

Program Developments and Benefit Trends in Voluntary Health Insurance

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In carrying out its statutory mandate to make studies concerning the advancement of economic security through social insurance, the Social Security Administration has followed closely the progress of voluntary health insurance. Important developments in this field have occurred during the 3 years that have passed since the Administration's Bureau of Research and Statistics published the results of an extensive and continuing study of voluntary prepayment medical care organizations.¹ Public interest in using the insurance method of meeting the cost of illness has increased rapidly, new prepayment plans have been established, wider geographic areas have been covered, and a greater proportion of the population has been enrolled. Certain significant trends are of major importance to the future of prepaid medical care.

VOLUNTARY HEALTH INSURANCE is available from two general sources—the commercial insurance companies and the prepayment plans sponsored by several types of organizations or groups. Prepayment plans, as distinguished from commercial insurance, are usually organized on a non-profit basis. Frequently they operate under enabling legislation that grants them special privileges as benevolent organizations and exempts them from some of the regulations applying to companies that are operated for profit.

Prepayment plans may be classified as follows: Blue Cross plans, which provide hospitalization (and in a few instances medical care), and medical care plans, which provide medical or medical and hospital benefits. When the medical care plans are grouped according to sponsor, they fall into the classifications of industrial, medical society, private group clinic, consumer-sponsored, and governmental plans.

Industrial plans are associated with some particular industry or firm. They may be financed by employer or by employees, or jointly by employer and employees. These plans provide

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¹Margaret C. Klem, *Prepayment Medical Care Organizations*, Bureau of Research and Statistics Memorandum No. 55, 3d ed., June 1945.

care for employees, and frequently their dependents. Financial arrangements often are made whereby the medical staff of the prepayment plan provides care for both industrial and nonindustrial accidents and illnesses.

Medical society plans are sponsored by either State or local medical societies. Private group clinic plans are those established and managed by physicians who practice as a group. Consumer-sponsored plans are established and controlled by the groups for whom the medical care is furnished. Government plans include both Federal and municipal programs established for the benefit of employees or for certain specified groups.²

The present article covers all these programs but places emphasis on program developments in relation to areas and groups served and on trends in types of benefits provided rather than on the types of plans providing benefits.

²In most cases the distinction between the various types of plans is self-evident, but in some instances plans may be classified in more than one way. For example, the term "industrial plan," as used in Bureau Memorandum No. 55, designates a program associated with a particular company or organization. Plans financed or partly financed by benefit associations connected with industry could be, and sometimes are, classified as consumer-sponsored plans. For study purposes, the Bureau has made it a practice to consider plans associated with one particular company as an industrial plan, because medical services are usually available only to the employees (and sometimes their de-

Developments in Relation to Areas and Groups Served

Commercial insurance.—Commercial insurance is available through both individual and group policies. Individual insurance is the older of the two, but its cost has always been too high, because of adverse selection, to make it practicable for the middle and lower-income groups. A recent report of the U. S. Chamber of Commerce³ estimates the number of persons covered by individual policies issued by insurance companies and fraternal societies as follows: 5,711,000 for hospital expense, 3,840,000 for surgical expense, and 840,000 for medical expense.

Within the past few years, several State medical societies that desired to inaugurate health insurance programs have entered into arrangements with commercial insurance companies. The increasing tendency toward this type of cooperation is discussed later in this article; it is one of the most interesting developments in the field of prepaid medical care.

Group insurance, which provides medical and hospital benefits to employed groups, was developed about 15 years ago, and enrollment has since increased steadily. Coverage is usually purchased through direct negotiations between industries and insurance companies and is available in all areas to groups meeting certain requirements as to the size and percent of the group participating. Many group policies now provide benefits for dependents.

Medical society and Blue Cross plans.—From the standpoint of en-

pendents) of one company. On the other hand, plans sponsored by unions, with benefits available to union members employed by more than one company, have been classified as consumer-sponsored plans, regardless of whether under the collective bargaining agreements the plans are financed wholly or partly by the companies with which these union members are associated. Differences in methods of classifying these plans are responsible for differences in enrollment figures reported for industrial and consumer-sponsored plans by various organizations compiling such figures.

³A. L. Kirkpatrick, "The Extent of Voluntary Health Protection," *American Economic Security*, August-September 1948, p. 25.

rollment and areas covered, the most significant development in the field of prepaid medical care has been the rapid membership increase in State medical society plans and in Blue Cross plans. In the main, enrollment in both Blue Cross and medical society plans is through group participation, though opportunity for individual enrollment has been considerably increased during the last few years. Both types of programs provide for enrolling dependents.

In 1945, medical care plans sponsored by State or local medical societies were in operation in 17 States and Hawaii. They had a membership of approximately 2.6 million people, including both subscribers and their dependents. Now such plans are in operation in more than 40 States, the District of Columbia, and Hawaii. As of January 1, 1948, their enrollment had reached approximately 7.5 million. A number of medical society programs are also in operation in Canada.

Although Blue Cross plans, providing hospital benefits, were well established before 1945, enrollment almost doubled during the following 3-year period. The plans are now in operation in almost every State, and they cover more than 30 million people in the United States, Canada, Puerto Rico, and Hawaii.

Medical society and Blue Cross plans are closely associated, for most medical society plans have entered into some type of administrative arrangement with Blue Cross plans operating in the same area. This relationship varies according to individual plans.⁴ Each plan usually has a separate corporation, governing body, and contract, but Blue Cross is responsible for certain joint administrative activities, such as enrollment, billing, accounting, and recordkeeping. Medical society plans are sometimes treated as riders to the Blue Cross contract. In several States, Blue Cross provides medical care in addition to hospitalization, usually with the approval of the local medical society. Since few medical society plans provide hospitalization, most subscribers to medical society plans

⁴ Louis S. Reed, *Blue Cross and Medical Service Plans*, Public Health Service, October 1947.

are also enrolled in Blue Cross plans; a few medical society plans have made Blue Cross membership an eligibility requirement.

In many States the development of medical society and Blue Cross plans has coincided with the enactment of State enabling legislation regulating both hospital and medical care programs, particularly the latter. As of January 1, 1948, laws regulating medical care plans had been enacted in 34 States and the District of Columbia.⁵ More than half these laws were adopted in 1945 and the early part of 1946, when 15 States passed their first laws on medical care plans and five States amended or reenacted legislation already in force.⁶

The laws are of particular significance in requiring that physicians' approval of plans be assured. In most of the 34 States the statutes include such requirements as an administrative board with a majority membership of physicians or of other persons approved by State medical societies or stipulate that a majority of the physicians practicing in the area must approve the plan or participate in it.

Union-sponsored programs.—Organized labor's efforts to promote health and welfare programs are not new, and welfare funds to provide medical care for members are now among the common goals of unions. During the war the policy of the National War Labor Board was favorable toward including health and welfare programs in collective bargaining agreements, and the Bureau of Internal Revenue ruled that—for income tax purposes—money advanced toward legitimate insurance plans for employees could be deducted from gross income as a proper business expense. Health and welfare programs have continued to grow in number during the postwar period, though they vary widely in methods of financing and administration, persons covered, and types of benefits. Some plans furnish care for dependents,

⁵ "Status of State Laws Regarding Prepayment Health Plans," *Information Letter*, Cooperative Health Federation of America, February 1948.

⁶ Margaret C. Klem, "Recent State Legislation Concerning Prepayment Medical Care," *Social Security Bulletin*, January 1947.

while others limit benefits to employees. The special needs of each union or industry are taken into consideration, as well as geographic areas covered, facilities available, and other factors. An undetermined number of plans include hospital and medical benefits (principally surgical) along with cash disability and other types of protection.

These programs furnish medical benefits in several ways. Some give services through their own facilities, while in others benefits are in terms of money, as set forth in schedules of indemnities. Benefits are frequently purchased through plans already in operation—commercial insurance, medical society plans, and Blue Cross plans. Unions whose members are widely scattered geographically often turn to commercial insurance, to Blue Cross, or to medical society plans as the only feasible present method of providing fairly uniform benefits. Statements from both AFL and CIO unions, however, indicate that participation with such organizations is a temporary expedient, rather than a withdrawal of their support of a Federal law giving wide and uniform health insurance coverage.⁷ The American Medical Association, on the other hand, is confident that voluntary health insurance will be able to spread the costs of illness and meet the needs of the public, and that compulsory health insurance is neither necessary nor desirable.⁸

Health centers established by unions are closely related to voluntary health insurance programs. These centers often limit their services to diagnostic and preventive care, however, and refer patients to their own private physicians for treatment. Frequently the patients are eligible for treatment on a prepayment basis through plans sponsored by the unions or some other organization. Diagnostic health centers have been in operation for a number of years, but many new centers have recently been established. One of the largest is that of

⁷ American Federation of Labor, *Health Benefit Plans by Collective Bargaining*, Collective Bargaining Series No. 1, May 24, 1946, p. 2; United Electrical, Radio and Machine Workers of America, CIO, *UE Guide in Group Insurance*, 1944.

⁸ *Journal of the American Medical Association*, December 22, 1945, p. 1201.

the United Automobile Workers of America (CIO) in Detroit, Michigan.

Among the oldest and most prominent of the union-sponsored health programs is that of the International Ladies' Garment Workers' Union (AFL). Its largest unit, the Union Health Center in New York City, is housed in a 27-story building and serves almost 200,000 ILGWU members in New York and vicinity. When it was established in 1916, the Health Center's services consisted of very limited care by general practitioners; it now furnishes general practitioner and specialist care in well-equipped offices.

The ILGWU specializes in providing preventive and diagnostic services. Health centers are now in operation in Philadelphia, Pennsylvania; Boston and Fall River, Massachusetts; and St. Louis, Missouri; and several others are being established or have recently been completed. The union hopes ultimately to maintain health centers in every city that has at least 5,000 members. For towns too small to warrant health centers, other methods of providing services are used. In 1944, less than 100,000 out of a total of 325,000 members of the ILGWU were covered by health and welfare programs. By the end of 1946, about 325,000 out of a total of 379,000 members were protected⁹ by some type of union plan.

Another union program offering comprehensive medical care is the Labor Health Institute of St. Louis, Missouri. The Institute was established as the result of negotiations by the St. Louis Joint Council, United Retail, Wholesale, and Department Store Employees (CIO), and is financed through employer contributions. It furnishes complete medical care including services in the home, hospital, and clinic for union members and their families.

Among other potentially extensive new programs is that established by the United Mine Workers (Independent) through collective bargaining to cover about 450,000 miners in 3,000 mines in 23 States. Employees in the basic steel industry have also ex-

tended their health and welfare programs considerably during the past few years. Space does not permit more than this brief summary of union health and welfare programs.¹⁰

Rural enrollment.—The need for better medical care in rural areas has centered attention on diverse methods of extending prepayment plans to the rural population. The U. S. Department of Agriculture and various farm organizations did considerable pioneer work in this field before 1945. Medical societies, Blue Cross, and commercial insurance companies have also joined in the effort, but progress has been slow.

In his address before the American Medical Association at its midyear session in January 1948, Clinton P. Anderson, then Secretary of Agriculture, declared that "Prepayment plans for surgical and other medical services offered by State and county medical societies have today reached less than 1 percent of the country people." He cited the work done by the Farm Security Administration in organizing medical service plans for rural rehabilitation clients in more than a thousand counties and pointed out that this work had been done with the aid of local medical societies. Mr. Anderson commented on the fact that, though many medical societies accepted the idea of prepayment plans in the rehabilitation program, some have not looked with favor on the efforts of farmers to apply the familiar principles of cooperation to their medical care problems.¹¹

Because of recent changes in legislative authority, the Department of Agriculture has had to abandon many phases of its medical care program, including the organizing of new

groups. The Farm Security Administration was abolished in August 1946, when the Farmers Home Administration Act was passed. In addition to prohibiting the field staff from assisting in the organization or management of prepayment medical care plans, the act withdrew authority to use Federal funds to finance the "experimental health programs." These plans, unlike the Farm Security Administration plans, had no income restrictions on membership. They were not limited to Farm Security Administration borrowers but were available to all residents of seven rural counties who obtained all or most of their income from agricultural pursuits. The dues were based on ability to pay, and the Department of Agriculture made up the difference between each family's contribution and the regular charges,¹² thus solving the major difficulty encountered in rural enrollment—the low cash income of many farm families.

Consumer groups.—Consumer-sponsored medical care programs represent the efforts of various groups of people to form and administer or assist in administering their own programs which will furnish the types of benefits they desire. In August 1946 a number of consumer groups met in conference at Two Harbors, Minnesota, and formed the Cooperative Health Federation of America to coordinate their efforts and further the establishment of other consumer health programs.¹³

The typical consumer-sponsored plan provides medical services through its own facilities and salaried personnel. While rural groups find consumer cooperatives of particular advantage, these cooperatives also operate in urban areas. In recent years the cooperative movement in medical care has been very active in the Pacific Northwest and in Texas, where more than a score of hospital associations were formed after the passage in 1945 of legislation that authorized the formation of medical care associations

¹⁰ For additional details see Bureau of Labor Statistics, *Health Benefit Programs Established Through Collective Bargaining, 1945 and Union Health and Welfare Plans*, Bulletins No. 841 and No. 900; National Industrial Conference Board, "Features of Union Health and Welfare Funds," in the *Conference Board Management Record*, April 1947; and Joseph Zisman, *Fifty Employee-Benefit Plans in the Basic Steel Industry*, Social Security Administration, Bureau of Research and Statistics Memorandum No. 65, November 1947.

¹¹ *The Farmer in Apollo's Temple* (press release of the Department of Agriculture), January 8, 1948.

¹² Franz Goldman, *Voluntary Medical Care Insurance in the United States*, New York University Press, 1948, p. 228.

¹³ Helen L. Johnston, "Better Health for More People," *Cooperative Health Articles, Series II*, Farm Credit Administration, June 1947, p. 19.

⁹ Adolph Held, "Health and Welfare Funds in the Needle Trades," *Industrial and Labor Relations Review*, January 1948, pp. 247-263.

of this type in places with a population of less than 2,500.¹⁴

The Farmers Union Hospital in Elk City, Oklahoma, is one of the oldest rural cooperative hospitals in the United States. Established in the early 1930's, it is often used as a pattern for other consumer programs. Group Health Mutual, Inc., which covers both urban and rural areas throughout Minnesota, and Group Health Insurance, Inc., whose members live in or near New York City, are also among the larger cooperatives. Both organizations have more than doubled their membership since 1945. In the District of Columbia the Group Health Association, which was organized in 1937 to serve Federal employees in the Nation's Capital, has increased its membership more than 50 percent in the same period. Membership in this organization is no longer restricted to Federal employees but is open to the general public.

The development of new consumer-sponsored programs has been hampered by legislation enacted in many States during the last few years. Also, many groups that might have started operations under existing State laws have not been able to make satisfactory arrangements with members of the medical profession. Cooperatives in several States have sought the enactment of special enabling legislation with varying degrees of success. Commenting on the defeat of such a bill introduced in the Minnesota Legislature in 1947, the Group Health Association in St. Paul, a prepayment medical care organization that is affiliated with Group Health Mutual, said: "The immediate consequence . . . has been to suspend or delay action in a number of communities that were proceeding with plans to provide facilities for their medical care . . . One thing the campaign in Minnesota brought out was that a substantial part of the medical profession looks with varying degrees of disfavor upon the position taken by the officialdom of organized medicine, and would like to see protective legislation that would permit them to cooperate on an organized

basis with their patients, without fear of reprisal."¹⁵

Meanwhile the Minnesota State Medical Society proceeded with a plan to provide prepayment medical care in accordance with enabling legislation sponsored by the medical profession. Faced with two divergent viewpoints, its organizing committee decided to recommend the setting up of both a nonprofit medical service corporation and a broad indemnity insurance program to be developed with insurance companies working in close cooperation with a liaison committee of the State association.¹⁶

On the other hand, new legislation enacted in Wisconsin, through the combined efforts of cooperatives and the medical profession, permits the formation of medical care cooperatives and also allows physicians to establish plans under their own control. At the National Health Assembly held in Washington in May 1948, the importance of the Wisconsin legislation was recognized and broadly accepted as a pattern for cooperation between medical and consumer groups. The Rural Health Section of the Assembly accepted a subcommittee report encouraging the enactment of similar enabling legislation in other States.

Municipal groups.—The establishment of relatively comprehensive prepaid medical care plans on a municipal basis has been extremely limited, but the formation of the Health Insurance Plan of Greater New York (HIP) is of special significance. After several years of planning, this program, which offers medical care insurance to employed groups in Greater New York and to their dependents, began operation in March 1947. By January 1948 the enrollment was 110,000.

The plan furnishes medical care through doctors engaged in group practice and offers hospitalization through Associated Hospital Service, the Blue Cross plan serving New York City. Subscribers have free choice of physicians among those who have agreed to participate in the plan.

¹⁴ Bureau of Labor Statistics, *Development of Consumer Cooperative Movement in 1946*, Bulletin No. 904; Helen L. Johnston, *Cooperation for Rural Health*, Farm Credit Administration Misc. Report 123, September 1948.

¹⁵ "The Legislative Front," *Group Health*, May-June 1947.

¹⁶ "Dual Approach Speeds Prepayment Medical Care Program," *Minnesota Medicine*, January 1947.

Service benefits include general medical, specialist, surgical, and obstetrical care, laboratory and diagnostic procedures, periodic health examinations, immunizations and other preventive services, physical therapy, radium therapy, and other therapeutic measures, eye refractions, visiting nurse service, and hospitalization. For any group membership the employer assumes 50 percent of the insurance costs.¹⁷

The future of the New York program has recently been the subject of considerable discussion as the result of a resolution adopted by the Medical Society of the State of New York at its annual meeting in May 1948. The society advised its members "not to become participating physicians in any voluntary health insurance plan unless it has been approved by the Medical Society of the State of New York." At the time the resolution was passed, only six voluntary nonprofit medical care plans in New York State—all of them operated under the sponsorship and control of the medical profession—had been approved.¹⁸ Not yet approved by the society, in addition to the recently established HIP, were other medical plans such as those of the Amalgamated Clothing Workers of America (CIO), the Consolidated Edison Company, and the Endicott Johnson Company—plans that have been in operation for many years.

The Health Service System of San Francisco, another municipal program, has been in operation since 1937. The system provides medical and hospital care for about 12,000 city and county employees and their dependents. Coverage of employees is compulsory; dependents enroll on a voluntary basis. The program is now experiencing considerable difficulty. More than 900 physicians in the community—almost all of those who had participated in the plan—recently resigned. The resignations came a few months after the Health and Hospital Insurance Committee of the San Francisco County Medical Society recommended "that the so-called 'social experiment' which the medical

¹⁷ Dean A. Clark, M. D., "The Program of the Health Insurance Plan of Greater New York," *Bulletin of the Medical Society of the County of Kings*, June 1946.

¹⁸ *New York Times*, May 20, 1948.

profession of San Francisco had conducted with the Health Service System of San Francisco be terminated" and "that the future activities of this committee be concerned with the operations of the California Physicians Service to the end that the California Physicians Service might be so improved that it will find its proper place in human society . . ."¹⁹

Benefit Trends

Voluntary health insurance has shown two definite trends in types of benefits provided—an increase in the number of programs providing indemnity benefits, and restriction and standardization of service benefits.

Increased emphasis on indemnity benefits.—Most voluntary health insurance, with the exception of commercial insurance contracts, formerly showed a decided preference for service benefits. The first medical society plans followed this pattern and furnished service benefits, or they combined service with cash indemnity benefits by giving services to individuals and families with incomes below a specified amount and cash indemnity benefits to those with incomes above that amount. A study of voluntary medical care plans published in 1947 by the Council on Medical Service, American Medical Association, shows quite definitely the present trend toward indemnity benefits among the more recently established medical society programs. At the time the study was made, only six medical society plans offered full service contracts to all subscribers; 31 plans were operating on a straight cash indemnity basis; and 28 plans offered a combination contract, providing service benefits to low-income subscribers and indemnity benefits to those with incomes exceeding a specified amount. The income limits ranged from \$1,500 for a single person to \$5,000 for a family, with \$2,000 for a single subscriber and \$3,000 for a family the most frequent maximums.²⁰ Indemnity payments are

based on a fee schedule and do not represent the actual bill for services received by the subscriber.

Blue Cross plans also have recently shown a tendency to switch to indemnity benefits. Recent estimates indicate that about one-fourth of the subscribers to Blue Cross plans are eligible for cash reimbursement for hospital room and board, although these plans continue to provide additional benefits, such as medication and laboratory services, on a service basis.

The trend toward indemnity benefits has resulted in establishing a new relationship between medical care plans and commercial insurance companies. As previously indicated, several State medical society plans now furnish their benefits through one or more commercial insurance companies operating indemnity plans in the State. There is an increasing tendency toward this type of combination.

The first State medical society plan to use this combination was the Wisconsin plan. Organized in 1946, the plan utilizes the existing casualty insurance companies licensed and operating under Wisconsin laws. Certain principles and provisions have been set up by the society's Committee on Extension of Insurance, and insurance contracts must meet these specifications to qualify for medical society approval. As of April 1, 1948, more than 100,000 subscribers and dependents had been enrolled under approved insurance contracts.

Increased costs have influenced the present trend toward indemnity benefits. Most plans have been forced to increase dues or to reduce benefits because of the increased cost of medical and hospital care. Indemnity benefits assure definite cash payment toward hospital and medical expenses and relieve the plans of the necessity for estimating the cost of service benefits at a time when rapid changes in prices have made such estimates difficult.

From the standpoint of subscribers, the trend toward indemnity benefits may be considered from two angles. Payments are made on the basis of a fee schedule and do not represent the total bill for services received. The patient is relieved of a portion of his bill—in many instances a major

part—through an organization that is able to plan its financing on more accurate estimates than would be possible if the changing cost of service benefits had to be considered. On the other hand, many subscribers are paying increased dues and receiving less protection than formerly. Unless fee schedules have been revised upward, the difference between indemnity benefits and the actual cost of services has increased considerably. Furthermore, whether wage increases have or have not kept pace with the increased cost of living, they have been sufficiently large to raise individual and family incomes above the income limits previously set by plans offering service benefits to the lower-income groups only. These income limits vary according to the individual plan; the extent to which plans have revised either income limits or fee schedules is not known.

According to a report of the Health and Accident Underwriters Conference, competitive conditions have brought a general reduction of premium rates and an increase in the coverage of group accident and health insurance.²¹ This they regarded as a dangerous trend; although loss ratios, it was indicated, have so far been quite satisfactory, they would certainly get worse in any sort of recession. It was suggested from the floor of the conference meeting that, instead of concentrating on fighting compulsory legislation, the insurance industry should frankly face the possibility of the adoption of such measures on both a State and national level and have draft legislation ready. The meeting also discussed the change to indemnity benefits by many Blue Cross plans and queried whether Blue Cross plans can continue to represent themselves as service organizations and maintain their status as nonprofit organizations if they go on a flat-rate basis.

In discussing cooperation with medical societies in a hospital medical care program, the Underwriters Conference considered several questions. Should plans in which insurance companies and doctors partici-

¹⁹ Ralph E. Scovel, M. D., "Health and Hospitalization Insurance Committee Report," *Bulletin of the San Francisco County (Calif.) Medical Society*, January 1947.

²⁰ American Medical Association, *Voluntary Prepayment Medical Care Plans*, rev. 1947, p. 89.

²¹ "Dangerous Trends Seen in A & H Group Competition," *The National Underwriter*, Life Insurance Edition, February 13, 1948.

pate give payment in full for medical services, and will the doctors accept insurance company benefits as payment in full? Should the doctors be allowed to assume any underwriting control? Should they be allowed to have a voice in rate making? The opinion of the group seemed to be that there should be cooperation with medical plans if enough freedom of underwriting and rate making were allowed and that doctors also should be free to determine whether benefits would be considered payment in full for persons in higher-income groups.

Benefit restrictions.—In 1945, most of the prepayment plans in operation were not only providing service benefits but also, in most instances, relatively comprehensive benefits. The study made in that year by the Bureau of Research and Statistics of 229 prepayment medical care organizations showed that approximately 60 percent of the persons who were members of the plans surveyed were eligible for physicians' service at home, in the office, and in the hospital, for both medical and surgical illnesses. Currently, benefits are more restricted.

When membership in the 229 plans included in the study was classified according to type of program, it was found that industrial, consumer-sponsored, private group clinic, and government plans made comprehensive services available to more than 50 percent of their membership; for most of these plans, as a matter of fact, the percentage was nearer 100. On the other hand, medical society plans, except those in Washington and Oregon,²² provided comprehensive benefits to only 6.2 percent of their membership. All medical society plans then in operation were included in the study.

Estimated Enrollment by Type of Benefit, January 1948

The last few years have shown an increased tendency for persons to enroll in more than one type of prepayment program. This practice has become so common that it is impossible to make an accurate estimate of the

²² Medical society prepayment plans in Oregon and Washington were established many years ago and differ in many respects from medical society plans more recently established in other States.

TABLE 1.—Estimated enrollment in voluntary hospital and medical insurance plans, January 1948¹

Type of benefit and plan	Number of persons ² eligible for—			
	Hospital room and board ³	Physicians' service in office, home, and hospital for medical, surgical, and obstetrical cases	Physicians' service in hospital only for—	
			Medical, surgical, and obstetrical cases	Surgical and obstetrical cases
Cash benefits:				
Commercial group insurance.....	14, 200, 000	500, 000	1, 100, 000	11, 100, 000
Blue Cross and medical society plans.....	7, 500, 000	400, 000	1, 600, 000	2, 600, 000
Service benefits:				
Blue Cross and medical society plans.....	22, 500, 000	500, 000	1, 000, 000	1, 500, 000
Other plans.....	2, 500, 000	2, 000, 000	(⁴)	(⁴)

¹ Estimates based on information contained in Blue Cross Bulletins; News Letters of the American Medical Association's Council of Medical Service; publications of the Insurance Department, Chamber of Commerce of the U. S. A.; Reports of the Committee on Survey of Accident and Health Business, Health Insurance Council; and various other sources, including publications of the Bureau of Research and Statistics, Social Security Administration. Columns cannot be added because persons frequently enroll in more than 1 type of plan.

² Excludes 18,700,000 individuals estimated by the Insurance Department, Chamber of Commerce of the U. S. A., to be covered by insurance companies and fraternal societies for health and accident benefits.

³ Plans may also provide 1 or more cash or service benefits, such as anesthesia, laboratory, and X-ray.

⁴ Less than 100,000.

total enrollment in voluntary health insurance. As previously indicated, a large percentage of the persons enrolled in medical society plans are also enrolled in Blue Cross plans. Data from various sources indicate that for other types of plans there is an undetermined amount of duplication in enrollment. For example, employees are sometimes eligible for medical and hospital benefits through industrial programs that provide only limited benefits or none at all to dependents. These employees often enroll in other plans to obtain protection for their families. Employees who are partially protected against hospital or medical expenses in one type of service plan supplement their protection by enrolling in a commercial plan. In discussing the present trend in benefits in terms of enrollment, therefore, it is preferable to estimate enrollment in terms of numbers eligible for specified types of benefits rather than to attempt any estimate of total enrollment in voluntary medical and hospital plans. Table 1 shows the estimated number of persons eligible for specified benefits under each type of program; it is not a distribution of total enrollment by type of benefit provided. As indicated in the table, the columns cannot be added because many persons are enrolled in more than one plan.

While it is impossible to determine

what percentage of the population is enrolled in all types of voluntary health insurance programs, the table indicates the extent to which each type of protection is on a cash or service basis. About 45 percent of the people enrolled for hospitalization benefits are entitled to cash benefits for the expense of hospital room and meals, and the rest are entitled to service benefits. The figures on other types of benefits also show a preponderance of enrollment in plans furnishing indemnity benefits and a restricted type of program. For surgical and obstetrical care in hospitalized cases, the ratio of cash indemnity to service benefits is 8 to 1; for physicians' service in hospitalized medical and surgical cases the ratio is about 2 to 1. In the main, service benefits rather than cash benefits are provided by plans giving physicians' service in the office, home, and hospital because of the large enrollment in "other plans," which include principally industrial, private group clinic, and consumer-sponsored plans.

Methods of providing benefits.—Programs recently developed have shown a decided shift in the method of providing benefits. Many of the plans included in the 1945 study reported the provision of services by physicians employed on a salary basis in hospitals owned or controlled by the plan

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both parents in the home and able, under present economic conditions, to provide for their support and care. Aid to dependent children was provided by Congress and the States for the relatively few children who live in broken families or have incapacitated parents.

The rapid postwar rise in the number of children receiving aid to dependent children represented, for the country as a whole, an increase from 1.5 percent of all children in June 1945 to 2.5 percent in June 1948. Furthermore, in only 14 States (four of them with new State-Federal programs)

did the increase in recipient rate from June 1940 to June 1948 represent as much as 1 percent of all children in the State. An increase of this size in an 8-year period does not seem to justify policies which result in denial of assistance to children in actual need.

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The plans also employed a fairly large number of dentists, nurses, and auxiliary personnel. In most instances, those older plans still adhere to that method of providing benefits. The plans developed since that time have shown a tendency—since most of them have been sponsored by medical societies and Blue Cross—to provide benefits through local hospitals and physicians engaged in fee-for-service practice. Members in the newer plans are permitted to select their own physicians and hospitals from among all those that have agreed to participate in the program. This provision has resulted in a tremendous increase in the number of physicians associated with voluntary medical care plans, has given them an opportunity to gain personal experience with prepaid medical care, and has assured them payment for services provided.

While the number of physicians associated with prepayment plans has thus increased, there has been little change in the number of dental and nursing personnel. With few exceptions, the dentists and nurses connected with prepayment plans are associated with plans that were in operation before 1945. Although the cost of dental and nursing services represents a significant portion of family expenditures for medical care, few of the most recently established plans include such services among benefits provided; separate dental and nursing prepayment plans are almost unknown.

Future of Prepayment Plans

The fact that some type of prepayment for medical care is desirable seems to be well accepted by all groups concerned. What type of program or programs will be developed in the future will depend in large measure on the cooperative efforts of persons and organizations interested in all

phases of medical care. An editorial in the *Weekly Bulletin of the St. Louis Medical Society* (October 1, 1948) states, "The issue now is not whether we should or should not have prepayment medicine, or budgeted medicine, or collective medicine or whatever else one wishes to call it, but what kind of prepayment medicine shall we have and who is to control it. If a plan can be worked out in which there is free choice of physician, there is reasonably adequate coverage, and in which the major issues are decided by the doctors and patients immediately involved, no harm can come to the spiritual or material development of medicine."

A recent issue of the *Journal of the American Medical Association* contains a report by the Association's Council on Medical Service that points the way toward better understanding among proponents of various types of plans in the future. Two statements in the report are of particular interest: (1) that proposed changes in the standards of acceptance that the Council developed as a guide to evaluating prepayment medical care plans are under consideration, and (2) that the application of the principle of free choice of physician and hospital as it applies to prepayment plans is not yet entirely clear to the Council, and the extent to which free choice of physician may possibly be limited in various plans has been reviewed and will be discussed further with the Judicial Council.²³

The National Health Assembly held in Washington in May 1948 at the invitation of Oscar R. Ewing, Federal Security Administrator, frankly recognized prepayment as a principal factor in medical economics. The following "Principles for the Improvement of Voluntary Prepayment

Plans," unanimously accepted by the Medical Care Section of the Assembly, indicate the desire of the various groups represented to effect practical consumer and professional cooperation in the development of such plans.²⁴

"1. There should be the freest opportunity for full cooperation among the providers and consumers of service in the establishment and the administration of medical care plans, provided that full control of the practice of medicine in the program must remain with doctors.

"2. The Medical Care Section strongly urges the importance of joint conferences at the earliest possible date among representatives of the American Medical Association and of groups representing the consumers of medical care and services to study the question of the establishment and administration of medical care plans."

²⁴ Oscar R. Ewing, *The Nation's Health—A Ten Year Program*, September 1948, p. 76. For a summary of one section of the report see this issue of the *Bulletin*, pp. 9-12.

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The survey's primary purpose is described by Ernest V. Hollis, who is directing it, as the development of a "well-grounded body of principles which is sufficiently inclusive to enable social work educators to reexamine and extend programs of study and development along lines which promise to supply the quantity and quality of social workers that are likely to be needed in the United States and Canada."

Mr. Hollis is taking leave of absence from the Office of Education to serve as director of the study; the assistant director is Alice L. Taylor, of the Social Security Administration. Arthur J. Altmeyer, Commissioner for Social Security, is a member of the national advisory committee.

²³ "Report of the Council on Medical Services," *Journal of the American Medical Association*, May 8, 1948, pp. 193-198.