

Cleveland State University  
**EngagedScholarship@CSU**



**Cleveland-Marshall**  
College of Law Library

---

Cleveland State Law Review

Law Journals

---

1959

# Non-Profit Hospital Service Plans

Leo A. Simpson

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/clevstlrev>

 Part of the [Health Law and Policy Commons](#), and the [Insurance Law Commons](#)

**How does access to this work benefit you? Let us know!**

---

## Recommended Citation

Leo A. Simpson, Non-Profit Hospital Service Plans, 8 Clev.-Marshall L. Rev. 492 (1959)

This Article is brought to you for free and open access by the Law Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Cleveland State Law Review by an authorized editor of EngagedScholarship@CSU. For more information, please contact [library.es@csuohio.edu](mailto:library.es@csuohio.edu).

## *Non-Profit Hospital Service Plans*

*Leo A. Simpson\**

**F**OR OVER 300 years attempts have been made in North America to prepay the cost of health services through voluntary group action. At Ville-Marie on the Island of Montreal a contract was made on March 3, 1655 which read in part as follows:

Urbain Tessier dit Lavigne (and) 36 others, acting both for themselves and their families and children (contracted with) Etienne Bouchard, Master Surgeon of the said Ville-Marie . . . (for the latter) to dress and to physic, of all sorts of illness, whether natural or accidental, except the plague of small pox, leprosy, epilepsy and lithotomy or cutting for the stone . . . in consideration of the sum of 100 sous each year, payable by each of the above mentioned persons . . . in two terms and quarters . . . and to treat also their children who may hereafter be born . . . <sup>1</sup>

Later, particularly in the 19th century, there was a rise in group health service activities sponsored by benevolent societies, trade unions and employers. Much of this activity stemmed from a desire to avoid the need for charity when sudden illness threatened a family with economic disaster.<sup>2</sup>

No widely accepted pattern of providing health services on a prepaid basis emerged in the United States, however, until the 1930's. In 1929 the school teachers of Dallas, Texas, organized a plan with the cooperation and agreement of Baylor University Hospital. In return for a stipulated annual fee each participating member of the group became entitled to semi-private room service plus board and nursing, use of the operating room, anesthesia, laboratory fees, routine drugs, dressings and hypodermics. There were many other single-hospital plans but the Baylor experiment became the most widely publicized. It is generally acknowledged to have been the true forerunner of the Blue Cross movement.<sup>3</sup> It is to this movement that the balance of this article is devoted.

---

\* LL.B., Cleveland-Marshall Law School; Member of the Ohio Bar; Undergraduate work at Western Reserve Univ.; Manager of Enrollment Division of Blue Cross of Northeast Ohio; etc.

<sup>1</sup> Hawley, *Non-Profit Health Service Plans*, 11, (Blue Cross Commission, Blue Shield Commission, 1949).

<sup>2</sup> Goldman, *Voluntary Medical Care in the United States*, 35-37, Columbia Univ. Press (1948).

<sup>3</sup> *Id.*, 94.

The next developments were the establishment of plans providing service not only at one hospital but at all hospitals in a community or in a county. The Blue Cross Plan which now serves the state of New Jersey was originally organized as a one county operation in 1933.<sup>4</sup> Five other community group hospitalization plans were started in 1933, and three more began in 1934.<sup>5</sup> An important factor in the growth of these community-wide plans was their free-choice aspect in the selection of a hospital.

By July 1, 1937 there were 33 such plans with a total enrollment of almost one million persons.<sup>6</sup> Today there are 83 Blue Cross plans with an over-all enrollment of more than 55 million.<sup>7</sup>

In 1938 the American Hospital Association elaborated upon a set of principles previously formulated, to which non-profit hospital service plans must conform in order to be approved by the Association. The term "Blue Cross" is copyrighted and can only be used by approved plans. Some of the standards to be met are representation of hospitals, the medical profession and the public on the governing board; non-profit sponsorship and control; free choice of hospital and physician; hospital responsibility for benefits to subscribers; inter-plan coordination of individual transfers, reciprocal benefits, and billing and enrolling of employees of national firms.<sup>8</sup>

The major distinction between Blue Cross operation and that of a commercial insurance company which offers protection against hospital bills is the guaranty by Blue Cross of service benefits rather than a limited cash indemnity. This guaranty is implemented and made effectual by means of an agreement with each participating hospital to furnish contract services, if available, and to look solely to Blue Cross for payment.<sup>9</sup> Although actuarial data is relied on to formulate rates and regulations, and although the insurance principle of "spreading the risk" among

<sup>4</sup> Hawley, *op. cit. supra* n. 1, p. 13.

<sup>5</sup> *Id.*

<sup>6</sup> Rorem, *Hospital Care Insurance*, 71, (Amer. Hosp. Ass'n. 1937).

<sup>7</sup> As of March 31, 1959. Public Service Bulletin PR-59-9A, (Blue Cross Commission of Amer. Hosp. Ass'n., June 19, 1959). This represents 30.31% of total population of the United States, Alaska and Puerto Rico. Leading states are Rhode Island, 73.86%; District of Columbia, 73.05%; Delaware, 61.68%; New York, 58.60%; Ohio, 50.90%; Pennsylvania, 50.63%.

<sup>8</sup> Hawley, *op. cit. supra* n. 1, pps. 16 and 17.

<sup>9</sup> As to statutory effect given to this provision, see below.

the entire body of subscribers makes the operation of these plans possible, the service benefit guaranty characterizes the plans as systems for the purchase of service through prepayments rather than insurance. (This distinction has not always been recognized as will be seen, nor is the issue free from doubt today.)

There is considerable variation in the extent of benefits offered throughout the nation. In general, however, most contracts provide from 21 to 730 days of bed patient care, consisting of room, board, general nursing, laboratory tests, x-ray service, use of the operating room, routine drugs and dressings, special diets, hospital-administered anesthesia, and basal metabolism tests. Emergency room service in accident cases are usually covered.

Similarly, rules for enrolling groups vary among the plans. By far the great majority of subscribers are enrolled through their places of employment, with the payments being made by payroll deduction or by the employer as a "fringe benefit," or by both methods. The minimum size of an eligible group varies from 5 to 25 with a further requirement that a certain percentage of the employees enroll. This percentage ranges from 40% for large groups to 100% for small employers.<sup>10</sup>

An important part of the program is the enrollment of non-group subscribers. This includes self-employed and retired persons, farmers and persons employed at a firm too small to form a group. In many plans these subscribers are offered identical benefits as group subscribers. The same is true for persons who leave a group and continue their subscriptions.

There are undoubtedly many reasons for the rapid growth of the pre-payment concept in the 1930's. Among them were collection problems of hospitals, heightened as they were by the depression; the reduction of hospital income from such sources as gifts and endowments coupled with a sharp increase in charity cases;<sup>11</sup> demand from the public for some system of distributing the risk of economic disaster brought about by sudden hospital bill. Mr. John R. Mannix, Executive Vice-President of Blue Cross of Northeast Ohio, believes that the wide-spread use of install-

<sup>10</sup> Rorem, *op. cit.* supra n. 6, pps. 29-31.

<sup>11</sup> "During the recent economic depression, hospital income from endowments and voluntary contributions was decreased by about two-thirds, the charity load was increased almost fourfold . . ." American Medical Association Bureau of Medical Economic Research, *Group Hospitalization 5* (Amer. Med. Assn. 1937).

ment sales during the 1920's led naturally to a demand for a similar system for hospital services.<sup>12</sup>

The sponsors of the early plans were quite naturally concerned with the legal status of their proposed operations. There were obvious objections to forming a stock insurance company to operate for profit a business which was designed to distribute the cost of services of non-profit hospitals. To incorporate as mutual insurance companies would invite sales resistance due to the possibility of assessments against members for operating losses. Also various statutory provisions required that insurance companies deposit with the state substantial sums as evidence of good faith and accumulate large amounts of working capital before commencing business. Such requirements would virtually have precluded hospitals from organizing service plans at all, since they were unable to raise such capital.<sup>13</sup>

Curiously enough, Ohio had a statute, passed in 1903, providing that no law pertaining to insurance was to be construed to apply to a non-profit corporation engaged in furnishing hospital services under contracts with residents of the county in which the hospital was located.<sup>14</sup> It was under this law that Ohio plans operated until 1939. By that time the limitations of operating within one county had been felt and experience of plans in other states which were regulated by the department of insurance under special enabling acts spurred the Ohio plans to request similar legislation.

The result was an amended law<sup>15</sup> which retained the insurance law exemption<sup>16</sup> but gave supervisory powers to the superintendent of insurance.<sup>17</sup> It also declared such corporations to be charitable and benevolent institutions and exempt from taxation,<sup>18</sup> and it required that funds of a hospital service association be invested only in securities permitted for the investment of funds of a life insurance company.<sup>19</sup> A key section insofar as the nature of a hospital service association is concerned provides that all subscriber contracts shall constitute direct obligations

---

<sup>12</sup> Personal interview, June 12, 1959.

<sup>13</sup> *Op. cit. supra* n. 11, p. 43.

<sup>14</sup> Rev. St., Sec. 289; Gen. Code, Sec. 669.

<sup>15</sup> *Id.*, (Code) Secs., 1739.01 to 1739.15.

<sup>16</sup> *Id.*, Sec. 1739.02.

<sup>17</sup> *Id.*, Sec. 1739.05 and 1739.13.

<sup>18</sup> *Id.*, Sec. 1739.07.

<sup>19</sup> *Id.*, Sec. 1739.11.

of the hospitals with which the association has contracted for hospital care.<sup>20</sup>

It is this section which assures a subscriber in good standing that he will be furnished needed contract services, if available, when he enters a contracting hospital. The hospital must then look solely to Blue Cross for payment.

Under the 1903 statute mentioned above<sup>21</sup> the Ohio Attorney General ruled in 1933 that hospital service plans proposed in Cleveland and Akron would be exempt from the insurance laws.<sup>22</sup> The same result was not reached in all states. In 1933 the Bureau of Medical Economics of the American Medical Association conducted a survey among the insurance departments of all states. Only ten states reported that group hospitalization contracts would not be insurance contracts.<sup>23</sup>

An official ruling by the New York Superintendent of Insurance declared that the plan proposed in New York City would be insurance. Promptly a bill was drafted, sponsored and passed, enabling non-profit hospital service plans to operate under the supervision of the Insurance Department but exempt from insurance laws.<sup>24</sup> Most of the provisions were later adopted in Ohio and have already been referred to.<sup>25</sup> One difference is a requirement that the commissioner of social welfare shall determine the adequacy of payments to hospitals.<sup>26</sup> The importance of such a provision will be treated later.

The New York law has served as a guide for enabling legislation in other states. By 1949 thirty-five states had similar laws.<sup>27</sup>

As has been indicated, certain basic principles of insurance characterize the economics of hospital service associations. Clearly the subscriber rates are actuarially determined. Certainly there are unknown contingencies involved. Neither the associations nor the subscribers *know* if or when hospital care will be needed and until such event takes place the association incurs no liability. In essence, however, the contract represents

<sup>20</sup> *Id.*, Sec. 1739.06.

<sup>21</sup> *Supra* n. 14.

<sup>22</sup> 1933 OAG No. 1630.

<sup>23</sup> AMA Bull. 28:113 (Oct. 1933).

<sup>24</sup> N. Y. Insur. L. Secs. 250-260.

<sup>25</sup> *Supra* ns. 15 to 20.

<sup>26</sup> N. Y. Ins. L. Sec. 254.

<sup>27</sup> Hawley, *op. cit. supra*, n. 1, p. 14.

the sale of hospital services on a prepayment basis. When that contract is implemented by another between the association and a hospital, the hospital incurs a contractual as well as a statutory duty to provide the services specified when needed and if available, whether or not the association has funds with which to pay the hospital. It is not, therefore, a contract of indemnity but of service.

Generally this distinction is recognized:

A majority of cases dealing with the subject hold that a corporation, whether or not organized for profit, the object of which is to provide the members of a group with medical service and hospitalization is not engaged in the insurance business . . .<sup>28</sup>

In *Michigan Hospital Service v. Sharpe, et al.*,<sup>29</sup> the Michigan Blue Cross Plan had paid a substantial bill on behalf of its subscriber, Sharpe. The causes of Sharpe's hospitalization were injuries incurred through the negligence of a third party. Sharpe claimed damages and included as an item his hospital services. During the negotiations, Blue Cross notified all parties that it had a right of subrogation for the amount paid. Disregarding such notice, Sharpe received a settlement which presumably included his item for the value of his hospital services. Suit was brought to enforce Blue Cross' alleged right of subrogation although the contract made no mention of such rights.

In denying recovery to plaintiff, the Michigan Supreme Court ruled that while subrogation is an equitable doctrine and does not depend upon a contract clause, it only arises in favor of one who discharges an obligation of another. The court construed the obligation for the hospital bill to be a primary liability of Blue Cross rather than of the subscriber. The case held that Blue Cross is not an insurance company but a provider of service and that it has no rights of subrogation.<sup>30</sup>

This case raises another inquiry. It is generally held that a plaintiff cannot be required to eliminate from his damages those items for which he was compensated by insurance or which were

<sup>28</sup> 29 Am. Jur. 1958 Supp. 5, citing *California Physicians' Service v. Garrison*, 28 Cal. 2d 790, 172 P. 2d 4, 167 A. L. R. 306 (1946); *Michigan Hospital Service v. Sharpe, et al.*, 339 Mich. 357, 63 N. W. 2d 638 (1954).

<sup>29</sup> *Michigan Hospital Service v. Sharpe, et al.*, supra n. 28.

<sup>30</sup> Cf. *Barmeier v. Oregon Physicians' Service*, 194 Ore. 659, 243 P. 2d 1053 (1952), holding that a similar corporation was not an insurance company but upholding a contract provision requiring the member to seek recovery from the tortfeasor before the corporation would pay.

paid by a party not having an obligation to do so.<sup>31</sup> Conversely, the proposition is well recognized that an injured party may not include as damages items for which he incurred no liability.<sup>32</sup>

Applying these rules it would seem that if the primary liability for hospital services rendered to its subscribers lies with the hospital service corporation, then an injured plaintiff should not be permitted to recover the value of the services paid for by Blue Cross from the party causing his injuries.<sup>33</sup>

Turning to examine the extent of regulatory powers over hospital service associations given to the superintendents of insurance we again find variation among the states. Since the problem of increasing subscriber rates has commanded wide public attention in recent years, it is the regulation of that aspect that will be treated here.

The pertinent portions of the Ohio statutes provide that before licensing any non-profit hospital service corporation, the superintendent of insurance shall be satisfied that the proposed subscriber contracts and subscriber rates are fair and reasonable; that any amendments to subscriber contracts or change in subscriber rates shall be subject to the approval of the superintendent;<sup>34</sup> that he shall have free access to all books, papers, and documents relating to the business of the association; and that he may conduct public hearings and summon witnesses to examine into the affairs, transactions, fairness and reasonableness of subscriber charges.<sup>35</sup>

It will be noted that the superintendent is not expressly granted supervision over hospital affairs or over the contracts between the association and the hospitals which form the basis upon which the hospitals are reimbursed by the association. This formula of reimbursement is based upon the cost of hospital services, and ineluctably is the major factor in determining

<sup>31</sup> 15 Am. Jur. 198; *Roth v. Chatlos*, 97 Conn. 282, 116 A. 332, 22 A. L. R. 1554 (1922).

<sup>32</sup> *Hudock, Appellee v. Youngstown Municipal Ry. Co.*, 164 Ohio St. 493, 132 N. E. 2d 108, 58 A. L. R. 2d 365 (1956); *McNaier v. Manhattan Ry. Co.*, 51 Hun. 644, 4 N. Y. Supp. 310, *aff'd*, 123 N. Y. 644, 26 N. E. 750 (1890); *Heater v. Delaware, L. & W. R. Co.*, 90 App. Div. (N. Y.) 495, 85 N. Y. Supp. 524 (1904); 25 C. J. S. 830 Section 162 (6).

<sup>33</sup> So far as research has revealed, this proposition has not been tested, probably because parties consider Blue Cross coverage to be a form of insurance. There is Ohio authority to the effect that it is insurance, even though exempt from insurance laws. *Cleveland Hospital Service Association v. Ebright*, 142 Ohio St. 51, 49 N. E. 2d 929 (1943).

<sup>34</sup> Rev. Code Sec. 1739.05.

<sup>35</sup> *Id.* 1739.13.



the necessary subscriber rates.<sup>36</sup> Thus the superintendent is charged with the regulation of rates but is given no regulatory powers over the costs which determine those rates. His express powers, by necessary implication, undoubtedly include the power to examine into hospital affairs for the purpose of finding out what the costs are, but not for the purpose of regulating the hospital in any way.

As stated in *Johnson v. Betts, et al., Corporation Commissioner*,<sup>37</sup>

It is well recognized that special tribunals exercising special summary powers must find their authority within the statute. They have no common-law powers, nor implied powers, except such as are absolutely necessary to carry out those powers expressly granted them . . .

In *Mutual Life Insurance Company of New York v. Prewitt, Insurance Commissioner*,<sup>38</sup> the court said,

The Insurance Commissioner is the creature of the statute. He has no authority except that which the statute confers upon him . . . The law is the source of his authority and all of his acts must be within the limits of that authority.

The Pennsylvania Non-Profit Hospital Plan Act<sup>39</sup> enumerates among the powers of the insurance department the power to approve rates of payments to hospitals and contracts between a plan and hospital. An interesting adjudication was made in 1958 by the Pennsylvania Insurance Commissioner when disallowing a rate increase requested by the Philadelphia Blue Cross Plan.<sup>40</sup> He rendered a comprehensive opinion during the course of which he criticized hospitals for failing to take measures to reduce costs and discourage excess utilization by Blue Cross patients.

He reviewed in detail evidence which had been presented at the public hearing concerning a voluntary program carried out at Sacred Heart Hospital of Allentown, Pennsylvania to

---

<sup>36</sup> Other factors are the maintenance of adequate reserves and administrative expenses of the plans. But nationally 94.16% of Blue Cross income is paid out in benefits. 1958 figures, Public Service Bulletin Pr-59-9A, (Blue Cross Commission of American Hospital Association, June 19, 1959).

<sup>37</sup> 21 Ariz. 365, 367, 188 P. 271, 273 (1920).

<sup>38</sup> 127 Ky. 399, 401, 105 S. W. 463, 465 (1907).

<sup>39</sup> 15 Penn. St. Secs. 2851-1301 et seq.

<sup>40</sup> Adjudication of Francis R. Smith, Insurance Commissioner, Commonwealth of Pennsylvania, April 15, 1958, In the Matter of the Filing of the Associated Hospital Service of Philadelphia (Blue Cross).

correct abuse of hospital care. The program consisted of a Committee on Admissions, Conduct and Discharges, which was to promulgate rules and regulations to correct abuses. Some of the rules were that x-ray and laboratory tests be ordered before noon on the day of admission, that consultation requests be answered immediately, and that doctors authorize a patient's discharge on the day before it was to occur. These and similar rules were claimed to have been responsible for the average length of a stay at this hospital decreasing by one-half day.

Basing his action upon this and similar evidence, the Commissioner issued an order containing eight directives aimed at reducing over-utilization of hospital facilities. Among them were orders that Blue Cross officials should review the Sacred Heart Hospital program and disseminate information on it to each member hospital; that Blue Cross notify each member hospital that the Commissioner would approve no hospital reimbursement formula unless the hospital had inaugurated a program similar to that at Sacred Heart Hospital; and that the Plan allocate a sum of money sufficient to maintain constant vigilance over the hospitals' efforts to eliminate abuses.

The Commissioner also reviewed evidence tending to show that hospitals could achieve substantial economies through joint action in purchasing practices, through uniform accounting methods and practices, through the sharing of specialized equipment, through standardization of certain salaries, and through other methods. He ordered the Blue Cross Plan to conduct studies into these practices and to disseminate information on them to member hospitals, to notify hospitals that future reimbursement contracts would not be approved unless the recommendations of Blue Cross had been put into practice, and to maintain constant vigilance over hospital actions with respect to such practices.

The first question which this report raises is whether the Commissioner's statutory power to approve payments by Blue Cross to hospitals includes something more than merely the power to determine if the payments proposed bear a proper relationship to the hospital costs *as they exist*. Does the Commissioner, in other words, have regulatory power over hospital costs? In view of principles concerning powers of regulatory officials generally, and in particular of insurance commissioners, as typified by the statements from the *Mutual Life Insur-*

*ance*<sup>41</sup> and the *Johnson*<sup>42</sup> cases quoted above, it would seem doubtful that the Commissioner's authority extends so far as to include orders of the nature issued in the Pennsylvania report.

Secondly, assuming that the authority exists, it may properly be questioned whether the method adopted to reach the heart of the problem was valid. It will be noted that the Commissioner did not directly order any hospital to take any action. (In fact the hospitals were not parties to the matter adjudicated although they were represented and examined at the hearing.) Rather the Commissioner ordered Blue Cross to inform the hospitals of the directives and to see that they were given effect. This appears at best to be an indirect, though possibly effective, means of accomplishing certain ends. If on the other hand the Commissioner has no regulatory control over hospitals, then his orders constitute an improper delegation of non-existent authority.<sup>43</sup>

It is not questioned, of course, that a legislature may properly grant to the insurance department or to some other body authority to regulate hospital operations. The New York statute has already been mentioned.<sup>44</sup> Under it the commissioner of social welfare rules on the adequacy of payments to hospitals while the insurance commissioner determines the reasonableness thereof. The statutes in Massachusetts set forth in detail the specific powers of the commissioner of administration on the subject of payments to hospitals.<sup>45</sup>

It should not be assumed from the above discussion that the problem of rising hospital costs and utilization has been ignored by hospitals and Blue Cross authorities. As in the past, the problems are being forthrightly met, and outstanding volun-

<sup>41</sup> *Mutual Life Insurance Company of New York v. Prewitt*, Insurance Commissioner, *supra* n. 38.

<sup>42</sup> *Johnson v. Betts, et al.*, Corporation Commissioner, *supra* n. 37.

<sup>43</sup> As to whether the orders attempted to regulate internal operations in too great detail, see *Hutchins Mutual Insurance Co. of District of Columbia v. Hazen et al.*, 70 App. D. C. 174, 105 F. 2d 53 (D. C. 1939).

<sup>44</sup> *Supra* n. 26.

<sup>45</sup> Mass. L. Ch. 176A, Sec. 5 (amend. 1956): "All rates of payments to hospitals made by such corporations, under such contracts, shall be approved in advance by the commissioner of administration, . . . No rates of payment shall be approved, or their continuance be permitted, by the commissioner unless such rates reflect reasonable hospital costs or are based on charges made to the general public, whichever is lower. The commissioner in determining reasonable cost shall give consideration to services provided by the hospital and the costs of comparable hospitals, and may give consideration to depreciation, amortization, interest, occupancy, and individual services which are rendered for partial or no payment."

tary efforts at solution are being made. Many studies are being conducted by committees composed of hospital and Blue Cross officials, civic, management and labor leaders and the medical profession. One of these groups in Cleveland is completing an exhaustive two year study on the use of hospital facilities.<sup>46</sup> The report of this committee has been anxiously awaited by interested parties throughout the field. In Pittsburgh there are at least four separate groups studying various aspects of the problems.<sup>47</sup>

It clearly appears that the voluntary prepayment system of health care, pioneered and developed as a community function, is just beginning to realize its full potential. Vast areas still exist in which the need for prepayment have been unfulfilled. Some of these areas are coverage for all types of admissions rather than excluding certain ones, coverage of the entire "package" of hospital services rather than segmenting certain ones as outside of the prepaid picture, extension of benefits to include services prior to admission and after discharge, (such as diagnostic tests and home nursing services), and protection for aged and retired persons. In commenting on this subject recently, Basil MacLean, President of the Blue Cross Association, said,

The public will choose service benefits, . . . deliberately deciding between health and dollars. It will recognize the greater security inherent in guaranteeing all necessary care regardless of cost. Experience will lead the public to turn away from inadequate cash indemnity practices which refer more aptly to property damage coverages than to matters of individual and national health.<sup>48</sup>

The community approach to the problem of assuring to all the availability of needed hospital services is widely recognized as sound and proper, although not necessarily, in every case, the cheapest method viewed from the short term standpoint. Malcolm L. Denise, General Industrial Manager—Labor Relations, Ford Motor Company, has said,

---

<sup>46</sup> Citizens Hospital Study Committee.

<sup>47</sup> Blue Cross Medical Review Section, Medical Advisory Committee on Blue Cross Cases, Hospital Council of Western Pennsylvania, Pennsylvania Economy League of Western Pennsylvania. Reported in "Greater Pittsburgh" (May 1959).

<sup>48</sup> Prepayment in the Jet Age, (Blue Cross Assn., 1959).

We could, to be sure, achieve better control of our own costs by going to indemnity-type plans. But so far, we are not convinced that, in this field, indemnity plans give as good *value* for the money expended as do prepayment service-type hospital and surgical plans. This, coupled with our interest in community programs, has influenced us against embracing the indemnity route to date.<sup>49</sup>

Hospital service plans fulfill a vital social need. In view of the continuing support and apparently expanding activities of the plans, it is well to understand their legal nature. At the present time problems are arising that could not have been foreseen 25 years ago. The favorable treatment which hospital service plans have received under the law should be continued so long as the plans continue realistically to meet these problems as they have in the past.

---

<sup>49</sup> Management Views Financing of Hospital and Medical Care, (Ford Motor Co., 1959).