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LEGAL PROBLEMS IN THE ORGANIZATION AND OPERATION OF GROUP HEALTH PLANS

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I. INTRODUCTION

This article is intended as a practical aid to the lawyer who is confronted with the legal problems involved in the organization and operation of a group health plan.[1] It covers the statutes and decisions of the states affecting the corporate structure,[2] the problems involved in membership service contracts and their comparison with insurance policies, and the unique requirements of physicians' contracts.

Group health plans here discussed are those in which the member-patients sponsor and control the nonprofit corporation on a democratic or cooperative basis,[3] or at least have an effective voice in its management.[4] The corporation usually owns the clinic building and its equipment[5] and through its lay board of directors manages this facility, as well as operating funds derived from periodic prepayments of the members which are used to maintain the facility and to pay for medical services rendered to the members. The physicians, specialists and technicians rendering the services are engaged as independent contractors and are compensated on a mutually agreeable basis which produces a known cost in advance, so that, with other overhead costs, the budget can be met with members' prepayments.

The objectives of a group health plan are to remove the economic hazards that keep the patient from obtaining timely medical care, to promote health conservation and provide preventive care, to foster group practice of medicine whereby general and specialist practitioners combine their skills to

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1. Based upon a survey of the experience of existing group health plans, conducted by the writer in 1950.

2. All those obtainable, through latest available session laws, code supplements and state reports.

3. As distinguished from plans controlled exclusively by doctors, such as Blue Shield plans, and by employers, such as industrial plans. Group health plans concede that the practice of medicine is properly in the exclusive control of the profession, but contend that business and financial functions of a voluntary service plan should be administered by those who provide the funds. See generally Hansen, *Laws Affecting Group Health Plans*, 35 IOWA L. REV. 209 (1950); Note, *Cooperation in Medicine*, 35 MINN. L. REV. 373, 380 (1951).

4. As in Health Insurance Plan, New York City, where the board of directors is composed of civic leaders not directly elected by members. See THE COOPERATIVE HEALTH FEDERATION OF AMERICA AND ITS MEMBER PLANS (1951) (pamphlet available from Federation's office, 343 So. Dearborn Street, Chicago 4, Illinois).

5. Hospital facilities are sometimes included, as in Group Health Cooperative at Seattle, Washington, and Farmers' Union Hospital Association at Elk City, Oklahoma. Clinic facilities may be leased by the plan, or leased by participating doctors, as in Health Insurance Plan in New York City.

provide efficient diagnosis and treatment, to provide a comprehensive program of medical care, and, by cooperative effort and budget prepayments, to make more and better medical care available to more people.[6]

These plans are a rather new development and their growth was not appreciable until the 1940's.[7] While the success of this approach by way of solving problems of medical economics has been adequately demonstrated,[8] it is still a pioneering effort, as is this discussion of its major legal problems.

II. The Corporate Structure

1. *Legal Authority to Organize*

It is not always simple to determine in a given state whether the plan will be able to operate without legal difficulty. In the absence of a specific enabling statute, the rule against corporate practice of medicine or the insurance laws may be effective obstacles.

The corporate practice rule followed in a majority of the states prohibits a corporation from furnishing medical services for fees through physicians engaged and paid by it.[9] The rule is usually grounded upon considerations of public policy,[10] medical licensure laws,[11] or professional standards.[12] However, this majority view is based largely upon cases involving plans engaged in the selling of physicians' services to the public for a profit;[13] while group health plans render physicians' services to their members on a non-profit basis, thus tending to distinguish them from the rule.[14]

If a given state has no special enabling statute permitting operation of group health plans, a study of decisions must be made to determine if the

6. The Cooperative Health Federation of America and Its Member Plans (1951); Goldmann, Voluntary Medical Care Insurance in the United States 183-87 (1948); Rothenberg and Picard, Group Practice and Health Insurance in Action (1949); Rorem, *Pattern and Problems of Group Medical Practice,* 40 Am. J. of Pub. Health 1521 (1950).

7. Goldmann, *op. cit. supra* note 6, at 149; *Health Insurance Plans in the United States,* Sen. Rep. No. 359, 82d Cong., 1st Sess. pt. 2, p. 63 (1951).

8. The Cooperative Health Federation of America and Its Member Plans (1951); Sen. Rep. No. 359, 82d Cong., 1st. Sess. pt. 2, pp. 60-62 (1951).

9. 1 Fletcher, Private Corporations § 97 (Rev. ed., Jones, 1931); see also Notes, 167 A.L.R. 322 (1947), 119 A.L.R. 1290 (1939), 103 A.L.R. 1240 (1936). *Contra:* Group Health Ass'n v. Moor, 24 F. Supp. 445 (D.D.C. 1938), *aff'd sub nom.* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939); Hansen, *supra* note 3, at 213-17; Note, 35 Minn. L. Rev. 373, 385-86 (1951).

10. Bartron v. Codington County, 68 S.D. 309, 329, 2 N.W.2d 337, 347 (1942).

11. People v. United Medieal Services, 362 Ill. 442, 454, 200 N.E. 157, 163 (1936).

12. People *ex rel.* State Board of Medical Examiners v. Pacific Health Corp., 12 Cal.2d 156, 158, 82 P.2d 429, 430 (1938).

13. People *ex rel.* State Board of Medical Examiners v. Pacific Health Corp., 12 Cal.2d 156, 82 P.2d 429, 430 (1938); Hansen, *supra* note 3, at 216.

14. Group Health Ass'n v. Moor, 24 F. Supp. 445 (D.D.C. 1938), *aff'd sub nom.* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939); People *ex rel.* State Board of Medical Examiners v. Pacific Health Corp., 12 Cal.2d 156, 82 P.2d 429, 430 (1938); Hansen, *supra* note 3, at 217.

court has ruled or is likely to rule with the majority or minority view. In this connection, the distinction stated should be kept in mind. If the corporate structure, plan for operations and contracts with physicians and members are properly drawn,[15] the distinction should be apparent and the possibility of later adverse judicial interference reduced or removed. In an uncertain legal situation a declaratory judgment proceeding, after formation of the corporate structure and proposed contracts and before commencement of operations, might be considered for obtaining advance judicial approval.

A contention is sometimes made that a group health plan is engaged in writing insurance without a license in violation of the state insurance statutes. This can usually be met with the majority view that the plan offers a "service" rather than an "indemnity."[16] Here again a declaratory judgment proceeding might be used in case of serious doubt.[17]

Some confusion might be presented by the existence in a state of special enabling legislation designed exclusively or primarily for operation of medical service plans by the medical profession. Following the success of "Blue Cross" hospital plans, medical associations in recent years have obtained enactment in most states of special enabling legislation for "Blue Shield" plans providing effective devices for control by the medical profession of all functions of the plan, business and financial as well as medical, and excluding the paying subscribers or members from any voice or control in administration.[18] These "Blue Shield" statutes give the plans operating under them

15. See appropriate sections *infra*.

16. Hansen, *supra* note 3, at 219; Notes, 167 A.L.R. 323 (1947), 35 MINN. L. REV. 373, 389 (1951).

17. Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939).

18. Ala. Acts 1945, No. 50, p. 52, ALA. CODE ANN. tit. 28, §§ 304 *et seq.* (Supp. 1947); Ariz. Laws 1945, c. 13, ARIZ. CODE ANN. §§ 53-421 *et seq.* (Supp. 1947); Cal. Stat. 1941, c. 629, CAL. CORP. CODE §§ 9201 *et seq.* (Deering 1947); Colo. Laws 1951, c. 227 § 17(m); Fla. Laws 1945, c. 22826, FLA. STAT. ANN. c. 641 (Supp. 1950); Idaho Laws 1947, c. 271, IDAHO CODE ANN. §§ 41-1701 *et seq.* (1948), *as amended*, Idaho Laws 1949, c. 42; Ill. Laws 1945, S.B. No. 652, p. 578, *as amended*, Ill. Laws 1949, H.B. No. 701, p. 633, ILL. STAT. ANN. c. 32, § 563 (Supp. 1950); Iowa Laws 1945, c. 209, IOWA CODE c. 514 (1946); Kan. Laws 1945, c. 216, KAN. GEN. STAT. § 40-1901 (Supp. 1947); Ky. Acts 1946, c. 51, KY. REV. STAT. §§ 303.160 *et seq.* (1948); La. Acts 1948, No. 383, p. 1034, LA. GEN. STAT. ANN. § 4023.31 (Supp. 1949); Me. Laws 1939, c. 149, ME. REV. STAT. c. 56, §§ 218-32 (1944) (see also Me. Priv. & Spec. Laws 1939, c. 24, *as amended*, Me. Priv. & Spec. Laws 1943, c. 21); Mass. Acts 1941, c. 306, MASS. ANN. LAWS c. 176B (Supp. 1950); Mich. Acts 1939, No. 108, p. 192, MICH. COMP. LAWS § 550.301 (1948); Minn. Laws 1945, c. 255, MINN. STAT. ANN. c 159 (1946); Mont. Laws 1947, c. 283, MONT. REV. CODE ANN. §§ 15-1401 *et seq.* (1949); N.H. Laws 1943, c. 166, *as amended*, N.H. Laws 1945, c. 96, and N.H. Laws 1947, c. 55; N.J. Laws 1940, c. 74, *as amended*, N.J. Laws 1944, c. 102, and N.J. Laws 1946, c. 259; N.C. Laws 1943, c. 537, *as amended*, N.C. Laws 1947, c. 820; N.D. Laws 1945, c. 154; Ohio Laws 1941, H.B. No. 51, p. 154, OHIO GEN. CODE ANN. §§ 669-14 *et seq.* (1946); Pa. Laws 1939, No. 399, p. 1125, PA. STAT. ANN. tit. 15 §§ 2851-1501 *et seq.* (Supp. 1948); R.I. Acts 1945, c. 1598; S.C. Acts 1948, c. 713; Tenn. Acts 1945, c. 113, TENN. CODE ANN. § 4186 (Williams, Supp. 1948); Vt. Laws 1939, c. 175, VT. REV. STAT. tit. 26, c. 261 (1947); Va. Acts 1940, c. 230, VA. CODE ANN. §§ 3848(67) *et seq.* (1942); W. Va. Acts 1943, c. 8, *as amended*, W. Va. Acts Extraordinary Sess. 1946, c. 5, and W. Va. Acts 1947, c. 40; Wis. Laws 1945, c. 494 WIS. STAT. §§ 148.01 *et seq.* (1947).

release from the corporate practice rule, exemption from taxation, and complete or partial exemption from state regulation by the Insurance or Health departments.[19]

The existence of a "Blue Shield" enabling statute in a state without a parallel statute for group health plans does not mean per se that group health plans are prohibited. The "Blue Shield" statutes are usually permissive in nature, but the statutes in a given state should be examined carefully to determine if the provisions concerning composition of the governing board, minimum requirements for participation by physcians, and "freedom of choice" of physician extends to all types of medical service plans, and thus preclude group health plans as a practical matter.[20] If such a statute is only permissive and is not restrictive, a group health plan formed under appropriate corporation laws could operate lawfully, unless of course the corporate practice rule or insurance law presents a decisive obstacle.

In some states the enabling statute grants equal privilege to all types of plans,[21] and in others there are separate enabling statutes for Blue Shield and group health plans.[22] In these states the common law presents no problems and a forming plan need only conform to the statute in setting up its corporate structure.

A lawyer engaged to form a group health plan would do well, beyond examining the legal situation, to take account of the existing attitude of the local medical association. While there is a tendency to a modern view,[23] some medical associations oppose group health plans on economic and ethical, as well as on legal grounds.[24] A plan might be properly and legally constructed, but unable to obtain participation of needed physicians.

In any event, if a group health plan is desired and needed, and no specific prohibition stands in the way, a group interested in forming a plan should not be expected to wait until the last possible objection from every side is

19. Hansen, *supra* note 3, at 225-29.

20. *Ibid.*

21. Conn. Acts 1939, c. 338, CONN. REV. GEN. STAT. §§ 5281 *et seq.* (1949); Md. Laws 1945, c. 752, MD. ANN. CODE GEN. LAWS art. 48A, §§ 235 *et seq.* (Supp. 1947); Miss. Laws, 1946, c. 410, MISS. CODE ANN. § 5310 (Supp. 1950); N.M. Laws 1947, c. 207, N.M. STAT. ANN. §§ 60-1401 *et seq.* (Supp. 1947); N.Y. Laws 1939, c. 882, *as amended,* N.Y. Laws 1941, c. 70, and N.Y. Laws 1946, c. 547, N.Y. INS. LAW §§ 250 *et seq.;* Okla. Laws 1949, c. 17, OKLA. STAT. ANN. tit. 36, §§ 841 *et seq.* (Supp. 1949); Ore. Laws 1917, c. 173, ORE. COMP. LAWS ANN. §§ 101-901 *et seq.* (1940); Wash. Laws 1947, c. 268.

22. ILL. REV. STAT. c. 32, §§ 599 *et seq.* (Supp. 1951); Mass. Acts 1941, c. 334, MASS. ANN. LAWS c. 176C (Supp. 1950); Wis. Laws 1947, c. 408, WIS. STAT. §§ 185.25 *et seq.* (1947).

23. In 1949 the American Medical Association adopted *"Suggested Principles for Lay Sponsored Voluntary Health Plans,"* consisting of 20 points which recognize the rights of group health plans and suggest standards for their operation. 140 A.M.A.J. 686 (1949). These principles are a noteworthy modification of the rigid requirements of its *Principles of Medical Ethics,* 140 A.M.A.J. 619-20 (1949).

24. Hansen, *supra* note 3, at 229-34; Note, 35 MINN. L. REV. 373, 391-94 (1951).

removed. In every field of human endeavor, more especially in the subject field, worthwhile progress is made by pioneering—not by waiting for laws to point the course or clear the way.[25] Historically, the usual pattern is the arrival of the development followed by the body of law evolved in its wake. In this new field of medical economics, the development increases year by year with the benefit of little or no applicable law to guide it.

Assuming that a proposed group health plan will adhere to good standards,[26] and no direct legal obstacle stands in its way, the advising lawyer would best fill his initial role by pointing to the problems and leaving the decision for going forward to the interested group of incorporators.[27]

2. *Articles of Incorporation and Bylaws*

The following comments on drafting articles and bylaws are based in part upon a survey of the experience of existing group health plans.[28] Detailed discussion is not indicated because of varying requirements of local law, and comment will be limited to those matters generally important or peculiar to these plans.

In the absence of specific statutes, a choice of corporation statutes may be open. Nonprofit association acts are the most logical choice in most cases,[29] while cooperative association acts are sometimes indicated.[30] In a few cases

25. Some plans of important size organized and exist successfully without benefit of enabling acts: *viz.*, Farmers' Union Hospital Ass'n, Elk City, Okla. (1929); Group Health Association, Washington, D. C. (1937); Labor Health Institute, St. Louis Mo. (1945); Group Health Cooperative, Seattle, Wash. (1946); Community Health Center, Two Harbors, Minn. (1944). The last named plan used the expedient of a dual organization, a *nonprofit corporation* to operate the facility and perform the administrative services for the *unincorporated association* which makes the contracts with members and physicians, thus avoiding the corporate practice rule while protecting the members against individual liability.

26. See the principles adopted by the American Medical Association, *supra* note 23; and CHFA BODY OF POLICY (pamphlet obtainable at Cooperative Health Federation of America Office, 343 So. Dearborn St., Chicago, Ill.).

27. Some lawyers tend to be overcautious in the face of the corporate practice rule and fail to see the distinction made in the minority view (see authorities, *supra* note 9) and in the dissent in People *ex rel.* State Board of Medical Examiners v. Pacific Health Corp., 12 Cal.2d 156, 82 P.2d 429, 432-33 (1938), especially when the corporate structure and contracts with members and physicians (see appropriate sections *infra*) are drawn with a view to overcome the objections which form the basis of the corporate practice rule.

28. See note 1, *supra*.

29. Sometimes referred to as social and charitable association acts, under which hospitals and medical teaching clinics are usually formed. These acts provide considerable latitude as to form of organization. With few exceptions, the important group health plans are formed under this act in their respective states. See THE COOPERATIVE FEDERATION OF AMERICA AND ITS MEMBER PLANS (1951).

30. S.D. Laws 1949, c. 23, *amending* S.D. CODE § 11.1101 (1939), and authorizing cooperatives to be formed ". . . for the construction and operation of hospitals and to provide for medical services." Tex. Laws 1945, c. 70, TEX. REV. CIV. STAT. ANN. art. 1302-2A (Vernon 1945), providing that nonprofit corporations may be formed to "own and operate nonprofit cooperative hospitals and providing a suitable place where members and their families may obtain medical, dental, health, surgical, nursing, hospitalization and related services and benefits." The Texas statute is limited in application to towns

the fraternal association[31] or mutual benefit association acts[32] are appropriate. In the case of a welfare fund provided under a labor union contract, a special problem is presented.[33]

As a general rule it is best to fulfill only the minimum requirements of the statute as to provisions included in articles of incorporation, leaving all other necessary provisions to bylaws. Amendments to articles require strict, formal procedure and may be difficult to accomplish when the need suddenly arises.

The purposes or powers provision should be stated in general language, broad enough to provide flexibility for expanding and engaging in allied activities, and to protect officers and directors against ultra vires liability. For example, the plan may commence operations as a health center providing only clinical services, and later may add a drug department, a few emergency beds, and an ambulance service, finally developing into a full-blown hospital with a nurses' training school, and perhaps add a special facility for the aged and chronic cases. In a successful plan, the members can be expected to demand expanded and allied services and the possibility for exceeding corporate power is always present if the articles in this respect are not properly drawn.

The keystone of the plan is its authority to engage physicians for providing medical services to the members. The provision on purposes should include this power in language making it clear that the corporation will simply act as agent for its members in arranging for the furnishing of medical services, and for this purpose will have power to contract with physicians and technicians as independent contractors.[34] This sort of language is more desirable than a direct statement that the corporation "shall furnish medical services to its members," which would imply a guarantee of such services. Obviously no plan can maintain an exact balance between the available services of its medical staff and the fluctuating demand for services by the members. Yet if in joining a plan the member was led to assume that he and his

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under 2500 population. Unless required, cooperative association acts are not usually recommended because of restrictions as to the allocation of income and requirement that net earnings be distributed as patronage refunds.

31. See comment in dissent, People *ex rel.* State Board of Medical Examiners v. Pacific Health Corp., 12 Cal.2d 156, 82 P.2d 429, 432-33 (1938). For example see MINN. STAT. ANN. c. 64 (1946).

32. For example, see MINN. STAT. ANN. § 63.36 (1946). The Northern Pacific Beneficial Association, St. Paul, Minn., a comprehensive plan in operation since 1882, is formed under this act. It is described in SEN. REP. No. 359, 82d Cong. 1st Sess. pt. 2, p. 194 (1951).

33. The Taft-Hartley Act requires employer-employee joint control of welfare funds contributed under a labor union contract. If such funds were to be used in the operation of a group health plan, a question arises as to control of stock of the corporation. One possibility is to place the stock in a trust wherein the joint board is trustee and the union members the beneficiaries.

34. See Pearl v. West End Street Ry. 176 Mass. 177, 57 N.E. 339 (1900).

family would be rendered unlimited medical service at any time when needed, and contributed to initial capital and paid regular monthly dues on that assumption, the plan might easily get into difficulty. The statement that physicians will be engaged as independent contractors makes it implicit that the corporation is neither in the position of a master commanding a servant as to performance, nor subject to the rule of respondeat superior[35] as to failure of performance.

The articles should provide for a membership rather than a capital stock operation. While not necessarily carrying that legal connotation, the word "stock" to a layman implies an investment. The essence of a group health plan is conservation of the member's health, based upon the insurance principles of spreading and sharing of the hazards, with equal contributions paid by each member of the same class of risks. Outside of providing service instead of money indemnities, a group health plan resembles a mutual insurance company wherein each policyholder has at once both voting and proprietary rights. To further carry out democratic principles in operation of the plan, the articles should provide that each member is entitled to only one vote regardless of amount of contribution to capital.[36]

Qualifications for membership[37] should not appear in the articles unless required by statute, since experience in almost all existing plans shows that bylaws which are more easily amended provide the needed flexibility. For example, some plans find it necessary to create several classes of membership to provide for certain groups special dues and benefits.[38]

Articles should contain broad financing powers so as not to preclude suitable and available means of financing when needed.[39] These plans are not operated with a view to accumulation of earnings or creation of large reserves, and the need of additional revenue to expand facilities or services may call for ready means of raising capital funds or borrowing money, either with or without security. Foreseeing the possibility for such needs, the drafter of articles might well include powers to borrow money upon notes

35. See note 69, *infra*.

36. This provides democratic equality, the emphasis being on the health of the individual, not how much he contributed to capital. Customarily, group health plans require a contribution of $100 by each family for initial capital purchases and organization expense, for which the member receives a certificate evidencing his proprietary rights. Voting is permitted only when the certificate is fully paid, and it is not assignable without consent of the board of directors.

37. Provision should be made for expulsion procedures for members who act against the interests of the plan.

38. For examples, (1) industrial groups entered *in toto* where welfare funds will provide employees with only partial services, (2) persons who cannot afford full services and want an alternate plan at lower dues and providing for extra charges for specified services, (3) associate members who receive little or no service but who support the plan financially.

39. Securities or "Blue Sky" laws of the state must be checked for requirements for sale of memberships as well as other forms of financing. In many states nonprofit corporations are exempt.

secured by mortgages, to issue mortgage bonds, certificates of indebtedness and contributing membership certificates, and to accept gifts, endowments and grants upon conditions acceptable to the board of directors.

Following requirements of the Internal Revenue Code,[40] the application for tax exemption[41] will be strengthened by a provision in the articles to the effect that all earnings of the corporation shall be devoted to its purposes and that no part thereof shall inure to the benefit of any member or individual, and that upon dissolution, after payment of all debts, any surplus shall be donated as a gift to a like nonprofit organization having like purposes as the board of directors may determine.

If the statute permits, the number of directors should be made flexible, as, for example, that the board shall be composed of from five to fifteen directors, elected in such manner and for such terms as the bylaws may provide. If the bylaws contain a simple amendment procedure, the size of the board may be determined in advance of elections at the same meeting.[42] The articles should also provide for an executive committee with such powers and duties as the bylaws may provide. The bylaws may then provide for the appointment by the board of the committee with authority to exercise powers of the hoard between its scheduled meetings. In this manner the executive committee would have clear power to make binding decisions and agreements on behalf of the corporation, and since it is less cumbersome to call it into meeting, actions can be taken quickly if need be. Also by creating the power of the committee in this manner, it can be limited at any time by simple amendment of the bylaws.

Some group health plans have made the mistake of including in bylaws provisions which spell out the contract for services to be rendered to the member, including exact lists of benefits and schedules of dues,[43] rules governing conditions for receiving medical care, and provisions governing compensation of the medical staff, and its relations with the lay board of directors. Besides requiring a membership meeting to amend such provisions whenever the need arises, these matters are not ordinarily proper subjects for bylaws. Members' service contracts[44] and physicians' contracts[45] require separate instruments if the rights and obligations of the parties are to be made clear, and may require changes arrived at only by negotiation and

40. INT. REV. CODE §§ 101(6), 101(8), and applicable regulations.
41. The affidavit and application for exemption can be submitted to the Internal Revenue Bureau only after a full year of operation. Sometimes an opinion can be obtained in advance by a hypothetical application.
42. An expanding membership may demand a larger board.
43. Example: in one rural plan bylaws contained dues rates later found to be inadequate. Several attempts to amend bylaws failed for lack of quorum of members from widely scattered areas.
44. *Infra,* pp. 22-29.
45. *Infra,* pp. 29-36.

mutual assent or action by the board of directors. Rules governing services require agreement between the medical staff and lay administration and also may require occasional board action.

Quorum provisions of the bylaws must specify the minimum number required to be present for legal meetings of members, the board, and executive or other committees so that actions taken at such meetings are not subject to challenge. These provisions usually go on to provide that a majority of those present may decide any question or election, provided a quorum is present. If proxy voting is to be permitted, the bylaws should state what constitutes a valid proxy and whether they are counted in determining a quorum. Permitting voting by mail is not advisable unless authorized by statute.[46]

In all matters concerning corporate structure, the guiding thought should be flexibility to meet changing needs. Experience in existing plans shows the difficulty of attempting to satisfy the fluctuating demands of members with a rigid and detailed pattern. Articles and bylaws should meet the minimum requirements of law, provide for the necessary powers, and for smooth procedure to make binding decisions. All else should be left to the democratic process.

III. MEMBERS' SERVICE CONTRACTS

1. *Service Contracts and Insurance Policies*

The contract between the group health plan and its member, stating the conditions for rendering of medical services, is a subject on which no body of law has yet been developed.[47] The only parallel which may be used as a guide is the general law of insurance contracts, particularly that on health and accident policies.

While the majority view is that direct-service plans are not subject to insurance laws,[48] yet their service contracts have points of similarity[49] with insurance indemnity policies which invite comparison. In making such comparison, however, some general observations should be kept in mind.[50]

The general law of contracts applies to both, except insofar as insurance statutes may apply.[51] This exception may make a difference on some points

46. The objection may be made that the ballot inadequately stated the question, or that the result might have been changed if mail voters had been present to hear debates. Statutory permission on this point would resolve such objections.

47. Except in Group Health Ass'n v. Moor, 24 F. Supp. 445 (D.D.C. 1938), *aff'd sub nom.* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939).

48. See note 16, *supra.*

49. *Infra,* pp. 23-24.

50. If the state has an enabling act exempting group health plans from insurance laws, the comparisons made *infra* based on general law of contracts would still be valid.

51. 13 APPLEMAN, INSURANCE LAW AND PRACTICE § 7381 (1943).

and none on others. The insurance statutes in many states impose relatively few requirements for health and accident insurance, as compared, for example, with fire and life insurance, where the statutory policy form in many states is set out verbatim.[52] Rate regulation laws recently adopted in many states may also affect policy provisions.[53]

The courts in construing insurance policy provisions often have in mind the competitive nature of the insurance business, the resulting pressure on the public and the possibility of misrepresentation of the coverage. Thus, in many cases courts will resolve ambiguities and doubts in policy provisions in favor of the insured.[54]

Keeping in mind such statutory provisions and court decisions, the lawyer who is called upon to draft a direct-service contract will still find many parallels in health and accident insurance contracts and in decisions upon them which are based solely upon general contract law. These parallels may serve as a checklist for the drafting of a complete contract in language having a tested meaning.

However, save to eall attention to these parallel guides, it is not intended here to exhaust the comparisons or even to hold them up as criteria. There are some basic differences between group health plans and insurance companies, however, which should be kept in mind.

In a service plan costs are generally known in advance. Overhead expense and physicians' compensation can be budgeted against income from member dues a year ahead with fair accuracy. If the service contract simply promises to render services within the training and ability of the medical staff, the budget should not be exceeded. In an insurance operation the frequency, severity and cost of claims is predicated on experience, but cannot always be forecast accurately. Thus, safeguards in an insurance policy, such as the conditions, limitations and exclusions, must be drawn with great care.

A service plan usually conducts a health examination of the applicant for the purpose of detecting existing or chronic conditions. If such condition is found, the plan may accept the applicant subject to certain special conditions, or may reject the applicant as an undue burden on the plan. A health and accident insurance company usually foregoes an examination because its competition does not impose this nuisance on its applicants, and thus it is apt to get some adverse selection of risks. Special care is required in the drafting of the policy as well as the application, to a greater degree than required for a service plan.

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52. *E.g.*, MINN. STAT. ANN. §§ 61.29, 65.01 (1946).
53. *Id.* § 70.37 (Supp. 1947). These laws give insurance commissioners implied power to influence benefit provisions which may affect the rate of premium.
54. 13 APPLEMAN, *op. cit. supra* note 51, §§ 7387, 7438-89.

Finally, there is an intimacy of dealing between a group health plan and its members not found between an insurance company and the public. In the plan there is usually a common bond of interest among the members, a management responsive to their needs, and a democratic process available to solve their administrative and medical problems. An insurance company has no such advantages, and must be on guard against those who consider it fair game for fraud and deceit. This difference alone indicates less need for legal niceties of language in service contracts than in policies of insurance.

2. *Methods of Expressing Members' Rights*

Existing group health plans use one of three forms for setting out conditions for rendering of services and amount and time of dues payments—(1) bylaw provisions, (2) benefit schedules, and (3) service contracts.

Bylaw provisions may set out fully all of the necessary provisions in the same detail as a complete contract, and with equal effectiveness, since a subscribing member agrees in advance to abide by the bylaws and a copy of them is issued to him.[55] But the disadvantages of this form are obvious.[56] Bylaws tend to take on an air of permanency. Changes in them require a favorable vote of the membership after relatively short consideration, which sometimes results in decision by whim instead of on fact or necessity. Some conditions for rendering care must be arranged with physicians on the staff by mutual agreement, rather than by vote of the members. Rates of dues must be arrived at in a business-like manner and on the basis of the budget and actuarial principles.

Since the entire matter of benefits and rates is a management problem, it is best to leave it to the board of directors, the manager and the medical staff cooperating together in the preparation of a workable service agreement.

Benefit schedules best afford flexibility, especially needed in a new or growing plan. The schedule of services is issued to the joining member with a membership card or certificate.[57] It lists the services available under certain conditions, limitations and exclusions, at the stated rate of dues, and contains a provision that the schedule is subject to change by the board of directors, effective after written notice to the member.[58] Thus benefits or rates may be changed unilaterally by the management without consulting the membership body or obtaining an agreement for the change with each member.

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55. As used in plans at Elk City, Okla., Washington, D. C., and St. Louis, Mo., *supra* note 25.

56. See note 43, *supra*.

57. This form is used in Community Health Center, Two Harbors, Minn., and Arrowhead Health Center, Duluth, Minn.

58. These schedules are in simple, informal style, sometimes printed only in the literature explaining the plan to prospective members.

Experience of existing plans, especially in their early stages, shows a tendency to promise too much and charge too little. Variance in availability of and demand for medical services is the rule, not the exception, and ease of correcting the service contract may avoid considerable trouble.

To protect the plan from members who persistently abuse the service, the schedule should either be on a term basis, such as a calendar month, renewable at the option of the plan from term to term, or cancellable on written notice to the last known address of the member.

If the schedule form is used, the prospectus or literature which invites the eligible person to join should carefully state the right of the plan to amend and to terminate the schedule, so that his act in joining will constitute a binding acceptance upon those terms.

The disadvantage of this form of contract is its uncertainty as to services, rates and termination. It may be agreeable to a loyal, closely associated group of members who accept it experimentally, but it may be unacceptable to those who misunderstand the purpose or who expect the kind of certainty afforded in an insurance policy.

Service contracts in existing plans follow generally the format of an insurance policy and, for the reasons indicated, contain in simpler language many of the same types of provisions. No model outline for all types of plans is possible because of the variables, but some of the important common provisions will be discussed.

3. *Terms of Service Contracts*

(1) *Pre-existing Conditions of Ill Health.*

This matter is as important to the plan as to an insurance company. The principle involved is that conditions of ill health existing at the time of coverage are uninsurable, and that only future incidence of illness and accident is insurable.

Even a health examination and answers to questions in an application may not disclose all possible pre-existing conditions, whether from dishonesty or misunderstanding, or otherwise, of the applicant or agent taking the application. Thus, a group health plan, as an insurance company, must take care in procedures for selection of risks to protect itself against undue burdens.

A typical insurance statute affecting this subject provides that statements in an application will not avoid the policy unless made with intent to deceive and defraud, or unless the matter represented increases the risk

of loss,[59] and requires that the application must be attached to the policy when issued in order for the statement to be available to the insurer as a defense.[60]

This type of statute imposes a burden on the insurer by way of reducing its defense. The question here arises as to the defensive position of a group health plan where it issues its contract on the basis of false or intentionally incomplete answers in an application. It would appear in the absence of statute that a group health plan could assert a defense of no coverage in such a case, without the application being attached to the contract, on general contract law.[61] In any event the importance of a searching application form is apparent.

Many insurance policies contain the familiar phrase that "this policy shall not cover conditions existing at the time the insurance becomes effective." In case of fraud, an insurer can avoid the policy on a showing of ill health existing at the time of delivery of the policy.[62] There is no good reason why the same defense should not be available to a group health plan having a similar condition precedent in its service contract.[63]

However, the defense of breach of the condition by the member may be lost by operation of the principles of waiver or estoppel. These principles are found in general contract law and would be applicable alike to service contracts and insurance policies. Thus, if the plan delivers its contract or collects dues with knowledge of misrepresentation by the applicant as to his health, it may be held to have waived the breach or to be estopped from denying coverage.[64] Knowledge of an agent or servant as to the breach may be held to be knowledge of the plan.[65] The only protection here is care in issuing the contract, and perhaps the development of underwriting rules to guide agents and employees, such as commonly used by insurance companies.

(2) *Statement of Benefits.*

The next important consideration is the statement of the nature and extent of the medical and allied services to be rendered to the member.

59. *E.g.*, MINN. STAT. ANN. § 60.85 (1946); TENN. CODE ANN. § 6126 (Williams, Supp. 1941).

60. *E.g.*, MINN. STAT. ANN. § 62.03(2) (1946); TENN. CODE ANN. §§ 6139, 6179(3) (Williams, Supp. 1941).

61. 1 APPLEMAN, *op. cit. supra* note 51, § 211; see generally RESTATEMENT, CONTRACTS §§ 13, 476 (1932).

62. Lindsey v. Metropolitan Life Ins. Co., 10 Tenn. App. 293 (W.S. 1929); generally, 1 APPLEMAN *op. cit. supra* note 51, c. 11.

63. 16 APPLEMAN, *op. cit. supra* note 51, §§ 9081-9160. If the contract is obtained by fraud, it is not void, but only voidable, and it would appear that in order effectively to avoid for fraud the plan must act with reasonable promptness in returning payments made by the member. See generally RESTATEMENT, CONTRACTS § 483 (1932).

64. 4 COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 821, 885i (1929). See generally RESTATEMENT, CONTRACTS, c. 10, topic 5.

65. 16 APPLEMAN, *op. cit. supra* note 51, §§ 9161-9400; 2 Couch, *op. cit. supra* note 64, §§ 530-530e, 842-842v.

Here a word of caution is necessary. These provisions should never be in the nature of a guarantee of service. One can imagine the possible liability of a plan in a case where the member suffers dire consequences as a result of failure to render timely service in an emergency case and where medical care at all times is virtually guaranteed in the contract.

In an insurance policy the provisions as to benefits contain (1) *conditions* under which they are obtainable, as when care is rendered only by a licensed doctor of medicine, (2) *limitations* on the amount payable for certain cases, such as fifty dollars limit for maternity care, and (3) *exclusions*, such as workmen's compensation cases where no benefits are payable.

Service contracts usually require the same types of provisions, notwithstanding the difference between services and money indemnities. However, it should be kept in mind that in a group health plan the physicians on the medical staff are independent contractors[66] and that supervision and control of services by the lay management of the plan is not possible, except to the extent that rules are worked out between the staff and the plan. Further, these rules must be subject to modifications arising from changing conditions in the staff or the patient load. The staff or its medical director must have exclusive right to determine the nature and extent of treatment, as this cannot properly be left to the whim of the member-patient or to the board of directors.[67] Hence, if an insurance policy is used as a guide, these factors must be considered in making proper adaptation.

Following are important and typical subject matters contained in service contracts of existing plans under the three parts of the benefit section.

Conditions: That medical services will be rendered only in accordance with existing rules governing services; that the member must be located within the service area as defined, and that emergency care outside of the area or by physicians not on the staff will be paid for within the limitation stated, subject to approval of the medical staff as to necessity;[68] that services are limited to the facilities and the talents of the existing medical staff; and that the member shall pay the stated monthly dues in advance and within the grace period allowed.

Limitations: That cosmetic surgery is limited to restoration only in accident cases; that drugs, dressings and medicines are limited to those ordinarily supplied in the clinic, subject to extra charges for deep X-ray therapy and the costly, so-called wonder drugs as listed; that ambulance service is limited to certain distances of travel and to stated types of cases;

66. See Pearl v. West End Street Ry., 176 Mass. 177, 57 N.E. 339 (1900).
67. Jordan v. Group Health Ass'n, 107 F.2d 239, 243-44 (D.C. Cir. 1939).
68. See the American Medical Association's statement of suggested principles, *supra* note 23, at point 7.

and that home calls are allowable only in the defined service area. Other limitations are sometimes included in the form of extra charges in certain cases, by way of deterring abuse of the service, such as indiscriminate demand for home calls.

Exclusions: That services do not extend to pre-existing conditions, except on the basis of agreed extra charges; that no service will be rendered for cases of alcoholism, drug addiction, tuberculosis and like conditions requiring special institutional care; that services are not allowable to persons entitled to workmen's compensation and to persons in the military services; that care arising from pregnancy and childbirth is not provided in the first ten months of coverage; and that expensive apparatus, such as wheel chairs, special braces, glass eyes and the like are not included.

(3) *General Provisions.*

This section includes the miscellaneous provisions, generally affecting the entire contract. Typical in existing service contracts are provisions to the effect that the corporation is simply the agent of the members in arranging for medical services and assumes no liability for acts of negligence or malpractice;[69] that the bylaws of the corporation are made part of the contract; that family dependents may be included in the coverage under the stated conditions; and that no person may alter or change the contract without authorization in the prescribed form.

(4) *Duration and Termination.*

Finally the contract must have a stated duration and must be terminable in some specific manner. In health and accident insurance policies, this customarily takes two forms: (1) a statement of the exact term of coverage (as, one month or three months), with a provision that it may be renewed from term to term at the option of the insurer, and (2) a statement of the term (as, one year) at the end of which time coverage automatically ceases, with a provision for cancellation during the term by either party in the specified manner.

In a service contract it would appear more suitable to use the renewable rather than the cancellable form, especially in case of monthly payments. The term may be stated as the calendar month commencing at 12:01 A.M. on the first and ending at the same time on the last day of the month. If coverage is to start during the calendar month, the contract can be written for

69. It is wise to include in both the application and service contract the understanding and agreement that the member waives any claim against the plan on account of negligence and malpractice in the rendering of medical care. This waiver of course would not preclude the member from a claim against the medical staff, which should be insured for this liability. Even if this waiver is carefully drawn, it might be advisable, where employees of the plan arrange appointments or assist the physicians, to include the plan as co-insured in the malpractice policy, if possible.

a preliminary term to the end of that month, after which it is on the regular calendar monthly-term basis. Thus renewal is effected by payment and acceptance of dues in advance of the first day of each month. This has several advantages: it permits the plan to terminate any coverage by exercising its option not to renew without the formal requirements of cancellation, and thus with greater ease terminate members who entered the plan by fraudulent representations, or who fail to pay dues on time, violate the rules or bylaws, or persist in abusing the service; it also permits a member to withdraw easily and without undue delay by simply ceasing to pay dues; it makes for simpler accounting and determination of the amount of earned dues at the end of any month or accounting period; it permits changes in dues, services and rules for services so as to be applicable to all members at the same time; and it provides for perpetual duration so long as the relations are satisfactory to both parties.

In most plans, a joining member or family is required to make an original contribution to capital, used for purchase of facilities, such as furniture, fixtures, office and medical equipment and supplies, and for initial operating expenses, and perhaps also for an equity in a building.[70] In case of termination by the plan, a question may arise as to whether the member's capital contribution should be refunded. This matter should be made clear in the bylaws (which are made part of the contract), so that the plan will not be involved in a contest on this point.

4. *General Comment*

While this discussion of service contracts necessarily has pointed up their practical, technical and legal aspects, it is not intended to give them overdue emphasis. As stated earlier, the member is not dealt with at arms' length as a potential troublemaker. The purpose is simply to give him a clear understanding of his rights and obligations. Fundamentally, the member is part-owner and controller of the corporate device which all the members use together in a democratic way to provide themselves with such degree of medical care as they feel they can afford in budgeted monthly payments. They operate the plan through their elected directors who cause the service contract to be drafted so as to treat all members alike. If the contract proves unfair or unworkable in any respect, the democratic process can be relied upon to right it.

IV. Physicians' Contracts

1. *Nature of the Contract*

The contract between the group health plan and the physicians engaged to render medical services to its members involves both ethical and legal aspects.

70. See note 36, *supra*.

On the *ethical* side, it must be clear that there will be no interference by the lay administration with the medical staff in the practice of medicine and that the confidential relationship of physician and patient will be preserved.[71]

On the *legal* side, the nature of his calling requires that the physician be regarded as an independent contractor.[72] With this in mind, the general law on personal service contracts applies.[73]

Since group practice by the medical staff is an essential ingredient in a group health plan,[74] it is desirable for the staff to organize a partnership,[75] permitting one contract to be made between the plan and the staff. On the other hand, in a new or small plan, feeling its way, it may be expedient to have a separate contract with each physician[76] until experience develops the desired cooperation with the plan and all of the physicians are well enough acquainted to want a partnership agreement.

2. *Provisions in the Contract*

There are several major points which must be considered in the physicians' contract. The provisions on each of these points may vary considerably, depending both on the general nature and organization of the plan adopted and on the wishes of the parties involved. In discussing these points it may be useful to consider variations in plans now in operation. In order to facilitate the discussion three existing plans are first described and designated by numbers.[77]

Plan I. Located in a large city, it serves 4000 families in its own clinic and hospital buildings. The staff of 23 general physicians and specialists practice as a group in a partnership. They are compensated by *annual salaries* stated individually in the contract with the partnership and by additional

71. See note 23, *supra*. For comment see Hansen, *supra* note 3, at 230-34.

72. "But, further, the doctor was not an agent or servant of the defendant in making his examination; he was an independent contractor. There is no more distinct calling than that of the doctor, and none in which the employee is more distinctly free from the control or direction of his employer." Pearl v. West End Street Ry., 176 Mass. 177, 179, 57 N.E. 339 (1900).

73. No case was found in which a physician's contract of the type here discussed has been the subject of court review.

74. See authorities, *supra* note 6.

75. A partnership is desirable also for the purposes of (a) having the staff appoint its medical director or chief of staff to become the responsible liaison with the plan's lay manager, facilitating understandings on rules for the rendering of services and on routine matters, (b) providing procedures for assignment of duties, division of total compensation among the physicians, and settlement of disputes in the staff, (c) providing methods of agreement as to adding or terminating staff members, (d) providing a single, coordinated set of accounting and medical records, and (e) engendering free consultations among staff members and their practice of medicine as a group.

76. These contracts, however, could each contain standard clauses providing for the type of coordination within the staff and cooperation with lay management as mentioned in note 75, *supra*.

77. These three plans were from the survey mentioned in note 1, *supra*.

amounts on a formula related to income of the plan. They devote their full time exclusively to the needs of the members.

Plan II. Located in a rural area, it serves 1400 families in its own combined clinic and hospital building. The staff of 3 general physicians and 2 specialists, is augmented by several visiting specialists from the nearest city who treat members on appointed days at the plan's facility for *per diem* compensation. Since the plan has the only hospital in a radius of 25 miles, nonmember patients must be eared for by the staff on a fee-for-service basis. The staff pays about 35% of such income to the plan for use of its facilities and other services in connection with such private practice. The plan has an individual contract with each of the staff members, who otherwise practice together as a group. Compensation is in the form of a *guaranteed minimum annual income,* with the plan paying a specified monthly salary. If the salary plus income from nonmember patients does not equal the guaranteed minimum, the plan pays the difference.

Plan III. Located in large metropolitan area, it serves over 250,000 members through 29 medical groups each having at least 13 specialists on its staff. Each medical group owns or leases its clinic facilities, and the plan maintains only its administrative office. Each member selects his medical group, which is then paid by *capitation* a fixed amount per member per year. Each medical group is a partnership and has a single contract with the plan. Most of the physicians in these groups also engage in private practice. The advantage in this type of plan is the relatively small requirement for initial capital, since the participating physicians own and maintain their own space and equipment.

(1) *Methods of Compensation.*

The ideal methods of compensating the medical staff are by *salary* (*Plan I)* or by *capitation (Plan III),* as these facilitate budgeting and calculation of the rate of members' dues. A *guaranteed minimum income* (*Plan II*) might be indicated when nonmember or private practice is included and that method is desired to induce physicians to participate.[78] It has the advantage of offering security without fixing maximum income. Another method is to base compensation on *percentage of dues income,* leaving the balance for administrative overhead.

In any of these methods, excepting salaries, there is a possibility for dispute if lay management feels that the membership has grown to the point

78. Particularly for rural areas, where, to attract physicians, it is necessary to form a community prepayment plan to (a) create a modern medical facility and (b) assure physicians adequate incomes, good times or bad. When the health center is established nonmember practice is inevitable in rural areas because of the general shortage of physicians and facilities.

where more physicians are needed. Enlargement of the medical staff may then mean reduction of individual compensation, and the contract should foresee and provide for this.[79] Incidental and automobile expense of the physicians in connection with their services must also be considered.

(2) *Benefits and Privileges.*

The contract should grant stated leaves for vacation and illness without loss of compensation. *Plans I and II* also provide a stated period for study leave in each year or biennium on the same basis. *Plan III* makes no provision for these matters and is concerned only with quality and adequacy of the services rendered. *Plan II* provides a pension plan for its physicians through equal contributions to a trust fund by the staff and the plan.

It is desirable to have a procedure for the staggering of absences from staff functions so that medical services will not be unduly disturbed.

With such privileges, granted in addition to adequate income and the overall security for the physician in the contract, both parties benefit—the members by having a staff functioning in a contented atmosphere, and the physicians in realizing the ideal situation for the practice of their science, free from concerns of the future and diversions of business functions common to private practice.

(3) *Equipment and Supplies.*

Almost all plans having their own facilities furnish from their funds the clinic space, equipment, furniture, fixtures, diagnostic and therapy devices, instruments, and the drugs, dressings and medicines commonly used or dispensed in office or home treatment. The notable exception is in the type of *Plan III* where the contract provides that the established clinic shall furnish all such items from its own funds, and capitation payments contemplate this additional cost to the physicians.

This part of the physicians' contract must be coordinated with the members' service contract, so that the physician is clear on what he may dispense with treatment and the member may know what items he must purchase from his own funds, such as the costly "wonder drugs." Experience has indicated the possibility for unreasonableness on both sides in this matter, and only properly drawn contracts will avoid unnecessary difficulty.

(4) *Services to Be Rendered.*

Usually the contract either repeats the services listed in the member's contract or attaches it as an exhibit. This is the simplest way to make clear the nature and extent of the services to be rendered by the staff.

79. A ratio, such as 750 to 1000 members to each general physician (more to various specialists) might be used, or arbitration provided if this matter cannot be resolved by mutual agreement.

If no private practice, in addition to prepaid practice, is contemplated, as in *Plan I,* the contract requires fulltime and exclusive service to the needs of the members; otherwise it provides adequate attention to their needs and includes a clause that the physicians will not engage in other contract practice without consent of the plan.

Requirements must be included for maintenance of proper medical records, and it is desirable to provide for periodic reports to the plan of at least the number and types of preventive measures and curative treatments by ailments as rendered in the clinic, hospital or homes of the members. Such simple statistics will aid the staff and the plan in determining utilization of services and ways to improve them, and in calculating costs of various units of service. In larger plans such information is all the more necessary.

Primarily important in this section of the contract are the provisions for cooperation between the staff and lay management for development of rules to be followed by the members, and to some extent by the staff, in the rendering of services. Rules include such matters as freedom for the member in choosing a general physician on the staff as his personal physician; times and manner of making clinic appointments; restrictions on home calls; conditions for admissions to hospitals, except in emergencies; pathology reports on all tissue removed by surgery; handling of contagious conditions; and mutual courtesies.

Nothing written on paper, of course, will create the desired mutuality of interest and cooperation among members of the staff and between them and the plan's management, but contract provisions for rule procedures, and for arbitration of differences can do much to maintain cordial and workable relations.

(5) *Technicians, Nurses and Lay Employees.*

The lines may sometimes be blurry concerning responsibility for and control over auxiliary personnel as between the medical staff and the plan. If the plan is to compensate such personnel and assume all employer's obligations, while the staff is to govern their functions, some inconsistencies may develop. Questions as to relative liability for negligence and malpractice may also arise.

It is clear that nurses, private secretaries and medical records librarians should be controlled by the staff, while accountants, clerks and the like should be controlled by the plan. Laboratory and X-Ray technicians may present a problem, except where the plan operates a hospital and the customary practice is followed in placing them under hospital control. In a clinic operation alone, technicians should probably be controlled by the staff.

When it is decided which personnel is properly controllable by the staff, the contract should make the matter clear. Then the obligations for compensation, federal and state contributions for unemployment and social security benefits, workmen's compensation insurance and the like, should be stated.

Existing plans either (1) make these the obligations of the staff with provision for payment to the staff of additional compensation equal to these burdens, or (2) assume these obligations and make a service agreement for providing such personnel to the staff as necessary, on conditions that the staff control their functions and save the plan harmless from any liability on account of their activities. This problem is not encountered in plans of the type of *Plan III*.

(6) *Insurance Protection Required.*

While care is exercised in defining the medical staff and its auxiliary personnel as independent contractors, the plan might be joined as an additional denfendant in an action by an injured member or third party, and its liability, or otherwise, may not always be crystal clear.

As mentioned, the members' application and contract should waive any claim against the plan for negligence and malpractice in the rendering of medical care. The physicians' contract should also save the plan harmless from such liability. Still the plan should be co-insured for such liability in the malpractice policy if this is possible. There may be instances when acts of auxiliary and lay personnel may enter the claim; also, such insurance would cover costs of defense.

When the staff and lay management occupy the same building, both should carry public liability insurance covering injuries on the premises, whether in the same or in separate policies. The contract must also be specific as to workmen's compensation insurance.

The contract should also require that members of the staff and auxiliary personnel carry public liability insurance on their automobiles with adequate limits of coverage and with the plan included as co-insured in such policies. The particular mission for which such an automobile is used at the time of an accident might well involve the plan directly, and dangerous exposure to sizable liability exists constantly.

Plans of the type of *Plan III* would not ordinarily be exposed to the above mentioned hazards.

(7) *Duration and Termination.*

The term of the contract should be sufficiently long to permit the physicians to think in terms of permanent participation in the plan and the fore-

going of possible opportunities elsewhere. In many cases, it is a new venture for a physician and a departure from traditional practice. If reasonable security is provided, the mutuality of interest, which the spirit of the contract should engender, will be enhanced. The physician should be given a feeling of "belonging" at the outset and the contract entered into with a desire for cooperation on both sides, and not in the spirit of a business deal.

Contracts in *Plans I and III* have terms of 5 ycars, and in *Plan II* a perpetual duration subject to termination by either party on stated notice, except on the part of the plan in the first year.

Termination by the physician on rcasonable notice presents no particular problem, but inherent in the security offered by the contract are the conditions as to termination by the plan.

A distinction between termination for *cause* and *without cause, i.e.,* any reason except for a stated cause, should be defined and notice and conditions in each case specified. For example, *Plan I* lists such things as gross negligence or incompetence, malpractice, habitual intemperance, violation of narcotics laws, and dishonesty as constituting *cause* for termination.

On the other hand, though not constituting such readily acceptable grounds for cause, repeated discourtesies toward members or obnoxious personality traits may equally justify termination. However, since reasonable men may disagree on the meaning of such phrases, they are not listed as good cause in the contract. Rather, the plan may in such cases, use the "without cause" provision which requires no stated reason but does require a longer period of notice and perhaps a stated amount of "severance" compensation, depending on how long the contract has been in force.

With or without cause, the nature of the partnership of physicians on the staff and their relations as a body with the lay management for the members, demands procedures for termination of individual physicians which will avoid whimsical or arbitrary action.

For example, the procedure for *cause* under the contract in *Plan I* requires the staff to determine guilt of the physician upon charge by the plan or any physician on the staff after notice and fair hearing to the physician so charged. Only on such determination by the *staff* may a physician be terminated for cause. On any other ground than those listed for cause, a two-thirds vote of the staff by secret ballot is required for termination. If such vote does not result in termination and the board of directors of the plan decides that the physician should nonetheless be removed, then the matter is submitted to the arbitration committee composed of one person chosen by each side, these two choosing a neutral third person, who together decide the matter by a two-thirds vote.

If the demand for services is less than anticipated, or because of financial condition of the plan, the staff must be reduced, considerably different provisions for termination must be stated. One plan provides in such case that the staff shall determine which physicians are to be terminated, or it may decide to reduce its income to meet the situation temporarily.

The contract should provide that if a physician leaves for any reason, all medical and other records shall remain the property of the staff and that no part of them shall be removed. In case private practice is included as in *Plan II,* a special problem is presented in this regard, particularly as to accounts receivable. Ordinarily all records on members should remain with the plan. If the plan has an equity in accounts receivable for private practice by virtue of a guaranteed minimum income, as in *Plan II,* the plan might continue to make collections after termination and render proper accountings and remittances periodically.

Some contracts provide that after termination for any reason, a physician shall not engage in practice in the vicinity of the service area for a stated period of years.

V. CONCLUSION

As indicated, group health plans assume different structures and operations, depending upon such factors as the size and character of the community, the needs and financial resources of the people and the availability and social attitudes of physicians. These are matters generally outside the training of the counseling lawyer. Nonetheless, the interested group who become his clients will often give him little more than the general idea and expect him to give it life and substance. At this point he will do well to review with them the legal problems involved and advise contact with experienced consultants.

Only when the organizing group is fully advised and prepared to strike the pattern should the legal work begin. At this point the entire character of the plan, created through its corporate structure and operating contracts, should be reviewed at one time, since one part affects all the others. It is difficult to imagine any other venture which presents such delicate problems of integration. Perhaps this arises from the novelty of the arrangement, the changed economic relationship between physician and patient, and the departure from old customs.

In any event there are few times in man's quest for health and security where a lawyer can participate with more satisfaction than in helping to create a successful group health plan.