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INNOVATIONS IN THE ORGANIZATION OF HEALTH SERVICES: INHIBITING vs. PERMISSIVE REGULATION

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The National Commission on Community Health Services has recommended as a national health goal that the American people have a civic right to the best attainable personal health care at the least cost.[1] In order to achieve this goal, the United States requires increases in both the numbers and productivity of medical service personnel. Since we cannot produce the quantity of doctors needed overnight, we must concentrate on the most efficient use of the available manpower.[2] The latter goal can be furthered by changes in the organization of health services, such as increased development and use of group practice,[3] institutional practice,[4]

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1. THE NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR, 17-37 (1966) [hereinafter cited as NAT'L COMM'N REPORT].

2. *See* NAT'L COMM'N REPORT 23, 24; *see also* REPORT OF THE GOVERNOR'S COMM. ON HOSP. COSTS (1965); *President's Message on Education and Health*, 25 CONG. Q. 319-22 (1967).

3. "Group medical practice can be defined as the application of medical service by a number of physicians working in systematic association with the joint use of equipment, technical personnel and utilizing centralized administration and financial organization." AMERICAN MEDICAL ASS'N, DIGEST OF OFFICIAL ACTIONS 1846-1958, at 332 (1959). Later recommedations of the A.M.A. have suggested a minimum number of three physicians to constitute group practice. The U.S. Public Health Service defines group practice as a formal association of three or more physicians generally providing services in more than one specialty with income being pooled and distributed according to a prearranged plan. *See* HUNT & GOLDSTEIN, MEDICAL GROUP PRACTICE IN THE UNITED STATES 1 (P.H.S. Pub. No. 77, 1951).

There are no legal barriers to physicians' associations as such. Many group practices are simply partnerships, and the medical partnership has never been challenged as an illegal form of medical practice.

4. Institutional practice can be defined as practice in which non-profit hospitals or other institutions such as medical schools or clinics employ salaried physicians to render a full array of personal health care to all patients served by the hospital or institution on an in or out patient basis.

and multi-disciplinary health care teams.[5] These modern practices provide more comprehensive and accessible patient service than do independent practitioners because they more effectively utilize a wider variety of special skills, paramedical assistance, and technical equipment.[6] The completely independent practice of medicine seems no longer either scientifically or economically feasible.[7]

The problem of the rising costs of health care, particularly hospital care,[8] can be met through innovations in prepaid health care coverage. Comprehensive prepayment programs[9] will not only help to control rising costs but may increase the productivity of health personnel. By combining preventive, diagnostic, therapeutic, and rehabilitative services, such programs allow these services to be managed as a single health care system.[10]

This article concerns the effect of current legal rules upon the possibility of developing non-profit, consumer-sponsored, prepaid comprehensive health-service programs. Concomitantly considered are the effects of existing law upon physician sponsored plans, such as Blue Shield, and upon institutional practice under which non-profit hospitals or other institutions employ salaried physicians. The legal areas covered include:

1. Rules prohibiting the corporate practice of medicine;
2. Enabling acts permitting the operation of prepaid health-service plans;
3. Insurance codes and regulations protecting the public against fraudulent or financially unstable prepayment plans; and
4. Restraint-of-trade rules protecting prepayment plans against harassment and interference.

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5. Multi-disciplinary health care teams can be defined as formally or informally organized groups consisting of physicians, professional nurses, practical nurses, medical technologists, physical therapists, clinical psychologists and medical or psychiatric social workers who have the coordinated responsibility for planning and delivering personal health care to patients served by a hospital or institution rendering medical care.

6. CITIZENS' COMM'N ON GRADUATE MEDICAL EDUCATION, THE GRADUATE EDUCATION OF PHYSICIANS 24-26 (1966). *See also* NAT'L COMM'N REPORT 24.

7. *See* CITIZENS' COMM'N ON GRADUATE MEDICAL EDUCATION, *supra* note 6, at 24-25.

8. *See generally* REPORT OF THE GOVERNOR'S COMM. ON HOSP. COSTS, *supra* note 2.

9. For a definition and explanation of prepaid health care coverage, see notes 44-53 *infra*, and accompanying text.

10. *See* NAT'L COMM'N REPORT, *supra* note 1, at 17-38. Prepaid programs may also reduce hospital utilization and thereby reduce total costs of care by providing prepaid coverage for out-patient and preventive services.

I. The Rule Against the Corporate Practice of Medicine

A. *Rationale and Application*

Rules prohibiting the corporate practice of medicine, which resulted from judicial interpretations of medical and dental practice acts,[11] currently exist in all states except Missouri[12] and Nebraska.[13] The following is a typical statement of the rule and its rationale:

> While a corporation is in some sense a person, and for many purposes is so considered, yet, as regards the learned professions which can only be practiced by persons who have received a license to do so after an examination as to their knowledge of the subject, it is recognized that a corporation cannot be licensed to practice such a profession.[14]

This rule has been produced by mandatory professional licensure. Licensure statutes specifically enumerate those individuals permitted to render health services; because these do not include corporations, they are not permitted to practice. As generally applied, the rule also prevents the practice of medicine (or surgery or dentistry) by a corporation even through licensed employees. The rule may not be applied, however, if the services being performed by the corporation are performable by other than licensed individuals.[15]

The rule prohibiting corporate practice is enforced primarily by the courts, but opinions of attorneys general[16] and decisions of professional disciplinary boards[17] contributed to its development. In recent years, ju-

11. *See generally* Willcox, *Hospitals and the Corporate Practice of Medicine,* 45 Corn. L. Q. 432 (1960); Hansen, *Group Health Plans—A Twenty-Year Legal Review,* 42 Minn. L. Rev. 527 (1958).

12. *See* Sager v. Lewin, 128 Mo. App. 149, 106 S.W. 581 (1907) (a corporation may contract with doctors of medicine to furnish medical care and may properly be chartered for that purpose); 1962 Op. Att'y Gen. No. 8 (Mo.) (contracting with licensed medical practitioners to furnish medical care does not constitute the practice of medicine).

13. *See* Tarry v. Johnston, 114 Neb. 496, 208 N.W. 615 (1926) (making contracts and collecting compensation therefore is not practicing medicine); State Electro-Medical Institute v. State, 74 Neb. 40, 103, N.W. 1078 (1905); State Electro-Medical Institute v. Platner, 74 Neb. 23, 103 N.W. 1079 (1905).

14. Willcox, *supra* note 11, at 438.

15. *See id.* at 444-59.

16. *See* opinions cited notes 24-27, 39 *infra;* 1957 Op. Att'y Gen. WW-278 (Tex.) ruling that it is corporate practice and a violation of the licensing act for a corporation to employ a licensed physician to treat patients and itself receive the fee.

17. *See, e.g.,* State Bd. v. Savelle, 90 Colo. 177, 8 P.2d 693 (1932) (dentistry—one of the "Painless Parker" cases); Taber v. State Bd., 137 N.J.L. 392, 60 A.2d 290 (1948) (dentist cannot be employed by unlicensed layman); Rockett v. Texas State Bd. of Medical Examiners, 287 S.W.2d 190 (Tex. Ct. Civ. App. 1956) (violation of medical licensing law for doctor to be employed by clinic owned by layman).

dicial interpretations have been explicitly accepted by several legislatures which have enacted statutory amendments embodying the rule.[18]

The evil that this rule was intended to combat was the use of the corporate form by unscientific or unethical practitioners in furtherance of their commercial motives.[19] It has modern relevance not only in preventing quackery, deception, and commercial exploitation, but, more significantly, in preventing lay interference with acts or decisions requiring professional judgment and in preventing division of professional loyalty between patients' interests and those of the corporation.[20] Unfortunately, the rule has occasionally evolved into a categorical prohibition of all corporate practice, without any necessary relation to the evils it is designed to prevent.

Despite the rule's limited purposes, courts and attorneys general in a majority of recent decisions have used a formalistic approach. Some courts have found the corporate form not controlling if the corporation was nonprofit, operated for the mutual benefit of its members, and did not hold itself out as practicing medicine.[21] Generally, however, decisions have been based upon the mere existence of the corporate form rather than upon how particular forms of organization actually affect the quality of health services.[22] Profit-making corporations, commercialized painless dentists, optometrists working in jewelry stores, and chiropractors are gener-

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18. *See, e.g.,* COLO. REV. STAT. ANN. § 91-1-17(1) (n) (1963) (physician may not practice as employee of corporation, association or partnership); GA. CODE ANN. § 84-916(18) (1957) (ground for license revocation for doctor to assist unlicensed associations or corporations); ME. REV. STAT. ANN. tit. 32 § 3751 (1964) (no person or corporation may practice a healing art unless licensed); WIS. STAT. ANN. § 147.225(3) (b) (1959) (no employer-employee relationship permitted between hospitals and physicians not permitted to receive salaries).

19. *See, e.g.,* Silver v. Lansburgh & Bros., 27 F. Supp. 682 (D.D.C. 1939); Funk Jewelry Co. v. State *ex rel.* La Prade, 46 Ariz. 348, 50 P.2d 945 (1935); State *ex rel.* Att'y Gen. v. Gus Blass Co., 193 Ark. 1159, 105 S.W.2d 853 (1937); Parker v. Board of Dental Examiners, 216 Cal. 285, 14 P.2d 67 (1932); People v. Painless Parker Dentist, 85 Colo. 304, 275 P. 928 (1929); State Bd. of Examiners v. Friedmans' Jewelers, Inc., 183 Ga. 669, 189 S.E. 238 (1936); Dvorine v. Castelberg Jewelry Corp., 170 Md. 661, 185 A. 562 (1936); Bartron v. Codington County, 68 S.D. 309, 2 N.W.2d 337 (1942). *See generally* Willcox, *supra* note 11.

20. *See* Willcox, *supra* note 11, at 444-45.

21. *See, e.g.,* Group Health Ass'n v. Moor, 24 F. Supp. 445, 446 (D.D.C. 1938). The court made a distinction between a profit-oriented scheme such as the commercial dentists and non-profit group health plans, which presented none of the social evils requiring enforcement of the rule.

22. *See generally* LAW DEP'T OF THE AMERICAN MEDICAL ASS'N, A STUDY RELATING TO THE CORPORATE PRACTICE OF MEDICINE IN THE UNITED STATES. This report provides numerous examples of the formalistic reasoning followed by courts and attorneys general throughout the United States.

ally lumped together with non-profit hospitals or service plans employing physicians.[23]

The California attorney general, for example, ruled that a non-profit hospital corporation could not be permitted to contract with physicians for the performance of professional services for fixed salaries because such contracts would tend to debase the profession and jeopardize the public health, safety, and welfare.[24] The Colorado attorney general refused to make any distinction between profit-making and non-profit corporations.[25] Perhaps the most extreme illustrations of this formalistic approach is provided by two opinions from Idaho attorneys general. One ruled that a hospital employing radiologists, anesthesiologists and pathologists was in violation of state law because of the hospital's potential control over them.[26] A subsequent attorney general, while sustaining his predecessor's opinion, offered to prepare a leasing agreement between a physician and a hospital which would allow the hospital to collect the physician's fees, furnish all of his facilities, provide for fair compensation to the physician and hospital, and yet not involve potential control of the physician by the hospital.[27] This opinion solved the control problem simply by labeling physicians as tenants, rather than as employees. It did not examine the actual opportunities for control in either situation. If it is possible to draw a leasehold contract which avoids potential lay control of a professional tenant, it should also be possible to preclude such potential through specific terms of an employment contract.

B. *Comparison with the Practice of Law*

The prohibition against corporate practice exists in the legal profession as well as the medical profession. Rules against corporate legal practice are now being reviewed because courts and legislatures recognize the demand for legal services in criminal actions, and now civil actions also.[28]

23. *Cf.* cases cited note 19 *supra.*

24. 2 OP. ATT'Y GEN. No. 48-32 (Cal. 1948).

25. 1954 OP. ATT'Y GEN. No. 2699-54 (Colo.). The opinion stated that the profit motive only affects the likelihood of the exercise of control rather than the power to exercise control. The power alone rather than the probability of its exercise governed this ruling; *cf.* 1956 OP. ATT'Y GEN. No. 056-322 (Fla.) (distinguishing between a non-profit hospital (where an employment relation was disallowed) and a publicly financed hospital (where it was allowed)).

26. 1954 OP. ATT'Y GEN. (Idaho May 26).

27. 1955 OP. ATT'Y GEN. (Idaho July 11).

28. *See* Brotherhood of R.R. Trainmen v. Virginia *ex rel.* Virginia State Bar, 377 U.S. 1 (1964); NAACP v. Button, 371 U.S. 415 (1963). *See also* Cheatham, *Availability of Legal Services: The Responsibility of the Individual Lawyer and of the Organized Bar,* 12 U.C.L.A.L. REV. 438 (1965).

In analyzing cases involving unauthorized practice of law, the courts look not to mere forms but to practical realities. While any case may involve particular possibilities of abuse of clients, courts often find such possibilities outweighed by the overriding necessity of assuring adequate, low-cost legal services.[29] It has been held that a non-profit legal assistance corporation may use a group of laymen to advise it on broad questions of policy, but the corporation must be controlled and supervised by attorneys who are directly responsible to the courts for the maintenance of professional standards.[30]

Although personal health services have never been held to be an enforceable right, Congress and state legislatures have recognized the importance of some services by publicly subsidizing them.[31] This recognition should be sufficient reason for the courts and attorneys general to treat corporate medical practice as they treat corporate legal practice.[32] The courts should balance protection of the public from abuses, such as lay control over professional acts and judgments, against the necessity of high quality, low-cost, comprehensive, and accessible personal health services.

C. *Recognition in Tort Law of the Institutionalization of Health Services*

In the preceding article, Professor Arthur Leff analyzed numerous malpractice cases affecting the delegation of tasks to health personnel. Three of these cases require attention here because they reflect, in the tort area, a growing recognition of trends in health care, such as increasing institutionalization, that have been ignored by courts when faced with corporate practice questions.

In *Bing v. Thunig*,[33] the New York Court of Appeals noted changes in the health-service role of hospitals:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but

29. *See generally* Comment, 54 CAL. L. REV. 1361 (1966).

30. Application of Community Action for Legal Services, Inc. 26 App. Div. 2d 354, 274 N.Y.S.2d 779 (1966). Comment, *supra* note 29, at 1362-63.

Society can guarantee equal justice only by providing all citizens with effective access to the institutions by which justice is obtained and by making a lawyer's services accessible to all, even his assistance in changing laws. Note, *Neighborhood Law Offices: The New Wave in Legal Services for the Poor,* 80 HARV. L. REV. 805 (1967).

31. The trend in federal health legislation since the enactment of the Social Security Act of 1935 establishes a national policy of extending comprehensive health services to all of the American people. *See* Bok, *Emerging Issues in Social Legislation: Social Security,* 80 HARV. L. REV. 717 (1967).

32. *Cf.* Application of Community Action for Legal Services, Inc., 26 App. Div. 2d 354, 274 N.Y.S.2d 779 (1966).

33. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

> undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. . . . [T]he person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him. . . .[34]

By this language the court demonstrated its singular awareness of the changing attitude towards health care services.

In *Manlove v. Wilmington General Hospital,*[35] a Delaware Superior Court held that a private hospital that received funds and publicly solicited tax free subscriptions was equivalent to a public service agency and therefore required to render emergency services. That characterization was rejected by the Delaware Supreme Court, but it concluded that if a private hospital maintains an emergency room and holds itself out to the public as providing emergency service, it is required to render services when it reasonably determines that an emergency exists.[36] The important point is that it is the hospital, not the doctors who work in it, which is responsible for making the emergency service available.

In *Darling v. Charleston Community Memorial Hospital,*[37] the plaintiff was taken to the defendant hospital's emergency room to be treated for a broken leg. The hospital was accredited by the Joint Commission on Accreditation of Hospitals. As a result of the attending physician's negligence, gangrene developed, requiring below-the-knee amputation. After settling his claim against the physician, the plaintiff sued the hospital alleging that its administrators had not exercised proper care in attending to his condition. The hospital contended that it had no duty to supervise the care given by the attending physician, and no duty to require the use of consultant physicians. In deciding for the plaintiff, the court stated that the duty of a hospital to a patient is not fulfilled merely by utilizing the means at hand in the community if they are not appropriate to the risk and if proper resources are readily available elsewhere. The court disallowed the hospital's contention that the corporate practice rule precluded tort liability based on the acts of one of its staff members. The court emphasized that the hospital must use reasonable care to retain only qualified physicians on its staff. An additional basis for the court's holding was the hospital's failure to comply with its by-laws and with standards of the Joint Commission an Accreditation, both of which required consultation in difficult cases.

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34. *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

35. 53 Del. 338, 169 A.2d 18 (1961).

36. Wilmington Gen. Hosp. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961).

37. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied,* 383 U.S. 946 (1966), *aff'g* 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964).

If the *Manlove* case makes the hospital responsible to provide care, the *Darling* decision indicates the possibility of the hospital's responsibility for its quality. All three cases indicate that increasing institutionalization of health services will receive judicial recognition and will be reflected in tort liability. This recognition, coupled with increased public interest in health services, will require a re-examination of those precedents in tort liability which conflict with current standards and practices in health-service performance.[38]

D. *Summary and Suggested Improvements*

When courts and attorneys general consider the corporate practice rule, they must recognize the present realities of providing personal health care. Legislation prohibiting corporations from practicing medicine is unnecessary; a corporation cannot diagnose and treat disease.[39] When a corporation contracts with persons to supply them with health services, it is not practicing medicine;[40] but, when a corporation contracts to purchase the professional services of physicians, its profit orientation may tempt it to cut costs by reducing the quality or the range of services offered—evils which the corporate practice rule was adopted to prevent. A possible solution is the non-profit corporation. By their articles of incorporation, these non-profit corporations could be required to confine their corporate activities to the economic aspects of medical or dental care; prevent lay judgments from interfering with the doctor-patient relationship; and observe ethical restrictions against advertising, solicitation, deception, or exploitation of the public.[41]

Legislative modification of the practice rule is a better and quicker method of change than interpretation of existing law by courts and attorneys general. Legislatures can formulate comprehensive policies regarding corporate health care activities that will promote institutional medical care while protecting against the evils that general recognition of corporate medical practice might entail. These statutory guidelines could be developed to aid courts and medical licensing agencies when they are

38. The *Darling* decision stated that the health profession and occupations may not set their own standards and unduly delay the adoption of new and available devices. *Id.* at 332, 211 N.E.2d at 257 (1965).

39. *See* 1956 MINN. ATT'Y GEN. REP. 80, 88; cases cited notes 12-13 *supra. But see* 1966 OP. ATT'Y GEN. No. 6179 (Ore.) (business and professional aspects of services are inseparable).

40. Some courts have distinguished non-profit group health plans from cases involving commercialization. *See, e.g.,* Group Health Ass'n v. Moor, 24 F. Supp. 445 (D.D.C. 1938).

41. *Id.*

called upon to resolve questions of possible abuse. Many legislatures have begun to make limited exceptions to the rule against corporate practice. For example, Ohio law was changed[42] so that corporations such as the Cleveland Clinic can now charge patients directly for physicians' services.[43] What is needed is a comprehensive revision that will permit full consideration of all sociological, economic, technological, and medical issues.

II. Enabling Acts for Prepaid Health-Service Plans

Prepaid health services may be provided by commercial insurance companies, by service companies sponsored by non-profit hospitals and physicians (Blue Cross and Blue Shield), and by non-profit consumer-sponsored organizations. Physician-sponsored plans are developed, organized, and managed by state and local medical associations. Consumer-sponsored plans are organized and managed by consumer groups, which employ a closed panel of physicians who are organized to practice as a group and are compensated by salary rather than fee-for-service. More than seventy-five per cent of the American people have prepaid health coverage of some form.[44]

Consumer-sponsored prepaid service plans faced initial and continuing legal difficulties because of the corporate practice rule.[45] In order to meet the public's demands for prepaid plans, physician-sponsored plans were initiated as an alternative. State legislatures had to pass specific enabling acts to avoid the application of the corporate practice rule to these physician-sponsored plans. Because some of these acts were broadly drawn, other prepayment plans have occasionally been able to come within their scope.

State enabling acts may be restrictive[46] or permissive.[47] The restrictive

42. Ohio Rev. Code Ann. § 1737.02 (1964).

43. *See* Cleveland Clinic v. Sombrio, 35 Ohio 2d 112, 215 N.E.2d 740 (1966).

44. Report of the Governor's Comm. on Hosp. Costs 47-59 (1965).

45. People *ex rel.* State Bd. of Medical Examiners v. Pacific Health Corp., 12 Cal. 2d 156, 82 P.2d 429, *cert. denied,* 306 U.S. 633 (1938); Benjamin Franklin Life Assur. Co. v. Mitchell, 14 Cal. App. 2d 654, 58 P.2d 984 (1936); Pacific Employers Ins. Co. v. Carpenter, 10 Cal. App. 2d 592, 52 P.2d 992 (1935). *But see* Group Health Assn. v. Moor, 24 F. Supp. 445 (D.C.C. 1938), which held that a non-profit mutual benefit corporation would not be prohibited from operating.

46. H. Hansen, Legal Rights of Group Health Plans, 2-4 (1964) [hereinafter cited as Hansen]; *see, e.g.,* N.M. Stat. Ann. § 58-25-1 to 58-25-48 (Supp. 1967). Some of these provisions might also be mandatory and disallow all plans which fail to qualify under the restrictive provision. New Mexico is an example.

47. Hansen, *supra* note 46, at 2-4; *see, e.g.,* N.C. Gen. Stat. §§ 57-1 to 57-20 (Supp. 1965).

acts are those that allow physician-sponsored prepayment plans only.[48] Those that permit consumer-sponsored plans as well are called permissive.[49] Restrictive acts may be unconstitutional either because they violate due process or because they delegate public functions to private medical societies.[50] Perhaps for this reason, some apparently restrictive enabling acts were construed by the courts to be permissive, thus consumer-sponsored plans were allowed to operate.[51] Some states with restrictive acts have passed special enabling provisions to allow consumer-sponsored plans.[52]

Comprehensive prepaid coverage should be expanded to reach more of the population and in ways most appropriate to individual needs.[53] This may be achieved by liberal construction of restrictive enabling acts or passage of permissive enabling acts.

III. Insurance Codes and Regulations

Insurance statutes and regulations governing advertising, cash reserves, and investment management are designed to protect the public against abuses by commercial fire, casualty, life and health insurers.[54] They can also apply to non-profit prepaid health service programs. For example, the non-profit Blue plans are subject in some jurisdictions to the regulations over commercial insurers, although in other jurisdictions they have been exempted explicitly by statute[55] or judicial interpretation.[56]

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48. Hansen, *supra* note 46, at 2-3.

49. *Id.*

50. Group Health Ins. v. Howell, 40 N.J. 436, 193 A.2d 103 (1963).

51. *Cf.* Complete Serv. Bureau v. San Diego County Medical Soc'y, 43 Cal. 2d 201, 272 P.2d 497 (1954) (construing the general non-profit corporation law of California as allowing operation of consumer-sponsored plans, even though the specific enabling act (Cal. Corp. Code, § 9201 (Deering 1962)) was restricted to physician sponsored plans).

52. Hansen, *supra* note 46, at 3-4; *see, e.g.*, Wis. Stat. Ann. § 185.981 (1957).

53. It should be recognized, however, that these statutes and cases in no way effect institutional practice and the employment of salaried physicians by non-profit hospitals. Willcox, *supra* note 11, at 463-64.

54. *See generally* R. Mehr, Principles of Insurance (1961); R. Hensley, Competition, Regulation and the Public Interest in Non-Life Insurance (1962).

55. *See, e.g.*, N.Y. Ins. Law §§ 250-60 (McKinney 1966) (providing for prepaid health service plans to operate under the supervision of the State Insurance Department); Ohio Rev. Code Ann. § 1738.04 (1964) (requiring consumer-sponsored plans to be regulated by State Superintendent of Insurance). *See generally* Report of Governor's Comm. on Hosp. Costs (1965), recommending transfer of the regulatory functions to the Health Department. This was partially accomplished in 1965 through an amendment to § 2807 of the Public Health Laws of New York State providing for the Health Commissioner to certify to the Superintendent of Insurance that rate schedules for hospital services are reasonably related to cost.

56. Although state insurance code provisions and federal antitrust laws may interfere

Some state insurance laws can be construed as defining insurance to include all enterprises which collect periodic payments as consideration for cash benefits payable upon the happening of certain contingent events.[57] The question raised by such definitions is whether the provision of services is legally equivalent to cash, and whether service plans should therefore be subject to the insurance laws. Some courts have answered the question negatively.[58] They have construed such plans to be contracts for services rather than indemnification against losses and, therefore, have exempted them from the coverage of the regular insurance statutes and regulations. They reason that there is no risk that the contract would not be performed because the physicians are engaged by the plan in advance and stand ready to render their services. The fallacy in such reasoning is that physicians stand ready only so long as the service company is solvent; they make no commitment to work without compensation. Consequently, these cases tend to rely on form over substance, and ignore the need of plan members for protection against fiscal instability or insolvency.

On the other hand, insurance regulations must not be applied to non-profit prepaid health care plans in a manner which hampers expansions and innovations in their coverage.[59] The key question is how to preserve sufficient flexibility for prepayment plans and still provide public protection.[60] Because non-profit plans do not have the profit motivation of the commercial insurers, they should not be identically regulated.[61] In regulating the non-profit plans, states must gear the protection to the specific

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with cooperative risk-sharing among the commercial companies and although certain state laws may interfere with some pooling of risks under the "Blue" plans, these questions are germane to the present study since they do not directly affect medical care organization or health manpower utilization.

57. HANSEN, *supra* note 46, at 5.

58. *See* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939) (indicating a substantial difference between contracting to render services even on a contingent basis and contracting merely to stand their cost when or after rendition); California Physicians' Serv. v. Garrison, 28 Cal. 2d 790, 172 P.2d 4 (1946).

59. NAT'L COMM'N REPORT, *supra* note 1, at 201-02.

60. In the case of non-profit service plans sponsored by physicians or consumers, there would seem to be less inducement to defraud the public or carry out financially dubious operations. "Non-profit," however, means very little because actual profits may be disbursed as salaries to plan operators or participating professionals. Regulation of prepaid health care plans is therefore essential to protect the public against the dishonest, financially weak, incompetently managed, or fly-by-night operations. Conversation with office of the Insurance Commissioner of California.

61. Conversation with Mr. Scott Fleming, General Counsel of the Kaiser Foundation. Prepaid comprehensive coverage plans have evolved very slowly in spite of minimal regulation, perhaps because there are serious administrative difficulties in establishing them.

problems presented: financial weakness, managerial incompetence, and poorly planned sales efforts which deplete their cash reserves.[62]

The proper degree of regulation can be accomplished by mandatory licensing of prepaid health care plans, and by exempting their operations from coverage by existing insurance laws.[63] Licensure laws can require contingency reserves protected by reinsurance or other underwriting, qualifications for agents, and regulatory surveillance against misrepresentation, lay interference with professional acts, commercialization, and exploitation.[64] Such legislation would provide appropriate public protection and still allow more flexibility for experimentation and expansion of the plans than do the stringent state insurance codes. A specific licensure program seems preferable to the present alternatives of either no protection of the public or restraining protection by insurance regulations.[65]

A licensure statute administered by a regulatory agency can also require or encourage prepayment plans to provide for: 1. maximum public coverage; 2. protection that continues when a member is unemployed; 3. equitable contribution by employers and employee members; 4. public subscriber and professional representation on the governing boards; 5. coverage of preventive, curative, and rehabilitative services; 6. coverage of ambulatory, hospital, extended care, or home care services; 7. increased risk-spreading; and 8. protection against arbitrary cancellation.[66]

Whether or not the licensure form is used, regulation of prepaid health plans should be administered by that agency having primary responsibility for promoting health services, such as the agency designated for health planning pursuant to the Partnership for Health Amendments of 1967.[67] This arrangement would facilitate effective coordination of de-

62. Conversation with office of the Insurance Commissioner of California.

63. *See* Assembly Bill No. 2089, California Legislature, Reg. (Gen.) Sess. (1963), which would have required licensure of prepaid health care plans and would have established licensing a Health Care Plan Board as part of the State Department of Public Health, consisting of three members of the public appointed by the governor. For the Knox-Mills Act, passed in lieu of this bill, see CAL. GOV'T CODE, §§ 12530-12539 (Deering Supp. 1966).

64. Conversation with office of the Insurance Commissioner of California.

65. A few states have special statutes requiring health service plans to maintain contingency funds to cover epidemics. *E.g.*, MISS. CODE. ANN. §§ 5615-01, -04 (1942) (corporation must establish epidemic reserve of $5,000 before beginning business and thereafter set aside 2½% of receipts until reserve equals $75,000 or 55% of net annual income, whichever is higher); ORE. REV. STAT. § 742.010 (1963) ($25,000 paid-up capital or $50,000 guaranty required).

66. Conversation with Mr. Scott Fleming, General Counsel of the Kaiser Foundation Medical Plan. *See also* NAT'L COMM'N REPORT, *supra* note 1, at 201, 202, 71, 74.

67. *See* REPORT OF THE GOVERNOR'S COMM. ON HOSP. COSTS 47, 52, 53-59 (1965);

veloping prepayment programs with state-wide efforts to plan for comprehensive personal health services.

IV. Preventing Harassment of Prepayment Plans

The development and continued operation of institutionalized health services and prepaid health care plans require that their activities be free from harassment from public and private sources.

In the early stages of the evolution of consumer-sponsored prepaid health care plans, local medical societies adopted an openly hostile attitude to their operations.[68] Much of this hostility, during and immediately following the Depression, was based on the contention that low salaries paid to participating physicians could lead to their exploitation and cause them to practice poor medicine. Supporters of such plans argued that by not paying physicians on a fee-for-service basis they were able to give low-cost, comprehensive services. This argument has little relevance today because the method of payment (fee-for-service vs. salary) no longer determines the ability to deliver low-cost, comprehensive coverage. A more important factor today is the reduced use of in-patient facilities and the concomitant increase in the use of out-patient care.

The major challenge to this hostility was presented in 1943 in *United States v. American Medical Association.*[69] In this case, hospital privileges and medical society membership had been denied physicians who cooperated in a consumer-sponsored plan. The United States Supreme Court held that harassing participating physicians constituted a violation of the Sherman Anti-Trust Act. Application of the Sherman Act to such interferences was based on findings of economic damage to the group and its physician members, and on a holding that, legally, medical practice is a trade.[70]

State restraint-of-trade laws have been similarly applied. For example, in *Group Health Cooperative v. King County Medical Society,*[71] the Supreme Court of Washington enjoined the medical society from excluding physician members of the Group Health Cooperative from hospital staff membership. The court held that the practice of medicine was a trade within the scope of common-law and statutory prohibitions against un-

H.R. 6418, 90th Cong., 1st Sess. (1967) (Partnership for Health Amendments of 1967—which provide for a three-year expanded partnership for health program).

68. *See* Hansen, *Group Health Plans—A Twenty Year Legal Review,* 42 Minn. L. Rev. 527, 535 (1958).

69. 317 U.S. 519 (1943), *aff'g* 130 F.2d 233 (D.C. Cir. 1942).

70. *Id.; cf.* United States v. Oregon State Medical Soc'y, 343 U.S. 326 (1952) (appeal dismissed as moot and for lack of evidence).

71. 39 Wash. 2d 586, 237 P.2d 737 (1951).

reasonable restraints of trade. Further, a report of the Commission on Medical Care Plans of the American Medical Association noted that medical societies and other associations were subject to state and federal anti-trust laws if their activities adversely interfered with a consumer-sponsored prepaid medical care plan.[72]

The actively hostile attitude of state and local medical associations towards consumer-sponsored prepaid plans is now of only historical significance.[73] The only remaining questions are whether the public interest in the development of prepaid medical care can be adequately protected by state or federal anti-trust laws, specific legislation prohibiting denial of hospital privileges to licensed physicians because of participation in consumer-sponsored plans,[74] or more far-reaching regulations. Both anti-trust statutes and medical anti-discrimination statutes place burdens of litigation and proof on those accused of unethical practice. It seems preferable, therefore, that such restraints on physicians be treated as interferences with activities essential to the public interest, with public agencies guarding against harassment. Regulation of attempted interference or discrimination would be an appropriate role for the proposed state agency for licensing and regulating prepaid plans.[75] In the meantime, regulations should be developed and enforced by a public agency such as state licensing boards or health departments.

CONCLUSION

Legal standards affecting the organization of health services can inhibit expansion of and innovations in consumer-sponsored prepaid medical care plans which employ a closed panel of physicians practicing as a group. Similarly, they can interfere with institutionally delivered services in which non-profit hospitals employ physicians on a salaried basis. These basic standards evolved at a time when problems of lay interference with professional acts and commercialization were real rather than theoretical and posed threats to delivery of high-quality, ethical medical care. It now appears that these standards are more matters of form than substance and require re-examination in light of the realities of stated needs for expanded delivery of low-cost, comprehensive personal health care.

72. *See* A.M.A. Commission on Medical Care Plans, J.A.M.A. (Special Edition), Jan. 17, 1959, at 50-52. *See also* NAT'L COMM'N REPORT, *supra* note 1, 71-74, 201-02; HANSEN, *supra* note 46.

73. A.M.A. Commission on Medical Care Plans, *supra* note 72, at 47-53, 92-93.

74. *E.g.*, N.Y. PUBLIC HEALTH LAW § 206-a (McKinney Supp. 1967). This statute deals only with direct harassment causing loss of staff privileges. Although it forbids discrimination by any tax-exempt hospital against any licensed physician, the burdens of litigation and proof are placed on the physician to establish that his rejection was the result of discrimination. *See* HANSEN, *supra* note 46, at 9.

75. Text accompanying notes 61-64 *supra.*