Opinion No. 46-4884

March 25, 1946

BY: C. C. McCULLOH, Attorney General

TO: Mr. Ralph Apodaca Superintendent of Insurance State Corporation Commission Santa Fe, New Mexico

*{*210}* We are in receipt of your letter of February 28, 1946, and the enclosed memorandum, Articles of Incorporation and By-laws, relating to a plan known as New Mexico Physicians' Service. You ask our opinion as to whether the plan, as outlined in the enclosed memorandum, constitutes the doing of an insurance business.

As outlined, the plan is briefly as follows: The corporation will be organized as a non-profit corporation. There are three types of members contemplated by the Articles of Incorporation and By-laws, to-wit:

First, there are the administrative members, who will constitute the governing authority of the corporation.

Second, there are the professional members. These members will be comprised of physicians who will render their services in carrying out the plan.

*{*211}* Third, there are the beneficiary members, who will be made up of all members of the public who desire to participate. Beneficiary members will contribute a monthly, quarterly, semi-annual and annual amount, which will run approximately $ 2.00 per month. A beneficiary member, when in need of medical service, will be given a card or certificate which will entitle him to go to any physician of his own choosing, who is a professional member of the corporation. The professional member will, instead of billing the patient, bill the corporation. His bill will be based upon a unit plan, to be worked out, so that every kind and character of service will constitute a certain number of units. At the end of the month or other specified period, the corporation will divide among the professional members the amount of funds available, the division to be made in proportion to the number of units set forth by each professional member. In no event will the professional member be paid an amount in excess of the value of the services rendered, as determined by the trustees of the corporation. Such excess, if any, will be carried forward for future payments paid to the doctors on a unit basis for periods of time in which they did not receive an amount equivalent to the value of their services, or the monthly payments of the beneficiary members will be cut so that no excess accrues. No profits will go to the beneficiary members except as services, or upon the dissolution of the corporation.

By Section 7, Paragraph (d) (1), the trustees are authorized to determine the scope of medical services to be available to beneficiary members, and any conditions thereto.

The insurance laws of the State of New Mexico do not define the term "insurance." Section 60-101 merely provides that:

"The word 'insurance' shall be held to mean any form of insurance, bond or indemnity contract, the issuance of which is legal in the State of New Mexico."

See also Section 60-501, Class 2 (a):

"Accident and Health. -- Insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age. and every insurance appertaining thereto."

As the word "insurance" is not defined by our laws, we must look to common law definition to determine what insurance is in New Mexico.

The author, in 29 Am. Jur. 47, says:

"The authorities are substantially agreed that insurance generally may be defined as an agreement by which one person for a consideration promises to pay money or its equivalent, or to perform some act of value, to another on the destruction, death, loss, or injury of someone or something **by specified perils.**

"As a general matter, the essential feature of policies of insurance at the present time is substantially that of indemnity to the insured. Insurance has consequently been defined, by statute in some jurisdictions, as a contract whereby one undertakes to indemnify another against loss, damage, or liability **arising from an unknown or contingent event.** It has likewise been defined as a contract whereby one party agrees to wholly or partially indemnify another for loss or damage which he may suffer from a specified peril. * * *"

Also see the many cases cited in 21 Words and Phrases, starting at Page 723. It will be seen, from these definitions, that there are three necessary elements of a contract of insurance, namely, consideration, contingency and indemnity, or its equivalent.

*{*212}* Where the other elements of insurance are present, a contract may be one of insurance, even though not payable in cash, if payable by a thing of value. See Benevolent Burial Association v. Harrison (Ga.), 121 S. E. 829.

Under the plan, as outlined above, the question resolves itself to whether the contracts, when made, would be contracted to indemnify the beneficiary members against loss upon the happening of a contingent event.

Aided by the case hereinafter set out at length, it appears that the indemnity feature of insurance is not necessarily present. Indemnity means compensation for loss. (See 20 Words and Phrases 679.) Under the plan there does not appear to be any agreement to compensate for loss, as neither the professional nor the administrative members

assume the risk of losses by the beneficiary members. The beneficiary members do not receive any compensation for a loss. Rather, it appears to be a plan by which the beneficiary members are provided with medical service, and the professional members receive compensation for their services. The compensation received by the professional members is not fixed by the value of the services received by the beneficiary members, but is determined by the amount available for such purpose. Thus, it appears that the feature of indemnity, as contemplated by the laws of insurance, is not present.

Further, there is a very close question as to whether the element of contingency or peril is present.

Strong arguments can be made that the contract is in the nature of a retainer arrangement, which has long been looked upon as outside the field of insurance. Under a retainer contract, a client pays his attorney a fee for services rendered over a future period at a time when the amount and character of services are unknown. While the services may be great or small during the specified period of time, both the client and attorney know that some services will probably be needed, and that on an average for such period they are worth approximately this specified amount.

The same may be said to be true of medical services of the average individual. At the start of a year, while not knowing the exact amount or character of medical services he will need, he knows, from his past experience, that he will need medical services, and the average amount of such services.

As the plan is new, there have been few decided cases upon the question. However, the case of California Physicians' Service v. Garrison, 155 P. 2d 885 is directly in point, as the Court in that case was passing upon the plan from which the New Mexico Physicians' Service is copied. I will quote at length from this case, as the Court, in passing upon the question, cited nearly all the authority upon the subject.

"Finally it is argued that the respondent is engaged in the insurance business and hence subject to the supervision and control of the appellant. The respondent's reply takes two lines of argument. First, that its method of operations is not that of insurance. Second, that if it be such it is not subject to the supervision of the insurance commissioner. * * * The appellant cites no authority directly in point. His argument is that the obligation to the beneficiary members assumed by respondent looks like insurance and should be so interpreted. On the other hand the respondent argues that it is similar to a producer - consumer cooperative organization, that it does not indemnify or compensate for the cost of an illness or injury, that it does not assume any risk, that its professional members do not assume any risk, that the beneficiary members do not receive any indemnity or compensation. The respondent emphasizes that its obligation is that of an agent to collect and administer the funds, to pay its *{*213}* professional members upon the unit basis out of these funds, only, but that the beneficiary members receive the professional services notwithstanding the condition of the treasury. The respondent denies the implication in appellant's brief that the beneficiary members must look to the

pooled fund for indemnity against medical bills and emphasizes that they merely pay for such services on a periodic basis rather than in a lump sum.

"As the operations of respondent are comparatively new there is little authority on the direct question whether these operations are to be classed as insurance. The decided cases favor the position of respondent. Butterworth v. Boyd, 12 Cal. 2d 140, 82 P. 2d 434, 126 A. L. R. 838, involved a portion of the San Francisco charter providing compulsory health service to all municipal employees paid by monthly payroll deductions on all salaries to maintain a fund to cover medical, surgical and hospital care. Physicians eligible to render service were paid on the unit system similar to that used by the respondent. In an action brought to test the validity of the charter, the state insurance commissioner appeared specifically to raise the question whether the activities proposed were a form of insurance and as such subject to the state insurance code. The court rejected the contention saying that the Insurance Code dealt only with the private business of insurance.

"In Commissioner Bank and Insurance v. Community Health Service, 129 N. J. L. 427, 30 A 2d 44, 45, the sole question was whether the corporation was engaged in the insurance business. It was incorporated to provide medical services to its subscribers. It made contracts with licensed physicians to render professional services for a stipulated compensation. The subscribers were entitled to the services whether or not they needed them. The corporation did not undertake to pay such debt as the subscribers might incur and did not indemnify them against any loss. The court there said: 'Neither as between the corporation and the physician, nor as between the physician and the subscriber is the compensation or any other element of the arrangement between them affected by any contingency, hazard or risk.' In holding that the business conducted by the corporation was not one of insurance the New Jersey court cited with approval State ex rel Fishback v. Universal Service Agency, 87 Wash. 413, 151 P. 768, Ann. Cas. 1916 C, 1017; Sisters of Third Order of St. Francis v. Guillaume's Estate, 222 Ill. App. 543; and Stern v. Rosenthal, 71 Misc. 422, 128 N. Y. S. 711.

"In Jordan v. Group Health Ass'n., 71 App. D. C. 38, 107 F.2d 239, a declaratory judgment was sought against the insurance commissioner of the District of Columbia to determine whether the activities of the Association were subject to the supervision of the commissioner. The Association was a nonprofit corporation organized to provide without profit medical services, surgery and hospitalization for its members. Its membership was limited to civil service employees of the executive branch of the government and its general plan was similar to that provided in the San Francisco charter. In holding that the Association was not engaged in the insurance business the Circuit Court of Appeals for the District of Columbia had this to say: 'Although Group Health's activities may be considered in one aspect as creating security against loss from illness or accident, more truly they constitute the quantity purchase of well-founded, continuous medical service by its members. Group Health is in fact and in *{*214}* function a consumer co-operative. The functions of such an organization are not identical with those of insurance or indemnity companies. The latter are concerned primarily, if not exclusively, with risk and the consequences of its descent, not with

service, or its extension in kind, quantity or distribution; with the unusual occurrence, not the daily routine of living. Hazard is predominant. On the other hand, the cooperative is concerned principally with getting service rendered to its members and doing so at lower prices made possible by quantity purchasing and economies in operation. Its primary purpose is to reduce the cost rather than the risk of medical care; to broaden the service to the individual in kind and quantity; to enlarge the number receiving it; to regularize it as an every-day incident of living, like purchasing food and clothing or oil and gas, rather than merely protecting against the financial loss caused by extraordinary and unusual occurrences, such as death, disaster at sea, fire and tornado. It is, in this instance, to take care of colds, ordinary aches and pains, minor ills and all the temporary bodily discomforts as well as the more serious and unusual illnesses. To summarize, the distinctive features of the cooperative are the rendering of service, its extension, the bringing of physician and patient together, the preventive features, the regularization of service as well as payment, the substantial reduction in cost by quantity purchasing, in short, getting the medical job done and paid for; not, except incidentally to these features, the indemnification for cost after the service is rendered. Except the last, these are not distinctive or generally characteristic of the insurance arrangement. There is, therefore, a substantial difference between contracting in this way for the rendering of service, even on the contingency that it be needed, and contracting merely to stand its cost when or after it is rendered.' And again 71 App. D. C. at page 47, 107 F.2d at page 248: 'But obviously it was not the purpose of the insurance statutes to regulate all arrangements for assumption or distribution of risk. That view would cause them to engulf practically all contracts, particularly conditional sales and contingent service agreements. The fallacy is in looking only at the risk element, to the exclusion of all others present or their subordination to it. The question turns, not on whether risk is involved or assumed, but on whether that or something else to which it is related in the particular plan is its principal object and purpose.' We find in that case the express admission 71 App. D. C. at page 47, 107 F.2d at page 248, 'that the identical plan and service rendered here would not be "insurance" or "indemnity" if offered by an organization owned, operated and controlled by physicians. It would then be a contract "for service on contingency," though the same element of risk and avoidance of its possible consequences would be present.' * * *"

The Attorney General of Wisconsin, in passing upon a similar plan, said, in 25 Opinions of the Attorney General of Wisconsin, page 192:

"Many other definitions of insurance and insurance contracts could be given but they differ in form only, and not in substance. Ordinarily, although not always, an insurance contract is a contract of indemnity, and the business of insurance is the business of making contracts of indemnity.

"The contract to which you have called our attention does not appear to be one of indemnity, nor does it appear that an insurance company could be organized for such purpose. Sec. *{*215}* 201. 04, Stats., lists some seventeen purposes for which insurance corporations may be formed in Wisconsin, but plans of the sort here under discussion are not included in the list.

"It seems to us that the plan merely involves payment in advance on a retainer basis for future medical services. As far as we know the plan is a relatively new one in medical practice in this country, and it may raise questions of professional ethics and social practice, which it is not the function of this office to discuss here. However, the principle of payment for professional services on a yearly or other periodic basis regardless of the amount of service rendered is of long standing in the legal profession. Many of the leading and most ethical lawyers of this and other states have been accepting annual retainers for years from corporations and individuals. Under these arrangements the lawyer is obligated in advance to furnish all legal service that may be required by the client during the course of the year. Such service may range from practically nothing on the one hand to situations where on the other hand very heavy demands may be made upon the lawyer's time and energy. Thus the retainer may amount to what is practically a gratuity in the one instance, to compensation which is entirely inadequate in other instances."

In view of the foregoing, it is my opinion that the New Mexico Physician's Service plan, as provided for in its Articles of Incorporation and By-laws, and outlined by the memorandum submitted in connection therewith, is not insurance within the laws of the State of New Mexico. However, as the Articles and By-laws give the administrative members broad powers, this opinion should not be construed to mean that the New Mexico Physicians' Service could not be so operated as to become insurance. This would especially be true if the vices which have caused the enactment of our insurance code should arise.

By ROBERT W. WARD

Asst. Atty. General