New York County Clerk's Index No. 650613/2010

Court of Appeals

State of New York

UNIVERSAL AMERICAN CORP.,

Petitioner-Appellant,

–against–

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.,

Respondent-Respondent.

OPPOSITION OF NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA., TO THE MOTION FOR LEAVE TO APPEAL

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Dated: May 1, 2014

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DISCLOSURE STATEMENT PURSUANT TO RULE 500.1(f)

Respondent-Respondent National Union Fire Insurance Company of Pittsburgh, PA. is a is a wholly-owned subsidiary of AIG Property Casualty U.S., Inc.; AIG Property Casualty U.S., Inc. is a wholly-owned subsidiary of AIG Property Casualty Inc.; AIG Property Casualty Inc. is a wholly-owned subsidiary of AIUH LLC; AIUH LLC is a wholly-owned subsidiary of American International Group, Inc., which is a publicly-held corporation.

Dated: May 1, 2014
New York, New York

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PRELIMINARY STATEMENT

Respondent-Respondent National Union Fire Insurance Company of Pittsburgh, Pa. ("National Union"), respectfully submits this brief in opposition to the motion for leave to appeal filed by Petitioner-Appellant Universal American Corp. ("Petitioner-Appellant" or "Universal American"). The Appellate Division, First Department, entered a decision on October 1, 2013, unanimously affirming the decision and order of the Commercial Division of the Supreme Court, New York County (O. Peter Sherwood, J.S.C.), granting National Union's cross-motion for summary judgment and denying Petitioner-Appellant's partial motion for summary judgment dismissing in its entirety Petitioner-Appellant's claim for insurance coverage of its Medicare billing fraud claims. Despite this unanimous decision, Petitioner-Appellant moved for leave to appeal to the Appellate Division, First Department, who denied the motion. Despite these two rulings, Petitioner-Appellant seeks leave to appeal, arguing that the First Department was "doubly wrong" in their decision.

Petitioner-Appellant, however, has not demonstrated that the Appellate Division, First Department's unanimous Order merits review by the Court of Appeals. This matter does not satisfy any of the three (3) requirements for appeal set forth in this Court's rules. Specifically this matter does not involve issues that are novel or of public importance, present a conflict with prior Court of Appeals

decisions, or involve a conflict among the departments of the Appellate Division. Petitioner-Appellant does not argue leave to appeal on any of these grounds. Instead, Petitioner-Respondent wrongly and inaccurately argues that it is entitled to leave based on reasons that do not exist in New York's Code of Rules and Regulations. Rather, Petitioner-Appellant reaches beyond the codified requirements and attempts to rely on additional reasons mentioned in a legal encyclopedia that cites, not to New York's Code of Rules and Regulations, but to cases decided in the 1920s. Petitioner-Appellant focuses the vast majority of its brief on the merits of the underlying case and Petitioner-Appellant's disagreement with the First Department and Commercial Division's unanimous conclusion that the Computer Systems rider does not provide coverage for Petitioner-Appellant's underlying claims of Medicare fraud. Without a recognized basis for granting leave to the Court of Appeals, Petitioner-Appellant's motion lacks merit and should be denied.

COUNTER-STATEMENT OF FACTS

A. Petitioner-Appellant Universal American

Petitioner-Appellant Universal American is a health insurance company which provides Medicare managed care plans, and traditional insurance products. The plan at issue here is Universal American's Medicare Advantage Private Fee-For-Service plans ("MA-PFFS"). Petitioner-Appellant states that the MA-PFFS

plan is a U.S. government-regulated alternative to original Medicare. Under the program, members enroll in healthcare benefit plans sponsored by private insurance companies like Universal American. The plans receive payments for their members from the Centers for Medicare and Medicaid Services ("CMS").

B. The Bond

The Financial Institution Bond, No. 00-669-71-43 with a policy period from July 29, 2008 to July 29, 2009 (the "Bond") has the following insuring agreements: Employee Dishonesty, Loss Inside the Premises, and In Transit. Rider #3 of the Bond adds additional coverage by way of an Insuring Agreement titled "Computer Systems," which provides:

> Loss resulting directly from a fraudulent
>
> (1) entry of Electronic Data or Computer Program into, or
>
> (2) change of Electronic Data or Computer Program within the Insured's proprietary Computer System or a Computer System listed in the Schedule below;
>
> provided that the entry or change causes
>
> (a) Property to be transferred, paid or delivered,
>
> (b) An account of the Insured, or of its customer, to be added deleted, debited or credited or
>
> (c) An unauthorized account or a fictitious account to be debited or credited

(*See* R. 249).

C. The Underlying Claim

The underlying matter for this coverage dispute involves alleged Medicare fraud. The fraud at issue was perpetuated by legitimate healthcare providers who sought to scam Universal American by submitting claims for medical services which were either padded or never performed. The Commercial Division and the First Department uniformly found that coverage under the Computer Systems insuring agreement was not triggered by Medicare fraud.

D. Orders Below

By Order entered on January 8, 2013, the Commercial Division, Supreme Court, New York County (O. Peter Sherwood, J.S.C.) denied Petitioner-Appellant's motion for partial summary judgment and granted National Union's cross-motion for summary judgment. (*See* Petitioner-Appellant's Brief, Appendix 1-7). The Commercial Division found that the words of the Computer Systems rider, "covers loss from a fraudulent 'entry of electronic data' or 'change of electronic data' within the insured's proprietary computer system, [and] was intended to apply to wrongful acts in manipulation of the computer system, i.e., by hackers, and did not provide coverage for fraudulent content consisting of claims by bona fide doctors and other health care providers authorized to use the system for reimbursement for health care services that were not provided." (*See id.*).

Petitioner-Appellant appealed to the Appellate Division, First Department. By Decision and Order entered on October 1, 2013 the Appellate Division, First Department unanimously affirmed the Supreme Court's order dismissing Petitioner-Appellant's complaint. (*See* Petitioner-Appellant's Brief, Appendix 10-12). The First Department unanimously agreed that "the motion court properly interpreted the policy as a matter of law," and based upon the correct and well-accepted approach to policy interpretation, found that the "unambiguous plain meaning" of the Computer Systems rider does not provide coverage for Petitioner-Appellant's claimed loss. (*See id.*). Petitioner-Appellant subsequently moved for leave to appeal to this Court which required Petitioner-Appellant to demonstrate the same requirements for appeal as this motion. The Appellate Division, First Department denied leave. (*See* Petitioner-Appellant's Brief, Appendix 16-17). This motion follows.

STANDARD OF REVIEW

The Court of Appeals' rules set forth three (3) distinct requirements for leave to appeal. Specifically, the Court of Appeals' rules require that the party seeking leave to appeal demonstrate "why the questions presented [on appeal] merit review by this Court, such as that the issues are novel or of public importance, present a conflict with prior decisions of this Court, or involve a

conflict among the departments of the Appellate Division." 22 N.Y.C.R.R. § 500.22(b)(4). Petitioner-Appellant's motion meets none of these criteria.

Petitioner-Appellant incorrectly cites to eight (8) bases for leave to appeal taken from the legal encyclopedia, Carmody Wait 2d Cyclopedia of Practice, *see* Petitioner-Appellant's Brief at 10. The additional criteria cited in Carmody Wait, are taken from 1920s cases predating the current 22 N.Y.R.R. § 500.22(b)(4). *See* 11 Carmody Wait § 71:72 citing *Wollman v. Newark Star Pub Co.*, 191 A.D. 881 (1st Dept. 1920) (questions that are likely to arise frequently); *Corvette v. Scott*, 243 N.Y. 66 (1926) ("question of first impression"). These additional criteria are not set forth in this Court's codified rules. Petitioner-Appellant bases its entitlement to leave on these obscure and outdated references found in this secondary source, and not the codification of the actual appellate rules.

Petitioner-Appellant's proffered criteria, do not trump the actual codification of the three (3) criteria this Court uses to decide whether leave to appeal should be granted and which Petitioner-Appellant cannot demonstrate here. First, none of the issues raised in this matter are novel or of public importance. This case centers on a rider in an insurance policy between an insurer and its insured. The case is specific to the interpretation of a specific rider between two parties. The issues presented here are based on long-standing principles of insurance policy interpretation. There is nothing new, or novel, presented here that makes the Order

of the Appellate Division, First Department an important matter to the public. The Appellate Division, First Department, and the Commercial Division simply have used established canons of policy construction, such as affording the plain meanings of words of the insuring agreement, and determined that coverage does not exist in this case. Second, the Order of the Appellate Division, First Department does not conflict with decisions from other departments. Quite the contrary, the Appellate Division, First Department's Order and approach to policy interpretation is in line with the other departments. There is also no allegation that the Order conflicts with the precedent of this Court.

Accordingly, there is no basis for leave to appeal and Petitioner-Appellant's motion should be denied.

ARGUMENT

I. THIS MATTER DOES NOT MERIT COURT OF APPEALS' REVIEW

Petitioner-Appellant's motion for leave to appeal to this Court is without merit. Petitioner-Appellant's arguments that leave to appeal is warranted because this matter gives rise to issues that will arise frequently, and are of first impression, do not satisfy the requirements set out by this Court for leave to appeal. Rather, 22 N.Y.C.R.R. § 500.22(b)(4) sets forth three (3) requirements for appeal, none of which are met here. Specifically, Petitioner-Appellant does not identify any point, or principle of insurance interpretation that raises an issue of novel or public

importance, presents a conflict with a prior decision of this Court, or involves a conflict amongst the departments of the Appellate Division. The issues presented in this matter require application of well-settled and long-standing canons of construction for insurance policy interpretation. Therefore, Petitioner-Appellant cannot satisfy the novel or public importance criteria. There is also no inconsistently between the First Department's unanimous Order and the decisions of the other departments or the Court of Appeals. Petitioner-Appellant has not written any support that it meets any of the criteria for leave to appeal to the Court of Appeals.

Petitioner-Appellant's reference to the insuring agreement at issue here as a "standard form insuring agreement for a computer fraud insurance policy" is wrong and has no bearing on whether appeal should be granted. Petitioner-Appellant's Brief at 11. At issue here is the Computer System rider to a Fidelity Bond. Thus, contrary to Petitioner-Appellant's arguments, the matter does not raise important questions about the meaning and scope of a standard industry insurance form. Rather, as the First Department unanimously held, this matter involves the interpretation of the Computer Systems rider which, based on a plain reading, does not afford coverage for Petitioner-Appellant's underlying claims of Medicare fraud. The merits of the case are not at issue in this motion. The only issue presented by this motion is whether Petitioner-Appellant can demonstrate one

or more of the requirements for leave based on the criteria set forth in 22 N.Y.C.R.R. § 500.22(b)(4). Petitioner-Appellant cannot meet any of the criteria and so it has spent the vast majority of its motion on irrelevant arguments that go to the merits of the case.

The fact is that the First Department unanimously agreed with the Commercial Division that the Computer Systems rider which "covers loss from a fraudulent 'entry of electronic data' or 'change of electronic data' within the insured's proprietary computer system, applies to wrongful acts in manipulation of the computer system, i.e., by hackers, and did not provide coverage for fraudulent content consisting of claims by bona-fide doctors and other health care providers authorized to use the system for reimbursement for health care services that were not provided." (*See* Petitioner-Appellant's Brief, Appendix 11-12). Petitioner-Appellant's contrary reading of the policy as affording coverage for run-of-the-mill Medicare fraud where padded and inflated bills are submitted by bona-fide doctors is a radical and unreasonable construction of the policy language and was properly rejected by the Commercial Division and the First Department. Such "Medicare Fraud Insurance" is simply not part of the coverage grant. Petitioner-Appellant's motion in support of leave rehashes the arguments it made before the Commercial Division and the First Department, all of which were unanimously and consistently rejected. Petitioner-Appellant's disagreement with the lower courts do not warrant

review by this Court and is not among the requirements that this Court looks at when determining leave to appeal. Accordingly, there is no reasonable basis to grant leave under any of the factors that have been enunciated by this Court.

1. The Courts Below Applied the Correct Legal Standards Governing The Interpretation of Insurance Policies

Not only has Petitioner-Appellant's argument with respect to the interpretation of the Computer Systems rider been soundly defeated, Petitioner-Appellant's argument here has nothing to do with whether leave to the Court of Appeals should be granted. There are three (3) well-defined reasons this Court will consider in granting leave to appeal, and disagreement with the ultimate decision of a lower court is not one of them. *See* 22 N.Y.C.R.R. § 500.22(b)(4). Nevertheless, to address Petitioner-Appellant's wayward objections to the merits of the case, even though the merits are not at issue here, the First Department was not wrong let alone, "doubly wrong" as Petitioner-Appellant contends, in its approach to policy interpretation. Rather, the following crucial determinations were made in concluding the policy at issue is not ambiguous and that coverage applies where the entry is fraudulent – such as where a hacker gains entry to a computer system:

- Rider #3 has two headings, Computer Systems and Computer Systems Fraud and no heading which refers to the content of medical claims submitted to the system.

- The headings indicate coverage is directed at misuse or manipulation of the system itself rather than through submissions of fraudulent bills.

- Rider #3 states that it covers "fraudulent entry" of Electronic Data (rather than entry of fraudulent data).

(*See* Petitioner-Appellant's Brief, Appendix 4-6). Accordingly, based on this analysis the Commercial Division concluded and the First Department unanimously agreed that "[t]he clause at issue in this case is not ambiguous." (*See id.*). National Union explicitly and without ambiguity limits coverage to claims resulting from fraudulent entry of Electronic Data or Computer Program into Universal American's Proprietary Computer System. It is uncontroverted that here, the physicians and healthcare providers were authorized to submit medical bills for reimbursement by Universal American. They did not fraudulently enter Universal American's computer system. Rather the medical bills, meaning the data itself, were fraudulent in that they were padded by the healthcare providers and contained charges for procedures that were not performed and/or patients they had not seen. The approach used by the First Department, and the motion court, such as reviewing the policy as a whole, and affording the plain meaning to the words of the policy, are in accord with well-settled principles of insurance construction.

Petitioner-Appellant conflates the test used to determine whether an ambiguity exists in an insurance contract with the notion that any imaginative

reading of the policy by the insured must be accepted by the reviewing court. This is not the case. Throughout this litigation, Petitioner-Appellant routinely omitted the word "entry" in its interpretation of the Computer Systems rider, and argued that coverage was afforded for losses resulting from "fraudulent data." This interpretation has been consistently found to be unreasonable and not applicable to the Computer Systems rider here. The fact that the First Department rejected Petitioner-Appellant's strained and unreasonable alternative reading of the Computer Systems rider which would have required coverage for Medicare fraud was not in error, but rather based upon a plain reading of the policy as a whole. The First Department did not ignore the ordinary meaning of the words used in the Computer Systems rider. Nor did the First Department fail to make the full inquiry required in interpreting an insurance contract. Instead, the First Department unanimously agreed that "the motion court properly interpreted the policy as a matter of law," and based upon the correct and well-accepted approach to policy interpretation, found that the "unambiguous plain meaning" of the Computer Systems rider does not provide coverage for Petitioner-Appellant's claimed loss. (*See* Petitioner-Appellant's Brief, Appendix 11).

Petitioner-Appellant's statement that insuring agreements are interpreted "highly favorable to the insured" is wrong and has been soundly rejected. In New York, insurance policies are interpreted the same as any ordinary contract. *See*

Tribeca Broadway Assocs. LLC. v. Mount Vernon Fire Ins. Co., 5 A.D.3d 198, 200, 200-01 (1st Dept. 2004); *Bretton v. Mut. of Omaha Ins. Co.*, 110 A.D.2d 46, 49, 492 N.Y.S.2d 760, 763 (1st Dept. 1985) (citing *Caporino v. Travelers Ins. Co.*, 62 N.Y.2d 234, 239, 476 N.Y.S.2d 519, 521 (1984). Where a policy provision is clear and unambiguous, as the Computer Systems rider was found to be here, the Court should not limit its effect by a strained construction. *See Parks Real Estate Purchasing Group v. St. Paul Fire & Marine Ins. Co.* 472 F.3d 33, 42 (2d Cir. 2006).

Given that the Court found that there was no ambiguity, and give that Court's determination did not implicate an exclusionary clause, there are no special canons of construction that apply here that would require the Court to apply a more favorable reading to the insured. Indeed, Petitioner-Appellant's snippet of quoted language from *Pioneer Tower* is just as misleading in these motion papers as it was in its papers before the First Department, and the Commercial Division. To clarify the record, *Pioneer Tower* addresses the canon of construction in interpreting exclusionary clauses which are generally construed more favorably to the insured. *Pioneer Tower Owners v. State Farm Fire & Cas. Co.*, 12 N.Y.3d 302, 306, 880 N.Y.S.2d 885, 886 (2009). The Computer Systems rider at issue here is not an exclusionary clause, but rather it is the insuring agreement. Therefore, as the Commercial Division found, and the First Department unanimously affirmed,

Pioneer Tower Owners, and the interpretive principle set forth therein, is not applicable to the analysis here. Contrary to Petitioner-Appellant's position, the court's job is not to rewrite the policy, provide more coverage to the insured than what was intended, or search the policy to find any way to afford coverage. *U.S. Trust Co. of New York v. Jenner*, 168 F.3d 630, 632 (2d Cir. 1999); *see also Gov't Employees Ins. Co. v. Kliger*, 42 N.Y.2d 863, 864, 397 N.Y.S.2d 777, 778 (1977) (stating that "where the provisions of the policy are clear and unambiguous, they must be given their plain and ordinary meaning, and courts should refrain from rewriting the agreement.").

Further, Petitioner-Appellant's argument that the First Department somehow erred by gleaning the intent of the parties by the words of the policy is flatly wrong and not a basis for leave to appeal to the Court of Appeals. Contracts "are construed in accord with the parties' intent. The best evidence of what parties to a written agreement intend is what they say in their writing. Thus, a written agreement that is complete, clear and unambiguous on its face must be enforced according to the plain meaning of its terms." *See Millennium Holdings LLC v. Glidden Co.*, Slip Copy, 2013 WL 6182552, N.Y. Sup. 2013 (Nov. 25, 2013) quoting *Greenfield v. Philles Records, Inc.*, 98 N.Y.2d 562, 569 (2002); 68A N.Y. Jur.2d Insurance § 857 (In interpreting an insurance policy "[p]articular words in an insurance policy should be considered, not as if isolated from the context, but in

the light of the obligation as a whole and the intention of the parties as manifested thereby." (internal citations omitted)).

Accordingly the Appellate Division, First Department recited the correct interpretive principles and Petitioner-Appellant cannot show a pressing need for review by this Court.

2. The Appellate Division Did Not Ignore the Ordinary Meaning of the Policy Language

The First Department did not ignore the ordinary meaning of the Computer Systems rider, nor is it a basis for leave to appeal. Petitioner-Appellant's argument in this regard is merely a continuation of its focus on the merits which do not fall under any of the reasons for leave to appeal as set forth in this Court's rules. Petitioner-Appellant's disagreement over the plain and ordinary meaning of the Computer System rider does not give rise to something novel, or of public importance. It is also not in conflict with other departments or with this Court. In short, it goes to the merits, and has no place in a motion for leave to appeal. Petitioner-Appellant is using this motion improperly as a vehicle to assail the First Department's Order which unanimously affirmed the Commercial Division and dismissed the matter against National Union it its entirety, finding no coverage.

The First Department unanimously agreed with the Commercial Division in finding that the words of the Computer Systems rider, which "covers loss from a fraudulent 'entry of electronic data' or 'change of electronic data' within the

insured's proprietary computer system, applies to wrongful acts in manipulation of the computer system, i.e., by hackers, and did not provide coverage for fraudulent content consisting of claims by bona fide doctors and other health care providers authorized to use the system for reimbursement for health care services that were not provided." (*See* Petitioner-Appellant Brief, Appendix 11-12). Petitioner-Appellant's argument based upon its recycled analysis of the term "fraudulent" was soundly rejected by the Commercial Division and the First Department. Similarly, Petitioner-Appellant's omission of the term "entry" in its interpretation of the Computer Systems rider, in favor of "fraudulent data" was rejected as having no basis in the language of the policy. Most importantly, Petitioner-Appellant's disagreement with the First Department rejection of Petitioner-Appellant's unreasonable construction of the Computer System rider, does not rise to the level of a novel issue, of public importance, and it does not demonstrate a conflict with this Court or a conflict with the other departments. In short, Petitioner-Appellant has not made out a basis for leave to appeal.

Petitioner-Appellant's comparative analysis of the term "fraudulent" and "unauthorized" has no effect on coverage, and, most importantly with respect to the within motion, has no relevance to the standards set out by this Court for leave to appeal. Petitioner-Appellant's proffered definition of the term "fraudulent" is anything but straightforward and designed to create the appearance of an ambiguity

where none exists. While Merriam-Webster's defines the term "fraudulent" simply as an adjective meaning to "trick someone for the purpose of getting something valuable," available at *http://www.merriam-webster.com/dictionary/fraudulent*, Petitioner-Appellant takes this unambiguous word and attempts to turn its meaning on its head by analyzing it against phrases such as "fraudulent statement" as found in *Eurycleia Partners LLP v. Seward & Kissel LLP*, 12 N.Y.3d 553, 559, 883 N.Y.S.2d 147, 150 (2009) which discusses the cause of action for fraud, and *Mikes v. Straus*, 274 F.3d 687, 696 (2d Cir. 2001) a case that discusses the False Claims Act. Both of these cases have no bearing on the context here. Petitioner-Appellant's motion for leave to appeal should be denied. As the Commercial Division noted "[t]he clause at issue in this case is not ambiguous. The policy does not extend as far as providing coverage for fraudulent claims which were entered into the system by authorized users." (*See* Petitioner-Appellant's Brief, Appendix 6). Petitioner-Appellant's attempt to create an ambiguity where none exist should be ignored as irrelevant to this Court's determination of whether leave to appeal should be granted.

Further, Petitioner-Appellant's hypothetical involving a crooked accountant is nonsensical. The fictional wayward accountant is a tale that acts out Petitioner-Appellant's jumbled reading of the Computer Systems rider and is not based on either fact or law. The fictional accountant story has absolutely no relevance to the

standards required for leave to appeal, but is based purely on Petitioner-Appellant's counsel's imagination. Similarly, Petitioner-Appellant's recycled discussion about the difference between "fraud" and "unauthorized" is also immaterial. This argument too has been rejected twice. (*See* Petitioner-Appellant's Brief, Appendix 4-6, 11-12). The term "authorized" is a descriptive term to make clear that the act of entering the computer system was not fraudulent because the providers had the necessary credentials to submit electronic invoices. Petitioner-Appellant's analysis of the term "authorized" versus "fraudulent" does not affect coverage and it certainly does not affect whether the issues presented in this matter are leave worthy. The First Department unanimously offered that coverage is only afforded to losses from the fraudulent entry of electronic data. No fraud was committed in entering the computer system – the prerequisite for coverage here based upon a plain reading of the Computer Systems Fraud Insuring Agreement. The Computer Systems rider is about "fraudulent entry" and no amount of linguistic acrobatics and reordering of the words in the policy can change that.[1]

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[1] Petitioner-Appellant's footnote criticizing the lower courts' review of the policy headings is misguided. Courts are required to "adopt an interpretation which gives meaning to every provision of a contract or, in the negative, no provision of a contract should be left without force and effect." *Muzak Corp. v. Hotel Taft Corp.*, 1 N.Y.2d 42, 46, 150 N.Y.S.2d 171 (1956). The headings and the language in the Computer Systems rider consistently indicate that the Computer Systems rider covers those instances when the loss incurred because of "fraudulent entry" into Petitioner-Appellant's computer system. Here, the courts appropriately viewed the policy as a
(Footnote continued on next page)

3. The Lower Courts Determined that there is only one Reasonable Construction of the Policy Language

As the Commercial Division found, and the First Department unanimously affirmed, there is only one reasonable reading of the Computer Systems rider which is that the Computer System rider covers losses "resulting directly from a fraudulent entry of electronic data or computer program into . . . the Insured's Proprietary Computer System" i.e., such as in the case of a hacker as the First Department found. (*See* Petitioner-Appellant's Brief, Appendix 4-6, 11-12).

The unreasonableness of Petitioner-Appellant's interpretation of the Computer Systems rider has been demonstrated at each phase of the litigation. The fatal flaw of Petitioner-Appellant's argument, and the reason Petitioner-Appellant's reading has been found unreasonable, is it necessarily rests upon omitting key words from the Computer Systems rider (i.e., the terms "Computer Systems" and "Computer Systems Fraud"), the reordering of other words (i.e., "fraudulent entry" into the nonexistent phrase "fraudulent data"), and convoluted definitions of otherwise unambiguous words (i.e., "entry" and "fraudulent"). The result of Petitioner-Appellant's interpretation of the Computer Systems rider is also unreasonable given that it would afford coverage to run-of-the-mill Medicare fraud

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(Footnote continued from previous page)
whole and gleaned guidance from the headings, "Computer Systems" and "Computer Systems Fraud".

affording coverage each time a doctor padded or inflated medical bills. The First Department reviewed the policy and found it clear and unambiguous and in so doing rejected Petitioner-Appellant's strained and overly broad reading of the policy. Petitioner-Appellant has not raised any reason enunciated in this Court's rules that would permit leave to appeal. Canons of insurance policy are well-settled and the Commercial Division and First Department properly utilized them in interpreting the Computer Systems rider at issue.

4. The Lower Courts' Construction of the Policy Language Does Not Render the Policy Meaningless

Just as with Petitioner-Appellant's arguments above, Petitioner-Appellant's argument that the Commercial Division and First Department's construction of the policy language renders the Computer Systems rider meaningless has been uniformly rejected by the lower courts here and do not form a basis for leave to appeal. Insurance coverage will only be deemed illusory where an insured is foreclosed from recovering benefits under any reasonably expected set of circumstances. *See Schwartz v. State Farm Mut. Auto. Ins. Co.* 174 F.3d 875, 879 (7th Cir. 1999). Coverage will not be deemed illusory where the insured can recover for at least one anticipated risk. Here, the First Department affirmed that coverage is afforded against loss due to an outsider using a computer to steal money by hacking into an insured's database. The Computer Systems rider is not illusory simply because it does not cover Petitioner-Appellant's efforts for

reimbursement for losses allegedly incurred because its doctors and healthcare workers billed it for services they did not perform. Nothing with respect to Petitioner-Appellant's argument gives rise to leave to appeal.

Petitioner-Appellant's theory that a hacker could only cause a loss if the hacker were working in concert with a medical provider is incorrect and misses the mark. The issue before this Court is whether leave to appeal is warranted. Petitioner-Appellant has not specified any of the criteria that would warrant leave to appeal to this Court. As the First Department explicitly stated, the Computer Systems rider "did not provide coverage for fraudulent content consisting of claims by bona fide doctors and other health care providers authorized to use the system for reimbursement for health care services that were not provided." (*See* Petitioner-Appellant's Brief, Appendix 11-12).

Like the story of the crooked accountant, Petitioner-Appellant's story of the colluding doctor and hacker are fictions designed to match the fictional policy Petitioner-Appellant tries to draft. Petitioner-Appellant takes the term "fraudulent entry of Electronic Data into" Petitioner-Appellant's computer system, and jumbles the order so the policy reads "entry of fraudulent electronic data into" Petitioner-Appellant's computer system. Petitioner-Appellant then creates fictional scenarios, such as the stories of the crooked accountant the colluding hacker and doctor, and applies its newly created fictional policy to try and

convince this Court that leave to appeal is warranted. However, the First Department, and the motion court, correctly rejected Petitioner-Appellant's incredibly convoluted machinations of the policy language and dismissed its case. Petitioner-Appellant has indulged in repetitive arguments on issues that have already been considered fully and correctly. There is simply no reason to grant leave to appeal.

With respect to Petitioner-Appellant's argument about premiums and deductibles, the amount of risk an insured is willing to absorb in deductible amounts has absolutely no bearing on the type of risk being insured for or policy interpretation or reargument or leave to appeal for that matter. Petitioner-Appellant has presented no factual or legal support for it argument regarding the deductible.

Petitioner-Appellant's motion plainly fails to discuss, let alone meet, the strict standards set out for leave to appeal and therefore Petitioner-Appellant has not demonstrated entitlement for leave to appeal to the Court of Appeals.

5. This Matter Involves Interpretive Principles of Insurance Coverage which are Not Novel or Leave Worthy

This case involves well-settled principles of insurance contract interpretation which do not give rise to Court of Appeals review. Petitioner-Appellant's statement that this is a computer fraud case is wrong. It is not a computer fraud case. It is an insurance coverage case where the Appellate Division, First

Department and the Commercial Division appropriately utilized standard rules of policy construction and found that the Computer Systems rider, based on a plain reading, does not cover Medicare fraud. Thus, Petitioner-Appellant's statement that computer fraud is implicated here is wrong. The underlying claims of this coverage action implicated Medicare Fraud. Universal American is in the best position to institute oversights and controls with respect to Medicare fraud. Universal American presently does have oversights with the healthcare providers who are given access to its plan. In fact, Universal American does provide Medicare fraud risk reduction to its providers. Universal American's website indicates that it provides training to its healthcare providers with respect to Medicare fraud prevention. Petitioner-Appellant is uniquely suited to guard against Medicare fraud through controls instituted.

The gravamen of this litigation is the Computer Systems rider. Thus, as with any insurance coverage dispute, the resolution of this case depends upon the meaning of the words in the insuring agreement. The legal principles involved in interpreting the policy provision are all well-settled and well-established canons of insurance policy interpretation. This is not an issue of first impression given that these interpretative rules are long-standing. Indeed, there is simply nothing novel about analyzing insurance policies that warrant review by the Court of Appeals.

Petitioner-Appellant did not and cannot point to actual codified criteria that would merit leave to appeal to the Court of Appeals. Petitioner-Appellant had to resort to outdated case law in the 1920s to try to ascertain a reason for leave to appeal to this Court. Not only did Petitioner-Appellant cite an outdated reason for leave to appeal to the Court of Appeals, it inexplicably argues that the unanimous decision by the Appellate Division, First Department, is "doubly wrong." Petitioner-Appellant already tried to obtain leave to appeal the affirmance of the summary judgment by the Commercial Division. The Appellate Department, First Department, denied Petitioner-Appellant's motion for leave because Petitioner-Appellant failed to meet its burden to merit leave to appeal. Petitioner-Appellant again has failed to meet its burden in this motion. Accordingly, Petitioner-Appellant's motion should be denied in its entirety.

CONCLUSION

For all the foregoing reasons, this Court should deny Petitioner-Appellant's motion for leave to appeal from the First Department's order.

Dated: May 1, 2014
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