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Brian A. Putra

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REGULATION OF MEDICAL SERVICE PLANS IN CALIFORNIA

To anyone who has enjoyed the benefits of modern medical science, it has become painfully obvious that the cost of medical care has constantly risen at an astronomical rate. This is particularly true in California.¹ Along with the significant rise in medical costs, there has been a correspondingly large increase in the number of Californians who are participating in some type of health plan designed to provide medical services at a reasonable price.² While most of these health plans have been honestly run and eminently successful in providing adequate medical treatment while preventing financial disaster, there have been enough instances of misconduct and of an inability to provide paid for services to foster legislative concern.³ This note will analyze the manifestations of such legislative concern as well as the past and present judicial treatment in California of medical service plans which provide for prepaid medical service.

Classification—Service or Insurance

The number of Californians who have taken advantage of some type of health plan is now over four million.⁴ Many of these health plans are of the prepaid medical service variety, and generally operate as follows: A nonprofit corporation or unincorporated association enters into contracts with members of the public, usually called subscribers, whereby the latter, on payment of a set periodic fee, are entitled to receive certain types of treatment by physicians who have agreed to look only to the prepaid fees for their compensation.

Many courts have experienced difficulty in classifying prepaid medical service contracts in order to determine which, if any, state regulation is applicable to them.⁵ The issue most frequently raised by the cases is “[w]hether grouping individuals together and placing periodic payments in a central fund so alters the nature of the activity that what was once *service* can be said to be *insurance*.”⁶

¹ See *Report of the Assembly Comm. on Finance and Insurance*, 15 ASSEMBLY INTERIM COMM. REP. No. 24, at 96, 101 (1961) [hereinafter cited as COMM. REP. No. 24].

² See *Report of the Assembly Comm. on Finance and Insurance*, 15 ASSEMBLY INTERIM COMM. REP. No. 26, at 24, 25-26 [hereinafter cited as COMM. REP. No. 26].

³ See *id.* at 24-36.

⁴ *Id.* at 26.

⁵ See, e.g., *Maloney v. American Independent Medical & Health Ass'n*, 119 Cal. App. 2d 319, 259 P.2d 503 (1953).

⁶ Peart & Hassard, *The Organization of California Physicians' Service*, 6 LAW & CONTEMP. PROB. 565, 570 (1939) (emphasis added).

The importance of this issue lies in the fact that if these plans are designated insurance, they will be subject to regulation by the state's insurance laws, which are generally more restrictive and comprehensive than those governing health plans. For example, the California Insurance Code⁷ requires the maintenance of large financial reserves by plans subject to its provisions. The purpose of such reserves is to guarantee that insurance plans will have adequate funds to meet the financial obligations imposed upon them under their insurance contracts, and to eliminate the possibility that those insured will have to pay the cost of medical care out of their own pocket in the event the insurer fails financially. If a medical service plan is required to maintain such large reserves, it will necessarily have to increase subscription rates, and thereby defeat its primary aim of providing low cost medical protection.

Judicial Tests

The California judiciary has consistently held that a health plan must contain an element of indemnity to warrant classification as insurance.⁸ This is in accord with the statutory definition of insurance contained in section 22 of the California Insurance Code: "Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent, or unknown event."⁹ Section 10272 of the Insurance Code¹⁰ defines indemnity as "benefits promised," while section 2772 of the Civil Code¹¹ states: "Indemnity is a contract by which one engages to save another from a legal consequence of the conduct of one of the parties, or of some other person."

In 1946, the California Supreme Court in *California Physicians' Service v. Garrison*,¹² held that the California Physicians' Service (C.P.S.) was not engaged in the insurance business. C.P.S., a non-profit corporation, was formed in 1939 by the California Medical Association to provide medical care for people in low-income brackets.¹³ Every physician licensed in California was invited to become a professional member. Beneficiary members were enrolled pursuant to contracts entered into by C.P.S. with lodges, clubs, employers and others who had the means to collect monthly dues from their in-

⁷ CAL. INS. CODE §§ 700.01-.02.

⁸ See *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 716, 441 P.2d 97, 99, 68 Cal. Rptr. 585, 587 (1968); *California Physicians' Serv. v. Garrison*, 28 Cal. 2d 790, 803-04, 172 P.2d 4, 12 (1946).

⁹ CAL. INS. CODE § 22.

¹⁰ CAL. INS. CODE § 10272.

¹¹ CAL. CIV. CODE § 2772.

¹² 28 Cal. 2d 790, 172 P.2d 4 (1946).

¹³ *Id.* at 792, 172 P.2d at 6. For a comprehensive article about the birth and structural organization of California Physicians' Service, see Peart & Hassard, *The Organization of California Physicians' Service*, 6 LAW & CONTEMP. PROB. 565 (1939).

terested members and employees. The contracts expressly provided that C.P.S. acted only as an agent for the professional members and was not liable if any of the physicians breached their obligations. The doctors agreed to look solely to the available funds for compensation. In holding that C.P.S. was not subject to the regulations of the Insurance Code, the court first said:

The business of the service lacks one essential element necessary to bring it within the scope of the insurance laws, for clearly it assumes no risk. Under the provisions of the contracts or group agreements, it is a mere agent or distributor of funds. It does not promise the beneficiary members that it will provide medical care; on the contrary, "the services which are offered to . . . beneficiary members of C.P.S. are offered personally to said members by the professional members of C.P.S. . . ."¹⁴

The court went on to formulate a new test for the classification of prepaid medical service plans:

There is another and more compelling reason for holding that the service is not engaged in the insurance business. Absence or presence of assumption of risk or peril is not the sole test to be applied in determining its status. *The question, more broadly, is whether, looking at the plan of operation as a whole, 'service' rather than 'indemnity' is its principal object and purpose.*¹⁵

The test enunciated in *Garrison* was significant in that it recognized that "the element of assumption of risk or indemnification of loss was not controlling"¹⁶ in the classification of a contract as insurance. The fact that a medical service plan incidentally offers some insignificant indemnity features in addition to the provision of services should not warrant the categorization of the whole plan as insurance, necessitating the buildup of financial reserves,¹⁷ and a corresponding increase in subscription rates. Such a result would not be justified by the elimination of the limited danger of personal liability to the subscriber caused by minor indemnity features.

Regulation of Medical Service Plans

Prior to 1965

Before 1965, if a medical service plan was not classified as insurance and regulated under the Insurance Code only three sections remained applicable,¹⁸ and only two of these provided for any regulation.¹⁹ Section 9200 of the Corporations Code²⁰ (formerly section 593

¹⁴ California Physicians' Serv. v. Garrison, 28 Cal. 2d 790, 804-05, 172 P.2d 4, 13 (1946) (quoting in part the C.P.S. contract).

¹⁵ *Id.* at 809, 172 P.2d at 16 (emphasis added).

¹⁶ Transportation Guar. Co. v. Jellins, 29 Cal. 2d 242, 249, 174 P.2d 625, 629 (1946).

¹⁷ CAL. INS. CODE § 700.01-.02.

¹⁸ CAL. CORP. CODE §§ 9200, 9201, 9505.

¹⁹ CAL. CORP. CODE §§ 9201, 9505.

²⁰ CAL. CORP. CODE § 9200 reads as follows: "A nonprofit corporation may be formed by three or more persons for any lawful purposes which do

of the Civil Code) provides that a nonprofit corporation may be formed for the purposes of rendering services. Section 9201 of the Corporations Code²¹ (formerly section 593a of the Civil Code) permits a nonprofit corporation to be formed for the express purpose of defraying the cost of medical services. Section 9201 places such a corporation under the supervision of the board that licenses the professional (physician) members of the corporation. In addition, section 9201 provides that the supervisory powers over nonprofit corporations holding property in trust, conferred by section 9505 of the Corporations Code, on the Attorney General, should be applicable to section 9201 corporations as well.²²

Whether a medical service plan, which was not classified as insurance, could be regulated at all prior to 1965 depended upon whether it was organized and operated under section 9200 or section 9201. Since section 9200 contains no regulatory provisions,²³ nonprofit medical service corporations organized under this section were subject to no supervision. Section 9201 corporations were placed under the limited supervision of a professional board and the Attorney General. The professional board, under section 9201, and the Attorney General, under sections 9201 and 9505, were given the power to supervise the

not contemplate the distribution of gains, profits, or dividends to the members thereof and for which individuals lawfully may associate themselves, such as religious, charitable, social, educational, or cemetery purposes, or for rendering services, subject to laws and regulations applicable to particular classes of nonprofit corporations or lines of activity."

²¹ CAL. CORP. CODE § 9201 reads as follows: "A nonprofit corporation may be formed under this part for the purposes of defraying or assuming the cost of professional services of licentiates under any chapter of Division 2 of the Business and Professions Code or of rendering any such services, but it may not engage directly or indirectly in the performance of the corporate purposes or objects unless all of the following requirements are met: (a) At least one-fourth of all licentiates of the particular profession become members. (b) Membership in the Corporation and an opportunity to render professional services upon a uniform basis are available to all licensed members of the particular profession. (c) Voting by proxy and cumulative voting are prohibited. (d) A certificate is issued to the corporation by the particular professional board whose licentiates have become members, finding compliance with the requirements of subdivisions (a), (b), and (c).

"Any such nonprofit corporation shall be subject to supervision by the particular professional board under which its members are licensed and shall also be subject to Section 9505."

²² CAL. CORP. CODE § 9505 (formerly CAL. CIV. CODE § 605) states: "A nonprofit corporation which holds property subject to any public or charitable trust is subject at all times to examination by the Attorney General, on behalf of the State, to ascertain the condition of its affairs and to what extent, if at all, it may fail to comply with trusts which it has assumed or may depart from the general purposes for which it is formed. In case of any such failure or departure the Attorney General shall institute, in the name of the State, the proceedings necessary to correct the noncompliance or departure."

²³ See CAL. CORP. CODE § 9200.

service plan and see that there was compliance with the obligations assumed. The extent of their authority, however, was not clearly delineated.²⁴

The California Supreme Court in *California Physicians' Service v. Garrison* held that if a corporation was operating under section 9201, this fact was sufficient to exclude the corporation from the provisions of the Insurance Code. In holding that C.P.S. was not an insurer, the court stated:

[T]he Legislature by the enactment of section 593a of the Civil Code [now section 9201 of the Corporations Code], with its express provisions for limited regulation of nonprofit organizations of a professional character by the Attorney General and the particular professional board, necessarily intended that such organization should be exempt from regulation by the Insurance Commissioner.²⁵

The court noted that one of the reasons the corporate practice of medicine had been held to be against public policy was that laymen could obtain control of the corporation. The court believed that a similar evil would result if C.P.S. were regulated by the extensive provisions of the Insurance Code. Therefore, the court reasoned that the legislature must have felt this factor outweighed any possible public exploitation by such organizations and regarded as sufficient the regulations of section 593a of the Civil Code.²⁶

In *Complete Service Bureau v. San Diego County Medical Society*,²⁷ the San Diego Medical Society contended that a nonprofit medical service corporation could be formed only under section 9201 of the Corporations Code.²⁸ Complete Service Bureau (C.S.B.) was organized under the general nonprofit corporation law, section 9200 of the Corporations Code.²⁹ The California Supreme Court, in rejecting the Society's claim, stated:

Section 9201 did not purport to repeal any portion of section 9200. The language of section 9201 is permissive and not mandatory. There would therefore seem to be no valid objection to the formation of a nonprofit medical service corporation under section 9200 as well as 9201.³⁰

In so holding, the court disapproved dictum to the contrary in *Maloney v. American Independent Medical and Health Association*.³¹

The court, in *Complete Service Bureau*, also noted that the Kaiser

²⁴ See CAL. CORP. CODE § 9201, 9505.

²⁵ *California Physicians' Serv. v. Garrison*, 28 Cal. 2d 790, 810, 172 P.2d 4, 16, (1946).

²⁶ *Id.* at 810, 172 P.2d at 17.

²⁷ 43 Cal. 2d 201, 272 P.2d 497 (1954).

²⁸ *Id.* at 207-08, 272 P.2d at 501; COMM. REP. No. 26, *supra* note 2, at 29; Comment, *Medical Service Plans in California*, 43 CALIF. L. REV. 674, 679 (1955).

²⁹ *Complete Serv. Bureau v. San Diego County Medical Soc'y*, 43 Cal. 2d 201, 209, 272 P.2d 497, 502 (1954); Comment, *Medical Service Plans in California*, 43 CALIF. L. REV. 674, 679 (1955).

³⁰ *Complete Serv. Bureau v. San Diego County Medical Soc'y*, 43 Cal. 2d 201, 209, 272 P.2d 497, 502 (1954).

³¹ 119 Cal. App. 2d 319, 324-25, 259 P.2d 503, 506 (1953).

Foundation Health Plan and many fraternal and beneficial organizations with medical service programs were incorporated under section 9200 prior to the enactment of section 9201. It was reasoned that the legislature could not have intended to eradicate existing section 9200 nonprofit medical service corporations when it enacted section 9201, since such an act might have been a violation of the constitutional prohibition against the impairment of contracts.³² Furthermore, the court felt that the legislature was not thinking of fraternal and other mutual nonprofit corporations when it enacted section 9201. According to the court, it would have been unreasonable for the legislature to require these organizations to include as members "one-fourth of all licentiates of the particular profession" or that these limited groups must provide "an opportunity to render professional services . . . to all licensed members of the profession."³³

The *Complete Service Bureau* case left a gaping hole in the already inadequate state supervision of medical service plans. Under the *Garrison* decision, a corporation organized under section 9201 of the Corporations Code was not subject to regulation by the Insurance Code.³⁴ And under *Complete Service Bureau*, a medical service plan need not even be formed under section 9201, so as to provide the subscribers with the limited protection of that section. A service plan could be organized and operated under section 9200,³⁵ which lacked any regulatory provisions, so that there was a complete absence of state supervision over nonprofit service operations formed under that section.³⁶

It should be noted that plans formed by unincorporated associations were not governed by either 9200 or 9201, as both these sections apply only to corporations.³⁷ Thus, unless categorized as insurance programs subject to the provisions of the Insurance Code, unincorporated medical service plans were also free from all state control.

Prior to 1965, then, the only state regulation of medical service plans which were not classified as insurance was the modicum of control provided by sections 9201 and 9505 of the Corporations Code, which gave a professional board and the Attorney General supervisory powers stated in only the most general of terms.³⁸

³² *Complete Serv. Bureau v. San Diego County Medical Soc'y*, 43 Cal. 2d 201, 209, 272 P.2d 497, 502 (1954).

³³ *Id.* at 210, 272 P.2d at 502.

³⁴ *California Physicians' Serv. v. Garrison*, 28 Cal. 2d 790, 810, 172 P.2d 4, 16 (1946).

³⁵ *Complete Serv. Bureau v. San Diego County Medical Soc'y*, 43 Cal. 2d 201, 209, 272 P.2d 497, 502 (1954).

³⁶ See CAL. CORP. CODE § 9200.

³⁷ See CAL. CORP. CODE §§ 9200, 9201.

³⁸ See CAL. CORP. CODE §§ 9201, 9505.

The Knox-Mills Plan Act

The California Legislature, in the early 1960's, began an extensive study of medical service plans. It recognized that

[f]rom the standpoint of State regulation, health plans existed in a vacuum. It is true that all plans known to this committee are incorporated under the General Nonprofit Corporation Law but its provisions for regulation and surveillance are more illusory than real, especially since the Supreme Court has held that the language of § 9201—which is concerned specifically with health service organization—"is permissive and not mandatory."

. . . For years health plans have performed many of the services, and operated in much the same manner, as insurers, yet they have not been obliged to comply with the many provisions of the Insurance Code nor with the regulations and orders of the Insurance Commissioner.³⁹

In 1960, Assemblyman Cameron of the Finance and Insurance Committee reported many complaints of misrepresentation and of an inability to deliver promised services among some health service plans in California.⁴⁰ A subcommittee of the Finance and Insurance Committee was formed, and it began an inquiry into these plans.⁴¹ Through public hearings, this subcommittee received complaints of misrepresentations, high-pressure sales tactics, loss of prepaid services when plans failed financially, and a lack of adequate information on subscriber benefits and their costs.⁴² One witness, the Assistant Attorney General, stated that "[t]he people who have these claims appear quite often to be on an economic level which makes it impractical for them to pursue any remedy of any kind to secure a reasonable and impartial review of the action by which they are deprived of benefits."⁴³

As a result of the Subcommittee's findings, the Finance and Insurance Committee recommended the regulation of health service plans for protection of the public.⁴⁴ In 1965, the legislature responded by enacting the Knox-Mills Plan Act.⁴⁵ The Act provides:

"Health care service plan" shall mean any form of organization or any arrangement whereby any person undertakes responsibility to provide, arrange for, pay for or *reimburse* any part of the cost of any health care services for a consideration consisting in part of prepaid or periodic charges; but the provisions of this article shall not apply to such a plan operated by an insurer, a nonprofit hospital service plan, or a fraternal benefit society, while such plan is so operated within the scope of the current certificate of authority issued by the Insurance Commissioner, or to such a plan operated under a trust fund negotiated by collective bargaining between an employer and a labor organization . . .⁴⁶

³⁹ COMM. REP. NO. 26, *supra* note 2, at 28.

⁴⁰ COMM. REP. NO. 24, *supra* note 1, at 118.

⁴¹ COMM. REP. NO. 26, *supra* note 2, at 30.

⁴² *Id.* at 30-32.

⁴³ *Id.* at 33 (emphasis in original deleted).

⁴⁴ *See id.* at 35.

⁴⁵ CAL. GOV'T CODE §§ 12530-39.

⁴⁶ CAL. GOV'T CODE § 12530(a) (emphasis added).

The effect of this legislation is to provide a measure of state supervision over previously unregulated nonprofit medical service corporations incorporated under section 9200 of the Corporations Code, over nonprofit corporations operating under section 9201 of the same Code,⁴⁷ and over unincorporated associations or groups of natural persons operating a medical care service plan on either a profit or nonprofit basis. The Act prohibits untrue or misleading advertising⁴⁸ or solicitation⁴⁹ and deceptive membership contracts.⁵⁰ The Attorney General is given regulatory responsibility,⁵¹ as well as power to enforce the provisions of the Act.⁵²

The Knox-Mills Plan Act is a major step toward eliminating many of the deceptive practices discovered by the Legislative Committee on Finance and Insurance, but it has raised some new problems. The Act allows a plan to reimburse, and thus indemnify,⁵³ subscribers, but does not require the maintenance of financial reserves. In the typical medical service plan which does not contain indemnity features, subscribers are not in danger of being personally liable for the costs of the services because they have paid their fees in advance, and the physicians usually agree to look only to the standard rates for their compensation. When an element of indemnity enters into the plan, however, so does a risk of personal financial liability to the subscriber, since if the plan becomes insolvent, it will be unable to reimburse the subscriber for the medical expenses for which he is personally liable. The Insurance Code, in contrast to the Knox-Mills Act, alleviates this danger by requiring insurers to maintain large financial reserves.⁵⁴ The questions posed by the Knox-Mills Plan Act are therefore: At what point are the indemnity features so extensive in a medical service plan that the whole plan should be classified as insurance, thereby giving the subscribers the protection of the financial reserves imposed by the Insurance Code; and did the legislature intend to place any limit on the amount of indemnity permissible in a medical service plan?

A New Classification Test

The questions raised by the Knox-Mills Plan Act were dealt with in a recent case decided by the California State Supreme Court, *People*

⁴⁷ While section 12530(a) of the Government Code uses the phrase "any person," a person can be a corporation. *Pasadena v. Stimson*, 91 Cal. 238, 248, 27 P. 604, 606 (1891); CAL. CIV. CODE § 14.

⁴⁸ CAL. GOV'T CODE § 12532(a).

⁴⁹ CAL. GOV'T CODE § 12532(b).

⁵⁰ CAL. GOV'T CODE § 12532(c).

⁵¹ CAL. GOV'T CODE § 12537.

⁵² See CAL. GOV'T CODE §§ 12533, 12534, 12535, 12538.

⁵³ See *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 717, 441 P.2d 97, 100, 68 Cal. Rptr. 585, 588 (1968).

⁵⁴ See CAL. INS. CODE §§ 700.01-.02.

ex rel. Roddis v. California Mutual Association,⁵⁵ which caused a radical change in the classification of medical service plans. An action was brought by the Insurance Commissioner to restrain the California Mutual Association (C.M.A.) from conducting an insurance business without procuring a certificate of authorization.⁵⁶ C. M.A. contended it was a health care service plan operating pursuant to the Knox-Mills Plan Act.⁵⁷ The subscribing members paid C.M.A. an annual consideration, plus a small monthly assessment which varied with the amount of medical expenses paid by C.M.A. The subscribers were entitled to benefits of up to \$1500 for hospitalization and up to \$500 for medical and surgical expenses. C.M.A. originally had contracts with 17 doctors, who agreed to look exclusively to C.M.A. for payment of the present fee, but the doctors retained the privilege of charging the subscriber an amount in excess of this fee. Most of the subscribers were treated by physicians associated with the San Bernardino Foundation for Medical Care and the Riverside Foundation. C.M.A. later terminated the San Bernardino contracts and procured new contracts with 38 doctors who were to receive payment only from C.M.A. C.M.A. also had contracts with seven doctors who did not limit themselves solely to C.M.A. as their source of payment; likewise, no hospital so limited itself. C.M.A. paid for services rendered by doctors chosen by subscribers in areas where it lacked medical service contracts.

The court first noted that a necessary element of insurance is that of indemnity. It then said:

The [Knox-Mills Plan Act] permits a health care service plan to "reimburse" a member and thus indicates that service plans may include some indemnity features, but by excluding an "insurer"⁵⁸ from the definition of a "health care service plan" the Legislature has evinced an intention to limit the extent of indemnity features permissible.⁵⁹

The court proceeded to develop a new test for classifying a medical service plan either as insurance or as a health care plan under the Knox-Mills Plan Act:

[W]here indemnity is a significant financial proportion of the business, the organization must be classified as an "insurer" for the

⁵⁵ 68 A.C. 713, 441 P.2d 97, 68 Cal. Rptr. 585 (1968).

⁵⁶ CAL. INS. CODE § 700 provides for the issuance of such a certificate.

⁵⁷ The Knox-Mills Plan Act is found in CAL. GOV'T CODE §§ 12530-39.

⁵⁸ Such exclusion is provided for by CAL. GOV'T CODE § 12530(a).

⁵⁹ *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 717-18, 441 P.2d 97, 100, 69 Cal. Rptr. 585, 588 (1968). The court also cited COMM. REP. No. 26, *supra* note 2, at 26, in which the committee stated that since Blue Cross was technically insurance, and since the report did not deal with insurance, then Blue Cross's estimated 2,090,000 insureds therefore should be added to the insurance category. Blue Cross provides service on an indemnity basis, and the court felt its exclusion from the Act's proposed coverage indicated an intent on the part of the committee to limit allowable indemnity features. *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 718 n.3, 441 P.2d 97, 100 n.3, 68 Cal. Rptr. 585, 588 n.3 (1968).

purposes of the Knox-Mills Plan Act

We realize that this determination involves balancing the indemnity aspects against the direct service aspects of the business, but only in the context of the plan as a whole can it be determined whether the indemnity feature is so significant as to warrant imposing the Insurance Code financial reserve requirements. Nor, should this requirement unreasonably restrict the development of new health plans or impinge on the growth of existing plans.⁶⁰

It could very well be argued that *Roddis* is an erroneous interpretation of the Knox-Mills Plan Act. The legislature was certainly aware of the fact that many existing medical service plans were similar to insurance and contained indemnity as well as direct service features, and it is also clear that the legislature did not feel that the presence of an element of indemnity warranted placing the entire plan under the Insurance Code, with its financial reserve requirements.⁶¹ This was manifested by an express allowance of indemnity features in health care service plans, without mention of a quantitative limitation.⁶²

It is also clear that the legislature wished to encourage rather than hinder the development of new medical care plans.⁶³ Yet, despite the court's assurance that the *Roddis* decision would not so hinder new plans,⁶⁴ there is a very real danger that it will. If the indemnity features of the service plan are a "significant financial proportion of the business," then the entire plan must comply with the financial reserve requirements of the Insurance Code.⁶⁵ But the reserve requirements are inconsistent with the nature and purpose of medical service plans, and the legislature recognized this fact by not including any requirements for reserves in the new legislation. The Supreme Court of California has itself recognized the inapplicability of the reserve requirements to those service plans. "[B]y the very nature of its operations, the service could not accumulate vast reserves. The flow of funds from patient to physician primarily is on a

⁶⁰ *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 719, 441 P.2d 97, 101, 68 Cal. Rptr. 585, 589 (1968) (emphasis added).

⁶¹ See COMM. REP. NO. 26, *supra* note 2, where the committee said: "[T]he direct service feature that is becoming an increasingly significant factor calls for special consideration. To assert that health plan contracts constitute insurance, pure and simple, because of indemnification features is analogous to insisting that porpoises are fish simply because they are found in the same environment.

"This committee therefore recommends that the dual nature of health plans be statutorily recognized while perceiving their essence: their real . . . purpose in preserving good health and preventing ill health." *Id.* at 39.

⁶² See CAL. GOV'T CODE § 12530(a).

⁶³ COMM. REP. NO. 26, *supra* note 2, at 36, where it was said: "[C]are must be taken to always make it possible for new plans to enter the stage, for health is a commodity that has too few purveyors"

⁶⁴ *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 719, 441 P.2d 97, 101, 68 Cal. Rptr. 585, 589 (1968).

⁶⁵ See *id.*

monthly basis of pay-as-you-go and to require reserves would be a useless and uneconomic waste."⁶⁶ It is obvious that if medical service plans are required to maintain the substantial reserve requirements of the Insurance Code, they will necessarily be compelled to raise the cost of the benefits provided, which will defeat their aim of providing inexpensive medical service.

The new test of the *Roddis* case, however, may also be viewed as being complementary to the Knox-Mills Plan Act in the sense that both are designed to achieve the legislative purpose of procuring protection for subscribers to medical service plans. The *Roddis* case is simply a judicial recognition of the fact that where indemnity features exist, there also exists the possibility of personal liability to the subscriber for medical costs, and that this risk is one that can be eliminated by requiring an insurer to maintain adequate financial reserves.⁶⁷ To the extent that the Knox-Mills Plan Act would allow this risk to continue by permitting significant indemnity features, it would fail in its task of protecting the public. It must be kept in mind that the purpose of these health plans is essentially that of providing *services* which are usually prepaid. The end result is medical care which is not only relatively inexpensive, but also guaranteed. To allow an infusion of indemnity provisions into medical plans would be to deny the public the protection of guaranteed medical benefits. And since public protection is the principal goal of the Knox-Mills Plan Act, it is submitted that the *Roddis* court was correct in refusing to allow unlimited indemnity provisions in a medical service plan.

Conclusion

As yet, no acceptable device has been found to assure the continued fiscal stability of medical service plans with indemnity features "[c]onsonant with the objective of all reputable plans to pare costs and hold to the minimum expenses so as to provide health care at the lowest possible rate for subscribers."⁶⁸

A more viable approach than the compromise of the *Roddis* case would be the enactment of new legislation aimed specifically at plans incorporating both service and indemnity elements. Such legislation

⁶⁶ *California Physicians' Serv. v. Garrison*, 28 Cal. 2d 790, 811, 172 P.2d 4, 17 (1946). See also *Jordan v. Group Health Ass'n*, 107 F.2d 239 (D.C. Cir. 1939), in which the court stated: "It is not the function or purpose of Group Health [a medical service plan] to pile up vast accumulations of capital to await the needs of a distant day; it is rather to keep a steady flow of funds, with as small a margin as possible, running from patient to physician as nearly contemporaneously with the reverse flow of service from physician to patient as can be To require it to maintain a guarantee fund . . . would be to direct funds from its primary purpose and keep them in idleness to no end of security for its members." *Id.* at 251.

⁶⁷ See *People ex rel. Roddis v. California Mut. Ass'n*, 68 A.C. 713, 719, 441 P.2d 97, 101, 68 Cal. Rptr. 585, 589 (1968).

⁶⁸ COMM. REP. NO. 26, *supra* note 2, at 36.

should contain regulatory provisions at least as comprehensive as those of the Knox-Mills Plan Act. There should be provisions requiring that advertising and solicitation be completely candid and forthright. It should be required that the membership contract set out explicitly what services are to be provided, the exact cost of such services, and the limits of the subscriber's personal liability for services provided under the plan. A registration requirement for all medical service plans incorporating an indemnity element should be included, thereby placing before the public eye all pertinent information concerning the plan's financial structure, benefit provisions, and expense.

Finally, there should be a provision requiring the maintenance of the minimal financial reserves necessary for that particular plan to ensure that those subscribers relying on the indemnity features of the plan will not be endangered by personal liability for medical expenses. There should be a predetermined formula whereby a certain percentage of each dollar of indemnity benefits provided must be placed in a reserve fund. The percentage amount should not be higher than is absolutely necessary for the subscriber's protection. By applying this formula to each individual plan, an adequate financial reserve could be maintained with a minimum increase in the cost of the service plan.

A state officer should be empowered to scrutinize the operations of these service-indemnity plans and to enforce their compliance with the provisions of the new law. It would be desirable to maintain a continuity of authority over all service plans which do not fall under the scope of the Insurance Code. Since the Attorney General already is vested with supervisory power regarding plans regulated by the Knox-Mills Plan Act, he would be the appropriate state official to enforce the new legislation.

The rapid growth of medical service plans has brought low-cost medical protection within the reach of millions of Californians. But such subscribers must be protected from the possibility of abuse of the plans inherent in the difficulty and the undesirability of subjecting them to close regulatory scrutiny. The Knox-Mills Plan Act has created such protection with regard to many existing plans. The enactment of the proposals suggested here would contribute greatly to the completion of this protection.

*Brian A. Putra**

* Member, Third Year Class