

Group Hospitalization

A REPORT OF
EXPERIENCES

1937

Bureau of Medical Economics, American Medical Association, Chicago

GROUP HOSPITALIZATION



A Report of Experiences

A REPORT PREPARED

By

THE BUREAU OF MEDICAL ECONOMICS
AMERICAN MEDICAL ASSOCIATION

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535 NORTH DEARBORN STREET
CHICAGO, ILL.

Reprinted with additions from *The Journal of the American Medical Association*, April 24, 1937, Vol. 108, pp. 141B-142B; May 1, 1937, Vol. 108, pp. 149B-151B; May 15, 1937, Vol. 108, pp. 160B-162B; May 22, 1937, Vol. 108, pp. 172B-173B; May 29, 1937, Vol. 108, pp. 179B-180B; June 5, 1937, Vol. 108, pp. 185B-186B; June 12, 1937, Vol. 108, pp. 193B-195B; June 19, 1937, Vol. 108, pp. 200B-202B; July 3, 1937, Vol. 109, pp. 5B-7B; July 24, 1937, Vol. 109, pp. 11B-13B; Aug. 7, 1937, Vol. 109, pp. 17B-19B; Sept. 4, 1937, Vol. 109, pp. 25B-28B; Sept. 11, 1937, Vol. 109, pp. 36B-38B.

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Introduction

No other development in medical economics, with the exceptions perhaps of sickness insurance and state medicine, has incited more interest and discussion than has group hospitalization, or prepayment plans for hospital care.

The purchase of hospital service on a group basis has existed in some form or other for many years, but only recently has "group budgeting for hospital expenses" been strongly advocated. The factors that have caused this sudden activity and the forces that are urging the adoption of group payment methods deserve careful study. It is important, moreover, to determine whether or not the plans that are being promoted will really bring about the better medical service which is desired by the medical profession, the hospitals and the public, or whether such arrangements will actually direct hospital service into channels harmful to the progress of medicine, inimical to the purposes of hospitals, and injurious to the public health.

The movement for group purchase of hospital facilities has developed most rapidly since 1931. Since then group hospitalization plans have been the subject of numerous articles, speeches and news stories. The present study was undertaken as an analysis of experiences with group hospitalization plans that might possibly be useful both to administrators of present plans and to those who desire to organize new plans.

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, and huge capital investments or fixed costs remained unmet. These conditions induced many hospitals in the United States to adopt group hospitalization plans as a means to secure

needed income. The plans are offered by their sponsors as an equitable method of providing low-cost hospitalization. If hospital administrators are to depend on financial assistance from group hospitalization plans, careful consideration should be given to the possible effects of such organized plans on the future of hospitals.

The observations in this report are necessarily drawn from a consideration of the characteristics and experiences of several plans as a group. The criticisms that are suggested do not, therefore, apply equally to all plans. Many plans are administered by directors and trustees who have been painstaking in their endeavor to develop an organization for the benefit of persons in need of low-cost hospital services. It is expected that these organizations will advance the best features of group hospitalization plans and will be the first to inaugurate the suggested changes for improvement.

Chapter I

THE BACKGROUND OF GROUP HOSPITALIZATION PLANS

GROUP PAYMENT PLANS

A group hospitalization plan is one in which groups of persons, or individuals, make periodic payments into a fund to enable each member to receive hospital care when needed. This concept must be more narrowly defined, however, to exclude the plans of industrial health services, medical and hospital benefit organizations and mutual benefit associations, trade union plans, fraternal or lodge plans, group medical practice plans and the plans of community health associations and college student health services. Although most of these plans provide for the collection of payments from members to establish a fund for hospitalization, they are not here considered as group hospitalization plans.

Medical and hospital service can be paid for either directly by the patient to the physician and hospital or by some organization which collects regular contributions from each of its members into a fund for the benefit of the individual member who may require such services. The first is the traditional fee-per-patient method. The second is the group payment or the so-called insurance method. The group payment or "insurance" plans came into existence largely to meet the uncertainties created by industrialism. An employee bound by a wage contract with his employer is largely dependent on his own resources to provide relief from misfortune. He can no longer expect the personal assistance from guild or overlord which existed under feudalism. The great shifts of popu-

lation, the destruction of old and the creation of new occupations, and the cyclic swings in production causing alternate periods of work and unemployment are some of the uncertainties of industrialism which have caused much individual poverty and called for group intervention. The resulting social dependence could be combated either by altering the industrial organization to increase insufficient incomes, thereby making the individual self-reliant, or by acknowledging the inevitability of insufficient incomes and devising methods to relieve the destitute. It is clear that group payment plans accept the inevitability of industrial uncertainties and insufficient incomes and are formed to serve as palliative methods.

Group payment plans for medical and hospital services seem to have evolved from one of two origins: (1) the early contract practice plans whereby medical and hospital services were made available to remote mining and lumbering communities, and (2) mutual benefit plans organized by fraternal societies, labor unions or employees and employers as a substitute for "passing the hat" when a worker was disabled by illness or accident and his family became impoverished.

The system of group payment through payroll deduction for medical and hospital care has been of long standing in the mining, lumbering and railroad industries. The employers in these industries, because of the isolation of the communities in which the workers lived, had to make contractual arrangements with physicians in order to secure necessary medical services to alleviate the consequences of sickness and accidental injuries. Likewise the employer furnished food, clothing, housing and all other essentials to his employees. These activities were undertaken when industry was developed in remote areas, but when independent com-

munity facilities became available the "company store" or "commissary" operations were discontinued.

In some places it was found necessary to pass laws prohibiting payment of wages "in kind" to prevent employers from monopolizing such services for employees. The provision of medical and hospital care, however, was retained despite the availability of these services through independent agencies.

As the legal responsibility of the employer for industrial injuries developed and was affirmed by laws, the employer either passed the liability on to insurance companies or used the plant medical system to care for injured workers. Furthermore, even when the compensation laws were passed to stop abuses under employers' liability by fixing definitely the financial responsibility of the employer for industrial injuries, the existing methods by which employees received medical care from the employer were not disturbed.

In certain states the compensation laws permitted the formation of associations to provide medical and hospital care for employees entitled to compensation and authorized payroll deductions from employees. Such associations almost surreptitiously added medical care and hospitalization for noncompensable injuries and illnesses and brought a loosely constructed organization into the medical and hospital fields. In other states the laws permitted the expansion of medical services provided by employers to care for noncompensable as well as compensable conditions, but most state laws stipulated that employers alone should pay for compensation claims. To provide the medical and hospital services, employers expanded their industrial health services, used subsidized or company-owned hospitals, and formed contracts with physicians, hospitals, and medical and hos-

pital benefit associations—generally with the expectation of lowering accident costs or of securing more favorable personnel relations with employees.

Much dispute and ill feeling have arisen because of the failure to differentiate between industrial health services and medical service systems. Industrial health services are maintained entirely at the expense of the employer to fulfil his responsibility, sometimes as a "self insurer," for industrial injuries. The objectives are to safeguard employees against accidents and to provide prompt medical supervision (first aid) for the prevention of serious complications from minor accidents. Under medical service systems the employees and their dependents, in consideration for a fixed periodic deduction from wages, are furnished medical and hospital care through medical personnel employed by or under contract to the employer. Industrial health services are extended to provide medical care for employees with acute and chronic illnesses and more or less complete medical care for the employees' dependents.

The creation of medical service systems to furnish complete medical, surgical and hospital care for employees does not seem to be the proper function of industry. Financial provisions may be made by industry to alleviate the lack of individual employee income, but the medical and hospital service should be given by physicians and hospitals independent of industry. Under such an arrangement the employer could help employees to purchase medical and hospital services without undesirable entanglements in the medical field. It is believed that personnel managers would welcome an arrangement for medical services which does not place their companies between the patient and his physician or hospital.

There is need for much further consideration of the discrimination against independent physicians and hospitals and of the inequities placed on the employee by industrial medical systems.¹ At present it is sufficient to note that, in certain industries, employees and their dependents receive medical and hospital care (part of which is definitely the legal liability of the employer), under a group payment plan, from physicians employed in company-owned hospitals or from physicians and hospitals under contract with the employer.

It was not long before medical and hospital benefit organizations were formed in imitation of the associations contracting for the care of patients entitled to compensation. Under the various plans, funds were accumulated from individual subscribers as well as from groups of employees through the sale of contracts. Complete medical and hospital services were offered through hospitals and clinics owned by the organizers or through physicians and hospitals under contract with the corporation. In the states where the laws or the courts denied corporations the right to practice medicine, these organizations made little progress; but in those states in which the laws did not restrict such corporations they were promoted at a pace that would astound even a firm believer in the gullibility of the American people. In one state alone 143 such organizations were formed, thirty-seven of which used two or more names. Many of these corporations (some of which appeared to be only on paper) defrauded thousands of people of money which they

1. For a full discussion of the evolution of industrial medical services see (a) *Medical Relations under Workmen's Compensation*, Revised, Bureau of Medical Economics, American Medical Association, Chicago, American Medical Association, 1935 (b) Williams, Pierce, and Chamberlain, I. C.: *The Purchase of Medical Care Through Fixed Periodic Payment*, New York, National Bureau of Economic Research, Inc., 1932. (c) Dodd, W. F.: *Administration of Workmen's Compensation*, New York, Commonwealth Fund, Division of Publications, 1936; (d) *Medical Supervision and Service in Industry*, New York, National Industrial Conference Board, Inc., 1931.

thought they were paying for future medical services until grand jury action was secured and the laws were altered to prohibit such swindling corporations. In other localities similar organizations were more honestly promoted, but, while avoiding criminal fraudulence, they still retained the contract features restricting free choice and preventing freedom of reasonable competition on a service basis.²

Many mutual benefit associations or sick benefit funds organized by employees, trade unions and fraternal societies developed alongside the industrial health services and medical systems. The primary function of these plans was to collect payments from the group into a fund to provide benefits in cash for members requiring assistance. These organizations, after the losses from industrial injuries were transferred to the employer, confined themselves to ordinary sicknesses or injuries not the result of employment. In addition to cash benefits for loss of time, several of the plans included payments for medical and hospital care. Only a few plans provided such service "in kind" through salaried physicians and association-owned hospitals or through physicians and hospitals under contract with the association. Most of the plans also included medical and hospital service for dependents of members. By far the greater number of these plans were little more than charity arrangements in that they were designed primarily to aid the member who became impoverished because of illness or accident.³

2. These organizations are discussed in *New Forms of Medical Practice*, Bureau of Medical Economics, American Medical Association, Chicago, American Medical Association, 1933, pp. 61-64. Leland, R. G.: *Contract Practice*, J. A. M. A. 98: 808 (March 5) 1932; *Some Phases of Contract Practice*, A. M. A. Bull. 27: 142 (Oct.) 1932. *New Plans of Medical Service*, Chicago, Julius Rosenwald Fund, 1936.

3. Medical benefits under mutual and sick benefit associations are discussed by Brundage, D. K.: *A Survey of Work of Employees' Mutual Benefit Associations*, Pub. Health Rep. 46: 2102 (Sept. 4) 1931. Williams,^{1b} chap. 12.

Group medical practice plans, or so-called private group clinics, whereby physicians cooperate in their practice, share office space, own certain kinds of equipment and employ lay assistants in common, are frequently cited as examples of desirable group payment arrangements. A comprehensive study of such groups,⁴ however, revealed that less than 9 per cent (twenty out of 224) had ever tried any arrangement for service in return for regular periodic payments. Furthermore, despite the claimed economies of group medical practice plans, it was found that the cost of practicing medicine in private practice varies from 27 to 34 per cent of gross income, with an average tendency of 33 per cent, whereas in group medical practice the cost varies from 40 to 42 per cent, or from 7 to 9 per cent more than in private practice.

A few communities organized "health associations" to provide hospitalization and medical or nursing services to subscribing members. While such organizations have usually been subsidized by foundations, welfare federations or other community institutions, the essential distinction is that the administration is separate from the physicians and hospitals providing the service. Such arrangements did not lend themselves to the average American community because of their dependence on community or special benevolent funds and the restricted character of their activities.⁵

4. Group Practice, Bureau of Medical Economics, American Medical Association, Chicago, American Medical Association, 1933, p. 29. Compare with Rorem, C. R.: Private Group Clinics, Committee on the Costs of Medical Care, Publication 8, Chicago, University of Chicago Press, 1931.

5. Williams and Chamberlain,^{3b} chap. 10. Peebles, A., and McDermott, V. D.: Nursing Service and Insurance for Medical Care in Brattleboro, Vermont, Committee on the Costs of Medical Care, Publication 17, Chicago, University of Chicago Press, 1932. Falk, I. S.; Griswold, D. M., and Spicer, H. I.: A Community Medical Service Organized under Industrial Auspices in Roanoke Rapids, North Carolina, Committee on the Costs of Medical Care, Publication 20, Chicago, University of Chicago Press, 1932.

In universities and colleges, student health services were organized to meet the requirements of supervising and protecting the health of students on the campus through entrance examinations, consultations and infirmary care, instruction in personal and public hygiene, and the control of communicable diseases. Such organizations might be compared to industrial health services with particular emphasis on health education. The tendency to extend student health services into comprehensive medical care plans is similar to that which exists under industrial health services. Again, the claimed economies of group arrangements do not seem to materialize, because, in spite of uncertain accounting methods, the reported cost per student is not appreciably less than the cost for similar services in the private purchase of medical and hospital care.⁶

It should be noted that all of the several plans which have been outlined have provisions for periodic payments by members to establish a fund for hospital, and sometimes medical, bills. Nevertheless, such plans are not group hospitalization plans. The characteristics which set group hospitalization plans apart from these plans will be outlined later.

THE BEGINNINGS OF HOSPITAL PLANS

With the background of industrially dominated group payment for medical and hospital care, it is not surprising that hospitals should form plans to accumulate funds through individual contributions and then through group payroll deductions.

In the latter part of the nineteenth century hospitals began selling "season tickets," entitling

6. University and College Student Health Services, Bureau of Medical Economics, American Medical Association, Chicago, American Medical Association, 1936. Compare with Griswold, D. M., and Spicer, H. I.: University Student Health Services, Committee on the Cost of Medical Care, Publication 19, Chicago, University of Chicago Press, 1932.

the purchaser to hospital benefits in case of accident or illness, as a means of securing advance working capital. The practice started, presumably, in the small hospitals of Michigan for workers in the lumber woods, although some hospitals in cities, such as the Broadstreet Hospital in New York City, were supported by annual pledges of employees and employers.

The first organized payment plan for hospital services offered to the general public by a hospital was that of the Grinnell Community Hospital, Grinnell, Iowa, which began operation in 1918. Subscription rates were \$8 a year for single persons and \$12 for husband and wife, with \$5 for the first child and \$2.50 for each additional child. Later, students of Grinnell College were admitted for \$5 per college year. The benefits included three weeks of hospital care, consisting of board and room and floor nursing service, but did not include use of the operating room or the delivery room, roentgen or laboratory examinations, dressings or special nursing. This plan is still in operation and has remained practically unchanged in rates, contract provisions or size of membership.

Many other plans for facilitating the purchase of hospital care were organized, such as those of the Hospital Service Association of Rockford, Ill., in 1912, the Thompson Benefit Association for Hospital Service, Brattleboro, Vt., in 1927, and the New Bedford Health Association, New Bedford, Mass., in 1929. These undertakings were community ventures to carry the risk of illness on a group basis but with the provision of hospital and medical service left largely to independent local agencies.

Alongside the organized undertakings, individual hospitals formed a multitude of other plans designed to bolster the diminishing income from patients, gifts and endowments and at the same time to make hospitalization costs less

•for patients of moderate means. A few of these plans will be indicated.

“Middle rate,” “fixed rate” and “flat rate” plans were three forms of an arrangement adopted with the intention of reducing the cost for hospitalized illness, of stabilizing widely fluctuating charges for extra hospital services, and of standardizing physicians’ fees. “Middle rate” plans did not guarantee that each patient would receive complete care for a set average charge but simply enabled a patient to consider his bill as a whole. Physicians’ and nurses’ fees and hospital charges were added together in one total, and all arrangements for payments were made through the hospital office. “Fixed rate” plans attempted to overcome uncertain charges under “middle rate” plans by fixing charges within a certain range—such as \$47.50 to \$100 for six days’ hospitalization of surgical and obstetric patients. “Flat rate” plans set a definite charge for specific hospital facilities—for example, \$50 for obstetric patients exclusive of extras or the services of physician and nurse. Under the various forms of the plan, the physician or surgeon agreed with the hospital to render his services for less than the usual fee, and the hospital was supposed to make similar concessions in its charges for hospital facilities and extra services.

The limitation of medical and surgical fees by the hospital seems to have developed in university hospitals, where fees were collected and retained by the medical school or hospital on the assumption that the salary of the physician was sufficient for both his teaching duties and his clinical services. Fixed fee schedules were of no benefit to patients who before the adoption of the protective schedule had not been paying fees beyond their means. Probably because medical exploitation of the patient of moderate means was not a common practice,

it was recognized that such plans offered no particular advantage to the patient, and their promotion subsided.⁷

Deferred payment plans based on the endorsement by the hospital of patients' notes were also tried as a method to aid the patient unable to pay his bill in full. Through an arrangement with a bank the notes, which were for nine or ten months and bore 6 per cent interest, were paid immediately to the hospital. Largely because of the high percentage of notes dishonored and the reluctance of banks to accept such paper, this method of financing patients' accounts was not very successful. A few "finance" companies were formed which, in addition to the 6 per cent interest charge, required the hospital or physician to endorse the note and to accept an 8 per cent discount from the face value. The hospital or physician was also charged a service fee (5 per cent) and had to pay a commission (15 per cent) on all accounts requiring collection. The best of these plans did not lower but usually added considerably to the costs of medical care. The worst of these plans contained provisions that caused hospitals and physicians annoyance and perhaps financial loss. Other financial arrangements for the patient were made possible by small loan companies, which claimed that 10 per cent of their loans were made to meet the expense of sickness bills. Plans were also organized through banks for regular and systematic savings—similar to Christmas clubs—to provide funds that could be withdrawn only to meet the expenses of illness.

Group nursing plans, whereby a team of three salaried graduate nurses would each work an eight hour schedule to cover the twenty-four hour period for three patients sharing adjoining

7. Goldwater, S. S.: *The Problem of the Patient of Moderate Means*, *Tr. Am. Hosp. A.* 32: 423 (Oct.) 1930.

rooms, were also heralded as a means of reducing the cost of hospitalization for the patient of moderate means. When the services of the nurse were shared in this manner, the cost of nursing to each patient equaled the wages of one nurse plus the customary hospital charges for meals. A patient, instead of paying about \$17 for twenty-four hours of personal nursing, would pay \$7.50 for twenty-four hours of group nursing. Although such plans were enthusiastically adopted by a number of hospitals, they did not prove to be as advantageous as expected. The bills of the patients who formerly would rely on floor nursing were increased, and the patients who demanded individual nursing were not satisfied. The physician also objected to a different nurse at hand on his various visits to the bedside. The plan probably has some desirable features,⁸ but it failed to be developed because of improper application.

These plans, and other similar plans, illustrate the searchings of hospital administrators for some method of broadening the base for hospital income. However, most of the plans had but little success and seemed destined to be but sporadic experiments until 1931, when a concerted movement toward group hospitalization plans began. The only essential difference between the later group hospitalization plans and the early plan of selling hospital "season tickets" or the hospitalization plan like that of the Grinnell Community Hospital was that the later plans were sold on a group payroll deduction basis instead of on an individual purchasing basis. The group selling arrangement permitted a rapid enrolment of members, avoided the selection of adverse risks and made the collection of the premium or dues more simple. These advantages were of great assistance in the pro-

8. Babcock, W. L., and De Long, M. D.: Group Nursing—Eight Years of Experience, *Bull. Am. Hosp. A.* 9: 64 (Oct.) 1935.

motion of group hospitalization plans. Before considering the recent development of group hospitalization plans, the experiences in England with "contributory" and "provident" schemes demand attention, because these schemes are frequently indicated as the origin of group hospitalization plans.

THE BRITISH SCHEMES

As early as 1920 the British hospitals were confronted with decreased incomes and increased free services, resulting in a financial stringency somewhat similar to the condition to be faced by American hospitals a decade later. To meet the situation two types of hospital plans—contributory or "poor men's" schemes, and provident or "middle class" schemes—were developed.

The contributory schemes were organized to provide funds for voluntary hospitals. These hospitals—endowed teaching institutions with large wards and staffed by unpaid physicians—were purely charitable organizations supported by philanthropic persons for the benefit of the poor. The economic conditions following the World War caused the wealthy and middle classes to reduce their gifts to voluntary hospitals, and as a result the hospitals devised plans to seek contributions from the industrial and low wage groups. The Oxford plan at Radcliffe Infirmary, organized in 1920, was the first English effort to adapt a contributory scheme of hospital support to the circumstances of a large urban and agricultural district.

The subsequently organized schemes differ in many details, but the customary fee is 3d. (about 6 cents) weekly, or 12s. (about \$3) annually, collected from groups of employees through payroll deductions. It is clearly indicated to the contributor that his payments do not create a contractual relation with the

hospital entitling him to any definite service, and that the objectives of the plan are (1) to raise funds for the maintenance of voluntary hospitals, and (2) to provide hospital care for persons with limited incomes. Payments are accepted as a voluntary contribution for the support of hospitals, and the conditions of admission of contributors are at the discretion of the hospital.

These low rate contributions are confined to the low income classes by specific income limits. Usually the contributor's income must not exceed \$20 a week for single men or women, \$25 a week for married men without dependent children, and \$30 a week for families with dependent children. Furthermore, contributors regarded by the hospital authorities as not coming within the definition of the phrase "of limited income" can be called on to make some additional payment toward the cost of the service they receive.

Despite the pronouncements by the special governmental committee appointed in 1921 to consider the financial conditions of voluntary hospitals, that the adoption of insurance schemes "might involve hospital authorities in contractual obligations which they might find exceedingly difficult to discharge,"⁹ by the British Medical Association that "it is undesirable that hospitals should themselves undertake any insurance risk in connection with hospital services,"¹⁰ and by a provision of the contributory schemes themselves that "membership of the scheme does not of itself ensure admission to any hospital,"¹¹ the schemes took on more and more of an insurance character and the contributor came to look on them as advance

9. Contributory Schemes, Voluntary Hospitals Commission, London, His Majesty's Stationery Office, 1923.

10. Hospital Policy, British Medical Association, London, 1933, p. 17.

11. Contributor's Card, Birmingham Hospitals Contributory Scheme.

payments for hospital care. The charitable nature of the schemes was reemphasized at a conference of administrators of contributory schemes¹² as follows:

It would be a great pity if it went abroad that we considered that a contributory scheme was in the nature of an insurance scheme. It cannot be that. If you are in an insurance scheme, you pay not only the full cost of treatment, but something else, a profit for your shareholders as well. Here we do not pay the cost by any means. What it really is, is an organised attempt to pay as much as possible, the maximum amount possible towards the cost, which is a very different thing. We cannot expect that 2d. a week can pay anything like the cost; we are not sure in Birmingham that even with 3d. a week it will pay the full cost, and therefore, we cannot really call it technically, anything in the nature of an insurance scheme.

The schemes were designed to obtain small amounts of money from workmen who were already receiving free services and were not "insurance" plans to distribute the cost of hospitalized illnesses among people accustomed to paying hospital bills. The inducements offered to the contributor in lieu of a guaranty of hospital service were:

1. He would be relieved of the necessity of securing a "hospital letter" for admittance.
2. He would not be subjected to any inquiry as to his means.
3. He would not be called on to make any donation after admittance to the hospital, as were other patients.
4. He would be provided with convalescent treatment, specialist services, spectacles and appliances at reduced rates not available to noncontributors.

Through these devices the hospital secured contributions without being obligated for the admission and free maintenance of contributors. The care taken by the voluntary hospitals to

¹² Report of Proceedings at a Conference of Contributory Schemes, Birmingham, British Hospitals Contributory Schemes Association, November 1930, p. 18.

avoid any contractual obligation was a recognition that, as a result of gifts and endowments, the necessitous poor should have first claim on the hospital facilities and that the urgency of a medical or surgical condition should be the only compelling reason for the admission of any person.

In 1934, according to the Hospital Year Book, there were 263 British contributory schemes, including about 6,500,000 contributors and their dependents, or a total of some 15,000,000 persons. Few of these schemes are self-supporting, and all have a backing of private gifts and endowments or of public funds. The financial situation was stated by one scheme¹³ as follows:

Although the Contributory Scheme disburses large sums of money to the Voluntary Hospitals, it is as yet unable to pay the full cost of the treatment received by its members. The Voluntary Hospitals are dependent therefore upon the generosity of private subscribers and other sources of revenue for the balance, and further, free treatment is provided continually for a large number of patients who are too poor to join the Contributory Scheme. The Management Committee would like to emphasize this point and to urge the just claims of our splendid Voluntary Hospitals to unstinted support in the efforts they make on behalf of suffering humanity.

Of the actual cost of maintenance to voluntary hospitals, not over 70 per cent is supplied by contributory funds.

Two additional tendencies of these schemes are of interest to the problem here. At the Conference of the British Hospitals Contributory Scheme Association in 1931, it was declared that the schemes were overworking hospital staffs, that the service was deteriorating, and that provision would have to be made to pay the hospital staff.¹⁴ At the same conference it was

13. Report for 1931, Birmingham Hospitals Contributory Scheme, Birmingham, p. 13.

14. Proceedings, First Annual Conference, British Hospitals Contributory Schemes Association, September 1931. See also The British Plan, editorial, J. A. M. A. 100:47 (Jan.) 1933.

also stated that "There is no doubt that, by means of the power of the purse, those who manage the schemes will soon start managing the hospitals." It should be noted that none of these schemes are for profit nor do they hire salesmen, but that they are voluntary organizations formed to raise funds for the support of hospitals. Administration, publicity and other operating costs are kept at a minimum and average about 6 per cent of total contributions.

The provident schemes are very similar to the contributory schemes excepting that the income limits are higher and that medical as well as hospital expenses are paid. These plans have but recently been promoted actively and are designed to deal with persons whose incomes are above the usually recognized limits. There is a variety of provident schemes—some have no income limits while others do have income limits; some are controlled by hospitals and others are controlled by independent organizations. The rates to subscribers also cover a wide range and the benefits vary accordingly. A rate of about \$25 a year for a family with an annual income up to \$2,500 entitles each member to three weeks' hospital care at \$25 a week, partial payments toward consultation fees and radium treatments, and contributions not to exceed \$125 for a surgeon's fee. A waiting period of six months before the member is entitled to benefits is a usual provision.¹⁵

The promoters of group hospitalization plans frequently refer to the British schemes, but the dominating pattern for the hospital plans in this country arose out of the extensive industrial and group payment arrangements so largely peculiar to the United States.

15. Provident Schemes for Treatment in Private Wards, Central Bureau of Hospital Information, Memorandum 4, London, March 1936.

THE ESSENTIALS OF A GROUP HOSPITAL-
IZATION PLAN

The number of periodic payment plans for medical and hospital care which have been described closely simulate the plans of group hospitalization. It is, however, essential to distinguish between these plans and group hospitalization plans. A discussion of group hospitalization cannot be logical if it cites the experiences and operation of a college student health service, a mutual benefit association or a British contributory scheme as comparable to that of a group hospitalization plan. The mere fact that the prepayment, or so-called insurance principle is common to most of these plans is no reason for considering them to be identical. It would be just as logical to compare the experience and operation of casualty insurance with that of life insurance. Confusion in a discussion or analysis of group hospitalization plans can be avoided only by setting aside the several group payment and insurance plans which closely resemble group hospitalization plans and by considering solely those plans which are real group hospitalization plans.

Group hospitalization, by its very name, connotes that the relationship is one of direct arrangements between hospitals and groups and that the use of hospital facilities alone is the service bargained for. Group hospitalization, then, is a plan whereby a hospital or an association of hospitals contracts with classified groups of persons to furnish hospital care when needed in return for the periodic payment or prepayment of a stipulated sum by every member of the group. A bona fide group hospitalization plan should exclude all professional or medical services of physicians or surgeons, pathologists, radiologists, physical therapists, anesthesiologists and special nurses. Strictly speaking, these plans should deal only with groups

of a homogeneous nature (teachers, department store employees, transportation employees, and others) to lessen the problems of collecting subscriptions and securing the enrolment of good risks. However, if a sufficiently large number of persons can be secured, they are frequently enrolled as a special group at a slightly higher rate.

The principles essential to an effective group hospitalization plan were outlined in a report of the experience of an early plan as follows: ¹⁶

1. Organization must deal with groups, not with individual risks.

2. Groups must be employed, full-time wage earners. Intermittent employment, such as teaching, nursing, etc., brings much higher actuarial risk.

3. The total number of members—spread in all groups to make the law of averages safely apply—should be at least 3,000 to 5,000.

4. Group hospitalization should give only *hospital* service and should not in any case give service that in any way competes with the physician's professional service. You have to depend on your medical staff to protect the hospital from malingering of patients. We have had no loss on this score.

5. We allow the patients belonging to groups full liberty of choice as to the physician treating him in the hospital.

6. A long-time commitment to a fixed rate should be avoided. One of the best by-products of such group policy is that coming to the hospital with the bill already provided for educates patients to be hospital-minded and will increase hospital patronage and eventually bring a higher rate.

7. Different types of employed groups present varying actuarial risks as to sickness and differing desires as to the types of accommodations. For instance, bank employees are better actuarial health risks than laundry employees, but desire better accommodations, so we make the same rate for both groups but contract for different accommodations for each group.

8. In our own hospital we have definitely adhered at all times to the policy of dealing directly with the groups through the employer or other representative,

¹⁶ Kimball, J. F.: Group Hospitalization, Tr. Am. Hosp. A 33:667, 1931.

and we have never employed any outside selling organization or middleman representative. We feel that this is far the safer course.

It should be observed that particular emphasis was placed on such matters as the preference for group risks, desirability of full time employment of members and a minimum number of members, hospital service only, freedom of choice, no fixation of rates or provisions, allowances for different actuarial risks, and no intervening third party.

Perhaps the best method of explaining the bases on which the group hospitalization plan is founded would be to follow a schematic outline of a fictitious plan, as follows: (1) expected enrolment, (2) expected hospitalization and (3) expected costs.

Enrolment estimates are based primarily on the number of gainfully occupied persons in the community. While the estimates of the proportion of employed groups that will be enrolled vary all the way from 6 to 50 per cent, it is estimated that about 10 per cent will become subscribers (the enrolment of dependents will not be considered, for the sake of simplicity). For a community of 100,000 employed persons it would therefore be estimated that 10,000 persons would subscribe to the plan.

The expected hospitalization will necessarily vary according to the benefits and limitations of the contract and the type of community, but it is generally accepted that about one patient day per member annually will be the hospitalization experience. Accordingly, it is expected that about 10 per cent of the membership will be hospitalized for an average stay of ten days. In other words, for the membership of 10,000, about 1,000 persons would be hospitalized for a total period of 10,000 days each year.

In the determination of the costs, a flat sum of, say, \$6 per member is estimated to be

adequate to pay for the average patient day cost, including allowances for bed and board, operating room, anesthetic, routine laboratory services and routine medicines; \$3 per member is allowed for the cost of administration, sales and reserves, and a \$1 enrolment fee is charged for initial recording or to cover promotional expenses. The total cost to the subscriber, for the first year, would be \$10.

Under the fictitious plan, then, the income from the 10,000 subscribers would be \$100,000. The expected costs of hospitalization would be \$60,000 (\$6 per patient day for 10,000 days). The difference between this anticipated liability and the total revenue, or \$40,000, would be available for all other costs. Roughly, the administrative costs are expected to be 10 per cent of the total income and the promotional and sales costs 20 per cent, or a total of \$30,000. Finally, the remaining \$10,000 would be utilized to create reserves and a surplus.

In an abruptly simple form, these are the fundamental factors on which the group hospitalization plan is based. No one plan would be organized exactly according to the method outlined, but, while the percentages would vary or the costs might be allocated in a different proportion, each group hospitalization plan is formulated approximately on the bases indicated.

Even within this more uniform concept of what a group hospitalization plan is, there seem to be four different types of plans: (1) single hospitals not employing sales agencies, (2) non-commercial associations or groups of hospitals not employing sales agencies, (3) a sales agency contracting with a single hospital, and (4) commercial associations or sales agencies contracting with several hospitals.

Classification according to nonprofit and profit plans does not seem valid, because a

nonprofit plan may include a contract with a sales agency which makes profit. Furthermore, it is essential for a plan to make profit if it is to remain solvent. The stigma attaches not to the making of profit but to the manner in which the surplus is used. A noncommercial plan is assumed to be operated not for profit but in addition avoids the excessive diversion of receipts from members to an intervening third party for services not directly resulting in benefits for the members. The classification "noncommercial" indicates a group hospitalization plan with the control of service provisions and membership funds in the hands of those responsible for the benefits, namely, the hospitals and physicians, or an association properly representative of them. The classification "commercial" includes nonprofit as well as profit plans which are organized by commercial sales agencies.

With a clearer conception of what a group hospitalization plan is, and is not, the developments that have transpired can be more accurately visualized.

Chapter II

DEVELOPMENT OF THE GROUP HOSPITALIZATION MOVEMENT

THE FORCES BEHIND GROUP HOSPITALIZATION

As has been indicated, one of the compelling forces urging the adoption of new methods of payment for hospital care was the financial plight of the hospitals. The specific circumstances—the decrease in pay patients and the increase in charity patients, the decrease in donations and in income endowments and the lack of support by responsible governmental agencies—are so familiar that it is not necessary to discuss them in detail or to offer substantiating statistics. The claim that approximately 100 hospitals have been forced to close their doors each year since 1930 is frequently cited as an index of the dire financial condition of hospitals during the depression.¹⁷ As a consequence, hospital administrators experimented with a multitude of plans in the search for a possible solution to the problem of decreased hospital income.

First, it was obviously necessary to broaden the base of hospital support by securing contributions from a larger number of persons in the community. Secondly, an increased use of hospital facilities, with an increase in the number of pay patients, was an essential requisite. It has already been shown that the majority of the schemes to achieve the double objective of an increase in hospital funds and more pay patients failed to live up to their expectations. Most of the plans were applicable only to restricted classes of patients and did not enable

17. The total number of hospitals in 1930 was 6,719 and in 1935 6,246. The decrease in the number of hospitals during this period is offset by the increase in capacity of 119,270 beds.

the hospital to receive a fixed amount of money regardless of the services rendered. The lack of appeal of such plans to the public and to the hospital was a large factor in preventing their widespread adoption.

The idea of group hospitalization was reintroduced at the 1931 annual convention of the American Hospital Association by a report for a southern hospital which outlined two years of experience with a group plan. In spite of the suggestion that the reading of the paper be dispensed with in order to continue a discussion of volunteer hospital workers, the plan of group hospitalization was presented and proved to be of considerable significance. The hospital administrators soon realized that the plan had a positive appeal for the American public because it was a businesslike insurance proposal and not a request for outright contributions. The sales possibilities were enhanced by the inclusion of many benefits obtainable for a low annual premium. The hospital administrators favored the plan also because it provided a sum of money before any services were rendered and immediate payments to the hospital when services were rendered. Most important of all, the plan drew public attention to the hospitals and encouraged the use of idle facilities. Furthermore, the extra services which would be required by the hospitalized subscriber, but which were not included under the contract, offered an additional opportunity to improve the financial condition of the hospitals. It was not long before the possibilities of the plan were recognized and its adoption became widespread.

While the primary motive for the adoption of a group hospitalization plan is admitted to be the bolstering of hospital finances, nevertheless it must be said that the promoters of bona fide group hospitalization plans also had the

desire to furnish hospital facilities on more equitable payment arrangements for patients with limited means.

Despite the prophecy made at the 1932 annual convention of the American Hospital Association that "in a few years we will look back and a great many of us will want to erect a monument to the man who started the plan," there is a likelihood that the group hospitalization idea would not have developed so rapidly if it had not been for two compelling factors.

The first was the publicity secured by the commercial organizations formed during 1931. The promoters of these plans, whose interest in making hospital service more available was secondary to the profits they envisioned, organized and conducted membership drives to sell the idea of group hospitalization. The majority of the early group hospitalization plans were formed by promoters interested in financial or advertising schemes. It was this type of plan which was criticized by the medical profession and by hospital administrators.

The second impetus to the development of the plan was the report of the Committee on the Costs of Medical Care, which advocated group payment plans "whereby the unequal and sometimes crushing burden of medical expenses can be distributed." The recommendation that the costs of medical care be placed on a group payment or insurance basis included the following supplementary recommendation:¹⁸

Voluntary Hospital Insurance.—The Committee recommends that, in the absence of a more comprehensive plan, general hospital service, not maintained by taxes or designed primarily for the wealthy, should be provided wholly or in part on a voluntary insurance basis, individuals or groups in the community paying agreed annual sums and receiving hospitalization when needed without further charge.

18. Medical Care for the American People, Final Report of the Committee on the Costs of Medical Care, Publication 28, Chicago, University of Chicago Press, 1932, p. 123.

Following the report of the Committee on the Costs of Medical Care, an inordinate amount of activity in the promotion of group hospitalization plans was begun and reached a peak during 1933, when fifty-eight plans were organized. The number of plans promoted during the year after the report of the committee was released has not since been equaled in any one year period.

It would, of course, be expected that the foundations largely responsible for the Committee on the Costs of Medical Care would also participate in the development of the plans recommended. Liberal grants and widespread publicity were given to group hospitalization plans by the several foundations interested in promoting new forms of medical and hospital practice. Two of the larger group hospitalization plans were aided by grants of \$30,000 and \$25,000 respectively from these foundations. The American Hospital Association has just received a grant of \$100,000 from a foundation for the study and development of group hospitalization plans.¹⁹

By 1933 the group hospitalization movement was well under way with commercially promoted plans and with noncommercial plans organized by hospital administrators and physicians striving to gain the favor of the general public. Daily newspapers, popular magazines, and medical and hospital journals carried innumerable articles describing inaugurations of the "new plan for low cost hospital service." Encouraged by the flare of interest in group hospitalization plans, hospital administrators everywhere began to consider the possibilities of starting a plan or of joining with some agency already organized to sell the plan. There was an amazing number of discussions and writings dealing with "voluntary hospital insurance,"

19. The foundations most interested in group hospitalization plans are the Julius Rosenwald Fund, Commonwealth Fund, Duke Endowment and Josiah Macy Jr. Foundation.

“cooperative hospital care insurance,” “prepayment plans,” “group insurance,” “hospitalization insurance” and “group budgeting,” but all too little regard was given to the effect such plans would have on medical and hospital service or to the actuarial soundness of some of the practices advocated or accepted.

PRINCIPLES AND APPROVALS

In *The Journal of the American Medical Association*, between October 1932 and February 1933, there appeared a series of articles on new forms of medical care, which outlined many of the schemes for “organizing” medical and hospital services. The January 1933 issues of *The Journal* contained a discussion of hospital insurance schemes and listed fifteen prospective defects as against four merits of such plans. Some of these defects were competition between hospitals with plans and hospitals without plans, interference with free choice of hospital and physician, organization by profit-seeking promoters, introduction of commercial influences in hospital and medical services, uncertain actuarial bases, improper regard for insurance laws, extension of benefits to include medical services, solicitation of patients by salesmen, and the possibility of undesirable control of hospital management. In February 1933 “Prepayment Plans for Hospital Care”²⁰ again emphasized the abuses that are caused by commercialization and the defects of certain group hospitalization practices.

Immediately following the publication of these criticisms, which were made for the purpose of helping to avoid unsound principles in the formation of group hospitalization plans, a storm of protest was raised by persons interested in promoting such plans. The medical pro-

20. Leland, R. G.: Prepayment Plans for Hospital Care, *J. A. M. A.* 100: 870 (March 25) 1933.

fession was erroneously accused of objecting to all group hospitalization plans and of attempting to obstruct a plan that would save the hospitals from a financial crisis. Nevertheless, the realization of some of the untoward effects of the unsound and commercial plans caused modifications in the utopian claims and started the adoption of principles to guide the development of better group hospitalization plans. Hospital associations and medical societies were aroused to the growing importance of group hospitalization plans as well as to the dangers of certain practices. They soon began to stipulate the principles that should be observed by these plans.

In February 1933 the board of trustees of the American Hospital Association approved the "general principle of group payment as applied to hospital service." A brochure outlining certain principles for group hospitalization plans was prepared by the Council on Community Relations and Administrative Practice of the American Hospital Association and copies were sent to hospitals and physicians throughout the country.²¹ Some of the principles outlined were: Emphasis should be placed on public welfare and not on hospital finances; control should be in the hands of a nonprofit organization representing the hospitals; no contract should be made with business agencies seeking to control the plan; benefits should be limited to the hospital charges only; free choice of physician and hospital should be permitted, and there should be cooperation instead of competition by including all hospitals of standing in the community. The action taken by the board of trustees was not endorsed by the American Hospital Association until September, when the annual convention of the association approved

21. The Periodic Payment Plan for the Purchase of Hospital Care, American Hospital Association, Chicago, February 1933.

"the basic principle of periodic payment for the purchase of hospital care."

In June 1934 the board of regents of the American College of Surgeons approved the report of the Medical Service Board, which recognized that the periodic prepayment plan "offers a reasonable expectation of providing them (dependents and families of moderate means) with more effective methods of securing adequate medical service."²² In view of the newness of the plan of hospital insurance, the board of regents recommended that such experiments be continued but that certain principles should be followed. These principles stipulated that there must be no intervention of commercial organizations for profit, organization must be under the control of the medical profession, free choice of physician and hospital by the patient must be assured, and the code of ethics of the medical profession must be observed.

Unfortunately, the promoters of group hospitalization plans did not always see fit to observe the principles outlined by the American Hospital Association and the American College of Surgeons. Their advertising matter, however, never failed to emphasize that the plan was approved by the American Hospital Association and the American College of Surgeons. Blanket approvals which do not specify the method of control over plans claiming approval generally result in a number of plans that ignore many of the requisite principles but still claim to be "approved." At a round-table conference of persons interested in group hospitalization²³ "it was pointed out that the American Hospital Association's recommendations for an approved plan frequently were quoted, but the actual plan

22. Report of the Medical Service Board, *Bull. Am. Coll. Surgeons* 18:3 (June) 1934.

23. Will Private Insurance Companies Sell Group Hospitalization? *Hosp. Management* 37:35 (March 15) 1934.

offered differed from these recommendations in important ways." An indication of the failure of many plans to comply with the principles stipulated by the American Hospital Association is also shown by the following resolution: ²⁴

Be it Resolved, That hospitals contemplating the establishment of or participation in Group Hospitalization Plans bear in mind the recommendations of the Association and, before any active participation in such plans, consult with the offices of the Association for information and advice concerning individuals or agencies sponsoring such periodic payment plans for the payment of hospital care.

Obviously, unless group hospitalization plans were closely supervised, a very undesirable form of commercialism would be introduced into hospital and medical practices.

GROWTH OF SUPERVISION

As early as 1926 the Judicial Council of the American Medical Association had taken cognizance of so-called hospital associations which, for the payment of annual membership dues, provided medical, surgical and hospital services when needed. The Judicial Council reported that: ²⁵

The Principles of Medical Ethics of the American Medical Association specifically condemn the solicitation of patients whether by individual physicians, by groups, by institutions, or by organizations of physicians. The Judicial Council is of the opinion, therefore, that, so far as these health or hospital associations are organized for the purpose of soliciting patients, they are distinctly unethical. It goes without saying that for any organization of any kind to offer for an agreed stipend more than the reasonable worth of that which is offered is wrong in principle, and physicians should guard themselves against being connected with such organizations.

These "hospital associations" were evidently misnamed, because they were not associations

24. *Tr. Am. Hosp. A.* 37:916 (Oct.) 1935.

25. Report of the Judicial Council, Proceedings of the House of Delegates, 1926, p. 28.

of hospitals but were merely the business offices of groups having medical contracts for sale.

As has been indicated, hospitals did not begin organizing group payment plans until the years 1929 to 1932. In 1931 the Judicial Council reported as follows on plans offered by hospitals: ²⁶

Within the last year, some community hospitals have announced their intention to provide medical, surgical and hospital service to families on a flat rate basis. In at least one instance, such service has been offered to families for \$35 a year, irrespective of the number of members in such families. In most instances, certain exceptions are made in that persons with chronic diseases are not entitled to receive the benefits of the plan and obstetric service is not supplied without additional compensation. The members of the Judicial Council doubt that it is wise to lead the people in any community to believe that all necessary medical and hospital service, even though chronic diseases and obstetric care be excepted, can be provided for the average family for \$35 a year. In the cases presented to it the Judicial council has advised against the adoption of such plans by community hospitals because it is believed that they are not economically sound in that they may be unfavorably affected by conditions entirely beyond control under which contracts cannot be fulfilled. There are other aspects of the matter that readily present themselves for consideration involving the interests of physicians in the community who cannot participate in such plans.

In regard to these new plans for hospital and medical service the House of Delegates of the American Medical Association adopted the following report of the Judicial Council: ²⁷

It is not enough that these plans be considered only in the light of present economic conditions; it is essential that they be examined with a view to determining their ultimate effects on the future of medical practice and on the progress of medical science and, above all, they should be examined with the most careful consideration of their possible untoward effects on public welfare.

^{26.} Report of the Judicial Council, Proceedings of the House of Delegates, 1931, p. 24.

^{27.} Index and Digest of Official Actions, American Medical Association, Chicago, American Medical Association, 1933, p. 120.

Accordingly, state and county medical societies and some hospitals were not swept aside by the general wave of enthusiasm with which group hospitalization plans were received but insisted on the inclusion of definite principles before they would cooperate with such plans.

In at least twenty-four states the state or county medical societies have taken action with regard to the group hospitalization plans in the territory under their jurisdiction. The majority of these actions were favorable toward plans which adhered to certain essential principles. The local medical societies usually asked for participation in the control of the plan and were in a position to judge whether or not the plan would follow the principles stipulated. No blanket approval of group hospitalization was given, and most of the projects were not sanctioned until a complete study had been made by the county medical society.

The following resolutions adopted by one state association are presented as an example of the action taken by medical societies at the time group hospitalization plans began to develop (1933):

The Council believes that the State Medical Association should interest itself in all proposals affecting the care of the sick. In considering any hospital group payment plan for hospital service, it feels that such plan will be contrary to public interest unless there is evidence that the provision is made for the following:

1. Determination of rate upon basis of accurate actuarial figures.
2. Establishment of adequate reserves.
3. Sufficient spread of the field so that disaster to any one group will not destroy the reserves of the insurer.
4. Selling of insurance only when adapted to the individual it aims to serve.
5. Definite provision that medical service will not be included at outset or at any future time.

In general this Council views any projects for hospital insurance with skepticism.

a. It doubts whether accurate actuarial information is available.

b. It doubts whether hospitals are able to establish adequate reserves in advance because of the financial difficulties under which most hospitals are known to be operating at present.

c. It feels that the selling of such insurance will become a promotion matter.

d. No assurance has been given that complete medical service will not be included at some future date; and further, the proposed inclusion of laboratory, roentgenological, resident and/or interne service is in itself furnishing medical service.

e. The alinement of insured groups to a certain hospital or group of hospitals is destructive of the traditional relationship of physician-patient.

f. The inevitable public advertisement of hospital insurance is certain to serve directly or indirectly as an advertisement of the members of the visiting and associated staffs, and would be a discrimination against many physicians not affiliated with the insuring hospitals.

Therefore, the Council recommends that any component society of the State Medical Association refuse sanction to any hospital insurance project until complete study has been made by the county medical society, and until pertinent data have been submitted to, and acted upon, by the Council of the State Medical Association.

In accordance with the growing demand for supervision of medical care plans, the House of Delegates, without recommending any plan, adopted the following ten principles to govern experiments for organizing medical and hospital services: ²⁸

First: All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

Second: No third party must be permitted to come between the patient and his physician in any medical

²⁸. Report of the Special Committee, Proceedings of the House of Delegates, 1934, p. 55. As revised in June 1935.

relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician." This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: In whatever way the cost of medical service may be distributed, it should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established.

Ninth: Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

These principles have been lightly referred to as the "Ten Commandments" of the American Medical Association, but their usefulness and importance have been demonstrated. County medical societies have been guided by these fundamental recommendations and have found the following statement submitted by the com-

mittee that suggested the adoption of the principles to be true:

Such restrictions will undoubtedly lower the enthusiasm of many of the present advocates of such schemes. They remove the interest of the politician, the commercial promoter and all those who consciously or unconsciously are seeking to achieve other objectives than better medical care for those unable to provide such care for themselves under present conditions. All these principles are directed toward protecting the character of the service to be given and all are directly designed to guard against abuses which experience shows are bound to arise when these principles are neglected.

The result of the position taken by medical societies and by hospital administrators in sympathy with medical ethics was to bring gradually into disrepute those plans which did not follow the more essential principles that have been outlined. New plans promoted by commercial agencies or profit-seeking promoters no longer appealed to hospital administrators. The day of the commercial and competitive schemes began to wane and in their stead rose the city-wide, noncommercial associations of hospitals designed to offer hospital facilities on a prepayment basis. Group hospitalization plans, after a splurge as a cure-all for hospital financial ills, settled down to a steady development on sounder principles. They lost many of their obnoxious features when they were taken over by hospital administrators, physicians, and civic-minded persons to be developed as community welfare agencies. The plans were then formed more to assist persons with insufficient incomes to receive necessary hospital care than to serve as a means to financial gain for promoters or hospitals.

THE INFLUENCE OF INSURANCE

The principle of spreading the costs of hospital service over a large group, as advocated by group hospitalization plans, was borrowed

from the insurance field. The promoters of early group hospitalization plans, however, maintained that their contracts offered to provide hospital *services* and not to indemnify the subscriber against loss because of necessary hospital care. Therefore, it was contended that group hospitalization plans did not constitute insurance in the sense that they should be subject to the insurance laws of the state. In most states the insurance commissioner had had no particular occasion to examine into the activities of these plans. It was a common practice for promoters to organize group hospitalization plans with inadequate legal advice, so that a number of plans were put into operation without proper regard for the insurance laws. The following discussion, from the report of a meeting in 1933 of persons interested in group hospitalization plans, is indicative of the then current attitude:

We made a bad mistake. We know it now. I am saying this for the benefit of the rest of you. Don't make the mistake of asking the Attorney General a thing about it. We wish we hadn't. He is delaying the game. We had our constitution and by-laws, the hospital certificates and advertising, all drawn up ready to go ahead and now we are on the side lines.

and

We just quietly put the thing into operation by degrees. had a plan. They were all set to go. They got all the hospitals together. Then the attorney for one of the hospitals said, "You had better take it up with the Attorney General." The Attorney General said, "That is insurance." If they had started it in the first place and then fought it out afterward as to whether it was insurance they would have done better.

In October 1933 the Bureau of Medical Economics of the American Medical Association published the results of a survey of the attitude of officials having charge of insurance affairs

in each of the states.²⁹ In only ten states did the insurance officials report group hospitalization contracts were not insurance contracts. However, in at least two of these states, laws have since been passed to govern hospital service corporations. In the remaining thirty-eight states and the District of Columbia, group hospitalization contracts were either reported to be insurance contracts or the officials were uncertain as to whether or not the hospital service contract was insurance.

The desire of certain promoters of group hospitalization plans to be freed from the legal supervision that has been found advantageous for both the buyer and the seller of insurance contracts can hardly be construed to be in the interest of the public welfare. Insurance regulations are designed to prevent undesirable ventures, improper rates, unfair contract provisions, misappropriation of funds and inadequate reserves and to encourage all sound practices for the purpose of protecting the interests of both parties to the contract.

When the attention of the commissioners of insurance departments was drawn to group hospitalization plans, it was feared that the entire movement would be stopped—at least in those states in which group hospitalization was deemed to be insurance. As an example of the difficulties faced, one state requires the deposit of \$100,000 as a guaranty of good faith and \$50,000 as working capital before any insurance plan can be put into operation. It was, of course, virtually impossible for hospitals to raise the funds required by certain state insurance laws for the operation of a group hospitalization plan. It would be difficult to raise \$150,000 and still retain the nonprofit nature of a group hospitalization plan. Accordingly, in these states it was necessary to have laws passed

29. Group Hospitalization Contracts Are Insurance Contracts, A.M.A. Bull. 28: 113 (Oct.) 1933.

which would exempt such plans from the deposit requirements of insurance regulations.

In one state the state medical society and the state hospital association were largely instrumental in securing the passage of the first so-called enabling law, in 1934, to permit the operation of nonprofit hospital service corporations by amending the insurance laws. Within two years, similar laws governing the regulation and control of nonprofit hospital service corporations were passed in six other states.³⁰ The full implication of these laws will be discussed later, but essentially they permitted nonprofit corporations of hospitals approved by the department of social welfare or public health to be exempted from the insurance requirement of a cash deposit. These corporations, however, were subject to the supervision of the commissioner of insurance in regard to rates, contracts, costs, funds and annual reports.³¹ The emphasis placed on the insurance nature of group hospitalization plans was of assistance in encouraging group hospitalization organizations to conform to rules and regulations for a more orderly administration.

However, persons interested in promoting commercial group hospitalization plans have begun to organize hospital insurance companies. Such companies are incorporated under the insurance laws, usually as mutual assessment associations, and sell what is called a "hospital expense only" policy, which provides cash payments for stipulated hospital services. Before considering the influence of these companies on hospital service and group hospitalization plans, it would be well to examine into the present status of group hospitalization plans.

30. The seven states are New York, Maryland, Massachusetts, California, Illinois, Alabama and Mississippi. Bills proposing similar laws were killed in Georgia, Kansas, Oklahoma and Washington. New bills are being considered for Georgia, Iowa, Michigan, Pennsylvania and Wisconsin.

31. See pages 219-228.

Chapter III

THE STATUS OF GROUP HOSPITALIZATION PLANS

THE EXTENT OF GROUP HOSPITALIZATION PLANS

In cooperation with the Council on Medical Education and Hospitals, a series of letters and schedules was sent, between October 1935 and March 1936,³² to every locality in the United States where a group hospitalization plan was thought to be in existence.

The schedule sent was detailed, but it was the first request for such data and it was believed that each group hospitalization organization would desire to present complete facts pertaining to its operation so that an analysis of the experience with group hospitalization plans would be of value. Some of the organizations cooperated immediately, but many failed to take an interest in the study. A follow-up letter and a third letter, which asked each director to answer a short list of questions or merely to send a letter describing his plan, were sent in an earnest attempt to include the experience of every organization. As a result, the plans of all but fifty-nine of the 140 organizations contacted were directly accounted for. In addition, information from other sources was available concerning the plans of these fifty-nine organizations.

According to direct answers received concerning eighty-one plans, thirty-four were in operation, five were proposed, ten had consolidated with other plans, three were discontinued and twenty-nine were not in existence (either they had never existed or the schedule was returned marked "not in directory" or "moved, left no address").

32. See appendix A for a copy of the schedule.

According to information from secondary sources, the remaining fifty-nine plans included seventeen which were in operation, two which were proposed, one which was discontinued and thirty-nine which were no longer promoted.

Finally, thirty-two plans came into existence during the course of the study, but the organizations responsible for them were not sent questionnaires because of their recent formation. Five of these plans were reported to be in operation and twenty-seven were proposed. In summarizing, of a possible 172 group hospitalization plans surveyed during the period ending October 1936,³³ fifty-six were in operation; thirty-four were still being promoted, and forty-two were discontinued, consolidated with other plans or otherwise not in existence. No answers were received from forty organizations, but their plans were believed to be inactive. Table 1 gives a short tabular summary of this material.

The classifications have been made as carefully as possible from all available data. In those instances in which repeated requests for information were unsuccessful, there is a possibility that the classifications might be altered.

As another measure of the extent of group hospitalization plans, at least 510 hospitals are participating in group hospitalization plans. (Hospitals participating in more than one plan are counted only once.) These hospitals represent approximately one eighth of the general hospitals in the United States.

Before examining the returned questionnaires in detail, it should be of interest to observe what has happened to plans that have been inaugu-

33. A list of the 172 plans on a geographic basis is given in appendix B. According to recent information, nine of the operating plans in this list have been discontinued, or the organizations responsible for them have been reorganized as insurance companies, and eight of the proposed plans have started operating. Hence, fifty-five of the 172 listed plans are now in operation. Also, twenty-five new plans have come into existence recently, five of which are reported to be operating. As of September 1937, sixty plans are in operation.

rated. In table 2 the first column lists the plans according to the year of inauguration, and the succeeding columns indicate their present status. As shown, the first plan was started in 1918 and is still in existence. The year 1933 was the peak year for group hospitalization plans. During

TABLE 1.—*Summary of Study of Group Hospitalization Plans*

Active Plans	
Questionnaire answered	
Plans with report of membership.....	31
Plans operating; no report of membership.....	3
Plans reported as proposed.....	5
	39
Questionnaire not answered	
Plans known to be operating which have a membership	12
Plans known to be operating but membership unknown	5
Plans known to be proposed.....	2
	19
Active plans, newly organized and not surveyed	
New plans, operating.....	5
New plans, proposed	27
	32
Total active plans.....	90
Operating	56
Proposed	34
Inactive Plans	
Questionnaire answered	
Plans consolidated (combined with an active plan).....	10
Plans discontinued (once in operation).....	3
Plans not in existence (no longer promoted).....	29
	42
Questionnaire not answered	
Indefinite information (status uncertain, but plan considered inactive according to best available information)	39
Plan discontinued (once in operation).....	1
	40
Total inactive plans.....	82
Total active and inactive group hospitalization plans.....	172

that year and after the report of the Committee on the Costs of Medical Care, fifty-eight plans were promoted. Of these, only fifteen are now in operation, and two are still being proposed. The remaining forty-one plans originally promoted in 1933 are now inactive; of these, five were consolidated with other plans, one was

discontinued, nineteen are no longer in existence and sixteen are no longer being promoted.

If the twenty-two plans formed in 1936 are not considered because they have not had a sufficiently long period of existence to determine whether or not they will endure, it appears that of 150 group hospitalization plans promoted between 1918 and 1935, fifty-one, or about 34 per cent, are in operation; seventeen, or 11 per cent, are proposed, and eighty-two, or 55 per cent, are inactive. This indicates a strikingly

TABLE 2.—*Progress of Group Hospitalization Plans in the United States*

Year of Inauguration or Proposal	All Plans	Plans Now Active*	Plans Considered Inactive			
			Consolidated	Discontinued	Not in Existence	Indefinite
1918	1	1 (O)	..	..	..	..
1929	1	1 (O)	..	..	..	..
1931	6	5 (O)	..	..	..	1
1932	18	8 (O)	1	3	2	4
1933	58	15 (O) 2 (P)	5	1	19	16
1934	27	6 (O) 3 (P)	3	0	6	9
1935	39	15 (O) 12 (P)	1	0	2	9
1936†	22	5 (O) 17 (P)	0	0	0	0
Totals	172	56 34 (P)	10	4	29	39

* (O) means operating and (P), proposed.

† First ten months.

high mortality for group hospitalization plans. The large number of plans which never started operating should be minimized somewhat, because many of the plans were never very formally promoted and some were consolidated with more successful plans. Likewise, some of the proposed plans may start operating. More complete information may also reveal that some of the plans considered to be inactive have been revived.

In considering the progress of group hospitalization plans in the United States, it would be well to know what types of plans are active and which of the different types of plans are most

likely to become inactive. Table 3 presents this information for the active plans and table 4 for the inactive plans. It will be remembered that the classification "noncommercial" includes both single and multiple hospital plans operated not-for-profit with the control of the service provisions and membership funds in the hands of the hospital administrators and physicians or an agency properly representative of them. The "commercial plans" include both single and

TABLE 3.—*Types of Active Plans*

Year of Inauguration or Proposal	Operating*	Proposed*	Total
1918	1 (N)	..	1
1929	1 (N)	..	1
1931	5 (3C, 2C')	..	5
1932	8 (3N, 1N', 4C)	..	8
1933	14 (5N, 6N', 2C, 2C')	2 (1N, 1N')	17
1934	6 (1N, 4N', 1C')	3 (2N, 1C')	9
1935	15 (9N, 6N')	12 (3N, 8N', 1C')	27
1936†	5 (N')	17 (6N, 9N', 1C, 1C')	22
Totals	56 (20N, 22N', 9C, 5C')	34 (12N, 18N', 1C, 3C')	90

Summary: 72 noncommercial plans (32N, 40N') or 80% of active plans
18 commercial plans (10C, 8C') or 20% of active plans

* (N) indicates noncommercial plan with a single hospital; (N'), non-commercial plan with more than one hospital; (C), commercial plan with a single hospital, and (C'), commercial plan with more than one hospital.

† First ten months.

multiple hospital plans operated for profit or not for profit and directed by a sales agency which contracts with the hospitals.

For the active plans, table 3 shows that seventy-two are classified as noncommercial and eighteen as commercial. For the inactive plans, table 4 shows that fifty-four are noncommercial and twenty-eight are commercial. Because of the preponderant number of noncommercial plans, there are more inactive noncommercial plans and more active noncommercial plans. However, of the forty-six commercial plans, 39

TABLE 4.—Types of Plans Considered Inactive

Year of Inauguration or Proposal	Consolidated*	Discontinued*	Not in Existence*	Indefinite*	Total
1981	..	..	..	1 (C)	1
1982	1 (N)	3 (2N, 1C)	2 (1N, 1C)	4 (1N, 3C)	10
1983	5 (3N, 2C)	1 (1N)	19 (10N, 4N', 1C, 4C')	16 (8N, 3N', 1C, 4C')	41
1984	3 (2N, 1N')	..	6 (3N, 1N', 1C, 1C')	9 (4N, 1N', 4C')	18
1985	1 (N')	..	2 (2C')	9 (5N, 2N', 1C, 1C')	12
Totals	10 (6N, 2N', 2C')	4 (3N, 1C)	29 (14N, 5N', 2C, 8C')	39 (18N, 6N', 3C, 12C')	82
Summary: 54 noncommercial plans (41N, 13N') or 66% of inactive plans					
28 commercial (5C, 23C') or 34% of inactive plans					

* N indicates noncommercial plans with a single hospital; (N'), noncommercial plans with more than one hospital; (C), commercial plans with a single hospital, and (C'), commercial plans with more than one hospital.

per cent are active and 61 per cent inactive, whereas of the 126 noncommercial plans, 57 per cent are active and 43 per cent are inactive. Noncommercial plans are apparently more likely to remain active than are commercial plans. It can also be observed from tables 3 and 4 that the noncommercial plan with more than one hospital appears to be the most stable type. The ranking of stability, as measured by the percentage of the plans remaining active, is as follows: first, the noncommercial plan with more than one hospital; second, the commercial

TABLE 5.—*The Development of Noncommercial and Commercial Group Hospitalization Plans*

Year of Inauguration or Proposal	Noncommercial Plans	Commercial Plans
1918	1	..
1929	1	..
1931	0	6
1932	9	9
1933	42	16
1934	19	8
1935	34	5
1936*	20	2
Totals	126	46

* First ten months.

plan with a single hospital; third, the noncommercial plan with a single hospital, and fourth, the commercial plan with more than one hospital. The average age of the plans in operation is about two and one-half years, which is not sufficiently long to judge the enduring quality of the various types of plans.

Table 5 shows the gradual ascendancy of the noncommercial over the commercial plans. It can be noted from the table that commercial organizations first began the promotion of plans in 1931, after a southern hospital reported two years of successful experience with a plan it started in 1929. By 1932 most of the plans were still commercial. It has already been shown

that in 1933 the interests of the medical profession and of hospital associations were drawn to these plans, and they began to point out the prospective defects in certain group hospitalization practices and to condemn the commercialization of the plans. As a result, after 1933 the number of noncommercial plans increased much more rapidly than the commercial.

Since 1934 the commercial plans have been tending to disappear. The trend toward noncommercial plans is even more pronounced than shown in table 5, because some of the plans listed as noncommercial started operations as commercial plans but later were reorganized and had their relations with sales agencies discontinued. Likewise, some of the commercial plans remain in existence because the agencies signed the hospitals to a five-year contract. When these contracts expire, the hospitals will probably form their own noncommercial association. However, it has been noted that persons who promoted commercial plans have now started hospital insurance companies. Thus, profit-making ventures continue in the hospital insurance field.

It is significant to observe that the factors which were indicated in the preceding chapter as responsible for the development of group hospitalization have had a direct influence on the number and type of group hospitalization plans.

ORGANIZATION

The information furnished by thirty-four group hospitalization organizations will be relied on in considering the essential features of group hospitalization. The plans presented by these organizations represent a good cross-section of all the group hospitalization plans, because they include the majority of operating plans, over two thirds of all members enrolled,

an adequate number of the plans organized between 1918 and 1936 and a fair proportion of commercial and noncommercial plans of both the single and the multiple hospital type. The exact numerical division of the replies will be given only when significant, since it is deemed better to be concerned about the nature of the provisions rather than whether fourteen or fifteen plans included a specific provision.

Administration.—The success of a group hospitalization plan is largely determined by the administrative personnel. The entire nature of the plan and the degree of control over undesirable features are dependent on whether the organization is commercial or noncommercial. Noncommercial associations most frequently have hospital administrators and representatives of the medical society and civic groups of the community in the administrative personnel. Noncommercial single hospital plans are mainly controlled by the hospital alone, either through the superintendent or through a special committee. Commercial plans are controlled by a corporation or a privately-owned company and seldom permit representation by other groups in the community.

It is clear that the interests of three groups should be represented—the patients, the hospitals and the physicians. However, such representation must not be at the sacrifice of competent insurance administration. Group hospitalization resembles casualty insurance, and in no branch of insurance can mismanagement be more disastrous than in casualty insurance. Because such insurance does not have the definite scientific basis that exists in life insurance, it is essential for the management to be insurance trained in order to avoid unwise practices or unsound underwriting. The success of a health and accident insurance company is

largely dependent on the ability of its personnel—down to the very salesman—to select risks properly and to develop good underwriting practices.

While the insurance aspects of group hospitalization will be reserved for later discussion, one of the basic principles overlooked in the early plans discussed in "Group Hospitalization Contracts are Insurance Contracts"³⁴ was that the determination of actuarially sound bases for premium rates, a careful selection of risks and the wise handling of the funds of the members were insurance duties which could not be lightly undertaken by the inexperienced. It is becoming increasingly recognized that the administration of group hospitalization plans should conform to those regulations which are designed to safeguard the handling of funds collected from others.

In those communities in which there was but a single hospital, or even in communities in which there were several hospitals, an individual hospital sometimes undertook to operate its own group hospitalization plan simply as an additional function of the superintendent or as a special undertaking.³⁵ Naturally, it would be expected that a group hospitalization plan sold by a single hospital would create a number of problems in any community which has more than one hospital. Such an arrangement brings into sharp relief all the undesirable features of advertising and soliciting, particularly if the hospital contracts with an agency to sell the plan.³⁶

To avoid such conflicts, the hospital administrators and physicians turned to a community-wide association of hospitals for the promotion of the plan. The association, frequently called

34. Leland, R. G.: *Group Hospitalization Contracts Are Insurance Contracts*, A. M. A. Bull. 28:113 (Oct.) 1933.

35. See appendix C, p. 267 for an example of such a plan.

36. See appendix C, p. 269, for a copy of such a contract.

a "hospital service corporation"³⁷ or a "hospital service association," varies in form, partly because of the differences in state laws and partly to suit the desires of the organizers.

In most communities, a nonprofit, no-stock corporation, governed by hospital administrators, physicians and lay persons, was formed to contract with individual hospitals for the services to be provided.³⁸ This arrangement made possible an effective selling organization, with the control of policy in the hands of persons who would tend to observe the principles of medical ethics as closely as possible. In other communities an association was formed to secure funds by regular subscriptions from its members so as to provide hospital service for the members in accordance with the by-laws and charter of the association. Hospitals which agreed to render service to members were made charter members, and the board of trustees to govern the association was composed of one representative from each member hospital.³⁹ It is important to note that under the first type of organization the subscriber receives an inviolable contract, but that under the second type he receives a certificate subject to the by-laws of the association.

In some communities a commercial sales organization or a private corporation developed the group hospitalization plan and supplied the services promised by contracting with certain hospitals in the community. Under this form of organization neither the trustees of hospitals nor the medical profession has much to say about the nature of the advertising program to be undertaken. The formation of a nonprofit community plan may be retarded by such an organization if the contract between

37. See pages 223-226, for a discussion of the laws authorizing the incorporation of these corporations.

38. See appendix C, p. 277, for a copy of such an interhospital contract.

39. See appendix C, p. 282, for an example of such an association.

the sales agency and the hospital prohibits the hospital from participating in any similar plan for a certain period.⁴⁰ One such contract appointed the agency exclusive agent for five years.

The medical profession and the hospital associations have demanded that there be no proprietary third party between the subscriber and the hospital. The wisdom of this demand is borne out by the fact that the most sustained progress has been made by noncommercial, community-wide group hospitalization plans. It is now generally accepted that a group hospitalization plan should be administered by an association properly representing the hospitals, the medical profession and the public. Under such an organization the service provisions adopted are more likely to be for the best interests of the public and to avoid policies injurious to hospitals or physicians.

Funds.—The funds necessary to start a group hospitalization plan are secured from four sources: gifts, loans, promoters and subscribers.

Foundations or individual philanthropists may make an outright gift to finance the group hospitalization plans. Some plans are financed by a considerable lump sum, such as \$30,000, while amounts such as \$5,000 a year for three years, with a decrease of \$1,000 each year thereafter, are donated for others. These sums do not have to be repaid and are used to finance the plan during the promotional stage.

The majority of the plans are financed by loans from a community fund, a welfare organization or the individual hospitals. A community fund or a welfare organization usually makes a rather liberal loan, of about \$3,000 to \$7,500, depending, of course, on the size of

40. See appendix C, p. 269.

the community. The individual hospitals contribute to the support of the plan in several ways. Often each hospital appropriates a flat amount to be loaned to the organizing committee, or each member hospital grants some credit for hospitalization, such as \$150 plus a cash sum of \$20. In other plans the financial participation of the hospital is based on the bed capacity; for example, each hospital will loan \$1 per bed with a minimum loan of \$100 and a maximum of \$200.

The financing of the plan through promoters is characteristic of the commercial plans. A corporation is formed, and the officers advance the necessary capital which is secured by notes. Sometimes a group of persons will advance the capital for the privilege of selling the hospital service on a fee-per-sale basis. Several plans which are now organized on a noncommercial basis were promoted in the initial year by such a selling agency.

In a surprisingly large number of plans no financing funds are collected, but instead the plan is financed out of the current subscription collection. This method of financing is common among single hospital plans.

There is little agreement among the organizers of group hospitalization plans as to the size of the fund required to promote the plan and to pay for the benefits used by members. One device employed is to withhold the inauguration of the plan until a specified number of members—sufficient to permit an average experience—has been secured. What the size of this minimum enrolment should be varies, according to different experts, from 1,500 to 5,000. Another device is to require an enrolment fee, usually \$1, to bear a portion of the burden of promotional or administrative expenses until the plan can finance itself. It

is generally believed that a loss will be experienced during the first year of the plan but that the premium income of subsequent years will absorb this loss and will permit the establishment of reserves.

The financial experiences as reported by the directors of several of the plans are discussed on pages 125 to 140.

Sales Program.—The presentation of the plan to the public and the actual securing of subscriptions may easily follow methods which are contrary to what is considered proper according to hospital and medical ethics. While there appears to be no definitely formulated code of ethics for hospitals, those prescribed for physicians have been interpreted to apply to hospitals.⁴¹ Hospitals are largely dependent on the services of physicians. Hence, it is evident that the hospital must conform to the principles which govern the practice of medicine; otherwise physicians could not continue to practice in hospitals.

Although the hospital is often spoken of as an animate being, it is clear that the hospital administrators, superintendents and trustees are the persons who must assume the responsibility for all acts done. In this regard it is significant that the American Hospital Association was formerly the American Association of Hospital Superintendents. It must therefore be realized that the principles of medical ethics apply, so far as possible, to the governing body of the hospital and to all persons directly or indirectly employed by the hospital in the care of the sick. The American Hospital Association in its Code of Ethics for Hospital Publicity⁴² has recognized the connection between medical ethics and hospital publicity.

41. MacEachern, M. T.: *Hospital Organization and Management*, Chicago, Physicians' Record Company, 1935, chapt. 16.

42. Report of the Committee on Public Education of the American Hospital Association, Bulletin 117, 1934, pp. 6-8.

Some state hospital associations have drawn up codes of ethics to govern hospital publicity. A statement from one such code is as follows:⁴³

Every hospital should hold that it is unprofessional and unethical to solicit patronage for an institution through the medium of paid advertising in the press or in publicly distributed pamphlets, placards, or handbills. No hospital should print, publish or circulate or cause to be printed, published, or circulated any advertisement, statement, or notice which states or implies comparative costs, charges, or quality of service obtainable. . . .

No hospital shall receive pay for any medical or surgical services rendered by a member of the medical profession unless such charges are comparable to those of other institutions, and in general accepted by the medical profession.

An interpretation of the principle that "solicitation of patients by the hospital, or by any person connected with it, is unethical," is as follows:⁴⁴

It is unprofessional to procure patients by indirection, through solicitors, or by furnishing newspaper or magazine comments concerning patients treated. Self-laudation lowers the tone of the hospital and is unjustifiable. It is unethical to promise radical cures, to boast of cures and secret methods of treatment, to unduly exhibit certificates of success, or to employ unfair methods of gaining the attention of the public in an attempt to attract business. Patients are attracted to physicians and hospitals because of their known merit and established reputation for satisfactory service. Therefore, any solicitation impliedly or openly must be positively prohibited by all ethical hospitals. This rule should not be interpreted as preventing the exhibition in the administrative offices of membership in or certificates of approval by any recognized society devoted to the improvement of the hospital.

Hospital administrators, in devising a sales program for group hospitalization plans, obviously cannot avoid their responsibility to adhere to the principles of medical ethics governing advertising and solicitation. Advertising of

43. Footnote 42, p. 8.

44. MacEachern,⁴¹ p. 791.

medical services and solicitation of patients almost invariably result in a deterioration of the service rendered. The principle of medical ethics opposing such advertising and solicitation is designed to protect the patient by maintaining the standards and quality of medical service. Hospitals cannot disclaim responsibility for the advertising programs of the group hospitalization plans in which they participate. Neither can responsibility be waived by the fact that all hospitals benefit equally when a hospital service corporation conducts the advertising campaign. The second principle of medical ethics stipulates that the rules applicable to an individual govern the group also and that a business organization does not relieve the members of their professional obligations.

One of the several problems involved in group hospitalization plans is the conduct of an effective and ethical sales program without spending too large a share of the receipts, which are primarily to pay for the hospitalization of members.

According to the reports received, a salaried director, with salaried assistants, usually has charge of the sales and publicity for the plan. However, solicitors on commission alone are frequently used, or the entire sales program and methods may be entrusted to an outside sales agency.

In the actual selling of the plan, there is a tendency to rely on compulsory payroll deductions secured by selling the plan to the employer rather than on voluntary participation of individual employees. It is probably necessary to have the employer's cooperation so that the payments can be collected on a payroll deduction basis to avoid adverse selection of risks and high acquisition costs. Nevertheless, directors in charge of sales should avoid any criticism of encouraging "check-off" systems in the develop-

ment of their plans. Employees must be given a genuine free option to accept or decline the plan.

The plan is brought to the attention of employees by direct mail advertising and talks by sales representatives. Employees are then brought together, the plan explained, questions answered and descriptive leaflets left by the sales representatives.

If the plan is to be presented as an undertaking of ethical hospitals, no "high pressure" sales tactics will be used to sell it. The director of one successful plan has stated:

From our experience so far we believe that it is an extremely dangerous practice to turn over any group hospital program in any part of the country to people who do not know thoroughly the philosophy of the hospital and something of the medical profession.

A major benefit can be realized from the sales activities if the contacts with the public are utilized to correct wrong impressions concerning physicians and hospitals.

Valuable free publicity is frequently obtained by securing the cooperation of women's clubs, charitable organizations and other civic agencies in the community. The desire to have the support of these allies has been a strong factor in encouraging the formation of real community plans rather than commercial schemes.

Newspaper articles, posters, dodgers, bulletin boards, circular letters, radio broadcasts, motion pictures and almost every conceivable advertising medium are utilized to bring the plan before the public. A constant danger in advertising is the encouragement of competition. Other organizations selling a hospitalization service will increase their activities to take advantage of the publicity. The public then becomes confused as to the merits of respective plans. The result is harmful to medical and hos-

pital services, since good service can seldom compete with inferior service on a price basis.

While the activities of noncommercial group hospitalization plans are sometimes restricted to the confines of a city or county, many of them do overlap, and there may be competition between adjacent plans. The following headlines taken from advertising folders of group hospitalization plans indicate the possibility of confusing price competition:

A Few Cents a Day will Keep Hospital Bills Away
 Hospital Care for 3-cents-a-day
 Your Hospital Care for 2½ Cents a Day!
 15c a Week for Hospital Care
 Hospital Care for 2¼ Cents a Day
 2¼ Cents a Day for Hospital Care, and No Red Tape
 2c per Day will Protect you Against the Unforeseen
 Disaster of Hospital Bills
 Hospital Care At Less Than 2c A Day
 Hospital Care at the Least Cost.

While none of these plans are operating in the same community, few have any restrictions limiting the area from which subscribers may be accepted. Already some of the larger organizations are reaching out into communities without group hospitalization plans and are offering to sell contracts to persons in those communities. The subscribers in such outlying communities are not expected to travel to the participating member hospitals of the plan but may be hospitalized in their own community at a fixed rate per day. The trustees of hospitals and the physicians in each community should be permitted to decide on the desirability of forming a group hospitalization plan without intervention by outside plans.

The main purpose of the advertising of a real group hospitalization plan should be simply to inform the public of the essential features of the plan. The aggressive or "scare" advertising characteristic of commercial plans conflict with ethical hospital publicity and should be

avoided. The most effective advertising is the word of mouth, person to person unpaid recognition of the plan's known merit and established reputation for satisfactory service. This is the ethical and professional method of securing patients without solicitation or self-laudation.

HOSPITAL SERVICE CONTRACT BENEFITS

Next to the type of administrative organization, the contract provisions for service benefits are of major importance. There is, of course, a tremendous variation among the several plans in the details of specific contract provisions. Nevertheless, a certain basic uniformity is followed throughout all contracts.

The provisions for hospitalization are uniform in that almost every plan provides for the essentials of hospital service—bed and board, use of the operating room, general nursing care, routine medicines, surgical dressings and routine laboratory services. However, there are many differences in the services included under these classifications.

Room Accommodations.—The type of accommodation offered naturally has an important influence on the entire structure of the plan. The rates charged, the costs for hospitalization of members and the hospitalization experiences are largely dependent on the kind of bed accommodations provided in the contract. An examination of the contracts of thirty plans indicates that ten offer semiprivate room service; eight, private room service, six, ward service; and six permit optional selection of private or semiprivate room or ward service. These classifications of hospital accommodations are supposed to be based solely on the number of beds per room (private, one bed only; semiprivate, not less than two beds but not more than four; ward, five beds or more). Sometimes, however, contracts offer "semiprivate hospital care"

in a four to six bed unit accommodation. Frequently the contract fails to specify what is included in the room service offered. Besides the question of the number of beds in a room, there are other details concerning room accommodations, such as charges for special diets and the type of nursing services provided, which should be explained to the subscriber. The subscriber is generally unfamiliar with the differences in room accommodations, and it would seem essential that he be clearly informed as to the exact nature of the services for which he contracts. A proper sales presentation that educates the subscriber may overcome these uncertainties.

A now common provision permits the subscriber to choose more expensive accommodations by paying the difference between the price of the room selected and the price of the room offered in the contract. For example, if a contract provides ward accommodations for which member hospitals receive \$3 a day, the subscriber may use this amount as a credit on the price of more expensive accommodations. A member generally agrees to be placed temporarily in a bed of a different classification, either more or less expensive, until a bed of the designated classification is available.

Days of Hospitalization and Discounts.—Most plans permit twenty-one days of hospitalization in a contract year. Subscribers are not required to use the twenty-one days during one hospital admission but are permitted as many admissions as necessary, provided that in the aggregate the limit of twenty-one patient days is not exceeded. Of thirty-one plans on which reports were received, twenty-seven offer twenty-one days of hospital care. The remaining four plans offer from twenty to fifty days. It is generally agreed that these twenty-one days are sufficient to care for over 90 per cent of the membership.

Apparently, the essential feature in a group hospitalization contract is the amount of service or benefits offered rather than the number of days of hospitalization guaranteed. As an inducement to continuation of membership, some contracts include an increase in the number of days of hospitalization permitted in each successive membership year up to a certain limit; that is, twenty days of hospitalization are permitted in the first year, thirty days in the second, etc., up to a limit of fifty days. Because different hospitals sometimes use different methods of computing a day of hospitalization, the contract may specify what shall be counted as one day of hospitalization.

For hospitalization after a period of twenty-one days, subscribers are allowed discounts ranging from 10 to $33\frac{1}{3}$ per cent. According to the reports on twenty plans, a discount of 25 per cent is granted by ten, $33\frac{1}{3}$ per cent by nine and 10 per cent by one. It is difficult to determine from the provision in many contracts which reads "Additional service will be furnished to the subscriber at one-third discount off regular hospital charges," whether the discount allowed to subscribers after the period of twenty-one days applies to all hospital charges or only to those services permissible under the contract. Also, some contracts restrict the discount to specified services, and in others the discount applies only to the charges for room accommodations. Frequently, the limitation on the length of time that the discount will be honored is not indicated. Presumably the discount after twenty-one patient days have been used would apply any time during the remainder of the contract year. One contract grants a discount of "25 per cent off the regular hospital charges, if paid before the patient leaves the hospital." Another stipulates that the dis-

count will be granted "provided the charges are paid weekly in advance."

Other variations in the number of days of hospitalization permitted and in the discounts allowed are introduced when dependents are entitled to participate in the plan. If the dependents are charged an additional rate, they are generally considered full subscribers and are subject to all the provisions governing the benefits for subscribers. However, if the dependents are entitled to some discount, the foregoing questions concerning discounts also apply. Even if it is certain that the discount permitted dependents is limited to the services specified in the contract, it is necessary to determine whether each dependent is entitled to twenty-one days of hospitalization or whether an aggregate of twenty-one days is provided for all the dependents in the family. The limitations on the length of time for which the dependents' discount will be honored are generally indicated. These limitations restrict the service benefits to a stipulated sum of money or to a specified period of time. For example, one contract provides that "in no event shall this discount be given or payment made for a period to exceed seven weeks in any year's membership period." Another contract limits the total liability of the hospital service association for dependents entitled to service under any one contract to a sum not to exceed \$150. The discount benefit for adult dependents has apparently been abused, because it is often suggested that the dependents be limited to wife or husband and minor children.

The manifold variations in the provisions for hospital benefits continue throughout the other service benefits. Since many of the plans are still in the developmental stage, the contract provisions reflect their experimental nature. The variations are recited here to indicate what

is being undertaken and to point out ambiguities which may lead to misunderstanding.

Operating Room.—Practically every contract includes the use of the operating room. Infrequently this benefit is restricted to a certain number of admissions or to a limited money allowance. Delivery room service, however, is often not included, even if the contract permits hospitalization of obstetric patients. Anesthetics are generally included as a benefit, as are the services of the anesthetist "if the anesthetist is a salaried employee of the hospital." Such services may be limited "not to exceed \$20 in any one year."

Nursing Service.—General nursing care is always a contract benefit and means that the subscriber is entitled to regular floor nursing service. The services of special nurses and their board are definitely not provided. "Nursing Supervision" is frequently listed as an additional service benefit. One wonders what particular service is offered by this benefit since every approved hospital in the Hospital Register must have all general nursing care supervised by qualified registered graduates.

Routine Medicines.—The subscriber is seldom aware of the limits of the benefits included in the provision "Routine Medicines." The benefits included will generally depend on the customary practices in the hospitals of the community. Sometimes the participating hospitals agree on a definition of "Routine Medicines" in order that the billing to the hospital service corporation will be uniform. One such agreement reads as follows:

Ordinary drugs will include all drugs and medications carried in stock by the hospital pharmacy and listed in the United States Pharmacopeia, the National Formulary, or New and Non-official Remedies, with the exception of such sera or expensive preparations as the hospital administration upon occasion may find

necessary to institute a special charge for. A special charge will be made for proprietary preparations and any special prescriptions for which the hospital has to send to an outside pharmacy.

In almost every instance special drugs or serums are excluded.

Surgical Dressings.—In a like manner, the benefits included under the provision “surgical dressings” usually cannot be determined from the contract. One contract stipulates that this provision means “surgical dressings carried out in the patient’s room or bed and includes all dressings and supplies used, such as gauze, cotton and various fabrics, and solutions.” Special appliances and splints are not generally included as surgical dressings.

X-ray and Laboratory Services.—Undoubtedly, the provision which causes most of the disputes about group hospitalization plans is that of “X-ray and Laboratory Services.” The discussion centers around the inclusion of the professional services of radiologists and pathologists. The provision for x-ray and laboratory services is frequently qualified as “routine” or “ordinary” to indicate that the services included consist of only those regularly provided by the hospitals of the community. Furthermore, it is difficult to determine the amount or type of these services simply by reading the contract, since the governing regulations are generally agreed on separately by the hospitals and the hospital service corporation. For example, the following regulations were agreed on by the participating hospitals under one plan:

Routine laboratory service shall include any laboratory service usually recognized as necessary for a usual type of disease deemed essential by the attending physician and based on the desire to secure a definite objective.

All urine examinations necessary for the patient’s diagnosis and treatment with the exception of special more complicated procedures, such as quantitative

determinations for lead or other biochemical examinations which the individual hospital may wish to exclude.

Blood counts, hemoglobin determination, differential counts, blood smears, blood groupings and blood Wassermanns. Blood chemistry, blood cultures, Widal and special serology may be excluded if the individual hospital desires to do so.

Spinal fluid examinations including cell counts, Wassermanns, colloidal gold, cultures.

Smears and cultures of exudates, transudates or other fluids for bacteriological examination, including animal inoculations.

Tissue examinations (gross and microscopic) both frozen section and routine histological preparations, if performed by the staff pathologist of the hospital.

Post-mortem examinations when performed by the staff pathologist of the hospital.

Electrocardiograms and basal metabolism.

If the individual hospital's facilities do not provide coverage for the above services, and the hospital has to assume expense for the particular examination at an outside laboratory, the hospital may bill the patient for the service if it so desires.

The subscriber's contract for this plan simply contains the provision that "routine laboratory services" are provided as a benefit.

The x-ray services offered are designated as "x-ray examinations," "x-ray services" or as "technical x-ray services excluding professional interpretation." Certain restrictions in the amount of such services may be specified, such as the allowance of a discount or a limitation on the number of roentgenograms or "photographs."

In twenty-eight plans the types of x-ray and laboratory services offered were specified as follows: All twenty-eight plans offered the customary entrance laboratory tests, such as urinalysis, blood count, blood chemistry, etc.; nine restrict other laboratory services to supplementary diagnostic examinations only; seven offer roentgen and radium treatments; nineteen offer roentgenograms as a benefit; and five permit additional tests, such as electrocardio-

grams, gastro-intestinal and basal metabolic tests, and certain other services, such as the use of the oxygen tent and physical therapy. Only four plans offer all the laboratory services indicated. Evidently, the special medical services of radiologists and pathologists are frequently included in the x-ray and laboratory benefits.

Professional Services.—The directors of twenty-eight plans indicated what professional services are included as benefits in the hospital contract. None of the contracts include the services of surgeons or special nurses; eleven include the services of pathologists, nine of radiologists and eight of physical therapists. In twenty-two of the contracts the services of an anesthetist were included, generally, however, with the restriction “if a salaried employee of the hospital.” Ten contracts include first aid or treatment of ambulatory patients. Only three of these limit the benefit to first aid. Intern service is included as a benefit in twenty-three contracts and special dietetic service in twenty-six. Immunizations, special urinalyses and yearly physical examinations are infrequently included as benefits. Postmortem examination, a professional service of dubious value to the subscriber, is included in one contract.

According to these twenty-eight plans, it appears that a considerable number of group hospitalization plans offer the services of physicians as a contract benefit.

Additional Benefits.—The most important extra benefit offered by group hospitalization plans is the hospitalization of obstetric patients. According to thirty plans, obstetric patients may be hospitalized, but in twenty-six of these it is stipulated that there must be a waiting period ranging from fifteen days to one year before hospitalization is permitted. A waiting period of ten months or one year is most common. Four of these plans further limit the hospitali-

zation of obstetric patients by allowing only 50 per cent of the costs of such hospitalization.

The hospitalization of patients with chronic illnesses is permitted by eighteen plans as a special benefit. This benefit may be restricted to conditions arising after the contract is signed, to a discount only or to preliminary hospitalization until a diagnosis is made. Patients with cancer are permitted to be hospitalized, according to twenty-two of twenty-seven plans. However, such hospitalization is limited to a short period, such as for one week, or while the cancer is in the acute stage only. A waiting period ranging from ten days to six months before a patient with cancer may be hospitalized under the contract is also specified in fourteen of twenty-two plans in which hospitalization for this condition is permitted.

Special service benefits are included as a sales feature in the contracts of a considerable number of plans. For example, two contracts offer a discount of 25 per cent on hospital services not specified in the contract, two offer yearly physical examinations and four include ambulance service as a special benefit.

A benefit that is frequently included in the subscriber's contract is the provision for out of town service. In the event the subscriber, while traveling, is unable to reach one of the participating hospitals because of sudden illness or an emergency, he may be hospitalized in another hospital, and the hospital service corporation will pay a certain sum per patient day to the out of town hospital. The number of days for which such payment will be made is specified in the contract. The hospitalization benefit in a nonmember hospital is usually less than in a member hospital. For example, a plan providing twenty-one days of hospitalization at \$6 per day in a member hospital may offer no more than eighteen days of hospitalization at \$6 per

day in a nonmember hospital. Other plans offer the same number of days of hospitalization in a nonmember hospital as in a member hospital but will pay a smaller amount for each day in a nonmember hospital. The payment allowed may be on the condition that satisfactory arrangements can be made between the out of town hospital and the hospital service corporation and that the patient will be removed to one of the participating hospitals as soon as possible. Hospitalization in a nonmember hospital in the same community may not be permitted except in an emergency or when all the beds of the member hospitals are filled.

There are few restrictions on the selection of an out of town hospital other than that it must be one of "recognized standing" and that the need for hospitalization must be indicated by a physician of "recognized standing." Some plans permit hospitalization in any hospital in the United States and others in any hospital in the United States or Canada. It is claimed by one plan that "hospitalization is provided in any hospital in the world."

The provision for out of town service is now being extended to permit the enrolment of subscribers in outlying communities and to entitle them to a flat payment for a specified number of patient days in any hospital in their community.

One provision not usually included in the contracts, but which may be of importance to the subscriber, is as follows:

In the event that the subscriber shall be a patient in any Participating Hospital at the end of his contract year, he may renew this contract for an additional year by the payment to the Service Corporation within twenty-four hours of the commencement of the ensuing contract year, of the full annual payment for such ensuing year.

If the subscriber is hospitalized during the last few days of his contract period, he would, of

course, be unable to enjoy the full twenty-one days' benefit offered. The hospital service corporation cannot be expected to grant an extension of the contract year, but the provision shown serves the purpose of guaranteeing a renewal of the contract.

It is probably more than likely that a hospital service corporation would permit a hospitalized member to renew his contract for another year, but there is a likelihood that the member ill in the hospital at the date of renewal could be denied the privilege of becoming a subscriber for another year. Even if the foregoing provision is included in the contract, it might be in conflict with the provision specifying that the subscriber is not entitled to hospitalization for any ailment which may require hospital care at the time of his original or any supplemental application for membership. If the hospital service corporation declines to renew the membership of a member who at the date of renewal is a patient in the hospital, it could not be criticized too severely, because it would be protecting the interests of the rest of the members. To accept the premium of \$9 when it is certain that payments up to \$50 will have to be made immediately would be unfair to the other members who have helped to provide the \$50.

Free choice of physician is mentioned in the majority of the plans. Free choice of hospital is not so commonly indicated, largely because of the number of single hospital plans. When a community has only one hospital, there is, of course, little need to stipulate free choice of hospital. Since most plans permit the subscriber to be hospitalized in out of town hospitals, he apparently has considerable freedom of choice. Free choice of hospital and physician may be interfered with where there are competitive plans or where all the hospitals in the community do not participate in the plan.

Even the community-wide noncommercial plans do not always include all the eligible hospitals in the community. The attending physician may want to hospitalize his patient in a non-member hospital, or the patient may ask to be attended by a physician not eligible to practice in any member hospital. It has been noted that the benefits for hospitalization in a nonmember hospital are usually less attractive.

The attempt to offer widespread free choice sometimes raises the possibility of opening all hospital staffs. Whether or not this would be good for hospital practice is not within the scope of this report. Some of the provisions for free choice of physician read as follows:

The subscriber shall be at liberty to select his or her physician or surgeon, provided only that such physician or surgeon be licensed to practice medicine by the State of.....and be a member of theMedical Society.

Each member is allowed the privilege of selecting his own doctor.

One proposed law specified:

It shall be stipulated in said contract that any doctor may be selected by the subscriber to treat him while he is a patient in the hospital, provided the doctor selected is a reputable doctor and eligible for membership in the county medical society.

However, provisions for free choice of physician frequently stipulate that the physician must be acceptable to the hospital selected, as follows:

In the event the member does not have a personal doctor, the hospital shall require her/him/them to select her/his/their personal doctor from among the regular staff of the hospital.

Each member shall select his own doctor, who shall be subject to the approval of the member's hospital.

The subscriber shall be at liberty to select his or her physician or surgeon, provided only that such physician or surgeon is acceptable to practice in the member hospital to which the subscriber is admitted.

The influence of the hospital service corporation in the selection of hospitals and phy-

sicians may be more far reaching than is apparent. An article in the by-laws of one hospital service plan is as follows:

The hospital service corporation will not contract for its service with employees of firms that are termed to be practicing corporate medicine, nor shall it be offered to groups who are collectively engaged in any prepayment plan for medical and surgical care where free choice of physician is denied.

It is agreed that all parties to this contract recognize the right of free choice of physician.

This provision is presumably designed in the interest of combating undesirable contract practice.

CONTRACT LIMITATIONS

There has been a noticeable increase in the number of limitations in hospital service contracts. A comparison of the first group hospitalization contracts with the later contracts issued by hospital service corporations reveals the growing importance of provisions restricting the benefits offered. The importance of these restrictions is frequently lost sight of when the hospitalization experiences of various plans are compared. The hospitalization experiences will, of course, be greatly affected by the limitations that are imposed.

In the preceding discussion of the contract benefits, it has been evident that every benefit is at the same time a limitation. In addition to the particular limits on each benefit offered, there are certain general limitations imposed.

Restrictions on Hospitalization.—The contract limitations are usually less emphasized than the benefits. The most uniform restrictions are those prohibiting or restricting the hospitalization of persons with certain conditions. Of thirty-one plans, twenty do not grant hospitalization to persons with contagious or venereal diseases. The other eleven plans permit hos-

pitalization of patients with these conditions under certain limitations, such as "preliminary hospitalization pending diagnosis," "\$10 per week extra charge" or "if hospitalized by participating hospital." Of twenty-nine plans, eighteen do not grant hospitalization to patients with tuberculosis. The remaining eleven plans permit hospitalization for these patients for surgical treatment or for preliminary hospitalization pending diagnosis. Persons with self-inflicted injuries or those who have attempted suicide and persons with nervous or mental disorders, injuries resulting from riots or civil commotion, diseases not common to both sexes or conditions resulting from the use of alcohol or narcotics are not permitted to be hospitalized according to the majority of the plans. Persons seeking rest cures are not entitled to hospitalization in a majority of the plans. Persons with injuries or diseases for which hospitalization is available without cost to the subscriber, as under workmen's compensation laws, are excluded by practically every plan.

Likewise, hospital care is not provided a person with a condition known to exist and to require hospitalization at the time of application. Prospective subscribers having conditions that may need hospitalization often are accepted, although hospitalization for the existing condition will be denied. When "sub-standard" risks are accepted, riders are attached to the contracts specifying the special conditions for which hospitalization is not granted or for which higher rates are charged.

Release of Liability.—The majority of the plans have a provision for release of liability if the hospitals are unable to furnish service because of overcrowded conditions or other extraordinary circumstances. Twenty-five of twenty-eight plans on which reports were

received have such a provision, which usually reads as follows:

In case of war, public disaster, general epidemic, or other conditions occasioning an overcrowding of all of the member hospitals to such a degree that it is impossible for them to provide the hospital care required by this Plan, or in the event that all of the member hospitals for any reason are unable to provide such care, the responsibility for this corporation of providing same under this Plan may be discharged by the refund to the subscriber in need of hospital care of a sum equivalent to the amount that has been paid by him during the current year, such payment constituting a full and final discharge of all obligations of the.....Hospital Service of.....
.....under this Plan.

Since the benefits are based on a twelve month period, this provision was considered a fair settlement of the obligation of the corporation. According to the usual wording of the provision, a member could pay for a number of years and then, when he needed hospital service, the hospital service corporation would refund him his current annual premium if all the hospital beds in the community were filled because of an epidemic or catastrophe. The repayment of the annual premium by the hospital service corporation in case of an extensive demand for service would be like a fire insurance company offering to return the premiums paid when a 4-11 fire alarm is sounded. No doubt the hospital service corporation cannot be expected to do the impossible, but it is questionable if the repayment of the current annual premium is a fair settlement of the services promised in the contract. The following comment on the release of liability provision appeared in a report made by a state insurance examiner:

It would seem that a refund of a premium paid in where, through no fault of the subscriber, admission to a hospital cannot be obtained, is an unfair discrimination.

Evidently the directors of hospital service corporations are aware of this probable inequity, because there have been a number of alterations in the phrasing of the provision for release of liability. Some plans offer to refund the subscriber twice the amount that has been paid during the contract year as a discharge of obligation. The contract of a prominent plan has been changed so that the corporation now agrees, in the event it is unable to provide services because of overcrowding, to pay the subscriber the prevailing patient day rate for an average period as experienced by the plan's subscribers for the particular illness. In no case is the average period to exceed twenty-one days. This arrangement returns to the subscriber an amount more nearly equal to the liability assumed by the corporation.

When considered in conjunction with the provision permitting service in almost any hospital in the United States, it appears that the provision for release of liability is pointless. It is not likely that all the hospitals in the United States will be overcrowded at the same time. The hospital service corporation, however, does not want to appear willing to assume the expense of transporting patients to distant hospitals if all the local hospitals should be overcrowded. If the subscriber travels to a distant city and becomes ill, the corporation will pay for his hospitalization. It will scarcely want to pay the expense of transporting the patient to another hospital. The application of the release provision cannot be definitely known until an actual catastrophe occurs.

If the subscriber becomes unemployed, the contract is canceled according to nine of twenty-eight plans; five plans cancel the contract outright, two permit the subscriber to continue his contract for the remainder of the year, one permits the subscriber to retain his contract

providing he pays his full year's premium in advance and one permits the subscriber to continue his contract for thirty days only. Of course, when the subscriber becomes unemployed he may retain his privileges under the remaining plans only if he continues to pay his premiums. Nonpayment of premium is a cause for cancellation in every contract.

A contract may usually be terminated by either party at any time by giving a few days' prior written notice to the other party. If the subscriber has applied for hospital care or is receiving hospital care, his contract may not be canceled by the corporation until the expiration of the subscription year.

In the event of the death of the subscriber, benefits for his dependents cease at the end of the contract year. Likewise, if dependent children attain a certain age or marry, their contract benefits may automatically terminate.

Waiting Periods.—The most direct limitation of all is the specified waiting period before the subscriber is entitled to service. For emergency cases, few plans impose a waiting period. Of twenty-nine plans on which reports were received, twenty-five have no waiting period for patients needing emergency treatment. The waiting periods that are required range from one to thirty days. In twenty of these plans, subscribers with general illnesses cannot be hospitalized except after a waiting period of from ten days to three months, with the majority of the restrictions fifteen days or less. For acute illnesses, thirteen plans have waiting periods which range from ten days to six months. The majority of these plans require a waiting period of fifteen days or less. Minor operations are included in all contracts, but twenty specify waiting periods from ten days to one year. Major operations are always included as a contract benefit, but twenty plans require wait-

ing periods from ten days to six months. It is evident that there is little agreement as to what is the correct waiting period before a person with a specified condition may be hospitalized.

What conditions would be classified as general illnesses or acute illnesses or what operations as minor or major operations is exceedingly uncertain in most of the plans. Sometimes the contract specifies the conditions, as in the following provision:

This Association will provide hospitalization for herniotomy, tonsillectomy, and adenoidectomy after 12 months from the effective date of the member's contract.

More frequently, the advertising literature must be depended on to learn for what conditions hospitalization is not granted. Whether or not a patient with a certain condition will be hospitalized apparently depends on the administrative policy adopted by the officers of the hospital service corporation.

After the subscriber has been a member for one year, the waiting periods cease to be restrictions on hospitalization. A new form of waiting period, however, was innovated by one plan after a year of rather heavy use of service by subscribers. The provision in the new contract is as follows:

This Association shall not be liable to provide service for any period of hospitalization less than three days, nor for any cost of room and board for the first two days of any period of hospitalization.

For every admission to the hospital, the contract holder must now pay for the first two days; furthermore, he must be an inpatient for five days before the association will be liable for the hospital expenses incurred. Another plan stipulates:

In no case shall the benefits hereunder receivable apply to the first two days of hospitalization, except in case of an emergency operation.

These waiting periods apply to every hospitalization, regardless of the time the subscriber has been a member.

It is also of interest that one proposed hospital service law stipulates the size of type to be used in hospital service contracts and specifies that limitations must be given greater prominence than the benefits to which they apply.

MISCELLANEOUS PROVISIONS

Some plans attempt to make certain that the physician will benefit through the organization of a group hospitalization plan by inserting a clause which makes the continuance of membership in the plan dependent on a satisfactory payment of the physician's bill. For example, one plan stipulates that:

The holder of this Certificate must be responsible for the payment of the doctor's fee for medical and surgical care given or ordered by her/his/their personal doctor during her/his/their stay in the Hospital, the continuance of this membership being contingent upon the satisfactory arrangement for the payment of said doctor's fee being made by the member with her/his/their doctor.

In consideration of the waiver of a physical examination, the subscriber permits the hospital service corporation to have access to all records of diagnosis, treatment and hospital care. In private practice these records are ordinarily considered privileged communications. However, under workmen's compensation and commercial insurance the insured person may permit the company required to pay a claim for sickness or injury to have access to all records dealing with the nature of the claim. Statutory regulations usually govern the release of hospital or medical records. Under some interhospital agreements, member hospitals may be required to furnish to the hospital service corporation the diagnosis by the sub-

scriber's attending physician and a history of the subscriber's hospitalization.

A subscriber is entitled to be hospitalized in accordance with the contract provisions only on the recommendation of a physician licensed to practice in the state. The subscriber is also entitled to service only while under the care of a physician. After being discharged by his physician, if the subscriber remains in the hospital he is responsible to the hospital for its regular charges.

Finally, most contracts include some of the customary provisions of health and accident insurance policies, such as "benefits are not transferable," "contract cannot be changed by agents or employees" and "grace period of thirty days will be allowed for premium payments."

The pro rata clause, whereby an insurance company pays only a proportionate amount of a loss if other insurance is carried, is not required by hospital service corporations. In fact, one such corporation made much of the fact that a member received over \$25 for each dollar of premium by belonging to two hospital service plans at the same time. Insurance companies have found that it is unwise to permit policyholders to benefit from double insurance. The "moral hazard" of large benefits may encourage members to make undue use of their contracts.

If the subscriber to a group hospitalization plan also has an accident insurance policy, a conflict in the payment of his claim for an accident may arise. The insurance company may disclaim liability if the bill is paid by the hospital service corporation, as it undertakes only to reimburse the subscriber for the expenses he has incurred as the result of an accident. The hospital service corporation may request the subscriber to have the insurance company settle his claim. One insurance com-

pany has generously agreed to pay the claims in cases of accident, which allows the policyholder, as a subscriber to a group hospitalization plan, the use of his twenty-one days of hospital service for health claims. Such an arrangement will lower the claim losses for hospital service corporations for those subscribers who have insurance policies and who would ordinarily present accident claims. Whether or not other insurance companies will agree to this practice is not known.

MEMBERSHIP

The membership of a group hospitalization plan consists of subscribers and dependents. The subscriber is the person who signs the contract agreement. The dependents are those persons in the subscriber's immediate family who are entitled to services.

Subscribers may be classified as "group" or "individual." Group subscribers are those who sign the contract agreement with a group of persons, usually in the same organization. Individual subscribers are those who sign the contract agreement not as a member of some group. The group subscribers make their payments to the hospital service corporation by means of payroll deductions or through a single collector; the individual subscriber makes his payments directly to the hospital service corporation.

Usually, the subscriber's wife and minor children constitute the dependents. Some plans classify dependents as adult dependents and children. The adult dependents are the wife and all adult persons in the immediate family, not further removed than the first cousin, who are entirely dependent on the subscriber and live in the same household. Children are all unmarried persons below a certain age, such as 19.

In connection with the administration of hospital service corporations, there are three classes of membership: voting members, members at large and hospital members. The voting members are the trustees of the hospital service corporation and primarily represent the hospitals and the medical profession. Members at large are the persons entitled to the benefits offered in the subscriber's contract. They may have certain voting rights conferred on them by the trustees. Member hospitals are the hospitals that sign the interhospital contract and agree to provide the services offered in the subscriber's contract. Member hospitals may or may not be represented on the board of trustees.

Before a person may become a subscriber to a group hospitalization plan, he must fulfil certain requirements. Usually these are simply that the prospective subscriber be employed and in good health. Some plans impose a few more particular requirements, such as age limitations, membership in a group of employed persons, racial restrictions and a specified place of residence.

The "good health" of the subscriber is accepted on his own statement. Two plans require individual subscribers to pass medical examinations. There is considerable variation in the age limitations, but most of the plans accept members up to the age of 65. Four plans accept only white persons as subscribers. Negroes and Orientals are excluded or are entitled to hospitalization in specified hospitals. In some plans the question of racial inclusions or exclusions is left to the judgment of the directors. A few of the plans indicate that membership is restricted to the residents within the county, the city or the state. The selection of members according to groups, employment, age and other restrictions is designed for the

purpose of improving the actuarial soundness of the plan by eliminating as many poor risks as possible.

While group hospitalization should presumably be restricted to homogeneous groups of subscribers, such as all the employees of a single organization, the tendency is to include individuals. The individual subscribers are considered as a form of group and are entitled to the same benefits as group subscribers. The individual subscribers are usually charged a higher rate than subscribers in groups, and sometimes they are not accepted unless their dependents are also included or unless they obtain a statement from their physician that they are in good health.

An important development in membership requirements is that the majority of the plans now enroll dependents. The subscriber's dependents are ordinarily entitled to participate in the plan through one of two methods: Either they are automatically included with the subscriber, perhaps at a nominal charge and are entitled to a discount on services; or they are optionally enrolled at some rate in addition to the subscriber's dues and are entitled to the same benefits as those granted the subscriber. The extension of benefits to dependents resulted from the demand by subscribers that their dependents be included and from the desire of directors of hospital service corporations to make their contracts more inclusive and more salable. The enrolment of dependents causes a significant alteration in the hospitalization experiences of the membership of a group hospitalization plan. The use of benefits by dependent members will be discussed later.

An income limitation as a membership requirement is noticeably absent. Only one of the plans restricts its membership to those in the "low income groups." When a drive for

membership in a hospital service plan starts, it is not unusual to find the names of prominent personages among the first subscribers. The original avowed purpose of a group hospitalization plan was to assist persons with limited means to secure low-cost hospital service. The current policy of ignoring an income limit may prove to be unwise. As the director of one plan said: "There will be criticism if we take too many millionaires." However, the promoters of group hospitalization plans contend that only semiprivate facilities are usually offered and that the persons in the higher income groups will want private accommodations. Since there will be no decrease in the use of private rooms and since the hospital will receive the same basic rates that it now receives, they argue that there is no necessity to observe an income limitation for members. If the group hospitalization plan is designed to aid persons with limited means to secure low-cost hospital services, it would seem that such services should be rendered at less than regular charges. Accordingly, an upper income limit would be necessary. If no consideration in rates is made for persons with limited means, there is little justification for an income limitation. It is not consistent to claim an altruistic purpose for group hospitalization plans when all members are charged the same premiums and hospitals receive full rates for services rendered.

Other objections to an income limit are that subscribers' financial conditions may change and that the formation of groups of persons on different wage levels would be difficult. These objections are scarcely of sufficient importance to be real obstacles.

The membership of group hospitalization plans changes rapidly. Some directors jealously withhold any information about the number of members in their plan. Others do not separate

subscribers from dependents in their membership statements. The fiscal years of the several plans cover different periods, and since reports are generally issued at the end of a fiscal year it is difficult to get membership statistics for comparable periods. All these obstacles make total membership statistics of doubtful value.

Table 6 presents the most complete membership statistics that could be obtained. As shown, the total membership of forty-nine group hospitalization plans is 684,824. Membership statistics could not be obtained for four small plans, and there is a slight possibility that some other new or small plans may be omitted. An estimated membership of 700,000 as of January 1937 would include every group hospitalization plan.⁴⁵ An increase in membership has since been reported for many plans.

As a measurement of the popularity of group hospitalization plans, the number of subscribers is more significant than the total membership. The number of persons who actually sign their names to a contract and pay membership dues for a group hospitalization plan is considerably less than the total membership. As shown in table 6, the total number of subscribers as of January 1937 is 455,032.

The rate of growth in group hospitalization membership is most interesting. Table 7 shows the change in membership for thirty-five plans between January 1936 and January 1937. These plans represent an increase in membership of 138 per cent during the twelve months. The total membership for all plans as of January 1936 has been estimated at 300,000, which, compared with the total for all plans as of January 1937, estimated at 700,000, indicates an increase of 133 per cent. The direction of this

45. Frequently published group hospitalization statistics include policyholders of hospital insurance companies, students eligible for college student health services and members of mutual benefit plans. The aforementioned membership figures are for group hospitalization plans only. See also page 227.

TABLE 6.—Membership of Group Hospitalization Plans,
Jan. 1, 1937

Name of Organization	No. of Subscribers	No. of Dependents	Total No. of Members
Hospital Service Corporation, Birmingham, Ala.	4,062	3,410	7,472
California Hospital Benefit Association, Los Angeles	550	?	550
Associated Hospitals Service Fund, San Jose, Calif.	1,060	None	1,060
Hospital Service Plan, Inc., Norwalk, Conn.	3,549	?	3,549
Group Hospital Service, Inc., Wilmington, Del.	4,455	2,040	6,495
Group Hospitalization, Inc., Washington, D. C.	30,000*	None	30,000*
The Hospitalization System, St. Luke's Hospital, Jacksonville, Fla.	1,256	212	1,468*
Hospital Service Corporation, Chicago	1,901	1,405	3,306
Methodist Hospital, Gary, Ind.	105	20	125
Fellowship Fund Plan, Indianapolis	600*	?	600*
Community Hospital, Grinnell, Iowa	86	149	235
Golden Rule Group Hospitalization Plan, Kansas City, Kan.	310	155	465
Wesley Hospital Hospitalization Plan, Wichita, Kan.	3,035	?	3,035
Ashland Hospital Service Association, Ashland, Ky.	812	1,626	2,438
Flint-Goodridge Hospital, New Orleans	530	212	742
Hospital Service Association, New Orleans	13,845	26,404	40,249
Mutual Hospital Service, Shreveport, La.	2,702	434	3,136
Weymouth Hospital Service Plan, Weymouth, Mass.	119	96	215
Minnesota Hospital Service Association, St. Paul	33,090	33,751	66,841
Group Hospitalization Plan of Research Hospital, Kansas City, Mo.	3,809	250	4,059
Group Hospital Service, Inc., St. Louis	7,000	None	7,000
Elizabeth General Hospital, Elizabeth, N. J.	10,051	None	10,051
Mutual Hospitalization Plan Department, Morristown, N. J.	1,357	1,829	3,186
Hospital Service Plan of New Jersey, Newark, N. J.	13,067	4,874	17,941
Mutual Hospitalization Plan Department, Perth Amboy, N. J.	1,418	1,513	2,931
Mutual Hospitalization Plan Department, Rahway, N. J.	648	922	1,570
Associated Hospital Service of the Capital Districts, Albany, N. Y.	1,794	1,319	3,113
Community Hospital Association, Geneva, N. Y.	750*	150*	900*
Associated Hospital Service, New York	147,949	68,246	216,195
Rochester Hospital Service Corporation, Rochester, N. Y.	31,372	25,624	56,996
Syracuse Hospital Service, Inc., Syracuse, N. Y.	7,881	None	7,881
Hospital Savings Association, Chapel Hill, N. C.	12,057	7,427	19,484
Hospital Care Association, Durham, N. C.	12,000	13,000	25,000
Cleveland Hospital Service Association, Cleveland	40,516	5,100	45,616
Ohio Hospitalization System, Sandusky, Ohio	336	?	336
Hospital Mutual, Inc., Oklahoma City	1,800	None	1,800
Associate Membership Department of Easton Hospital, Easton, Pa.	6,000*	?	6,000*
Black Hills Methodist Hospital, Rapid City, S. D.	65	53	118
Hospital Service Plan, Holston Valley, Kingsport, Tenn.	2,269	4,283	6,552
The Hospitalization System, Fort Sanders Hospital, Knoxville, Tenn.	2,057	250	2,307
Baptist Memorial Hospital, Memphis, Tenn.	2,741	764	3,505
Memphis Hospital Service, Memphis, Tenn.	4,994	2,235	7,229
Baylor University Hospital, Dallas, Texas	20,000	7,000	27,000*
Methodist Hospital of Dallas, Dallas, Tex.	4,493	?	4,493
St. Paul's Hospital, Dallas, Texas	3,944*	1,900*	5,844
Tidewater Hospital Service Association, Norfolk, Va.	3,599	1,933	5,532
Richmond Hospital Service Association, Richmond, Va.	2,054*	None	2,054*
Associated Hospitals, Inc., Bluefield, W. Va.	3,921	6,179	10,100
Hospital Service, Inc., Charleston, W. Va.	3,023	5,027	8,050
Total 49 plans	455,032	229,792	684,824

*Approximate.

increase in membership is also shown in table 7, particularly for the ten largest plans. The number of members of many of the larger plans increased over 200 per cent during the year; for one plan the increase was 700 per cent. The membership of these plans has increased relatively faster for some than for others, and that for one plan has decreased. The second largest plan in January 1936 was the sixth

TABLE 7.—*Growth of Group Hospitalization Membership*

Plan No.	Membership January 1936	Plan No.	Membership January 1937	Percentage Increase January 1936 to January 1937
1	55,324	1	216,195	...
2	42,420	3	66,841	...
3	26,224	5	56,956	...
	123,968	47%	340,032	54% 174
4	19,600	7	45,616	...
5	17,500	2	40,249	...
6	15,898	6	30,000	...
7	13,747	4	27,000	...
8	10,800	8	25,000	...
9	9,976	10	19,484	...
10	2,431	9	17,941	...
	89,952	34%	205,290	33% 128
25 plans	50,166	19%	85,408	13% 70
35 plans	264,086	100%	630,730	100% 138

largest plan in January 1937, whereas the fifth largest plan in January 1936 was the third largest plan in January 1937. These ten large plans include 87 per cent of the membership and show the concentration of members among a few plans. The three largest plans include 54 per cent of the membership. The tendency for an increasingly disproportionate share of the members to be enrolled in the ten large plans is shown by the increase from 81 to 87 per cent of the membership during the year 1936.

Even if the total membership of 700,000 for all group hospitalization plans is considered, the three largest plans still have 49 per cent of all members. It is evident that the major development in the membership of group hospitalization plans has been restricted to a few plans.

The concentration of group hospitalization membership in a few particular areas is illustrated in another form by the distribution of plans according to localities. Table 8 gives the distribution by communities of all plans for which membership was reported, and shows the membership of the plans and the population of the communities. Only eighteen of these plans are in communities with a population of less than 100,000. The problems of collecting subscriptions and enrolling large employed groups are difficult in small communities. In such communities it is necessary to sell to a relatively small number of persons, which generally results in an adverse selection of risks and greatly increases the acquisition costs. The small city may be suitable for a group hospitalization plan if it is an industrial or manufacturing center with a number of groups of employed persons.

The plans in the table designated ‡ are known to draw their membership from a considerable area, such as from several counties or the entire state. It can be seen that many of the plans include persons other than those in the immediate community and that few of the larger plans in communities with a population of less than 100,000 restrict their membership to persons in the one community. Table 8 also indicates the communities which have competitive plans. Two communities have two plans each, and one has three plans. These are plans which have memberships. Other communities have more than one plan, although the additional plans

may be only proposed. Sometimes the organizers of an additional proposed plan seek to consolidate the other plans in the community.

TABLE 8.—*Relation of Group Hospitalization Membership to Population*

Community	Number of Plans	Group Hospitalization Membership*	Population of Community†
Birmingham, Ala.....	1	7,472‡	259,678
Los Angeles.....	1	550‡	1,238,048
San Jose, Calif.....	1	1,060‡	57,651
Norwalk, Conn.....	1	3,549‡	36,019
Wilmington, Del.....	1	6,495	106,597
Washington, D. C.....	1	30,000‡	486,869
Jacksonville, Fla.....	1	1,468	129,549
Chicago.....	1	3,306‡	3,376,438
Gary, Ind.....	1	125	100,426
Indianapolis.....	1	600	364,161
Grinnell, Iowa.....	1	235	4,949
Kansas City, Kan.....	1	465	121,857
Wichita, Kan.....	1	3,035‡	111,110
Ashland, Ky.....	1	2,438	29,074
New Orleans.....	2	40,991	458,762
Shreveport, La.....	1	3,136	76,655
Weymouth, Mass.....	1	215	20,882
Minneapolis.....	1	66,841	464,356
St. Paul.....			271,606
Kansas City, Mo.....	1	4,059	399,746
St. Louis.....	1	7,000‡	821,960
Elizabeth, N. J.....	1	10,051	114,589
Morristown, N. J.....	1	3,186	15,197
Newark, N. J.....	1	17,941‡	442,337
Perth Amboy, N. J.....	1	2,931	43,516
Rahway, N. J.....	1	1,570	16,011
Albany, N. Y.....	1	3,113‡	127,412
Geneva, N. Y.....	1	900	16,053
New York.....	1	216,195‡	13,860,892
Rochester, N. Y.....	1	56,996‡	328,132
Syracuse, N. Y.....	1	7,881‡	209,326
Chapel Hill, N. C.....	1	19,484‡	2,699
Durham, N. C.....	1	25,000‡	52,037
Cleveland.....	1	45,616‡	900,429
Sandusky, Ohio.....	1	336‡	24,622
Oklahoma City.....	1	1,800	185,389
Easton, Pa.....	1	6,000	34,468
Rapid City, S. D.....	1	118	10,404
Kingsport, Tenn.....	1	6,552‡	11,914
Knoxville, Tenn.....	1	2,307	105,802
Memphis, Tenn.....	2	10,734‡	253,143
Dallas, Tex.....	3	37,337‡	260,475
Norfolk, Va.....	1	5,532‡	129,710
Richmond, Va.....	1	2,054	182,929
Bluefield, W. Va.....	1	10,100‡	19,339
Charleston, W. Va.....	1	8,050‡	60,408
Total communities—46.....	49	684,824	26,343,626

* Membership as of January 1937.

† Census population.

‡ Members accepted from other communities.

In those plans with large memberships, not more than 10 per cent of the population is included. For all plans, it appears that about 3 per cent of the total population of the com-

munities in which group hospitalization plans are located would be equivalent to the total members in the plan. However, in most of the plans membership is restricted in one manner or another, so that the total population is not eligible for membership. The eligible population, in most instances, would consist of persons employed in groups of ten or more and their dependents. The exact number of such persons is not available, but it is apparent that any sizable percentage of the eligible population has not yet been enrolled in group hospitalization plans. Furthermore, since the membership of most of the plans is drawn from widely scattered areas, the number of members enrolled represents a small portion of the total population reached.

Considering all of the sixty operating plans, thirty-seven are located in thirty-six communities with a population of over 100,000, and twenty-three are located in nineteen communities with a population of less than 100,000. There are ninety-three communities in the United States with a population of over 100,000 and 16,505 with a population of less than 100,000. It can be observed that 38 per cent of the communities with a population of over 100,000 have group hospitalization plans, whereas 0.1 per cent of the communities with a population of less than 100,000 have such plans. In communities with a population of over 100,000 are 86 per cent of the known membership of group hospitalization plans and 30 per cent of the total population of the United States. In communities of less than 100,000 are 14 per cent of the members of group hospitalization plans and 70 per cent of the population. The progress of group hospitalization plans has evidently been restricted to a small number of plans in the densely populated sections of the United States.

RATES

The employed person who becomes a member of a group hospitalization plan pays from \$7 to \$12 annually. For thirty-three plans, the distribution of annual rates for subscribers was as follows: Six charged rates below \$9, twelve charged rates of \$9, nine charged rates of \$10 and six charged rates above \$10. There is a variation in the rate, depending on whether the subscriber joins as an individual or as a member of a group. Group rates are usually less, since the majority of group rates are below \$10, whereas the majority of individual rates are above \$10. The rates charged subscribers also vary with the type of room accommodations offered and with the geographic location. Subscribers' rates for ward accommodations range from \$7 to \$12, for semiprivate accommodations from \$7.80 to \$11 and for private accommodations from \$9 to \$12. The prevailing patient day cost in the community is the most important factor in determining the subscriber's annual rate. Such basic costs, of course, vary with the geographic location of the community. The most usual rate charged is \$9 for semiprivate accommodations.

An initial enrolment fee ranging from 75c to \$3, with a most usual fee of \$1, is generally required. The enrolment fee is likewise higher for individual subscribers than for group subscribers.

There are two rate scales for dependents. Rates for dependents entitled to discounts only range from \$1 to \$7.80, according to the number of dependents included and the type of room accommodation offered. A few plans entitle the subscriber's dependents to a discount at no additional charge. Rates for dependents entitled to full service range from \$10 to \$35.40, also according to the number of dependents included

and the type of room accommodation offered. For the average group of four dependents entitled to full services in semiprivate facilities, the annual rate is about \$15.

Rates are also quoted for the entire family, including the subscriber, and provide full services for each member. These family rates range from \$12 to \$49.20, depending on the number of members in the family and the type of room accommodation offered. For the average family of five entitled to full service in semiprivate facilities, the annual rate is about \$24.

The initial subscription dues may be paid on a weekly, monthly, quarterly, semiannual or annual basis. The most commonly used payment methods are the monthly and the annual. As is customary, the rates are based on an annual payment method, and a higher rate is charged if payments are made monthly or quarterly. A provision requiring the prepayment of the annual premium before hospitalization will be permitted is a part of the contract for ten of twenty-eight plans. Some contracts call for the payment of the annual premium before the patient leaves the hospital.

One of the questions asked concerning the membership rates was: "What was the basis for selecting the specific rate charged?" The answers to this question varied extremely but can be classified in three groups: (1) on the basis of "experience," (2) on the basis of the experiences of other plans and (3) on the basis of the patient day cost plus certain allowances for expenses and reserves.

What constituted the "experiences" in the first group was not generally stated. Perhaps the rate-making for these plans was as indicated by the auditor for one plan:

A rate of 90c a month was arbitrarily determined as the local rate, possibly because 90c happened to

be a convenient, nice, round, even number, less than \$1, yet more than a dime, equally divisible into thirds; two for the hospital, and one for the sales agent.

The answers in the second group evidently were meant to indicate that the promoters had examined the rate structures of other plans and adopted the one most suitable. Imitation of methods used by others is often helpful, but unfortunately mistakes may also be copied. The answers in the third group were apparently made on a more logical basis. If a sum sufficient to pay administrative expenses and to set up reserves is added to the cost of one patient day, the total should be a fairly proper rate, provided each member uses only one patient day and provided the administrative expenses and reserves do not exceed the sum apportioned for them.

The directors of the plans were also asked: "What percentage of your membership could not afford to pay for hospital facilities in private hospitals?" The answers to this question stated that from 10 to 75 per cent of the members could not afford to pay for private hospitalization. Not very enlightening replies were made to the further question asking the director how he determined the percentage of members unable to pay for regular hospital services. Most of the replies indicated that the percentages given were estimates, based largely on the earning capacity of the members. The average monthly or weekly income of the percentage of the membership given was considered insufficient for the payment of full rates. Only one plan, however, made a close investigation of its membership by questionnaires and interviews.

It seems to be rather generally accepted that group hospitalization plans do not reach the

very low income groups. One reply was as follows:

So far the membership has come chiefly from economically favored groups, but the prime purpose of the plan is to protect against hospital costs those for whom the expense of serious illness will entail onerous indebtedness or cause the patient to claim free hospitalization.

A rate of approximately \$2 a month apparently has to be charged to offer hospital service contract benefits to the average subscriber and his family. This is a fairly high charge for a wage earner in the low income group, and he apparently does not care to subscribe to the plan unless his family is included. The directors of several plans agree that the rates will have to be lowered before persons with small incomes will be able to become members.

The adequacy and actuarial bases of the rates charged will be discussed in more detail after an examination has been made of the payment arrangements for member hospitals and the hospitalization experiences with plans operating under the present rate structures.

MEMBER HOSPITALS

The payment arrangements for hospitals under group hospitalization plans are primarily dependent on the form of organization. Under the single hospital plans, all the money received is simply considered hospital income. There is seldom an allocation of group hospitalization funds by a single hospital because of the difficulty of apportioning administrative expenses. The member hospitals of an association plan contract to provide the services and are usually guaranteed a flat rate per patient day. These flat rates include a payment for extra or special services provided in the hospital service contract. Some associations pay the hospitals according to an agreed fee schedule, which

includes a specific amount for bed and board and for each of the special service benefits. Nonmember hospitals are promised a flat per diem rate, which usually amounts to less than the payments to member hospitals.

The payment arrangement of a single hospital which utilizes a sales agency is illustrated by the following statement:

The Association pays us 50c per member per month, and 25c per member per month is retained by the Association, plus the initiation fee.

If the individual hospital operates its own plan, the fees are often considered additional hospital income, and no specified amount is charged for each patient day of service used by a subscriber to the plan.

Depending on the locality and the type of room accommodations offered, the flat, all-inclusive rates paid to the member hospitals by hospital service corporations range from \$3 to \$6 per patient day. Ward accommodations range from \$3 to \$5; semiprivate, from \$4.50 to \$6, and private, from \$4 to \$6. The flat, all-inclusive payment arrangement is evidently considered the most satisfactory, as it is used by the majority of the organizations. To the basic room charge of, say, \$5, a small additional sum of either 50c or \$1 is added. This additional sum charged each subscriber is considered sufficient to pay the cost of the extra services that will be utilized by the subscriber who is hospitalized. For a tonsillectomy or for special surgical treatment which hospitalizes the patient for one day, a minimum payment of \$12 may be specified. Under some plans the payment arrangement for a short stay is as follows:

The corporation agrees to pay to the hospital the sum of Fourteen Dollars (\$14) for a one-day stay, the sum of Seventeen Dollars (\$17) for a two-day stay, or the sum of Twenty Dollars (\$20) for a three-day stay.

The corporations which pay the member hospitals a certain sum for room and board and specify payments for the additional services usually adopt a fee schedule. The following is an example of the schedule of charges for services to be rendered by participating hospitals:

For Hospital Service Proper

Room and board, usual case, per day.....	\$ 5.00
Room and board, obstetric case, per day....	2.00
Anesthesia (any type).....	5.00
Use of operating room.....	5.00

For Diagnostic X-ray Examinations

Hand or foot.....	5.00
Extremity (ankle, knee, hip, leg, thigh, forearm, arm, wrist, elbow or shoulder) ..	10.00
Head, chest, back or pelvis.....	10.00
Gastrointestinal series (stomach and duodenum)	15.00
Gastrointestinal series (complete and including colon).....	20.00
Colon only.....	10.00
Gall-bladder (Graham test).....	15.00
Pyelogram	10.00
For stereo films add to each item.....	2.00
Any follow-up (repeat).....	5.00
Maximum x-ray charge for any diagnostic problem	25.00

For Diagnostic Cardiologic Examination

Electrocardiogram	10.00
Follow-up (repeat) any time one year.....	5.00

*For Diagnostic Clinical Laboratory
Examinations*

Urinalysis	1.00
Kidney function test (PSP).....	3.00
Complete blood count.....	3.00
L. & D.....	2.00
Coagulation test.....	1.00
Typing	5.00
Wassermann	3.00
Widal	3.00
Blood chemistry (each item).....	5.00
Spinal fluid (routine).....	3.00
Spinal fluid (including puncture).....	5.00
Spinal fluid Wassermann.....	3.00
Gastric contents (collected and examined) ..	5.00

Stool examination.....	3.00
Smears	2.00
Sputum	3.00
Cultures	5.00
Animal inoculation.....	10.00
Tissue (including microscopic section).....	5.00
Basal metabolism.....	5.00
Basal metabolism (repeat).....	2.00
Maximum laboratory charges one diagnostic problem or one illness.....	25.00

Another form of the agreed fee schedule is as follows:

Hospital Fees

Hospital ward and private room rates including general nursing, material for dressing, board, routine medicines, and dressings.

Hospital ward rates per day.....	3.50
Private room, maximum allowance per day	6.00
Operating room, major operation.....	10.00
Operating room, minor operation.....	5.00
Anesthetic, major operation.....	10.00 and 15.00
Anesthetic, minor operation.....	5.00

X-ray Fees and Rules

A maximum of three pictures to one injury or illness will be allowed for in accordance with schedule of fees.

Minimum x-ray charge.....	5.00
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Plaster Casts

Plaster casts, including material and depending on location, as follows:

Elbow, forearm, hand, ankle and foot.....	5.00
Shoulder spica, thigh including leg.....	7.50
Body cast and high spica.....	10.00

Emergency Room Service

First dressing not to exceed.....	2.50
(For subsequent care, patient must be referred to family physician)	

Tonsil and Adenoid Operations

Payment for twenty-four hour service will be made by the service, except in case of hemorrhage or complication, when additional hospitalization will be allowed in accordance with judgment of the Executive Committee.

Simple Fractures

Hospitalization will not be paid for.

Miscellaneous

Services such as dental x-rays and electrocardiograms are not covered by this service for diagnostic purposes, particularly dental x-ray work, which should be done by a dentist.

Laboratory Fees

Routine laboratory work, surgical case....	3.00
Laboratory work, medical case, maximum..	5.00
Wassermann, when necessary.....	3.00
Blood typing, \$2.00 for each donor— maximum allowance in any one case....	10.00
Outpatients, \$2.00 for each examination— maximum allowance in any one case....	5.00

These schedules illustrate the payments agreed to and at the same time show the nature of the services other than hospital room accommodations.

The member hospitals are usually paid on a monthly basis. In the contract with member hospitals which specifies that payments shall be made weekly or monthly, certain restrictive provisions, such as "according to the funds available," "contingent payments as conditions warrant" and "so long as receipts permit," qualify the payments that are to be made. On the other hand, a certain liberality in payments to member hospitals is sometimes indicated as follows:

These services are not guaranteed, but actually they will usually be given.

Of particular importance to member hospitals is the agreement in regard to discounts offered to subscribers and dependents. It would seem that the hospital service corporation would reimburse the hospitals for the discount offered under its contract. However, in many instances it is not certain whether the hospital service corporation or its member hospitals assume the expense incurred by the granting of the discounts. The subscriber's contract usually indicates that a discount is offered, but the contract with member hospitals frequently fails

to specify who shall assume the expense of the discount provision. Some agreements between the member hospitals and the corporations are definite, as in the following provision:

The hospital agrees to provide hospital care over and above the twenty-one-day period at its regular rates, less a discount to the subscriber of 10 per cent. This discount is offered by the hospital as additional consideration, for which it receives no reimbursement from the corporation.

Often the subscriber's contract does not designate the services for which the discount applies and does not put a time limit on the period for which the discount will be honored. The director of one plan, in discussing this provision, stated:

We feel that the blind moves made by some of the associations, such as offering any discount after the expiration of the benefit period, is most unsafe and unsound.

In other respects, the contractual arrangements between the member hospitals and the hospital service corporation leave much room for speculation.

In the interhospital contracts ⁴⁶ the participating hospitals agree to accept the conditions of the subscriber's contract, to protect the corporation against malpractice or damage suits and to abide by changes in payment rates or type of services that may be stipulated by the corporation. The specified benefits and limitations in the contract between the corporation and the subscriber is made a part of the interhospital contract. Under some forms of organization, the hospital service corporation is simply the agency of member hospitals. Such an agreement reads as follows:

The Hospital Service Corporation, herein referred to as the Service Corporation, has been organized for the purpose of acting as agent

46. See appendix C, p. 277, for a copy of such a contract.

of the Participating Hospitals as herein provided, its Board of Directors to be composed of one representative designated by each of the Participating Hospitals, a representative of County Medical Society, the Director of Public Welfare of the City of, and the Director of the..... Community Fund.

By this arrangement the member hospitals assume full responsibility for the entire undertaking and, in effect, underwrite the hospital service contracts. Under other forms of organization, the member hospitals merely contract with the hospital service corporation. The contract agreement is as follows:

The Hospital agrees to furnish hospital service to Subscribers of the Corporation according to the contract made between the Corporation and its Subscribers, a copy of which contract is attached and made a part of the agreement.

The status of the member hospitals in regard to the responsibilities of the hospital service contracts sold by an independent corporation of this type is not always clear. The member hospitals apparently agree only to provide certain hospital services in return for a specified payment per patient day. With the formation of separate hospital service corporations, the question arises as to the liability of the member hospitals to provide the contract services even if the funds of the hospital service corporation are insufficient.

HOSPITALIZATION EXPERIENCE

The actual hospitalization experience, which means the number of members hospitalized and the number of patient days used, should serve as one test of the value of group hospitalization. The reports received are difficult to compare because of the lack of uniformity in the methods used to calculate the number of members hospitalized and the number of patient days used.

It would seem that these basic data could be obtained simply by counting the number of patients hospitalized and the patient days used by the members of a plan. Unfortunately, this is not the case. It is first necessary to know the period of time that the members have been entitled to use their contract benefits. It is as important to know the period of time that the plan was exposed to losses as it is to know the actual number of losses. In order to render the reported experiences in any way comparable, it is necessary to use a basic unit to measure the period of time that the members were entitled to benefits.

The Member Month Unit.—The basic unit generally used is the “member month,” which indicates that one member has had the benefit of one month’s subscription to the hospital service contract. It will be remembered that the plan of group hospitalization is based on the expectancy of 10 per cent of the members being hospitalized for an average stay of ten days each during one contract year. For 1,000 members it is expected that 100 will be hospitalized during a contract year and that these hospitalized members will utilize 1,000 patient days. An entire contract year for 1,000 members is comparable to 12,000 member months (1,000 members times twelve months). Therefore, for each member month, 0.00833 member will be hospitalized (100 members hospitalized divided by 12,000 member months). Likewise, for each member month, 0.08333 patient day will be utilized by the members hospitalized (1,000 patient days divided by 12,000 member months).

These two figures, 0.00833 patient per member month and 0.08333 patient day per member month, are the basic measuring units of hospitalization under group hospitalization plans. If more than 0.00833 patient per member month

is hospitalized, it means that more than 10 per cent of the members are being hospitalized. Similarly, if more than 0.08333 patient day per member month is used by the members of a group hospitalization plan, it means that the average patient stay is longer than one day per member per year. The converse in both instances also follows.

Such measurements appear to be rather cumbersome, but they are used to indicate the hospitalization experiences under group hospitalization plans and do make possible a comparison of the experience under one plan with that under another.

The utility of the member month unit becomes even more apparent when month by month throughout the year new members enrol in the plan or old members discontinue their membership. It is unsatisfactory to state that the number of members hospitalized during the year is a certain percentage of the total membership, because most of the members may have been subscribers for only part of the year. It is doubly unsatisfactory to attempt to compare hospitalization under one plan with that under another plan by comparing the percentage of members hospitalized. In practically every instance the conclusions drawn will be inaccurate. Even if the average membership is used, the inaccuracy cannot be totally avoided.

For example, if during one year one plan has 1,000 members and 100 are hospitalized, 10 per cent of the members are hospitalized; and if another plan has 5,000 members and 600 are hospitalized, 12 per cent of the members are hospitalized. Under which plan have the members been most inclined to be hospitalized? To say that 10 per cent of the members of the first plan were hospitalized as compared with 12 per cent of the members of the second plan

does not mean anything, unless the two groups of members have been entitled to the benefits of each plan for the same period of time. The member month method of indicating the experience makes the periods during which the members of each of the plans were entitled to service equal and permits a comparison. According to the method of calculating member months, the members of the first plan actually used 5,000 member months, whereas the members of the second plan actually used 60,000 member months. Hence, the hospitalization experience under the first plan is 0.020 patient per member month (100 members hospitalized divided by 5,000 member months) and that under the second plan is 0.010 patient per member month (600 members hospitalized divided by 60,000 member months). The hospitalization experience under the first plan is two times greater than under the second!

The directors of some plans have insisted that the "member day" is a more accurate measurement than the member month because some months have thirty days and some have thirty-one days and because the payment arrangements are on the basis of each day in the hospital. For example, if 1,000 members enroll in a plan on January 1 and remain members until December 31, they would use 365,000 days of membership instead of 12,000 member months. For the member month, however, it is not assumed that there are thirty days in each month. A February member month must be compared with another February month to be exactly equal. It is acknowledged that the member day is a refinement of the member month, but in view of the fact that the experiences under all too few plans can now be expressed on the basis of member months and since the difference between the member month

and the member day is slight, the member month can be accepted as a measurement of hospitalization experience.

Hospitalization experience is also measured according to the member year. This is simply a unit twelve times as large as the member month. Hospitalization under some plans is therefore recorded as so many patients and so many days per member year. The standard expectancy is 0.100 patient and one patient day per member year. Since the member year designates one complete year of membership for one member, it may be used as a compact way of expressing the statistics of hospitalization. It is erroneous, however, to assume that the fiscal year of a plan with 1,000 members represents 1,000 member years. The member year must consist of exactly twelve member months used and is dependent on the prior computation of the number of member months used.

If the member month unit is to serve as an index of hospitalization experience, it will be well to standardize the method of computation and to develop an understanding of this concept. At present there are several methods of calculating member months. The most complete method of computation is presented in table 9.

The 1,000 members considered in this table were entitled to 12,000 member months. Less than 12,000 member months were used, because not all of the 1,000 persons became members on January 1. As indicated in the table, those entering in January have used the twelve member months which they purchased, but those entering in December are entitled to eleven more member months before their annual subscription expires. Of the 1,000 members, 970 are still entitled to 7,000 member months. During that time some of these members will

certainly be hospitalized, a fact which must be considered in calculating hospitalization and costs.

The following are examples of hospitalization and costs based on member months used. If forty-two patients were hospitalized during the year and used 378 days of hospital service, the number of patients hospitalized per member month would be 0.00840 (forty-two patients divided by 5,000 member months used) and the

TABLE 9.—*Method of Computing Member Months (As of December 31, for an Example Year)*

Date	Net Membership	Sold		Used		Unused	
		No. of Months	Member Months	No. of Months	Member Months	No. of Months	Member Months
Jan.	30	12	360	12	360	0	...
Feb.	50	12	600	11	550	1	50
March	100	12	1,200	10	1,000	2	200
April	20	12	240	9	180	3	60
May	40	12	480	8	320	4	160
June	70	12	840	7	490	5	350
July	80	12	960	6	480	6	480
Aug.	100	12	1,200	5	500	7	700
Sept.	70	12	840	4	280	8	560
Oct.	140	12	1,680	3	420	9	1,260
Nov.	120	12	1,440	2	240	10	1,200
Dec.	180	12	2,160	1	180	11	1,980
	1,000		12,000		5,000		7,000

number of patient days per member month would be 0.07560 (378 patient days divided by 5,000 member months). If hospitalization rates are 75c for each member month (i. e., 75c per member per month), the total income for the plan would be 12,000 member months multiplied by 75c, or \$9,000. This is equivalent to 1,000 members at the rate of \$9 annually. According to table 9, the earned portion of the total income would be 5,000 member months multiplied by 75c, or \$3,750, and the unearned portion would be 7,000 member months multiplied by 75c, or \$5,250. It should be noted that the calculations of the patients per member month, the patient days per member month and the earned income

are on the basis of member months used, *not* on the basis of total member months.

There are other methods of calculating the number of member months. Most of these are short cuts and frequently lead to inaccuracies. If the net monthly membership (the number of members less cancellations) is cumulated month by month, the total will equal the number of member months used. For example, the cumulated net membership in table 9 would be:

January	30
February	80
March	180
April	200
May	240
June	310
July	390
August	490
September	560
October	700
November	820
December	1,000
Total	<u>5,000</u>

The total is the same as the number of member months used. This method may be continued beyond twelve months only if the *new* net membership is cumulated. The renewal contracts issued, as well as the cancellations, must be subtracted from the total contracts issued for the thirteenth, fourteenth, fifteenth, etc., months; otherwise the cumulation of monthly memberships will overstate the member months used.

Under several plans premiums are collected almost entirely on a monthly basis. The payments received are considered earned income, and no record is kept of the unearned income. This is not strictly accurate, but if only a small number of members pay in advance, on an annual or quarterly basis, the total income can be considered as earned income. If the

members paying in advance increase in number, the unearned premiums should be separated from the earned.

Still other short methods of calculating the member months used are:

1. Divide the earned subscription payments by the monthly subscription rate to find the number of member months used.

2. The average net membership multiplied by the number of months in the period under consideration gives an *approximate* number of member months used.

The member month unit necessitates some calculations, but it need not be considered too complicated to be understood. It is simply a unit showing the length of time during which a member is entitled to use the benefits offered by the group hospitalization contract. The member month is the common denominator which makes it possible to compare one plan with another. It is, of course, necessary to use the unit correctly. A subscriber member month means one month of membership for a subscriber; a dependent member month means one month of membership for a dependent, and a member month alone means one month of membership for a member—a composite of subscriber and dependent.

It is also important to indicate the age of the member month, because the member months under the first year of a plan will show a different experience from the member months of the second year. Unfortunately, the member months of different ages are not kept separate. To show how many persons will be hospitalized under the first, second or third year of a group hospitalization plan, it is, of course, necessary to separate the experience for each year. Frequently the number of new members in the second year is so great that the second year's experience for the plan is really the first year of experience for the members.

The member month unit has been considered in some detail here because the reporting of hospitalization experience and costs by group hospitalization associations is so fragmentary and unstandardized as to be almost valueless. Some progress is being made under certain plans, but even the most recent reports are not presented in a satisfactory form to permit adequate comparison.

Reported Experiences.—Reports on eighteen plans contained fairly usable statistics concerning member months, the number of patients hospitalized, the length of the patient's stay and costs. Several tables of the reported hospital experiences appear in appendix D. These statistics are presented for what they are worth. It is necessary to bear in mind all of the limitations of the data used and the wide differences among the individual plans, which are lost when "averages" are shown. It is also necessary to examine the essential features of each plan given in the list preceding the tables to interpret the reported hospitalization experiences properly. All of the influences of such features on the number of members hospitalized and the patient days used must be considered.

For example, hospitalization experiences vary for group subscribers as compared with individual subscribers, for women subscribers as compared with men subscribers, for employed subscribers as compared with unemployed subscribers, for subscribers as compared with dependents, for dependents entitled to full services as compared with dependents entitled to partial services and for adult dependents as compared with children. Significantly different experiences are reported for these several classes of members. Even the manner in which members are enrolled, whether by payroll deduction or by direct payment arrangements, has an effect on the hospitalization experience.

The differences in contract benefits also influence the hospitalization experiences. It is a well established fact that sickness rates are in direct relation to the amount of benefits offered. The "moral hazard" of large benefits induces members to take advantage of their contracts. More specifically, if a contract for one plan imposes a waiting period of two days before a person may be hospitalized, it is certain that the experience under this plan will be different than that under a plan which has no waiting period. Plans which do not include hospitalization of obstetric patients are likely to have fewer members hospitalized than plans which do include hospitalization of such patients. Plans offering ward accommodations have relatively fewer members hospitalized than plans offering private or semiprivate accommodations. Fewer members are hospitalized if they are entitled to small discounts than if large discounts are offered. The same relations hold true for the rest of the particular benefits of each plan.

The hospitalization experiences for all classes of members also vary for the first several months of membership as compared with later membership. The experience under a plan in operation for five months is hardly comparable with that under a plan in operation for thirty-six months. The first year's experience may be the same as the third year's, but each year must be considered separately.

When the reported statistics can differ according to so many variables, it is difficult to make worthwhile comparisons or to draw accurate conclusions. The segregation of the membership experiences into each of the foregoing categories frequently leaves only a few plans to serve as examples.

Because of the numerous variables involved, no great accuracy can be claimed for the

reported statistics of hospitalization experiences. It is hoped that in the future the directors of group hospitalization plans will take the trouble to collect detailed information on each of the hospitalization tendencies indicated. Group hospitalization plans cannot be properly administered unless the policies adopted are based on sufficiently extensive records of hospitalization experiences.

Analysis of the statistics reported shows that the number of subscribers hospitalized is 0.00933 per member month. This is higher than the expected 0.00833 by 12 per cent. Therefore, instead of 10 per cent of the subscribers being hospitalized, 11.2 per cent were actually hospitalized. For every thousand members this means twelve more subscribers hospitalized than expected. The patient days reported for subscribers are 0.07813 per member month. This is lower than the expected one day per member year, or 0.08333 day per member month, by 6 per cent. Therefore, the average number of days used per subscriber in one complete year is 0.94. For each thousand subscribers this is sixty days less than expected. For a group of 1,000 subscribers, 112 are hospitalized during an entire contract year for an average stay of 8.4 days each. (See table A in appendix D.)

The number of subscribers and dependents entitled to full services who were hospitalized is 0.01089 per member month. This is higher than the expected 0.00833 by 31 per cent. Therefore, instead of 10 per cent of subscribers and dependents entitled to full services, 13.1 per cent were actually hospitalized. This increase in hospitalization is apparently caused by the inclusion of dependents. For every thousand members this means thirty-one more members hospitalized than expected. The patient days for these subscribers are 0.08941 per member

month, which is higher than the expected 0.08333 by 7 per cent. Therefore, the average number of days used per member in one complete year was 1.07. For each thousand members this was seventy days more than expected. For a group of 1,000 members, including subscribers and dependents entitled to full benefits, 131 are hospitalized during an entire contract year for an average stay of 8.2 days each. (See table B in appendix D.)

The hospitalized number of both subscribers entitled to full benefits and dependents entitled to discounts is 0.00620, which is less than the expected 0.00833 by 25 per cent. Therefore, instead of 10 per cent of the members, consisting of subscribers entitled to full benefits and dependents entitled to discounts, being hospitalized, 7.5 per cent were hospitalized. When the dependents are offered discounts only, the result is apparently a considerable curtailment of the number hospitalized. Likewise, the number of patient days for these members is 0.04195 per member month. This is approximately 50 per cent of the expected 0.08333 day per member month, which is equivalent to one patient day per member per year. Hence, the actual number of days per member per year is 0.50. For each thousand members this is five-hundred days less than expected. For a group of 1,000 members, including subscribers entitled to full benefits and dependents entitled to discounts, seventy-five are hospitalized during an entire contract year for an average stay of 6.7 days each. (See table C in appendix D.)

The number of dependents entitled to discounts who were hospitalized is 0.00460 per member month. This is equivalent to 5.5 per cent of the dependents being hospitalized. The offering of restricted benefits to dependents apparently reduces the expected hospitalization by one-half. The patient days per year for each

dependent entitled to discounts only is but 0.34. The offering of discounts only is a deterrent to both the number of dependents hospitalized and the length of stay. For a group of 1,000 dependents offered discounts only, fifty-five are hospitalized during an entire contract year for an average stay of 6.1 days each. (See table D in appendix D.)

A summary of the reported experiences is given in table 10. Even within the wide classi-

TABLE 10.—*Hospitalization Experiences Under Group Hospitalization Plans*

Membership Classification	Percentage Hospitalized	Average Length of Stay in Days
Subscribers entitled to full benefits*.....	11.2	8.4
Subscribers and dependents entitled to full benefits†	13.1	8.2
Subscribers entitled to full benefits, with dependents entitled to discounts‡.....	7.5	6.7
Dependents entitled to discount§.....	5.5	6.1
Subscribers and dependents—all reported plans#..	11.0	8.2
Subscribers and dependents—standard expected..	10.0	10.0

* Based on reports for thirteen groups, equivalent to 60,894 subscribers, over a period of thirteen member months.

† Based on reports for twelve groups, equivalent to 28,803 subscribers and dependents, over a period of nineteen member months.

‡ Based on reports for six groups, equivalent to 25,478 subscribers and dependents, over a period of thirteen member months.

§ Based on reports for five groups, equivalent to 28,128 dependents, over a period of seven member months.

Based on all reports considered as one group, equivalent to 98,995 members, over a period of sixteen member months.

fications of members shown in this table, large differences appear in the use of the benefits. Considering all reports as one group and ignoring the variations in membership classes and in benefits, it appears that 11 per cent of the members of a group hospitalization plan are hospitalized for a stay of 8.2 days each. This, compared with the expected hospitalization of 10 per cent of the members for ten days each, indicates that the actual experience has been less than expected.

The present experience is none too favorable, particularly in view of the tendency to liberalize

contracts by extending more complete benefits to dependents. The experience of insurance companies is that benefits are not used to the full extent during the initial period of rapid increase in the number of members. Because of the rapid enrolment of members in group hospitalization plans—the membership of some has increased by over 200 per cent—the present number of members hospitalized and patient days used must be considered as at a minimum. Future hospitalization experiences will probably tend to be progressively higher.

Unfortunately, in none of the records have experiences been separated according to years. It is therefore impossible to determine whether or not a member tends to increase or decrease his use of benefits in the second or third year of membership as compared with the first year of membership. Reports on a few plans contain separate yearly total experiences, but because of the rapid increase in membership the hospitalization experiences for the second and third year do not differ appreciably from those of the first year. The directors of hospital service plans should be interested in knowing whether a member increases or decreases the use of his benefits as the number of months he remains a member increases. It is a common insurance practice to segregate the policies according to policy years or the years elapsed since the date of issuance of the policy. It would likewise be desirable for the experiences under group hospitalization plans to be separated according to years of membership, even though the contracts are terminable in one year.

Few classifications of members according to age were reported. There is a definite age curve of days in bed on account of illness,⁴⁷ so that it

47. Falk, I. S., and others: *The Incidence of Illness and the Receipt and Cost of Medical Care Among Representative Families*, The Committee on the Cost of Medical Care, Publication 26, Chicago, University of Chicago Press, 1933, p. 83.

would seem worth while to have members classified according to age. Likewise, few records are kept of the principal causes of hospitalization. For example, a group of 2,447 hospital admissions from the general public show that 26 per cent of such admissions are caused by operations for removal of tonsils and adenoids; 15 per cent by confinements, miscarriages and abortions; 11 per cent by accidents and accidental injuries; 8 per cent by appendectomies, and the remaining 40 per cent by all other conditions and diseases.⁴⁸ It appears that hospitalization of persons in the general population is more dependent on conditions requiring surgical intervention than on the severity of illness. For 1,245 hospitalizations of group hospitalization members during a three year period, the classifications were: operations for removal of tonsils and adenoids, 8 per cent; confinements, miscarriages and abortions, 11 per cent; accidents and accidental injuries, 14 per cent; appendectomies, 4 per cent; minor diseases of the respiratory tract, 23 per cent, and all other conditions and diseases, 40 per cent. The minor diseases of the respiratory tract, including bronchitis, tonsillitis, pharyngitis, influenza, grip, colds, catarrh, coryza, croup, laryngitis and other simple infections of the respiratory tract, constituted only 2 per cent of the hospitalizations for persons from the general population. Whether or not the members of a group hospitalization plan are hospitalized for different conditions and diseases than are non-members would seem to be a question of sufficient importance to warrant the collection of statistics by directors of group hospitalization plans.

It is also of some importance to know whether the twenty-one days of hospitalization provided

48. Falk, I. S., and others: *The Costs of Medical Care*, The Committee on the Costs of Medical Care, Publication 27, Chicago, University of Chicago Press, 1933, p. 559.

are sufficient or not. Eight plans reported the length of stay for hospitalized members as follows:

Discharged within one week.....	1,248
Discharged within two weeks.....	559
Discharged within three weeks.....	997
Remaining longer than three weeks.....	203
	3,007

From this small sample it appears that 93 per cent of the members hospitalized remain in the hospital less than three weeks. Apparently twenty-one days are sufficient for a large majority of the members. The prolonged catastrophic hospitalization is not completely provided for and in fairness to the majority of subscribers, probably cannot be provided for. It is deemed better to give more complete services to the majority of subscribers than to meet the large expenses for a few.

In viewing the reported hospitalization experiences as a whole, the expectancy that 10 per cent of the membership will be hospitalized during one complete contract year is probably too low, particularly if dependents are entitled to full benefits. The increase in the number of members hospitalized is offset somewhat by the shorter period of hospitalization. These two results reflect the greater hospitalization of members for minor ailments than is common in the general population.

The increase in hospitalization of the members of group hospitalization plans as compared with the hospitalization of persons in the general population may indicate the beginning of an excessive increase in the number of patients in hospitals. For the general population, 6 per cent are hospitalized in one year for an average stay of about fifteen days, or 0.92 day per person.⁴⁹ This includes hospitalization

⁴⁹ J. A. M. A. (Hospital Number) 106:792 (March 7) 1936. Falk,⁴⁷ p. 115.

of all patients, including those with tuberculosis and mental conditions. Hospitalization in the general hospitals, which would be more comparable to group hospitalization plans, is 5.8 per cent for an average stay of about twelve days, or 0.74 days per person.

The number of days spent by the general population in bed each year on account of illness, at home and in the hospital, is reported to be 3.4 days per person.⁵⁰ The number of days in the hospital alone is said to be less than one day per person. If the approximate two and one-half days now spent in bed at home on account of illness become hospital patient days, the rates of group hospitalization plans will have to be raised considerably. In view of the apparent tendency to hospitalize persons with minor ailments under group hospitalization plans, this is not an exaggerated supposition. The hospitalization for the members of group hospitalization plans has already exceeded that for the general population, although these plans do not offer hospitalization to patients with many conditions and impose restrictions on practically all benefits. If it is denied that hospitalization of persons with conditions now adequately cared for in the home will result, it should be noted that one day per subscriber serves as the basis for group hospitalization plans, whereas the need for hospitalization in general hospitals, "according to strictly medical factors," has been estimated at 1.38 days per person.⁵¹

From the general tenor of the reports, as well as from a few specific records, it can be observed that certain types of subscribers have particularly high hospitalization records. Hospital employees, nurses and employees of phy-

50. Falk,⁴⁷ p. 276.

51. Lee, R. L., and Jones, L. W.: *The Fundamentals of Good Medical Care*. The Committee on the Costs of Medical Care, Publication 22, Chicago, University of Chicago Press, 1933, pp. 118-120.

sicians are three groups of subscribers for which hospitalization rates are frequently reported to be higher than expected. The contributing reasons as reported by one plan are:

- (a) A high percentage of female membership in each group.
- (b) Unusual occupational hazards of exposure to contagions.
- (c) These groups are unusually "hospital-minded."

As a result of excessive use of benefits by nurses and hospital employees, these groups are not accepted under some plans, unless each hospital underwrites the cost of hospitalization for its nurses and employees. This means that if \$500 is the value of the services at expected rates, the hospital must assume all costs over \$500. Employees of physicians and physicians participating in group hospitalization plans also have high hospitalization rates reported against them.

Consistently higher hospitalization rates are reported for women subscribers than for men. This is explained by one plan as follows:

The morbidity risk of men and women is the same for the identical mechanistic functions of living, but in addition the woman carries an equal added hazard of feminine functions.

When high hospitalization rates are reported for a certain group of members, the French maxim *cherchez la femme* seems to apply. Another plan offered the following in regard to its hospitalization experiences:

Next in order in morbidity are the large department stores with a large percentage of middle-aged, scantily nurtured female employees.

Teachers and housewives are apparently unusually "hospital-minded." The director of one plan was forced to raise the rates for teachers because they were inclined to take "rest cures" during the summer vacations.

Dependents make much greater use of their benefits than subscribers if they are entitled to the same benefits. Many plans restrict the benefits for dependents to discounts only because of this tendency. Even with limited benefits, dependents continue to take advantage of the hospital service contract. The director of one large plan, after a loss of several thousand dollars on the dependents enrolled, reported to the board of trustees:

The steadily increasing number of days used by dependents of members in spite of the effort being made to narrow the list of eligible dependents indicates the need for revision at this point.

Adult dependents, particularly dependent women, are more responsible for the use of benefits than dependent children.

Individual subscribers and those subscribers joining in small groups who make their payments direct to the hospital service corporation are inclined to use the benefits of their contracts excessively. These subscribers have approximately twice as many patient days per member year as compared with members in payroll deduction groups. The selection in the direct payment groups is against the hospital service corporation, in that those who become subscribers evidently have firm intentions of benefiting by their contracts. The same tendency is true where only a small percentage of a payroll deduction group become members. Those who sign as members are the ones who will be most likely to become patients. Many of the plans now require a certain percentage of membership in a group before any of the group are accepted.

The hospitalization experience under plans which accept unemployed subscribers or which permit subscribers who become unemployed to continue as members is higher than that under plans which require members to be employed.

It is significant that those persons who are brought into contact with the care of sick persons (nurses, hospital employees, physicians and employees of physicians) tend to want to be hospitalized themselves. Even allowing for the occupational hazards, it appears that such groups are unusually hospital-minded, because they demand an excessive amount of hospital service. Similarly, those persons who have leisure time (teachers, housewives, dependents and unemployed) are also inclined to spend their free time in the hospital.

These facts indicate the germ of developments, such as already have taken definite shape in foreign countries under sickness insurance. The tendency for the insured persons to want to "get something back" for their money has been emphasized in regard to sickness insurance in foreign countries. It was not commonly believed that the American people would run to physicians' offices or to hospitals unless they were really sick. The hospital experiences under group hospitalization plans, however, seem to indicate that the same inclination toward "bagatelle" ailments exists in the United States when encouraged by an insurance plan.

It was reported for one large plan that the subscribers were stricken with the desire "to spend the week-end in a hospital." A sharp increase in the number of persons hospitalized over week-ends was noticed. The administrators in charge stated that the hospital stays were not for recreation, but that the members presented themselves during the week-end to avoid conflict with business hours and because of the increase in sickness and accidents during the Saturday and Sunday holidays. One newspaper in commenting on the situation stated:

The fact remains, however, that "illnesses" which are amenable to elective week-end treatment are hardly to be considered of importance from the stand-

point of public health. Moreover, a complaint which does not interfere with business and which can be cured or even completely studied in forty-eight hours surely does not require hospitalization, not denying the undoubted curative value of bed-rest alone.

It is perhaps true that the hospitalization of persons when they so desire may be beneficial. The rest in the hospital with proper food may permit the alleviation of many minor ailments. Unfortunately, such hospitalization does not result in an improvement in the general health of the public. It has been fairly conclusively shown that the medical systems which permit the treatment of thousands of minor ailments do not result in a decrease in the morbidity and mortality rates.⁵²

Encouragement of hospitalization for minor ailments can be countenanced only if the result is a betterment of the public health. If such a betterment does not result, serious consideration must be given to the possibility of a breakdown of the patient's will to get well. Also, since encouragement of hospitalization for minor ailments does not necessarily result in an increase in the discovery and treatment of incipient diseases, there is a likelihood that hospitals may become so cluttered with persons with insignificant ailments that those with serious illnesses requiring real medical and hospital services will suffer.

The administrators of group hospitalization plans specify that patients may be admitted only on the recommendation of a licensed physician. It is held, therefore, that the physician will be the one to judge whether or not a patient's condition is serious enough for hospitalization. When the demand on the part of the subscribers to get something for their money

52. Influence of Sickness Insurance on Diphtheria Morbidity and Mortality, *J. A. M. A.* 104:1335 (April 13) 1935; Tuberculosis and Insurance, *J. A. M. A.* 104:1423 (April 20) 1935; and Les Assurance Sociales et la Mortalité, *La presse medicale*, 45:242 (Feb. 13) 1937.

grows, it becomes a force which cannot be easily resisted. The individual physician faced with a patient who has a group hospitalization membership card which allows free hospital services may not be able to refuse that patient hospitalization for some minor ailment. If he does refuse, the patient may find another physician who will certify to the necessity for hospitalization.

The foregoing examination of the reported hospitalization experiences indicates what might possibly be important future tendencies for group hospitalization plans. As long as the membership of these plans is rapidly increasing, it appears that the basis on which they are founded is not greatly inaccurate. However, as the membership grows older and it becomes more difficult to obtain new members in groups large enough to avoid adverse selection, an increase in hospitalization experience and costs will be probable. Furthermore, the members who remain in the plan will be those most likely to require hospitalization. Thus, when the membership of these plans reaches a stationary point or begins to decline and the adverse features mentioned have an opportunity to operate, the actuarial basis for these plans will require close scrutiny. If such developments take place, those plans in which the setting up of reserves has been ignored will be in a particularly hazardous position.

FINANCIAL EXPERIENCE

The soundness of group hospitalization plans cannot be judged simply by computing the percentage of members hospitalized and the number of patient days used. An essential criterion is the financial experience—a comparison of the income received with the costs of the benefits provided and the expenses of administration. A plan under which there is less hospitalization

than is expected is not necessarily on a sound basis unless its expenses are also not more than expected.

The financial structure of group hospitalization is briefly illustrated as follows:

Membership rate.....	\$9.00
Less hospitalization expense (the cost for the anticipated use of one patient day by each member).....	6.00
	\$3.00

The \$3 balance is to provide for administrative expenses and reserves. Obviously, if the \$3 proves insufficient to meet all expenses of administration and to provide adequate reserves, the plan will be unsound. Likewise, if the \$6 proves insufficient to pay the costs of the benefits used by members, the plan will be unsound. An additional enrolment fee of \$1 is often charged and increases the income from members to \$10, but only for the first year. The enrolment fee may be considered as a partial offset to the extraordinary expenses incurred during the first year.

A fairly representative budget, as an illustration of the prospectuses for group hospitalization plans, is given in table 11.

In the determination of the anticipated income, most prospectuses assume that the 3,000 members will enrol in the plan at the beginning and remain throughout the entire year. This is seldom true, New members enrol and old members drop out. Accordingly, it is necessary to account for earned and unearned income separately, as has been previously explained. On the basis of an assumed average membership of 3,000, table 11 gives a typical outline of the idea behind group hospitalization. The expenses vary for individual plans, but the table can be accepted as an example of a modest budget for the inauguration of a community-

wide plan in a middle-sized city. It is held that the membership will increase in the second and successive years and that expenses will be proportionately less because of the smaller administrative and promotional costs expected.

TABLE 11.—*Estimated Budget for the Operation of a Group Hospitalization Plan During One Year **

Anticipated administrative and promotional expenses (will be about the same for any membership up to 3,000)		
Salaries		
Director	\$ 2,500	
Field representative.....	1,500	
Secretary	960	\$ 4,960
Promotion		
Advertising and publicity		1,000
Office Expense		
Furniture and equipment.....	400	
Rent	600	
Postage, telegraph and telephone.....	300	
Record cards and miscellaneous supplies.....	100	
Printed forms	300	
Insurance and bonding.....	120	
Traveling	100	1,920
Total administrative and promotional expenses..		<u>\$ 7,880</u>
Anticipated Hospital Charges (based on a membership of 3,000)		
Average number of patients expected—10%, or 300		
Average number of patient days of service expected—10 days per patient, or 3,000		
Anticipated payments to the hospitals at \$6 a day		<u>\$18,000</u>
Anticipated Income (based on a membership of 3,000)		
From enrollment fees at \$1 per member.....		\$ 3,000
From monthly dues at \$9 per member per year..		27,000
		<u>\$30,000</u>
SUMMARY		
Anticipated income	\$30,000	100%
Anticipated administrative and promotional expenses	7,880	26%
Available for hospital charges.....	\$22,120	74%
Anticipated hospital charges.....	18,000	60%
Surplus	\$ 4,120	14%

* Illustrative only—based on actual promotional prospectuses.

Actual Financial Experiences.—It remains for the actual testing in practice to prove the correctness of the expectations involved in the group hospitalization idea. However, there are certain difficulties to overcome before comparable financial statistics can be obtained.

The several income and expense items are not always considered in the same manner by directors of hospital service associations. A different allocation of some items may greatly influence the financial operating results.

Several associations among those which furnished data for this report failed to separate earned from unearned income. On the basis of total income, surpluses have been reported. If, however, hospitalization costs and administrative and promotional expenses are deducted from the *earned* income, surpluses would, in some instances, be materially reduced and apparent profits might be transformed into losses. The unearned income, which is paid in advance and really belongs to the subscriber, should be subtracted from the total income to obtain the earned income. Often the premiums are collected almost entirely on a monthly basis, and all income is considered as earned. This is not strictly accurate, but if only a small number of the members pay in advance the total income can be considered as earned income.

Once the earned income from members for a specific period has been decided, it is necessary to determine how much of that income has been spent for hospital benefits for members and how much has been used for administrative and promotional expenses to operate the plan.

To determine the cost of hospitalizing members during the period is not so simple as it might seem. The cost is made up of three items: claims paid, claims incurred but unpaid and an estimate of the claims yet to be paid for members still in the hospital at the end of the period. Many reports show only one or two of these cost items. Not until a report is made of all three items by each plan can the hospitalization costs be compared.

The determination of the cost of administration and promotion is no less involved. Most

financial reports show only the depreciation of furniture and equipment as an expense. There are at least seven different methods of calculating the amount to allow for depreciation, and it is not likely that all plans are using the same method. For certain plans organization expenses are capitalized, which means that the money spent in starting the plan is carried as an asset and increases the surplus. For other plans organization expenses are considered simply as an expense.

Many plans have particular arrangements for handling certain overhead expenses; for example:

The hospital service plan has office space in the hospital. Furniture and equipment is part of the original expenditure for furnishing the hospital. Expenses incurred on account of the hospital service plan prior to the opening of the hospital and the beginning of the operation of the plan are considered as part of the preopening expenses of the hospital and are eliminated from the above figures.

The hospital used one of its furnished offices for this work and did not charge the group hospitalization department for the furniture.

We charge only patients' service against group funds. Our other items of cost are less under this plan of collection than under the usual collection plans, so they are not fairly chargeable as peculiar to this plan.

No administrative expense is charged to this separate "Supplemental Plan."

Fewer expenses are reported for plans that have these arrangements than for plans without such arrangements.

For many of the plans loans were made by member hospitals or community agencies. Most of these loans have been repaid, but some are included with the income from members. Sizeable gifts are sometimes considered as part of, or at least included with, the income from members. Interest on funds invested or in the bank

may also be considered as operating income. Widely different practices are followed in accounting for these items.

Apparently some method of allocating the various income and expense items on a comparable basis is necessary. Since group hospitalization plans are essentially insurance and in many states the directors are required to report annually to the insurance department, the uniform method of reporting for insurance companies was followed. According to such a method, it is possible to determine the entire cost incurred during the specified period for the benefit of members, including claims paid, claims unpaid and an estimate for claims of members still receiving benefits. Likewise, all the expenses incurred, including the entire amount spent for every activity of the organization, can be ascertained. Certain expenses, such as office equipment and organization expenses, are charged off entirely instead of depreciating or amortizing them over a certain number of years. This practice is followed by insurance examiners because it shows the cash position of the company and rules out indefinite or unstandardized accounting customs, such as evaluation of intangible assets and depreciation or amortization methods. Such a statement of affairs presents the actual operating results of the company during the indicated period.

In some respects this method may seem unfair to newly organized plans, because supplies and equipment purchased and certain other administrative expenses incurred during the initial period will be of value for many years or possibly throughout the life of the plan. Some directors have incurred large expenses in anticipation of future enrolment. However, not all such expenditures can be considered as "for the future." Plans which entail small administrative expenses and continue to

increase in membership and to acquire a surplus are more economically managed. Expenditures for supplies and office equipment are, of course, necessary for the operation of the plan, but such items are not admitted as assets in reports for insurance companies because they are not liquid assets and cannot ordinarily be used to pay insurance claims or expenses. The reduction of all items to a cash income and disbursement basis makes it possible to compare the results of operation more accurately.

Table 12 presents the complete financial experiences for several plans. The distribution of the receipts from members, as shown in the table, indicates the operating results of the several plans prepared in accordance with insurance examination methods. Each director was sent a copy of the distribution of the receipts for his plan with the request to verify the accuracy of the statistics. All but five replied, and no important changes were necessary. This table includes statistics on every type of plan and accounts for the majority of the members, income and costs of all plans. Again, the peculiar differences of each plan must be emphasized. For example, those offering discounts to dependents tend to have less hospitalization expense than those offering full service to dependents. The list in appendix D gives the main features for each plan that may influence its hospitalization experience. Wide variations in hospitalization costs and other expenses for individual plans are apparent and should be considered. The extreme differences among the several plans are caused by particular conditions which influence either the hospitalization experience or the costs. A change in the status of any one plan will affect the resulting total experience, particularly if the plan has a large membership. Since each plan cannot be discussed separately, the totals,

TABLE 12.—Reported Financial Experience Under Group Hospitalization Plans During Specified Periods—Not Later Than March 1, 1936

Plan	Experience Period (Months)	Member Months Used	Earned Receipts from Members	Costs for Hospitalization of Members*	Percentage of Earned Receipts Used for Hospitalization of Members	Costs per Patient	Other Costs (Administrative and Promotional)	Percentage of Earned Receipts Used for Other Costs	Excess of Earned Receipts Over All Costs (Includes Reserves and Surplus or Losses)	Percentage of Earned Receipts Used for Reserves and Surplus or Losses
A	12	65,582	\$ 44,485.21	\$ 36,112.50	81	\$53.34	\$ 8,004.28	18	\$ 868.43	1
B	36	126,342	99,435.27	51,931.80	52	62.04	31,517.49	32	15,985.98	16
C	10½	284,535	197,379.71	113,977.30	58	61.18	94,576.63	48	-11,174.22	- 6
E	24	45,420	25,900.14	20,832.62	80	42.52	3,119.93	12	1,947.59	8
F	30†	414,954†	209,639.08†	242,983.14†	116	53.37	.....‡	..	.....	..
G	15	91,502	64,958.25	31,551.00	49	45.79	24,773.90	38	8,633.35	13
H	26†	40,908†	19,781.50†	23,633.22†	119	52.99†	.....||	..	.....	..
K	36	119,028	70,780.74	57,556.85	81	42.23	18,116.58	26	- 4,892.69	- 7
M	24	91,863	66,221.65	55,893.65	84	39.55	28,101.06	43	-17,773.06	-27
O	5	44,848	20,677.10	11,918.11	58	36.99	5,636.35	27	3,127.64	15
Q.1	27	49,275	16,012.47	13,242.12	83	54.49	7,504.80	47	- 4,734.45	-30
Q.2	7	6,861	8,973.52	9,896.23	110	60.71	2,365.28	26	- 3,287.99	-36
Q.3	7	791	1,313.61	557.66	42	39.83	1,772.20	135	- 1,016.25	-77
R	5½	4,801	2,454.31	577.50	24	24.06	2,628.13	107	- 751.32	-31
Total.....		930,818#	618,591.98	404,042.34	65	49.89	228,116.63	37	-13,566.99	- 2

* Usually only incurred hospital charges. Some plans estimated the costs for hospitalized members not yet discharged.

† Not included in total.

‡ Charged to publicity budget.

|| Amount retained by agency not given.

Equivalent to a membership of 54,754 for seventeen months.

despite their limitations, can serve to summarize the aggregate experience and point to general trends in this type of insurance.

Many significant points are revealed in table 12. For each dollar of earned income, 65 cents was used to pay for hospitalization of members and 37 cents was used for other costs (administrative and promotional expenses), resulting in a loss of 2 cents. The unfavorable experiences under two of the older plans are not included in the totals. Under these plans more than the earned receipts for hospitalization of members was used, and the administrative and promotional expenses were not reported. If the experiences under the five plans in operation two years or more are considered separately, 72 cents was used for hospitalization costs and 31 cents for administrative and promotional expenses—a loss of 3 cents for each dollar of earned income. Funds to carry the initial losses incurred are sometimes borrowed from member hospitals or from community agencies.

It should not be overlooked that several of the hospital service corporations have income from sources other than earned premiums. Additional income may be derived from interest on reserve funds or from gifts. The good will which has been built up in establishing the corporation and in securing subscribers has a certain value. Each corporation also has an equity in the unearned premiums approximately equal to the portion of such premiums that will be earned when all contracts are carried to expiration less the expenses for claims and overhead that will be incurred. To determine the exact amount, due consideration would have to be given to the acquisition costs and the average loss experience of each hospital service corporation. However, these and other extra funds need not be shown in the table as

they do not arise from the direct operation of the plan. While the income from such sources adds to the financial stability, it should be considered separately because the operating result of the plan is first dependent on the earned premium income from members.

The average hospital bill paid under the hospital service plans listed in table 12 was \$49.89. This was based on the bills for 8,098 patients. Including the amount spent for hospitalization costs by all hospital service plans from which reports were received, an average bill of about \$50 was paid for each member hospitalized. It is seldom possible to determine the exact amount of hospitalization costs for members, because some members may still be in the hospital when reports are published. Some plans estimated the costs for members still hospitalized, but many reported only the actually incurred costs.

As has been indicated by the review of the hospital service contract benefits, there are several services which are not included in the contract. Even though a subscriber's contract entitles him to hospitalization for the condition with which he is afflicted, he may be required to pay for extra services. His bill is not always marked, "paid in full by the hospital service corporation." Extra charges are made for special serums and medicines, individual diets, appliances, services which are only partly paid by the hospital service corporation and for all services not included in the subscriber's contract. According to the information received concerning three plans, extra charges average from \$10 to \$12 per patient for subscribers and considerably more for dependents entitled to discounts only.

The average hospital bill, as determined by the Committee on the Costs of Medical Care, consists of the following: \$62.89 for the phy-

sician (including the cost of surgery and all calls by general practitioners or specialists); \$54.26 for the hospital (exact services included were not stated, but possibly includes all services not otherwise mentioned); \$10.44 for the services of special nurses in the hospital, and \$11.55 for all other services (including cost of medicines, nursing services outside of the hospital and other services which were not identified). The total average hospital bill, including the services of physicians and special nurses, is \$139.14. Accordingly, the bill for the use of hospital facilities and including certain extra services would average between \$54 and \$65. While some of the members of group hospitalization plans evidently do have to pay for services not included as contract benefits, the average bill paid by the hospital service corporation apparently provides for a large percentage of the usual bill for hospital services.

As also shown in the table 12, on the basis of the 930,818 member months used, the earned income of \$618,591.98 amounts to 66.4c per member month. Likewise, during one member month, 43.4c was used for hospitalization costs and 24.5c was spent for administration and promotion, resulting in a loss of 1.5c per member month. Since the earned receipts for members was 66.4c per member month, the annual earned receipts per member was \$7.97. This amount must provide for the hospitalization and administrative expenses incurred for each member during an entire member year.

It is noticeable that the plans in operation for a short period of time tend to show a more favorable hospitalization experience than the older plans but that a larger percentage of the earned receipts was used for the administrative costs of the newer plans because of the promotional expenses during the first several months. After the extraordinary promotional

expenses of the first year, the percentage of earned income spent for administration is less, but the hospitalization costs increase. According to reports received, from 12 to 47 per cent of the earned income was expended for administration and other costs for the plans in operation two years or more. For these same plans from 52 to 119 per cent of the earned income was used for hospitalization costs. The hospitalization of members apparently does not really begin until the plan has been in operation sufficiently long for the members to be freed from waiting period restrictions and to become aware of the possible benefits.

The foregoing financial experiences during the specified periods ending March 1, 1936, included the initial period of operation for many plans. During 1936 the plans received wide publicity and the membership increased rapidly. In table 13 is presented the financial experiences for several plans during a period approximating the year 1936. As shown by the decrease in administrative and promotional costs, the extraordinary expenditures of the initial period for operation were lowered for most of the plans. In view of the rapid increase in membership and the tendency to restrict certain benefits, it is significant that the expenditures for the hospitalization of members were not appreciably decreased. During the extremely favorable year of 1936, out of each dollar of earned income 64c was used for the hospitalization costs of members and 20c for administrative and promotional costs, leaving 16c for reserves.

The accumulation of reserves under most of the plans during 1936 is looked on by many persons as definite proof of the financial soundness of group hospitalization. If the judgment of insurance men is at all accurate, the rapid enrolment of members was largely responsible

TABLE 13.—*Reported Financial Experience for Group Hospitalization Plans During an Approximate Year in 1936*

Plan	Experience Period (Months)	Earned Receipts from Members	Costs for Hospitalization of Members*	Percentage of Earned Receipts Used for Hospitalization of Members	Other Costs (Administrative and Promotional)	Percentage of Earned Receipts Used for Other Costs	Excess of Earned Receipts Over All Costs (Includes Reserves and Surplus, or Losses)	Percentage of Earned Receipts Used for Reserves and Surplus, or Losses
A	12 (2d year)	\$ 76,099.55	\$ 78,508.95	103	\$ 12,585.12	17	—\$ 14,994.52	—20
B	12 (4th year)	122,146.28	83,898.38	69	33,604.40	27	4,643.50	4
C	13 (in 2d year)	1,506,139.83	984,541.14	65	300,702.58	20	220,896.11	15
F	12 (6th year)	110,411.85†	116,855.41‡	106	.....‡	..	— 6,443.56	— 6
G	12 (2d year)	235,525.35	143,711.50	61	34,073.09	14	57,740.76	25
K	12 (4th year)	49,332.20	37,153.90	75	10,378.16	21	1,800.14	4
L	19 (in 2d year)	23,082.72	5,520.95	24	10,049.39	43	7,512.38	33
O	15 (in 2d year)	270,475.49	158,460.05	59	34,928.84	13	77,086.60	28
R	12 (1st year)	14,970.01	6,354.20	42	5,637.08	38	2,978.73	20
T	18½ (in 2d year)	46,642.10	11,468.40	25	15,158.86	32	20,014.84	43
Total.....		2,344,413.53	1,509,617.47	64	457,117.52	20	377,678.54	16

* Usually only incurred hospital charges. Some plans estimated the cost for hospitalized members not yet discharged.

† Not included in total.

‡ Charged to publicity budget.

for the low loss ratio. It is therefore not at all certain that the future costs will remain at the present low level. Furthermore, the reserves that have been accumulated do not appear to be adequate. The membership of the plans in table 13 is about 396,000, so the total reserves accumulated amount to less than \$1 per member. As will be shown later, \$5 per member is considered a conservative reserve.

TABLE 14.—*Complete Operating Results for Four Large Group Hospitalization Plans**

Premiums from members		
Total earned premiums		\$2,549,967.53 (100%)
Expenses		
Costs for hospitalization of members		
Hospital claims paid	\$1,357,804.00	
Hospital claims unpaid.....	226,494.78	
Estimated hospital claims payable.....	11,500.00	
		\$1,595,798.78 (63%)
Administrative and promotional costs...		571,122.94 (22%)
		2,166,921.72
Earned surplus.....		\$ 383,045.81 (15%)
Other Income		
Gifts, interest on investments, discounts, etc.....		34,400.70
Total reserves.....		\$ 417,446.51

* An average two and one-half years of operation during 1933-1937 is represented.

The dominating part played by the few larger group hospitalization plans has been pointed out. The complete financial experiences for four of these larger plans, including about one half of the members in all plans, were obtained. Table 14 illustrates the combined operating results of these plans, representing an average of two and one-half years of operation during the period 1933-1937 for the most successfully managed of all group hospitalization plans. The \$2,549,967.53 earned is approximately equal to the premiums that would be received from a cohort of 125,000 members during two and

one-half years of membership. For each dollar of earned income received, 63c was spent for hospitalization costs and 22c for administrative and promotional costs, leaving 15c for reserves. The \$383,045.81 earned surplus amounts to about \$1.15 for each of the 335,000 members of the four plans. Other income from gifts, investments and discounts adds 10c per member, making the total reserves about \$1.25 per member.

It is believed that the financial experiences reported have been treated fairly and as accurately as possible. Because of the reluctance of the directors of the plans to report losses, and because of the incompleteness of the plans showing losses, the totals in the several tables represent the favorable side of the financial experiences. The following published results of an examination of one of the larger group hospitalization plans made by a state insurance examiner may serve as a check on the accuracy of the reported financial experiences:

	1935 (7 months)	1936 (5 months)
Premiums earned [earned receipts from members]	\$116,520.87	\$266,916.83
Losses incurred [claims paid]	66,510.50	175,751.10
Expenses incurred [administrative and other costs]	75,303.94	71,669.07
Ratio		
Losses incurred to premiums earned.....	57.08%	65.80%
Expenses incurred to premiums earned....	64.62%	26.85%
Losses and expenses incurred to premiums earned	121.70%	92.65%

The unusual expenses during the first period were reduced in the second period, but the hospitalization losses increased. The membership

increase for the plan during both periods was 132 per cent. This had an important influence in keeping costs down.

Whether or not a surplus will accumulate under a plan depends on a large number of variable factors. Perhaps the most important of these is the liberality of the contract provisions. One plan had the lowest hospitalization costs and the highest reserves, mainly because of the following: Dependents were entitled to discounts only; obstetric patients were offered but a 50 per cent discount after ten months; special laboratory examinations, x-ray services, physical therapy and anesthetist services were not allowed; a discount of 10 per cent permitted after twenty-one days of hospitalization was absorbed by the member hospitals, and a portion of the agreed per diem rate was retained to be paid later if funds permitted.

Conclusions concerning the financial experiences for group hospitalization plans cannot be made definite because of the highly experimental and varying nature of the plans. The larger and better managed plans, under which administrative and promotional costs have been kept at a minimum and subscribers have been selected very conservatively, do accumulate actual surpluses. Losses are usually incurred during the first year or so, and then administrative costs are lowered and a surplus may appear. Hospitalization costs remain constant or tend to increase, but again the rapid enrolment of members temporarily prevents the actual hospitalization that may be expected in later years. During the present period of rapid growth in membership, a low loss ratio should be expected. When the number of members is increasing at a rate of over 100 per cent annually, it would be unwise to accept the

resulting costs as representative of normal, long-time operations.

According to the financial experiences reported, it appears that from 24 to 119 per cent of the earned income, with an average of about 65 per cent, is used for hospitalization costs. Administrative expenses, including promotional and sales expenses, range from 135 per cent down to a low of 12 per cent of the earned income, with an average of about 25 per cent. Hence, when hospitalization costs are high and administrative expenses are large, the plan is likely to be in a precarious financial condition. The reduction of administrative expenses is the most promising source for lowered costs. A careful examination of available data indicates that hospital costs will tend to increase as the plan grows older; that is, unless the directors of the plan continue to reduce benefits or increase limitations. Requiring the subscriber to pay for the first few days of hospital service, placing further limitations on the hospitalization of obstetric patients, restricting the benefits for dependents and insisting on the enrolment of a large percentage of each group with payments through payroll deductions are indicative of the devices used to keep losses as low as possible. It remains to be seen if these or other devices will be able to stem the tide of increasing use of hospital benefits by members of group hospitalization plans.

The advantages for the subscriber and the salability of the contract will be interfered with by such restrictions, but the plan will be made more secure. If the plan is to endure, it cannot offer benefits beyond the resources that will be available. Loose talk about lowering rates, offering more benefits, including medical services and accepting all classes of members may lead the plans into financial difficulties. Insur-

ance companies have been unable to make a great financial success out of accident and health insurance. Can hospitals expect to do better with group hospitalization plans? Not unless, in general, more successful underwriting ability, less costly salesmanship and more economical administration are developed. Several of the more capably managed plans show promise of developing the best possible features in a hospital insurance plan.

SURPLUS AND RESERVES

The method of allocating the surplus after all expenses have been met is not clearly indicated. In general, the surplus may be applied by the hospital service corporations in the following order: first, to repay the hospitals any sum not previously paid to them on account of hospital services rendered under the subscriber contracts; second, to create reserves for future claims, operating expenses and other contingencies, and third, to create a special fund with the remainder, if any, for the benefit of member hospitals and subscribers. The surplus under a single hospital plan frequently becomes a part of the general hospital fund. The discussion of surplus and reserves applies mainly to hospital service corporations or associations.

Because of the nonprofit-sharing nature of most of the plans, the surplus may be distributed to subscribers only in the form of lower rates or extended benefits. Under the mutual association or membership corporation plans the surplus can be distributed to the subscribers either as refunds on their subscriptions, so-called "dividends," or as the board of trustees may direct. It is peculiar that those plans which are supposed to be mutual associations and which designate that an assessment may be made if rates prove insufficient, frequently fail

to make any provision for the sharing of the ownership of the plan with the subscriber or for the distribution of the surplus that may accrue. One contract that does incorporate a provision for apportioning of the surplus is as follows:

When this certificate is renewed for a second or subsequent year the certificate holder shall be entitled to share in such divisible surplus of the Association as may be ascertained and apportioned by the Board of Directors. The share of such divisible surplus as may be apportioned to this certificate shall be applied only in the reduction of the annual dues for that following year, or in a proportionate reduction of dues for that part of a year, for which this certificate may be renewed.

After operating expenses have been paid, the hospital service corporation may agree to distribute any surplus to member hospitals according to the number of days of hospital service each such hospital has provided. If the funds collected are insufficient to pay operating expenses, and a deficit arises, the member hospitals may be required to advance, in proportion to the number of days of hospital service provided, their part of the deficit. The hospitals which have rendered the most service are the ones which must pay the largest part of the deficit. This is not inequitable when it is remembered that the hospitals rendering the most service have received the most money from the hospital service corporation.

A lack of concern regarding reserves is very noticeable. The amount of reserves and the type of reserves have not been seriously considered. It is commonly held that the contracts sold are essentially service contracts and that the hospitals always stand ready to render services. Consequently, the necessity for reserves is minimized. The attitude of executives of

hospital service plans in regard to reserves was summarized as follows: ⁵³

The ultimate risks of a nonprofit hospital service plan are borne by the participating hospitals, which agree to provide hospital care to the subscribers. These risks have been borne in the past by these same hospitals through their tradition of charity and free service to the entire community. The introduction of hospital service plans reduces rather than increases any financial risks which they might incur from serving subscribers.

From the standpoint of protection of subscribers, the guarantee of a group of well-administered hospitals, with permanent staffs and millions of dollars of capital investment is greater than could be offered by the deposit of any reasonable reserve of cash.

Furthermore, the enabling legislation creating hospital service corporations had as its first objective the exemption of hospital service corporations from the deposit requirements of the insurance laws. These deposits, in addition to the stipulated amounts to be retained by insurance companies, constitute the so-called legal reserves of insurance companies. In those states in which group hospitalization was held not to be insurance, the observance of reserves was likewise held unnecessary. From such a beginning it is not surprising that the promoters of group hospitalization plans have shown but slight regard for the necessity of reserves.

It does seem unsound to claim the advantages of the "insurance principle" for group hospitalization plans and then to deny the necessity of reserves which are an integral part of insurance. Where the hospitals are responsible for the plan, their facilities are perhaps as good a guarantee as cash reserves. However, when the hospitals apparently contract with an independent corporation to render services only on the payment of a specified rate per diem, it is essential that the corporation have funds avail-

53. Report of a Round Table on Group Hospitalization, Chicago, American Hospital Association (Sept.) 1935, p. 8.

able when subscribers need services. The proper guarantee to the subscriber is the use of available facilities of member hospitals and adequate cash reserves.

The following statements indicate the nature of the reserves that are kept:

The reserve fund consists of \$1 of each registration fee charged subscribers. This fund is being allowed to accumulate.

Out of any surplus there shall be set aside and withheld as a reserve, such sum as shall be determined by agreement of two-thirds or more of the representatives of the participating hospitals.

A portion of all dues received by this Association are deposited in a Reserve Fund.

A reserve fund is set up based on one patient day per year per member.

The minimum reserves that seem essential are: (1) an unearned premium reserve, (2) an outstanding loss reserve and (3) a catastrophe reserve.

The unearned premium reserve consists of the unearned portion of all premiums received, calculated on the member month or the monthly pro rata method. For example, if \$9 is the annual premium, after the first month 75c is the earned premium available for expenses and \$8.25 is still unearned. The setting aside of the unearned premium is to provide for the claims which may commence during the remainder of the time for which premiums have been paid.

The outstanding loss reserve consists of two items: hospital bills incurred but unpaid and an estimated amount for bills to be incurred by subscribers already in the hospital. Since the hospitalization expectancy is one patient day per member, it seems reasonable that the outstanding loss reserve should consist of a sum at least equivalent to the cost of one patient day for each member. If the expectancy is accurate, such a reserve would provide for the afore-

mentioned two items and, in addition, would provide a safety factor for excessive claims.

The catastrophe reserve is a special contingent reserve to protect against losses because of epidemics or catastrophies and should consist of at least 2 per cent of the premiums earned each year.

The unearned premium reserve is simply a bookkeeping procedure to separate the money earned and usable for expenses from the money unearned. The unearned premium really belongs to the subscriber until it is earned. The outstanding loss reserve and the catastrophe reserve are funds to meet special contingencies. If the actual patient day cost per member is \$6 and the earned income per member is \$7.97, the outstanding loss reserve will consist of \$6 and the catastrophe reserve will consist of \$1.59 for each member, or a total of \$7.59 per member. This amount is according to the bases given. The patient day cost and the earned annual premium per member vary for each plan. A conservative amount for both reserves would be \$5 per member.

A source of added income for group hospitalization plans may arise from interest on the reserve funds, including the interest on unearned premiums. For insurance companies the interest on mean reserves is conservatively estimated at 3 per cent.⁵⁴ Where any regulations governing the funds of a group hospitalization plan exist, they usually provide that monies received may be invested only in securities permitted for the investment of the assets of life insurance companies.

Not until adequate reserves are created will the plan be on a firm foundation. The primary requisite of an insurance plan is safety—the ability to meet all present and future obligations. The following statement by the president

⁵⁴ Best's Insurance Reports—Casualty, Surety, and Miscellaneous, New York, A. M. Best Company, Inc., 1936, p. vi.

of an insurance company indicates the importance of adequate reserves:⁵⁵

While a company can continue without proper reserves for a long period during which new business is being produced at an increasing rate, and show apparent financial progress, a slackening of production will soon reveal the necessity of reserves. To be sound a company must always be in a position to meet its future obligations from its reserves together with future premium collections on existing business, without anticipating profits or income from future new business. This is the fundamental theory of reserves.

Because surpluses have been reported for many plans, there is a growing belief that appreciable reserves are being accumulated. The directors of these plans are promising reduced rates or extended benefits. However, it has been shown that the financial statements of group hospitalization plans may be deceptive. On an earned income basis, with proper allowance for all hospitalization and administration losses, surpluses are frequently wiped out or only inadequate reserves remain. Actual surpluses and reserves are reported for several of the better managed plans, but even these amount to less than \$2 per member. Allowance must also be made for the present rapid growth in membership. It would be unwise for hospital service corporations to base permanent policies on hospitalization and financial experiences that are more than likely to be temporary.

EVALUATION

The discussion of the status of group hospitalization plans, their extent, the various forms of organization, the hospital service contract benefits and limitations, membership, rates, member hospitals, hospitalization experiences, financial experiences and reserves does not make very easy reading. It is just these facts, however,

55. Young, C. W.: Noncancellable Accident and Health Insurance, *Best's Insurance News (Casualty Edition)*, 34:147-8 (July 10) 1934.

that are most needed for a proper appraisal of what has been done and what can be done with the plan for group hospitalization. While the evaluation of the plan here will be mainly from the financial point of view, the essential relationship with medical practice will be discussed in detail later.

For the subscriber, the plan offers one hospitalization at \$50 in return for \$90 collected in premiums. On the basis of anticipated hospitalization experiences, it is expected that each subscriber will be hospitalized once in ten years. From the financial point of view, an income of \$90 (\$9 annually for ten years) is received from each subscriber, in return for which the expenses of one hospitalization are expected to be paid. The cost of this hospitalization is, as reported, about \$50. The difference of \$40 is for administration, promotional expenses and reserves. As has been shown, the actual income per member—including subscribers and dependents—is about \$8 annually, so that \$80 is the income to provide for the hospitalization of each member at the expected cost of \$50. The difference of \$30 is used for expenses other than costs of hospitalization and for reserves. Individual members of various plans, of course, may receive more benefits or pay less in premiums, but a surcharge will be added to the cost of hospital care for administering the plan.

Obviously, the addition of administrative expenses to hospital charges cannot lower the cost of hospital care. This fact is gradually being recognized by the proponents of "insurance" payment plans. Insurance never lowers costs; it simply distributes the costs for one person among a group of persons. The expenses for the administrative machinery to effect such a distribution are also distributed along with the basic costs. In the case of group hospitalization

plans, the \$50 cost for one hospitalization is distributed among ten persons, but instead of each paying his share of \$5 each must pay \$8, as \$3 per member is required for administrative expenses.

The benefit of the insurance method is that it lifts the burden of meeting a large bill from the individual and places it on a group of individuals. For this service the individual is willing to pay a surcharge. Generally, however, the burden is so large as to be beyond the individual's power to deal with it. In the case of fire insurance the loss is frequently several thousand dollars; in life insurance the average amount of insurance is \$2,250, and even in accident and health insurance the losses may be several hundred dollars. These sums are too large for the individual to administer. He cannot act as a self insurer by building up cash reserves to pay for probable losses. The maintenance of cash funds large enough to meet losses amounting to several thousand dollars requires too many administrative and investment duties for the person whose time is fully occupied with other business. He is quite willing to allow insurance companies to assume these duties for him and to pay them for their services.

It is questionable whether an insurance plan for the payment of hospital bills is desirable, because of the small losses involved. The sum of \$50, which is the average bill, or even the sum of \$126, which is about the largest bill payable under group hospitalization, is often not too large to be handled by the individual. Even the Committee on the Costs of Medical Care, while recognizing the economic desirability of hospital insurance for hospitals, stated: ⁵⁶

Hospital insurance cannot, of course, be considered a panacea for equalizing the uneven distribution of

56. Falk,⁶⁶ p. 484.

medical charges, and its advantages must be accepted or rejected according to the needs of each community and institution.

To determine whether the fee of the physician, the dentist, the nurse or the hospital was responsible for the "uneven burden of medical costs," the committee substituted the average charge for the actual charge in each of the specified services. The conclusion reached after average hospital charges were substituted for actual charges was "that eliminating variations due to the costs of hospitalized illness changes very little the percentage of families with charges of less than or more than \$100 and increases only from 30 to 53 per cent the families whose charges fall between \$40 and \$100." This conclusion dealt specifically with the families in the \$1,000 to \$2,000 annual income group. However, for families in all income groups, about the same conclusion was reached; namely, that no substantial solution of the problem of variations in medical costs could be effected unless the variations in charges due to all four services (physicians, dentists, nurses and hospitals) were eliminated. The committee considered the failure of charges for hospitalized illnesses to be responsible for the variations in medical costs of special interest "because there are many informed persons who consider insurance for this class of illness a practical procedure."

One of the compilers of the report on "The Costs of Medical Care" was even more specific when he wrote: ⁵⁷

If these families [in the \$1,200 to \$2,000 income group] had had to budget \$6 to \$10 *per capita* for hospital costs (the premium charged in the voluntary group hospitalization)—instead of \$9 *per family* [the

57. Falk, I. S.: Changes in Paying for Hospital Care Considered from a General Economic Point of View, *Western Hospital Rev.*, June 1934, vol. 22.

average hospital charge]—there would have been more families with large charges and their burdens would have been greater. . . .

I do not cite this analysis to depreciate group budgeting of hospital costs but to caution those of us who tend to become enthusiastic in this cause that it offers only a partial solution of medico-economic problems. We must not expose ourselves to the undesirable reaction which will develop when people discover that hospital insurance does not accomplish what it cannot do.

Apparently, the present total cost of hospital care will be increased by an insurance plan. The chief advantage of such a plan is that it facilitates the payment of hospital bills by enabling each prospective patient to pay in advance.

If a person would place \$50 in the bank for hospital bills, it would likely pay for the amount of service he would receive as a member of a group hospitalization plan. He could then save the \$30 used for the expenses of the plan. Many persons do not have the \$50 to set aside and feel that before they could accumulate such an amount they might need to be hospitalized. Likewise, they may have to be hospitalized in several successive years. There is also a possibility that the benefits received may be considerably more than \$50. For these reasons, group hospitalization plans do have an appeal for certain persons. However, the payment of about \$30 for the expenses of a plan to administer a probable \$50 loss is very doubtful economy. In keeping with the charitable nature of hospitals, any plan to assist persons to meet their hospital bills should be designed for those really needing help and as little as possible of the monies collected should be used for administrative expenses.

For member hospitals the plan offers immediate cash payments ranging from \$3 to \$6 for each patient day of service. The essential question is: What does it cost the hospital to provide

the services guaranteed by the group hospitalization contract? The cost per patient day is the most discussed and least understood term in hospital statistics. In a manual⁵⁸ prepared by the Council on Community Relations and Administrative Practice of the American Hospital Association it was stated that the cost per patient day should be simply the operating expenses divided by the number of patient days, that the only service which can be measured in terms of patient days is the bed and board costs to inpatients, and that operating costs should exclude nonoperating expenses, such as interest, depreciation, taxes, rent and expenses for nonhospital activities.

Somewhat involved accounting would be necessary to allocate all hospital operating expenses into separate expenses for bed and board, operating room, delivery room and x-ray and laboratory services. Logically, only the operating expenses for bed and board should be divided by the number of inpatient days to obtain the cost per patient day. The patient day unit cannot be used to measure the costs for operating room, delivery room, and x-ray and laboratory services. Each of these services can be more adequately expressed in terms of the services rendered; for example, operating room expenses should be expressed as a certain cost for each use of the room, delivery room expenses should be expressed as a certain cost for each delivery, and cost of the other services should be expressed on the same basis.

These desirable procedures are not always followed. Most hospitals simply divide the total expenses for services to inpatients by the number of patient days. The result is an all-inclusive cost per patient day, including expense items for bed and board, for operating room,

58. Hospital Accounting and Statistics, Chicago, American Hospital Association, 1935, pp. 18 and 72.

for delivery room, for x-ray service, for laboratory service and for other services. In addition, there are several different beliefs as to what should be included in operating expenses and what a patient day is. Furthermore, hospital expenses vary widely with the investment per bed, the rate of occupancy and the geographic location of the hospital. For these reasons the cost per patient day is not an accurate or uniformly calculated measurement of the costs of hospital service. It is little wonder that a comparison of hospital expenses on the basis of patient day costs is unsatisfactory and sometimes impossible.

It is generally accepted that the average hospital represents an investment cost of \$5,000 per bed and requires annual maintenance costs amounting to \$700 per bed even if no patients are admitted.⁵⁹ The fixed charges for each hospital bed do not vary with the amount of service and consist of \$250 for interest and \$150 for depreciation. A "readiness to serve" cost of \$300 per bed includes expenses for the salaries of the administrative staff, for the heat, light and power service, for the maintenance of laundry and kitchen and for the supervision of nursing, all of which must be incurred if the hospital is to accept patients. A total of \$700 per bed, then, must be spent before a patient is admitted to the hospital. If each bed should be occupied every day during the year, the maintenance cost of \$700 per bed would amount to \$1.92 per patient day; if 50 per cent occupied, the cost per patient day would be \$3.84.

In addition to maintenance costs there are "service" costs which are incurred only when patients are accepted and treated. These costs

59. Report of the Committee on Planning and Equipment of the American Hospital Association, *Tr. Am. Hosp. A.*, 1935, p. 740. *Capital Investment in Hospitals, Committee on the Costs of Medical Care, Publication 7*, Chicago, University of Chicago Press, 1930. Neegaard, C. F.: *How Many Hospital Beds Are Enough?* J.A.M.A. 108:1029 (March 27) 1937.

include drugs and medicines, laboratory supplies, food for patients and the costs for special services, such as use of the operating and delivery rooms, anesthesia, laboratory examinations, x-ray services and physical therapy. No amount has been determined as an average for these "service" expenses. However, the average cost per patient day in a general hospital is accepted to be \$5. This cost includes an approximate \$3 for maintenance costs—the fixed charges and "readiness to serve" costs that have been shown. The difference of \$2 apparently allows for all the additional "service" expenses.⁶⁰

It is significant to observe the effect of idle beds on hospital costs. Out of the total 402,605 beds in general hospitals, the present occupancy of 67.4 per cent leaves 130,947 idle beds. Not all of these idle beds are wasted, as a certain number of excess beds are required to accommodate a sudden influx of patients. However, the fluctuation in the percentage of beds occupied has not been more than from 8 to 10 per cent during any one year for the last eight years. The fluctuations from a low to a high occupancy have not exceeded 25 per cent. A number of excess beds equivalent to 25 per cent of the average patient census over a period of several years has been considered as a conservative safety reserve. If 67,947 beds of the 130,947 idle beds are kept idle as a safety reserve, which represents 25 per cent of the average patient census of 271,658, a surplus of 63,000 idle beds still remains. According to the average investment cost of \$5,000 per bed and the annual maintenance charges of \$700 per bed, these 63,000 idle beds represent \$315,000,000 in frozen capital and \$44,100,000 in unnecessary

60. For further elaboration of the calculations of patient day costs see the *Costs of Medical Care*, Committee on the Costs of Medical Care, Publication 27, Chicago, University of Chicago Press, 1933, pp. 336-344.

annual maintenance costs. The wasted annual maintenance costs alone, on the basis of \$5 per patient day, would have paid for the hospitalization of nearly one tenth of all patients admitted to general hospitals.

The "hospital problem" is intimately concerned with the 63,000 vacant beds. These beds must be taken out of service or they must be filled with paying patients. If the beds are taken out of service, the "readiness to serve" cost alone will be saved, as the capital sunk in them is beyond recall and the interest and depreciation costs also cannot be avoided. However, a saving of \$18,900,000 would result by avoiding the \$300 annual "readiness to serve" cost for each of the 63,000 idle beds.

It is claimed that the plan for group hospitalization proposes to overcome the expense of idle beds by filling them with paying patients. To equal the \$18,900,000 saved by taking the beds out of service, under group hospitalization 525,000 new patients would have to be hospitalized. This number is determined on the basis that each patient stays eight days and that fully \$4.50 for each patient day is used for "readiness to serve" costs alone. At the present rate of hospitalization the plans would need to have a membership of 4,770,000 before 525,000 members could be hospitalized yearly. To avoid disturbing the present hospital income, all these patients would have to be new patients. It is not likely that this will be accomplished.

The hoped-for economy of group hospitalization plans is that additional persons will be induced to become hospital patients, thereby increasing the bed occupancy, which in turn will make possible a lower patient day cost. If the present occupancy of 67 per cent resulting in a patient day cost of \$5 could be increased to 83 per cent, all the 63,000 beds would be put into service and the patient day cost would be

lowered to about \$14.45. A total of 22,995,000 additional patient days would be required to occupy fully the 63,000 beds. This would mean the hospitalization of more than 2,800,000 new patients from a membership of 25,000,000, since 11 per cent of the members of group hospitalization plans are hospitalized for an average stay of eight days. It is very unlikely that the full maintenance cost of \$14,100,000 for the 63,000 idle beds can be provided by group hospitalization plans.

Another objective of the group hospitalization plan is to provide full payments for hospital services for persons with limited or no means. Unfortunately, on the present basis of organization the plans apparently do not lighten the load of free or part-pay patients. As has been indicated, it is generally recognized that persons in the low income groups and in rural areas are not greatly benefited by the plan. In an exhaustive survey⁶¹ of a community where a large group hospitalization plan is located it was found that only about 1 per cent of the number of persons ordinarily treated free in general hospitals had their bills paid by the prepayment plan. Unless the rates can be lowered to permit the enrolment of a great number of persons with small incomes who have hitherto not been able to pay for hospital care, group hospitalization plans will have no appreciable effect on hospital finances.

The hospital routing plan, based on a central admitting bureau which determines the ability of the patients to pay hospital bills, will remove most of the abuse of free hospital services. Funds from philanthropic and governmental sources or free services can be made available for those deserving of assistance. In several communities a postpayment plan for those per-

61. Report of the Hospital Survey for New York, New York, United Hospital Fund, 1937, vol. 2, p. 309.

sons really unable to meet their hospital bills is considered more economical than a group hospitalization plan. In these communities the county medical societies have organized special plans whereby persons having low incomes may secure medical and hospital care at reduced rates on a deferred payment arrangement.⁶² The cost of administration for such plans is about 10 per cent and is borne by the physicians and the hospitals. No interest, carrying charges or credit-rating costs are added to the patient's bill. While such plans mortgage the future income of persons who incur medical and hospital bills, they do not exact any charges from the patient which are not used in his own behalf, they do not charge the patient for the administrative expenses, they make possible a real concession in charges for those who are deserving, and they can arrange for every medical and hospital service for all classes of patients.

A more direct solution to the hospital problem of idle beds and free patients than seems possible under group hospitalization plans could be accomplished by avoiding unnecessary expense for idle beds, by establishing a hospital routing plan to prevent the abuse of free services, by organizing a medical service bureau postpayment plan to provide deserving patients with low cost medical and hospital services under an equitable payment arrangement, by obtaining community philanthropic or governmental funds for the care of the patients unable to pay and by encouraging economical and efficient methods of administration. The development of organized care of the sick in their homes and the provision of low cost beds

62. Medical Service Plans, Bureau of Medical Economics, American Medical Association, Chicago, American Medical Association, 1935. Organization of Medical Services, Bureau of Medical Economics, American Medical Association, Chicago, American Medical Association, 1937.

for convalescent patients will also do much to lessen the expense of hospitalized illnesses.

Apparently the superintendents of participating hospitals are well satisfied with the \$3 to \$6 paid under the group hospitalization plans for each patient day. The basic cost for room and board plus the additional costs of the special services included in the hospital service contract seems to be less than the amount paid by hospital service corporations. The per diem rate offered is accepted by member hospitals as sufficient for all services to be rendered under the subscriber's contract. The extra charges for services not included in the contract, which are paid by the subscriber, add to the willingness of hospitals to accept the rate paid by the plan.

One of the previously indicated objections to group hospitalization plans was that the hospital rate might be frozen at a level too low for good hospital service. The slogan "3 cents a day," the idea that rates could be lowered by the offering of discounts and other sales features of the contract placed undue emphasis on bargain prices. Nevertheless, hospital administrators saw that the promised rate of \$3 to \$6 was higher than their actual per diem cost. Consequently, they contracted to provide the services at the stipulated rates. The recent strikes among the lay workers in the hospitals of the larger cities point to an increase in the remuneration of technical employees. A definite increase in the cost of food and supplies has taken place. As a result, some hospitals may have to strain their resources to provide the agreed services at the contracted rates.

Even if the payments do not quite provide for the regular per diem cost, hospital trustees and superintendents are favorably inclined toward the plan because it provides immediate cash payments and lowers collection costs. In

the case of single hospital plans, a fund of money is accumulated that can serve as working capital. It is also held that some of the patients hospitalized under the plan would ordinarily be charity or part-pay patients, so whatever payment is made would be better than that formerly received. Furthermore, since it costs a certain amount to maintain hospital beds ready for service, whether they are used or not, an increase in the number of patients does not necessarily mean a proportionate increase in costs, because services can be rendered for the additional patients without appreciably increasing expenses. Hence the additional patients hospitalized under a group hospitalization plan can be taken care of at less than regular charges. If an actual loss results from the services rendered members, the plan is still acceptable because it gives publicity to hospitals, encourages hospitalization of patients formerly remaining at home and adds to the prestige of the hospital for having "done something." Because of these attitudes, the plan is not held strictly to financial standards.

The financial success or failure of group hospitalization plans cannot be determined if they are subsidized or if costs are not uniformly calculated. When hospitals charge against the funds of the plan only the additional costs incurred by the hospitalization of members and not the total hospitalization costs, or when total hospitalization costs are charged against the plan but not the administrative expenses, strict financial accounting for the plan is impossible. Single hospital plans, using over 100 per cent of the receipts for the hospitalization of members, are nevertheless continued, since the patient day rate paid for members is often larger than the hospital per diem cost. The result is an operating profit for the hospitals, even if the plans are actually managed

at a loss. The hospital association plan which is subsidized by gifts from foundations or by special concessions from member hospitals cannot be considered as financed with premiums from subscribers.

When hospital funds raised by community subscription or philanthropic endowments are used to complete the payments for the costs of hospitalizing members, it seems more imperative than ever that the plan be restricted to persons who are deserving of assistance. The necessity for an income limitation as a condition of membership becomes apparent. Will donations continue to be made to community funds if it becomes known that the funds are used to meet hospital deficits caused in part by the hospitalization under a group hospitalization plan of persons well able to meet their own hospital bills?

Certain hospitals have recognized that the underlying feature of a group hospitalization plan is that it is a collection plan, hospital bills being collected in advance instead of after they have accrued. The deficits incurred by the plan are considered "bookkeeping deficits" because it is believed that in no other way could several hundred thousand dollars worth of accounts be handled with a shrinkage of only a few thousand dollars. The hospital collects more for the services rendered under the advance payment plan than it could have collected from the same clientele without the plan. No doubt this explains much of the appeal of the plan for hospitals, but at the same time it emphasizes the desirability of presenting the plan in its true light.

As a benefit for physicians, it is claimed that the plan relieves the patient of his hospital bill and enables him to pay his physician. Against this possible benefit is the objection that the plan gives the hospital prior claim to a patient's

resources and often enables the hospital to receive full payment from patients who cannot pay the physician. The hospitalization of pay patients in beds endowed for free service is a maladministration of funds secured by donations and endowments as well as an injustice to the physicians who are expected to render free service.

The financial benefits of the plan for physicians are largely illusory. None of the \$50 paid to the hospital for each hospitalized patient goes directly to the physician. The medical services included in the contract are rendered as part of the regular functions of the hospital. The salaried pathologist and radiologist or the technicians are simply called on to do more work. If the pathologist and the radiologist receive a percentage of the profits of the department, they stand to benefit by the plan. Likewise, whether the pathologist and radiologist are salaried or not, the increased patronage under the group hospitalization plan may afford them more consultations and more remuneration.

The medical profession does not object to group hospitalization plans on the ground that the financial benefits are primarily for the hospital. The effect on medical practice by the inclusion of medical services in group hospitalization contracts is the main concern of the medical profession with group hospitalization plans. When physicians become employees and permit their services to be peddled as commodities, the medical services deteriorate and the public which purchases such services is injured. It is for this reason that physicians object to the selling of their services by hospitals or corporations.

Chapter IV

RELATIONSHIP OF GROUP HOSPITALIZATION PLANS TO THE PRACTICE OF MEDICINE

SOME ESSENTIAL CONSIDERATIONS

Why do physicians object to the inclusion of medical services in group hospitalization contracts? Why do most physicians strive to avoid becoming employees of a hospital and resist any control over their services by outside organizations or "third parties"? Is it for monetary considerations, or is it because they are determined to maintain the quality of the medical service they render? Is the insistence of the medical profession on the maintenance of "free choice of physician" and the "personal patient-physician relationship" for the financial benefit of physicians or for the best interests of patients?

A person who requests the services of a physician places himself in the physician's hands presumably because of the physician's knowledge of health and disease. The physician who undertakes to treat a patient is constantly making decisions of life and death importance. For this reason the physician alone must be entirely responsible for the results of his decision, so that he will exercise the greatest care and the best possible skill in his practice. Because of the magnitude of his responsibilities the physician must have an absolute right to choose freely from the methods of treatment that which is appropriate for his patient, and he needs the complete obedience and confidence of his patients to make more certain the anticipated results. These are the essentials for an

effective medical service. They are upheld by tradition and sometimes by law.

No outside person, organization or condition must be permitted to interfere with either the patient or the physician as they strive to achieve that *esprit* which imbues the patient with the will to get well and the physician with the zeal to prevent and cure disease. A system of organizing payments for medical or hospital services which encourages the patient to demand medicines, tests or hospitalization from physicians and to sham illness in order to receive benefits is certain to interfere with proper medical treatment. Likewise, a system which permits some lay administrator to dominate the physician's judgment by limiting the amount and type of treatment or by dictating rules and regulations to govern methods of practice is certain to destroy the essentials of proper medical care.

The quality of medical service is best tested and maintained by guaranteeing prospective patients a free choice of physician. To secure the best conditions for this test, the medical profession has long excluded the incompetent by high educational standards of admission to practice. Medical licensure laws have made this barrier effective. It is also insisted that further preference among those chosen to practice should depend on the ability of the practitioner to convince patrons, by skill and personality, of any individual superiority. To assure that such preference is impartially made, each physician must subscribe to the ethics of his profession, which are designed to promote fair competition. He must not utilize such devices as advertising, rebating of fees or contracts to apportion off a section of the market for himself, thereby to exclude competition with

physicians equally qualified, or perhaps better qualified, to perform the services.

The experience of ages has shown that the best purposes in medical practice are served by maintaining the personal patient-physician relationship. The advantages of this relationship may be stated as follows:⁶³

The physician-patient relationship as ideally found in the private practice of medicine is extremely valuable and every effort should be made to preserve it. Among the reasons for subscribing to this belief, two are perhaps most important: First, the right of the patient to terminate promptly the services of the physician if those services are not satisfactory is, in most instances, a potent and self-operating device for protecting the patient against inadequate medical care; second, the patient who chooses his physician and pays him directly for personal services rendered, is more apt than not to value and, therefore, respect and follow the advice thus sought.

The intimate nature of medical practice demands that the patient have confidence in his physician and that the physician be personally concerned about his patient. If the patient withholds important information from the physician because of lack of confidence, it is impossible for good medical services to be rendered. Similarly, if the patient is considered as a "compensation case" or a "policy holder," the physician may not give his best service.

If free choice of physician is limited and if the personal patient-physician relationship is disturbed, the result is a deterioration in the medical service furnished. Physicians may easily increase their income by advertising, by solicitation, by contracts, by accepting rebates, by patenting new drugs or appliances, by selling their services to some organization which resells

63. Smiley, D. F.: The Place of Student Health Work in the Educational and Medical Scheme of Things, Bulletin 17, Proceedings of the Fourteenth Annual Meeting of the American Student Health Association, December 1933, p. 25.

them to the public and by utilizing other devices to peddle their services. However, where such conditions exist, the medical services become inferior and the public is injured. Professional, and sometimes legal, opposition to these practices is for the purpose of protecting the *patient* by maintaining standards of quality. It is a curious paradox that the principles of medical ethics are so frequently berated and denounced by those for whom these principles afford protection. The principles of medical ethics are often twisted by these persons into "trade rules by means of which physicians get rich"! However, without those essential ingredients in medical practice which are provided by the principles of medical ethics, medicine would become a huge racket capitalized on human misery, subservient to greed and unmindful of truth and honesty.

It should be clearly understood that the medical profession, in insisting on safeguards of the quality of medical service, does not oppose *all* plans for the organization of medical services. The medical profession has never opposed plans which do not prohibit free choice of physician nor alter the personal relationship between the patient and the physician.

Physicians should know what is good and what is bad for medical practice. The noble history of medicine should convince the public that the medical profession, in viewing any proposal for the organization of medical and hospital services, gives first consideration to the welfare of the sick person. When a person is ill and his physician prescribes a certain treatment, that person usually follows his physician's advice. In a similar manner it would be well to follow the advice of physicians that certain *plans* are as dangerous and inappropriate in distributing medical services as certain drugs or treatments are in the control of disease.

THE ATTITUDE TOWARD GROUP
HOSPITALIZATION PLANS

The primary concern of the medical profession with group hospitalization plans is to see that such plans do not destroy the basic features of medical service or permit hospitals to practice medicine. If hospitals are allowed to include medical services in contracts for the sale of hospital facilities, the precedent is set for institutionalized contract medical practice with all its destructive effects on the art and science of medicine. The Judicial Council of the American Medical Association has stated succinctly: ⁶⁴

Whether the scheme [meaning group hospitalization] is or is not financially or economically sound is not the problem of our organization, but it is our business to see that the furnishing of medical service is not included in the sale of insured hospital accommodations.

It cannot be claimed that group hospitalization plans merely have to do with the payment for hospital services, because the services themselves are directly furnished. Neither can it be claimed that medical services are not included, because it is clear that anesthesia, radiologic, pathologic and other special medical services are included in most group hospitalization contracts. These services are universally held to constitute the practice of medicine whether performed by hospital employees under the direction of salaried physicians or by a physician who is practicing privately and has no contractual arrangement with the hospital. Whether physicians are salaried or not, they are governed by the Principles of Medical Ethics, which include the principle that:

It is unprofessional for a physician to dispose of his professional attainments or services to any lay

⁶⁴. Report of the Judicial Council, Proceedings of the House of Delegates, 1936, p. 37.

body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

If physicians fail to register a strong protest against the inclusion of medical service in the hospital service contract of group hospitalization plans, they cannot consistently object when at some future time other special medical services are added to the contract. The attitude of the directors of many group hospitalization plans and the possible accumulation of reserves are tendencies that point to the inclusion of more medical services in the hospital service contract.

Why do physicians maintain that the inclusion of medical services in hospital service contracts is harmful to medical practice and ultimately will be harmful to the patient? For years physicians and hospital administrators have been trying to develop the most equitable arrangement for anesthesia, radiologic, pathologic and other special medical services in hospitals. The arrangements in many hospitals to afford patients more ready access to special medical services have not been entirely satisfactory to the physicians or to the hospitals concerned and have often prevented the best medical practice. Recently, in some of these hospitals a more satisfactory relation between the physician performing special services and the hospital seemed to be in view. However, hospital service contracts which include medical services accentuate and perpetuate the very condition that the medical profession and some

hospital authorities have sought to improve. Group hospitalization plans do not create any particularly new problems between the physician and the hospital, but they do force the continuation of undesirable practices and relations which existed before group payments for hospital facilities became a popular movement. The effect of group hospitalization plans on each of the special medical services will be shown in detail.

ANESTHESIA

In the early history of anesthesia a physician had greater opportunities in surgical work and in general practice than in the limited field of anesthesia. This may account for the failure to train medical anesthetists. The nurse anesthetist was, therefore, called into existence. Since anesthesia induced by inhalation of a gaseous agent required a relatively simple technic, surgeons and hospitals found that nurses could be trained to administer general anesthetics. Under the policy of using nurse anesthetists adopted by hospitals and surgeons, it is not surprising that nurse anesthetists became more numerous than medical anesthetists.

In the meantime, the practice of anesthesia has undergone a tremendous transformation. In addition to ether, the nurse anesthetist administers nitrous oxide, ethylene, cyclopropane and a few other anesthetics. When these are compared with the great many other anesthetics, it is apparent that the services of nurse anesthetists are limited. The dosage and administration of these other anesthetics is a challenge to the knowledge and experience of the keenest physician. Endotracheal, intravenous and spinal anesthesia are often used to facilitate surgical work and to safeguard the patient, but they can be properly administered

only by a medical anesthetist. The development in the administration of anesthetics is illustrated as follows:⁶⁵

A few years ago it was: "Drop a little ether on here," or, "Give this patient a few whiffs of gas," or, perhaps, "Soak it to him; can't you get him down?"

But more recently the evolution of the practice of anesthesia has become much more complex and refined, due to new agents, new methods and new machines.

Now, what should be expected of the anesthetist before operation? He should be able to evaluate the risk by

Physical examination,
Correlating the laboratory findings, and
Estimating the probabilities of the proposed operation.

He should be able to choose the most suitable pre-medication and the most suitable anesthetic from a knowledge of their pharmacologic action. The past few years have seen the introduction of the barbiturates, avertin, vinethene, cyclopropane, evipal, pentothal, pontocain, nupercain—each with its own technique.

He should know the pharmacology of these and their antidotes; such as saline infusion, CO₂, coramine, caffeine, metrazol, and picro-toxin.

He should know the physiology of the respiratory and circulatory systems.

He should know the anatomy of the spine and spinal nerves, and be able to make a neat spinal tap.

He should know the anatomy of the larynx and be able to properly place airways and intratracheal tubes.

During operation he must diagnose the condition of the patient moment by moment; noting respiration, pulse rate and tension, blood flow, temperature, color and moisture of skin, eyes, movements of chest and abdomen, muscular relaxation, sounds, and psychology if awake.

He must treat the patient moment by moment, varying the anesthesia according to its controllability and the needs of the surgeon; but not neglect his own job to inspect the operation.

He should recognize danger signals and be ready to apply remedies for respiratory depression or obstruction, shock, chilling, vomiting, convulsions, etc.

⁶⁵. Dill, Wallace W.: Anesthesia: Is It the Practice of Medicine? Pittsburgh Med. Bull. 26: 53 (Jan. 16) 1937.

He should be able to advise the surgeon when to modify or suspend his procedure.

After operation he should be able to give instructions regarding position of patient, position of bed, resuscitation measures, and whatever will facilitate reaction.

He should be able to shoulder a licensed physician's responsibility for his part of the operation, reducing by that much the responsibility of surgeon and hospital, in case of legal complications.

The safety of ether was a large factor in the development of nonmedical personnel in the administration of anesthetics. These persons, trained in the technic of ether inhalation, progressed into the use of other gases, such as nitrous oxide and ethylene, and became familiar with the new machines and apparatus for the administration of anesthetics. The young graduate physician with little training in anesthesia could not be expected to be familiar with the machinery use and as a result was not considered as competent as the trained nurse with experience. A concise summary of the place of nurse anesthetists in America was given by a foreign physician who visited this country for a study of the problems of anesthesia: ⁶⁶

No account of American anaesthesia would be complete without some reference to the delicate subject of nurse anaesthetists. It is a phase of anaesthesia of which we in Australia are fortunately free. The startling fact was soon elicited that 97 per cent of the anaesthetics in the United States of America are administered by nurse anaesthetists. The reason of this, to us, almost incomprehensible position are as follows: (i) Until within the last few years the medical student received practically no instruction, theoretical or practical, in anaesthesia. Even a hospital intern or resident medical officer learned little or nothing of the subject. The result was that the average general practitioner started his professional life not knowing how, and in many cases not wanting to know how, to give an anaesthetic. (ii) The hospital authorities soon learned that to employ a nurse anaesthetist at \$120 a month, instead of a qualified medical anaesthetist, was to their economic advantage. (iii) To

66. Troup, Gilbert: *Anaesthesia in America*, M. J. Australia 2: 862 (Dec. 21) 1935.

supply the demand due to lack of trained medical anaesthetists, professional nurse anaesthetists have arisen, with their own strong association, who can automatically administer a moderately good routine anaesthetic of ether or even gas-oxygen-ether. Their knowledge of physiology, pharmacology, and pathology is, of course, lamentably lacking, but they do what they are told by the surgeon, who incidentally in many cases fails to recognize the advantages of modern anaesthesia.

In this connection it is of interest that in England the Code of Ethics permits only physicians to administer anesthetics. Likewise, any physician who gives an anesthetic for any one but a registered physician or dentist is subject to removal from the medical register.

However, it is apparent that a change is taking place in the practice of anesthesia in America. As stated by one anesthetist: ⁶⁷

Today, anesthesia is coming into its own. The great teachers, like Lundy, Waters, and Sise, are showing the young graduates the possibilities of this branch of medicine, and the demand for instruction is rapidly exceeding the supply of instructors. Even in smaller communities younger men are trying to become proficient, that they may be the choice for the anesthetic work at their local hospitals. Anesthesia is a part of the practice of medicine, and as such should be carried out by doctors. In some states legal methods have been tried to prevent its practice by others, but it is obvious that the eventual solution must be an adequately trained medical personnel. But as Waters says, this takes time—at least three years' intensive training for an average medical graduate.

Forward-looking surgeons are encouraging the development of physician anesthetists. . . . In Boston we have established the Boston Anesthesia Service, under the workings of which, for one telephone call, a surgeon may secure a medical specialist in anesthesia. Similarly through the Central Directory for Nurses, he may secure a nurse anesthetist. The choice is directly up to him. I think the eventual outcome may safely be left to advanced surgical and public opinion.

67. Sheldon, Russell F.: Remarks on the Safety of Ether, from Twenty-Five Years' Experience in Its Use, *Anesth. & Analg.* 16:7 (Jan.-Feb.) 1937.

The strongest advocates of nurse anesthetists are willing to agree that a well-trained medical anesthetist is superior to a well-trained nurse anesthetist. The difficulty is the shortage in skilled medical anesthetists and the disturbances that will be created in transferring the administration of anesthesia from nurse anesthetists to medical anesthetists. However, the opportunities for increasing the number of medical anesthetists are favorable. At present there are thirteen hospitals in the United States which are considered by the Council on Medical Education and Hospitals as capable of furnishing acceptable residencies in anesthesia. Such hospitals have steadily increased in number, and in addition there are now twenty-nine which offer courses in anesthesia for graduate physicians.

One large hospital made a change in the administration of its anesthesia service from that of nurse technicians supervised by a graduate in medicine to an organization of medical graduates exclusively with a full-time director. A residency in the specialty of anesthesia was created comparable in length and scope of training with other recognized specialties. The necessity for the change was indicated by the following: ⁶⁸

. . . Recent advances in the practice of medicine have given anesthesia many opportunities and have widened its field of usefulness. The constant increase in complexity and severity of surgical manipulations, the more liberal use of inhalation therapy, the increasing demand for therapeutic and diagnostic nerve blocking, the advanced methods and more opportunities for the practice of resuscitation, the almost daily introduction of new methods and drugs for sedation and hypnosis have contributed to make the practice of anesthesia more and more specialized despite its definite appointment as an accessory to other specialties.

68. Rovenstine, E. A.: Anesthesia at Bellevue Hospital, *Hospitals* 10: 84-88 (June) 1936.

. . . The staff, being composed mostly of nurse technicians who were trained in inhalation methods only, did not participate in the conduct of anesthesia by spinal, regional, intravenous, or other routes and had little or no responsibility in the preliminary or post-operative care of patients. Instruction to the house staff was neglected and there were no facilities for post-graduate training for physicians. Clinical and laboratory investigations by the staff were rarely attempted.

After one year of experience with a medical organization of the anesthesia service, which was accomplished without increased expense and which faced difficulty in the supplanting of nurses and technicians with physicians because anesthesia was not so attractive as other specialties, a consideration of the reported results indicates that when the anesthesia service is so organized it is more satisfactory. A few of the resultant benefits were stated as follows:

It is evident that one problem, that of securing the services of any anesthetist when needed, has been practically solved. There is now an immediate response to every request for anesthesia.

The duties of the "ether nurse," a nurse in the operating room assigned to assist the anesthetist, have been minimized to the extent that she may devote practically all her time to other duties. This has presented an opportunity for improving the service of nurses at operations.

. . . Endotracheal anesthesia for operations about the upper air passages, and cyclopropane anesthesia in thoracic surgery, may be cited as examples where surgeons have expressed an opinion that a definite advance was made. Utilization of the less toxic agents for minor and superficial procedures has evidently reduced nausea and emesis and the other minor sequelae and consequently simplified post-operative nursing care for these patients.

A rather abrupt indicator of the difference between nurse anesthetists and medical anesthetists is that nurse anesthetists have not con-

tributed anything of importance to improve the practice of anesthesia, whereas many noteworthy contributions have been made by medical anesthetists.

The tendency is for anesthesia to progress toward an increasingly important position in the practice of medicine. It is also noticeable that considerable attention is being given to the transference of anesthesia from nurse anesthetists to medical anesthetists. The influence of group hospitalization plans on these developments in anesthesia is far reaching. Under the plan the hospital is paid a specific amount for every anesthesia administered, or a flat sum per patient day is paid to the hospital out of which the hospital meets the expenses of the specified benefits including "anesthesia when administered by a salaried employee of the hospital."

The attitude of anesthetists toward such inclusion of anesthesia in group hospitalization contracts was expressed by the following resolution, which was passed by the Boston Society of Anesthetists after a series of conferences with anesthetists from New York, Rochester, Washington and other places during the Congress of Anesthetists in Philadelphia:⁶⁹

Resolved: that it is the sense of this Society that the hospital prepayment plan as at the present drawn up would, if the anesthetists should be included, tend to reduce them toward the position of technicians, would tend to place them under the control of the hospitals and would set them apart from other branches of medicine; that these influences would tend to stop progress in anesthesia and to push the practice of anesthesia back to its status of a few decades ago, and would ultimately result in poorer service to the patient; and that for these reasons the Society stands against being included in the contract as now proposed.

69. Attitude of Anesthetists Toward Hospital Service Plan, New England J. Med. 216: 481 (March 18) 1937.

This resolution resulted from the belief that under group hospitalization plans "it would be financially advantageous for hospitals to furnish lay technicians in anesthesia"; that "patients and surgeons would not have a free choice of anesthetists unless the patients were to pay a second time for anesthesia service"; that "price competition between physicians and lay technicians would be accentuated"; that "anesthesia would gradually pass from the control of physicians to the control of hospitals"; that "this condition would tend to halt the progress in anesthesia that has been so noteworthy in the last decade"; and that "the administration of anesthetics is the practice of medicine and therefore, it is not a suitable service for hospitals to sell or for lay technicians to practice."

Whatever the argument for or against the nurse anesthetist, the problem should be solved according to merit. If medical anesthetists are superior, they may eventually supplant nurse anesthetists. If such an evolution is imminent, it should be allowed to take place. No forcing by legislation or coercion of any sort is desirable. Neither is it desirable to prevent the medical anesthetist from practicing anesthesia by selling a hospital service contract which includes anesthesia only if rendered by a nurse anesthetist.

Hospital administrators and surgeons cannot conscientiously continue to oppose the development of medical anesthetists by insisting on the use of nurse anesthetists, if the furtherance of the practice of anesthesia is more certain in the hands of medical anesthetists. However, when the anesthesia service is sold in a contract which specifies the use of nurse or salaried anesthetists, the progress toward medical anesthetists is stopped. It is unlikely that a patient holding such a contract will be willing to pay a separate fee for the use of a medical anesthetist.

RADIOLOGY

Since 1920 there has been a growing complaint that lay practitioners, technicians and others were acquiring the technic and machinery used by radiologists and were competing with radiologists for the patronage not only of patients but also of physicians. Such conditions may have been encouraged by the attempt of certain physicians to perform radiologic services for which they were not qualified.

These circumstances led the House of Delegates in 1928 to assign to the Council on Medical Education and Hospitals the task of supervising and certifying those who claimed to be radiologists. The Council, assisted by a committee of prominent radiologists, prepared the "Essentials for Admission to List of Physicians Specializing in Radiology." The object was to provide a list of physicians who were qualified radiologists. The first list published in 1931 contained 930 names, and the final published list contained 1,286 names. By means of this list and by outlining definite requirements for radiologic service in hospitals to be approved for training of interns, the Council has served as an educational force in elevating the standards of radiologists and in curbing the attempts of lay practitioners and technicians to practice radiology. The standards for radiologists were further improved with the formation of the American Board of Radiology in 1933 to determine the competence of those who profess to be radiologic specialists.

Largely because of the expensive equipment required, hospitals have held an important position in the field of radiology. While the radiologist was becoming recognized as a medical specialist, the hospitals assumed considerable responsibility and financial deficits in

developing their departments of radiology. For a time the making of "x-ray pictures" was delegated to photographers and amateur electricians. Because of the employment of such technicians and the necessity for extensive apparatus, it was commonly believed that radiology was a laboratory specialty. This impression fostered the notion that the technologic element was dominant. Furthermore, some hospitals were long accustomed to employ their radiologists on a full-time basis, paying them salaries or agreeing to a certain division of the income from the department of radiology. Frequently the payment arrangement resulted in a considerable profit for the hospital.

With the development of standards for radiologists, it was not surprising that the relation between radiologists and hospitals became acute. The radiologists held that only a physician fully trained in radiology was competent to practice radiology and that the technicians employed and the policies adopted should be under his jurisdiction. The hospital administrators maintained that the department of radiology consisted of two elements: the technical and the professional. The roentgenographic equipment and the services of lay assistants in the making of roentgenograms were considered as technical services of the hospital. The hospital claimed jurisdiction over the technical portion of radiology and insisted that only the interpretation of roentgenograms and the therapeutic use of the roentgen ray were professional services. The radiologists insisted that the practice of radiology could not be divided into professional and technical portions any more than the practice of surgery. They claimed that the technical aspects of radiology must at all times

be under the supervision or control of a competent radiologist.

At about this juncture group hospitalization plans were organized by hospitals, and hospital service contracts were offered which often included roentgenologic service and sometimes provided roentgen and radium treatments. As a consequence, the relation between radiologists and hospitals became still more acute. The hospitals or the corporations representing hospitals insisted that the roentgenologic service included in most contracts was simply the use of the facilities of the hospital and the services of technicians, which in no manner constituted the practice of medicine. The promoters of group hospitalization plans maintained that there could be a separation of the technical service from the professional practice of radiology and that technical services could be sold as a contract benefit. The discontent raised by this attempt to include radiologic services as a contract benefit can best be shown by the official actions of groups intimately concerned with radiology.

The following resolution was presented by the Board of Chancellors of the American College of Radiology in February 1934 to govern the arrangements which relate to the practice of radiology: ⁷⁰

WHEREAS, It has come to the attention of the American College of Radiology that certain practices are now in operation in many localities adversely affecting the practice of radiology and the best interests of the patient, and that others are proposed which are not only prejudicial to radiology but to the practice of other branches of medicine, namely, the charging of fees for roentgenological examinations on a flat rate basis, the fee being charged and collected by the hospital, and the proposal that a group hospitalization plan should include roentgenological and other medical services; and

70. Am. Coll. Radiol., Bull. 1, 1934, p. 6.

WHEREAS, The American College of Radiology adheres to the principle that a hospital is a cooperative enterprise of the physician on the one hand furnishing medical care, and of the hospital on the other hand furnishing hospitalization, and that the physician is in no sense an employee of the Hospital, and

WHEREAS, The principle is now well recognized by the American Hospital Association, the American Medical Association and other national medical organizations, that hospitals should not enter into the corporate practice of medicine; and

WHEREAS, Radiology is recognized as a medical specialty by the American Medical Association and the medical profession in general, and the practice of radiology is the practice of medicine;

Therefore, Be It Resolved, by the American College of Radiology, through its Board of Chancellors, that all such practices are hereby condemned as prejudicial to the interests of the medical profession and the laity and contrary to sound public policy; and

Be It Further Resolved, That a copy of this resolution be sent to the Council on Medical Education and Hospitals and to the Bureau of Economics of the American Medical Association, the American Hospital Association and the American College of Surgeons, and to such other organizations as the Commission on Medical Economics may determine, with a letter of transmittal, requesting the support of the above named organizations in combating such practices.

In 1934 the Section of Radiology of the American Medical Association sent the following petition to the House of Delegates:⁷¹

WHEREAS, It has been reported to the officers and members of the Section on Radiology of the American Medical Association that an intolerable condition exists between certain otherwise acceptable hospitals and their departments of radiology; and

WHEREAS, It is known that in several such hospitals the business management does the collective bargaining for x-ray business with staff members and outsiders to the detriment and the professional and financial loss of their staff roentgenologist; and

WHEREAS, Such practice is not only unethical but places such hospitals on a direct competitive medical

71. Proceedings of the House of Delegates, 1934, p. 33.

practice basis with their respective roentgenologists, which practice has been declared illegal in several states; and

WHEREAS, the practice of roentgenology or radiology is ipso facto the practice of medicine and cannot be separated therefrom; be it therefore

Resolved, That the House of Delegates of the American Medical Association go on record as opposing the exploitation of members of their own body in the manner outlined; and be it further

Resolved, That the House of Delegates of the American Medical Association in session duly assembled orders this resolution to be referred to the Council on Medical Education and Hospitals for the study and formulation of plans tending to the abatement of these highly unprofessional and obnoxious evils.

At the 1936 Session, the Reference Committee on Medical Education in considering two resolutions, one directing the Council on Medical Education and Hospitals to take steps that would result in the practice of medicine being conducted by physicians and not by hospitals and the other disapproving of the division of any branch of medicine into technical and professional portions, reported as follows:⁷²

1. It reiterates the principle enunciated by the House of Delegates at Cleveland in 1934 "That the practice of radiology, whether for diagnostic or therapeutic purposes, constitutes in fact the practice of medicine." The action of the House of Delegates in 1925 establishing a section on radiology confirms this principle.

2. It further recommends that all services connected with the practice of radiology be under the direct control and supervision of the medical profession, and this same principle pertains to other technical and professional services.

To clarify the position of hospitals in the widening breach between physicians and hospitals, the Board of Trustees of the American Hospital Association adopted the following as

72. Proceedings of the House of Delegates, 1936, p. 45.

a statement of principles and relations between radiologists and hospitals: ⁷³ .

In view of the current discussions concerning the relationship of radiologists to hospitals and because of the desirability of protecting the public, of maintaining radiological services of high efficiency, and of safeguarding the hospitals, the hospital radiologist and the interests of the nonhospital radiologist, the following basic principles are hereby approved by the Board of Trustees of the American Hospital Association.

1. The radiological service of the hospital shall be maintained primarily for the benefit of the sick.

2. Every hospital radiological department should be under the direction of a competent radiologist, preferably a diplomat of the American Board of Radiology (in Canada this would read "American Board of Radiology or an equivalent body") or one who is working toward that objective. If, because of size or isolation, such arrangement be not feasible, some member of the general medical staff trained in radiology should be in charge and a consultation service arranged with a nearby radiologist.

3. The radiologist is entitled to recognition as a professional member of the medical staff and as head of a hospital department.

4. The preservation of the unity of the hospital and its component departments and activities is an essential administrative principle. This principle can be maintained without any infringement on professional rights or professional dignity.

5. Inasmuch as no one basis of financial arrangement between a hospital and its radiologist would seem to be applicable or suitable in all instances, that basis should be followed which would best meet the local situation. This may be on the basis of salary, commission or privilege rental, but in no instance should either the hospital or the radiologist exploit the other or the patient.

6. When an arrangement is effected whereby the radiologist of the hospital pays a rental for space and service, cares for nonpay patients and in return retains all private fees collected, such contract should clearly cover the matter of depreciation of equipment, replacements and additions, should protect the radiologist against excessive nonpay work and should take into

73. Resolution of the Board of Trustees of the American Hospital Association (mimeographed copy); *Hospitals* 11:66 (July) 1937.

consideration the "goodwill" by virtue of which a large proportion of the paying clientele is attracted.

7. The American Hospital Association views with disapproval the proposal that the actual cost of films and associated overhead be separated from the professional charges of the radiologist or that the responsibility for this department be divorced from the hospital. While in many instances this would be a financial relief to the hospitals, it would probably result in frequent omission of the radiological consultation with a specialist in radiology, would mean less efficient radiological service with potential legal complications and would tend to create difficulties with national and other organizations requiring supervision of the radiological work by a competent radiologist.

Despite the dissatisfaction shown by physicians toward the inclusion of their medical services in contracts for the sale of hospital facilities, the selling of group hospitalization contracts which embody medical services has continued. Consequently, the four radiologic societies: the American Roentgen Ray Society, the American Radium Society, the Radiological Society of North America and the American College of Radiology, created by joint action the Radiological Inter-Society Committee to coordinate and express the views of the American radiologists. The following letter sent by the Committee in February 1937 to physicians throughout the United States dealt specifically with group hospitalization plans and their effect on radiology:

In order to better coordinate the activities of the Radiological Societies of America, and to more clearly and authoritatively set forth the views of American radiologists, the National Societies named above have constituted a joint committee to represent them in such matters as may be considered pertinent to the purposes for which the Committee was formed.

This Committee, representing all of the National Societies of radiologists, and thus practically all radiologists of America, notes the gift by the Julius Rosenwald Fund to be used for the furtherance and betterment of voluntary Hospital Service plans. Like

all physicians, radiologists are interested in such plans, and are anxious to cooperate fully in their organization and operation. It is undoubtedly true that the majority of American families are poorly prepared to meet the sudden demands of severe illness, and constructive steps toward enabling such demands to be met should be encouraged and supported by all physicians and by their clientele. Not only as physicians, but as citizens, we have the strongest desire to cooperate in the study and the furtherance of hospitalization plans, and anticipate the day when the hospitalization of all those who may come within their scope shall be under a hospitalization service plan, and it is our strongest desire to engage in friendly discussion with your committee concerning the exclusion of medical services and especially radiological practice from group hospitalization plans and contracts.

Simply stated, the questions which concern us most deeply are these: Shall Radiology be included in Voluntary Hospital Insurance plans? If this question is answered in the affirmative, then shall it be included as, (a) a hospital service, or (b) as a medical service so closely allied to hospital service as to be inseparable in practice, but to be paid for by indemnification? If it can be established that Hospital Insurance plans are not feasible without the inclusion of Radiology, then the answer to our first question *must* be in the affirmative and we must pass at once to the second question and bend all our efforts toward its satisfactory solution.

But can it be so established? Is it essential that X-ray services be provided as part of hospital service, and will it be possible to devise satisfactory and workable plans for its inclusion? To these questions we are constrained to answer: "NO." No one disputes the thesis that Radiology is a medical specialty, that it is a department of the practice of medicine, and that its practitioners are and must be physicians. This being true, then it is not difficult to see that if X-ray services are included in a hospital insurance plan, surgical, obstetrical, and urological services could be included with equal propriety. When such services *are included*, we will have taken irrevocable steps toward the complete socialization of both Medicine and Hospitalization, and Compulsory Health Insurance will be upon us.

To argue (as has been done) that only the so-called "technical services" will be included, is to state a thesis incapable of being successfully defended. No professional procedure can be divided into parts

without the fatal wounding of that professional procedure. No one conversant with the problem can have any doubt but that such separation will result in two things: the ruin of a medical specialty, and increasingly poor practice within hospitals. Examples and arguments can be drawn at great length but are not necessary here. We will be glad to amplify any of these points to any degree if you deem it advisable.

May we call your attention to the fact, known to you, of course, that the oldest and most successful of the plans now in operation, namely, the Baylor (Dallas, Tex.) and Washington, D. C. plans, do not include and never have included X-ray services? The Memphis (Tenn.) plan has lately discontinued its X-ray benefits. The Alameda County (Cal.) plan furnished X-ray and clinical pathology as a medical service, but does so by indemnifying its subscribers for the amounts expended by them. The Intercoast Society (Cal.) has a like provision. It would seem, therefore, that it is possible to operate these plans without the inclusion of these medical services.

May we not ask you, then to consider carefully, and to consult further with us, before making any recommendations which may not only destroy a medical specialty, but may lead to a lowering of hospital standards, to a lessening of the value of the service received by patients, and may even result in placing numerous hospitals in the unenviable position of violating the several Medical Practice Acts.

We will welcome inquiry or further discussion, and beg the privilege of bringing you the opinions, reactions, and joint experience of the Radiologists of this country.

Obviously, these resolutions and actions of medical societies, special medical groups and hospital associations throughout the United States point to the unanimous opinion that radiology is the practice of medicine. The courts have been fairly definite and uniform in maintaining that hospitals and corporations cannot practice medicine. The question is: Will hospitals and hospital service corporations operating group hospitalization plans recognize that the taking of roentgenograms and "routine x-ray examinations" are as much the practice of medicine as the interpretation of the roent-

genogram or the use of the roentgen ray and radium in the treatment of patients? To insist that the technician can take the roentgenograms and that the patient's own physician can interpret them is a retrogressive step. The trend in practically every type of medical practice is to discourage if not actually to prevent physicians from undertaking work for which they are not definitely qualified. The hospital certainly should not encourage lay persons to take roentgenograms or unqualified physicians to interpret them.

It seems inconsistent for hospital administrators who urge greater proficiency for those who would supervise or administer hospitals to contend that certain radiologic services do not require professional control and can be performed by technicians. Even the technical work of producing roentgenograms directly involves the patient in medical procedures. The Executive Committee of the Pacific Roentgen Club indicated the following reasons for considering the taking of a roentgenogram as a medical procedure:⁷⁴

(a) It involves the penetration of the human body by a very dangerous physical agent. In this sense, it is as much a medical procedure as the administering of drugs intravenously, subcutaneously, or by any way other than the patient's own conscious act.

(b) A knowledge of medical anatomy and at least a working knowledge of gross pathology is necessary to properly direct the angles of projection in order to demonstrate the various parts involved, and in some cases a knowledge of diseases is required really to know what is to be shown.

(c) Medical judgment is required to decide the adequacy or inadequacy of the films obtained.

(d) The making of films is part of the examination of ill, often seriously ill, persons and thus should be under the immediate direction of a physician (roentgenologist).

74. The X-Ray Problem and a Solution, editorial, *Radiology* 23: 635 (Nov.) 1934.

In addition there are definite limitations in the roentgen method of diagnosis that only a trained radiologist can recognize.⁷⁵ For example, osteomyelitis cannot be detected until alterations have taken place in the structure or chemical constituents or contents of the bone cells. Most gallstones cannot be seen on the roentgen plate as the atomic weight of the stone so closely resembles that of the surrounding bile. Cartilage does not, in the usual way, cause roentgen shadows; hence, requests for diagnosis of fractures of the costal cartilages, of the semilunar cartilages of the knee and of the wrists of small infants should not be made. Even such an apparently simple phase of radiology as the making of roentgenograms of fractures calls for a knowledge of anatomy. Certainly in the more intricate branches of radiology the correct position of the patient is essential for the making of an accurate roentgenogram which will permit a proper diagnosis.⁷⁶ As an example of difficulties involved in roentgen diagnosis unsupervised by a radiologist or a roentgenologist, a case is cited⁷⁷ in which a technician made the plates for an emergency examination of a patient with involvement of the frontal sinus, and because the sinuses did not show the diagnosis by the attending physician was that the sinuses were filled with fluid. The patient, however, was a child of the age at which the frontal sinuses were not well formed.

The problem cannot be solved by insisting that the radiologic services be included in the group hospitalization contract but that the radiologist be the one to take the roentgenograms and interpret them. To do so places the

75. Van Allen, Harvey W.: *The Limitations of the Roentgen Method of Diagnosis*, *New England J. Med.* 215: 482 (Sept. 10) 1936.

76. Teall, C. G.: *Whither Radiology*, *Brit. J. Radiol.* 9: 9 (Jan.) 1936.

77. Footnote 75, p. 484.

hospital or the hospital service corporation between the physician and his patient. Corporations are frequently proscribed from practicing medicine, even though they attempt to do so through the medium of salaried employees who are physicians. This legal attitude toward the practice of medicine has been taken for the purpose of promoting the safety, health and welfare of the people. If the physician becomes an employee, he is entitled to immunity from responsibility for his employer's misconduct. Hospitals and corporations cannot be held to an examination to determine their ability to render good medical services. Hence, it is deemed necessary for the best interests of the public that only individual physicians who can be subjected to examinations for medical licensure should be allowed to practice medicine. In regard to radiology, it can be concluded that the hospital service contract which includes radiologic services introduces conditions considered by the foremost radiologists and by all the national radiologic societies in the United States to be injurious to the practice of medicine.

PATHOLOGY

The important position of the laboratory as an auxiliary in the field of diagnosis and therapy is now well established. The marshaling of medical forces for the World War placed emphasis on auxiliary laboratory aids. On their return from military service, physicians demanded similar technical assistance from their local communities or hospitals. Laboratories and more laboratories were called into existence. However, trained personnel to staff these laboratories was lacking. At one time the interns were burdened with most of the laboratory work, but the advantages of employing lay technicians became evident. Technical assistants, properly trained, were almost indis-

pensable to the smooth handling of the increased work in laboratories. Unfortunately, overemphasis on the use of technicians often resulted in only a gesture at sufficient laboratory training of interns and medical students. Even the necessity for the supervision and direction of a laboratory by a qualified pathologist was not adhered to. The fulfilment of the immediate need for additional workers in the laboratory resulted in less attention to the complete training of such workers and, as a consequence, an insufficient number of qualified pathologists resulted.

The deficiency in trained personnel was so great by 1924 that the Council on Medical Education and Hospitals began the publication of annual lists of approved laboratories where the pathologic and clinical pathologic work was at least supervised by qualified physicians. In 1931 the system of listing approved laboratories was changed to one of listing individual physician-pathologists according to a minimum standard of qualifications. In 1926 the American College of Surgeons also specified as a minimum standard for laboratories that the director be a graduate in medicine and especially trained in clinical pathology. In 1936 the American Board of Pathology was formed to certify physicians as qualified pathologists. As a result of these actions, an increasing number of hospitals throughout the country employed qualified physician-pathologists instead of placing the pathologic service in the hands of technicians under nominal or no supervision. Likewise, commercial laboratories under lay direction received less and less patronage. Because of the encouragement of physician-pathologists, a clinical pathologist for every approved hospital now seems possible of realization, at least on a part-time basis.⁷⁸

78. Hilkwitz, Philip: A Clinical Pathologist for Every Approved Hospital, *Am. J. Clin. Path.* 7: 1 (Jan.) 1937.

Despite the improvement in qualifications and number of clinical pathologists, more than one fourth of the clinical laboratories in the United States are directed by persons other than physicians.⁷⁹ Three conditions are largely responsible for the tendency to continue to use technicians instead of physician-pathologists: an insufficient number of pathologists to fill all of the positions of lesser importance; the impression among lay persons, and some physicians as well, that laboratory work is technical and not diagnostic; and the capitalization of this belief by hospital administrators who own and operate their own laboratories.⁸⁰ Along with the improvement in qualifications of the physician-pathologists, steps have also been taken to determine and improve the competence of technical assistants. For example, the Registry of Technicians of the American Society of Clinical Pathologists and the approval of schools for clinical laboratory technicians by the Council on Medical Education and Hospitals are indicative of the elevation of the standards for laboratory technicians. The use of competent technical workers under the supervision of qualified physician-pathologists is the goal desired. The insistence by the organizers of group hospitalization plans that lay technicians can perform many of the important pathologic services is an attempt to reverse the developments toward a more extensive use of competent physician-pathologists.

Pathologists seem to have been less vocal than radiologists or anesthetists in resenting the encroachment on their profession by the growing practice among hospital administrators to use lay technicians wherever possible.

79. Hospital Service in the United States, *J. A. M. A.* 108: 1050 (March 27) 1937.

80. Johns, F. M.: Establishing Certification and Regulation of the Practice of Pathology, *Am. J. Clin. Path.* 6: 326 (July) 1936.

This may be due to the fact that the mechanical laboratory work in the pathologic service is greater than in the radiologic or anesthesia services. The examination of specimens and cultures and laboratory procedures are completed separate from the examination of the patient, and the personal relationship between the patient and the physician is much less close in pathologic work than in the other specialties. It is not surprising, therefore, that the contract sold by group hospitalization plans is most liberal in including "laboratory" benefits. While the services of the pathologist, in consultations or for the direct interpretation of the laboratory findings, are only infrequently made a benefit, the usual hospital service contract does include such services as urinalysis, blood count, chemical examination of the blood, examinations of the spinal fluid, smears and cultures, examination of tissue and gastro-intestinal and basal metabolic tests.⁸¹

Again, the influence of the hospital service contract on pathology is essentially the same as on radiology or anesthesia in that an attempt is made to separate technical from professional services. Such a separation minimizes the importance of the professional services and ultimately will damage the value of the entire service. To place a share of the practice of pathology in the hands of technicians trained only in the mechanics of the laboratory may appear to reduce the cost of laboratory service, but this apparent reduction in cost may obscure the more important fundamental issues. Medical students and interns must be encouraged to train themselves for greater proficiency in pathologic work. This can be accomplished only by insisting on standards of education before admission to practice. If technicians or physicians not

81. See pages 68-70.

specifically trained in pathologic work are permitted to direct laboratories, what incentive remains for students to train themselves as qualified pathologists?

The alleged infallibility that has been placed on laboratory diagnostic aids, which is greatly encouraged by the advertising of these devices by group hospitalization plans, is unfortunate. The public has been sold so completely on the wonderful machinery in laboratories that the more important human skill is held to be second rate in importance and accuracy. Lord Horder gave expression on this subject in the following words: ⁸²

. . . The public has come to believe that machinery is revolutionizing the healing art and is dispensing with the need for human judgment. It is true that the introduction of instruments of precision into medicine has been of great service but the interpretation of the results obtained by them in the individual case still demands wisdom and experience on the part of the doctor. Where the machine is greater than the man the patient perishes. A large section of the public does not understand this. It has such an incorrigible love for apparatus, and what it produces, that it hailed with acclamation a box of gadgets, constructed in defiance of all scientific principles, which claimed to hand out an exact diagnosis, and even the appropriate treatment, and thus make the application of so fallible a thing as the human mind unnecessary.

If physicians also come to depend entirely on mechanical diagnostic aids, the practice of medicine will not be able to rise above the level of existing diagnostic machinery.

An unfortunate development in modern medicine is the decline of the clinical pathologist—the physician who correlates all of the various diagnostic procedures and interprets the results in terms of clinical medicine. Such a physician considers the patient as a whole and not as a diseased organ or a laboratory test.

82. Horder: *The Clinician's Function in Medicine*, New York State J. Med. 36: 846 (June 1) 1936.

In recent years there has been a revival of interest in clinical medicine and some prospect that clinicians would regain their rightful position in the practice of medicine. Under group hospitalization plans, however, the tendency is to push the clinical pathologist back into the laboratory by promoting "technical" medicine. The services of clinical pathologists would thereby be undermined, resulting in a serious injury to the practice of clinical medicine.

The other professional services in the hospital are considered by the promoters of group hospitalization plans in the same light as the anesthesia, radiologic and pathologic services. The treatment of ambulatory patients in outpatient departments is offered by several contracts. Physical therapy benefits are sold by some plans. Proposals to include additional special medical services, such as surgical service, are not inconceivable. In view of the influence of the present group hospitalization plans on anesthesia, radiology and pathology, these tendencies constitute a major problem to be faced by physicians, hospital administrators and the public.

The present high plane of medical practice is largely the result of constant supervision of the practice of medicine by organized societies of physicians. The formation of the American Medical Association was for the purpose of raising the standards of medical education to the end that a better medical service would be possible. The several councils and bureaus of the American Medical Association have as their central function the protection of the quality of medical service by an appraisal of the various elements entering into that service. The supervision of the conduct of physicians, the adoption of standards of education, the appraisal of equipment, personnel and service

in hospitals, the analysis of chemical preparations, the evaluation of physical appliances, the investigation of medical articles and services offered for sale; and the critical analysis of proposed laws illustrate a few of the activities of the American Medical Association which are designed to improve the character of medical service and to protect the health of the public.

The medical profession continues to merit the trust and confidence of the public largely because of the effort it has expended for the benefit of the patient. If medical societies had sanctioned or permitted monetary gain to individual physicians, political advantage, protection of inferior physicians or any purpose other than the welfare of the patient to govern their actions, they would have been discredited long ago. It is to the everlasting credit of the medical profession that the organized county and state medical societies and the American Medical Association have been relentless in their condemnation of anything that might be harmful to the welfare of sick persons and have been equally firm in their insistence on continuous improvement of medical education and the quality of medical service.

It does not appear that corporations, hospitals, nurses, technicians or other groups of lay persons are as capable as the medical profession of protecting the public health and developing the practice of medicine to an increasingly higher plane of service. These agencies give no assurance that they will foster a medical service equal to that now offered in the private practice of duly qualified physicians. It is to be expected, therefore, that the medical profession will oppose any new form of medical practice by such agencies which may lower the quality of medical service. At the same time the medical profession can be relied on to encourage any new form of medical practice

that will improve the quality, effectiveness or adequacy of medical service. It is for the public to decide whether the principles of medical ethics which are designed for its benefit and protection are to continue to govern the medical care and advice in sickness and in health or whether these ethics are to be supplanted by commercial standards of corporations and lay groups.

METHODS OF COMPENSATION

Aside from the effect on the practice of medical specialties in hospitals, group hospitalization plans have also provoked considerable disagreement concerning the method of dividing the income from these specialties between the physician and the hospital. The disagreement is essentially the same for all three of the most directly affected specialties (anesthesia, radiology and pathology) and can be discussed as one problem.

There are three general methods of compensation used: first, *salary*, whereby the hospital collects all charges and pays the physician a specified annual sum; second, *commission or percentage*, whereby the physician and the hospital agree to a certain percentage division of the gross or net income, and, third, *reimbursement*, whereby the physician collects the fees and reimburses the hospital for the use of equipment, technicians and space.

There are many variations of these payment arrangements; for example, the physician may be paid an annual salary and a percentage of the gross or net income, or the physician may pay the hospital rent for the privilege of using space. Because of the many different local conditions, no one single method of compensation embodies virtues to the exclusion of all other methods. The pronouncement of the House of Delegates concerning the method of compensating radiologists is indicative of the

attitude toward the proper method of compensating physicians in hospitals: ⁸³

. . . without violating the Principles of Medical Ethics of the Association his remuneration may be in the form of salary, fees or commission, or any combination of these; but in no case should an economic arrangement be operative which is designated to provide a direct profit to the institution from private patients. While these principles have been clearly and repeatedly affirmed by the House of Delegates, the application of the principles to individual cases sometimes involves complex accounting problems. It is believed that where differences of opinion arise they should be adjudicated by the local medical societies.

It is frequently stated that the method of compensation is the underlying cause of the dispute concerning the separation of technical and professional services. Various arrangements have been suggested to harmonize the different attitudes of hospital administrators and physicians toward the division of income and the relation of technical and professional services. Most of these suggestions deal with radiology, but their implications apply to the other specialties. One of the suggestions is the "Cleveland Plan," which was described as follows: ⁸⁴

. . . The hospital fixes all charges for the technical work, attends to their collection and pays all expenses of this service. The technical service is supervised by the staff radiologist and he receives compensation from the hospital for that supervision, but as a consultant he is placed on the same footing as other members of the staff, assesses all fees for his service as consultant, and collects them himself. Roentgenographic examinations are made at the order of the radiologist or of the physician in charge of the patient, but only the radiologist or his assistant is permitted to make roentgenoscopic examinations. Interpretations are made by the radiologist when requested by the attending physician, but the latter has the privilege of making diagnoses without consulting the radiologist.

83. Proceedings of the House of Delegates, 1935, p. 31.

84. Kirklin, B. R.: *The Radiologist*, J. A. M. A. **104**:1426 (April 20) 1935.

Another suggested plan is:⁸⁵

Separate the finances of the department from those of the hospital, but make the account books accessible to the hospital bookkeeper for inspection and audit. Let the department, not the hospital, collect all bills for radiologic service.

Out of the departmental revenues, pay current expenses, give to the hospital a reasonable return on its investment, making due allowance for depreciation, and freely acknowledge the right of the radiologist to whatever surplus remains.

Still another plan is as follows:⁸⁶

. . . the physician agrees to pay the hospital a stated sum for the use of the space, etc., which it provides. This amount should be based on the value of the space occupied, just as it would be for space in an office building, plus items to cover whatever other expenses the hospital has in connection with the operation of the department. A proper amount can thus be fixed whether the physician is provided with space alone and provides everything else himself, or is provided with space, equipment and supplies by the hospital. If the hospital provides everything, it could base the amount charged on the number of patients examined. In other words, the radiologist would pay the hospital a stated amount for each examination performed. The amount paid by the radiologist bears no relation to the fee he collects. Can you imagine a hospital collecting an operating-room charge based on the amount of the fee collected by the surgeon?

In this connection the suggestion has been made that the payment for the *use of the x-ray room* be handled the same as for the use of the operating room—the payments to be made to the hospital and to include the cost of upkeep of equipment, certain supplies and the salaries of professional workers, such as nurses and orderlies.⁸⁷ The radiologist would bill the patients directly for his services, including the

85. Footnote 84, p. 1427.

86. The Practice of Medical Specialties in Hospitals, Report to the Medical Problems Group of the San Francisco Medical Society, California & West. Med. 46:137 (Feb.) 1937.

87. Heerman, R. E.: The Relationship of Radiology to the Hospital, Hosp. Management, 43:15 (Feb.) 1937.

services of technicians, in the same manner as the surgeon. In regard to pathologic service, it has been suggested that:⁸⁸

Perhaps the fairest way for every one concerned to finance the clinical laboratory is to segregate the entire income of this department. A contract should be drawn between the hospital and the pathologist whereby the pathologist agrees to render satisfactory and efficient laboratory service at a definite fixed schedule of prices, agreed upon by the hospital administration, the executive professional staff, and the pathologist. Irrespective of collections from patients, the hospital agrees to pay the pathologist for services rendered on a monthly basis. The pathologist in turn agrees to furnish all equipment, material, and technical help. To cover all cost of space used by the laboratory and the collection of guaranteed bills, the hospital adds a certain agreed percentage on the laboratory bill to the patient. For instance, if the cost of laboratory service received by the patient amounts to \$4.00, the hospital in turn charges the patient \$5.00. By this method, there is a fixed responsibility for both parties. At the same time neither the patient, the hospital, nor the pathologist is being exploited. In addition, the smaller institution can be assured the advantage of a large institution at a minimum cost to the patient, the pathologist is assured a reasonable income commensurate with his training, and the hospital is assured a proportional remuneration for its service.

The reimbursement, lease or rental basis, whereby the specialist collects all fees and pays the hospital according to an agreed arrangement is favored by many physicians. Hospital administrators disapprove of such plans which divorce the responsibility for medical departments from the hospital on the ground that less efficient service will result. Anesthetists, radiologists and pathologists complain that hospitals are insisting on a profit from the anesthesia, radiologic and pathologic departments to make up for losses in clinics, wards and other hospital services. Physicians accuse the hospitals

88. Giordano, A. S.: A Simple Plan for the Financing of the Hospital Laboratory, *Hosp. Management*, 43: 26 (June) 1937.

of exploiting them, and the hospital administrators retort that physicians demand a monopoly on medical service in hospitals. Such statements breed antagonism and retard desirable understanding and cooperation on important services. The essential principle to which adherence should be sought is that neither the hospital nor the physician should have a financial advantage over the other. Moreover, the patient should not be made to suffer by having to accept an inferior service or by paying excessively for services received.

The total income of a hospital department is derived from the fees paid by or for patients examined or treated therein. Out of this income must come the expenses of the department, the incomes of the specialist and his assistants, funds for the replacement of worn-out equipment and a certain amount for the general administrative expenses of the hospital. It is undesirable for a hospital to make any substantial profits from any one of its medical departments. If such a condition exists, the services rendered may not be maintained at a proper standard because of inadequate equipment or insufficient or unpaid personnel; the specialist may be receiving an insufficient income; or the patients may be overcharged.⁸⁹

Clearly, the hospital should not attempt to finance the deficits of special activities out of the income from the medical departments. The nurse anesthetist can be hired on the basis of \$170 monthly (\$125 salary and \$45 for maintenance). The expected average of one hundred anesthetic hours per anesthetist per month would make the cost \$1.70 for each hour. An additional 30c to 80c an hour must be allowed for incidentals (gauze, towels, replacement of equipment, repairs, etc.) and for the cost of the anesthetic materials. The total cost

89. Christie, A. C.: An Evaluation of the Present Situation in Radiology, *Am. Coll. Radiol., Bull.* 3, 1936, p. 36.

per hour is somewhere between \$2 and \$2.50.⁹⁰ Against this total cost figure of \$250 for one hundred hours of anesthesia, it is expected that the hospital will realize over \$600. After allowing for administrative expenses, the difference represents a considerable profit and is frequently cited by medical anesthetists as the reason why hospitals and surgeons insist on using nurse anesthetists instead of medical anesthetists. The same accusation that a considerable profit accrues to the hospital has been made concerning the departments of pathology and radiology.

As long as physicians and hospital administrators are free to discuss the problems of compensation, there is hope that an agreement may be reached. With the advent of group hospitalization plans, however, the disagreement between hospital administrators and physicians has been greatly intensified. Physicians decry the selling of their services by hospital service corporations, but the hospitals, in order to participate in the plan, must agree to furnish the services as provided in the contract. The result is an impasse. The hospital service contract, including medical services, places physicians and hospitals in an unwholesome state of discord.

There are two possibilities of avoiding disturbances caused by including medical services in group hospitalization contracts:

1. Restrict the benefits solely to hospital facilities, such as bed and board in the designated room accommodation, use of the operating room and the delivery room, surgical dressings and ordinary medications. Likewise, the contract should specify that anesthesia, all radiologic service, every service in the pathologic department and any other medical service are not included.

90. Cost of Anesthesia Service, *Hospitals* 10:109 (Feb.) 1936.

2. Offer cash benefits to subscribers. This arrangement would avoid most of the objectional features of group hospitalization plans concerning the practice of medicine in hospitals. The cash benefits can be made assignable to the hospital or physician, or the benefit checks can be issued jointly to the patient and the hospital or physician. The cash benefit basis will be discussed later.

If group hospitalization plans were to confine their benefits strictly to hospital facilities or to cash payments for the subscriber, the movement would avoid most of the undesirable disturbances in the field of medical practice without impairing the value of the plan as a method of assisting persons with limited incomes to receive hospital services. In this connection there is need for a thorough understanding on the part of the organizers and administrators of the plans as to what constitutes medical services.

It would be erroneous to conclude that physicians and hospitals are becoming unalterably opposed. On the contrary, only a small group of hospitals or hospital administrators pursue activities that tend to disrupt medical practice. The following resolution unanimously adopted by the Catholic Hospital Association of the United States and Canada is an example of the unanimity of opinion concerning medical practice in hospitals: ⁹¹

Be It Further Resolved, That this Association again hereby proclaim its adherence to the principle that medical and hospital practice must rest upon a personal relationship between the patient and physician, which relationship implies moral obligations; that, therefore, under the usual conditions of medical practice the patient's right to choose a physician, qualified legally, professionally and morally, must not be curtailed; that, therefore, this confidential relationship between patient and physician be deemed a necessary

91. Reports of the Nineteenth Annual Convention of the Catholic Hospital Association, Hosp. Progr. 15: 326 (July) 1934.

basis for good medical practice; and that finally our hospitals commit themselves to the formulation and administration of only such hospital policies as are consistent with the maintenance of this fundamental personal relationship.

Be It Further Resolved, That this Association hereby restate its adherence to the principle that the medical profession must be recognized as preeminent in any method of medical practice and service; that, therefore, the medical profession must be accorded predominant influence in the medical activities of all institutions giving health and sickness care and that, therefore, the hospital members of this Association commit themselves to the policy that the rights, duties and privileges of the medical profession be considered directive and authoritative in hospital science and service.

The conclusion that can be drawn from this examination of the relation of group hospitalization plans to the medical profession is that the inclusion of medical service in a hospital service contract may seriously interfere with medical practice in hospitals. Whatever the desirabilities of group hospitalization plans may be, it must be recognized that they place hospital service corporations in control of the services of individual hospitals and interfere with medical practice in hospitals. The direct offering of "services" by these contracts accentuates and perpetuates many undesirable conditions. Some of these are the solicitation of patients, the entrenchment of nurse anesthetist, the placing of more and more of the practice of radiology in the hands of incompletely trained lay technicians and the forcing of pathology from its rightful position in the practice of clinical medicine. The continuation of these tendencies will place the medical profession under the domination of hospital service corporations similar to the position of the Cuban physicians, who are regarded as little better than the skilled employees of the "mutual societies" or "centros" which furnish complete

medical and hospital services to thousands of Cubans.⁹² When the professional practice of medicine is destroyed, the public must face the consequences of an impersonal, perfunctory medical service.

If the best interests of medical practice are to be served, hospital administrators must not forget their responsibilities to the medical profession and to the community. Hospitals owe their existence primarily to the medical knowledge of antiseptics, asepsis, anesthesia and surgery and their development to the donations of money and service by public-spirited persons in the community. Certainly, without the first, and very largely without the latter, hospitals would still be "pesthouses" where patients would go to die. The trustees and superintendents of hospitals should realize that their institutions are not an end but only a means to medical services. Hospitals are entirely dependent on physicians and should strive to serve them by offering improved facilities and educational opportunities to better their skill. To attempt to control or to employ physicians will lessen their initiative and self-reliance and will adulterate the quality of the service they render.

92. For an examination of these Cuban organizations, which in many respects might be considered as the end result of group hospitalization plans, see Leland, R. G.: *The Practice of Medicine in Cuba*, A. M. A. Bull. 28:92 (June) 1933. Stevens, H. S.: *Cuba's Health Trusts*, M. Economics 8:9 (Dec.) 1930. *Cuban Doctors Call Strike for Fee Rise*, California & West. Med. 37:207 (Sept.) 1932.

Chapter V

INSURANCE AND GROUP HOSPITALIZATION

The close relation of group hospitalization to insurance has been frequently mentioned. The statement that group hospitalization is "no different than fire insurance or life insurance" is commonly offered as an argument in favor of extending the insurance principle to the costs of hospitalization. Fire insurance or life insurance can scarcely be compared with group hospitalization. However, a review of the experiences of insurance companies with accident and health policies which are closely analogous to group hospitalization contracts may reveal some facts of importance that can be transferred to the group hospitalization field.

EXPERIENCES OF ACCIDENT AND HEALTH INSURANCE COMPANIES ⁹³

Accident and health insurance comprises two forms of insurance: the accident contract which insures against the effects of injuries caused by all or certain specified accidents and the health contract which insures against the effects of all or certain specified diseases or sicknesses. Accident policies are far more numerous than health policies or accident and health policies combined. Health insurance is not readily written except in combination with accident insurance. At present there are some

93. Except where noted, the review of accident and health insurance is based on the Proceedings of the Casualty Actuarial Society, especially the following papers: (a) Hart, W. V. D.: Recent Developments in Commercial, Accident, and Health Insurance, Proc. Casualty Actuarial Soc. 31:291, 1934-1935. (b) Miller, John H.: History and Present Status of Noncancellable Accident and Health Insurance, *ibid.* 31:235, 1934-1935. (c) Lamont, S. M.: The Contract of Personal Accident and Health Insurance, *ibid.* 18:9, 1931-1932. (d) Craig, J. D.: The Actuarial Basis for Premiums and Reserves in Personal Accident and Health Insurance, *ibid.* 17:50, 1930-1931. The assistance of Harold R. Gordon, Executive Secretary of the Health & Accident Underwriters Conference, is gratefully acknowledged.

ninety major accident and health insurance companies which offer more than 800 different policies.

Accident insurance preceded health insurance by many years. In the early years of the twentieth century, for a premium of \$5 the accident policy provided the following benefits: \$1,000 for accidental death; \$250 to \$1,000 for dismemberment; \$5 per week for total disability, limited to one or two years; \$2.50 per week for partial disability, limited to ten weeks, and limited benefits for hospitalization and specified surgical procedures. By 1929 these benefits had been extended either by increasing the cash amounts above \$1,000 for death and dismemberment or by removing or extending the limitations on the disability income benefits. The premium was not increased.

Not long after 1929 conditions began to change rapidly. Up to that time the drafting of accident policies had been a process of experimentation. Insurance men saw dimly the large risks involved because of the elements of adverse selection, moral hazards and the machinations of the unscrupulous. Their main aim, however, was to make an attractive offer to the public.

Accident insurance had been largely handled as a sideline, which induced a constant temptation to ignore rate inadequacies and to be overinfluenced by competitive considerations. Unlike casualty insurance, where pooled statistics were handled by bureaus with mandatory powers, and unlike life insurance, where reasonably good statistics were available, a scientific, actuarial basis for accident and health insurance was conspicuous by its absence. The lack of effective machinery for a coordinated rate and benefit program led accident and health insurance companies into difficulties.

The companies prior to 1929 absorbed a large portion of the underwriting losses with the huge investment profits of the boom years. These profits dwindled away in the depression years. Likewise, the improvement in industrial accident loss ratios resulting in modest underwriting profits were offset after 1922 by increased accident losses because of the automobile.

These conditions focused the attention of executives of the companies on eliminating all possibility of underwriting losses. As a result, the benefits were reduced, the "frills" were removed and the limitations were replaced so that the accident policy is now being restored to its original normal function of insuring against accidental death and dismemberment and loss of income because of disability.

The present accident policies provide benefits restricted to the amounts offered by the early twentieth-century policies. For an annual premium of \$5 for men and \$6 for women in nonhazardous occupations and between the ages of 18 to 59, policyholders are entitled to \$1,000 for accidental loss of life; from \$250 to \$1,000 for bodily dismemberment—loss of sight, hands, feet, etc.; \$5 per week for fifty-two weeks of total disability which prevents the insured from engaging in his occupations, and \$5 per week thereafter "so long as injuries prevent engaging in any occupation or employment for wages or profit"; \$2 per week for twenty-six weeks for partial disability, if injuries "prevent performing one or more important daily duties pertaining to his occupation"; \$5 for physician's treatment of nondisabling injuries; specified benefits for surgical operations caused by injuries as named in a schedule; \$2.50 per week additional for twenty weeks if injuries require the insured to be confined in a hospital or attended by a graduate nurse; \$100 to "defray expense necessary to transmit information to

friends or place insured in their care"; certain elective benefits for fractures and dislocations; and double benefits if injuries are the result of certain specified causes. Such a policy protects the insured against loss resulting directly and independently of all other causes from bodily injuries sustained and effected solely through accidental means during the term of the policy, subject to the provisions, conditions and limitations of the policy. Most policies, of course, are issued in larger amounts; for example, a premium of \$25 for men provides five times the foregoing benefits.

Health insurance policies written by commercial insurance companies developed along with accident insurance and in about the same direction. Prior to 1898 the attempts to write health insurance were characterized by many failures. Those engaged in the work were not insurance men, financial backing was insufficient, and the only experience on which to base such insurance was that of friendly societies in England. Not one of several companies organized during this period survived, nor did they furnish any experiences in regard to sickness rates that could be considered of value.

The second period of health insurance, between 1898 and 1931, opened with the issuance of health policies by stock casualty companies. At first special health provisions were issued in conjunction with accident policies. Weekly indemnities were paid in case of disability as a result of specified diseases. Disability benefits were allowed only for illnesses necessitating confinement in the home or hospital and could not be claimed for less than one week or for more than twenty-six consecutive weeks. Later, separate health policies were issued. These policies required a medical examination and insured against total and

partial disability caused by any disease or condition with the exception of tuberculosis, venereal diseases, insanity or those caused by the use of intoxicating liquors or narcotics. The rates for this coverage were based on the experiences of English friendly societies for the probable amount of genuine sickness, and then a certain percentage was added to cover expenses and sham sickness. The annual premiums for such policies increased progressively with the age of the policyholder.

After 1900 the benefits of health policies were greatly extended. Payments were made for certain surgical operations according to a specified fee schedule. The requirements of a medical examination and sickness for at least one week were eliminated. An additional benefit allowed payments for hospital charges or nursing services. Disability benefits were offered, even for life, whether the insured was confined to the house or not. The progressively increasing premium rate was discontinued for a flat premium for all ages from 18 to 50.

By 1931 the experience with the extended benefits of the health insurance contract was even worse than the experience with the liberal accident policy. Alarming losses resulted. Even the attempts to correct the situation by increasing premiums only resulted in a vicious circle of adverse selection and ever greater losses. The mounting losses caused many companies to refuse to issue health policies except in conjunction with an accident policy and to discontinue policies with excessive benefits.

For an annual premium of \$5.50 for men and \$7.50 for women in nonhazardous occupations and between the ages of 18 to 49, the present health policy provides \$5 per week for fifty-two weeks if "disease prevents performing any and every duty pertaining to his occupation and

confines insured to house"; \$2.50 per week for the same period if insured is not confined to house; specified benefits for surgical operations "by reason of disease," as named in a schedule; and \$2.50 per week additional for twenty weeks, if the disease requires the insured to be confined to hospital or attended by a graduate nurse. After an elimination period of two weeks, such a policy protects the insured against loss resulting directly and independently of all other causes from disease contracted during the term of this policy, subject to the provisions, conditions and limitations of the policy. For an increased premium the elimination period may be removed and the benefits increased. The elimination period does not apply to the surgical, hospital and nursing benefits.

An accident and health policy combines in one policy both the accident contract and the health contract which have been outlined. The premium charged and the benefits provided by an accident and health policy are not essentially different from those offered by an accident policy and a separate health policy. Hence, whenever the phrase "accident and health insurance" is used, it may mean the protection given by a single policy or by an accident policy and a health policy.

Actuarial Considerations.—The lack of reliable sickness and accident rates to permit an accurate allocation of expenses has made competent actuarial findings extremely difficult. When incapacity because of sickness or accident varies with such factors as the amount of benefits, the occupation of the insured, the duration of insurance and underwriting and claim adjustment practices, it naturally follows that there would be no standard tables of sickness or accident rates.⁹⁴ The Manchester Unity

94. Craig,^{sup} p. 51.

Tables showing the sickness rates experienced by members of the Independent Order of Odd Fellows, Manchester Unity of Great Britain and Ireland (during the five years 1893-1897) have been used with certain modifications as a basis for the calculation of premium rates in the United States. The first attempt to publish data, suitable for insurance purposes, on disability caused by sickness and accident in the United States was made by the Bureau of Personal Accident and Health Underwriters in November 1929.⁹⁵ The health experiences under the commercial policies for several member companies during the policy years 1921-1926 were combined. The data collected offered a more definite basis for actuarial calculation of net premiums. It is true that previous to this time a few of the larger accident and health insurance companies had fairly complete records of accident and morbidity experiences for their own policyholders. In 1931 the Health and Accident Underwriters Conference, an association of another group of companies, published statistics collected from member companies showing the distribution and amount of sickness and accident claims during the five year period of 1924-1928 inclusive for some 35,000 accident claims and 42,000 sickness claims. A series of tables was also published showing the net premium believed necessary to pay the actual claim costs under a variety of accident and health policies.⁹⁶

In the accident and health field not only are the actuarial computations restricted by the lack of comprehensive experience tables, but there are a great number of extraneous factors which tend to impede the establishment of

95. Report of the Committee of Five on Statistics to the Bureau of Personal Accident and Health Underwriters, Nov. 15, 1929.

96. Annual Net Premiums, Personal Accident and Health Insurance, Jan. 1, 1931.

such insurance on a scientific basis comparable to life insurance or fire insurance.

The first extraneous factor to contend with is false claims—fake accidents, sham sicknesses and malingering. When a claim for life insurance is received, there is seldom any difficulty in determining that the insured is actually dead, but when a claim for sickness is received, it is often difficult to determine whether or not the insured actually is sick. Problems also arise in the settlement of accident and health claims that are seldom encountered in life or fire insurance. One person with a fractured arm may require two weeks to recover; another, four weeks or longer. The one receives twice the indemnity as the other for the same claim. Such a state of affairs makes it almost impossible to determine the probable losses accurately. Furthermore, a policy which guarantees the insured an income payable as often and as long as he is disabled places him under a temptation to “enjoy” disability that is hard to resist. The human equation is involved in accident and health insurance to a tremendously important degree.

Likewise, it is recognized that the sickness rate will be higher for relatively, or even actually, higher amounts of benefits than where the amounts are low. The tendency for higher sickness rates to accompany large benefits is shown for practically every classification of amount of benefit. The disability benefits offered by life insurance companies furnish a costly example of an attempt to disregard this fundamental principle. At first the life insurance companies offered a small benefit—waiver of premiums if the insured person became disabled—then the benefit was increased by offering the payment of a weekly income during the time the insured was disabled. The resulting experience was so disastrously unfavorable that

the granting of weekly disability income benefits by life insurance companies was practically discontinued.

The rate of sickness also varies with such other factors as the form of policy issued, the amount of weekly indemnity, residence, race, physical condition of insured and the different periods of sickness, such as the first three months, second three months, etc. The previous medical history, age, sex, height, weight and occupation are additional factors that are ordinarily used in underwriting.

These are only a few of the factors influencing sickness rates, which make it apparent that the selection of an accident and health risk is not simple. With such a great number of factors influencing the claim experience, it is not surprising that the early underwriting of accident and health insurance was almost entirely a series of experiments. Of the seventy odd companies organized to write accident and health insurance in the United States during the years 1864 to 1869, only one survived beyond the year 1870. The pioneer company (Travelers) issued no less than seven different rate manuals during the years 1864-1868. There has been a steady refinement in the actuarial bases for accident and health insurance. However, there still remains a great need for the insurance companies to strengthen themselves by compiling their experiences to obtain basic statistics and net premiums.

Not until the problem of obtaining reliable statistics of sickness and accident experience has been solved can any progress be made in improving the methods of employing such statistics. For the year 1935 the aggregate sickness losses paid amounted to over 63 per cent of the health premiums *written*. The operating experiences of health insurance companies for

1935 would be approximately as follows:⁹⁷ For every \$1 of premiums earned, the expenses incurred would be 67c for losses, 3.8c for investigation and adjustment of claims, 14.5c for field supervision and acquisition expenses and 9.8c for underwriting expenses, which leaves a net gain of 4.9c. The underwriting experiences ranged from a loss of \$3 for every \$1 of premium earned to a gain of 50c for every \$1 of premium earned. Another reporting source⁹⁸ for almost the same group of companies gives the underwriting experiences during the approximate period of 1929-1935. For every \$1 of premium earned, losses and claims expenses amounted to 68c and underwriting expenses to 36.1c, or a net loss from underwriting of 4.1c. For accident insurance the experience is slightly better. During the year 1935, the aggregate accident losses paid amounted to over 50 per cent of the premiums written. Noncancellable accident and health insurance shows an extremely unfavorable underwriting experience.

It is unfortunate that the experience under accident and health insurance has been so unfavorable. The executives of insurance companies realize the desirability of these contracts for the satisfaction of a public need. Students of disability insurance, however, have long maintained that disability contracts cannot be written at a profit. The theory is that whatever rate may be charged for the benefits, the selection is against the company and will keep the cost of claims larger than premiums. The actual experiences, particularly with noncancellable accident and health insurance and life

97. Based on the Nation-Wide Underwriting Experience of Health Insurance Companies Operating in New York State in 1935, Spectator Pocket Register of Accident Insurance, Philadelphia, Spectator Co., 1936, p. 61.

98. Best's Insurance Reports—Casualty, Surety, and Miscellaneous, New York, Alfred M. Best, Inc., 1936, p. 770.

insurance disability benefits, have given considerable support to this view.⁹⁹

Medical Benefits.—The most important part of the accident and health insurance contract, from the point of view of group hospitalization, is the offering of medical benefits. The benefits for loss of life and dismemberment and the weekly income payments for total or partial disability are, of course, not included in group hospitalization contracts.

There are three forms of medical benefits in accident and health insurance. The oldest and most widely used form is the offering of stipulated specific medical, surgical, hospital and nursing benefits. After 1930 many companies replaced these stated amount benefits with a provision that the company would reimburse the insured for an amount actually expended by him for such services, as a result of accidents only, not to exceed a specified limit. This is the "medical reimbursement" clause. Recently, partly induced by the popularity of group hospitalization plans, "medical, surgical and hospitalization expense supplements" have been added to accident and health policies or sold as separate policies which provide that the company will pay, subject to certain limitations, the actual amount expended by the insured for medical or surgical treatment or hospitalization. Under the regular surgical and hospital clause, specified amounts for medical benefits are a trivial part of the contract. Under the medical reimbursement clause and under the newer expense supplements, the medical benefits become a major part of the contract.

Policies with the clause providing stipulated sums for surgical, hospital and nursing care

⁹⁹. For a complete review of the experiences with disability insurance, see *Disability Losses*, in *Best's Insurance News*, Life Edition, New York, Alfred M. Best, Inc., March 1931, p. 844; *ibid.* March 1937, p. 841. The actual losses reported between 1930 and 1935 by companies writing disability insurance amounted to \$315,000,000, which will be only a portion of the total loss during the entire life of the policies issued.

also allow a fee equal to a single week's indemnity for the treatment by a physician of nondisabling injuries. The physician's fee is not allowed for sickness. The accident policy and the health policy which have been outlined contain this clause.

Under the medical reimbursement clause, the policyholder is reimbursed for any medical expense up to \$500, if incurred because of injuries covered by the policy. Medical reimbursement for sickness is not included. The original policy of \$5,000 principal sum, \$25 weekly indemnity and \$500 medical reimbursement sold for a premium of \$30. The premium has now been raised to \$35 for the most favorable occupation class.

With the exception of the surgical benefits, the expense supplements are almost identical with the contract for group hospitalization. In one form of the supplement the policyholder is allowed the following benefits: thirty days in the hospital at \$3 a day, \$10 for use of the operating room, \$5 for anesthesia, \$3 for roentgen examination and \$1.50 for laboratory fees. The schedule for surgical benefits, allowing \$10 for an operation on the eyes, ears, nose or throat and \$75 for an abdominal operation, includes most of the common surgical services. The estimated net or basic cost of this "allocated expense" supplement is \$5.60, to which must be added acquisition costs, taxes and other items of expense. Nursing benefits can also be included at a cost of 60c annually for each dollar per day of nursing indemnity. Another form of the supplement provides a reimbursement up to \$100 a month for hospital expenses, including room and board, operating room, laboratory fees, medicines, anesthetics and the salary of a graduate nurse. A waiting period of sixty days is imposed and a three-month limit is placed on any one accident or

disease. The schedule of operations given previously is also included. This monthly "reimbursement expense" supplement has an estimated claim cost of \$4. These two supplements have only recently been presented by the Health and Accident Underwriters Conference, but several member companies are now offering policies including such a supplement. To the minimum estimated claim costs for these supplements, each company adds its own expenses, so that rates are extremely variable even for the same contract. The premium for the "allocated expense supplement" is generally \$12 and that for the "monthly reimbursement supplement" is \$8.

The most striking feature of the three different forms of medical benefits in accident and health policies is the highly experimental nature of the contract provisions and the lack of a definite actuarial basis for determining costs.

A COMPARISON OF ACCIDENT AND HEALTH POLICIES WITH GROUP HOSPITAL- IZATION CONTRACTS

A comparison of the accident and health policy with the group hospitalization contract should be of value. Unfortunately, there are at least ten major types of accident and health policies among the 800 or more different policies issued. The general accident and health policy, insuring against all injuries and diseases, with certain exceptions and limitations, of course, and the surgical and hospital expense supplements are most nearly comparable with a group hospitalization contract. Group accident and health insurance policies are also written by a few companies but are not greatly different from the individual accident and health policy, except that the rates may be

lower and that the employer may contribute a percentage of the costs.

Because of the wide difference in group hospitalization contracts and accident and health policies, it is particularly difficult to make a satisfactory comparison. Table 15 does present a listing of the essential features of a group hospitalization contract and of an accident and health policy with an allocated expense supplement and with a monthly reimbursement expense supplement.

The reader is warned against drawing hasty conclusions as to the advantages of either form of hospital insurance. Each benefit and limitation, in fact almost each provision of these policies, presents a problem of interpretation and involves a multitude of conflicting advantages and disadvantages. Without attempting to compare the relative amounts of benefits offered, it is apparent that insurance companies offer medical and hospital benefits very analogous to those provided by group hospitalization contracts. In addition, the accident and health policy includes surgical benefits.

While most of the accident and health losses have resulted from disability income benefits, the companies have been cautious about offering liberal medical, surgical and hospital benefits. In the early stages of development of group hospitalization plans (1933) a letter was sent to some major insurance companies to determine "What Some Big Insurance Companies Think of Group Hospital Insurance."¹⁰⁰ The replies indicated that the presidents and officers of these insurance companies did not regard the plan for group hospitalization as "satisfactory," "sound" or "practical." The letter received from Harold R. Gordon, executive secretary of the Health and Accident

100. Hendricks, Thomas A.: What Some Big Insurance Companies Think of Group Hospital Insurance, *J. Indiana M. A.* 26: 387 (Aug.) 1933.

TABLE 15.—Comparison of Group Hospitalization Contracts and Accident and Health Insurance Policies

	Group Hospitalization Contract	Insurance Companies' Hospitalization Coverage	
		With an Allocated Expense Supplement	With a Monthly Reimbursement Expense Supplement
Membership Qualifications			
Age limits	To 65 years	From 18 to 49 years (50 to 54, higher rates)	
Employed	Usually, subscribers must be in good health and employed in groups	Usually, prospective policy holders must be employed	
Benefits			
Insurance coverage	All injuries and illnesses except as limited and when authorized by a licensed physician	Against loss resulting from all bodily injuries effected solely through accidental means and from diseases contracted during the term of the policy, subject to the limitations in the policy	
Hospital benefits	Hospital service for 21 days at \$6 per day, including semiprivate room, board, use of operating room, general nursing care, routine medicines, surgical dressings and routine laboratory services; 25% discount after expiration of hospitalization period allowed, and "preliminary hospitalization pending diagnosis" for chronic conditions	Room and board \$3 per day for 30 days; operating room, \$10; anesthesia, \$5; x-ray examination, \$3; laboratory fees, \$1.50	Reimbursement for hospital expenses, including room and board, use of operating room, laboratory fees, medicines, anesthetic and graduate nurse hire at the rate of \$100 a month limited to 3 months
Surgical benefits	None	Specified benefits ranging from \$10 for tonsillectomies to \$75 for abdominal operations	
Limitations			
Benefits not allowed	Diseases or conditions existing at the time of application; contagious or venereal diseases; tuberculosis; self-inflicted injuries or attempted suicide; nervous or mental disorders; injuries resulting from riot or civil commotion; diseases not common to both sexes; conditions resulting from the use of alcohol or narcotics; rest cures and injuries or diseases for which hospitalization is available without cost to the subscriber	Diseases contracted or conditions acquired before application; disability from diseases not treated by a physician; contagious diseases; pregnancy and childbirth; suicide; war injuries; injuries sustained in air travel; hernia, and diseases contracted or disabilities sustained in certain geographic zones	
Waiting period	Emergency treatment .....None General illnesses .....15 days Acute illnesses .....15 days Obstetrics .....12 months Minor operations .....15 days Major operations .....15 days	15 days before policy becomes effective. No waiting period for accidents; 30 days for sickness	
Rates			
Amount	\$9 annually	\$12 annually	\$8 annually

Underwriters Conference, was especially interesting. He wrote in part:

Due to some rather sad experience our companies had a few years ago with a so-called hospital expense only policy (the loss ratios were terrific and the companies withdrew from the field) our companies are now reluctant to enter into this field again. The selection is against the company and if adequate premiums are charged for such coverage the policies are not salable.

In answering your inquiries as to whether \$12 or \$30 would be an adequate premium for group hospitalization coverage, I would have to know the indemnity provided and the restrictions or limitations placed on a contract before I could even estimate an accurate answer. I am informed that at the present time there is about a half day of hospitalization per insured risk per year and I believe the existing plans base their charges roughly on an expected loss ratio involving one whole day of hospital service per person per year. Personally, I doubt whether this is quite sufficient as we in the accident and health insurance business know without any question that loss ratios increase tremendously on any new form of policy during the first four or five years. In other words, the average person with a new form of hospital policy does not become "insurance conscious" until he has had his policy a year or two—then the claims start to come in.

Insurance companies have had many tentative plans for embracing some form of medical or hospital insurance. The experience has not been favorable. Under medical reimbursement, for example, losses have been higher than expected, and the rates have been revised upward. Certain other forms of medical and hospital policies have been discontinued. No doubt insurance companies are watching the developments in group hospitalization plans, and if sufficient actuarial experience can be gathered, they may reenter the field.

The preceding review of the history of accident and health insurance companies has indicated the experimental nature of the policies issued. The conclusion that seems

inevitable is that considerable doubt is cast on the wisdom of hospitals rushing into hospitalization insurance when insurance companies have feared to enter that field. Will hospital service corporations be able to avoid those forces which have created trouble for accident and health insurance companies? The present accident and health insurance policy is the result of almost a century of experience in the underwriting of personal accident and health risks. Nearly every one of the accident and health insurance companies would be glad to write a hospital insurance policy if a premium income in excess of claims and expenses could be expected.

The first principle to carry into the group hospitalization field from the operating results of accident and health insurance companies is to caution against drafting contracts with large benefits. The desire to furnish the broadest possible coverage and to outdo competitors may appear commendable, but it invariably leads to increased losses. The notoriously unstable history of accident and health insurance has been caused largely by inability to determine the costs of the benefits offered. The first false step is the addition of "frill" benefits or extras, the premium costs of which are incalculable separately and are often naively assumed to be equally costless collectively.

The necessity for careful compilation of statistics on hospitalization and financial experiences cannot be emphasized too much. Directors of group hospitalization plans must not allow themselves to be duped into believing that individually and alone they can fashion the future of group hospitalization plans and that they alone have the correct understanding of benefits and rates. Competitive accident and health insurance companies were jealous of their experiences and failed to cooperate in a

study of their common problems. The result was insufficient knowledge of sound practices, causing instability and unnecessary failures. There are no valid reasons why nonprofit organizations should withhold statistics on experience or why they should decline to cooperate with other organizations toward the end of discovering sound and unsound practices. It therefore seems desirable for a centralized statistical bureau to be organized¹⁰¹ which will collect statistics on experience and assist in the drafting of contract benefits and rates.

A long list of judicial decisions has been an important factor in determining the scope and meaning of many provisions in accident and health policies. The possibility of the influence of court action on the interpretation of group hospitalization contracts should not be ignored.

The importance of a coordinated rate and benefit program calls attention to the need for constant supervision of the actuarial basis. It would be extremely dangerous for directors of group hospitalization plans to become convinced that the present actuarial structure of group hospitalization is absolutely sound. The brief study of the reported experiences that has been undertaken indicates the presence of many conditions which call for careful inspection and possible adjustment.

GROUP HOSPITALIZATION PLANS AND INSURANCE COMPANIES

It has been shown that in the beginning many group hospitalization plans were organized with but little regard for existing insurance laws. The organization of these plans without the

101. The Committee on Hospital Service of the American Hospital Association has been formed as a central information bureau. An association of hospital service corporations for the formulation of underwriting practices, similar to the Bureau of Personal Accident & Health Underwriters or the Health & Accident Underwriters Conference, might be considered.

approval or supervision of the commissioner of insurance continued, despite the fact that in most states hospital service contracts were considered as insurance contracts. Whether or not the plan of group hospitalization is an insurance contract depends on the existing state statutes and case laws and the ruling of the attorney general in each state. The relation of the plan to the insurance laws in two states will suffice to illustrate the divergent attitudes.

The attorney general of one state issued the following ruling concerning the legality of a commercial group hospitalization corporation proposing to transact business in the state without being organized under the insurance laws of the state:

What constitutes the "business of insurance" or a "contract of insurance" may be taken from the definition laid down in *Commonwealth v. Wetherbee*, 105 Mass. 149, and included in Cooley's Briefs on the Law of Insurance, vol. 1, page 5:

A contract of insurance is an agreement by which one party, for a consideration, promises to pay money or its equivalent, or to do an act valuable to the assured, upon the destruction, loss or injury of something in which the other party has an interest.

In the case before us, there is to be an agreement between the parties, the payment of a consideration by the purchaser of the certificate, and the furnishing of free hospital service by the intended corporation. Construed in the light of this definition, the specimen certificate is a contract of insurance. And the agreement is, nevertheless, a contract of insurance even though the member holding such certificate receives no actual payment in money. That there may be indemnity without money compensation is supported by authority.

The corporation, by the proposed contract, agrees to furnish hospitalization in case of sickness to the person purchasing the certificate. In other words, it is insuring the health by supplying free hospital service and insuring the member against payment of hospital bills. This clearly brings it within the spirit of the insurance law.

At the other extreme, the insurance commissioner of another state ruled:

Our law defines as insurance any contract by which one undertakes to indemnify another against loss or damage from an unknown or contingent event. This plan does not contemplate any indemnity but merely provides for hospital service in case of sickness. It is therefore our opinion that it is not insurance as contemplated by our statutes. . . . This plan for hospital service is a service contract.

Similarly, throughout the other states the group hospitalization contract is either an insurance contract subject to the insurance laws or merely a service contract which does not have to qualify under the insurance laws. The difference between an insurance contract and a service contract is not always well understood. The distinction seems to be that a service contract undertakes to *do* something, whereas an insurance contract *hires* it done. The difficulties in distinguishing between services rendered and services paid for are now being recognized. Clearly, the present trend is away from distinguishing between an agreement to indemnify in the form of services and one to indemnify in cash. The real distinction lies not in whether the services are rendered or paid for but in the importance of the services from the point of view of the public and the likelihood that the party promising to provide the services will be able to perform his agreement. Even when the contract is a service contract, if it assumes sufficient proportions so as to affect a considerable number of persons, it may become a matter of public concern and be held subject to the supervision of the insurance commissioner.

According to the present division among the states, in twenty-nine group hospitalization is looked on as essentially insurance, whereas in nineteen states and the District of Columbia the plan is presumably held not to be insurance. In the first group are included Alabama, Cali-

for-
nia, Illinois, Maryland, Massachusetts, Mis-
sissippi and New York, where special enabling
laws have been passed to permit the organiza-
tion of nonprofit hospital service corporations,
with specified supervision by the insurance
commissioner; Georgia, Iowa, Michigan, Penn-
sylvania and Wisconsin, where similar enabling
acts are being proposed, and Arkansas, Florida,
Idaho, Indiana, Kansas, Maine, Nebraska, New
Hampshire, New Mexico, Oklahoma, Oregon,
Rhode Island, South Dakota, Texas, Utah, Ver-
mont and Washington, where group hospital-
ization plans are considered as insurance, and
the plans must be organized under the existing
laws or special enabling legislation has to be
passed. The second group of states includes
Arizona, Colorado, Connecticut, Delaware, Dis-
trict of Columbia, Kentucky, Louisiana, Min-
nesota, Missouri, Montana, Nevada, New Jersey,
North Carolina, North Dakota, Ohio, South
Carolina, Tennessee, Virginia, West Virginia
and Wyoming. In the latter list of states, group
hospitalization plans are exempt from the regu-
lations of the department of insurance, and
nonprofit hospital service corporations are
organized under the mutual benefit, member-
ship corporation or the general laws governing
service contracts. In several of these states
group hospitalization is considered not to be
insurance only on the basis of certain qualifica-
tions or limitations; for example, if the hospital
itself contracts to render the services or if the
benefits are limited to \$150. As was indicated
before, the tendency is for these states which
now consider the group hospitalization contract
as a service contract to change to the attitude
that such plans are insurance. This is par-
ticularly true in Kentucky, Louisiana, Missouri,
Tennessee, Virginia and West Virginia. Also,
no definite position has been taken in Colorado,
South Carolina and Wyoming.

There is little doubt but that the primary purpose of the organizers of group hospitalization plans in their desire to be considered as selling service contracts was to be exempt from the deposit of large sums of money as usually required by insurance laws and from the rather rigid supervision of the insurance commissioner. While it is acknowledged that there should be as few obstacles as possible to the organization of nonprofit enterprises by responsible persons for apparently praiseworthy purposes, the exemption of group hospitalization plans from proper supervision cannot be construed in the interests of the public welfare. As was stated by one insurance commissioner:

Various plans are being proposed throughout the United States whereby the public is solicited to purchase for a small annual fee the right to obtain hospital service of much greater normal cost in case of need. The general principle behind all proposals is the creation of a common fund made up of a large number of small fees from which the hospital care of those who are unfortunate enough to need such care will be provided.

The proponents of these projects vary all the way from wholly irresponsible individuals out to make money by any available means, legitimate or otherwise, to groups of distinguished public spirited citizens interested only in working out a much needed supplement to the existing methods of financing the care of that class of patients now borne by the hospitals upon a charitable or semicharitable basis.

The above named plan is sponsored by a group whose disinterestedness and public spirit are beyond the slightest question. If there is any legitimate means whereby any public official can aid the purpose which is sought to be accomplished that course should be adopted. It is my reluctant conclusion that there is no such course open to the Superintendent of Insurance at the present time.

Another insurance commissioner stated:

Might we add that we appreciate the fact that a serious condition confronts the hospitals of the coun-

try and that perhaps some plan whereby persons would be induced to contribute to their support would be a panacea for their ills. Yet, as stated in our communication of December 28th, we are continually confronted with other schemes similar to the one in question and in approving such plan as requested by you we would be opening the door to other practices which are not so humanitarian in their nature.

The procedure that is now being followed is to secure the passage of a special enabling act which exempts hospital service corporations from the deposit requirement of the insurance law but at the same time gives the insurance commissioner certain supervisory powers over these corporations.

The change in the legal relation of group hospitalization plans has served to make it difficult to promote commercial plans. The enabling laws focused attention on several important requirements: The majority of the directors of a hospital service plan were required to be directors or trustees of the hospitals which had contracted or might contract to render the hospital service; some method of approval of the participating hospitals was also required; the certificate of incorporation had to be endorsed by the commissioner of insurance or the department of social welfare; the proposed contract rates, acquisition costs and methods of operation were subjected to the approval of the commissioner of insurance; annual reports had to be filed, and the records and affairs were open to inspection by examiners from the insurance department; and the investment of funds was restricted to those investments permitted life insurance companies.

These provisions constitute a notable step forward in the supervision of hospital service plans. In many respects, however, they fail to

serve adequately their full purpose. Briefly, these shortcomings are as follows:

The enabling legislation frequently does not define clearly the regulatory powers of the insurance commissioner. As a result, in only a few states has the insurance commissioner taken a definite or prominent part in the supervision of group hospitalization plans. The funds available for such supervision are often inadequate and explain much of the apathy shown by insurance commissioners toward certain hospital insurance plans.

It would probably be more in accord with good public policy if the majority of the governing body of a hospital service plan should be chosen from among members of official hospital associations and medical societies. A director of a participating hospital who is at the same time a director of the hospital service corporation may be called on to represent interests that are likely to be in conflict.

It would also be desirable for the directors of a hospital service plan to serve without salary or remuneration of any kind. Care should be taken to assure the nonprofit character of these ventures. There are in existence a number of hospital service corporations which assume the nature of nonprofit undertakings but which permit the diversion of a considerable portion of the income to the directors and to those who have invested money in the ventures.

The failure to specify what is to constitute the "hospital services" offered by a hospital service plan is a serious fault. The limitation of benefits to the essential hospital facilities, such as bed and board, general nursing care, use of the operating room and

the delivery room, ordinary medications and surgical dressings, would remove most of the disputes that have arisen in connection with group hospitalization. The inclusion of various forms of medical services complicates the actuarial structure of the plan, interferes with the practice of medicine in hospitals and tends to produce an inferior medical service for the patient.

A definite method of inspection and approval of participating hospitals by the proper state agency needs to be outlined in detail. The mere statement that hospitals are to be approved is inadequate. Likewise, consent to the incorporation of a hospital service plan ought to be based on something more than routine inspection of paper forms. The incorporation of two competing plans in one city, each presumably nonprofit, has occurred. The result can only be a duplication of administrative costs and a division in the support of hospital administrators and the public toward each plan. A certificate of convenience and necessity, similar to the requirements for the organization of a public utility, might be considered as applicable to a hospital service corporation.

While the primary purpose of the enabling laws is to secure the exemption of a hospital service plan from the deposit of a large sum of money prior to commencing operations, it is evident that adequate reserves must be maintained. The present condition of reserves has been discussed. A plan ought not to be allowed to claim the advantages of the insurance principle without being held to guarantee adequate reserves which are an essential part of insurance. A hospital service corporation

should be required to maintain a reserve equal to at least \$5 for each member.

In some of the enabling laws, the commissioner of insurance is powerless to revoke his consent to the operation of a hospital service plan. This nullifies his ability to supervise such plans properly. He should certainly be delegated the power to prevent a hospital service corporation from continuing to do business if it indulges in fraudulent practices or neglects to perform its contract. It would also be well to specify a limit on acquisition and administrative costs, based on a percentage of earned income. Some insurance commissioners have promulgated certain regulations, but it is debatable as to what would happen if a hospital service corporation became recalcitrant.

Despite these shortcomings, the resulting closer supervision of hospital service corporations has forced the promoters of commercial plans, as well as those who desire to offer a more extensive contract, to form a new institution—the hospital insurance company. The necessity to organize a nonprofit corporation, with hospital administrators and physicians controlling the policies, was too much of a deterrent for profit-taking and overzealous promoters. Furthermore, hospital insurance companies could be readily formed in states in which enabling acts would have to be passed to permit the operation of hospital service plans. The mutual assessment insurance laws provided a direct method of organizing such companies. The requirements usually were that a company had to have a few hundred applicants, several thousand dollars as “legal” reserve and a certain reserve for unearned premiums. Even where an enabling law was on the statute books of one state, a group hos-

pitalization plan, in operation for four years before the passage of the law, and a newly organized plan each elected to qualify as a mutual assessment insurance company by depositing \$25,000 with the insurance commissioner rather than to organize under the enabling law. The enabling law contained a definition of hospital service which was interpreted to exclude the services of radiologists and anesthetists. The possible competition of lay organizations and insurance companies selling a more complete hospital insurance

TABLE 16.—*Hospital Insurance Companies—Jan. 1, 1937*

Name	Number of Policy Holders
Insurance Association of Approved Hospitals, Oakland, Calif.	2,000
Intercoast Hospitalization Insurance Association, Sacramento, Calif.	13,413
National Hospital Service Society, Inc., Washington, D. C.	?
Sentinel Hospitalization Company, Des Moines, Iowa.....	1,000
National Hospital Service Association, Duluth, Minn.....	?
National Hospital Insurance, Inc., Jackson, Miss.....	?
Hospitalization Corporation, Lincoln, Neb.....	?
Texas Income Insurance Company, Dallas, Texas.....	?
The American Hospital and Life Insurance Company, Houston and San Antonio, Texas.....	16,068
Total.....	32,481

policy under the mutual insurance laws was the compelling factor which caused the organization of these plans as hospital insurance companies.

Likewise, in other states hospital insurance companies which issue a policy offering cash benefits for all services are gaining considerable favor as they avoid most of the disputes inherent in the so-called service contract plan. As shown in table 16, there are at least nine of these companies organized solely to sell hospital insurance policies, four of which had, as of Jan. 1, 1937, 32,481 policyholders. Despite the similarity in organization, there is a wide difference in the administrative policies of

these plans. Some are organized with the sole interest of benefiting their community and assisting persons to secure more adequate hospitalization. One such plan was formed by a county medical society. Others are organized as private business ventures.

The development of hospital insurance companies raises another problem. Should group hospitalization be placed on a cash basis and be operated by insurance companies or should hospitals continue to contract to render the services? Which plan will be best for patients, hospitals and physicians? The advocates of group hospitalization maintain that with a service plan controlled by hospitals and physicians, the community can expect a larger share of the subscriber's premium to be returned in hospital benefits. The proponents of hospital insurance companies insist that since the plan is insurance, the hospitals are not properly qualified to conduct such a business. It is also claimed that the group hospitalization plan places a hospital service corporation in control of the services of individual hospitals and interferes with medical practice in the hospital. On the other hand, a hospital insurance company introduces another commercial institution into the medical field.

Perhaps a compromise organization may prove desirable. A hospitalization plan offering cash benefits to the subscriber would remove the objectional features of the hospital service corporation, and if it were organized and managed as a community institution, it would avoid the disadvantages of the hospital insurance company. A special enabling act embodying all the principles discussed before, which would also stipulate that the benefits are payable in cash, would make such an institution possible. The enabling act would promote the ready formation of a hospital service plan

without necessitating the accumulation of the large sum of money required by hospital insurance companies. At the same time, however, the provisions of the enabling act would specify adequate reserves and the plan would be as strictly supervised as any insurance company.

When hospital insurance companies begin to offer medical and surgical benefits, the hospital service corporations are likely to extend their benefits to include more medical services. The inclusion of medical services in a hospital service contract is certain to cause disturbances in the relations between hospitals and physicians concerning the practice of medicine in hospitals. The compromise organization offering cash benefits might be able to avoid these disturbances, and, with the combined support of the medical profession and the public, it might be able to compete successfully with hospital insurance companies which are organized as business ventures.

The continued successful operation of even a hospital service plan organized on a cash benefit basis is, of course, dependent on the financial success of the principles of group hospitalization. As has been indicated by the reported financial experiences, group hospitalization plans cannot yet be considered as fulfilling sound actuarial requirements. Furthermore, insurance actuaries and the officials of insurance companies are extremely skeptical of such plans because of the benefits now offered and the premiums now charged.

Chapter VI

CONCLUSIONS AND GUIDING PRINCIPLES

This survey reveals the great need for careful and unemotional guidance in the organization and administration of group hospitalization plans, in order that the good in them may be retained and developed. No one can deny that elements of harm to the public, to the hospital and to the medical profession are intermingled with the contemplated benefits of the plans.

✓ Group hospitalization is neither a simple, direct method of paying for hospital bills nor a solution to the economic problems of hospitals and patients alike. Its inauguration intensifies other problems which are as difficult of solution as those sought to be removed. Those who persist in forcing the furtherance of the movement are probably sincere in their efforts to improve the relation of patients, hospitals and physicians. Their zeal must not blind them to the necessity for safeguards which may seem like obstacles to the rapid development of the plan but which are necessary to insure the continuation of the real benefits.

The confusion and misunderstanding that have arisen about hospital insurance plans can be dispelled to a large extent by the wider dissemination of accurate information concerning such plans. It is hoped that this study of the entire subject will lead to a better understanding of the issues involved. Nothing short of the complete report can adequately present certain aspects of hospital insurance plans, but the following summary reviews the information gathered.

The group hospitalization plan, whereby the hospital or an association of hospitals contracts

with groups of persons to furnish specified hospital facilities when needed in return for the prepayment of an agreed sum by each member of the group, has arisen out of a background of industrial group payment arrangements for medical and hospital services. Such group payment plans evolved from the contract practice plans of the mining and lumbering communities or from the mutual benefit plans organized by fraternal societies, labor unions or employees and employers.

It is not surprising, therefore, that hospitals began to offer their facilities in a similar manner. The selling of season tickets led to individual annual subscriptions and then to group payment arrangements. Hospital administrators organized a multitude of other plans designed to bolster the diminishing income from patients, gifts and endowments and at the same time to make hospitalization costs less for patients of moderate means. None of these plans permitted a rapid enrolment of members, avoided the selection of adverse risks or facilitated the collection of premiums. In addition to these advantages, the group hospitalization insurance plan also had a positive appeal to the public because it was a business-like proposal and not a request for contributions.

The publicity secured by the early commercial plans and the advocacy of the "group payment or insurance method" by the Committee on the Costs of Medical Care gave considerable encouragement to the organization of group hospitalization insurance plans. As the number of plans increased, many undesirable and commercial practices were introduced into hospital and medical services. Medical societies and hospital associations were aroused to the growing importance of the movement, and they began to criticize the undesirable practices and

to stipulate principles that should be observed. As a result, the commercial plans directed by sales agencies were gradually overshadowed by noncommercial plans, which included nearly all of the hospitals in the community. Likewise, the recognition of the insurance nature of the plans led to a more orderly administration because of the necessity to observe state statutes and the rules and regulations of state insurance departments.

ORGANIZATION

Different forms of organization have been developed because of local conditions and state statutes. In most communities either a non-profit no-stock corporation or a nonprofit association governed by hospital administrators, physicians and lay persons has been formed. The favoritism shown to these organizations by permitting them to be exempt from the deposit requirements of insurance laws and from all taxes except those on real estate and office equipment can be justified only if they give a special consideration in rates to persons in the low income groups.

The funds for organization and the initial stage of operation are obtained from foundations, individual philanthropists, community chests, welfare organizations or member hospitals. There is little agreement among the organizers of group hospitalization plans as to the size of the fund required to promote the plan and to pay for the benefits used by members until the income from premiums becomes sufficient. Obviously, such a fund needs to be large enough to provide for all costs of the plan during a period of several months. The attempt to finance an insurance plan during the initial period out of subscriptions from members is "insurance on a shoestring." Such a practice is fraught with many dangers. The initial funds

may be repaid out of *earned* premiums after operating expenses, payments to member hospitals and reserves have been met.

✓ Hospital administrators cannot avoid their ethical responsibilities in devising a sales program for group hospitalization plans. ✓ Advertising of medical services and solicitation of patients almost invariably result in a deterioration of the services rendered and are denounced by the principles of medical ethics and by the code of ethics of hospitals. The medical ethics opposing such advertising and solicitation are designed to protect the *patient* by maintaining the standards and quality of medical service.

THE CONTRACT

Generally, the group hospitalization contract offers the subscriber twenty-one days of hospital service with an allowance of one-fourth discount after the period of twenty-one days. Hospital benefits include bed and board in semi-private room accommodations; the use of the operating room; the services of the anesthetist, if "a salaried employee of the hospital"; general nursing care; routine medicines; ordinary surgical dressings; and routine laboratory services. Certain special benefits may be offered as sales features. These include the hospitalization of members with chronic conditions for "preliminary hospitalization pending diagnosis," a discount on services not included in the contract, yearly physical examinations, special urinalyses, specified services in the outpatient department and ambulance service. The listing of doubtful benefits, such as "nursing supervision" and postmortem examinations, is indulged in by a few plans.

The services of pathologists, radiologists, physical therapists, anesthetists and interns are admittedly included in many plans. The medi-

cal services offered are indicated by the following benefits: roentgen and radium treatments, roentgenograms, anesthesia, general services of intern and resident staff, urinalysis, blood count, chemical examination of the blood, gastro-intestinal tests, basal metabolic tests, electrocardiographic and other clinical and laboratory examinations, physical therapy, yearly physical examinations, first aid or treatment of ambulatory patients and immunizations.

The limitations to the contract benefits are more extensive than they appear on the casual reading of the contract. No member may be hospitalized for conditions which exist at the time of application. A waiting period of fifteen ✓ days is often required before any member, excepting in an emergency, may be hospitalized. Obstetric patients cannot be hospitalized before one year. Waiting periods of ten or twelve months may be imposed for certain specified surgical procedures, such as for tonsillectomies, removal of adenoids and herniotomies. There is always a list of conditions for which hospitalization is restricted or not permitted. This usually includes contagious or venereal diseases, tuberculosis, self-inflicted injuries or attempted suicide, nervous or mental disorders, injuries resulting from riots and civil commotions, diseases not common to both sexes, conditions resulting from the use of alcohol or narcotics, "rest cures" and injuries or diseases for which hospitalization is available without cost to the subscriber.

MEMBERSHIP

Most plans are open to employed persons and their dependents in "good health." In the initial stage of promotion, membership may be restricted to employed groups of persons. Ultimately, it appears that most plans will accept the dependents of group members as

well as individuals and their dependents. Only one plan imposes an income limit as a barrier to membership. The selection of members according to groups, employment, age and other restrictions was designed to improve the soundness of the plan by eliminating as many adverse risks as possible.)

The current policy of ignoring an income limit as a condition of membership seems to be at variance with the original purpose of enabling persons with limited means to secure low-cost hospital services.

At least 197 group hospitalization plans have been proposed. As of Jan. 1, 1937, sixty of these plans were in operation, with a total known membership of approximately 700,000, consisting of 450,000 subscribers and 250,000 dependents. An increase in membership has since been reported for many plans. The rapid enrolment of members and the concentration of the membership among a few plans are noticeable tendencies. During the year 1936 the membership increased from 300,000 to 700,000 or 133 per cent. Three plans include over 50 per cent of the membership, and ten plans include almost 90 per cent of the membership. These tendencies have had an important influence on the financial and hospitalization results of the plan. There have also been at least nine hospital insurance companies organized, three of which have about 33,000 policyholders.

(It is significant to observe that the membership of group hospitalization plans does not yet appear to include persons in the low income groups or those in rural areas.) Likewise, the unemployed, persons with chronic conditions and the aged are frequently excluded. The directors of the plans are aware of the failure to reach these groups, and suggestions have been made to include certain of the persons now excluded if financial conditions will permit.

These suggestions are: (lowering of the premium rate to reach the low income groups, liberalization of the contract benefits to include the unemployed and to permit hospitalization of persons with chronic conditions and a federation of hospital service plans to permit the enrolment of persons in rural areas.)

RATES

The employed person who becomes a member of a group hospitalization plan pays from \$7 to \$12 annually. (The variation in the rate depends on whether the subscriber joins as an individual or as a member of a group. Group rates are usually less.) Rates for subscribers also vary according to the type of room accommodations offered. The prevailing rate is usually \$9 for semiprivate facilities, with an initial enrolment fee of \$1.

The rates charged for dependents vary according to the number of dependents included and the type of room accommodations offered. Dependents entitled to discounts only are included for a charge of \$1 to \$7.80, and dependents entitled to full services, for \$10 to \$35.40. annually. For the average group of four dependents entitled to full service in semiprivate facilities, the annual rate is usually \$15. Special family rates, ranging from \$12 to \$49.20, are also quoted. For the average family of five entitled to full services in semiprivate facilities, the annual rate is about \$24.

The determination of the rate to be charged has usually followed a process of imitating the rate structures of plans already in existence. (What actuarial basis there is for the rates charged consists in adding to the allowed annual cost for one patient day a sum estimated as sufficient to pay the administrative expenses and to create reserves.) This is not illogical *provided* each member uses only one patient

day during the year and *provided* the administrative expenses and reserves do not exceed the sum apportioned for them. The prevailing annual rate of \$9 usually allows \$6 for hospitalization costs for each member and \$3 for all administrative expenses and reserves.

MEMBER HOSPITALS

In the present stage of development of hospital service plans, the legal relation of member hospitals to hospital service corporations and to subscribers has not been definitely fixed. The contract between a hospital service corporation and a member hospital varies from a simple agreement on the part of the hospital to hospitalize the subscriber and on the part of the corporation to pay a stipulated per diem rate to an involved document which seems to make the hospital directly responsible for the fulfillment of the contract between the hospital service corporation and the subscriber. With the formation of separate hospital service corporations, the question arises as to the liability of a member hospital to provide services even if the funds of the hospital service corporation are insufficient.

Under the association type of plan a member hospital is paid either an all-inclusive flat rate or a stipulated sum for room and board with specified payments for additional services based on an adopted fee schedule. (If the individual hospital operates its own plan, the fees are often simply considered additional hospital income. If the hospital utilizes a sales agency, a certain percentage of the fees is turned over to the hospital.)

HOSPITALIZATION EXPERIENCE

The plan is based on the expectancy that 10 per. cent of the members will be hospitalized during one year for an average stay of ten days

each. Considering all reporting plans as one group and ignoring the variations in membership classes and in benefits, it appears that the number of members hospitalized has been greater than expected, but the average length of stay has been less. The basis on which the plan is founded is not inaccurate as long as the membership is rapidly increasing. Because of the rapid enrolment of members—the membership of most plans has increased over 100 per cent—the present hospitalization experience must be considered as at a minimum. However, when the present membership has been retained for several years and it becomes difficult to secure new members in groups large enough to avoid an adverse selection of risks, an increase in the hospitalization experience will be probable. Thus, when the number of members becomes stationary or begins to decline, the actuarial basis for the plan will require close scrutiny.

It has been consistently observed that certain types of members are unusually "hospital-minded." Persons who are brought into contact with the care of sick persons (nurses, hospital employees, physicians and employees of physicians) and persons who have leisure time (teachers, housewives, dependents and unemployed) frequently desire to be hospitalized.

The hospitalization experience under group hospitalization plans indicates that members are hospitalized twice as frequently as persons in the general population, despite the limitations in the contract. The increase in the number of members hospitalized is offset somewhat by the shorter period of stay. These two results reflect a greater hospitalization of members for minor ailments than is common in the general population. If the encouragement of hospitalization for minor ailments does not result in an increase in the prevention of disease

or in the discovery of incipient diseases, it is possible that hospitals may become so cluttered with persons with insignificant ailments that good medical and hospital services will suffer.

FINANCIAL EXPERIENCE

According to the financial experiences reported, it appears that from 24 to 119 per cent of the earned income, with an average of about 65 per cent, is used for hospitalization costs. Administrative expenses, including promotional and sales expenses, range from 135 per cent down to a low of 12 per cent of the earned income, with an average of about 25 per cent. The highly experimental and varying nature of the plans renders uncertain the conclusions concerning financial experiences. The larger and better managed plans, which have kept administrative and promotional costs at a minimum and which have selected subscribers very conservatively, do accumulate actual surpluses. Losses are usually incurred during the first year or so, and then administrative costs are lowered and a surplus may appear. Although hospitalization costs remain constant or tend to increase, the rapid enrolment of members prevents the actual hospitalization that may be expected in later years. During the present period of rapid membership growth, a low loss ratio should be expected. When members are increasing at a rate of over 100 per cent annually, it would be unwise to accept the resulting costs as representative of normal, long-time operations.

Up to 1936 most of the plans suffered losses. During the year 1936 the plans received wide publicity and the membership increased rapidly, with the result that many were able to show surpluses. However, the reserves that have been accumulated do not appear to be adequate. A reserve of \$5 per member is con-

sidered a conservative amount to provide for outstanding losses and catastrophes. Even among the better managed plans the reserves are less than \$2 per member. The current attitude among executives of hospital insurance plans is that reserves are unnecessary, although reserves are an integral part of insurance.

Since it is expected that each member will require one hospitalization during ten years, the income from each member during the ten year period must be sufficient to meet the costs of one hospitalization. The actual income per member is about \$8 annually, so that \$80 is the income to provide for the one hospitalization, which, as reported, costs about \$50. The difference of about \$30 is used for expenses other than hospitalization cost and for reserves. The payment of \$30 for the expenses and the creation of reserves under group hospitalization plans to administer a probable \$50 loss is questionable economy. It is also apparent that the addition of administrative expense to hospital charges cannot lower the cost of hospital care. Insurance never lowers costs; it simply distributes the costs for one person among a group of persons. In keeping with the charitable nature of hospitals, any plan to assist persons to meet their hospital bills should be designed for those really needing help, and as little as possible of the moneys collected should be used for administrative expenses.

It is questionable whether an insurance plan for the payment of hospital bills, exclusive of physicians' services, is desirable because of the small losses involved. The Committee on the Costs of Medical Care recognized that hospital insurance, even if it included medical as well as hospital charges, could not be considered as a solution to the problem of the uneven distribution of medical charges. The chief advantage of such a plan is that it facilitates the payment

of hospital bills by enabling each prospective patient to pay in advance. The underlying feature of the group hospitalization plan is that it is a *collection plan*, collecting hospital bills in advance instead of after they have accrued.

Participating hospitals receive from \$3 to \$6 for each patient day of services rendered. It cannot be exactly determined whether these amounts fully reimburse the hospitals for the expenses incurred in providing the benefits specified in the contract. Apparently the superintendents of the participating hospitals are well satisfied with the rates paid because the plan provides immediate cash payments and lowers collection costs.

EVALUATION

It does not appear that group hospitalization plans can solve the problem of idle hospital beds. The membership required and the number of new patients who would have to be hospitalized to fill the existing idle beds appear to be far beyond the possible development of the plans. Unless rates can be lowered to permit the enrolment of a great number of persons with small incomes who have hitherto not been able to pay for hospital care, group hospitalization plans will have no appreciable effect on hospital finances.

A more direct solution to the hospital problem of idle beds and free patients than seems possible under group hospitalization plans could be accomplished by avoiding unnecessary expense for idle beds, by establishing a hospital routing plan to prevent the abuse of free services, by organizing a medical service bureau postpayment plan to provide deserving patients with low-cost medical and hospital services under an equitable payment arrangement, by obtaining community philanthropic or governmental funds for the care of the patients unable

to pay and by encouraging economical and efficient methods of administration.' The development of organized care of the sick in their homes and the provision of low-cost beds for convalescent patients will also do much to lessen the expense of hospitalized illnesses.)

RELATION TO MEDICAL PRACTICE

Regardless of financial considerations, the effect on medical practice in hospitals by the inclusion of medical services in group hospitalization contracts is the main concern of the medical profession. Medical services are certainly included in group hospitalization contracts when roentgen and radium treatments, radiologic services, outpatient treatments, anesthesia and pathologic examinations are offered by many plans. (The inclusion of the professional services of anesthetists, pathologists and radiologists in the contract for the sale of hospital facilities has caused the medical profession to question the propriety of such a policy.) The inclusion of the services of physicians as a benefit in a contract to be sold to persons who have the services of other physicians available has always been held injurious to the practice of medicine and to the public health.

The direct offering of "services" by these contracts accentuates and perpetuates many undesirable conditions of medical practice in hospitals. Some of these are the solicitation of patients, the entrenchment of the nurse anesthetist, the placing of more and more of the practice of radiology in the hands of incompletely trained lay technicians, and the forcing of pathology from its rightful position in the practice of clinical medicine.

The present high plane of medical practice is largely the result of constant supervision of that

practice by organized societies of physicians. When professional control of the practice of medicine is destroyed, the consequence is an impersonal, perfunctory medical service. The selling of medical services by a corporation or by a group of lay persons substitutes commercial standards of service for the principles of medical ethics. (When physicians become employees and permit their services to be peddled as commodities, the medical services deteriorate and the public which purchases such services is injured. It is for this reason that physicians object to the selling of their services by hospital service corporations.)

To disavow clearly any desire to interfere with the practice of medicine, every group hospitalization plan should specify in its contract that the hospital services offered include only bed and board in the designated room accommodation, the use of the operating room and the delivery room, surgical dressings and ordinary medications. Likewise, the contract should specify that anesthesia, all radiologic services, every service that is rendered in the pathology department and any other service that can be construed as professional are *not* included.

INSURANCE COMPANIES AND GROUP HOSPITALIZATION

A review of the experience of accident and health insurance companies indicates the highly experimental nature of the policies issued, despite the fact that the present policy is the result of almost a century of experience in the underwriting of accident and health risks. Nearly every one of these companies would be glad to write a hospital insurance policy if a premium income in excess of claims and expenses could be expected.

Insurance companies have been unable to make a great financial success out of accident

and health insurance. This is particularly true of noncancellable accident and health and separate health insurance policies. Experience with disability income policies has likewise been unsatisfactory. Despite the desirability of such insurance, the selection is against the company and will keep the cost of claims larger than the premiums regardless of the rates charged. Hospitals cannot expect to do better with group hospitalization plans unless more successful underwriting ability, less costly acquisition methods and more economical administration are developed. The officials of insurance companies and insurance actuaries are extremely skeptical of the soundness of group hospitalization plans on the basis of the benefits now offered and the premiums now charged.

Two suggestions can be carried into the group hospitalization field from the operating results of accident and health insurance companies. The first is to caution against the drafting of contracts with large benefits or with extra or "frill" benefits. Large benefits invariably lead to increased losses, and the premium costs of extra or "frill" benefits are usually incalculable separately and are too often naively assumed to be equally costless collectively. The second suggestion is to emphasize the necessity for careful compilation of statistics on hospitalization and financial experiences. The notoriously unstable history of accident and health insurance has been caused largely by the inability to determine the costs of the benefits offered.

Whether or not the plan of group hospitalization is regarded as insurance depends on the existing state statutes and case laws and the ruling of the attorney general in each state. According to the present division among the states, in twenty-nine the plan is looked on as

essentially insurance, whereas in the remaining nineteen states and the District of Columbia the plan is presumably held not to be insurance. The tendency, however, is for the states which now consider the group hospitalization contract as a service contract to change to the attitude that such plans are insurance. The procedure that is now being followed is to secure the passage of a special enabling act which exempts hospital service corporations from the deposit requirements of the insurance law but at the same time gives the insurance commissioner certain supervisory powers over these corporations.

The enabling laws by focusing attention on several important requirements, such as the necessity to organize a nonprofit corporation, the regulation that the majority of directors be hospital administrators or physicians, and the supervision by the insurance department, have served to make it difficult to promote commercial plans. The most important shortcoming of these laws is the failure to specify what is to constitute the "hospital services" offered by the hospital service plan. Likewise, considerable indefiniteness exists concerning the approval for the incorporation of a hospital service plan, the regulatory powers of the commissioner of insurance and the reserve requirements.

Largely because of the popularity of group hospitalization plans, hospital insurance companies have been formed. These companies are organized under the mutual assessment laws and issue policies offering cash benefits for all services. Despite the similarity of the several companies now in operation, there is a wide difference in their administrative practices. Some are organized with the sole interest of benefiting their community and of assisting

persons to secure more adequate hospitalization. Others are organized as private business ventures.

The comparison of group hospitalization plans and hospital insurance companies suggests that a compromise organization may prove desirable. Such an organization would operate as a community hospitalization plan but would offer cash benefits directly to the patient or jointly to the patient and the hospital or physician. A hospitalization plan offering cash benefits would remove most of the objectionable features of the group hospitalization plan by avoiding the disturbances between hospitals and physicians concerning the practice of medicine in hospitals.

PRINCIPLES

The failure to provide for persons in the low income groups who really need assistance and to meet the complete expense of hospitalized illnesses may lead to the demand for compulsory subscription and expansion of benefits to include medical and surgical services. It is extremely doubtful whether hospital service corporations are the proper agency to control and regulate the distribution of medical services. However, it appears that they will attempt to do so unless supervised by hospital administrators and physicians who recognize the fundamental values of professional control of medical services. The importance of professional control and of adherence to ethical principles needs to be reaffirmed for all agencies concerned with medical services.

The decision as to whether or not a group hospitalization plan is essential must rest primarily with the medical profession and the hospital officials of the local community. The following principles are suggested in the inter-

ests of fairness, efficiency and greater security, and in the event that hospital insurance is deemed necessary.

1. The plan of organization should conform to state statutes and case law. The majority of the governing body of the hospital insurance plan should be chosen from among members of official hospital groups and members of medical societies. Great care should be taken to assure the nonprofit character of these new ventures.

2. The plan should include all reputable hospitals. The qualifications of the participating hospitals should be closely supervised. Member hospitals should be limited to those on the Hospital Register of the American Medical Association or to those approved by the state departments of public health or other state agencies in those states in which there is approval, registration or licensing of hospitals.

3. The medical profession should have a voice in the organization and administration of the plan. Since hospitals were founded to serve as facilitating means to the practice of medicine, the medical profession must concern itself intimately with plans likely to affect the relations of hospitals to physicians.

4. The subscriber's contract should exclude all medical services—contract provisions should be limited exclusively to hospital facilities. (If hospital service is limited to include only hospital room accommodations such as bed, board, operating room, medicines, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear.)

5. The plan should be operated on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision by state insurance departments has been advantageous for both the buyer and the seller of insurance contracts. Laws permitting the formation of hospital service corporations should not remove the benefits of such supervision or violate the principles enumerated.

6. There should be an upper income limit for subscribers. If group hospitalization plans are designed to aid persons with limited means to secure hospital services, they should render such service at less than regular rates. If no consideration in rates is made

for persons with limited means, group hospitalization plans lose their altruistic purpose and there may be little justification for an income limit.

✓ 7. There should be no commercial or high pressure salesmanship or exorbitant or misleading advertising to secure subscribers. Such tactics are contrary to medical and hospital ethics and are against sound public policy.

✓ 8. There should be no diversion of funds to individuals or corporations seeking to secure subscribers for a profit. The moment hospitals lose their traditional character as institutions of charity and humanitarianism, the entire voluntary hospital system will break down.

✓ 9. Group hospitalization plans should not be utilized primarily or chiefly as means to increase bed occupancy or to liquidate hospital indebtedness. Such plans, if they are necessary, should place emphasis on public welfare and not on hospital finances.

10. Group hospitalization plans should not be considered a panacea for the economic ills of hospitals. They can serve only a small portion of those persons needing hospital services. Hospitals must continue to develop efficient methods of administration and service independent of any insurance method of selling their accommodations.

These ten principles have been adopted by the House of Delegates of the American Medical Association.¹⁰² It seems reasonable that any program which may affect all hospitals and all physicians should be subjected to the ratification of democratically selected representatives. The House of Delegates of the American Medical Association is a democratically selected group of representatives of the entire medical profession in the United States. The apportionment of delegates on the basis of one delegate for every 775 members, or a fraction thereof, of the constituent state associations gives democratic representation to a large majority of all physicians in the United States. The action of the House of Delegates is the considered action of responsible delegates reflecting the convic-

¹⁰². Proceedings of the House of Delegates, J. A. M. A. 108: 2219 (June 26) 1937.

tions of the physicians of the United States and not the opinion of some minority group. The Reference Committee of the House of Delegates called particular attention to principle 4 and recommended its application in contracts for group hospitalization. The committee expressed its complete sympathy with every provision to exclude any and all types of services that involve medical care. The value of conferences between interested medical groups and hospital administrators to clarify the zone between hospital service and medical care was also suggested.

The best interests of the patient are paramount and must be protected. This is the duty of the medical profession and hospital associations, because prospective patients are not always able to evaluate critically the effect of a plan on the medical services promised. The group hospitalization movement is clearly one of the major issues demanding concerted action by physicians and hospital administrators if the future of medical practice is to be maintained on a basis which guarantees that the welfare of the sick person is the first consideration.

Appendix A

SCHEDULE ON GROUP HOSPITALIZATION

For the sake of a more logical procedure it has seemed advisable to divide this schedule into seven sections: I. Organization, II. Services, III. Membership, IV. Membership Rates, V. Hospitals, VI. Statistics, VII. General. Each group of questions attempts to secure information on its respective section. If you feel additional information is pertinent please append as much material as you wish.

For each question only the known possible variations are indicated. If your plan contains variations not indicated, please include them on a separate page or on the back of the schedule.

To conserve time and effort, answers "Yes" or "No" are suggested.

If you do not have all the information asked for, please give what you have. We are hopeful that the replies may be as complete as possible.

The following suggestions are offered to clarify possible doubts and to avoid misunderstandings:

I. ORGANIZATION: If you think the questions do not present a complete picture of your organization, please give a clear description of its origin, inauguration and operation. In addition, however, will you kindly answer the questions in the schedule?

II. SERVICES: Your contract may list and explain these items, but please answer all questions.

III. MEMBERSHIP: For the sake of uniformity we suggest the following classification definitions: *Subscribers* are all who sign the group plan contract. Ordinarily they are included as a group but they may also be individual subscribers; *Dependents* are the immediate family or relatives of the subscribers; *Members* are all persons entitled to service as subscribers, individuals or groups, and their dependents.

IV. MEMBERSHIP RATES: It is desired that the *annual* contract or membership rate be given. It is hoped that the various arrangements for including dependents will be clearly stated.

V. HOSPITALS: Under V.1., if the printed material concerning your plan contains an up-to-date list of member hospitals (if your plan is an association), this printed material will be sufficient. If the names of the member hospitals are not printed, please attach a list.

VI. STATISTICS: It will be helpful if you find it convenient to consolidate the statistics of all participating hospitals. If the statistics are from less than the full number of hospitals, please indicate how many hospitals and specify the period (month and year) for which statistics are given.

Under VI.1., it will assist materially if you will kindly determine the number of member months for each period. The number of months a member is entitled to the protection offered by the plan is the number of "member months." This can be determined accurately from the date of each membership or it can be estimated as indicated in the schedule.

Under VI.2., the distribution of receipts and under VI.3., the causes of claims are asked for. If necessary, indicate your own classifications, but please give examples to illustrate your experience with these items.

You may not have separate records of experience for groups, individuals, women subscribers and dependents, but we shall appreciate as much as possible of the information asked for.

VII. GENERAL: The general questions are intended to elicit special information. Please answer them to the best of your knowledge and add any other statements or opinions which you feel may be of value.

PLEASE RETURN WITH THE COMPLETED SCHEDULE ALL LITERATURE, BY-LAWS, HOSPITAL CONTRACTS, SUBSCRIBER CONTRACTS, REGULATIONS AND OTHER DOCUMENTS DESCRIPTIVE OF THE GROUP HOSPITALIZATION PLAN.

Council on Medical Education and Hospitals

Date.....1935

From:.....
 Street:.....
 City:..... State:.....

O. Group Hospitalization Plans

I. ORGANIZATION to administer the Group Hospitalization Plan

1. Type:.....
 (Non-profit association of hospitals or privately
 owned association or corporation)

2. Date:.....
 (Of organization) (In operation or proposed) (Discontinued?)

3. Funds:..... \$.....
 (Loan from participating hospitals) (Amount)
 \$.....
 (Loan from Community Chest) (Amount)
 \$.....
 (Loan from special sources:
 philanthropists, foundations, etc.) (Amount)

 (Other sources of funds, or method of initial
 financing)

4. Control:

Administration of plan, if two or more hospitals are participating, by:

(Committee of participating hospitals—number of representatives of each hospital, and whether presidents, superintendents, etc.)

(Representatives of hospitals and community—Number and manner of selection)

(Board of Directors, Governors or Trustees—Members chosen from special groups, e. g., Hospitals, Medical Society, Nurses and General Public and methods of selection.)

Administration of plan, if single hospital, by:

(Superintendent of Hospital) (Staff physicians or surgeons)

(Board of Directors, Governors or Trustees—Members chosen from specific groups: Medical Society, Nurses, Staff or General Public.)

5. Sales program and methods:

Indicate how subscribers are secured,—

(a) By contract with a sales agency.....

(b) Director in charge of sales with salaried assistants.....

(c) Employees on salary and commission.....

(d) Employees on commission alone.....

(e) Through cooperation of community organization
 (Women's clubs, charitable organizations and other
 specific groups.)

(f) Voluntary participation by groups or individuals.....

Working arrangement of sales organization—(Describe)

II. SERVICES

1. Does hospital care include?—

Operating room..... Routine Medicine.....
 Bed and board..... Surgical dressings.....
 General nursing..... Routine laboratory tests.....

What type of room is offered?—

Ward..... Semi-private..... Private.....

Does routine medicine include?—

Special serums..... Anesthesia.....

Do routine laboratory tests include?—

Diagnostic examinations only.....
 Treatments: x-ray..... radium.....
 Urinalysis.....
 Blood chemistry..... blood count.....
 X-rays: teeth..... sinuses..... chest.....
 Gastro-intestinal.....
 Basal metabolism.....
 Electrocardiograph.....
 Emergency examination only.....
 (List others).....

2. Are the services of the following included?

	Yes or No	If yes—With what limitations:
Physician or surgeon
Graduate or special nurse
Pathologist
Radiologist
Physiotherapist
Anesthetist
Internes
Dietitians

3. Limitations:

(a) Complaints or diseases not hospitalized under your group hospitalization plan. If hospitalized, state what the arrangements are, or under what limitations.

Contagious and/or venereal.....
 Tuberculosis.....
 Self-inflicted.....
 Mental or nervous disorders.....
 Injuries caused by riot, civil commotion or through act of felony.....
 Attempted suicide.....
 Cancer.....
 Rest cures.....
 Alcoholic or drug conditions.....
 Workmen's Compensation cases.....
 (List others).....

(b) Waiting period before any

service is rendered for:	Number Days	Number Months	Not Hospitalized
Emergency cases
Sickness
Acute abdominal cases
Cancer cases
Obstetric cases
Major surgery
Minor surgery (tonsils, adenoids)

(c) Special service provisions:

Number of days of hospitalization permitted each subscriber per year.....
 Are discounts given for services rendered after above number of days is exceeded?..... How much?..... %
 Is there a money limitation on service to be given? \$.....
 Is there a provision for release of obligation to render service during an epidemic, or in case hospital facilities are overcrowded?.....

- Are discounts given to subscribers on services not included under the group hospitalization plan?.....
- If so, state what discounts, and on what services.....
- Are yearly physical examinations given?.....
- Are first-aid or ambulatory clinic treatments included?
- Are immunizations performed?.....
- Is ambulance service provided?.....
- Are persons having chronic diseases given any hospitalization under the plan?.....
- Is prepayment of annual membership rate required before hospitalization?.....
- Is subscriber's agreement or contract cancelled:—
- For non-payment of agreed rate?.....
- After what period.....
- For unemployment?.....
- After what period.....
- Any other special services:.....
-
-

III. MEMBERSHIP

1. What are the requirements for persons to be eligible as subscribers?.....
- As dependents?.....
2. Can the membership of your plan be classified as:
 - (a) Individuals alone?.....
 - (b) Individuals and their dependents?.....
 - (c) Employed groups alone?.....
 - (d) Groups and dependents?.....
 - (e) Groups and individuals?.....
 - (f) Groups and individuals and dependents?.....
 What are the age limitations?.....
- Any occupation or employment restrictions?.....
- Any income limitations?.....
- Any racial distinctions or exclusions?.....
- Other special selection of membership. (Religious; as to place of residence; sex; etc.).....
3. Are subscriber's dependents entitled to service?—
 - (a) Automatically included in regular annual charge to subscriber, and entitled to full service.....
 - (b) Automatically included in regular annual charge to subscriber but entitled to a discount on services.....
 - What discount?.....%
 - (c) Optionally enrolled at an additional rate to subscribers' regular annual charge, and entitled to:
 - Full subscribers' service.....
 - Discount on service.....
 - (d) Not included under subscribers' rate or under any additional rate plan.....
 - (e) For a separate annual rate..... What is the rate \$.....
4. What special provisions or restrictions pertain to individual subscribers?.....
5. What special provisions or restrictions pertain to women subscribers?.....
6. What percentage of your membership could not afford to pay for hospital facilities in private hospitals?.....% How determined.....
-
-

IV. ANNUAL MEMBERSHIP RATES

1. What is the subscriber's *annual* rate for a contract year?—
 In groups \$..... as individuals \$.....
 What enrollment fee is charged? \$..... Is an enrollment fee charged annually.....; of members who renew contracts.....; or only of first year subscribers.....
 What was the basis for selecting the specific rate charged?

2. Is there a special rate for groups?.....
 Specify examples. \$.....
3. Is there a special rate for individuals, if accepted?.....
 What is the rate? \$.....
4. If dependents are not included under subscribers' rate, what is the charge for dependents *in addition* to the subscribers' rate?—
 For each dependent \$.....
 If entire family included \$.....
 Wife only \$.....
 Special rate according to number of dependents \$.....
 Special enrollment fee for dependents \$.....
5. Is the annual rate graduated according to income classes?....

Income Limits and Classifications	Annual Rates
.....
.....
.....
6. Is some special method of determining the rate used? (Certain percentage of monthly income? Are life memberships sold, etc.).....

7. May payments of the rate charged be made:—
 Weekly..... Semi-annually.....
 Monthly..... Annually.....
 Quarterly.....

V. HOSPITALS

1. If an association of hospitals, how many hospitals have agreed to participate..... List or append names of the hospitals included.....

 2. What are the provisions for participating hospitals as outlined in the contract with the association?.....

 3. What are the methods of paying participating hospitals?—
 A flat rate per patient day specified to be paid in full, or accordingly as funds permit?

- What is the flat rate? \$..... How are payments made?

- Are payments to hospitals to be made by the corporation or association according to an agreed fee schedule (a money limitation for specific services to be rendered)?

- What is the fee schedule? \$..... How are payments made?

If a sales agency is employed, what portion of the total receipts is retained by the agency and what are the methods of paying the hospitals rendering services under the plan?

4. If a single hospital plan, what are the provisions for handling receipts?

If a sales agency is employed, what portion of the total receipts is retained by the agency and what are the methods of paying the hospital rendering service under the plan?

VI. STATISTICS (Financial)

(Periods may be Calendar or fiscal years)	First Period	Second Period	Third Period
	Mo.	Mo.	Mo.
	Yr. 19....	Yr. 19....	Yr. 19....
	to	to	to
	Mo.	Mo.	Mo.
	Yr. 19....	Yr. 19....	Yr. 19....
Number of Members	.....	.....	.....
Number of Patients	.....	.....	.....
Total cost of Services under Group Plan (at regular rates.)	.....	.....	.....
Average cost per Patient	.....	.....	.....
Average cost per Member	.....	.....	.....
Total cost of extra services provided	\$.....	\$.....	\$.....
Total Expenses (other than hospital service)	\$.....	\$.....	\$.....
Receipts from Members	\$.....	\$.....	\$.....
Profit or Loss	\$.....	\$.....	\$.....
Number of Hospitals for which statistics are given	.....	.....	.....

(If the plan has been in existence more than three years, as indicated in the preceeding table, please give additional experience on a separate page.)

1. What was the number of member months for each of the periods given in the preceeding table:

	Number of Member Months
First Period (Calendar or fiscal year)
Second Period	"
Third Period	"

(If a record of member months has not been kept, estimate according to the following formulas:

$$\frac{\text{Membership at beginning of period} + \text{Membership at end of period}}{2} \text{ or } \frac{\text{Total income from members for period}}{\text{Monthly subscription rate for members}}$$

or determine from each subscriber's contract the exact number of months for which all members were entitled to protection during each of the periods.)

2. Indicate the distribution of receipts for the period from:

Mo..... 19..... to Mo..... 19....		
Distribution of Receipts	Amount	Per cent
Claims (cost of service)	\$.....
Salaries	\$.....
Printing	\$.....
Others (List).....	\$.....
.....	\$.....
.....	\$.....
Reserves	\$.....
Total all Receipts	\$.....	100%

3. Indicate the number and type of cases receiving service for the period from: Mo.....19... to Mo.....19...

Causes of Claims	Number	Per Cent
Respiratory infections
Accidents
Obstetrics
Gastro-intestinal
Tonsils
Others (List)...
.....
.....
.....
Total (all causes of claims)

4. What is the actual patient day cost for hospital service? \$.....

(If medical or surgical services are provided, separate patient day cost into cost for hospital service and cost for medical or surgical service.)

5. How is your patient day cost determined?.....

6. What is the average hospital bill per patient \$.....

7. What is the agreed day rate to be paid to participating hospitals:

\$..... Private service \$..... Ward service \$.....
Semiprivate service \$.....

8. What method was followed in the initial financing or promotion of the plan?.....

Private promotor (Give details).....

Initial cost financed by regular subscription rates (Give details).....

Promotion by private corporation (Give details).....

Capital loaned or donated (Give details).....

9. What percentage of the total receipts is allotted for administration and overhead costs?.....

10. What amount was actually spent for administrative costs according to past expenses?.....

11. How are membership funds and reserves handled?.....

VI. STATISTICS (Experience)

(Periods may be Calendar or fiscal years)	First Period	Second Period	Third Period
	Mo.....	Mo.....	Mo.....
	Yr. 19....	Yr. 19....	Yr. 19....
	to	to	to
	Mo.....	Mo.....	Mo.....
	Yr. 19....	Yr. 19....	Yr. 19....
Number of Members
Membership composed of:			
Number of Subscribers in groups
Number of individual Subscribers
Dependents entitled to full Subscriber's Service
Dependents entitled to discount only
Average number of mem- bers during period
Number of Members Hospitalized
Total number of Patient Days
Average number of Patient Days per Member
Average Number of Patient Days per Member Hospitalized
Number of Members Hos- pitalized who exceeded the limitation set on number of days hos- pitalization offered
Number discharged within one week
Number discharged within two weeks
Number discharged within three weeks
Number of Lapses (Members discontinuing contracts)
Total number of monthly payments received
Number of hospitals for which statistics are given

(If the plan has been in existence more than three years as indicated in the preceding table, please give additional experience on a separate page.)

- Has the operation of the plan adversely affected philanthropic or community support of hospitals?.....
- What have been the effects of the plan upon the collection of physicians' accounts for services rendered members as compared with the collection of medical bills to non-members?.....
- What have been the effects of the plan upon the amount of free hospital service rendered?.....
- What have been the attitudes of subscribers and lay members of the community toward the plan?.....
- What are the local hospital administrators' opinions of the plan (both favorable and unfavorable)?.....
- What has been the relationship of the plan with the local medical profession (approval, disapproval or attitudes)?.....

Appendix B

GEOGRAPHIC LIST OF GROUP HOSPITALIZATION PLANS

The status of the plans is shown according to the following classifications:

- | | |
|--|--|
| <p>(a) Operating—open for business but may or may not have a membership.</p> <p>(b) Proposed — actively promoted but not formally organized.</p> <p>(c) Consolidated — combined with another active plan either operating or proposed.</p> | <p>(d) Discontinued—was once in operation.</p> <p>(e) Not in existence—is definitely no longer being promoted.</p> <p>(f) Indefinite—status uncertain but considered inactive according to the best available information.</p> |
|--|--|

The type of plan is shown according to the following classifications:

- | | |
|---|---|
| <p>N. Noncommercial plan with single hospital.</p> <p>N'. Noncommercial plan with more than one hospital.</p> | <p>C. Commercial plan with single hospital.</p> <p>C'. Commercial plan with more than one hospital.</p> |
|---|---|

“Noncommercial” designates a plan operated not for profit with the control of the service provisions and membership funds in the hands of hospital administrators and physicians or an agency properly representative of their interests. “Commercial” designates a plan operated for profit or not for profit and directed by a sales agency which contracts with the hospitals.

The classifications given in the following tabulation were made on the basis of the best information available as of October 1936.

Plan	Year of Organization	Status as of October 1936*	Type
ALABAMA			
Hospital Service Corporation of Alabama, Birmingham	1936	b†	N'
ARKANSAS			
Continental Hospital, Fort Smith.....	1933	e	N
Riverside Hospital, Fort Smith.....	1933	f	C
CALIFORNIA			
Approved Hospital Association Hollywood Hospital, Hollywood	1933	e	N
Associated Hospital Service, San Francisco	1936	b	N'
Associated Hospitals Service Fund, San Jose	1933	a	N'
California Hospital Benefit Association, Los Angeles	1933	a	N
County Mutual Hospitals, San Francisco	1934	e	N'
Hospital Service Association, Los Angeles	1934	b	C'
Hospital Service Plan, San Francisco.....	1933	e	N'
Insurance Association of Approved Hospitals, Alameda	1933	b‡	N'
Intercoast Hospitalization Insurance Association (formerly Superior California Hospital Association), Sacramento.....	1932	a‡	N'

* Changes and corrections according to most recent information are:
 † now operating; ‡ reorganized as an insurance company; ‡ discontinued;
 # consolidated with another plan.

Plan	Year of Organiza- tion	Status as of October 1936*	Type
CALIFORNIA—Continued			
Long Beach Community Hospital, Long Beach	1935	f	N
Mutual Hospital Service Plan, Fresno.....	1933	f	N'
Mutual Protective Association, San Jose..	1934	c	N'
(No name), Los Angeles.....	1933	f	N'
San Diego County Mutual Association, San Diego	1933	e	N'
San Luis Sanitarium Medical Group, San Luis	1933	e	N
Santa Barbara Hospital Health Insurance, Santa Barbara	1931	f	O
South San Francisco Hospital, South San Francisco	1934	f	N
West Coast Hospital Association, Oakland	1932	f	O'
COLORADO			
Colorado Health and Hospital Service, Montrose	1933	e	O'
Greeley Hospital, Greeley.....	1932	a	C
Parkview Hospital, Pueblo.....	1933	f	N
Presbyterian Hospital, Denver.....	1932	d	N
CONNECTICUT			
Hospital Service Plan, Inc., Norwalk.....	1935	a	N'
DELAWARE			
Group Hospital Service, Wilmington.....	1935	a	N'
DISTRICT OF COLUMBIA			
Group Hospitalization, Inc., Washington..	1934	a	N'
FLORIDA			
Florida Health Service Association, Orlando	1932	d	O'
(No name), Miami.....	1934	f	O'
The Hospitalization System, St. Lukes Hospital, Jacksonville	1933	a	O
IDAHO			
Samaritan Hospital Service Fund, Nampa	1934	a	N
ILLINOIS			
American City Bureau Plan, Chicago.....	1934	f	O'
Blaine-Ramsay Hospital, Chicago.....	1933	f	N
Champaign-Urbana Hospital Association, Champaign	1936	b	N'
Central Hospitalization, Inc., Chicago.....	1935	e	O'
Central Illinois Hospital Association, Peoria	1936	b	N'
Chicago Hospital Service Association, Inc., Chicago	1932	e	O'
Decatur and Macon County Hospital, Decatur	1933	e	N
Eldorado Hospital, Eldorado.....	1933	e	N
Hospitalization Service Co., Inc., Chicago.	1933	e	O'
Hospital Service Corporation, Chicago....	1936	b†	N'
Illinois Mutual Hospital Aid Society, Chicago	1936	b	C
Mutual Hospitalization Plan, Chicago.....	1933	e	O'
National Hospital Service, Chicago.....	1935	f	O'
North Chicago Community Hospital, Chicago	1933	f	N
Rogers-Post Hospital, Chicago.....	1935	a‡	N
St. Anthony's Hospital, Rock Island.....	1935	b	N

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consolidated with another plan.

Plan	Year of Organiza- tion	Status as of October 1936*	Type
INDIANA			
Delaware-Blackford County Medical Society Plan, Muncie	1935	b	N'
Fellowship Fund Plan, Methodist Hospital, Indianapolis	1933	a	N
Methodist Hospital, Gary.....	1935	a	N
(No name), Fort Wayne.....	1936	b	N'
IOWA			
Community Hospital, Grinnell.....	1918	a	N
KANSAS			
Atchison Hospital, Atchison.....	1933	e	N
Golden Rule Group Hospitalization Plan, Kansas City	1933	a	N
Wesley Hospital Hospitalization Plan, Wichita	1932	a	N
KENTUCKY			
Ashland Hospital Service Association, Ash- land	1936	a	N'
Kentucky Baptist Hospital, (National Hos- pitalization System), Louisville.....	1932	a||	C
Louisville Hospital Service Association, Louisville	1935	f	N'
Mutual Hospital Aid Service, Owensboro	1935	b	C'
Wm. Mason Memorial Hospital, Louisville	1935	f	C
St. Joseph's Infirmary (National Hospitali- zation System), Louisville.....	1932	a||	C
LOUISIANA			
Baton Rouge General Hospital, Baton Rouge	1935	b	N
Flint-Goodridge Hospital, New Orleans....	1933	a	N
Hospital Service Association, New Orleans	1934	a	N'
Mutual Hospital Service, Shreveport.....	1934	a	C'
Schmidt Hospitalization System, New Iberia	1934	f	C'
MARYLAND			
Baltimore Group Hospitalization Plan, Baltimore	1933	f	C'
MASSACHUSETTS			
Greater Boston Hospitalization Corp., Inc., Boston	1933	e	N'
Boston Hospital Council Plan, Boston....	1935	b	N'
(No name), Pittsfield.....	1936	b	N'
(No name), Waltham.....	1935	b	N'
Weymouth Hospital Service Plan, Wey- mouth	1935	a	N
MICHIGAN			
(No name), Battle Creek.....	1934	e	N
Kent County Health Council Plan, Grand Rapids	1933	e	N'
(No name), Flint.....	1936	b	C'
MINNESOTA			
Group Hospital Service, Inc., St. Paul....	1933	e	C'
Minnesota Hospital Service Association, St. Paul	1935	a	N'
Webber Hospital Group, Duluth.....	1933	f	N'
MISSISSIPPI			
Grenada General Hospital, Grenada.....	1935	f	N
(No name), Hattiesburg.....	1935	b	N'
United Hospital Savings, Jackson.....	1935	e	C'

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Plan	Year of Organiza- tion	Status as of October 1936*	Type
MISSOURI			
Barnes Hospital, St. Louis.....	1933	e	N
Group Hospitalization Plan, Research Hos- pital, Kansas City.....	1932	a	N
Group Hospital Service, Inc., St. Louis....	1936	a	N'
Kansas City Hospital Council Plan, Kansas City	1935	f	N'
Menorah Hospital, Kansas City.....	1934	e	N
Nation Wide Hospital Service, St. Louis....	1934	e	C'
NEBRASKA			
(No name), Omaha.....	1936	b	N'
NEW JERSEY			
Dover General Hospital, Dover.....	1935	f	N
Elizabeth General Hospital, Elizabeth.....	1932	a	N
Hospital Service Plan of New Jersey, Newark	1933	a	N'
Monmouth Memorial Hospital, Long Branch	1934	b	N
Mutual Hospitalization Plan, Elizabeth..	1935	f	N
Mutual Hospitalization Plan Dept., Morris- town Hospital, Morristown.....	1935	a	N
Mutual Hospitalization Plan Dept., Perth Amboy Hospital, Perth Amboy.....	1935	b†	N
Mutual Hospitalization Plan Dept., Rahway Hospital, Rahway	1936	b†	N
(No name), Asbury Park.....	1935	b	N'
NEW YORK			
American Hospitalization Service Co., New York City	1934	e	C'
Associated Hospital Service, New York City	1935	a	N'
Associated Hospital Service of the Capital District, Albany	1936	a	N'
Community Hospital Association, Geneva..	1935	a	N
Horton Hospital Service Corporation, Middletown	1935	a#	N
Hospital Insurance of Western New York, Buffalo	1935	b	N'
Jewish Memorial Hospital, New York City	1933	c	N
M. L. Johnstone, Inc., New York City	1932	f	C'
Lenox Hill Hospital, New York City.....	1932	c	N
Lutheran Hospital, Brooklyn.....	1933	c	N
Margaretville Hospital, Margaretville....	1936	b	N
(No name), Troy.....	1933	a||	N'
(No name), Watertown.....	1935	b	N'
Rochester Hospital Service Corp., Rochester	1935	a	N'
Sydenham Hospital, New York City.....	1934	c	N
Syracuse Hospital Service, Inc., Syracuse	1936	a	N'
U. S. Travelers Hospitalization Corp., New York City	1932	f	C'
Westchester Hospital Association, White Plains	1935	e	N'
NORTH CAROLINA			
Burrus Memorial Hospital, High Point....	1933	a	C
Hospital Care Association, Durham.....	1933	a	N'
Hospital Savings Association, Chapel Hill	1936	a	N'
North Carolina Baptist Hospital, Winston- Salem	1934	f	N
St. Leo's Hospital, Greenboro.....	1934	c	N
Watts Hospital, Durham.....	1933	c	N

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Plan	Year of Organiza- tion	Status as of October 1936*	Type
OHIO			
City Hospital, Akron.....	1933	e	N
Cleveland Hospital Service Association, Cleveland	1934	a	N'
Flower Hospital, Toledo.....	1934	f	N
Friendship Hospital Association Plan, Cleveland	1932	e	N
(No name), Cincinnati.....	1934	f	N'
Ohio Hospitalization System, Good Sa- maritan Hospital, Sandusky.....	1933	a	C'
OKLAHOMA			
Community Hospital Association, Okla- homa City	1931	a||	C
General Hospitalization of Tulsa, Tulsa...	1933	f	C'
Hospital Mutual, Inc., Oklahoma City....	1933	a	C'
Hospitalization Service, Oklahoma City...	1933	f	C'
PENNSYLVANIA			
Adrain Hospital Association, Punxsutwaney Associate Membership Department, Easton Hospital, Easton	1936	bf	N
.....	1935	a	N
.....	1933	e	N
.....	1932	d	N
.....	1934	b	N
.....	1936	b	N
.....	1936	b	N
SOUTH CAROLINA			
Greenville City Hospital, Greenville.....	1934	e	N
(No name), S. C. State Hospital Associa- tion, Columbia	1936	b	N'
SOUTH DAKOTA			
Black Hills Methodist Hospital, Rapid City	1935	a	N
TENNESSEE			
Baptist Memorial Hospital, Memphis.....	1933	a	N
The Hospitalization System, Fort Sanders Hospital, Knoxville	1932	a	C
Hospital Service Plan, Holston Valley Hospital, Kingsport	1935	a	N
Memphis Hospital Service, Memphis.....	1934	a	N'
National Hospitalization Bureau, Memphis	1933	f	C'
TEXAS			
Baylor University Hospital, Dallas.....	1929	a	N
Fort Worth Hospital, Fort Worth.....	1932	f	N
Hospital Service Association, Houston....	1931	a†	C'
Hospital Service Association, San Antonio	1931	a†	C'
Hospital and Medical Insurance, Texas City	1934	f	C
Hospital Service System, Inc. of Texas and Oklahoma, Dallas	1933	e	C'
Methodist Hospital, (National Hospitaliza- tion System), Dallas.....	1931	a	C
Rushing Clinic and Sanitarium, Dallas.....	1933	f	N
St. Paul's Hospital (National Hospitaliza- tion System), Dallas.....	1931	a	C
VIRGINIA			
Danville Community Hospital, Danville....	1934	f	N
Henry Franklin Hospital Corporation, Richmond	1933	e	C
Lee General Hospital, Pennington Gap....	1933	f	N
Masonic Hospital, Appalachia.....	1933	f	N
Richmond Hospital Service Association, Richmond	1935	bf	N'
Tidewater Hospital Service Association, Norfolk	1935	a	N'
Winchester Memorial Hospitalization Plan, Winchester	1936	b	N

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Plan	Year of Organiza- tion	Status as of October 1936	Type
WASHINGTON			
Longview Memorial Hospital, Longview...	1933	f	N
South Bend General Hospital, South Bend	1933	e	N
WEST VIRGINIA			
Associated Hospitals, Inc., Bluefield.....	1933	a	N'
Citizen's Hospital, Welch.....	1933	c	C'
Hospital Service, Inc., Charleston.....	1933	a	N'
Oak Hill Hospital, Oak Hill.....	1933	f	N
St. Mary's Hospital Service Plan, Hunt- ington	1933	b	N
WISCONSIN			
Mercy Hospital, Janesville.....	1935	f	N
Mount Sinai Hospital, Milwaukee.....	1933	d	N

Summary		
Year of Organization	Status as of October 1936	Type of Plan
1918—1	a—56	N—73
1929—1	b—34	N'—53
1931—6	c—10	C—15
1932—18	d—4	C'—31
1933—58	e—29	—
1934—27	f—39	172
1935—39	—	
1936—22	172	
—	172	

NEWLY ORGANIZED PLANS

Plans not included in the tabulation are as follows (O, operating; P, proposed):

- Bridgeport Hospital, Bridgeport, Conn. (P)
- Danbury Hospital, Danbury, Conn. (P)
- Hospital Service Fund, Inc., New Haven, Conn. (O)
- (No name) Coeur D'Alene, Idaho (P)
- Associated Hospital Service of Illinois, Inc., Chicago (O)
- Decatur Hospital Service Corporation, Decatur, Ill. (P)
- (No name) Gary, Ind. (P)
- (No name) Indianapolis (P)
- Finley Hospital, Dubuque, Iowa (P)
- College Hospital, Berea, Ky. (P)
- Community Hospital Service Association, Louisville, Ky. (P)
- Associated Hospital Service of Baltimore, Baltimore (P)
- Philadelphia Hospital, Philadelphia, Miss. (P)
- Central New York Hospital Service Corporation, Utica, N. Y. (O)
- Jamestown Hospital Service Corporation, Jamestown, N. Y. (O)
- (No name) Cortland, N. Y. (P)
- (No name) Elmira, N. Y. (P)
- (No name) Schenectady, N. Y. (P)
- (No name) Steuben County, N. Y. (P)
- Hospital Service Association of Summit County, Akron, Ohio (O)
- (No name) Toledo, Ohio (P)
- Abington Memorial Hospital, Abington, Pa. (P)
- (No name) Providence, R. I. (P)
- (No name) Woonsocket, R. I. (P)
- (No name) Atlanta, Texas (P)

Appendix C

CONTRACT BETWEEN INDIVIDUAL HOSPITAL AND A GROUP OF SUBSCRIBERS—NO SALES AGENCY

We, the employes of.....Company, do hereby undertake to provide for each other, as need and occasion may arise and require, hospitalization benefits and services in.....Hospital under their Group Hospitalization Plan to the extent and under the limitations hereinafter set forth. This hospitalization group is to be known as the.....Group and is composed of bona fide full time regular employes of.....Company, whose representative to contact.....Hospital, mutually satisfactory to all concerned is to be.....

Name Service Capacity

It is the purpose and intent of the said.....Hospitalization Group,.....Hospital being duly advised and consenting, to provide for its members the following hospital service at.....Hospital when and as needed while bed patients in said hospital and in the care and on the written authorization of the personal private physician of each individual patient then and there attending said patient in the said hospital, the said benefits to apply, as if and when needed and professionally authorized, for a maximum period of 35 hospital days each year hereafter, with 33 $\frac{1}{2}$ per cent reduction for necessary hospitalization after the first 35 days have been used by the member-patient.

1. A \$5.00 private or semi-private room.
2. Meals—In.....a selective menu is furnished from which to choose.
3. General nursing care, including graduate head nurses and supervisors.
4. The services, at the disposal of the patient's personal physician, of the house staff of.....Hospital, including a medical director, a resident house physician, a resident house surgeon, a resident obstetrician, and thirteen other graduate physicians ready at any hour to render first aid or relief assistance, on the requirement of the patient's physician.
5. Personal service—Nonprofessional.
6. All needed operating room service.
7. All necessary anesthetics and anesthetic service.Hospital's anesthetic department is under the personal charge of a full-time employe, a physician specialist of many years experience, recognized nationally as a leading authority in anesthesiology. There is no better service than this in all the nation.
8. All needed pathological laboratory service of every kind, as indicated, and ordered by your doctor during your hospitalization, including blood count, blood chemistry, urinalysis, blood typing, gross and microscopic examination of all surgical sections, etc., etc.—in brief, the entire services of a great pathological laboratory devoted entirely to hospital service under the full-time direction of an experienced physician specialist in pathology, assisted by a large staff of competent technicians. Few hospitals can give such service.
9. All medicines.
10. Surgical dressings.
11. Hypodermics.

12. First aid and emergency treatment, at direction of your physician.

13. Surgical binders.

14. Casts and operating room supplies.

15. Electrocardiogram tracings when needed in heart cases while in hospital.

16. Use of pollen machine in unusual cases of asthma or acute hay fever while in hospital.

17. Free use of oxygen tent when needed and prescribed while in hospital.

18. All of the services of the general employes and staff ofHospital.

19. 50% reduction on maternity cases where the patient has been a member of the plan ten months.

20. 50% reduction in cases of diseases not common to both sexes when the patient has been a member ten months or more.

All hospital services herein above enumerated are to be given subject to the approval of the Medical Director of..... Hospital.

Except in accidents, group hospitalization benefits do not apply in surgical cases until the subscriber has been a member for at least ninety days. (This provision is inserted at the urgent request of members to prevent exploitation of their group funds by newcomers seeking the avoidance of an immediate hospital bill.)

No age limit applies as long as the member is actually and actively employed and employable, and is actually in active service in the employ of the said employer.

The above mentioned benefits do not include or apply to rest cures, ambulant treatments, incurable cases, semi-invalidism or continuing convalescence, but are limited to active cases under progressive therapy and needing bed care.

This group hospitalization shall not apply in cases of pulmonary tuberculosis, or chronic mental and nervous disorders, or acute venereal infections, or virulent or quarantinable contagions.

This plan does not apply to workmens' compensation cases, industrial hazards or cases coming under the supervision of the Industrial Accident Board, or to injuries received while in the line of occupational duty.

The plan does not include the patient's doctor bill, either physician or surgeon, nor does it include the services of a special private nurse, nor unusual serums.

The employment of the patient's physician is in his own hands and at his own cost.Hospital has no part in his selection.Hospital furnishes no medical service except under the direction of the patient's own personal physician and then only to bed patients in the hospital. Admission to the hospital under this plan is only on the written authorization of the patient's personal physician.

All members of the.....County Medical Society are eligible to use the facilities of.....Hospital, and no patient can be admitted toHospital except under the care and upon the authorization of some member of the.....County Medical Society, patient to leave hospital when discharged by doctor. When a patient is discharged by his doctor, the benefits of group hospitalization no longer apply, and any further stay in the hospital is at the charge and expense of the patient, and is not chargeable either to the funds of the Group Hospitalization or to the hospital.

In case of epidemic, public disaster or other conditions occasioning an over-crowding of the capacity of.....Hospital to such a degree that it is not possible to provide accommodations and in case adequate accommodations cannot be secured elsewhere in the city, then in the face of such an emergency, the responsibility of.....Hospital under this contract shall be discharged by the refund to the patient of twice the

amount that has been paid by the patient under this contract during the last twelve months immediately preceding, and such payment shall constitute a full and final discharge of the obligations of.....Hospital hereunder.

It is agreed and understood that the sum of seventy-five cents per month, subject to any special rating credits as endorsed hereon, shall be collected by the said representative of this group and by him or her transmitted and paid to.....Hospital to be there held and disbursed in payment for hospital services as herein specified and rendered to members of this said Hospitalization Group by and in said.....Hospital.

It is further and specifically understood and agreed by all concerned, and more particularly by the signatories hereto, thatHospital has no control or nor responsibility for the funds collected under this Group Hospitalization Plan, and is not in any manner or measure obligated to furnish hospitalization hereunder, until the said funds as collected by the representative of the Group and its membership shall have been paid over by the group representative to.....Hospital.

In any and all events, it is expressly understood and mutually agreed that the.....Company is in no wise or sense or degree a guarantor or insurer under the terms of this memorandum either to the said.....Hospital or to any employe of the said employer and no liability is attached by this memorandum in any wise hereunder to the said employer. The sole object and purpose for the said hospitalization group to be "company handled" or "company fostered" is to provide a mutually convenient and economical means and mode of collecting the monthly dues of the employes who are members of the said.....Hospitalization Group.

Hospital protection for the aforesaid group under.....Group Hospitalization was begun....., 193., and is henceforth continued under the terms of this memorandum from date hereof, to-wit,....., 193...

As part of this memorandum.....riders are attached below and made part hereof.

.....
 Hospitalization Group
 by.....
 Group Representative

 Firm Representative

 HOSPITAL
 by.....

**CONTRACT BETWEEN HOSPITAL AND SALES AGENCY
 FOR PROMOTION OF A GROUP HOSPITALIZATION
 PLAN**

THE STATE OF.....
 COUNTY OF.....

THIS AGREEMENT made and entered into by and betweenHospital, hereinafter designated as First Party, and.....Hospitalization System, Inc., a Corporation, with an office in....., herinafter designated as Second Party, WITNESSETH:

That First Party hereby constitutes and appoints Second Party its exclusive agent for a period of Five years from the date hereof, which appointment Second Party here and now accepts, for the purpose of canvassing and soliciting, through agents appointed by it, applications for membership in First Party's hospitalization plan, and the forwarding of such applications to First Party and the collecting of all payments due from such applicants.

In consideration of such appointment Second Party agrees to secure at least 2,000 Hospital Plan members for First Party within a period of One Year from date hereof, and should First Party fail to secure said number of members by the end of said yearly period, this contract may be canceled at option of First Party.

Second Party is hereby authorized to secure during said Five Year period not more than 5,000 members. All persons certifying to good health, between the ages of 15 and 65 regularly engaged in occupations from which they earn a livelihood and college students, excepting housewives, shall be eligible for membership and applications secured from such persons shall be accepted by First Party and First Party agrees to enter into contract with such applicant as per Exhibit "A" attached hereto and made a part hereof.

The annual price per member, including a cash membership fee of \$1.00 shall be \$10.00 the first year and may be payable as follows: \$1.75 for the first month and 75c per month thereafter, or same may be paid on the same basis, quarterly, semi-annually or annually.

The Second Party shall receive as compensation for services rendered during the period of this contract, a commission of \$4.00, including membership fee of \$1.00, on each annual membership for the first year and \$3.00 on each annual collection thereafter during the life of this contract.

Second Party shall collect all payments due and payable by the members and shall remit \$6.00 on each annual membership to the First Party, if, as and when collected. Annual payments shall be made to the respective parties to this contract as herein set out on all memberships which are renewed.

During the period of time this contract is in force, First Party agrees not to sell or offer for sale, directly or indirectly, any plan for membership in its hospital similar to the one to be sold by Second Party through any other agent or person except Second Party, except in case the State and County Society offer a plan of hospitalization and medical care, which this hospital would wish to enter into.

First Party further agrees that at the termination of this contract, it will not sell or offer for sale any similar plan for membership in its hospital until it has first offered such plan to Second Party, who shall have ten days from the date such offer is made in which to accept or reject First Party's offer.

Second Party or its agents, is to furnish all literature, make all collections, maintain its own offices or office and have all clerical work done at its own expense and First Party is not obligated to incur any expense or cost except that it shall write a letter to be sent with identification card and certificate to its members.

Second Party,Hospitalization System, Inc., will procure from its agents or representatives who have control of collection of funds under this contract, a bond with corporate surety, (satisfactory to First Party) payable to First Party in the sum of \$2,500.00 which bond shall be conditioned that such agents and representatives of Second Party will faithfully account and pay over to First Party all amounts collected under this contract to which First Party may be entitled. Said bond shall be procured and tendered to First Party before any collections shall be made by Second Party's agents, territory to be solicited and included as follows: [List of cities.]

It is the intention of the parties to this contract that it be construed as a contract of "Agency" only and not a contract of sale. This contract becomes effective from.....193...

EXECUTED THIS.....day of.....A. D. 193...

.....HOSPITAL

By....., Pres.

....., Sec.

.....HOSPITALIZATION SYSTEM, INC.

By....., Pres.

Party of the Second Part

CONTRACTS AND BY-LAWS OF HOSPITAL SERVICE
CORPORATIONS

CERTIFICATE OF INCORPORATION

We, the undersigned, desiring to form a corporation under and by virtue of the Laws of the State of..... pursuant to the provisions of the Insurance Law and the provisions of the Membership Corporations Law, do hereby make, sign, acknowledge and file this certificate for that purpose, as follows:

1. The name of the proposed corporation shall be.....
HOSPITAL SERVICE CORPORATION.

2. The purposes for which it is to be formed are:

(a) To establish, maintain and operate a nonprofit Hospital Service Plan, whereby hospital care may be provided by this corporation, or by a hospital with which it has a contract for such care, and which is maintained by the state, or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as shall be designated by the state department of social welfare, to such of the public who become subscribers to said Hospital Service Plan.

(b) To make and enter into contracts with hospitals maintained by the State, or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as shall be designated by the state department of social welfare for such purposes for the providing of hospital care to such of the public as become subscribers to said Hospital Service Plan.

(c) To do anything and everything necessary, suitable, proper, convenient or incidental to the aforesaid purposes, or which may be done by a corporation organized for such purposes under the laws of the State of....., together with all the powers now or which may hereafter be permitted to it by the laws of the State of.....

3. The territory in which its operations are principally to be conducted is the City of.....and adjacent territory.

4. The city and county in which its office is to be located are the City of....., County of.....

5. The number of its directors shall be eleven (11).

6. The names and residences of the directors until the first annual meeting are: [List of names and residences.]

7. Of the persons named as directors, at least one is a citizen of the United States and a resident of the State of..... and at least a majority are directors or trustees of hospitals designated in..... of the Insurance Law.

8. All of the subscribers to this certificate are of full age; at least two-thirds of them are citizens of the United States; at least one of them is a resident of the State of.....

IN WITNESS WHEREOF, we have made, subscribed and acknowledged this certificate this.....day of....., 193...

BY-LAWS

ARTICLE I

Membership

Section 1. *Classification of Members.* Members in the Association shall consist of three classes, viz: Voting Members, Members at Large and Participating Hospital Members.

Section 2. *Voting Members.* The Voting Members of the Association shall consist of [designated officers of hospital associations and medical societies].

SECTION 3. *Members at Large.* Members at Large shall consist of such individuals, associations, firms or corporations as may be elected by vote of a majority of the members of the board of directors of the Association, and who shall have such voting rights, if any, as may be conferred upon them by such a majority of the members of the board of directors of the Association.

In the event that voting rights be conferred on any Members at Large, and if the membership be in the name of an association, firm or corporation, the name of the individual representative of such association, firm or corporation who shall exercise the power of membership, shall be certified to the Secretary of the Association. No individual association, firm or corporation shall have more than one vote. A member who is absent from any annual or special meeting of the Association may be represented by another member of the Association, firm or corporation if certified to the secretary of the Association or by written proxy given to some person actively associated with such firm or corporation.

Section 4. *Participating Hospital Members.* Participating Hospital Members shall consist of hospitals maintained by the state, or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as have been designated by the state department of social welfare, with which the Association may at the time have a contract for the providing of hospital service to subscribers to the hospital service plan of the Association, and who have been elected by the vote of a majority of all of the directors of the Association. Participating Hospital Members shall be entitled to no voting rights. The membership of any participating hospital in this Association shall cease when the contract between this Association and such hospital for hospital service has been terminated.

Section 5. *Application for Membership.* Any person, firm, corporation or association desiring to procure a Membership at Large or Participating Hospital Membership in the Association shall present to the Association a written application signed by the applicant which in the case of applicants for Participating Hospital Membership shall have attached thereto an agreement signed by the applicant for the rendering of Hospital service to the subscribers to the hospital service plan of the Association.

Upon receipt of the application for membership, the president shall cause a vote of the directors to be taken thereon at a meeting of the directors. All questions in relation to the admissions of members shall be determined by the majority vote of all the directors of the Association. If the vote is favorable, the secretary shall notify the applicant of its election and the applicant shall be enrolled in the membership of the Association.

Section 6. The Association shall not issue any stock but it may, if desired, issue certificates of membership which will be executed by the president and the secretary.

ARTICLE II

Meetings of Members

Section 1. *Annual Meetings of Members.* The annual meeting of the voting members of the Association shall be held at the office of the Association in the City of on the second Monday in April in each year at five o'clock p. m. for the election of directors and the transaction of such other business as may properly come before said meeting. If such second Monday in April falls on a legal holiday then such meeting shall be held on the next ensuing business day.

Section 2. *Notice of Annual Meeting of Members.* Notice of the time, place and purposes of such annual meeting shall be served either personally or by mail upon each member of the Association entitled to vote at such meeting not less than ten nor more than forty days before the meeting. If mailed it shall be addressed to each such member at his address as it appears on the records of the Association.

Section 3. *Special Meetings of Members.* Special meetings of the members shall be held at the office of the Association in the

City of or at such other place within the City of as may from time to time be designated in the call for and notice of the meeting and may be called at any time by the president or by a majority of the board of directors.

Section 4. Notice of Special Meetings. Notice of the time, place and purposes of every special meeting of the members shall be served either personally or by mail upon each member of the Association entitled to vote at such meeting not less than ten nor more than forty days before the date of such meeting. If mailed it shall be addressed to each member at his address as it appears on the records of the Association.

Section 5. Quorum. At all annual and special meetings of members there shall be present at least ten members of the Association entitled to vote at such meeting, either in person or by proxy, in order to constitute a quorum for the transaction of business, but less than a quorum may adjourn such meeting from time to time without notice until a quorum is present.

Section 6. Voting. Each Voting Member and each Member at Large who shall have been given voting rights as provided in these by-laws shall be entitled to one vote at any meeting of the members.

ARTICLE III

Board of Directors

Section 1. Number and Qualifications. The affairs, property and business of the Association shall be managed by a board of eleven (11) directors, all of whom shall be of full age and at least one of whom shall be a citizen of the United States and a resident of the State of At least a majority of the directors of the Association must be at all times directors or trustees of hospitals which have contracted or may contract with the Association to render to its subscribers hospital service, and which are hospitals maintained by the State of or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as have been designated by the state department of social welfare. The directors of the Association need not be members.

Section 2. How elected. The directors of the Association shall be elected at the annual meeting of the members in each year by a plurality of the votes of the members entitled to vote therefor, or their duly constituted proxies, cast at such election.

Section 3. Filling of Vacancies. Except as otherwise provided by law vacancies in the board of directors occurring during the year may be filled for the unexpired term by a majority vote of the remaining directors, though less than a quorum, at any meeting of the board of directors.

Section 4. Powers and Duties. The board of directors shall have the general management of the affairs, property and business of the Association and subject to these by-laws may adopt such rules and regulations for that purpose and for the conduct of its meetings as the board may deem proper. It shall have the power to appoint an executive committee, an investment committee and such other committees as from time to time shall be deemed advisable, each such committee to have such number of members and such powers as shall be fixed in the resolution of the board of directors creating and appointing such committee.

The board of directors may delegate the powers and duties, or any portion or portions thereof, of any absent officer to any other officer or director. They shall have power to elect and remove officers, appoint and discharge agents and employees, and shall have authority, by a concurring vote of a majority of all of the board of directors, to fix and determine their salaries or compensation.

ARTICLE IV

Meetings of Directors

Section 1. Annual Meeting of Directors. A meeting of the newly elected board of directors elected at the annual or any other meeting of the members of the Association shall be held for the

purpose of organization, election of officers and the transaction of other business at such time and place as shall be fixed by the members at their meeting at which such election is held or by written consent of all such directors or upon two days' written notice mailed to each duly elected director at his last known post office address.

Section 2. Regular Meetings. Regular meetings of the board of directors shall be held at such time and place as may be determined by resolution of the board of directors and no notice shall be required for any regular meeting except as otherwise provided by law. Any business may be transacted at any regular meeting.

Section 3. Special Meetings. Special meetings of the board of directors may, unless otherwise prescribed by law, be called at any time by the president or the secretary. On the written request of any two directors the secretary shall call a special meeting of the board. Special meetings shall be held at the office of the Association in the city of, or at such other place as may from time to time be designated by resolution of the board of directors.

Section 4. Notice of Special Meetings. Unless otherwise prescribed by law notice of the time, place and purposes of any special meeting of the board of directors shall be served either personally upon each director or mailed or telegraphed to his address as it appears upon the records of the Association or to his last known post office address not later than two days prior to the meeting.

SECTION 5. Quorum. At all meetings of the board of directors a majority of the directors shall constitute a quorum for the transaction of business but less than a quorum may adjourn such meeting from time to time without further notice until a quorum is present. Except as otherwise by law or in these by-laws provided, any act of a majority of the directors constituting a quorum shall be the act of the board of directors.

ARTICLE V

Officers

Section 1. The Association shall have as executive officers a president, one or more vice presidents, a secretary and a treasurer, all of whom shall be chosen by the directors annually at the first meeting of the board of directors following the annual meeting of members and each officer shall hold office until the corresponding meeting in the next year or until his successor shall have been duly elected and qualify. The president shall be chosen from among the members of the board of directors. Any vacancy in any of the above offices shall be filled for the unexpired portion of the term by the board of directors at any regular meeting, or at any special meeting called for such purpose. The Association may also have one or more assistant secretaries, one or more assistant treasurers and such other officers or agents as the board of directors may deem necessary, who shall hold office for such term as the board of directors may fix and who shall have such authority and perform such duties as the board of directors may prescribe.

Section 2. President. The president shall be the chief executive officer of the corporation. It shall be his duty to preside at all of the meetings of the board of directors and members. He shall have power to make and execute contracts in the ordinary business of the corporation and for and in the name of the corporation, to execute with the secretary all deeds, mortgages, bonds, certificates of membership and other obligations or instruments when authorized by the board of directors. He shall have the power with the treasurer to execute all annual or other reports or statements of the corporation, which may be required by law. He shall have, subject to the approval of the board of directors, general management of the affairs of the corporation and perform all duties incidental to his office.

Section 3. *Vice Presidents.* In the absence or inability to act of the president or if the office of president be vacant, the vice-presidents in order of seniority may exercise all the powers of the president. The vice-presidents shall have such power and perform such other duties and execute such contracts on behalf of the corporation as may be assigned to them or authorized by order of the board of directors.

Section 4. *The Treasurer.* The treasurer shall have general supervision over the care and custody of the funds and securities of the Association and shall deposit the same or cause the same to be deposited in the name of the Association in such bank or banks, trust company or trust companies, and in such safe deposit company or safe deposit companies, as the board of directors or any committee designated and vested with such power by the board of directors, may designate. He shall keep or cause to be kept full and accurate accounts of all receipts and disbursements of the Association and whenever required by the board of directors he shall render or cause to be rendered financial statements of the Association. He shall prepare and execute with the president and file any annual report or reports, statement or statements, which may be required by law.

Section 5. *The Secretary.* The secretary shall keep the minutes and act as secretary of all meetings of members of the board of directors. He shall be responsible for the giving and serving of all notices of meetings of the members and the board of directors of the Association. He shall be the custodian of the corporate records and of the corporate seal of the Association and shall see that the corporate seal is affixed to all documents, execution of which, on behalf of the Association, under its seal is duly authorized, and when so affixed may attest the same. He shall have the power with the President to make and execute for and in the name of the Association all certificates of membership, deeds, bonds, contracts and other obligations or instruments when authorized by the board of directors. He shall in general perform all duties usually instant to the office of secretary and such other duties as may from time to time be assigned to him by the board of directors.

Section 6. *Compensation of Officers.* No officer of the Association shall receive directly or indirectly any salary, compensation or emolument from the Association as such officer or in any other capacity unless authorized by the concurring vote of majority of all directors.

Section 7. *Bonds.* The board of directors shall have power to require any officer or employee of the Association to give bond for the faithful discharge of his duties in such form and with such surety or sureties as the board of directors may deem advisable.

ARTICLE VI

Contracts of Association

Section 1. *Limitation on Contracts.* No director or officer of the Association shall be interested directly or indirectly in any contract relating to the operations conducted by the Association, nor any contract for the furnishing of supplies to the Association, unless authorized by the concurring vote of two-thirds of the directors. Nothing in this section contained, however, shall be construed as preventing or in any way limiting the right of a hospital of which a director or an officer of the Association may be directly or indirectly interested as a member of its staff or otherwise, from contracting with the Association for the furnishing of the hospital care and service to subscribers for the benefits of the Association's Hospital Service Plan.

Section 2. *Contracts for Hospital Care.* This Association may enter into contracts for rendering of hospital service to any of the subscribers to its hospital service plan only with hospitals maintained by the State, or of any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of this state, or such other hospitals as have been designated by the state department of social welfare for such purpose.

ARTICLE VII

Negotiable Instruments

Section 1. *Signature on Checks, etc.* All checks, drafts, bills of exchange, notes or other obligations or orders for the payment of money shall be signed in the name of the Association by such officer or officers, person or persons as the board of directors of the Association may from time to time designate by resolution.

ARTICLE VIII

Funds

Section 1. *Investments.* The funds of this Association shall be invested only in securities provided by the law of this state for the investment of life insurance companies.

ARTICLE IX

Principal Office

SECTION 1. *Location.* Principal office of the Association shall be located in the City and State of The location of said office in may at any time be changed by vote of the board of directors. It shall then be the duty of the secretary to notify the members of such change of location of the principal office.

ARTICLE X

Seal

Section 1. *Description.* The seal of the Association shall be circular in form, with the name of the Association in the circumference and the words and figures "Incorporated—1934—....." in the center.

ARTICLE XI

Fiscal Year

Section 1. *Definition.* The fiscal year of the Association shall be from the first day of January to the 31st day of December, inclusive, in each year or such other twelve months as the board of directors may by resolution designate.

ARTICLE XII

Waiver of Notice

Section 1. *Meetings Held on Waiver.* Whenever under the provisions of these laws or any laws of the State of, the Association, the members, the board of directors or any committee is authorized to take any action or hold any meeting after call, notice, the lapse of any prescribed period of time or any other prerequisite, such action may be taken or such meeting may be held without such call, notice, lapse of time or other prerequisite if such action be authorized or approved and such requirements be waived in writing by every person entitled to notice or to participate in such action.

ARTICLE XIII

Amendments

Section 1. *How Made.* These by-laws may be amended, added to or altered or repealed, or new by-laws may be adopted at any meeting of the members of the Association, or of the board of directors, by a vote of at least a majority of the voting members or two-thirds of the directors of the Association, as the case may be, provided notice that said proposed action is to be considered and acted upon and stating the nature thereof is inserted in the notice or the waiver of notice of said meeting.

CONTRACT WITH MEMBER HOSPITAL

THIS AGREEMENT, made and entered into this day of, 19....., by and between HOSPITAL SERVICE CORPORATION, a corporation (hereinafter called "the Corporation") and of (hereinafter called "the Hospital"),

WITNESSETH:

WHEREAS, the Corporation has undertaken to operate the Non-Profit Plan for Hospital Care (hereinafter referred to as "the Plan") more specifically described in the copy of the Plan annexed hereto and made a part hereof; and

WHEREAS, the Hospital desires to become a member hospital under the Plan upon the terms and conditions herein specified;

NOW, THEREFORE, in consideration of the premises and the agreements herein contained, it is covenanted as follows:

1. The Hospital agrees to render hospital care as defined in the Plan to all subscribers to the Plan and their designated dependents who may apply for admission to the Hospital in the manner specified in the Plan.
2. The Hospital agrees not to charge or collect from any subscriber to the Plan any amount whatsoever for any hospital care included in the Plan which it may render such subscriber.
3. The Hospital agrees that, for all hospital care included in the Plan which it may render any designated dependent of a subscriber, it will charge and collect from such dependent not to exceed fifty per cent (50%) of its regular fixed charges for such services.
4. The Hospital agrees at all times to maintain insurance in a company or companies satisfactory to the Corporation indemnifying the Hospital and the Corporation against claims for malpractice in the Hospital to the extent of not less than Five Thousand Dollars (\$5,000.00) for each person and with a limit of not less than Ten Thousand Dollars (\$10,000.00) per year.
5. The Hospital further agrees to indemnify and keep and save the Corporation harmless from and against any and all claims, damages, costs and expenses that may be made against or incurred by the Corporation by reason of any refusal by the Hospital, its agents or employees, to admit, when reasonably able to do so, any subscriber or dependent to the Hospital pursuant to the terms of the Plan.
6. The Corporation agrees to pay to the Hospital for all hospital care covered by the Plan which the Hospital may render to each subscriber the sum of Six Dollars (\$6.00) for each day of hospital care as defined in the Plan, provided that if on any one admission any subscriber shall receive less than four (4) days of such hospital care then the Corporation agrees to pay to the Hospital the sum of Fourteen Dollars (\$14.00) for a one-day stay, the sum of Seventeen Dollars (\$17.00) for a two-day stay or the sum of Twenty Dollars (\$20.00) for a three-day stay; and provided, further, that in case of treatment of an ambulatory accident case, the Corporation shall not pay to the Hospital any amount in excess of the Hospital's regular fixed charge for such services.
7. The Corporation agrees to pay to the Hospital on account of all hospital care covered by the Plan which the Hospital may render to each designated dependent of a subscriber the sum of Three Dollars (\$3.00) for each day of hospital care as defined in the Plan; provided that if on any single admission any such dependent shall receive less than four (4) days of such hospital care, then the Corporation agrees to pay to the Hospital the sum of Seven Dollars (\$7.00) for a one-day stay, the sum of Eight and 50/100 Dollars (\$8.50) for a two-day stay or the sum of Ten Dollars (\$10.00) for a three-day stay; provided, further, that in case of treatment of an ambulatory accident case, the Corporation shall not pay to the Hospital any amount in excess of one-half of the Hospital's fixed charges for such services.

8. As conditions precedent to the obligation of the Corporation to make any payment for care rendered by the Hospital to a subscriber or designated dependent, the Hospital shall, prior to its discharge of such subscriber or dependent, mail to the Corporation the identification card issued to such subscriber or dependent together with a notice of admission duly signed by the admitting officer of the Hospital, and the Hospital shall likewise promptly furnish the Corporation such information and records concerning the diagnosis, treatment and care of such subscriber or dependent, and the Hospital's regular charges for such care, which the Corporation may, within thirty (30) days after its receipt of notice of admission, in writing request. Within sixty (60) days after full compliance by the Hospital with the foregoing conditions, the amount fixed in Paragraph Seven or Eight shall be due and payable by the Corporation.

9. In the event of any dissolution or liquidation of the business of the Corporation at any time, then the Corporation hereby agrees to pay to the Hospital an amount equivalent to that proportion of the assets of the Corporation remaining after the payment of all obligations of the Corporation (other than obligations to other hospitals similar to the obligation in this paragraph contained) which the total number of days of hospital care theretofore rendered subscribers (but not dependents) by the Hospital hereunder bears to the aggregate number of days of hospital care theretofore rendered subscribers by all member hospitals with which the Corporation at any time since its incorporation has contracted or may contract.

10. The Corporation reserves the right to change from time to time the amounts payable to the Hospital hereunder or the type of hospital care to be furnished by the Hospital to subscribers to the Plan or their designated dependents, subject, however, to the approval of the State Department of Public Welfare. Written notice of each such change shall be mailed to the Hospital, and no change decreasing the amounts payable to the Hospital or increasing the hospital care to be furnished by the Hospital shall be effective until the expiration of not less than forty-five (45) days after the mailing of notice thereof. No such change shall in any event affect the amounts payable for hospital care theretofore rendered by the Hospital.

11. This agreement may be terminated by either party at any time upon thirty (30) days' prior written notice to the other.

IN WITNESS WHEREOF, the parties have caused this agreement to be duly executed, as of the day and year first above written.

HOSPITAL SERVICE CORPORATION
 By.....
 President
Hospital
 By.....
 President

CONTRACT WITH SUBSCRIBER

I. Definition of the Term "Subscriber."

1. The term "subscriber" shall mean any individual with whom the Hospital Service Corporation enters into a subscription agreement.

II. Subscription Agreement and Effective Date of Benefits Thereunder.

1. The term "subscription agreement" is deemed to mean the agreement entered into between this Corporation and the individual subscriber under and by virtue of which said subscriber becomes entitled to the benefits of this Plan, and shall consist of the application of the subscriber and the certificate issued by the Corporation evidencing the acceptance of the application.

2. Any person desiring to obtain the benefits of this Plan shall make written application therefor on the forms furnished by this

Corporation. No such application shall become effective as a subscription agreement until the same is approved and accepted by this Corporation, which acceptance shall be signified by a subscriber's certificate executed in the name of the Corporation by a duly authorized officer, bearing the date of said acceptance. Hospital service shall be available to the subscriber ten days after the effective date of the subscription agreement, except that in case of accident or emergency illness the hospital care shall be provided immediately. Such hospital service, however, shall not include the treatment of conditions known to the subscriber to exist and to require hospital service on the date of the application of the subscriber for a subscription agreement.

III. *Effective Period of Benefits Under This Plan—Contract Year.*

1. The effective period of each subscription agreement is the period of one year from its effective date and from year to year thereafter until terminated as hereinafter provided and the term "contract year" shall mean the period of one year following the effective date of any subscription agreement and each yearly period thereafter during the time the subscription agreement is in effect and shall not mean a calendar year.

IV. *Member Hospitals Covered By This Certificate.*

1. The term "member hospitals" shall mean any hospital with which this Corporation has a contract for the rendering of hospital service covered by this certificate.

2. This Corporation will compensate member hospitals periodically for the services rendered by them to the subscribers to this Plan by paying to each a fixed amount per day of hospital service rendered, which amount is at all times subject to the determination of the Board of Directors of this Corporation and subject to the approval of the State Department of Social Welfare.

3. In the event of accident or emergency illness, this Corporation will compensate hospitals, other than member hospitals for services rendered by them to the subscribers to this plan upon the approval of such hospital by the State Department of Social Welfare and in an amount per day for hospital services rendered which shall at all times be subject to the determination of this Corporation, and shall in no event exceed the rate of payment to member hospitals adopted by this Corporation and approved by the State Department of Social Welfare.

4. The membership in this Corporation of any member hospital and the agreement between this Corporation and the member hospital for the rendering of hospital service by such member hospital to the subscribers to this Plan may be terminated by either this Corporation or the member hospital at any time upon thirty days' prior written notice to the other and in the event of such termination the obligation of such hospital to render hospital service shall thereupon cease as to all subscribers to this Plan making application for such service after the effective date of termination.

V. *Hospital Service.*

1. Hospital service includes bed and board, general nursing care, use of the operating room, use of the delivery room, ordinary medications and dressings, anesthesia when such service is supplied by the member hospital and administered by a salaried employee of the hospital, laboratory examinations consisting of urine examinations, complete blood counts, basal metabolism tests, stool examinations and examinations of pathological tissue and other equivalent examinations, and ordinary X-ray examinations, and other customary routine care. The benefits do not include admission of patients to member hospitals for laboratory or X-ray examinations solely for diagnostic purposes. Hospital Service shall include the care of obstetrical cases only after the first year from the effective date of any subscription agreement. Obstetrical care shall include any condition resulting from pregnancy, the care of the mother and shall include the ordinary nursery care of the new-born child during the duration of the hospital stay of the mother.

2. The benefits included hereunder cover the treatment and care of all illness and injuries regularly accepted for treatment by the member hospital selected by the subscriber, but do not in any event cover pulmonary tuberculosis after diagnosis as such, venereal diseases, hospital care provided for under the Workmen's Compensation laws of any state, quarantinable diseases or mental disorders.

3. THE BENEFITS HEREUNDER DO NOT INCLUDE SERVICES OF THE SUBSCRIBER'S ATTENDING PHYSICIANS, SURGEONS, SPECIAL NURSES OR THEIR BOARD. Separate arrangements must be made with the physician, surgeon and special nurse for the payment of their fees for services.

4. This Plan does not confer upon any member hospital any right to select a physician or surgeon for the subscriber. The subscriber shall be at liberty to select his or her physician or surgeon, provided only that such physician or surgeon is acceptable for practice in the member hospital to which the subscriber is admitted, and nothing contained in this Plan shall interfere with the ordinary relationship between the subscriber and any such physician or surgeon selected by the subscriber.

VI. *Conditions Under Which Hospital Service Will Be Rendered.*

1. This Corporation shall not be liable under its subscription agreement unless evidence shall be produced, if and when requested by this Corporation, establishing to the satisfaction of this Corporation that hospital service was not sought or has not been rendered for any condition requiring hospital service known to the subscriber to exist and to require hospital service at the date of the original application.

2. Hospital services shall be rendered under this Plan only upon the recommendation of a physician or surgeon who is a member of the medical staff of or acceptable to the member hospital selected by the subscriber, and any hospital care hereunder shall continue only during such time as the subscriber is under treatment and care of such physician.

3. The subscriber may select any hospital which at the time is a member hospital at the time application is made for hospital service. All service furnished hereunder is subject to the rules and regulations of the member hospital so selected by the subscriber, including the rules and regulations governing admittance.

4. The subscriber when admitted to a member hospital shall occupy a bed in a room designed to serve semi-private patients, but the subscriber may occupy a private room with the consent of his or her physician or surgeon upon payment directly to such member hospital of the difference between \$4.50 and the daily rate for the private room selected.

5. If at the time the subscriber applies for hospital care the member hospital selected by him or her is unable to furnish the required service, the subscriber on the recommendation of his or her physician shall be free to utilize the service of any other member hospital.

6. This Corporation hereby waives a physical or oral examination of any subscriber as a condition to the issuance of this certificate. However, in consideration of such waiver, the subscriber agrees that any physician, surgeon, nurse or hospital that has made a diagnosis or rendered treatment in connection with any illness for which hospital service is sought under this Plan may furnish and is authorized to furnish to this Corporation at any time upon its request any and all information and records or copies of records relating to the diagnosis, treatment or service rendered to the subscriber; it being understood that this Corporation in contracting to render hospital service to its subscribers shall be in the same position with regard to the aforesaid information and records as if this Corporation were itself rendering said hospital service.

VII. *Extent and Duration of Hospital Care.*

1. Hospital service will be furnished on one or more admissions up to and including twenty-one (21) days for each contract year during the times that each subscription agreement is in force, provided service thereunder is begun before the expiration date of such contract year.

2. In computing the number of days of hospital service furnished by a member hospital to a subscriber, the day of the subscriber's admission shall be counted only if the admission is before noon, and the day of the subscriber's discharge shall be counted only if the discharge is after noon; provided, however, that if a subscriber is discharged on the same day that he is admitted, said day shall be counted as one day, and if the subscriber is admitted after noon and discharged before noon on different days, then such portions of the different days shall be considered together as one day.

3. Hospital service in any one contract year in excess of the stipulated twenty-one (21) days will be furnished to the subscriber by any member hospital in which treatment has been begun at a discount of 25% of said hospital's semi-private charges.

4. If the subscriber shall remain in a member hospital after he has been advised by the attending physician that further hospital care is unnecessary, whether or not the stipulated twenty-one (21) days included under this Plan for any one contract year have been exhausted, the subscriber shall pay to the member hospital in cash the full hospital charges for all services received after such advice.

VIII. *Conditions Making the Plan Inoperative.*

1. In case of a war, public disaster, general epidemic or other conditions occasioning an overcrowding of all the member hospitals to such a degree that it is impossible for them to provide hospital service, or in the event that for any reason all member hospitals are unable to provide such service, this Corporation will compensate subscribers for illnesses for which hospital service would otherwise under this Plan have been provided by this Corporation, in the following manner and on the following terms and conditions:

(a) There shall be presented by the subscriber to this Corporation an affidavit satisfactory to this Corporation on the forms furnished by it of the attending physician or surgeon setting forth the nature of the illness for which payment is sought, that in his opinion the illness required and should have received hospital service; and that to his knowledge all member hospitals were unable to provide such service.

(b) The amount which will be paid to the subscriber per day of such illness will be equivalent to the then prevailing rate of payment per day of hospital service by this Corporation to its member hospitals.

(c) The number of days for which such payment will be made shall be the number of days which the records of this Corporation indicate is the average period of hospital service rendered to its subscribers for such illness, which period shall not in any event exceed the period of twenty-one (21) days.

Payment by this Corporation to the subscriber in the manner aforesaid shall constitute a full and final discharge of all the obligations of the Corporation hereunder for said illness.

IX. *Benefits Non-Assignable.*

1. The benefits of any subscription agreement are personal to the subscriber and are in no way assignable.

X. *Payment of Annual Charges.*

1. The amount of the annual charges for subscribers for a contract year shall be determined by the Board of Directors of theHospital Corporation from time to time, and shall be subject to the approval of the Superintendent of Insurance of the State of.....

2. The amount of the annual charges as above determined and the time or times and manner of payment thereof shall be as set forth in the subscription application and as specified thereon by the subscriber.

3. In the event of a change in the amount of the annual charges by the Board of Directors, the subscribers shall be notified of such change. Such change shall, however, not affect the amount of the annual charges under existing subscription agreements until

the end of the contract year, prior to which time the subscriber will be required to sign a new subscription application setting forth the new annual charges. If the subscriber fails to execute such new subscription application, his or her subscription agreement shall automatically terminate.

XI. Automatic Termination.

1. In the event of any default in making payment to this Corporation of the annual charges, in accordance with the provisions of the subscription application of the subscriber, the subscription agreement with such subscriber shall automatically terminate and the subscriber thereafter shall not be entitled to any further benefits under this Hospital Service Plan.

XII. Reinstatement of Subscription Agreement.

1. Any subscription agreement or any agreement between this Corporation and the remitting agent which shall have terminated in any manner as provided herein, may be reinstated by this Corporation in its sole discretion, upon such terms and conditions as it may determine.

XIII. Voluntary Termination.

1. Any subscription agreement may be terminated by either party hereto at any time by giving twenty days' prior written notice to the other, provided, however, that the..... Hospital Service Corporation may not elect to terminate a subscription agreement prior to the expiration of a contract year if at the time the subscriber shall have applied for hospital service, which shall not at the time have been furnished or shall then be receiving hospital service under a subscription agreement.

2. Notice of termination of a subscription agreement, if given by.....Hospital Service Corporation to the subscriber, shall be sufficient if and when mailed to the subscriber at his address as it appears on the records of this Corporation, and if given by the subscriber if and when mailed to this Corporation at its principal office at.....

3. In the event that this Corporation shall elect to terminate a subscription agreement before the expiration of a contract year, it shall refund to the subscriber a sum equivalent to the amount of the annual charges, if any, which have been paid by the subscriber covering the unexpired part of the current contract year and such payment shall constitute a full and final discharge of all obligations of this Corporation hereunder.

CERTIFICATE OF MEMBERSHIP CORPORATION OR ASSOCIATION

HOSPITAL SERVICE CORPORATION OF.....
(Herein referred to as the Corporation)

Agrees to provide for Hospital Service, in any member hospital of this Corporation, for.....the Subscribing Member, herein referred to as member, in accordance with and subject to all the terms and conditions of the By-Laws and Charter of the Corporation.

BY-LAWS

ARTICLE I

[The twelve sections of Article I present the usual provisions of the subscriber's contract.]

ARTICLE II

Section 1. Charter Members shall be those hospitals, herein referred to as Member Hospitals, which enter into a written contract with this Corporation to furnish hospital service to its subscribing and associate members, in accordance with the By-Laws and Charter of the Corporation.

SECTION 2. Subscribing Members. Subscribing Membership in this Corporation shall be limited to approved persons who reside in the state of.....

Section 3. Associate Members. Those eligible for associate membership shall be the following persons only who live in the household of the subscribing member, namely: (a) wife; (b) husband; (c) unmarried minors who are not gainfully employed; and (d) such other persons under the age of 61 in the immediate family of, and entirely supported by the subscribing member, who are specially approved by the Corporation.

[The remaining four sections of Article II discuss the regulations governing application for a Certificate.]

ARTICLE III

Section 1. The Surplus of the Corporation shall consist of such moneys as may be allocated thereto by action of the Board of Trustees and shall be held for the benefit of the subscribing members, to be disbursed to them at such time, or times, in such manner, either as dividends or refunds on their subscriptions, or otherwise as the Board of Trustees may direct.

ARTICLE IV

Section 1. Name and Location. The name of this Corporation shall be Hospital Service Corporation. Its principal office shall be located in.....

Section 2. The purpose of this Corporation shall be to secure funds by regular subscription from its members so as to provide for hospital service for members in accordance with the By-Laws and Charter of the Corporation.

Section 3. This Corporation shall be incorporated not for profit. All monthly dues collected from members shall be set aside in a fund for the benefit of said members as set out in Section 2 next above, and for defraying the administrative and operating expense of the Corporation.

ARTICLE V

Section 1. This Corporation shall have a Board of Trustees consisting of not less than five. The Board of Trustees shall be composed of one representative from each member hospital and such others as said Board may elect. All business of the Corporation shall be under the supervision and direction of the Board.

[The remaining sections of Article V and Article 6 discuss the appointment and duties of officers.]

This Certificate, with endorsement for associate members, if any, is issued in consideration of the statements made in the application, subject, however, to the terms of the Charter and By-Laws of the Corporation, and the payment of the Registration Fee of \$.....and dues of \$....., and is effective according to its provisions from twelve o'clock noon, eastern standard time, of the day this Certificate is dated, and as long thereafter as it may be continued in force by mutual consent of the subscribing member and the Corporation by payment of the monthly dues herein prescribed and acceptance of the same by the Corporation at its election (subject, however, to the privilege of having a new Certificate issued as herein provided), and should the dues herein prescribed be more or less than sufficient to meet the requirements of the Corporation, such dues may be decreased or increased by the Corporation subject to the election of the subscribing member to continue this Certificate in force after such change in dues.

IN WITNESS WHEREOF, Hospital Service Corporation has caused this Certificate to be signed by its duly authorized officer at the principal office of the Corporation at..... this.....day of.....193...

.....
 Manager,

Appendix D

TABLE A.—Reported Experience of Group Hospitalization Plans Showing Subscribers Hospitalized and Patient Days During the Specified Periods for Subscribers Entitled to Full Benefits

Plan	Experi- ence Period (Months)	Subscriber Months	No. of Subscribers Hospi- talized During Period	Subscribers Hospi- talized per Subscriber Month	Patient Days (No. of Days)	
					Were Hospi- talized During Period)	Patient Days per Subscriber Month
B	24	50,190*	349	0.00695	3,544	0.07061
F	30	414,954†	4,553	0.01097	35,569	0.08572
G.1	15	24,455	171	0.00699	1,282	0.05242
G.2	15	67,047	518	0.00773	4,297	0.06409
L.1	5	2,873	20	0.00696	130	0.04525
M.1	12	21,842	152	0.00696	2,625	0.12018
M.3	12	70,021	589	0.00841	5,302	0.07572
O.1	5	23,800	72	0.00303	606	0.02546
Q.1	27	49,275†	243	0.00493	2,454	0.04980
Q.2	7	6,881†	163	0.02369	1,825	0.26522
Q.3	7	791†	14	0.01770	114	0.14412
R.1	5½	2,953*	21	0.00711	63	0.02133
S.1	15	56,542	518	0.00916	4,041	0.07147
		791,624‡	7,383	0.00933	61,852	0.07813

* Based on a computed average membership (subject to error if membership increases or decreases rapidly).

† Based on actual average membership (subject to error if membership increases or decreases rapidly).

‡ Approximately equal to a membership of 60,894 insured for thirteen months.

TABLE B.—Reported Experience of Group Hospitalization Plans Showing Members Hospitalized and Patient Days During the Specified Periods for Subscribers and Dependents Entitled to Full Benefits

Plan	Experi- ence Period (Months)	Member Months	No. of Members Hospi- talized During Period	Members Hospi- talized per Member Month	Patient Days (No. of Days)	
					Were Hospi- talized During Period)	Patient Days per Member Month
A	12	65,532*	677	0.01033	6,396	0.09760
B	12	76,152*	488	0.00640	5,108	0.06707
D	12	7,080*	66	0.00932	509	0.07189
H	36	40,908*	446	0.01090	3,975	0.09717
J.1	12	17,427	363	0.02063	2,550	0.14632
J.2	8	2,224	27	0.01214	260	0.11691
J.3	12	8,775	109	0.01242	842	0.09595
J.4	12	2,595	27	0.01040	225	0.08670
J.5	12	97,493	..	.....	10,504	0.10866
K	36	119,028†	1,363	0.01145	8,234	0.06918
N	9	6,471*	176	0.02720	953	0.14727
P	36	103,572*	1,156	0.01116	9,284	0.06964
		547,257‡	4,896||	0.01089||	48,930	0.08941

* Based on a computed average membership (subject to error if membership increases or decreases rapidly).

† Based on actual average membership (subject to error if membership increases or decreases rapidly).

‡ Approximately equal to a membership of 28,803 insured for nineteen months.

|| Based on 449,764 member months, excluding Plan J.5.

TABLE C.—*Reported Experience of Group Hospitalization Plans Showing Members Hospitalized and Patient Days During the Specified Periods for Subscribers Entitled to Full Benefits and Dependents to Discounts*

Plan	Experi- ence Period (Months)	Member Months	No. of Members Hospi- talized During Period	Members Hospi- talized per Member Month	Patient Days (No. of Days Were Hospi- talized During Period)		Patient Days per Member Month
E	24	45,420†	490	0.01079	3,249	0.07153	
I	24	2,724*	28	0.01028	290	0.10646	
L.1-2	5	7,270	37	0.00509	241	0.03315	
O.1-2-3	5	44,848	150	0.00334	1,107	0.02468	
R.1-2	5½	4,801*	24	0.00500	72	0.01500	
S.1-2	15	226,147*	1,325	0.00586	8,934	0.03951	
		331,210†	2,054	0.00620	13,893	0.04195	

* Based on a computed average membership (subject to error if membership increases or decreases rapidly).

† Based on actual average membership (subject to error if membership increases or decreases rapidly).

‡ Approximately equal to a membership of 25,478 insured for thirteen months.

TABLE D.—*Reported Experience of Group Hospitalization Plans Showing Patients Hospitalized and Patients' Stay During the Specified Periods for Dependents Entitled to Discounts*

Plan	Experi- ence Period (Months)	Dependent Months	No. of Dependents Hospi- talized During Period	Dependents Hospi- talized per Dependent Month	Patient Days (No. of Days Were Hospi- talized During Period)		Patient Days per Dependent Month
L.2	5	4,397	17	0.00387	111	0.02524	
O.2	5	4,679	29	0.00619	243	0.05193	
O.3	5	16,370	49	0.00299	258	0.01576	
R.2	5½	1,848*	3	0.00162	9	0.00487	
S.2	15	169,605*	807	0.00476	4,893	0.02885	
		196,899†	905	0.00460	5,514	0.02801	

* Based on a computed average membership (subject to error if membership increases or decreases rapidly).

† Approximately equal to a membership of 28,128 insured for seven months.

Several tables have presented the hospitalization and financial statistics reported by various plans. To assist in the interpretation of these tables the following essential features were determined:

1. Classes of members.
2. What service is offered dependents?
3. Special Membership requirements.
4. Are obstetric patients hospitalized?
5. Type of room accommodations.
6. Limitation on number of days of hospitalization.
7. Discount after the specified number of days has been used.
8. Subscribers' annual rate.
9. Patient-day payment to hospital.
10. Special provisions.

These features are indicated for each plan:

PLAN A—

1. Groups, individuals and dependents.
2. Full service.
3. Medical investigation for all individual subscribers. Dependents must be financially dependent on subscriber.
4. Yes, after 15 days at 50% discount.
5. Private.
6. 10 days' hospitalization a year for each 25c of monthly premium.
7. 33 $\frac{1}{2}$ %.
8. \$10.80.
9. \$5, plus fee schedule.
10. Hospital assumes discount. Outpatients receive laboratory, x-ray, operating room and anesthesia services.

PLAN B—

1. Groups and dependents.
2. Full service.
3. Subscriber must be over 3 months and under 65 years of age.
4. No.
5. Semiprivate.
6. 21 days.
7. 33 $\frac{1}{2}$ %.
8. \$10.
9. \$6 (all inclusive).
10. Laboratory or x-ray examinations solely for diagnostic purposes and not for treatment incidental to inpatient care are not included.

PLAN C—

1. Groups and dependents.
2. Full service.
3. Subscriber less than 65 years of age.
4. Yes, after 10 months.
5. Semiprivate.
6. 21 days.
7. 25%.
8. \$10.
9. \$6 (according to funds available).
10. None.

PLAN D—

1. Groups, individuals and dependents.
2. Full service.
3. Subscriber between 3 and 35 years of age with reasonably good health.
4. No obstetric patients, but first cesarean.
5. Ward.
6. 21 days.
7. 25% discount after 21 days up to 30 days.
8. \$9.
9. \$4.50. Additional for extra services.
10. First aid in outpatient department.

PLAN E—

1. Groups and dependents.
2. 50% discount for \$1 per month per family.
3. Subscriber employed—admitted with group of 4 of same concern.
4. Yes, after 12 months at 50% discount.
5. Private.
6. 21 days.
7. 33 $\frac{1}{3}$ %.
8. \$9.
9. Own funds—no specified payment.
10. No x-ray or laboratory services. Negroes excluded.

PLAN F—

1. Groups and dependents.
2. A special plan for families.
3. Subscriber must be a bona fide employee.
4. Yes, after 10 months at 50% discount.
5. Private and semiprivate.
6. 35 days.
7. 33 $\frac{1}{3}$ %.
8. \$9 for private room.
9. Own funds—no specified payment.
10. First aid and emergency treatment at direction of physician in outpatient dept. X-ray service and physical therapy not included.

PLAN G—

1. Groups and dependents.
2. Half rate.
3. Subscriber: employed by one employer—group of 10 is minimum. Dependent: contingent on employed member's subscription; must be father or mother, husband or wife, unmarried brothers or sisters living at the same address.
4. No.
5. Ward and semiprivate.
6. 21 days.
7. No.
8. \$7.20, ward; \$9, semiprivate.
9. \$4.50, ward; \$6, private (all inclusive).
10. None.

PLAN H—

1. Groups, individuals and dependents.
2. Full service.
3. Subscriber in good health; between the ages of 1 to 65 years. Dependent wholly dependent on subscriber and in good health.
4. Yes, after 12 months.
5. Private.
6. 21 days.
7. No.
8. \$9.
9. Own funds—no specified payment.
10. No x-ray or radium service.

PLAN I—

1. Groups, individuals and dependents.
2. 33 $\frac{1}{3}$ % discount for \$1 extra a year.
3. Subscriber employed and in good health. Dependent must be husband or wife of employed subscriber. Age limitation, 70 years.
4. Yes, after 10 months at 33 $\frac{1}{3}$ % discount.
5. Semiprivate.
6. 21 days.
7. 33 $\frac{1}{3}$ %.
8. \$7.
9. Own funds—no specified payment.
10. No x-ray or radium treatments. Blood pressure and kidney check-up free each year.

PLAN J—

There are five different classes of members indicated as J.1, J.2, J.3, J.4 and J.5.

1. J.1 and J.2—groups of 25 or more and dependents; J.3—selected groups under 25; J.4—individuals, and J.5—small groups and individuals.
2. Full service for all members.
3. Over 3 months old and in sound health. (All plans.)
4. J.1, J.3, J.4 and J.5—yes, after 12 months; J.2—yes.
5. J.1 and J.2—private; J.3, J.4 and J.5—private and ward.
6. J.1 and J.3—20 days; J.2—10 days; J.4—18 days; J.5—18 days (individuals) and 20 days (groups).
7. No. (All plans.)
8. \$12 private; \$9, ward. (All plans.)
9. \$5, private; \$3, ward, plus fee schedule. (All plans.)
10. J.5—association not liable for any period of hospitalization of less than 3 days or for the cost of room and board of the first 2 days of any period of hospitalization.

PLAN K—

1. Groups, individuals and dependents.
2. Full service.
3. Doctor's certificate for individuals. Salary limitation \$150 for single subscribers and \$200 for married subscribers. Dependents: unmarried minors who are not gainfully employed and who live in the household of the subscriber and other dependents under 61 years of age who are specially approved (such as mother or father).
4. Yes, after 6 months.
5. Ward and private.
6. 42 days per year.
7. No.
8. \$12, ward; \$15, private.
9. \$3.50, ward; \$6, private, plus fee schedule.
10. Service will provide for one visit daily by the attending physician and allow \$2 for each visit—not to exceed a total of \$40. Outpatient service included.

PLAN L—

1. Groups, individuals and dependents.
2. Dependents of group members entitled to 25% discount for 25c a month.
3. Medical examination for individuals. Subscriber must be resident of or employed in hospital area and in sound health; member of group of 10 employees, in case of group membership. Dependents must be relatives of subscriber, residing in same household; must be in sound health and listed on records.
4. Yes, after 10 months.
5. Ward.
6. 21 days.
7. 33⅓%.
8. \$9.
9. Own funds. Payment to other hospitals \$3 per day—limit of \$45.
10. None.

PLAN M—

1. Groups and dependents.
2. 25% discount for \$1 a year.
3. Subscriber must be in good health, employed and a member of a group of at least 10, representing at least 40% of the eligible employees. Dependents must be wife or dependent children.
4. Yes, after 10 months at 50% discount.
5. Ward.
6. 21 days.
7. No.
8. \$9.
9. \$5 (all inclusive).
10. X-ray and radium treatments at 25% discount. First aid in outpatient department.

PLAN N—

1. Groups and dependents.
2. Dependent children, full service for \$3 each for an aggregate of 42 days for family; adult dependents, \$12.
3. Employed adult under 65 years; average hospital risk as to health. Dependent must be dependent on subscriber for support; between the ages of 6 months and 65 years, with good health record.
4. Yes, after 10 months at 50% discount.
5. Private.
6. 42 days for family. 21 days individual subscriber.
7. No.
8. \$9.
9. \$4, plus fee schedule.
10. Temporary service, pending consultation with physician, given in outpatient department in emergency.

PLAN O—

1. Groups and dependents.
2. 50% discount.
3. Subscriber must be under 65 years of age and admitted with a group of 10 or more working in same place and must have no physical defect requiring immediate hospitalization. Dependents must be under 21 years of age, must be dependent on subscriber for support and must have no physical defect requiring immediate hospitalization.
4. Yes, after 10 months.
5. Semiprivate.
6. 21 days.
7. No.
8. \$7.80.
9. \$5. Additional for extra services.
10. None.

PLAN P—

1. Groups, individuals and dependents.
2. Full service.
3. Subscriber and dependents must be in normal health and mind and under the age of 55 years, unless a member of a group of 10 subscribers.
4. Yes, after 12 months.
5. Semiprivate.
6. 21 days.
7. No.
8. \$11.
9. \$4.50. Additional for extra services.
10. None.

PLAN Q—

There are three separately reported plans indicated as Q.1, Q.2 and Q.3. Provisions are the same for all plans.

1. Groups and individuals.
2. No dependents—each contract individual.
3. Subscriber must be between the ages of 6 and 64 years and in good health.
4. Yes, after 10 months.
5. Private.
6. Subscribers between the ages of 6 and 16 years, 14 days; adults, 21 days.
7. 25%.
8. \$12.
9. Own funds—no specified payment.
10. No x-ray service and neither laboratory nor anesthesia service, except for maternity patients. Outpatient service included.

PLAN R—

1. Groups and dependents.
2. 25% discount for wife and oldest child at no extra charge.
3. Subscriber must be in good health and gainfully employed; at least 60% of employees must accept contracts. Age limits of 1 and 65 years. Dependents must be wholly dependent on subscriber and in good health.
4. Yes, after 10 months.
5. Ward.
6. 21 days.
7. 25%.
8. \$10.
9. \$5 (all inclusive).
10. First aid given in outpatient department.

PLAN S—

1. Groups and dependents.
2. One-third discount off on all services.
3. Subscriber must be regularly employed. Dependents must be wife or children under 21 years of age; mother and father (under 65 years of age) may be accepted if unemployed, residing with, and wholly dependent on subscriber.
4. Yes, after 10 months.
5. Ward and private.
6. 25 days.
7. 33 $\frac{1}{3}$ %.
8. \$9, private; \$7.20, semiprivate.
9. \$6, private; \$4, semiprivate (all inclusive).
10. One-third off on all special services, including x-ray. Negroes excluded.

PLAN T—

1. Employed groups and their dependents.
2. Dependents are entitled to discounts only.
3. Subscribers must be between the ages of 16 and 65 years, in good health and regularly employed in an occupation having the approval of corporation.
4. Yes, after 10 months at 50% discount. Corporation will pay hospital \$1 per patient per day for nursing care of infant.
5. Semiprivate.
6. 21 days.
7. 10% discount absorbed by member hospitals.
8. \$9.
9. \$5 (all inclusive).
10. No special laboratory or x-ray service or anesthesia or physical therapy benefits. \$1 of payment guaranteed to hospitals retained. Negroes entitled to ward service only.

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