustain unjust enrichment claims. The within cases are entirely distinguishable from *Shah* and *Mobarak*.

Ruocco v. Bateman, Eichler, Hill, Richards, Inc. (903 F.2d 1232 [9th Cir. 1990]) ("Ruocco") and *Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Brotherhood. of Teamsters* (2005 U.S. Dist. LEXIS 42877 [N.D. Ill. Mar. 4, 2005]) ("*Chi. Truck*")—two ERISA cases on which the First Department relied in *Schaffer* —are plainly inapposite because neither involved a state law unjust enrichment claim. *See Scott* Order, Appdx. 1016 (comparing the ERISA claims at issue in *Ruocco* and *Chi. Truck* with the state law unjust enrichment claim at bar, and holding that "[t]he federal ERISA authorities are of no assistance in this regard").

Instead, both *Ruocco* and *Chi. Truck* concerned whether demutualization proceeds were ERISA "plan assets"—a question clearly not involved here. Whether the proceeds were "plan assets" was material because ERISA plan assets generally cannot "inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable [plan] expenses . . . ." 29 U.S.C. § 1103(c)(1). Ultimately, the *Ruocco* and *Chi. Truck* courts determined whether the demutualization proceeds were plan assets (and if so, to whom they were entitled) by looking to the applicable Department of Labor ("DOL") ERISA advisory opinions, ERISA statutes, and any

contracts or legal instrument related to the ERISA plans.

Ruocco pre-dated the applicable ERISA advisory opinions (cited in *Chi. Truck)*, and it appears that neither the ERISA statutes, nor any plan-related contracts or documents, provided any direction as to the distribution of the demutualization funds. As such, the court resorted to balancing the equities, concluding that the employees should receive the funds because (a) they paid the premiums (and the funds themselves were surplus premiums), and (b) ERISA plans are intended to inure to the benefit of plan participants and beneficiaries (not employers). In *Chi. Truck,* the court was guided by the ERISA statutes and DOL advisory opinions.

Significantly, neither *Ruocco* nor *Chi. Truck* references any plan-related contracts or documentation that provided guidance as to the distribution of the demutualization proceeds. By contrast, in the instant case, the Plan of Conversion and the DFS Decision, as well as Insurance Law §1211(a) and §7307(e)(3), expressly provide that (a) the Policyholders are the owners of their Membership Interests, and (b) absent a designation or assignment to the Policy Administrator (neither of which occurred here), the Policyholders are entitled to the Consideration paid on account of the extinguishment of their Membership Interests. *See RLJCS Enters. v. Prof'l Benefit Trust, Inc.*, 438 F. Supp. 2d 903, 912 (Dist. Ct. N.D. Ill. 2006) (declining to "balance the equities" as in *Ruocco* because "in the instant case, there was a contract that governed the administration of the Trust, and that contract

stated that the Trust, not the Defendants, owned the policies.").[40]

Appellant's reliance on *Mell v. Anthem, Inc.* (2010 U.S. Dist. LEXIS 19056 [S.D. Ohio Mar. 3, 2010], *aff'd*, 688 F.3d 280 [6th Cir. 2012]) is similarly misplaced. *Mell* involved a dispute between the City of Cincinnati, the holder of a group health insurance policy (rather than the individual polices herein) and its employees, the holders of certificates of benefits under the policy (rather than policyholders/members/owners of the MLMIC policies herein) over the proceeds of Anthem Insurance's demutualization. The Ohio statute governing "Rights of mutual policyholders" in a demutualization stated, "Shares shall be issued to the owner or owners of a mutual policy" as "such owners appear on the face of the policy." While the statute used the terms "policyholder" and "owner," the latter was undefined.

Even though the record contained no evidence that the group policy named plaintiffs as policyholders, the District Court assumed as true the employees' claim that they were the statutory "policyholders." Nevertheless, the District Court sought to determine who the owner was, and thus the party entitled to the demutualization proceeds. To determine the meaning of the word "owner," the court applied the

[40] Appellant's reference to *Wright v. Nimmons* (641 F. Supp. 1391 [S.D. Tex. 1986]) being cited in *Ruocco* is unavailing. The *Wright* court held that the employer could recapture excess ERISA plan contributions under 29 U.S.C. § 1344(d) where either (a) the "trust plan is silent regarding the distribution of excess assets" and the employer exclusively funded the plan, or (b) "excess assets have accumulated as a consequence of actuarial error." *Id.* at 1406-07. Here, by contrast, the Insurance Law, Plan of Conversion and DFS Decision are not "silent" as to the distribution of Consideration—it is to be paid to Policyholders. And, the Consideration is not "excess [ERISA plan] assets"; it is proceeds from extinguishing Policyholders' Membership Interests.

standard maxim of statutory construction that the undefined term should be given its plain meaning. The District Court ultimately held that the employees could not be the "owners" of the policy, because the employees "had nothing to do with the choice of insurance carrier, nor with its governance, and they received what they bargained with the City to get: insurance coverage." 2010 U.S. Dist. LEXIS at *32-33.

The Sixth Circuit affirmed, holding that the pre-merger bylaws for Anthem's predecessor-in-interest, CMIC, "which adopted the policyholder definition found under Ohio insurance law," provided additional support for the City's claim to the proceeds. Specifically, the Court noted that CMIC's bylaws established that the City, as the member, would be the holder of the group master policy. 688 F.3d at 286. Accordingly, the employees' attempts to transmute themselves from mere beneficiaries of the insurance policy to "policyholders" was unavailing. *Id.* at 287.

In the instant case, unlike the Ohio statute, §7307(e)(3) does not use the undefined term "owner." Rather, Insurance Law §1211 and §7307(e)(3) establish that a mutual company is owned by its "members," that the "members" are the "policyholders," and that upon demutualization, the "policyholders" are entitled to consideration in exchange for the extinguishment of their membership interests. Pursuant to those provisions, the Plan and DFS Decision require that the Consideration be paid to the Policyholders (such as Respondents). *Mell,* as well as *Ruocco* and *Chi. Truck,* therefore are entirely inapposite.

CONCLUSION

Based upon the foregoing, Respondents respectfully request that this Court affirm the *Scott* Order, and the Decisions and Orders in the *Goldenberg*, *Arevalo*, *Sundaram*, *Mutic* and *Youkeles* cases, in their entirety.

Dated: June 21, 2021
Albany, New York

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ADDENDUM OF UNPUBLISHED CASES

Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Bhd. of Teamsters

United States District Court for the Northern District of Illinois, Eastern Division

March 4, 2005, Decided ; March 4, 2005, Filed

02 C 3115

Reporter
2005 U.S. Dist. LEXIS 42877 *

CHICAGO TRUCK DRIVERS, HELPERS AND WAREHOUSE WORKERS UNION (INDEPENDENT) HEALTH AND WELFARE FUND, Plaintiff, v. LOCAL 710, INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHICAGO TRUCK DRIVERS, HELPER AND WAREHOUSE WORKERS UNION (INDEPENDENT) PENSION FUND, Defendants.

Judges: HONORABLE RONALD A. GUZMAN, United States Judge.

Opinion by: RONALD A. GUZMAN

Prior History: *Chi. Truck Drivers, Helpers & Warehouse Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Bhd. of Teamsters, 2004 U.S. Dist. LEXIS 4657 (N.D. Ill., Mar. 19, 2004)*

Opinion

MEMORANDUM OPINION AND ORDER

Counsel: [*1] For Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Health and Welfare Fund, Plaintiff: Michael Joseph Kralovec, Joseph R. Lemersal, Sara R. McClain, Nash, Lalich & Kralovec, Chicago, IL.

For Local 710 International Brotherhood of Teamsters, successor Chicago Truck Drivers, Helpers and Warehouse Workers Union, Defendant: Marvin Gittler, Stephen Jay Feinberg, Asher, Gittler, Greenfield, Cohen & D'Alba, Chicago, IL.

For Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Pension Fund, Defendant: David George Huffman-Gottschling, Joseph M. Burns, Sherrie E. Voyles, Jacobs, Burns, Orlove, Stanton & Hernandez, Chicago, IL.

Judge Ronald A. Guzman

Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Health and Welfare Fund ("Health and Welfare Fund") seeks a declaratory judgment against Local 710, International Brotherhood of Teamsters ("Local 710") and Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Pension Fund ("Pension Fund") that the demutualization compensation [*2] for four employee-benefit plans of Principal Financial Group ("Principal") is a plan asset and should revert to the participants of the plans. Before the Court is the Health and Welfare Fund's motion for summary judgment and Local 710's motion for partial summary judgment. For the reasons provided in this Memorandum Opinion and Order, the Court grants in part and denies in part both motions.

FACTS

This controversy stems from Principal's conversion from a mutual insurance company into a public stock company, a process known as a "demutualization." Principal adopted its plan for demutualization on March 31, 2001. (Pl.'s LR 56.1(a)(3) P 27.) When a mutual insurance company undergoes a demutualization, eligible policyholders receive compensation. (*See* Local 710's LR 56.1(a)(3) P 2; Local 710's Ex. 1, Letter from Principal to Policyholders of 10/26/01.) This compensation is given because policyholders lose ownership interests in the mutual insurance company when it becomes a stock company. (Local 710's Ex. 1, Letter from Principal to Policyholders of 10/26/01.) In the instant case, the Health and Welfare Fund received compensation from Principal for four different employee [*3] benefit plans: an in-house pension plan, a severance plan, a life insurance plan, and a 401(k) plan. The Health and Welfare Fund now seeks a declaratory judgment as to whom is entitled to the demutualization compensation. The issues in this case are whether the demutualization compensation is an asset of the plans, and, if so, whether the compensation reverts to the participants of the plan or to the employers.

Local 710 is a local union affiliated with the International Brotherhood of Teamsters. (Pl.'s LR 56.1(a)(3) P 5.) The Chicago Truck Drivers, Helpers and Workers Union Independent (the "CTDU") merged into Local 710 on February 1, 2001. (*Id.* P 7.) The CTDU was an independent labor union representing employees in the trucking, warehousing, and related industries in and around the Chicago area. (*Id.* P 6.) After the merger, the CTDU ceased operation as a labor organization, and Local 710 is a successor to the rights and liabilities of the CTDU. (*Id.* PP 12-13.) The Health and Welfare Fund and Pension Fund were established by the CTDU for the benefit of CTDU members covered by collective bargaining agreements with participating employers. (*Id.*)

The first of the benefit [*4] plans at issue in this case, a retirement plan for their office employees (the "in-house pension plan"), was established by the Health and Welfare Fund, the Pension Fund, and the CTDU in 1961. (*Id.* P 14.) This plan was funded through a group annuity contract with Bankers Life and Casualty and later Principal. (*Id.*) It was funded by contributions from the Health and Welfare Fund, the Pension Fund, and the CTDU on behalf of their employees. (*Id.* P 15.) The plan was terminated in 1987. (*Id.* P 16.) When the plan was terminated, all active employees who would have been eligible for a benefit received a lump sum payment, while former employees who had retired and were receiving benefits continued to receive a defined monthly benefit through a group annuity contract with Principal. (*Id.* PP 17-18.) This contract was fully funded at the time of the discontinuation of the plan. (Pl.'s Ex. 3, Boudreau Aff. P 20.) The Health and Welfare Fund received a check from Principal in the amount of $ 1,200,280.00 as demutualization compensation in connection with the in-house pension plan. (Pl.'s LR 56.1(a)(3) P 31.)

The supplemental retirement and security plan ("severance plan") [*5] was established in 1969. (*Id.* P 22.) Like the in-house pension plan, the severance plan is funded by an annuity contract with Principal. (*Id.* P 23.) The severance plan is currently in effect for employees of the Health and Welfare Fund and the Pension Fund, but employees of the CTDU left the severance plan and received their benefit payments on or before the CTDU and Local 710 merged. (Pl.'s Ex. 3, Boudreau Aff. PP 26-27.) The Health and Welfare Fund received a check from Principal in the amount of $ 78,329.00 as demutualization compensation in connection with the severance plan. (Pl.'s LR 56.1(a)(3) P 30.)

The employees' savings plan ("401(k) plan") was established in July, 1983. (*Id.* P 20.) This plan is a voluntary program for employees and is funded by contributions by the employees. (*Id.* P 21.) The 401(k) plan is in effect for the employees of all three parties in this case - the Health and Welfare Fund, Pension Fund, and Local 710. (Pl.'s Ex. 3, Boudreau Aff. P 32.) The Health and Welfare Fund received a check from Principal in the amount of $ 85,766.00 as demutualization compensation in connection with the 401 (k) plan. (Pl.'s LR56.1(a)(3) P 31.)

Finally, the [*6] member life, accidental death, and dismemberment policy (the "life insurance plan") was established in February 1992. (*Id.* P 24; Pension Fund's Ex. F, U.S. Dep't of Labor's Pension & Welfare Benefits Admin. Office of Regs. & Interpretations Advisory Op. 94-31 A.) This plan was funded by contributions from

the Health and Welfare Fund, the Pension Fund, and the CTDU on behalf of their respective employees. The benefits of this plan are paid through a group policy with Principal. (Pl.'s LR 56.1(a)(3) P 26.) Employees of the Health and Welfare Fund and the Pension Fund currently participate in the plan, but the CTDU ceased participation in the life insurance plan upon its merger with Local 710. (Pl.'s Ex. 3, Boudreau Aff. P 35.) The Health and Welfare Fund received 541 shares of Principal common stock as demutualization compensation in connection with the life insurance plan. (Pl.'s LR 56.1(a)(3) P 32.)

Local 710 argues that the compensation from the demutualization reverts to the employers -- the Health and Welfare Fund, the Pension Fund, and Local 710 as successor to the CTDU, with the exception of the 401(k) plan. (*Id.* P 34.) The Health and Welfare Fund, on the other hand, [*7] argues that the demutualization compensation should be used for the benefit of the participants of the various plans. (*Id.* P 35.) The Health and Welfare Fund brought suit, seeking a declaratory judgment of the rights of the parties to the demutualization compensation. (Compl. P 32.) Before the Court is the Health and Welfare Fund's motion for summary judgment seeking a declaratory judgment that the demutualization compensation is a plan asset to be used for the benefit of the participants of the plans and Local 710's motion for partial summary judgment, seeking a declaration that the demutualization compensation reverts to the employers.

DISCUSSION

Pursuant to *Federal Rule of Civil Procedure 56(c)*, the court may grant summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *FED. R. CIV. P. 56(c)*. When considering the evidence submitted by the parties, the court does not weigh [*8] it or determine the truth of asserted matters. *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986)*. All facts must be viewed and all reasonable inferences drawn in the light most favorable to the non-moving party. *NLFC, Inc. v. Devcom Mid-America, Inc., 45 F.3d 231, 234 (7th Cir. 1995)*. "If no reasonable jury could find for the party opposing the motion, it must be granted." *Hedberg v. Ind. Bell Tel. Co., Inc., 47 F.3d 928, 931 (7th Cir. 1995)*.

Summary judgment is appropriate in this case because there are no material facts in dispute. Therefore, the movants are entitled to a judgment as a matter of law.

The first issue is whether the demutualization compensation is a plan asset of the various plans. ERISA does not define plan assets. *See Bannistor v. Ullman, 287 F.3d 394, 402 (5th Cir. 2002)*. The U.S. Department of Labor has issued advisory opinions that address the issue of whether the demutualization compensation is a plan asset. (Pension Fund's Ex. A, U.S. Dep't of Labor's Pension & Welfare Benefits Admin. Office of Regulations & Interpretations Advisory Op. 92-02A (2002); Pl.'s Ex. 5, EBSA Advisory Op. [*9] 2001-02A n.1 (2001).) "[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Mead Corp. v. B.E. Tilley, 490 U.S. 714, 722, 109 S. Ct. 2156, 104 L. Ed. 2d 796 (1989)*. An agency's advisory opinions are not binding authority, but they are "entitled to deference, such that the interpretation will be upheld so long as it is reasonable." *Reich v. McManus, 883 F. Supp. 1144, 1153 (N.D. Ill. 1995)*. "[A] court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984)*.

According to the Department of Labor:

> The proceeds of the demutualization will belong to the plan if they would be deemed to be owned by the plan under ordinary notions of property rights. . . . In the case of an employee pension benefit plan, or where any type of plan or trust is the policyholder, or where the policy is paid for out of trust assets, it is the view of the department that all of the proceeds [*10] received by the policyholder in connection with a demutualization would constitute plan assets.

(Pl.'s Ex. 5, EBSA Advisory Op. 2001-02A n.l (2001).) Determining whether the demutualization compensation consists of a plan asset under ordinary notions of

property rights requires "consideration of any contract or other legal instrument involving the plan documents. It also requires the consideration of the actions and representations of the parties involved." (Pension Fund's Ex. A, U.S. Dep't of Labor's Pension & Welfare Benefits Admin. Office of Regulations & Interpretations Advisory Op. 92-02A (2002).)

In *Ruocco v. Bateman, Eichler, Hill, Richards, Inc., 903 F.2d 1232 (9th Cir. 1990)*, the Ninth Circuit Court of Appeals considered the issue of whether stock issued as demutualization compensation for a long-term disability insurance plan could revert to an employer. This plan was wholly funded by contributions from the participants of the plan. *Id. at 1238*. The court held that allowing the compensation to revert to the employers would give the employers an undeserved windfall. *Id.* As a result, the "balancing of equities" weighed in favor [*11] of allowing the demutualization compensation to revert to the employees. *Id.*

Like the disability plan in *Ruocco*, the contributions to the 401(k) plan in this case were made entirely by the employees, outside of minor administrative costs. Therefore, the demutualization compensation should revert to the employees. This conclusion was undisputed and is now stipulated by the parties. (*See* Pension Fund's Resp. Pl.'s Mot. Summ. J. at 11-12; Local 710 Mem. Opp'n Pl.'s Mot. Summ. J. at 14; Joint Mot. Partial Dismissal & Release of Funds P 4.) Moreover, like the plan in *Ruocco*, the 401(k) plan in this case is an employee pension benefit plan wholly funded by the participants of the plan. Because the plan was fully funded by the employees, they are entitled to the compensation as a result of their loss of ownership in Principal. As in *Ruocco*, awarding this compensation to the employers would give them an undeserved windfall -- they would be receiving money as a result of the investment of the participants of the plans, not their own efforts. Accordingly, the demutualization compensation attributable to the 401(k) plan reverts to the employees.

Determining whether the demutualization [*12] compensation is a plan asset for the remaining plans is a closer issue. Following the guidelines of the EBSA, this Court will follow ordinary notions of property rights and look to the plan documents and representations by the parties to determine whether the demutualization compensation is a plan asset. There is no evidence that the parties made any representations other than in the plan documents as to whether or not the demutualization compensation is a plan asset. Therefore, this Court will focus on the language of the plans to determine this issue.

After examining the plan documents, this Court holds that the demutualization compensation is a plan asset for the in-house pension plan and the severance plan, but not for the insurance plan. At first blush, the compensation would appear not to be a plan asset for any of the remaining plans because it is undisputed that these plans were funded by the employers. Determining that the compensation reverts to the plans and not the employers could therefore result in an undeserved windfall to the plans. However, both the in-house pension plan and severance plan are "employee pension benefit plans." As a result, the compensation would be [*13] presumed to be a plan asset under the EBSA Advisory Opinion unless language in the plan documentation suggests otherwise.

In interpreting the language of a contract, a court's primary purpose is to discern the intent of the parties. *See Volt Information Sciences v. Board of Trustees, 489 U.S. 468, 488, 109 S. Ct. 1248, 103 L. Ed. 2d 488 (1989)*. In this case, however, neither the in-house pension plan nor the severance plan specifically addresses the issue of demutualization compensation. The demutualization compensation would therefore be presumed to be a plan asset under the EBSA Advisory Opinion 2001-02A quoted above. The plans do address the issue of whether any dividends awarded under the plans would revert to the employers or become plan assets. Both plans declare that "[d]ividends declared under the Group Contract and forfeitures shall be applied to reduce future Employer Contributions." (Pl.'s Ex. B, Health & Welfare Fund *&* Pension Fund Employees Retirement Plan at 21, Pl.'s Ex. D, Health & Welfare Fund & Pension Fund Employees Restated Supplemental Retirement & Security Plan at 22.) This language suggests that the dividends would become plan assets used to pay for the [*14] plans, rather than simply reverting to the employers to be used however they wish. Like dividends, the demutualization compensation at issue in this case comes from Principal. The language in the plans regarding dividends shows that the parties intended future compensation from Principal to become a plan asset. Although the language

of the plans with regard to the disposition of dividends alone is not determinative, coupled with the EBSA's view that demutualization compensation ordinarily becomes a plan asset for an employee pension plan, it is sufficient to convince the Court that the demutualization compensation is a plan asset for the in-house pension plan and the severance plan.

Local 710 argues that the language in the plans regarding dividends should not affect the outcome of this case because demutualization compensation is not a dividend. (Local 710's Mem. Opp'n Pl.'s Mot. Summ. J. at 10.) It is true that the demutualization compensation is not a dividend, but it is awarded to policyholders in exchange for loss of ownership interests in the company. Dividends are payments by a company to its stockholders. RICHARD A. BREALEY & STEWART C. MYERS, PRINCIPALS OF CORPORATE FINANCE [*15] 64 (5th ed. 1996). When a mutual insurance company demutualizes, it compensates policyholders for the loss of their ownership interests, which therefore includes their ability to receive dividends. *See id.* at 417-38.

Local 710 points out that Principal "will continue to pay policy dividends as declared." (Pl.'s Ex. K, Plan of Conversion of Principal Mut. Holding Co. at A-3.) However, this language only means that Principal will continue to pay *declared* dividends. It does not mean that Principal can award new dividends in the future. In addition, there is no evidence that Principal has awarded dividends for any of the plans at issue in this case. Therefore, the fact that demutualization compensation is not a dividend is insufficient to overcome the strong presumption that it is a plan asset given the specific facts of this case.

Although the demutualization compensation is a plan asset for the in-house pension plan and severance plan, this does not necessarily mean that it reverts to the participants of the plans. The plans state: "No part of the plan assets shall be paid to the Employer at any time, except that, after the satisfaction of all liabilities under the Plan, any [*16] assets remaining will be paid to the Employer. The payment may not be made if it would contravene any provision of law." (Pl.'s Ex. B, Health & Welfare Fund & Pension Fund Employees Retirement Plan at 47; Pl.'s Ex. D, Health & Welfare Fund & Pension Fund Employees Restated Supplemental Retirement & Security Plan at 56.) Under the terms of the plans, therefore, the demutualization compensation, as a plan asset, may be distributed to the employers if the plan has satisfied all of its liabilities.

Because the in-house pension plan has been terminated, it has satisfied all of its liabilities to the participants and their beneficiaries. The Pension Fund argues that since former employees are continuing to receive benefits under this plan, the plan has not satisfied all of its liabilities. (Pension Fund's Resp. Mot. Summ. J. at 13;) However, it is undisputed that these participants are receiving their benefits under a plan that was fully funded at the time of the termination of the in-house pension plan. Therefore, the in-house pension plan has no "liabilities" and the demutualization compensation reverts to the contributing employers -- the Health and Welfare Fund, the Pension Fund, [*17] and Local 710 as successor to the CTDU.

The plan provides that residual assets may be distributed to an employer so long as no provision of law is violated. ERISA addresses the issue of whether residual assets may be distributed to an employer:

> (d) Distribution of residual assets. . . .
>
> (1) Subject to paragraph (3), any residual assets of a single-employer plan may be distributed to the employer if-
>
> (A) all liabilities of the plan to participants and their beneficiaries have been satisfied,
>
> (B) the distribution does not contravene any provision of law, and
>
> (C) the plan provides for such a distribution in these circumstances.
>
> (3)(A) Before any distribution from a plan pursuant to paragraph (1), if any assets of the plan attributable to employee contributions remain after satisfaction of all liabilities . . . such remaining assets shall be equitably distributed to the participants who made such contributions or their beneficiaries.

29 U.S.C. § 1344 (2003). The in-house pension plan satisfies all of these requirements. As noted above, all liabilities of the plan have been satisfied and the plan provides for a distribution of [*18] the assets to the employers. In addition, no provision of law has been violated, and the Health and Welfare Fund does not cite to any law that would be violated by distributing the compensation to the employers. Finally, it is undisputed

that the employers were responsible for the contributions to the plans, not the employees. Therefore, no equitable distribution to the participants need be made.

The Health and Welfare Fund argues that the compensation cannot be distributed to three employers, *i.e.*, the Health and Welfare Fund, the Pension Fund, and Local 710, because the language of the statute is in the singular. The statute provides "any residual assets of a single-plan may be distributed to *the* employer. . . ." *29 U.S.C. § 1344(d)* (emphasis added). The Court is not persuaded that this language prevents the compensation from being distributed to three employers when all three employers have made contributions to the plan. This is especially true because, as the Health and Welfare Fund points out, the plans at issue in this case are single-employer plans despite the fact that multiple employers fund the plans. (*See* Mem. Supp. Mot. Summ. J. at [*19] 7.) The Court therefore holds that the demutualization compensation for the in-house pension plan reverts to the three employers that are parties in this case -- the Health and Welfare Fund, the Pension Fund, and Local 710.

Unlike the in-house pension plan, the severance plan has not been terminated and is currently in full force and effect for employees of the Health and Welfare Fund and the Pension Fund. Because the plan provides that the assets of the plan shall not be distributed to the employers until after satisfaction of all liabilities of the plan, the demutualization compensation does not revert to the employers. The compensation should be used to reduce future contributions by the two remaining employers in the case - the Health and Welfare Fund and the Pension Fund. If at some point the Health and Welfare Fund and the Pension Fund satisfy all of their liabilities under the plan, Local 710 would then be entitled to a share of the demutualization compensation, using the same reasoning as applied to the in-house pension plan.

Unlike the in-house pension plan and the severance plan, the life insurance plan is not an employee pension plan. A "pension plan" is defined by ERISA [*20] as:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program --
> (i) provides retirement income to employees, or
> (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond. . . .

29 U.S.C. § 1002(2)(A). Unlike a pension plan, the life insurance plan fits under the ERISA definition of "an employee welfare benefit plan" because it provides "benefits in the event of . . . death. . . ." *29 U.S.C. § 1002(1)(A)*. The EBSA discussed the disposition of demutualization compensation for an employee welfare benefit plan in the Advisory Opinion 2001-02A, which states:

> [I]n the case of an employee welfare benefit plan . . . the appropriate plan fiduciary must treat as plan assets the portion of the demutualization proceeds attributable to participant contributions. . . . [and] the plan fiduciary should give appropriate consideration to those facts and circumstances [*21] that the fiduciary knows or should know are relevant to the determination, including the documents and instruments governing the plan. . . .

(Pl.'s Ex. 5, EBSA Advisory Op. 2001-02A at n.2.)

In this case, it is undisputed that the employers made all of the contributions to the plans. Therefore, there is no reason to treat any portion of the demutualization compensation as a plan asset. In addition, there is nothing in the language of the plan to suggest that the parties intended demutualization compensation to become a plan asset. Unlike the in-house pension plan and the severance plan, there is no language in the life insurance plan regarding dividends. The plan is silent with respect to possible assets such as dividends or demutualization compensation. *As* a result, the employers have made no representations suggesting that demutualization compensation would be a plan asset in the language of the plans. Therefore, the Court holds that the demutualization compensation is not a plan asset for the life insurance plan and that it reverts to the Health and Welfare Fund, the Pension Fund, and Local 710.

The Pension Fund argues that Local 710 is not entitled to any of the demutualization [*22] compensation for the life insurance plan because Local 710 has not contributed to the plan. (Pension Fund's Resp. Pl.'s Mot

Summ. J. at 11.) It is undisputed that the CTDU made contributions to the life insurance plan, however, and it is also undisputed that Local 710 is a successor to all the rights and liabilities of the CTDU. Therefore, Local 710 is entitled to a share of the demutualization compensation attributable to the contributions made by the CTDU.

CONCLUSION

For the reasons provided in this Memorandum, the Court grants in part and denies in part the Health and Welfare Fund's Motion for Summary Judgment [doc. no. 12-1] and Local 710's Motion for Partial Summary Judgment [doc. no. 19-1]. The Court enters a declaratory judgment that: (1) the demutualization compensation attributable to the 401(k) plan reverts to the participants of the plan as stipulated in the Joint Motion for Partial Dismissal and Release of Funds; (2) the demutualization compensation attributable to the severance plan must be used to offset future employer contributions; and (3) the demutualization compensation attributable to the in-house pension plan and life insurance plan reverts to the [*23] employers. This case is hereby terminated.

SO ORDERED

ENTERED: March 4, 2005

HON. RONALD A. GUZMAN

United States Judge

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Columbia Mem. Hosp. v Hinds

Supreme Court of New York, Columbia County

September 3, 2019, Decided

14064-19

Reporter
2019 N.Y. Misc. LEXIS 5072 *; 2019 NY Slip Op 51508(U) **; 65 Misc. 3d 1205(A); 118 N.Y.S.3d 368; 2019 WL 4620674

[**1] The Columbia Memorial Hospital, Plaintiff, against Marcel E. Hinds, M.D., Defendant.

Notice: THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

PUBLISHED IN TABLE FORMAT IN THE NEW YORK SUPPLEMENT.

Subsequent History: Affirmed by *Columbia Mem. Hosp. v. Hinds, 2020 N.Y. App. Div. LEXIS 6521 (N.Y. App. Div. 3d Dep't, Nov. 5, 2020)*

Counsel: [*1] For Plaintiff: Anthony Prinzivalli, Esq., of counsel, Kevin G. Donoghue, Esq., of counsel, Garfunkel Wild, P.C., Great neck, New York.

For Defendant: Seth A. Nadel, Esq., of counsel, Weiss Zarett Brofman Sonnenklar & Levy, P.C., New Hyde Park, New York.

Judges: Henry F. Zwack, Acting Supreme Court Justice.

Opinion by: Henry F. Zwack

Opinion

Henry F. Zwack, J.

Pending before the Court is a motion to dismiss the complaint in this action filed by defendant Marcel E. Hinds, M.D., and for declaratory judgment. The defendant alleges that dismissal is required pursuant to *CPLR 3211(a)(1)* and *CPLR 3211(a)(7)*; and an order pursuant to *CPLR 3001* declaring that he is legally entitled to cash consideration in the amount of $412,418.93 arising from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC"). The plaintiff opposes.

The dispute arises out of the sale and demutualization of MLMIC, a mutual insurance company formed and existing under New York Law, which plan was approved by the Department of Financial Services ("DFS") on September 6, 2018. The DFS Decision confirmed, on pages 4, 23 (affirmation of Seth Nadel, Exhibit "A") that it is in the *Insurance Law 7307 (e)(3)* which explicitly defines those policyholders who are [**2] eligible to receive the purchase price consideration." [*2]

In connection with the demutualization, certain sums of money were to be paid to the policyholders (physicians) who were the mutual owners of MLMIC during the statutory eligibility period prior to the sale. An objection procedure was put in place (and later extended) by MLMIC where certain employers of eligible physician policyholders were given the right to object to the cash distribution, to the extent the employer believed that it, and not the physician, was entitled to the funds. The plaintiff is the former employer of the defendant, and submitted an objection and commenced this action seeking a determination of its right to the cash contribution presently held in escrow.

According to the complaint, the $412,418.93 in dispute represents what the plaintiff paid to MLMIC for professional liability insurance on behalf of the defendant from July 15, 2013 to July 15, 2016. The complaint sets out four causes of action: declaratory judgment, unjust enrichment, money had and received, and breach of implied covenant of good faith and fair dealing. The plaintiff alleges that it is entitled to the MLMIC funds, currently being held in escrow, because

it alone paid for the policies, administered [*3] and controlled them as the designated Policy Administrator, was always the beneficiary of any dividends, rebates or refunds under the policies, and because the defendant has no rights to receive any additional monies following his separation from the plaintiff hospital. The defendant has refused to sign the Assignment Agreement, requested by the plaintiff in order for the escrow funds to be turned over to it. The plaintiff argues that allowing the defendant to receive and retain the MLMIC funds would result in his unjust enrichment. The complaint alleges that the defendant has already received all that he is entitled to under his employment agreement.

In lieu of an answer, the defendant has moved to dismiss the complaint on the grounds that the complaint fails to state a cause of action, and on the basis that the claims fail due to documentary evidence.

The defendant argues he is entitled to the cash proceeds under the authority which governs the demutualization, the Plan of Conversion of Medical Liability Mutual Insurance Company adopted on May 31, 201, and *Insurance Law 7307*. The Plan provided that policyholders, or their designees would be provided with cash consideration for their membership interest [*4] according to the premiums timely paid under their eligible policies. The Plan further provided that the cash consideration was to go directly to the policyholder unless they had affirmatively [**3] designated a policy administrator to receive the benefit—the affirmative designation is the only instance in which the policy administrator could receive the cash consideration payable to the policyholder. The defendant asserts that he is the policyholder (as demonstrated on the policy declarations page supplied by defendant); he did not sign an Assignment Agreement (although asked to do so on at several occasions); and the plaintiff is not entitled to receive any of the cash consideration. The defendant explains that according to his Employment Agreement, at Section 3 (b) — which is attached as an Exhibit to his affidavit — he actually paid the premiums, as the plaintiff deducted the amounts it paid for his malpractice insurance from his incentive compensation. The policy administrator designation served only to appoint the plaintiff as the defendant's agent for the purposes of managing the policy, and to receive dividends to offset the cost of the policy. The defendant argues that the cash consideration [*5] is not a dividend or return premium as 1099 forms were sent to policyholders that confirm the proceeds arose from the sale of stock.

In opposition, the plaintiff argues that the defendant's dismissal motion is improper, by utilizing affidavits to establish "facts" rather than just to introduce documentary evidence. According to the plaintiff, there is a bona fide dispute which must be determined by the court. The plaintiff argues that the complaint should not be dismissed because there is a binding decision from the Appellate Division on point in this case. In *Shaeffer, Schonholtz & Drossman, LLP v Title, 171 AD3d 465, 465, 96 N.Y.S.3d 526 [1st Dept 2019]* the Court found that despite respondent being named as the policyholder, appellant had paid all the premiums and all the costs related to the policy and there was no record of bargaining for the benefit of the demutualization proceeds, so "awarding respondent with the cash proceeds of the MLMIC's demutualization would result in unjust enrichment." The plaintiff argues that this is the situation here — Dr. Hinds did not pay any of the premiums for the insurance, and awarding him the funds from the demutualization results in unjust enrichment. The plaintiff also argues that stare decisis applies, and this Court must follow the [*6] determination made by the First Department. Stare decisis provides that once a court has resolved a legal issue, it should not be re-examined each and every time it is presented *(Battle v State, 257 AD2d 745, 682 N.Y.S.2d 726 [3d Dept 1999])*.

For the reasons that follow the Court grants the defendant's motion to dismiss the plaintiff's complaint.

Here, the Court is mindful, on a motion to dismiss pursuant to [**4] *CPLR 3211*, it must "accept the facts as alleged in the complaint as true, according the plaintiffs the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (*Leon v Martinez, 84 NY2d 83, 87-88, 638 N.E.2d 511, 614 N.Y.S.2d 972 [1994]*). "[A]llegations consisting of bare legal conclusions as well as factual claims flatly contradicted by documentary evidence are not entitled to consideration" (*Mass v Cornell University, 94 NY2d 87,91, 721 N.E.2d 966, 699 N.Y.S.2d 716 [1999]*).

Insurance Law 7307 governs the process by which

MLMIC was converted from a mutual insurance company into a stock insurance company. *Insurance Law 7307 (e) (3)* provides in pertinent part that "each person who had a policy of insurance in effect at any time during the three year period immediately proceeding the date of the adoption of the resolution shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting shares of the insurer or other [*7] consideration, or both." The statute repeatedly refers to those eligible for cash consideration as the "policyholder." It is important to note that "[n]o distinction is made between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. *Insurance Law 7307* does not confer an ownership interest...on anyone other than the policyholder" (*Maple-Gate Anesthesiologists, P.C. v Nasrin, 63 Misc 3d 703, 709, 96 N.Y.S.3d 837 [Sup Ct, Erie County, 2019]*).

Here, the defendant is clearly the policyholder, and the plaintiff the policy administrator. The documentary evidence — the Employment Agreement — establishes that the insurance premiums were deducted before the defendant received any incentive pay. That is, the defendant was to receive incentive pay, 65% of the amount by which his revenue exceeded the expenses paid by the hospital, and one the expenses being his medical malpractice insurance. Stated differently, the defendant would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance. Further, under the plain language of the Insurance Law, the cash consideration cannot be given to the plaintiff unless the defendant signs the agreement to do so. [*8] Here, the defendant has not signed such an agreement, and given the circumstances of this case — the Employment Agreement which required him to pay the cost of his malpractice premiums by way of his salary incentives — does not have to agree to do so.

The plaintiff's entire argument, as framed by the complaint, [**5] focuses on the bare and incorrect assertion that the hospital paid the policy premiums and that equity, not ownership, dictates that it should be the recipient of the cash contribution. However viewed, this assertion is belied by the terms of the Employment Agreement, whereby the defendant's incentive compensation is reduced by the policy premiums. On this record, equity does not dictate that the plaintiff should be compensated.

Nor has the plaintiff demonstrated that the defendant has been unjustly enriched. Unjust enrichment, also known as an action for money had or received, or implied contract (*Federal Ins. Co. v Groveland State Bank, 37 NY2d 252, 258, 333 N.E.2d 334, 372 N.Y.S.2d 18 [1975]*), arises when a plaintiff demonstrates "that (1) the other party was enriched, (2) at (the plaintiff's) expense, and (3) that it is against equity and good conscience to permit the other party to retain what is sought be recovered" (*New York State Worker's Compensation Bd. v Program Risk Mgt, Inc., 150 AD3d 1589, 1594, 55 N.Y.S.3d 790 [3d Dept 2017]*). Given that the plaintiff received the defendant's [*9] services in exchange for compensation — which was reduced by the cost of the premium payments made on the defendant's behalf by the plaintiff — there is simply no merit to the plaintiff's claim of unjust enrichment.

"The implied covenant of good faith and fair dealing between parties to a contract embraces a pledge that neither party shall do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract" (*Moran v Erk, 11 NY3d 452, 456, 901 N.E.2d 187, 872 N.Y.S.2d 696 [2008]*, internal citations and quotations omitted). In all likelihood neither party appreciated that a windfall could occur as a result of the MLMIC sale, because, quite simply, they did not appreciate the meaning and the value of an ownership stake prior to the demutualization plan (*Urgent Medical Care PLLC v Amedure, 64 Misc 3d 1216[A], 117 N.Y.S.3d 459, 2019 NY Slip Op 51188[U] [Sup Ct, Greene County 2019]*) . It cannot therefore be said that this cash contribution was negotiated or bargained for, but is simply rather an operation of law, and therefore no one's interest in the actual contract was compromised. This cash contribution, by law, is not a return to the hospital of any insurance premiums it paid on behalf of the defendant, it represents the policyholder's share in MLMIC.

Contrary to plaintiff's arguments [*10] that *Shaeffer, Schonholtz & Drossman, LLP v Title, 171 AD3d 465, 465, 96 N.Y.S.3d 526 [1st Dept 2019]* controls, this case is not entitled to stare decisis treatment. The doctrine of

stare decisis clearly exists to provide guidance and consistent results in cases that share essentially the same facts (*Matter of Howard Johnson Co. v State Tax Commn., 65 NY2d 726, 727, 481 N.E.2d 551, 492 N.Y.S.2d 11[1985]*). It does not apply where, as here, the facts are not the same. Here, like the defendant Nasrin in *Maple-Gate Anesthesiologists (63 Misc 3d 703, 96 N.Y.S.3d 837*) the defendant's insurance premiums were paid in lieu of compensation (Nasrin received her [**6] malpractice insurance as part of her employee compensation plan, and the Court awarded the cash contribution to her). That being said, it is equally well established that courts are free to correct prior erroneous interpretations of the law (*Matter of Charles A. Field Delivery Serv. (Roberts), 66 NY2d 516, 488 N.E.2d 1223, 498 N.Y.S.2d 111 [1985]*).

Finally, the plaintiff's complaint itself is some what of a 'ticking time-bomb." Paragraph 10 affirmatively provides the following: "The Hospital compensated Defendant for his services with a 'Base Salary' plus ***incentive compensation***, on call compensation, and afforded him the ***full panoply of benefits, including payment of premiums for medical malpractice insurance***..." There is no other way to read this than for it to mean that the defendant's medical malpractice insurance premiums were a part of his employee compensation plan. As to the Employee Agreement [*11] itself, at Article 9 it reads that the hospital "shall maintain an individual occurrence -based medical malpractice policy in the minimum amounts required....and provide you with evidence of same upon request." Following the determination in *Maple-Gate Anesthesiologists* (63Misc 3d 703), the Court dismisses the plaintiff's complaint.

Accordingly, it is

ORDERED, the defendant Marcel Hinds M.D.'s motion to dismiss is granted, and the plaintiff's complaint is dismissed, and it is further

ORDERED, that the defendant Hinds is entitled to the $412,418.93 arising from the sale and demutualization of Medical Liability Mutual Insurance Company, and the funds are to be dispersed accordingly.

This constitutes the Decision and Order of the Court. This original Decision and Order is returned to the attorneys for the defendant. All other papers are delivered to the Supreme Court Clerk for transmission to the County Clerk. The signing of this Decision and Order shall not constitute entry or filing under *CPLR 2220*. Counsel is not relieved from the applicable provisions of this rule with regard to filing, entry and Notice of Entry.

Dated: September 3, 2019

Troy, New York

Henry F. Zwack

Acting Supreme Court Justice

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GHVHS Med. Grp., P.C. v. Arthurs

Supreme Court of New York, Orange County

October 7, 2019, Decided

EF001609-2019

Reporter
2019 N.Y. Misc. LEXIS 7166 *; 2019 NY Slip Op 33988(U)

GHVHS MEDICAL GROUP, P.C., PLAINTIFF, - AGAINST- GILLY ARTHURS, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A., DEFENDANTS. Index No. EF001609-2019

Subsequent History: Summary judgment denied by, Dismissed by, in part, As moot, Judgment entered by *GHVHS Med. Group, P.C. v. Cornell, 2020 N.Y. Misc. LEXIS 1883 (N.Y. Sup. Ct., Jan. 16, 2020)*

Judges: [*1] Hon. Maria S. Vazquez-Doles, J.S.C.

Opinion by: Maria S. Vazquez-Doles

Opinion

DECISION AND ORDER

VAZQUEZ-DOLES, J.S.C.

Plaintiff commenced this action to determine its right to receive monies from the sale and demutualization of Defendant Medical Liability Mutual Insurance Company, (hereinafter MLMIC). MLMIC demutualized the insurance company with the approval of the NYS Department of Insurance, and sold their company to Berkshire, Hathaway. As part of the plan which was approved by the NYS Department of Insurance, each "Eligible Policyholder" or its "Designee" were to receive a payment reflecting its pro rata share of the cash consideration, allocated according to the amount of the premium paid on the policy. In this case, Gilly Arthurs was the "eligible policy holder" entitled to receive approximately $4,744.00. The money is currently being held in escrow by Computershare. Plaintiff alleges that they are entitled to the money as they have paid all the premiums on behalf of Arthurs, have been the administrator of the medical malpractice insurance policy and the sole recipient of any dividends.[1] Plaintiff further alleges that many other doctors and nurse practitioners agreed to assign their rights to Plaintiff, [*2] but Arthurs refused because of a dispute about money owed on her final paycheck. Plaintiff seeks relief of a declaratory judgment which finds Plaintiff is the rightful recipient of the funds as they have paid all the premiums for the insurance policy, without contributions from Arthurs. Plaintiff argues in the alternative that Arthurs will be unjustly enriched if she is declared to be the recipient.

Defendant, Gilly Arthurs, has not filed a response to this motion sequence number 2, but in her pro-se response to motion sequence number 1, she states that Plaintiff owes her money for accrued time and has refused to pay because she breached the employment contract. The

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

letter also indicates that she would assign her rights if Plaintiff paid her the $9,887.50 which she alleges is owed from leave accrual.

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

DISCUSSION:

The pertinent undisputed facts in the case show that an employment contract was signed between Plaintiff and Arthurs in May of 2016. The employment contract specifically stated that Plaintiff "...will maintain professional liability insurance on behalf of each party at its sole cost and [*3] expense." (Employment Contract Pg 5). The contract is silent as to demutualization and acquisition with future profits. The plan for demutualization and acquisition was approved by the NYS Department of Insurance on September 6, 2018, thus the parties were unaware that this future event would occur when they signed the employment contract.

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

Under a plain reading of the insurance law, which addresses reorganization of a mutual insurer, Arthurs is clearly the policy holder. *New York Insurance Law §7312* states in part, "Policyholder" means a person, as determined by the records of a mutual life insurer, who is deemed to be the "policyholder" of a policy or annuity contract...". Gilly Arthurs is the named policyholder. The Plan which was approved by the Department [*4] of Insurance, allows for the policyholder to assign its rights to the profit. In this case, Arthurs refused to assign her rights, thus a plain reading of the contract and law would result in Arthurs receiving any profit from the demutualization and acquisition.

However, Plaintiff argues that this result would be unjust as they have paid the cost of the policy since the inception and have been noted as the policy administrator. To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]* (citing *Goel v. Ramachandran, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428*, quoting *Paramount Film Distrib. Corp. v. State of Nov York, 30 N.Y.2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695*)."). A court should "...look to see if a benefit has been conferred on the defendant under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the defendant; and whether the defendant's conduct was tortious or fraudulent. (citations omitted)". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]*. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law if the benefit remains with Defendant as neither party was even aware of this benefit at the time the employment [*5] contract was signed. The benefit still remains with the Defendant as the Department of Insurance considered Plaintiff's claims during the demutualization process and did not change the language of what constitutes an "eligible policyholder", when Plaintiff and others made objections at the public hearing.

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

ORDERED, ADJUDGED and DECREED that Plaintiff's motion for partial summary judgment on the first and eighth causes of action is denied. This Court declares that the "eligible policy holder" is Gilly Arthurs and she is entitled to $4,774.00 as her share of the sale and demutualization as determined by the Plan. The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits, but Defendant, Arthurs chose not to do so. The employment contract required Plaintiff to pay all the premiums of the medical malpractice insurance held by MLMIC, but it did not bargain in the agreement for who should receive any monies which might flow should there be a demutualization and sale, and it [*6] is further

ORDERED, ADJUDGED and DECREED that Plaintiff's motion for a finding of unjust enrichment is also denied. There has been no unjust enrichment because Plaintiff agreed to pay the premiums as part of the employment agreement offered to Dr. Arthurs. "To prevail on a claim of unjust enrichment, a party must show that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered" (citing *Goel v. Ramachandran, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428* [internal quotation marks omitted])." *FoxStone Group, LLC v Calvary Pentecostal Church, Inc., 173 AD3d 978, 981, 104 N.Y.S.3d 663 [2d Dept 2019]*. While Dr. Arthurs may be enriched by receiving this profit, she is not being enriched at the expense of the Plaintiff. Plaintiff fully expected to pay all the insurance premiums, without repayment, as part of the compensation to Defendant, when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit paid to the policyholders. Therefore, Defendant's enrichment is not at Plaintiff's expense, but rather an unforeseen benefit of the bargain, and it is further,

ORDERED that Defendants, MLMIC and Computershare take all steps necessary to transfer the payment now being held in escrow, to Gilly Arthurs [*7] within 30 days of the posting of this notice to NYSCEF.

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

The foregoing constitutes the Decision and Order of the Court.

Dated: October 7, 2019

Goshen, New York

ENTER,

/s/ Maria S. Vazquez-Doles

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

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GHVHS Med. Group, P.C. v Cornell

Supreme Court of New York, Orange County

January 16, 2020, Decided

EF001610/2019

Reporter
69 Misc. 3d 611 *; 132 N.Y.S.3d 235 **; 2020 N.Y. Misc. LEXIS 1883 ***; 2020 NY Slip Op 20104 ****

[****1] GHVHS MEDICAL GROUP, P.C. and ORANGE REGIONAL MEDICAL CENTER, Plaintiffs, against DAVID CORNELL, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A., Defendants.

Prior History: *GHVHS Med. Grp., P.C. v. Arthurs, 2019 N.Y. Misc. LEXIS 7166 (N.Y. Sup. Ct., Oct. 7, 2019)*

Case Summary

Overview

ISSUE: Whether a physician or the health care provider that employed the physician was entitled to a distribution payment made by medical malpractice insurance company that issued a policy covering the physician that was paid for as part of the employment contract by the provider as the physician's employer. HOLDINGS: [1]-The "eligible policy holder" pursuant to *Insurance Law § 7307(e)(3)* was the physician, and he was entitled to his share from the distribution of the sale of the mutual insurer as determined by the plan for the insurer. Furthermore, the physician was not unjustly enriched, and the plan allowed for the policy holder to assign the benefits if it chose to do so, but the physician chose not to assign the proceeds.

Outcome
Physician's motion for summary judgment granted. Provider's motions for summary judgment and to dismiss denied.

Judges: [***1] HON. MARIA S. VAZQUEZ-DOLES, J.S.C.

Opinion by: MARIA S. VAZQUEZ-DOLES

Opinion

[**236] [*612] Maria S. Vazquez-Doles, J.

The following papers numbered 1 - 18 were read on plaintiffs' motion for summary judgment on their first and eighth causes of action or, in the alternative, on their

fifth and eighth causes of action against the defendants and dismissing defendant, David Cornell's counterclaim:

Notice of Motion/Berns Affidavit/Exhibits A - G/Anesi Affidavits/

Exhibits A-F/Memorandum of Law 1 - 7

Gitomer Affirmation in Opposition/Cornell Affidavit/Exhibits 1-2/

Memorandum of Law 8 - 11

DeLaHoz Affirmation in Response/Exhibit 1 12, 13

Craw Affidavit in Response/Exhibit A 14, 15

Reply Affirmation/Exhibit A/ Memorandum of Law 16 - 18

In this action, the single legal issue is whether the physician employee, defendant, David Cornell, or the employer, Orange Regional Medical Center together with GHVHS Medical Group, P.C., (the "Provider") is entitled to a distribution payment made by Medical Liability Mutual Insurance Company ("MLMIC"). MLMIC is a medical malpractice insurance company that issued a policy covering Cornell [**237] that was paid for as part of the employment contract, by the Provider as his employer. The parties seek, in essence, [***2] a declaratory judgment resolving this one central issue.

GHVHS Medical Group, P.C. (the "P.C.") is affiliated with two not-for-profit hospitals, one of which is plaintiff, Orange Regional Medical Center ("ORMC") located in Orange County, New York. ORMC is an acute care hospital licensed to operate 383 beds in Middletown, New York. Pursuant to the employment agreement effective October 22, 2013, between Cornell as employee and ORMC as employer, Cornell served as Medical Director for ORMC's trauma program. The Agreement was later assigned to the PC on December 1, 2014. Cornell was employed by the PC until September 10, 2015. The Agreement [*613] details Cornell's compensation [****2] and other party obligations. It specifies that the employer is to provide medical malpractice coverage to the Physician at the employer's expense (Agreement at ¶5). There is no dispute that Plaintiff/Provider was designated by Cornell to serve as his agent for the purpose of administering the policy, the coverages, the reporting requirements, and the payment of the premium.

The policy insuring Cornell was issued by MLMIC. At the time the insurance policy was issued, MLMIC was a mutual insurance company owned by its policyholders, [***3] one of whom was Cornell. Thereafter, MLMIC negotiated a sale of its business to a subsidiary of Berkshire-Hathaway, which formed a stock company, and paid MLMIC $2.5 Billion for the MLMIC assets. This demutualization plan ("the Plan") was approved by the New York State Department of Financial Services pursuant to *Insurance Law §7307*. The Plan includes the methodology for the pro rata distribution of the proceeds of the sale to parties in interest. As for Cornell's policy, the amount for the distribution allotted to the policy is $197,539.89 ("the Payment" - $181,104.82 related to Cornell's employment with ORMC and $16,435.07 related to his employment with the PC. The question presented here is whether Cornell or plaintiffs are entitled to the Payment.

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

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

Plaintiffs ask the Court to follow the recent decision of the Appellate Division, First Department in *Matter of Schaffer, [*614] Schonholz & Drossman, LLP v. Rachel Title, MD, 171 AD3d 465, 96 N.Y.S.3d 526* (the "Matter of Schaffer"), decided April 4, 2019. Plaintiffs

argue that it is dispositive of the issues raised in this matter.

In the *Matter of Schaffer*, the parties, pursuant to CPLR 3222(b)(2), filed directly with the Appellate Court a statement of [**238] 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, [***5] like this action, involved a physician named as insured on a MLMIC policy. The doctor's employer, similar to the Provider, purchased the policy and paid all of the premiums and costs related to the policy. Like Cornell, the doctor acknowledged that she did not pay any of the premiums or any of the other costs related to the policy. Further, like Cornell, the doctor designated her employer as the 'Policy Administrator'. Plaintiff argues that as policy administrator, they had the right to receive return premiums, including dividends when due. Both doctors acknowledged that she did not [****3] bargain for the benefit of the demutualization proceeds, but then neither did the hospital/provider. Under the facts of *Schaffer*, the court held that: "Awarding [the doctor] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment (citations omitted)." Similar to the *Matter of Schaffer*, the named employer here purchased and paid all of the premiums on the medical professional insurance policy covering the physician who now seeks the distribution payment based on the policy.

In the instant case, Defendant/Cornell attempts to distinguish the facts from the facts in the *Matter of [***6] Schaffer* alleging that he specifically bargained for the right to obtain and receive his own MLMIC professional liability insurance policy and all benefits that flowed from such policy including the right to any demutualization proceeds. Cornell acknowledges that he agreed to designate Plaintiff as a "policy administrator' but that designation said nothing about demutualization proceeds. Cornell submits the policy administrator change form in support of this argument. This form states in part, [*615] "*The Policy Administrator is the agent of all insureds herein for the paying of the premium, requesting changes in the policy, including cancellation thereof and receiving dividends and any return premiums when due. By designating a Policy Administrator each insured gives us permission to release information about each such Insured, your practice or any other information that we may have to such Policy Administrator*." Nowhere in this form does it mention proceeds of demutualization.

In support of his claim to have bargained for the benefit of the Payment, Cornell submits an affidavit in which he acknowledges the Employment Agreement which requires that the Provider provide the physician with malpractice [***7] "coverage", from a company of the Providers choice, including self-insured plans. There was no requirement that the physician be provided with a policy from a mutual insurer featuring ownership benefits. Cornell further argues that this medical coverage was an employment incentive- "...was part of my compensation..."(Cornell Aff'd ¶9), and that this contract was carefully negotiated with his attorney. Cornell makes no allegation that the Agreement is ambiguous in any way and does not allege that demutualization was discussed at all, simply that neither party anticipated the demutualization event.

Cornell further argues that the First Department's decision in the *Matter of Schaffer* is not binding on this court as this case was filed in the Second Department. Cornell further contends that, in any event, the First Department's determination based on the principles of unjust enrichment was in error because the issue [**239] was not properly argued to the appellate court.

While it is true that courts are bound by the doctrine of *stare decisis*, to apply precedent established in another Department until a contrary rule is established by the Appellate Division in its own Department or by the Court of [***8] Appeals, (see Phelps v. Phelps, 128 AD3d 1545, 9 N.Y.S.3d 519 [4th Dept. 2015]; D'Alessandro v. Carro, 123 AD3d 1, 992 N.Y.S.2d 520 [4th Dept. 2015]; *see* Mountain View Coach Lines v. Storms, 102 AD2d 663, 664-665, 476 N.Y.S.2d 918 [2d Dept. 1984],) caution must be applied in some cases. (See People v Hobson, 39 NY2d 479, 489-90, 348 N.E.2d 894, 384 N.Y.S.2d 419 [1976], which recognized that conclusory assertions should be carefully scrutinized.) In this instance, the First Department's two paragraph decision summarily concludes [*616] that it would be an unjust enrichment to award the proceeds to the doctor.

In the facts of this case, the parties agreed upon an extensive employment contract. It is clear from the terms of the contract that the cost of medical malpractice insurance would be additional compensation for the doctor as it was being paid by the Provider. Neither party [****4] anticipated or bargained for the demutualization, and there are no terms in the contract which suggest how the profits should be disbursed. Applying the clear law of contracts to the case at bar, two contract principals are present in this case. First "... a contract is to be construed in accordance with the parties' intent, which is generally discerned from the four corners of the document itself. Consequently, 'a written agreement that is complete, clear and unambiguous on its face must be enforced according to the plain meaning of its terms' " (citing *MHR Capital Partners LP v. Presstek, Inc., 12 NY3d 640, 645, 884 N.Y.S.2d 211, 912 N.E.2d 43*, quoting *Greenfield v. Philles Records, 98 NY2d 562, 569, 750 N.Y.S.2d 565, 780 N.E.2d 166*)." *Legum v Russo, 133 AD3d 638, 639, 20 N.Y.S.3d 124 [2d Dept 2015]*. Moreover, this Court is mindful of the fact [***9] that "...courts may not by construction add or excise terms, nor distort the meaning of those used and thereby 'make a new contract for the parties under the guise of interpreting the writing.' (citing *Heller v. Pope, 250 NY 132, 135, 164 N.E. 881*; *Friedman v. Handelman, 300 NY 188, 194, 90 N.E.2d 31*.)" *Morlee Sales Corp. v Manufacturers Tr. Co., 9 NY2d 16, 19-20, 172 N.E.2d 280, 210 N.Y.S.2d 516 [1961]*. Applying this law to this employment contract, there are no terms which address proceeds of demutualization.

A review of the Superintendent's Decision approving the demutualization plan orders that the proceeds shall go to the " eligible policyholders", or their "assignees" unless an objection is timely filed, in which case the proceeds are to be held in escrow until the dispute is resolved. *Insurance Law §7307(e)(3)* defines the group of persons who are eligible to receive the proceeds of demutualiztion as "Eligible Policyholders". There is no dispute that Dr. Cornell is the 'eligible policyholder'. This definition does not differentiate between who pays the premiums and who does not. In fact, because every situation/employment contract is different, a [*617] process was set up to put disputed funds in escrow until the dispute is resolved by the courts or arbitration. In the instant case, Dr. Cornell, the eligible policy holder, chose not **to** assign the proceeds to the Provider and is contesting their right to [***10] the same.

To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain [**240] what is sought to be recovered ". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]* (citing *Goel v. Ramachandran, 111 AD3d 783, 791, 975 N.Y.S.2d 428*, quoting *Paramount Film Distrib. Corp. v. State of New York, 30 NY2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695*)."). A court should "...look to see if a benefit has been conferred on the defendant under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the defendant, and whether the defendant's conduct was tortious or fraudulent. (citations omitted)". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]*. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed. A close reading of the Department of Insurance decision reveals that Plaintiff's claims were considered during the demutualization process, but they did not change the language of what constitutes an "eligible policyholder", even though Plaintiff and others made objections at the public hearing. Accordingly there is no unjust enrichment if the Defendant/doctor receives the money in this case.

In rendering this decision, the Court [***11] has considered its prior ruling in the case of GHVHS MEDICAL GROUP, P.C. v. GILLY ARTHURS, et al under Orange County Index No. EF001609-2019 wherein this Court found that the rightful owner of those funds was the policy [****5] holder, Gilly Arthurs. Although the Second Department has not addressed one of these cases thus far, many similar cases have been filed in Orange County. To rule that the Providers should receive the money in every case would unjustly enrich the Providers who never bargained for this windfall. Furthermore, it may open the flood gates to every type of profession which negotiated the payment of malpractice insurance as part of the employment contract. This Court believes the issue is fact specific, and turns on the language of each individual [*618] contract of employment. Plaintiff argues the catchall phrase of 'unjust enrichment' to support a finding that this windfall profit should go to them. However,

factually no one knew that this company would be demutualized and there were no contract terms addressing the situation. This Court finds that when a contract fails to state the terms specifically, a ruling must be against the drafter of the contract, which in this case is [***12] the provider. (See for example, *Mejia v Trustees of Net Realty Holding Tr., 304 AD2d 627, 628, 759 N.Y.S.2d 91 [2d Dept 2003]*).

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

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

ORDERED, ADJUDGED and DECREED that plaintiffs' motion for an order granting summary judgment on the fifth and eighth causes of action in the complaint as against all defendants is denied. There has been no unjust enrichment because Plaintiff agreed to pay the premiums as part of the employment agreement offered to Dr. Cornell. While Dr. Cornell may be enriched by receiving this profit, he is not being enriched at the expense of the Plaintiff. Plaintiff fully expected to pay [**241] all the insurance premiums, without repayment, as part of the compensation to Defendant, when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit [***13] paid to the policyholders. Therefore Defendant's enrichment is not at Plaintiff's expense, but rather an unforeseen benefit of the bargain, and it is further

ORDERED, ADJUDGED and DECREED that the second, third, fourth, sixth and seventh causes of action in the complaint are dismissed as moot; and it is further **ORDERED, ADJUDGED and DECREED** that Defendant, David Cornell's counterclaim for a declaratory judgment in his favor, is granted. This Court declares that the "eligible policy holder" is David Cornell and he is entitled to both the $181,104.82, already disbursed, as the amount of the ORMC payment, and the escrowed amount of $16,435.07 as the amount of the PC payment, as his share of the sale and demutualization as determined by the Plan. **The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits if they chose to do so, further** [*619] **illustrating that the rightful owner of the proceeds would be the Policy Holder, Dr. Cornell, and no one else. However, Defendant Dr. Cornell chose not to assign the proceeds; therefore he is entitled to the distribution**, and it is further

ORDERED, ADJUDGED AND DECLARED that Defendant, David Cornell, MD, is entitled [***14] to the receipt from the escrow agent currently holding funds due it in the amount of $16,435.07 plus accrued interest, if any, as to said amount representing the pro rata amount [****6] assigned to the account of DAVID CORNELL, which amount shall be paid to Defendant, David Cornell, within fifteen (15) days of the service of this Order, with Notice of Entry, upon the escrow agent; and it is further

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

The foregoing constitutes the Decision and Order of this Court.

Dated: January 16, 2020

Goshen, New York

ENTER:

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

End of Document

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

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

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

GHVHS MEDICAL GROUP, P.C.,

PLAINTIFF,

-AGAINST-

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

DEFENDANTS.

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

VAZQUEZ-DOLES, J.S.C.

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

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

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

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

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

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

should receive the cash consideration.

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

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

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

Accordingly, it is hereby

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

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

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

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

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

The foregoing constitutes the Decision and Order of the Court.

Dated: January 6, 2020
Goshen, New York

Enter,

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

To: Counsel of record via NYSCEF.

Grossman v Akker

Supreme Court of New York, New York County

August 8, 2016, Decided

652402/15

Reporter
2016 N.Y. Misc. LEXIS 3007 *; 2016 NY Slip Op 31551(U) **

Opinion by: Joan B. Lobis

[**1] HOWARD L. GROSSMAN, on behalf of himself and all others similarly situated, Plaintiff, -against- MICHAEL AKKER, EVELYN F. MURPHY, DAVID JEFFERSON, DEBORAH AGUIAR-VELEZ, THERESA BALOG, SAMUEL M. BEMISS III, G. THOMAS ROGERS, ROBERT DAMANTE and PROSPERITY LIFE INSURANCE GROUP, LLC as successor to SBLI USA MUTUAL LIFE INSURANCE COMPANY, INC., Defendants. Index No. 652402/15;In the Matter of the Application of HOWARD L. GROSSMAN, on behalf of himself and all others similarly situated, Petitioner, -against- BENJAMIN W. LAWSKY, Superintendent of Financial Services New York Banking Department, ROBERT EASTON, Executive Deputy Superintendent, Insurance Division and DEPARTMENT OF FINANCIAL SERVICES, Respondents. Index No. 100199/15

Notice: THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

Prior History: *Grossman v. Akker, 2016 N.Y. Misc. LEXIS 3060 (N.Y. Sup. Ct., Aug. 8, 2016)*

Judges: [*1] Joan B. Lobis, J.S.C.

Opinion

Motions bearing sequence numbers 002 and 003 in the action commenced under index number 652402/15 are consolidated for disposition. Motions bearing sequence numbers 001 and 002 in the special proceeding commenced under index number 100199/15 are consolidated for [**2] disposition.

This is a class action (Class Action) and a special proceeding under *Article 78 of the CPLR* (*Article 78* proceeding), arising in connection with the conversion of SBLI Mutual Life Insurance Company (SBLI) from a mutual life insurance company into a stock life insurance company, pursuant to *New York Insurance Law § 7312*. In the *Article 78* proceeding, respondents Benjamin Lawsky, Robert Easton and the Department of Financial Services move to dismiss the petition of petitioner Howard L. Grossman (Grossman), which seeks an order setting aside a decision by respondents which approved the conversion of SBLI. In motion sequence 002, respondents move for an order granting consolidation of the Class Action and the *Article 78* proceeding.

In the Class Action, in motion sequence 003, defendants Michael Akker, Evelyn F. Murphy, David [*2] Jefferson, Deborah Aguiar-Velez, Theresa Balog, Samuel M. Bemiss III, G. Thomas Rogers, Robert Damante (collectively, the Individual defendants) and Prosperity Life Insurance Group, LLC (Prosperity) move, pursuant to *CPLR 3211 (a) (1)* and *(7)*, for an

order dismissing the amended complaint. Defendants also move, in sequence 002, for an order granting consolidation of the Class Action and the *Article 78* proceeding.

For the reasons stated below, the motions for consolidation are denied as moot. The motion to dismiss the amended complaint is granted. The motion to dismiss the petition is granted.

[**3] **Parties**

Grossman was a policyholder of SBLI, which was a mutual life insurance company organized under the laws of the State of New York. Essentially, a mutual life insurance company is one which is owned by the policyholders (Policyholders), who have voting rights and who receive dividends arising from their ownership interests.

Michael Akker was the President and Chief Executive Officer of SBLI and a member of its board of directors. Robert Damante was an Executive Vice President and the Chief Financial Officer of SBLI and a member of its board of directors.

Defendants Evelyn Murphy, David Jefferson, Deborah Aguiar-Velez, Theresa Balog, Samuel [*3] M. Bemiss III and G. Thomas Rogers were also members of SBLI's board of directors. According to the amended complaint, these defendants, along with Akker and Damante, comprised the board of SBLI at the time the plan to convert SBLI was approved. Prosperity is a privately held life and annuity insurance holding company, and is the successor to SBLI.

Benjamin Lawsky was the Superintendent of Financial Services New York Banking Department (Superintendent) when the conversion was approved and one of the parties under whose name the decision to approve the conversion was issued. Robert Easton was Executive Deputy Superintendent, Insurance Division of Financial Services at the relevant time, and was also a [**4] signatory to the decision approving the conversion. The Department of Financial Services is the agency of the State of New York which approved the conversion.

Background

According to the amended complaint, SBLI began in 1939 as The Savings Banks Life Insurance System. It was incorporated as SBLI Mutual Life Insurance Company of New York, Inc. in 1999 and was licensed to issue life insurance, annuities, and accident and health insurance on December 28, 1999.

The complaint alleges that, at [*4] some point thereafter, SBLI invested a significant portion of its assets in mortgage-backed securities (MBS). However, the value of such MBS's collapsed in 2008, which caused SBLI's financial condition to deteriorate to the point that the New York Superintendent of Insurance ordered SBLI to stop writing new insurance policies.

The complaint states that, in March 2012, Prosperity contacted SBLI with a proposal and plan (Plan) for a sponsored demutualization in which Prosperity, through a subsidiary, would acquire SBLI. Specifically, SBLI would be converted to a domestic stock company, which would then issue stock to be acquired by Prosperity.

The parties executed a Stock Purchase and Investment Agreement in October 2012, [**5] and on November 25, 2013, SBLI's Board of Directors unanimously approved a merger agreement to complete the acquisition. The merger agreement was executed on November 27, 2013 and provided, as relevant here, for $36 million to be paid to the Policyholders.

In order for the demutualization and merger to be effective, *New York Insurance Law § 7312* required: (1) approval by three-fourths of the board of directors upon finding it fair and equitable to the Policyholders; (2) approval by two-thirds of [*5] participating voting Policyholders; and (3) a determination by the Superintendent, after a public hearing, that the demutualization plan is fair and equitable to the Policyholders.

In July 2014, the SBLI Board approved the Plan, and, soon thereafter, mailed an information booklet (Information Booklet) to the Policyholders, which included a copy of the Plan as well as a notice of public hearing, as required by *Insurance Law § 7312 (i)*.

On August 21, 2014, the Superintendent held a public hearing to consider: 1) the reasons and purposes for SBLI's demutualization; 2) the fairness of the Plan; 3)

whether the reorganization was in SBLI's interest and in the interest of the Policyholders; and 4) whether demutualization was detrimental to the public.

Five witnesses spoke in support of the Plan, while eight Policyholders spoke in [**6] opposition. The Superintendent also received an written submissions, six of which supported the Plan and seven of which opposed it, including written submissions from Grossman in opposition. One of the main issues raised by opponents was whether the compensation provided to Policyholders was too low.

The Superintendent approved SBLI's demutualization in a 41-page written decision dated October 8, [*6] 2014. The Superintendent found that the Plan satisfied *Insurance Law § 7312* because, among other things, it provided fair and equitable compensation to the Policyholders, it was not detrimental to the public, it did not violate the Insurance Law and it left SBLI with sufficient resources for its future solvency.

Relevant here, the Superintendent also reviewed and approved the contents of the Information Booklet, determining that it provided sufficient information to SBLI's Policyholders to enable them to make an informed decision about the merits of the Plan.

The Policyholder vote was held on August 28, 2014. Out of the 186,211 Policyholders eligible to vote, 34,769 Policyholders actually voted with respect to the Plan. 81.82% of the voting Policyholders voted in favor of the Plan. 18.18% voted against the Plan.

On February 6, 2015, Grossman commenced the instant *Article 78* proceeding against [**7] the Superintendent and the individual officials who approved the Plan. Grossman seeks a determination that the Superintendent's approval of the Plan was improper, and seeks rescissory damages.

On July 7, 2015, Grossman commenced the instant Class Action on behalf of himself and other Policyholders against SBLI's Board [*7] of Directors and against Prosperity. The amended complaint asserts three causes of action. The first cause of action alleges: 1) that defendants violated *section 7312 of the Insurance Law* because the Information Booklet failed to provide Policyholders with sufficient information to cast a meaningful vote; and 2) that the terms of the Plan were not fair and equitable to the Policyholders.

The second cause of action is for breach of the implied covenant of good faith and fair dealing. Specifically, it alleges that the Policyholders entered into contracts with SBLI, and that defendants breached the implied covenant of good faith and fair dealing in those contracts by disseminating an insufficient Information Booklet and by approving an unfair plan for SBLI's demutualization and reorganization.

The third cause of action is against Prosperity for unjust enrichment. The amended complaint alleges Prosperity obtained SBLI through the Plan at less than fair value.

[**8] **Consolidation**

As noted above, the defendants in the Class Action and the respondents in the *Article 78* proceeding have moved for consolidation of the two matters. However, at oral argument, on March 29, 2016, the parties to both the *Article 78* proceeding and the Class [*8] Action agreed that, in lieu of consolidation, the parties would conduct both cases in a coordinated manner. Therefore, the motions to consolidate are denied as moot.

Class Action/Collateral Attack

Defendants move, pursuant to *CPLR 3211 (a) (1)* and *(7)*, for an order dismissing the amended complaint in the Class Action. As set forth above, plaintiffs assert three causes of action, each of which arises from plaintiffs' central contention that the terms of the demutualization and conversion of SBLI were not fair or equitable to the Policyholders and that the Information Booklet failed to provide Policyholders with sufficient information to cast a meaningful vote.

Defendants contend that these causes of action must be dismissed because they constitute an impermissible collateral attack on the Superintendent's approval of SBLI's demutualization Plan. Specifically, defendants argue that the determinations as to whether the Plan was fair, and whether the Information Booklet was sufficient, were solely within the purview of the Superintendent in considering whether to approve the Plan. As such, defendants contend that any party challenging the Superintendent's determination that the

Plan was fair, or that the Information [*9] [**9] Booklet was sufficient, may only do so by means of an *Article 78* proceeding, and plaintiffs are therefore precluded from relitigating these issues in a plenary action.

Plaintiffs contend that the collateral attack doctrine does not apply here because: 1) nothing in *Insurance Law § 7312* indicates an intent to extinguish the rights of Policyholders who object to a demutualization plan to assert claims in a plenary action; and 2) the Superintendent's decision was not the result of a quasi-judicial proceeding which permitted Policyholders a fair opportunity to be heard prior to the Superintendent making his determination.

For the reasons stated below, the court finds that the three causes of action in the amended complaint constitute an impermissible collateral attack on determinations made by the Superintendent in approving the Plan, and, as such, the amended complaint must be dismissed. To sustain these causes of action would permit plaintiffs to relitigate, through a plenary action, issues that were previously decided by the Superintendent, as required by *Insurance Law § 7312*, and which therefore must be challenged in an. *Article 78* proceeding.

It is well-settled that a party challenging the Superintendent's approval of a demutualization [*10] plan under *Insurance Law § 7312* must do so in a proceeding under *CPLR article 78*. See *Fiala v. Metropolitan Life Ins. Co., 6 A.D.3d 320, 321, 776 N.Y.S.2d 29 (1st Dep't 2004)*; Financial Services Law *§ 308*; *CPLR 7801*. This is because, in the context of a demutualization plan, "'the Legislature [**10] expressly placed the determination as to whether a plan of reorganization complied with the statute and was fair and equitable to policyholders in the (exclusive jurisdiction) of the Superintendent [citation omitted]." *ABN AMRO Bank, N.V. v. MBIA Inc., 17 N.Y.3d 208, 225, 952 N.E.2d 463, 928 N.Y.S.2d 647 (2011)*(ABN AMRO).

Under the collateral attack doctrine, a party is precluded from indirectly challenging the Superintendent's approval of a demutualization plan through a plenary action. See *Fiala v. Metropolitan Life Ins. Co., 6 A.D.3d at 321*; *Chatlos v. MONY Life Ins. Co., 298 A.D.2d 316, 749 N.Y.S.2d 230 (1st Dep't 2002)*, In other words, because the Superintendent has exclusive jurisdiction to determine whether a plan complies with the statute, litigants may not use a plenary action as a means to achieve a different result, but rather, must avail themselves of *CPLR Article 78*.

The collateral attack doctrine is limited, however, to the extent that "where a claim challenges the sufficiency of a plan approved by the Superintendent . . . . the preclusive effect of the Superintendent's decision is necessarily limited by the scope of the Superintendent's review." *Aurelius Capital Master. Inc. v. MBIA Ins. Corp., 695 F. Supp. 2d 68, 74 (S.D.N.Y. 2010)*, citing *Fiala, 6 A.D.3d at 321*. Thus, a plaintiff "cannot be precluded from litigating an issue upon which the Superintendent [*11] did not pass." *Aurelius Capital Master, Inc., 695 F. Supp. 2d at 74*.

In the case at hand, it is undisputed that, before the public hearing was held, SBLI was [**11] required to send the Policyholders "a true and complete copy of the plan, or . . . a summary thereof approved by the Superintendent, and such other explanatory information as the superintendent shall approve or require." See *Insurance Law § 7312 (i)*. SBLI was then required to demonstrate to the Superintendent that the Plan was fair and equitable to the Policyholders. See *Insurance Law § 7312 (c)*, *(j)*.

Relevant here, SBLI was also required to send a true and complete copy of the Plan to the Policyholders before the vote on whether to approve or disapprove the Plan, and the Superintendent was authorized to supervise such vote. See *Insurance Law § 7312 (k) (1)* and *(3)*.

In the Decision, the Superintendent considered both whether the Information Booklet, which contained a copy of the Plan, was sufficient to permit voters to make an informed decision and ultimately, whether the Plan was fair and equitable to the Policyholders. The Superintendent found that the Information Booklet, along with related policyholder notices and accompanying documents, "contained sufficient information about the proposed Demutualization to enable Eligible Policyholders to make an informed [*12] decision regarding the Plan and, for that reason, were approved by the Department pursuant to

Sections 7312 (i) and *(k) (1)*." Decision at 38. The Superintendent then found, after a detailed analysis, that the Plan was fair and equitable to the Policyholders. Id. at 36.

[**12] As described above, each cause of action in the amended complaint arises directly from plaintiffs' contentions that: 1) the terms of the demutualization and conversion of SBLI were not fair or equitable to the Policyholders; and 2) that the Information Booklet failed to provide Policyholders with sufficient information to make an informed decision in voting whether to approve the Plan.

However, both of these issues were necessarily addressed and decided by the Superintendent in approving the Plan, under his exclusive jurisdiction to determine whether the demutualization of SBLI complied with the statute. Therefore, for this court to sustain plaintiffs' causes of action asserted in the Class Action would impermissibly enable the Class Action plaintiffs to collaterally attack the Superintendent's decision through a plenary action, rather than through an *Article 78* proceeding. See *Fiala, 6 A.D.3d at 321*. This would clearly violate the plain language of *Insurance Law § 7312* and plaintiffs' claims must therefore [*13] be dismissed.

Despite the foregoing, plaintiffs argue that the amended complaint should not be dismissed because there is nothing in *Insurance Law § 7312* which indicates an intent to extinguish all rights of Policyholders who object to a demutualization plan to assert claims in a plenary action. However, that is not the issue here and defendants do not make such an argument.

It is clear that certain claims may arise in connection with a demutualization plan that [**13] were not within the purview of the Superintendent, and not addressed by the Superintendent, and, as such, are sustainable in a plenary action. See *Fiala, 6 A.D.3d at 321*; see also *ABN AMRO, 17 N.Y.3d at 225* (sustaining causes of action under the Debtor and Creditor Law in connection the corporate restructuring of an insurance company, which restructuring was approved by the Superintendent). However, this is not such a case, as discussed above, because the issues underlying plaintiffs' claims were specifically delegated to the Superintendent by the Insurance Law.

Plaintiffs also argue that their claims should not be dismissed because the public hearing conducted by the Superintendent here was not quasi-judicial in nature. This argument is also unpersuasive. "An administrative decision is quasi-judicial [*14] in character when it is rendered pursuant to the adjudicatory authority of an agency to decide cases brought before its tribunals employing procedures substantially similar to those used in a court of law [internal quotation marks and citations omitted]." *ABN AMRO, 17 N.Y.3d at 226*. Here, it is undisputed that the public hearing and proceeding conducted by the Superintendent did not rise to the full level of those employed in a court of law. However, plaintiffs have not demonstrated that a quasi-judicial proceeding was required under *Insurance Law § 7312*.

Plaintiffs' argument arises from the decision in *ABN AMRO, 17 N.Y.3d 208, 952 N.E.2d 463, 928 N.Y.S.2d 647*, in which the Court found that policyholders were not collaterally estopped from bringing claims in a plenary action under the Debtor and Creditor Law in connection with the corporate restructuring of [**14] an insurance company, where the restructuring was approved by the Superintendent. In that case, the Court found that the plaintiffs' claims were sustainable for two reasons. First, nothing in the Insurance Law placed the review of claims asserted under the Debtor and Creditor Law under the exclusive jurisdiction of the Superintendent. Therefore, the statute did not specifically exclude the assertion of such claims in a plenary action. [*15]

Furthermore, even if the Superintendent had addressed the Debtor and Creditor claims, which it did not, the plaintiffs could not be collaterally estopped from asserting such claims because they had not had a full and fair opportunity to contest the issues. Specifically, for collateral estoppel to apply, the proceeding conducted by the Superintendent would have to have been quasi-judicial in nature, which, as described above, would be one employing procedures substantially similar to those used in a court of law. *Id. at 226*.

In finding that the plaintiffs did not have a full and fair opportunity in that case, the Court noted that the corporate defendant had submitted a private application to the Superintendent and the Superintendent accepted the truth of defendants' submissions. Id. The Court also noted that the Superintendent did not conduct public

hearings or provide public notice before rendering his determination. Id.

The case at hand is distinguishable from the decision in *ABN AMRO*. Here, the [**15] issues underlying plaintiffs' causes of action were specifically placed within the exclusive purview of the Superintendent, to be decided pursuant to the procedures set forth in the Insurance Law. Further, [*16] such procedures, unlike those at issue in ABN AMRO, provided plaintiffs with an opportunity to be heard by the Superintendent before the Plan was approved.

Specifically, a copy of the Plan was provided to the Policyholders along with notice of the public hearing. Moreover, the Superintendent held such a public hearing and Grossman, among others, spoke at the hearing and submitted written opposition to the Plan to the Superintendent. In fact, it is undisputed that the objections raised in Grossman's submission, particularly as to the fairness of the Plan, were directly considered by the Superintendent and rejected. Moreover, unlike ABN AMRO, the Policyholders here were given a chance to vote to approve or disapprove the Plan, and they voted overwhelmingly to approve it. In light of the foregoing, the court finds that plaintiffs have not demonstrated that the public hearing held by the Superintendent had to be quasi judicial in nature as described in the ABN AMRO decision.

In sum, the Court finds that the issues underlying plaintiffs' causes of action, i.e., whether the terms of the demutualization and conversion of SBLI were fair or equitable to the Policyholders and whether the Information [*17] Booklet provided Policyholders with sufficient information to make an informed decision in voting whether to approve the Plan, are within the exclusive jurisdiction of the Superintendent to determine in the first instance. As such, they must [**16] be challenged pursuant to *CPLR Article 78*, as Grossman has done under a separate index number, rather than in a plenary action. Therefore, the motion to dismiss the amended complaint is granted and the amended complaint is dismissed.

Article 78

Grossman commenced the instant *Article 78* proceeding in February 2015, against the Superintendent and the individual officials who approved the Plan. Grossman seeks a determination that the Superintendent's approval of the Plan was improper, and seeks rescissory damages. Respondents move to dismiss the petition for failure to state a cause of action. For the reasons stated below, the motion is granted and the petition is dismissed.

The petition sets forth two causes of action. The first cause of action alleges that the Superintendent abused his discretion by electing, under such discretion, to hold an adjudicatory hearing, i.e. a quasi-judicial hearing, rather than an informational public hearing as required by *Insurance Law § 7312 (i)*. The petition [*18] further alleges that, in holding such a hearing, the Superintendent failed to follow the procedures for such adjudicatory hearings as set forth in the New York State Administrative Procedure Act (APA), *§ 301, et seq.*

This cause of action is dismissed. *Insurance Law § 7312 (i)* provides that, in the context of a demutualization,

> [**17] "The superintendent shall hold a public hearing upon the fairness of the terms and conditions of the plan of reorganization, the reasons and purposes for the mutual life insurer to demutualize, and whether the reorganization is in the interest of the mutual life insurer and its policyholders, and not detrimental to the public."

It further provides, in relevant part, that

> "Notice stating the time, place and purpose of the hearing shall be mailed by the mutual life insurer to each policyholder entitled to notice of the hearing . . . . Such notice shall be preceded or accompanied by a true and complete copy of the plan, or by a summary thereof approved by the superintendent, and such other explanatory information as the superintendent shall approve or require."

Here, it is undisputed that the Superintendent held a public hearing after proper notice to the Policyholders. Further, it is undisputed that several [*19] of the Policyholders, including Grossman, submitted oral and/or written arguments against the Plan, which submissions were directly considered by the. Superintendent in the Decision. In light of these facts, it is clear that the Superintendent followed the requirements of *section 7312*.

Grossman's assertion that the Superintendent, in fact, held an adjudicatory hearing, is unpersuasive. First, the

Decision specifically states that "[c]ontrary to Mr. Grossman's assertion, the public hearing required by *Section 7312(i)* does not constitute an adjudicatory proceeding under the New York State Administrative Procedure Act." Decision at 10, n. 33. Moreover, it is well-established that public hearings do not generally rise to the level of quasi-judicial hearings. See [**18] *Tuccio v. Central Pine Barrens Joint Planning and Policy Commn, 67 A.D.3d 689, 692, 888 N.Y.S.2d 562 (2d Dep't 2009)*; *Yilmaz v. Foley, 63 A.D.3d 955, 956, 881 N.Y.S.2d 154 (2d Dep't 2009)*.

Nothing in the record here indicates that the Superintendent held an adjudicatory hearing, such as would be governed by the APA. The record indicates that the Superintendent held a public hearing as set forth in the Insurance Law, and that Grossman availed himself of the opportunity to participate in that hearing and to have his arguments considered by the Superintendent.

The court notes Grossman's assertion that the hearing held by the Superintendent was flawed because the Superintendent [*20] failed to accept a supplemental submission from Grossman, which, Grossman admits, was submitted after the deadline for such submissions. However, the Decision specifically states that "on September 12, 2014, over a week after the hearing record closed, the Department received a supplemental submission from Howard Grossman. This submission was not made a part of the hearing record but was considered as part of the Department's review and analysis of the Sponsored Demutualization." Decision at 10, n 33. Thus, Grossman's assertion that the Superintendent failed to consider his supplemental submission is unpersuasive.

In light of the foregoing, the first cause of action in the petition is dismissed.

[**19] Grossman's second cause of action asserts that the superintendent's approval of the Plan is not supported by substantial evidence, under *CPLR 7803 (4)*. Specifically, the petition alleges that the Superintendent erred in finding the compensation provided to the Policyholders was fair and equitable. The gravamen of the petition is that the amount of such compensation was derived from an inaccurate assessment of SBLI's financial health at the time of the demutualization. Grossman alleges that, after the Plan was conceived by the [*21] SBLI's board, SBLI's financial status improved, as the market for mortgage-backed securities improved. Thus, the petition contends that the Policyholders are entitled to an increased amount of monetary compensation.

As a threshold matter, the court finds that whether the Decision is supported by substantial evidence is not the appropriate standard of review here. As discussed above, the public hearing held by the Superintendent was not quasi-judicial in character, "employing procedures substantially similar to those used in a court of law." *ABN AMRO, 17 N.Y.3d at 226*. As such, review under *CPLR 7803 (4)* is not appropriate. See *Board of Trustees of Inc. Vil. of E. Williston v. Board of Trustees of Inc. Vil. of Williston Park, 119 A.D.3d 679, 679 (2d Dep't 2014)*.

Instead, the court finds that review of the Superintendent's decision is appropriate under *CPLR 7803 (3)*, which provides, in relevant part that the court must review whether a determination was made in violation of lawful procedure, was affected by an error of law or was arbitrary and capricious or an abuse of discretion. Grossman contends that the petition should be [**20] granted, in any event, because the Superintendent's decision was arbitrary and capricious and not supported by the facts.

"The test for whether an administrative agency's determination is arbitrary and capricious is whether the determination is without [*22] sound basis in reason and is generally taken without regard to the facts." *Muhammad v. Zucker, 137 A.D.3d 429, 430, 26 N.Y.S.3d 276 (1st Dep't 2016)*(internal quotation marks omitted), quoting *Pell v. Board of Educ. of Union Free School Dist. No. 1 of Towns of Scarsdale & Mamaroneck. Westchester County, 34 N.Y.2d 222, 231, 313 N.E.2d 321, 356 N.Y.S.2d 833 (1974)*; *Mankarios v. New York City Taxi & Limousine Commn., 49 A.D.3d 316, 317, 853 N.Y.S.2d 69 (1st Dep't 2008)*.

"[I]t is not the role of the court to weigh the desirability of the proposed action, choose among alternatives, resolve disagreements among experts, or substitute its judgment for that of the agency." *Coalition Against Lincoln W., Inc. v. Weinshall, 21 A.D.3d 215, 222, 799 N.Y.S.2d 205 (1st Dep't 2005)* (internal quotation marks and citations omitted); see *Roosevelt Islanders for Responsible Southtown Dev. v. Roosevelt Is. Operating*

Corp., 291 A.D.2d 40, 54, 735 N.Y.S.2d 83 (1st Dep't 2001). Here, the petition fails to demonstrate that the Decision is arbitrary and capricious or without sound basis in reason or that it was made without regard to the facts. The court finds that the Superintendent based his decision on a detailed analysis of the merits of the Plan and reasonably found that the Plan, particularly the amount of Policyholder compensation, was fair and equitable to the Policyholders.

[**21] In the Decision, the Superintendent recognized that, "[w]hile all of the statutory factors must be satisfied, the issue of whether the Plan fairly and equitably compensates SBLI's policyholders is the overarching concern of *Section 7312*, and is the fundamental issue for the Department's review." Decision at 12. In order to determine whether the compensation was fair, the Superintendent considered expert [*23] opinions as well as the testimony and objections of Policyholders, including Grossman.

The Superintendent conducted a detailed analysis of SBLI's financial history, including its dividend history, as well as its current financial status and its financial prospects. Based on all these factors, the Superintendent first determined that it was in the best interests of SBLI to be reorganized and sold to a third party, rather than to maintain the status quo or to be placed in receivership.

In determining whether the specific amount of compensation was fair, the Superintendent considered similar cases of demutualization and examined the amount of compensation received in such cases. He noted that SBLI had been searching for a buyer since at least 2004, but had only found one prospect, i.e. Prosperity. The Superintendent noted that

> "Valuing a small life insurance company such as SBLI is imprecise in that there is a limited market for such companies, and, thus few similar transactions available to use as benchmarks. The limited market is due to the fact that the potential profit margin to be realized from acquiring a small life insurance company is small while the potential loss is large, resulting [*24] in an uncertain or even unfavorable [**22] risk/reward calculus."

He also noted that Prosperity's first offer was for only $12.5 million in consideration to eligible Policyholders. However, that offer eventually improved to $36 million, on top of $4 million in expenses. He further stated that, the fact that Prosperity's offer was by far the best that the company had "received either before or after the financial crisis tends to support a determination that the Policyholder Consideration is fair and equitable."

The Superintendent also considered the risk to Prosperity in purchasing SBLI. He stated that

> "In acquiring SBLI, Prosperity will need to rebuild a sales platform and SBLI's name recognition by developing a viable market strategy, constructing products suitable to that strategy and hiring and training sales staff to sell these products. It will have to grapple with the inadequate records left behind by the SBLI System and confront an unusually high expense structure that, despite the fact that SBLI does not have any acquisition expenses, ranks in the fourth quartile for per policy expenses."

"In other words, Prosperity is spending $40 million - $36 million of which will go to Eligible Policyholders [*25] - for the opportunity to right the SBLI ship." Decision at 23.

Based on these factors, and others, the Superintendent reasonably found that the amount of compensation was fair and equitable to the Policyholders.

[**23] The Superintendent also analyzed the sufficiency of the "Closed Block", which "is an accounting mechanism that provides certain protections to owners of traditional dividend-paying life insurance policies. Assets are allocated to the Closed Block to produce income which, together with anticipated revenue from the Closed Block Policies, is reasonably expected to be sufficient to pay claims, expenses, and to maintain SBLI's current dividend scale." Decision at 18.

The Superintendent found that the amount of funds in the Closed Block set forth in the Plan, approximately $900 million, "are estimated to be sufficient to pay for the claims and dividends owed on the Closed Block Policies . . . ." Decision at 26. Grossman has not demonstrated that this finding is without basis in reason or was made without regard to the facts of this case.

With regard to the issue of funding the Closed Block with sufficient assets to maintain SBLI's current dividend scale, the Superintendent acknowledged the complaint of some of the Policyholders [*26] that the

current dividend scale was lower than its historical dividend scale. However, the Superintendent reasonably found that the current dividend scale was the correct means by which to measure such funding because it reflected SBLI's current experience on its in-force policies. Id.

Grossman contends that, in any event, the Superintendent's analysis is flawed because the financial markets began to improve after the Plan was developed. Specifically he contends that, by 2013, the market for mortgage-backed securities had improved, which meant that SBLI's [**24] financial condition was improving. He contends that the Superintendent failed to account for this change. However, in the Decision, the Superintendent specifically addressed this issue, stating

> "Mr. Grossman . . . . believes that the terms of the Sponsored Demutualization are stale, as Prosperity and SBLI entered into an agreement in 2012. However, the terms of the Sponsored Demutualization have changed since that time. The proposal first submitted to the Department called for SBLI policyholders to receive $12.5 million in policyholder consideration. The Department deemed the Policyholder Consideration to be insufficient under the [*27] circumstances. The current terms of the Plan did not come together until November 2013.

As set forth above, the court's role here is not to substitute its judgment for that of the Superintendent, but to determine whether his decision was arbitrary and capricious. Petitioner has not made such a showing. Based on the foregoing review of the Decision, it is clear that the Superintendent's approval of the Plan had a sound basis in reason and was not made without regard to the facts of this case.

Finally, the court notes that the parties sharply dispute two other issues. Specifically, they dispute whether the petition would be moot because, as argued by respondents, SBLI's conversion cannot be undone, and whether rescissory damages would be available to respondents. However, in light of the dismissal of the petition, the court need not address those issues. Accordingly, it is

ORDERED that the motion by defendants Michael Akker, Evelyn F. Murphy, David [**25] Jefferson, Deborah Aguiar-Velez, Theresa Balog, Samuel M. Bemiss III, G. Thomas Rogers, Robert Damante and Prosperity Life Insurance Group, LLC for an order dismissing the amended complaint is granted and the amended complaint is dismissed; [*28] and it is further

ORDERED that defendants' motion for consolidation is denied as moot; and it is further

ORDERED the motion by respondents Benjamin W. Lawsky, Robert Easton and Department of Financial Services move to dismiss the petition is granted; and it is further

ADJUDGED that the petition is denied and the proceeding is dismissed; and it is further

ORDERED that respondents' motion for consolidation is denied as moot; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly.

DATED: August 8, 2016

ENTER:

/s/ Joan B. Lobis

Joan B. Lobis, J.S.C.

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Mell v. Anthem, Inc.

United States District Court for the Southern District of Ohio, Western Division

March 3, 2010, Decided; March 3, 2010, Filed

NO: 1:08-CV-00715

Reporter
2010 U.S. Dist. LEXIS 19056 *; 2010 WL 796751

RONALD D. MELL, SR., et al., Plaintiffs, v. ANTHEM, INC., et al., Defendants.

Subsequent History: Affirmed by *Mell v. Anthem, Inc., 2012 U.S. App. LEXIS 15299 (6th Cir.) (6th Cir. Ohio, 2012)*

Prior History: *Mell v. Anthem, Inc., 264 F.R.D. 312, 2009 U.S. Dist. LEXIS 107539 (S.D. Ohio, 2009)*

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For Anthem, Inc., now known as Wellpoint, Inc., Anthem Insurance Companies, Inc., Community Insurance Company, formerly known as Community Mutual Insurance Company, Defendants: Christopher G Scanlon, PRO HAC VICE, Paul Alan Wolfla, LEAD ATTORNEYS, Anne K Ricchiuto, PRO HAC VICE, Baker & Daniels LLP, Indianapolis, IN; Glenn Virgil Whitaker, Kent Allen Britt, LEAD ATTORNEYS, Vorys Sater Seymour & Pease - 1 Atrium Two, Cincinnati, OH; Robert Neal Webner, LEAD ATTORNEY, Vorys Sater Seymour and Pease LLP, Columbus, OH; Adam K Levin, PRO HAC VICE, Hogan & Hartson, Washington, DC; Craig A Hoover, Peter R. Bisio, PRO HAC VICE, Hogan & Hartson LLP, Washington, DC.

For City of Cincinnati, [*2] Ohio, Charlie Luken, former mayor of Cincinnati City Council, and his successors in office, Laketa Cole, former members of Cincinnati City Council, and his successors in office, Minette Cooper, former members of Cincinnati City Council, and his successors in office, John Cranley, former members of Cincinnati City Council, and his successors in office, David Crowley, former members of Cincinnati City Council, and his successors in office, Pat DeWine, former members of Cincinnati City Council, and his successors in office, Chris Monzel, former members of Cincinnati City Council, and his successors in office, David Pepper, former members of Cincinnati City Council, and his successors in office, Alicia Reece, former members of Cincinnati City Council, and his successors in office, James Tarbell, former members of Cincinnati City Council, and his successors in office, Defendants: Paul Alan Wolfla, LEAD ATTORNEY, Baker & Daniels LLP, Indianapolis, IN; Terrance A Nestor, LEAD ATTORNEY, City of Cincinnati, Cincinnati, OH.

Judges: S. Arthur Spiegel, United States Senior District Judge.

Opinion by: S. Arthur Spiegel

Opinion

OPINION AND ORDER

This matter is before the Court on the cross motions of the parties: The Wellpoint [*3] Defendants' Motion for Summary Judgment (doc. 32), Plaintiffs' Response in Opposition (doc. 47), and Defendants' Reply (doc. 50); Plaintiffs' Motions for Partial Summary Judgment on Liability (docs. 33, 36), The City of Cincinnati's Response in Opposition (doc. 45), The Wellpoint Defendants' Response in Opposition (doc. 46), and Plaintiffs' Reply (doc. 52); and the City of Cincinnati's Motion for Summary Judgment (doc. 37), Plaintiffs' Response (doc. 48), and the City's Reply (doc. 51). The Court held a hearing on these matters on November 4, 2009, after which it found it appropriate to order supplemental discovery. The Court held a second hearing, on February 25, 2010, at which time it considered the outcome of such discovery, as well as the arguments of the parties as to Defendants' Motion to Certify Question to the Supreme Court of Ohio (doc. 87) and Plaintiffs' Response in Opposition (doc. 89).

For the reasons indicated herein, the Court GRANTS the Wellpoint Defendants' motion for summary judgment, DENIES the Plaintiffs' motions, GRANTS IN PART AND DENIES IN PART the City's motion, and DENIES Defendants' motion to certify as MOOT.

I. General Background

This case involves Plaintiffs' [*4] claims that they were cheated out of proceeds as insureds, when Defendant Anthem Insurance ("Anthem") demutualized in 2001 and issued 870,021 shares of stock to the City of Cincinnati ("the City"), Plaintiffs' employer, instead of to Plaintiff policy holders (doc. 1). The City ultimately sold the stock for approximately $ 55 million, the amount Plaintiffs seek to recover in this action (*Id.*). Plaintiffs allege they are a class of 2,460 individuals named as insured persons, or who were members of a group of insured persons covered under the Group Policy during the relevant time period (*Id.*). In addition to Anthem and the City, Plaintiffs name as Defendants Anthem, Inc. (n/k/a "Wellpoint Inc."), the parent corporation of both Defendant Anthem Insurance and its subsidiary, Defendant Community Insurance Company ("CIC"). Plaintiffs assert numerous state common law claims in diversity for breaches of multiple contracts, conversion, and misappropriation, aiding and abetting conversion and misappropriation, breach of fiduciary duties, breach of agency agreement and fraudulent concealment, and seek compensatory damages and other relief (*Id.*).

On November 4, 2009, the Court conditionally certified [*5] this matter as a class action encompassing employees and retirees of the City who were named insureds or members of groups named as insureds, insured continuously from June 18, 2001, to November 2, 2001 (doc. 53). The class includes two subsets, 1) "Class A," those who had insurance prior to the merger between Community Mutual Insurance Company ("CMIC") and Anthem in 1995, and 2) "Class B," those who received insurance post-merger (*Id.*).

The parties filed cross motions for summary judgment (docs. 32, 33, 36, 37), all asserting there are no genuine issues of fact in dispute, while taking diametrically opposing views of how the law applies to this case. Essentially, Plaintiffs argue Ohio law entitles Class A members to demutualization proceeds. They premise their argument on the definition section in the Ohio demutualization statute, *Ohio Rev. Code § 3913.20(B)*, which defines the person "named as the insured," as the policyholder. They contend under the law the policyholder is entitled to demutualization proceeds. Plaintiffs argue they are the persons named as the insureds and therefore they were entitled to the demutualization proceeds as policyholders under Ohio law. Plaintiffs further [*6] argue that Class B members are entitled to proceeds based on express terms in the merger agreement, and, at least originally, based on a certificate in the possession of one of the class representatives. Defendants argue Ohio demutualization law does not apply, and even if it does, that Plaintiffs misinterpret such law. Defendants contend there is no dispute the City owned the group policy, and as such, even if Ohio law applies, the City appropriately took the proceeds of the demutualization. Defendants further argue the Plaintiffs incorrectly assert claims for Class B members, because there was never a requisite break in insurance coverage to trigger the rights they assert.

Finally, Defendants contend the document Plaintiff Schenck (o/b/o Wilmes) proffers proves nothing as it does not identify the insured and contains no information tying it to the City's retiree benefit plan. At the February 25, 2010 hearing, it appears that all parties agreed the Schenck document, and the few others unearthed in discovery, do not serve to establish rights of Class B members. [1]

II. The Summary Judgment Standard

Although a grant of summary judgment is not a substitute for trial, it is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Fed. R. Civ. P. 56*; *see also, e.g.,* Poller v. Columbia Broadcasting System, Inc., 368 U.S. 464, 82 S. Ct. 486, 7 L. Ed. 2d 458 (1962); LaPointe v. United Autoworkers Local 600, 8 F.3d 376, 378 (6th Cir. 1993); Osborn v. Ashland County Bd. of Alcohol, Drug Addiction and Mental Health Servs., 979 F.2d 1131, 1133 (6th Cir. 1992) (per curiam). In reviewing the instant motion, [*8] "this Court must determine whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Patton v. Bearden, 8 F.3d 343, 346 (6th Cir. 1993), *quoting in part* Anderson v. Liberty Lobby, Inc., 477 U.S. 242 251-252, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986) (internal quotation marks omitted).

The process of moving for and evaluating a motion for summary judgment and the respective burdens it imposes upon the movant and non-movant are well settled. First, "a party seeking summary judgment … bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrate the absence of a genuine issue of material fact [.]" Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986); *see also* LaPointe, 8 F.3d at 378; Guarino v. Brookfield Township Trustees, 980 F.2d 399, 405 (6th Cir. 1982); Street v. J.C. Bradford & Co., 886 F.2d 1472, 1479 (6th Cir. 1989). The movant may do so by merely identifying that the non-moving party lacks evidence to support an essential element of its case. *See* Barnhart v. Pickrel, Shaeffer & Ebeling Co. L.P.A., 12 F.3d 1382, 1389 (6th Cir. 1993).

Faced [*9] with such a motion, the non-movant, after completion of sufficient discovery, must submit evidence in support of any material element of a claim or defense at issue in the motion on which it would bear the burden of proof at trial, even if the moving party has not submitted evidence to negate the existence of that material fact. *See* Celotex, 477 U.S. at 317; Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). As the "requirement [of the Rule] is that there be no genuine issue of *material* fact," an "alleged factual dispute between the parties" as to some ancillary matter "will not defeat an otherwise properly supported motion for summary judgment." Anderson, 477 U.S. at 247-248 (emphasis added); *see generally* Booker v. Brown & Williamson Tobacco Co., Inc., 879 F.2d 1304, 1310 (6th Cir. 1989). Furthermore, "[t]he mere existence of a scintilla of evidence in support of the [non-movant's] position will be insufficient; there must be evidence on which the jury could reasonably find for the [non-movant]." Anderson, 477 U.S. at 252; *see also* Gregory v. Hunt, 24 F.3d 781, 784 (6th Cir. 1994). Accordingly, the non-movant must present "significant probative evidence" demonstrating that "there [*10] is [more than] some metaphysical doubt as to the material facts" to survive summary judgment and proceed to trial on the merits. Moore v. Philip Morris Cos., Inc., 8 F.3d 335, 339-340 (6th Cir. 1993); *see also* Celotex, 477 U.S. at 324; Guarino, 980 F.2d at 405.

Although the non-movant need not cite specific page numbers of the record in support of its claims or defenses, "the designated portions of the record must be presented with enough specificity that the district court can readily identify the facts upon which the non-moving party relies." Guarino, 980 F.2d at 405, *quoting* Inter-Royal Corp. v. Sponseller, 889 F.2d 108, 111 (6th

[1] Counsel for Plaintiff stated, "The rights in Group B. . .to demutualization compensation when Anthem demutualized, are [*7] similarly not dependent on any of the documents that were produced in the supplemental discovery." Moreover, Plaintiffs stated in their Reply to Defendants' Responses to Plaintiffs' Motion to Approve Notice to Non-Class Members, "These documents [the Summary of Benefits form and the Certificate of Membership form] do not provide the legal entitlement to demutualization compensation; they merely demonstrate which path to demutualization compensation the worker is entitled." (doc. 82).

Cir. 1989) (internal quotation marks omitted). In contrast, mere conclusory allegations are patently insufficient to defeat a motion for summary judgment. *See* McDonald v. Union Camp Corp., 898 F.2d 1155, 1162 (6th Cir. 1990). The Court must view all submitted evidence, facts, and reasonable inferences in a light most favorable to the non-moving party. *See* Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986); Adickes v. S.H. Kress & Co., 398 U.S. 144, 90 S. Ct. 1598, 26 L. Ed. 2d 142 (1970); United States v. Diebold, Inc., 369 U.S. 654, 82 S. Ct. 993, 8 L. Ed. 2d 176 (1962). Furthermore, the district [*11] court may not weigh evidence or assess the credibility of witnesses in deciding the motion. *See* Adams v. Metiva, 31 F.3d 375, 378 (6th Cir. 1994).

Ultimately, the movant bears the burden of demonstrating that no material facts are in dispute. *See* Matsushita, 475 U.S. at 587. The fact that the non-moving party fails to respond to the motion does not lessen the burden on either the moving party or the Court to demonstrate that summary judgment is appropriate. *See* Guarino, 980 F.2d at 410; Carver v. Bunch, 946 F.2d 451, 454-455 (6th Cir. 1991).

III. Mutual Companies and Demutualization

The insurance industry is organized under two basic corporate structures: stock and mutual. In general, mutual insurance exists where several persons have joined together for their united protection, each member contributing to a fund for the payment of losses and expenses. [2] Generally speaking, each member is both an insurer and an insured, and the mutual company is owned and controlled by its policyholders. [3] Most mutual insurers are incorporated under state laws that establish provisions for such entities. [4]

Stock insurance companies, by contrast, are owned by their shareholders, and their purpose is primarily to earn profit for their shareholders. [5] Stock companies can issue stock and therefore possess the ability to increase their reserves and surplus beyond what mutual companies can generate internally. [6] For this primary reason, among others, there has been a strong trend of mutual companies changing their corporate structure to stock companies, through a process called demutualization. [7]

The demutualization process involves a variety of professional disciplines and legal issues, and requires expert actuarial, legal, and accounting advice. [8] The process of demutualizing requires preparing and printing substantial information to policyholders. [9] The mutual must make a determination, based on the company's by-laws, articles of incorporation, and applicable law, as to which policyholders are entitled to vote on the demutualization and receive consideration. [10] Moreover, in the context of group policies, the mutual must determine who the owner is, the employer or the individual insureds. [11]

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[2] Lee R. Rust and Thomas F. Segalla, *Couch on Insurance 3D*, § 39.15 (1995).

[3] *Id.*

[4] Robert E. Keeton [*12] and Alan I. Widiss, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines and Commercial Practices*, § 2.1(a)(3) (1988).

[5] John Alan Appleman, *18 Insurance Law and Practice*, Ch. 344, § 10041 (1945).

[6] James A. Smallenberger, Insurance Law Annual: Restructuring Mutual Life Insurance Companies, 49 Drake L. Rev. 513 (2001). Naturally, restructuring implicates other issues, as the company must also be prepared to deal with consequences of a new corporate structure including proxy solicitations, periodic shareholder reports, and the risks of proxy contests and takeover threats. Gordon O. Pehrson, Jr., David R. Woodward, and James H. Mann, Demutualization of Insurance Companies: A Comparative Analysis [*13] of Issues and Techniques, 27 Tort & Ins. L.J. 709 (1992).

[7] *Id.* Since the 1930's over 200 mutual companies converted to stock companies. *Couch on Insurance 3D*, § 39:43. From 1996 to 2001, twenty-eight mutual life insurance companies either completed or announced plans to reorganize into a different corporate structure. Smallenberger, 517. By the end of 1999, only 106 out of 1470 life insurance companies in the United States were mutual companies. *Id.*

[8] Gordon O. Pehrson, Jr., David R. Woodward, and James H. Mann, Demutualization of Insurance Companies: A Comparative Analysis of Issues and [*14] Techniques, 27 Tort & Ins. L.J. 709 (1992).

[9] *Id.*

[10] Smallenberger, 532.

[11] *Id.*, 533.

In Ohio, the conversion of mutual companies to stock companies is governed by *Ohio Revised Code §§ 3913.10 to 3913.23*. The provisions are divided such that the initial sections pertain to the conversion of mutual life insurance policies, while the latter sections pertain to non-life insurance policies. *Section 3913.21* sets out a detailed procedure by which a mutual company can convert to a stock company. [12] The rights of mutual policy holders are set out in *Section 3913.22*. Each mutual policyholder is entitled to such shares of stock in the new corporation as his or her portion of equitable value of the mutual company will purchase. *Ohio Rev. Code § 3913.22*. "Shares shall be issued to the owner or owners of a mutual policy in force on the date of the examination. . . as such owner or owners appear on the face of the policy." *Id*. at *§ 3913.22(C)*. In an earlier definitional section, which Plaintiffs rely on in this case, the Ohio statute also states "'Policyholder' means the person, group of persons, association, corporation, partnership, or other entity named as the insured under a mutual policy of insurance. [*15] . ." *Id*. at *§ 3913.20*. [13] As such, the Ohio demutualization statute uses both the terms "owner" and "policyholder," in relation to demutualization proceeds.

IV. The Record

The factual background, as taken from the record, is as follows. In February 1986 the City entered into a Master Contract with Community Mutual Insurance Company ("CMIC") to provide Blue Cross/Blue Shield medical and hospitalization coverage for its employees, in addition to dental coverage for City firefighters. CMIC, an Ohio mutual insurance company, [*17] had bylaws in place stating that each policy holder of the company is a member, but then more specifically stated that "[i]n the case of a master contract for group insurance, the member shall be the holder of the master policy, and the holder of any certificate or contract issued subordinate to such master policy shall not be a member unless it makes specific provision for such membership."

In October 1995 CMIC merged with an Indiana company, Associated Insurance Companies ("AIC"), a predecessor of the Wellpoint Defendants. The merger was governed by *Ohio Revised Code § 3941.35 et seq*., which requires the merging entities to seek approval from their members and to file an agreement with the state superintendent of insurance to petition for approval of the merger. In their Joint Petition, CMIC and AIC stated that group policyholders are members and "[t]he holders of certificates of benefits issued under CMIC's group policies are not members of CMIC, are not entitled to vote and do not have proprietary rights in CMIC." The Ohio superintendent of insurance queried whether the certificate holders under CMIC's group contracts, rather than the employers, would receive guaranty policies/membership [*18] certificates, and thus become members of AIC. In response, CMIC stated the terms of the guaranty policies would provide that "the group policyholders (e.g., the employers), not the certificate holders (e.g. the employees), are the members. . .and will have equity rights. . ." The superintendent ultimately approved the merger in all respects. As a result of the merger, CMIC ceased to exist, and its members became insured by Community Insurance Company ("CIC"), a subsidiary of AIC. Although CMIC disappeared, the merger documents

[12] The process involves filing a resolution adopted by majority vote, along with financial statements and other documentation, with the Ohio superintendent of insurance. The superintendent, after a review of the documents, if satisfied that the proposed conversion is not contrary to law, must order an examination of the company, after which the superintendent should appoint an appraisal committee. The committee makes a determination of value of the company and determines the number of shares of the new corporation. Within sixty days of such determination, the policyholders, who must have thirty days notice, are called to a meeting to vote on the proposed conversion. If a majority favors conversion, then the superintendent sets a hearing, providing thirty days notice to all policyholders and notice by publication in a newspaper of the county where the home office of the company is located. If after the hearing, the superintendent is satisfied the conversion is proper, he shall issue an order accepting the report of the appraisal committee [*16] and authorizing the conversion. After such order issues, the new articles of incorporation of the new corporation shall by filed with the secretary of state.

[13] Indiana has a similar statutory scheme authorizing and regulating the process of demutualization. *Ind. Code Ann. § 27-15-1-1 et seq*. Instead of using the terms "policyholder," "owner" or "insured," Indiana uses the term "member," and defines members to be a person that according to the records, articles of incorporation, and bylaws, is a member of the converting mutual. *Ind. Code Ann. § 27-15-1-9*. Members are given "interests" in voting rights, as provided by law and by the company's articles of incorporation and bylaws, as well as rights to receive cash, stock, or other consideration in the event of a conversion to a stock insurance company. *Ind. Code Ann. § 27-15-1-10*.

provided that the former CMIC members would retain their rights under Ohio law, even though they were now members of an Indiana mutual insurance company. Soon after the merger, AIC changed its name to Anthem Insurance Companies, Inc. ("Anthem").

CMIC was not the only acquistion of AIC/Anthem. In the 1980's and 1990's it merged with numerous companies around the country to expand its geographic presence outside of Indiana. In 1993 AIC/Anthem acquired a Kentucky Blue Cross/Blue Shield licensee, Southeastern Mutual Insurance Company ("Southeastern") and in 1997 it merged with Blue Cross/Blue Shield of Connecticut (BC/BS-CT). As a result of these mergers, AIC/Anthem [*19] had diverse members with grandfathered rights based on the original entities' bylaws and on varying state laws. AIC/Anthem's original Indiana members, for example, were defined as the "enrollees" (the insureds); the group policyholders (the employers) were not.

In June 2001, the Board of Directors of AIC/Anthem approved a plan to demutualize, and submitted their proposal to the Indiana Department of Insurance. The Indiana Department completed a review of the merger documents, CMIC bylaws, and the Ohio superintendent's approval of the merger, and then conducted a public hearing regarding the proposed conversion. Following the hearing, the Indiana Department approved the plan of conversion, issuing an Order stating that "individual certificate holders under group Policies issued to groups by Anthem Insurance's Kentucky, Ohio and Connecticut subsidiaries prior to its mergers with those former mutual companies are not Statutory Members (the group policyholders are Statutory Members)." The demutualization became effective on November 2, 2001, and Anthem issued 870,021 shares of its common stock to the City, as well as shares to others it considered members entitled to proceeds. [14]

V. The Parties' Arguments

The Court has reviewed the briefing in this matter, which is extensive. The Court further held hearings on November 4, 2009, and February 25, 2010, which served to boil [*21] this matter down to its core elements. Those core elements, as the Court sees it, are 1) the issue of what law applies and what that law means 2) the issue of whether new rights were triggered under the merger document, and 3) the significance of the Schenck document and the others like it.

Defendants argued first that the City was the policyholder and member of the mutual by virtue of the CMIC by-laws, that regulators specifically addressed such question in the 1995 merger, and the insureds received what they were entitled to: insurance. In Defendants' view, Ohio demutualization law does not even apply to this case, because when Anthem demutualized in 2001, it was an Indiana company and the process was governed by Indiana law.

The Court queried whether the Plaintiffs would have been entitled to demutualization proceeds in 1994, had CMIC demutualized in Ohio. Defendants took the position that Plaintiffs would not have been entitled to such proceeds, as Ohio demutualization law authorizes and directs that such proceeds go to the owner of the policy. As there is no dispute that the City owned the policy, Defendants contend it would have been entitled to the proceeds.

Looking at the exact [*22] same documents, Plaintiffs arrive at the opposite legal conclusion. Plaintiffs responded that in their view, had CMIC demutualized before the merger, under Ohio law, the City workers would have been entitled to demutualization proceeds. In Plaintiffs' view, the CMIC bylaws conflict with Ohio law when it comes to demutualization. Under Ohio law,

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[14] Anthem's [*20] demutualization has been no stranger to controversy. Kentucky retirees insured under a Kentucky State Retirement System plan sued claiming entitlement to $ 1.3 million shares of Anthem stock. *Love, et al. v. Board of Trustees of the Kentucky Retirement System, et al.*, No. 02-CI-00122, (Franklin Circuit Court, Division II) May 27, 2004. Connecticut and Ohio employees did so as well. *AFSCME et al. v. Andover, No. X01CV030182395S, 2004 Conn. Super. LEXIS 3240, 2004 WL 2829835, *1 (Conn. Sup. Nov. 3, 2004)*, *Gold v. Rowland, No. CV02813759, 2006 Conn. Super. LEXIS 2837, 2006 WL 2808629, *1 (Conn. Sup. July 26, 2006)*, *Greathouse v. City of East Liverpool, 159 Ohio App. 3d 251, 2004 Ohio 6498, 823 N.E.2d 539 (Ohio Ct. App. 2004)*, *State of Ohio, ex rel. Teamsters Local Union No. 637 v. City of Marietta, 2005 Ohio 7108 (Ohio Ct. App. 2005)*. Even the Indiana insureds, who unlike the Ohio, Kentucky, and Connecticut insureds received demutualization proceeds, sued claiming they did not get their fair share. *Ormond v. Anthem, No. 1:05-CV-1908-DFH-TAB, 2008 U.S. Dist. LEXIS 30230, 2008 WL 906157, *1 (S.D. Ind. March 31, 2008)*.

argue Plaintiffs, "policyholder" is defined as the person "named as the insured," which would be the employee, and not the City. Ohio demutualization law applies, contend Plaintiffs, because the rights and interests of CMIC members were frozen in time based on the merger agreement. Under Ohio law, Plaintiffs contend, "policyholders" are entitled to demutualization proceeds.

The parties also addressed the issue of the "Class B" Plaintiffs. These Plaintiffs assert rights based on the merger document. As Plaintiffs see it, any new insurance issued after the merger would trigger equity rights for employees. [15] Plaintiffs contend that a human organ transplant rider ("HOT rider") added in 1998 did just that. Moreover, at the November hearing, Plaintiffs proffered a certificate of membership held by Plaintiff Schenck that states "As long as the guarantee [*23] policy is in effect, you'll be a member of Associated, entitled to all rights of membership in Associated accorded to members of a mutual insurance company under the Indiana Insurance Law. . .including. . .equity rights in the event of. . .demutualization." Plaintiffs argued this certificate, dated October 1995, evidences new coverage issued post-merger, and on its face shows Plaintiffs have equity rights.

Defendants responded that the merger documents provide that there must be a break in coverage in order to trigger equity rights for the employees. In their view, so long as the original master contract was renewed, amended or replaced, without a lapse in coverage, the City retained its status as "member" post-merger. At the November hearing, Defendants further contended the Schenck document "makes no sense at all," all the other documentary evidence is inconsistent, and no other employee or retiree from the City has come forward with a similar document.

Plaintiffs [*24] replied at the November hearing that no other employee had come forward with a document like Schenck's document because the Defendants refused to provide a list of class members until the Court would certify this matter as a class action. As such, Plaintiffs contended at they did not have the opportunity to survey the class to see if others had such a document. For this reason, the Court ordered discovery on the question, so as to leave no stone unturned, and set the issue of the significance of the Schenck document, and any others like it, for the second hearing on February 25, 2010 (docs. 58, 62, 85).

At the November hearing, the City also proffered a copy of its "Group Guaranty Health Policy and Certificate of Membership," on its face dated "Rev. 4/97," which explicitly states that enrollees or covered persons shall not "receive any equity rights by virtue of being an Enrollee." Because Plaintiffs are saying they are a third-party beneficiary to the Guaranty Policy, the City argued the very terms of such policy preclude Plaintiffs from claiming demutualization proceeds, and such claims should fail.

A final matter addressed at the November hearing was the question of the statute of [*25] limitations. Plaintiffs filed their Complaint in October 2008. Plaintiffs contend that as to their contract claims, the applicable statute is fifteen years, and so there is no statute of limitations issue as to such claims. As for their tort claims, Plaintiffs contend a four-year statute of limitations applies, but even if the City is correct that a two-year limitations period applies, they timely filed their Complaint because they discovered their claims in December 2007 and in April of 2008.

Defendants argue the discovery rule does not apply to toll the statute of limitations because the 2001 demutualization and relevant transactions were public facts about which Plaintiffs undoubtedly were aware. In Defendants' view, constructive knowledge of facts, rather than their legal significance, is enough to start the statute of limitations running. Here, Defendants contend, Plaintiffs claim to have "discovered" their injuries after they were contacted by a lawyer. Such a "discovery," Defendants claim, should not allow Plaintiffs to circumvent the statute of limitations.

VI. Analysis

Having reviewed this matter, the Court finds that Plaintiffs' theory as to Class A members is predicated on [*26] the view that Ohio law categorically excludes a group policy holder from possessing equity rights in a mutual insurance company. Under this view, CMIC's

[15] Plaintiffs premise their theory regarding the new insurance "trigger" on an unexecuted boilerplate form entitled "Group Policy for Future Community Contract Holders" (doc. 31-21), which Defendants contend the City never possessed.

bylaws were ultra vires, and in conflict with Ohio law, which would require that employees automatically gain equity rights when provided insurance through a mutual company.

The two Ohio demutualization cases cited by the parties *Greathouse v. City of East Liverpool, 159 Ohio App. 3d 251, 2004 Ohio 6498, 823 N.E.2d 539 (Ohio Ct. App. 2004)*, and *State of Ohio, ex rel. Teamsters Local Union No. 637 v. City of Marietta, 2005 Ohio 7108 (Ohio Ct. App. 2005)* cast some light on whether Plaintiffs' view is correct. Only *Greathouse* made a determination of who was entitled to demutualization proceeds, and the decision was predicated on the determination that the employer owned the insurance policy. The state appellate court found that because "the City, not appellant, contracted with Anthem and owned the policy, appellant was not entitled to the stock proceeds. As 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 stock proceeds." Such decision is not [*27] inconsistent with *Ohio Revised Code § 3913.22(C)* which states that in a demutualization "[s]hares shall be issued to the owner or owners of a mutual policy. . .as such owners appear on the face of the policy."

Although the court in *State of Ohio, ex rel. Teamsters Local Union No. 637* found the reasoning of the *Greathouse* court "sound," it expressly declined to decide the issue of who owned the policy because of the different procedural postures of the cases. *Greathouse* involved an appeal from summary judgment, whereas the *State of Ohio, ex rel. Teamsters Local Union No. 637* case involved an appeal from a Ohio R. Civ. P. 12(B)(6) dismissal. *2005 Ohio 7108, *P12-14*. [16]

In its analysis the state appeals court found the allegation that the bylaws granted equity rights to the plaintiffs precluded the granting of a motion to dismiss. *2005 Ohio 7108 at *P13*. However, the Court made no finding that Ohio law categorically excludes the possibility that an employer could possess the equity rights in a mutual insurance company. Indeed, the very fact that the Court remanded the matter for further proceedings concerning the issue of who owned the policy shows the state court of appeals did not read Ohio law to automatically grant equity rights to insured employees.

Plaintiffs argue the definition section in *Ohio Revised Code § 3913.20* makes them the "policyholder" because they were "named as the insured under a mutual policy." Putting aside the fact that the Court has no policy before it naming any of the Plaintiffs as insured, the Court [*30] finds no question that Plaintiffs were insured by the City's contract with CMIC for group coverage. There appear to be competing authorities on the question of whether insureds in a group policy context are automatically considered "policyholders." At the February 25, 2010 hearing, Plaintiffs' Counsel cited the Ohio Health Insurance Guide, Couch on Insurance, and Anthem's own documents for the proposition that in a group policy those "named as insured" are policyholders. However, the portion of the Ohio Revised Code pertaining to group sickness and accident insurance, *Ohio Revised Code § 3923.12(C)(2)*, appears to define the policyholder in group insurance contexts as

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[16] In *State of Ohio, ex rel. Teamsters Local Union No. 637 v. City of Marietta*, the appellant union and employees had claimed they were entitled to demutualization proceeds instead of the City of Marietta. *2005 Ohio 7108*. The City filed a motion to dismiss pursuant to ***Rule 12(b)(6)***, which the Washington County Court of Common Pleas granted. *Id*. Appellants challenged such ruling on appeal, contending they had alleged in their complaint that the insurer historically provided in its articles of incorporation and/or bylaws that [*28] employees under a group health insurance plan were the policyholders or owners of the plan. *Id*. The Ohio Court of Appeals reasoned that it had to accept such allegation as true for purposes of evaluating the City's motion to dismiss, and could not look beyond the complaint to evaluate the allegation. *Id*. The Court reversed the trial court's judgment and remanded the matter for further proceedings. *Id*. The Court noted that the question of whether appellants were in fact owners of the health insurance policies was an issue to be explored in further detail on summary judgment, as was presumably done in *Greathouse*. The instant case, too, obviously is in a different procedural posture as the Court has the CMIC bylaws before it, and not mere allegations. The CMIC bylaws specifically state that "In the case of a master contract for group insurance, the member shall be the holder of the master policy, and the holder of any certificate or contract issued subordinate to such master policy shall not be a member unless it makes such provision for such membership." The bylaws then give members (the City here) rights as are prescribed by law for members of mutual insurance companies organized under [*29] the laws of Ohio, by the Articles of [CMIC], the regulations and bylaws, and any policy of insurance issued by CMIC and held by the member (doc. 32-2, Ex. A). The group policy the City held, moreover, explicity states "No Enrollee [insured employee]. . .shall receive any equity rights by virtue of being an Enrollee." (doc. 46-3).

the employer. Finally, Plaintiffs' Complaint indicates there is no dispute the City owned the policy, and states it may have been deemed a "policyholder" for other purposes, including voting, but contends the City was not a policyholder within the meaning of the demutualization statute.

The Court notes that *Section 3913.22*, which delineates the "Rights of Mutual Policyholders" in a demutualization, uses both the terms policyholder and owner. The term, "policyholder" is defined in *section 3913.20*, while the term "owner" is [*31] not defined. Under the plain meaning rule of statutory construction, the word "owner" can be presumed to be used in its ordinary sense. *Caminetti v. United States, 242 U.S. 470, 485-486, 37 S. Ct. 192, 61 L. Ed. 442 (1917)*("Statutory words are uniformly presumed, unless the contrary appears, to be used in their ordinary and usual sense, and with the meaning commonly attributed to them.") Here, even if Plaintiffs' interpretation is correct that they are "policyholders" under the definition in *section 3913.20*, there is no dispute: they certainly were not owners. *Section 3913.22* states the "shares shall be issued to the owner or owners." [17] *Section 3913.22* specifically addresses who is ultimately entitled to demutualization shares. Effect should be given to every clause and part of a statute, with specific terms prevailing over the more general which otherwise might be controlling. *D. Ginsberg & Sons, Inc. v. Popkin, 285 U.S. 204, 208, 52 S. Ct. 322, 76 L. Ed. 704 (1932)*. Here, should the Court interpret the Ohio statute to only allow insureds to possess equity rights in demutualization proceeds, such interpretation would give no effect to the express specific terms of *section 3919.22(C)* which the Court understands gives "owners" such right. A [*32] better reading of the statute, in the Court's view, is that as a general rule, "policyholders" are the insureds, who are typically "owners" and entitled to proceeds. However in some specific situations, like the one at bar where the City is indisputably the owner of the group policy, the insureds do not necessarily have equity rights.

The Court does not believe the legislature intended to automatically grant employees in the group insurance context equity rights by the simple happenstance of the corporate structure of the mutual insurance company with whom their employer contracted. Nor does the Court believe the legislature intended to prohibit an employer from owning a group policy. The Plaintiffs here had nothing to do with the choice of insurance carrier, nor with its governance, and they received what they bargained with the City [*33] to get: insurance coverage. The employees were not so concerned about what insurance entity provided their coverage, or what legal form such entity took, but rather whether the benefits they had been promised by the employer would be available. There is no evidence in this case the employees were ever denied the benefits they were promised, when the insurer was a mutual or later a stock company. [18]

The Court's conclusion is consistent with the limited Ohio authority on the subject, [*34] but also with the Ohio insurance superintendent's approval of the 1995 merger, and with the Indiana Department of Insurance's approval of the demutualization. [19] Having thus concluded, the Court finds Plaintiffs' interpretation of Ohio law incorrect, and therefore finds that Defendants prevail on their motion for summary judgment as to the Class A Plaintiffs. The City was a legitimate member of CMIC, and after the merger, the City possessed grandfathered rights as a member of the Indiana mutual insurance company. The Indiana demutualization, which took account of the City's rights as a member of CMIC pre-merger, therefore properly awarded the

[17] Plaintiffs read this section to mean that the owner in a group policy context is issued the demutualization proceeds by the insurance company, and then is charged to distribute the proceeds to the insureds. The Court finds Plaintiffs are reading more into the statute than what it says on its face, and opts for traditional statutory construction instead.

[18] From the Court's point of view, unless the terms of the policies or the state law governing insurance have clearly and unqualifiedly stated the employees were entitled to demutualization proceeds, then the Plaintiffs carry a heavy burden to upend the determination that they are not so entitled. Here the Court finds no real question that the insurance policy and the law give equity rights to the employer. In the Court's mind, however, should there be any doubts in this regard, such doubts should be resolved in favor of the employer because the employees, under their compensation package, have never been denied insurance coverage provided for in their insurance agreements. They got what they bargained for.

[19] The Court notes that the regulatory actions by state agencies are entitled to deference, and that the Ohio superintendent was required under law, *Ohio Revised Code § 3941.38(B)(2)*, to ensure the protection of the equity rights of the members. The Court believes the superintendent did so.

demutualization proceeds to the City.

As for Class B members, the Court further finds Plaintiffs' interpretation of the merger document incorrect. Plaintiffs frame the "triggering event," that would provide equity rights to Class B Plaintiffs, as the issuance [*35] of new insurance. No doubt, the issuing of new riders to the underlying policy could be viewed as new insurance. However the merger document does not state that new insurance is the "triggering event." It states:

> The Associated guaranty insurance policy/membership certificate shall continue in effect as long as (a) the insurance policy or health care benefits contract assumed by CIC pursuant to Clause (A) of this Section 3.1 is in effect, or has been renewed, amended, or replaced, without a lapse in coverage, by any CIC insurance policy or health care benefits contract and (b) the membership fees required. . .are paid when due. . .

The Court's reading of this provision is that the guaranty stays in effect so long as there is no lapse in coverage. The Court finds there has been no lapse in coverage in this case. The City has continually maintained its Group Guaranty Health Policy. For this reason, the Court rejects the theory that those Class B "newly-insureds" with human organ transplant coverage gained equity rights.

Finally, the Court finds the existence of the Schenck document proves nothing. First, it cannot serve, as Plaintiffs first claimed, as the evidence of "new insurance" triggering [*36] a change in equity rights for the reason articulated above-- there was no lapse in coverage. Second, the certificate was issued subordinate to the Group Guaranty Policy. The only Group Guaranty Policy in the record, although on its face apparently post-dating the Schenck document, expressly contradicts it. Under both Ohio and Indiana law the terms and conditions of an insurance policy trump any terms listed in the certificate of coverage. *Talley v. Teamsters, Chauffeurs, Warehousemen, and Helpers, Local No. 377, 48 Ohio St. 2d 142, 357 N.E.2d 44, 46-47 (Ohio 1976)*("It is generally held that the certificate of coverage merely evidences the employee-member's right to participate in the insurance provided under the terms and conditions imposed in the group policy. Consequently, the provisions of the group policy are controlling over the provisions in the certificate, and the rights of the parties in a group insurance enterprise are dependent upon the group contract."), *American Family Insurance Co. v. Globe American Casualty Co., 774 N.E.2d 932, 939 (Ct. App. Indiana, 2002)*(the insurance certificate evidences that insurance has been obtained but in itself does not constitute a policy, nor can its terms contradict [*37] the terms of the policy). Third, the Schenck document fails to name who the "member" is or to identify specifically what group policy it relates to. Finally, at the February 25, 2010 hearing, it became clear that discovery only yielded a confusing result in that Class A Plaintiffs possessed documents one would presume would be found in the possession of Class B Plaintiffs, and vice-versa. Although the Court expressed its dismay at Defendants' position that Athem issued the documents by mistake, it appears the documents are simply legally irrelevant here. Under these circumstances, and in the light of the overwhelming record evidence to the contrary, the Court cannot find that the Schenck document or those similar to it salvage any of Plaintiffs' claims to demutualization proceeds.

Because the Court has visited the core issues at stake and concluded Defendants are entitled to summary judgment, it need not devote substantial attention to the other arguments raised by Defendants, which as it has indicated before, it considers as affirmative defenses. However, the Court does find it appropriate to indicate that it finds that Plaintiffs have alleged both contract and tort claims, but that [*38] in its view, this case sounds in tort, that is, in the various alleged breaches of fiduciary duty allegedly owed to Plaintiffs under Ohio demutualization law. There can be no contract claims, because the controlling group policy is between Anthem and the City, and such policy explicitly excludes enrollees (that is insured employees) from possessing equity rights in the mutual insurance company. The Court does not find such provision contrary to Ohio law. Moreover, Plaintiffs' Complaint alleged breaches of contract based on Schenck document, which as explained above, is trumped by the group policy as a matter of law.

The Court further disagrees with the City that it is entitled to immunity under Ohio Revised Code § 2744, because clearly, Plaintiffs' claims arise out of their employment relationship with the City. *Ohio Revised Code § 2744.09*. Finally, because Plaintiffs contend they were oblivious to their claims due to Defendants'

alleged concealment and fraudulent misrepresentation, the Court finds the application of the discovery rule appropriate here, such that there is no issue of Plaintiffs' action being barred by the statute of limitations. [20] A reasonable person very well would [*39] not have known of his or her potential rights in the context of a demutualization, and moreover, the interests of justice here call for the Court to reach the merits of this matter, so as to bring clarity, and put it to rest.

VII. Conclusion

The Court finds no genuine dispute of material fact and concludes that as a matter of law, the City, by express terms of the CMIC bylaws, was the party entitled to equity interests in mutual insurance policy that it contracted and owned. It concludes that the award of demutualization proceeds to the City did not violate Ohio law. Accordingly, the Court GRANTS The Wellpoint Defendants' Motion for Partial Summary Judgment (doc. 32), DENIES the Plaintiffs' Motions (docs. 33, 36), and DENIES IN PART the City's Motion as to its immunity and statute of limitations defenses (doc. 37), while GRANTS IN PART the City's Motion as to the legal determination that [*40] it was the eligible statutory member entitled to demutualization proceeds (doc. 37). Finally, the Court DENIES as MOOT the Joint Motion of Defendants to Certify Question to the Supreme Court of Ohio (doc. 87), and DENIES as MOOT Defendants' Joint Motion to Stay Pending Ruling on Petition for Permission to Appeal Order on Class Certification (doc. 56). The Court DISMISSES this matter from the docket.

SO ORDERED.

Dated: March 3, 2010

/s/ S. Arthur Spiegel

S. Arthur Spiegel

United States Senior District Judge

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[20] Decedent Plaintiff Wilmes was the first to learn of her potential claims, in December 2007, Plaintiffs Espel and Matacia learned of their claims on April 3, 2008. Plaintiffs filed this action on October 15, 2008, within four years of discovery of their potential claims. *Ohio Revised Code § 2305.09(C)*.

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