issued a document entitled "Some Provisional Notes on a Program of Temporary Disability Compensation Administered by a State Employment Security Agency," and this document is now being revised to take account of new developments. The Social Security Administration stands ready to lend every assistance in formulating a sound program of temporary disability insurance and in developing an administration integrated with unemployment insurance.

Conclusion

The next sessions of the State legislatures will probably convene at a time when employment is at high levels and unemployment remains low. However, major economic adjustments may occur within the next few years. Whether they take the form of a slight or a more severe recession we do not yet know. The task ahead, however, is to prepare the program for its maximum contribution to the maintenance of high-level employment in a free democratic society, through broadening its coverage and providing adequate benefits to individuals when they are unemployed because of lack of work or illness.

Recent State Legislation Concerning Prepayment Medical Care

By Margaret C. Klem*

In this study of State legislation in the field of voluntary prepayment medical care plans, the author points out the characteristic pattern followed in recent laws. As in all Bulletin articles, the opinions expressed are those of the author and do not necessarily reflect official views of the Social Security Administration.

DURING THE PAST few years the increasing public interest in problems of medical economics has been expressed many times through legislation, either proposed or enacted, at both national and State levels.

On the national scene the Wagner-Murray-Dingell bill, which provides for personal health service on a compulsory insurance basis, has aroused most interest. The Senate hearings on the bill, which ran from April to mid-July of last year, brought together testimony from many of the Nation's most eminent authorities on the medical, economic, and social aspects of health problems.

State legislation has also assumed much importance during this period. Many States have made provisions for committees to study various aspects of personal health services, such as medical facilities, expenditures for medical care, and the need for more adequate services to all or to certain groups of the State's population. Since 1943 alone, health commissions to inquire into the problems of medical care have been established through legislative action in nine States—California, Illinois, Maryland, New York, North Carolina, Rhode Island, South Carolina, Virginia, and West Virginia. Commissions have also been appointed, although not specifically authorized by legislative acts, in Alabama, Colorado, and Florida.

State interest in health matters is further evidenced by the fact that by February 1946, 18 months after the Commission on Hospital Care was set up by the American Hospital Association in cooperation with the Government, all 48 States and the District of Columbia had made plans for or were conducting State-wide hospital surveys. On January 31, 1946, studies were in progress in 31 States and the District of Columbia; 2 additional States had completed preliminary studies; studies had been authorized but not started in 8 States; and the other 7 were forming study groups.[1]

The Commission on Hospital Care, inaugurated to study the Nation's hospital facilities, has been helping the States in their surveys. To assist the Commission in its work, the U. S. Public Health Service has made technical personnel and physical facilities available to the staff. State health departments have given assistance and in some instances are actually conducting the studies. The introduction in January 1945 of the Hill-Burton bill, which authorized Federal grants to States for surveying hospital needs and for constructing hospitals and public health centers, and the hearings that followed gave great importance to the studies. This bill was enacted by the Seventy-ninth Congress as the Hospital Survey and Construction Act and was approved August 13, 1946.

Nonprofit Medical Care Plans

Although all State legislation relating to medical problems is of interest to those who want to improve health conditions, one aspect is of particular concern to everyone interested in prepayment plans. Physicians, labor unions, industries, and various consumer groups who are sponsoring or hope to establish such plans will find significant implications in legislation which specifically authorizes the establishment and control of prepayment medical care organizations.

To date, 29 States have enacted laws dealing with medical service plans. More than half these laws were enacted during 1945 and the early part of 1946, when 15 States[2] passed such laws for the first time and 5 States[3] amended or reenacted legislation already in force. Thirty-six States have also passed laws regarding nonprofit hospital service plans.

Medical Participation

Recent legislation on voluntary nonprofit prepayment medical care plans is particularly significant from one aspect—the provisions made for participation by physicians. The 15 States recently enacting new laws for the regulation of these plans have followed the precedent set by such States

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[1] *Hospital Survey News Letter*, February 1946, p. 4.

[2] Alabama, Arizona, Florida, Illinois, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, North Dakota, Rhode Island, Tennessee, Texas, and Wisconsin.

[3] Connecticut, New Hampshire, New Jersey, New York, and West Virginia.

as New Jersey, Ohio, and Pennsylvania, where the legislation was formulated along lines demanded by medical society groups. In most of these 15 States, under the present laws, the future of prepaid medical care will be largely in the hands of the medical profession, as it is now in New Jersey, Ohio, and Pennsylvania, to the exclusion of other nonprofit or profit organizations or groups.

This type of legislation has been sponsored by medical societies or by persons interested in prepayment medical care programs similar to those now operated by many State medical societies. Individuals or groups who are interested in other types of prepayment programs must either seek to have such acts amended or must sponsor other legislation.[4]

Experience in Massachusetts, for example, shows that the passage of an act adapted to the needs of one particular type of program does not preclude passage of legislation providing greater latitude of operation. In 1941, Massachusetts passed two separate acts (table 1). The first, sponsored by those favoring the medical society

[4] No attempt has been made to study other types of legislation in the various States under which such plans can be organized, such as the laws authorizing the formation of cooperatives and nonprofit organizations.

Table 1.—*State legislation regarding nonprofit medical care corporations enacted before 1945 in selected States*

State and legislation enacted	Purpose	Who may incorporate	Administrator of corporation	Scope of services	Source of services	Legal jurisdiction	Tax exemptions and other significant provisions
Massachusetts (Ann. Laws, Cum. Suppl. 1942, c. 176B). Approved: 1941.	Provides for formation of medical service corporations to preserve public health by furnishing services at low cost.	Seven or more persons, in manner specified.	Board of directors approved by a medical society incorporated not less than 10 years and having not less than 2,000 physicians as members; at least one-third of directors must be subscribers to plan.	Services provided by registered physicians in accordance with accepted practices in the local community. Any person residing in the Commonwealth may subscribe if he meets corporation's qualifications.	Every registered physician in area where corporation operates has a right to participate. Subscriber has free choice of participating physicians.	Commissioner of Insurance.	Corporations are exempt from provisions of insurance laws, except as especially provided, and from taxes, except as provided. Salaries limited to $5,000 annually.
(Ann. Laws, Cum. Suppl. 1942, c. 176C). Approved: 1941.	Provides for medical service corporation or medical organization operating in connection with a medical service plan. Exempts such corporations operating under chapter from provisions of chapter 112 relating to practice of medicine.	Medical service corporations endorsed by the Department of Public Health and Commissioner of Public Welfare.	Board of directors with not less than 9 members, of whom at least 3 and not more than a third shall be subscribing members of corporation, and at least 3 and not more than a third physicians who are members of the Massachusetts Medical Society or other recognized association of physicians and who are not associated with physicians of the medical service plan. Any person in Commonwealth who meets qualifications specified in bylaws may become a subscribing member.	Corporation shall not provide medical services but may contract for them with medical organizations composed of at least 5 physicians. Corporations may pay a stipulated percentage of subscriptions or other receipts; specified amounts shall not be paid whether or not based on number of services.	Every registered physician complying with qualifications of medical organization conducting business in community has a right to become an associate member of organization.	Commissioner of Insurance and Commissioner of Public Health.	Corporations are exempt from provisions of insurance laws and from taxes except as provided. Salaries limited to $5,000 annually.
New Jersey (Rev. Stat., Cum. Suppl. 1941, sec. 17: 48A-1 to 17: 48A-25). Approved: 1940. Amended: 1944 and 1946.	Provides for medical nonprofit service corporations and limits operation of medical service plans to those corporations except when authority is granted by the Commissioner of Banking and Insurance or in the case of medical services under workmen's compensation.	Nonprofit corporations without capital stock. 51 percent of the physicians in area must agree to participate in plan.	Board of trustees. No person can be approved as trustee unless approved by a recognized medical society or a professional organization having not less than 2,000 members licensed to practice medicine and surgery.	All general and special medical and surgical services ordinarily provided by physicians in accordance with accepted practices in community at time services are rendered. Cash indemnity benefits will not be paid except for medical services for which corporation was liable at time of such payment. Contracts can cover only one person and dependents. Under certain circumstances subscriber may be charged additional sum by participating physicians.	Licensed physicians in New Jersey who agree to participate.	Commissioner of Banking and Insurance.	Corporations are tax exempt. Organization must have unencumbered funds of not less than $5,000.

Table 1.—*State legislation regarding nonprofit medical care corporations enacted before 1945 in selected States*—Continued

State and legislation enacted	Purpose	Who may incorporate	Administrator of corporation	Scope of services	Source of services	Legal jurisdiction	Tax exemptions and other significant provisions
Ohio Gen. Code (Page, Cum. Suppl., 1942) sec. 669-14 to 669-38. Approved: 1941.	Authorizes nonprofit corporations to operate voluntary nonprofit medical care plans.	Nonprofit plans providing medical services. At least 51 percent of physicians and surgeons practicing in each county where plan operates must participate. Certificates will not be issued until written agreements have been signed with at least 10 physicians.	Fifteen-member board of trustees, representing the public and the medical profession; at least 6 public representatives.	Professional services by physicians and surgeons in office, hospitals, and homes; hospitalization not included. Contracts cannot be issued to persons without dependents and with income exceeding $900 during 6 preceding months, or persons having dependents whose income exceeded $1,200 during preceding 6 months' period.	Licensed physicians and surgeons in State who reside in area of operation and who comply with corporations' requirements; subscribers have free choice of physician.	Superintendent of Insurance.	Corporations are taxed the same as domestic insurance companies and are entitled to the same exemptions. Employees of State or political subdivisions or any institution supported by State, may authorize deductions from salaries.
Pennsylvania (Acts 398 and 399). Approved: 1939. Amended: 1943.	Provides for nonprofit medical service plans.	Nine or more persons, residents of Pennsylvania, majority physicians.	Nine persons, residents of Pennsylvania, majority physicians. All questions involving professional ethics to be decided only by physicians selected in accordance with bylaws of corporation.	Medical services (not cash) for persons of low income and their dependents as follows: Person with one dependent whose income for preceding 25 weeks averaged not more than $30 weekly or whose income with dependent's averaged not more than $45; persons with more than one dependent whose income with incomes of all dependents averaged not more than $60 during 25-week period. All persons of low income entitled to apply for membership. Persons with higher incomes may become members with understanding that physicians may make extra charge for services.	Every physician practicing in area served who complies with regulations of the corporation and who registers with corporation. Corporation, with approval of Department of Health, may refuse to place doctor's name on the register.	Department of Health and Insurance Department. Secretary of Health may order corporation to extend or improve services if they are not adequate.	Corporations are tax exempt. Minimum reserve of $25,000 required.

type of organization, provides for the formation of medical service corporations to be managed by boards of directors composed of persons approved by a medical society which has been incorporated for at least 10 years and has not less than 2,000 members; not less than one-third of the directors must be subscribers to the medical care plan. The second act, sponsored by those who favored a plan that would not give a monopoly to medical societies, provides for the formation of medical service corporations, approved by the Department of Public Health and managed by boards of directors with not less than 9 members, of whom at least 3 but not more than a third are subscribing members, and at least 3 but not more than a third are physicians who are members of the Massachusetts Medical Society or of some other recognized association of physicians. Both laws are on the statute books.

Eleven of the 15 States recently enacting legislation have made definite provisions for medical supervision and participation. Illinois and Tennessee specify that a certain number of citizens (7 in one State and 9 in the other) may incorporate, but the majority must be physicians. Moreover, before plans in these States are approved, proof must be given that the majority of the physicians in the area of operation are willing to participate.

The Minnesota act states that not less than 21 persons, all doctors of medicine, may incorporate. Wisconsin legislation provides for the incorporation of plans by the State medical society or by county medical societies having State medical society approval. Alabama has amended State hospital legislation to permit hospitals which have been approved by the State hospital and medical associations to provide medical services.

Legislation in Rhode Island provides for double approval—by the Governor, who must certify that the plan is a public convenience, and by the State medical society, which must give approval before a plan may incorporate.

While the Kentucky law does not specify the type of persons who may incorporate, it requires that at least 51 percent of the physicians in the area of operation must signify their willingness to provide services before a certificate of incorporation will be granted. Neither Iowa nor Kansas made any special regulations about incorporation, but the former requires that 150 physicians must participate in any plan, and the latter specifies 50.

Both Florida and North Dakota, while giving latitude for the types of plans that may be incorporated, specify that the plans must be managed by boards of directors, the majority of whom are physicians.

Other Aspects

Boards of directors.—The regulations regarding boards of directors in-

Table 2.—*State legislation regarding nonprofit medical care corporations enacted during 1945 and early 1946*

State and legislation enacted	Purpose	Who may incorporate	Administrator of corporation	Scope of services	Source of services	Legal jurisdiction	Tax exemptions and other significant provisions
Alabama (Governor's Act No. 50, Acts 1945). Approved: June 1, 1945.	Amends existing nonprofit hospital legislation.	Representatives of 2 or more hospitals approved by the Alabama Hospital Association.	Board of trustees. Representatives of participating hospitals entitled to membership. Physicians may be elected.	Hospital services, which may include medical and/or surgical and/or obstetrical care or benefits.	Any member of county medical association selected by patient.	Superintendent of Insurance.	Previous legislation (1939) grants tax exemption.
Arizona (Ch. 13, Laws 1945). Approved: Oct. 3, 1945.	Provides for organization, regulation, operation, and taxation of nonprofit hospital and medical service corporations.	Any organization not inconsistent with the provisions of the act.	Board which includes representatives of participating physicians, hospitals, and the general public.	Hospital or medical service or a combination of the two.	Licensed physicians (or hospitals) with whom organization enters into contract. Patient has free choice of participants.	State Corporation Commission.	Corporations are exempt from all but general property tax. Organizations must have deposit of $5,000–10,000 with State Treasurer. Salaries limited to $5,000 annually unless approved by board of directors.
Connecticut (Special Act No. 284, Laws 1945). Approved: July 23, 1945.	Authorizes the Connecticut Hospital Service Association to act as agent for medical service corporations organized under existing legislation.						
Florida (House Bill No. 883). Approved: June 11, 1945.	Provides for and regulates nonprofit medical and/or surgical and/or hospital service plans.	Five or more persons.	Board which includes representatives of participating physicians, hospitals, and the general public; majority physicians.	Medical and/or surgical and/or hospital services.	Licensed physicians and approved hospitals with whom organization enters into contract.	Insurance Commissioner.	Corporations are exempt from all provisions of insurance laws and all other laws conflicting with act. Pre-existing plans need not incorporate or reincorporate but must file an acceptance of the act.
Illinois (Senate Bill No. 652). Approved: July 25, 1945.	Provides for incorporation, supervision, regulation, and dissolution of medical service plan corporations.	Seven or more persons, all residents of Illinois, majority physicians. Majority of physicians in county must participate.	Board of directors with same general qualifications as incorporators.	Ordinary and usual medical professional services; no hospitalization.	Any licensed physician in good standing in county is eligible to participate.	Insurance Director.	Corporations are exempt from all taxes and license fees from which charitable and benevolent corporations are exempt. Must have working capital of $5,000.
Iowa (Senate Bill No. 128). Approved: Feb. 15, 1945.	Amends laws relating to nonprofit hospital service and authorizes nonprofit corporation to furnish medical and surgical services.	Corporations organized to establish, maintain, and operate a plan providing medical and surgical service.	Board of at least 9 members, majority physicians.	Medical and surgical services.	Licensed physicians in community; at least 150 must participate.	Commissioner of Insurance.	Corporations are tax exempt.
Kansas (House Bill No. 90). Approved: Mar. 29, 1945.	Prescribes certain powers and duties and provides for supervision of nonprofit medical service corporations.	Corporations must have contracts with at least 50 participating physicians.	Board of directors with 2 public representatives appointed by Governor.	Medical services of such types as corporation desires.	Licensed physicians; at least 50 must participate.	Commissioner of Insurance.	Corporations are tax exempt. Plans must have assets of at least $5,000.
Kentucky (House Bill No. 171). Approved: Mar. 23, 1946.	Provides for the incorporation and regulation of nonprofit medical service plans.	Corporations with at least 51 percent of licensed physicians in county participating in providing services.	Not specified	General and usual services rendered by physicians.	Every licensed physician in county has a right to participate.	Insurance Director and State Board of Health.	Corporations are exempt from insurance laws except as specifically provided. A $10,000 security must be deposited with the Custodian of Insurance Securities.
Maryland (Ch. No. 752). Approved: Apr. 27, 1945.	Repeals and reenacts, with amendments, nonprofit hospital legislation to provide for nonprofit health plans.	Corporations, without capital stock, organized to provide health services.	Not specified	Hospital, medical, or dental care provided by hospitals, physicians, and/or dentists.	Licensed physicians, dentists, or hospitals having contracts with corporation.	Insurance Commissioner.	Corporations are exempt from insurance laws unless expressly designated. Must have a working capital sufficient for 3 months' operation.

cluded in recent legislation are of particular interest not only to organizers of plans but to the general public—especially the beneficiaries of such plans. Six States—Florida, Illinois, Iowa, North Dakota, Rhode Island, and Tennessee—specify that the majority of the board members must be physicians; only Arizona, Florida, and Kansas mention representation of the subscribers.

Odin Anderson, in his study of State enabling legislation in 1944, observed that control over policies and operations of voluntary plans was definitely placed in the hands of the hospital officials (for hospital plans) and of the medical profession (for medical plans), subject to the decisions of the commissioner of insurance; the subscriber has little or no voice except through sales resistance or organized appeals to the commissioner of insurance. "Whether the representation of the public on the boards of directors is desirable or not is a very debatable issue," Mr. Anderson declares.[5] "It may be said, however, that if the nonprofit plans regard themselves as public service institutions sponsored by the community, it follows that representatives of the community at large should have a voice in policy making, perhaps even a dominant voice; if the plans regard themselves as simply another insurance company, it follows according to precedent that the community should have no more voice in the policy making than it has at present in the operation of commercial insurance companies."

Legal supervision of plans.—Legislation in almost all States places voluntary plans under the direction of the State insurance commissioner, whose power over them varies considerably. In some instances it extends far beyond what would ordinarily be expected, permitting him to determine whether the plan duplicates services already provided, to limit the area of operation, and to determine the amount of funds to be spent for administration or for solicitation.

The Tennessee law, passed in 1945, gives the commissioner jurisdiction over rates, approval of hospitals,

[5] Anderson, Odin W., *State Enabling Legislation for Nonprofit Hospital and Medical Plans, 1944,* Public Health Economics Research Series No. 1, University of Michigan, Ann Arbor, 1944, 56 pp.

Table 2.—*State legislation regarding nonprofit medical care corporations enacted during 1945 and early 1946*—Continued

State and legislation enacted	Purpose	Who may incorporate	Administrator of corporation	Scope of services	Source of services	Legal jurisdiction	Tax exemptions and other significant provisions
Minnesota (Ch. No. 255). Approved: Apr. 12, 1945.	Provides for the incorporation and regulation of nonprofit medical service plans.	Not less than 21 doctors licensed under State laws and legal residents of State.	Not specified	Medical services, no cash indemnification of subscriber.	Patient selects physician; physician-corporation contracts prohibited.	Commissioner of Insurance and Secretary of State.	Corporations are exempt from insurance laws of State except as specifically provided. Must have at least $25,000 capital.
Mississippi (House Bill No. 712). Approved: Apr. 10, 1946.	Provides for incorporation of medical, surgical, and other corporations organized to improve physical, mental, and moral conditions of mankind.	Three members of organization. Organizations may operate on share or nonshare basis. Nonprofit organizations shall not be required to publish charter and shall issue no stock.	Not specified	Medical and surgical benefits as well as other social programs.	Not specified	Secretary of State and Attorney General.	
New Hampshire (Ch. No. 96) Approved: Apr. 5, 1945.	Amends previous medical service legislation.	Organization with 50 percent or more of the eligible physicians in State, or area of operation participating.					
New Jersey (Ch. 259) Approved: May 2, 1946.	Amends previous act affecting medical services to permit corporations to receive grants from government agencies or other sources for payment of medical and hospital services.						
New York (Ch. 548) Approved: Apr. 5, 1946.	Amends insurance membership corporation and cooperative laws relating to nonprofit medical and dental indemnity and hospital service corporations to permit organizations under these laws to furnish medical, dental, and hospital service benefits.	Membership corporation and consumer cooperatives.		Medical, dental, and hospital benefits.			

scope of services to be offered, and conditions under which a doctor may be paid as a specialist; he has no professional advisory body, and the law is so worded as to allow appeal from his decisions only on points of law, not of fact.

Special privileges conferred by enabling legislation.—Most recent legislation has continued the pattern set in earlier acts by declaring nonprofit corporations to be charitable and benevolent institutions and making them tax exempt. The notable exception is the Tennessee act, which declares that the corporations are subject to fees and taxes as prescribed for life, health, and accident insurance companies, as it is not the purpose of the act to discriminate in favor of medical service corporations. In most States, also, medical care prepayment plans are allowed to operate without large reserves.

These exemptions raise an interesting question concerning the place of nonprofit plans in relation to commercial insurance. By declaring the plans charitable and benevolent and exempting them from the regular insurance laws and from the necessity of maintaining large reserves, the States are endowing them with certain privileges, in return for which the people have a right to expect a more comprehensive type of benefit

Table 2.—*State legislation regarding nonprofit medical care corporations enacted during 1945 and early 1946*—Continued

State and legislation enacted	Purpose	Who may incorporate	Administrator of corporation	Scope of services	Source of services	Legal jurisdiction	Tax exemptions and other significant provisions
North Dakota (Ch. 154) Approved: Feb. 28, 1945.	To promote public health and bring about a wider distribution of medical care through nonprofit medical service corporations.	No particular specifications.	Board of at least 9 members, majority participating physicians.	Usual services rendered by physicians.	Every licensed physician in State has a right to participate.	Commissioner of Insurance.	Corporations are tax exempt; law governing charitable and benevolent organizations applicable.
Rhode Island (House Bill No. 836) Approved: Apr. 24, 1945.	Provides for incorporation of nonprofit medical service corporations.	Organizations approved by Governor and State medical society. Hospital corporations may amend charters to provide medical care.	Board of directors, majority licensed physicians.	Medical services, drugs, medicines, supplies, and nursing care; indemnity benefits may be provided.	Not specified.....	Director of Business Regulation.	Corporations are exempt from insurance laws.
Tennessee (Ch. 113) Approved: Feb. 27, 1945.	Authorizes the organization and operation of medical service corporations.	Nine citizens, majority doctors licensed in Tennessee. Fifty-one percent of doctors in county must participate. Corporation must not duplicate services already provided.	Board of directors, possessing same general qualifications as incorporators.	Either general or special medical benefits or both.	Every practicing doctor in good standing in the county is eligible to participate.	Insurance Commissioner.	Corporations are subject to fees and taxes as prescribed for life, health, and accident insurance. Must have 6 months' working capital or $2,500, whichever is larger.
Texas (Senate Bill No. 181) Approved: Apr. 10, 1945.	Amends civil statutes (article 1302, title 32) to provide for creating and operating charitable corporations to own and operate nonprofit cooperative hospitals and to provide medical, dental, health, surgical, nursing, and related services and benefits for members and families of members.	Corporations cannot operate where population is more than 2,500.	.....	See *Purpose*.....	Not specified.....	.....	
West Virginia (Senate Bill No. 3-X) Approved: Mar. 28, 1946.	Amends and reenacts previous legislation to encourage expansion of hospital and medical services.	Nonprofit, nonstock hospital or medical service organizations.	Not specified.....	Medical and surgical services by physicians; hospitalization.	Physicians and hospitals with whom corporation has contracts.	Insurance Commissioner.	Corporations are exempt from taxes and general insurance laws of State. Must have sufficient working capital to pay expenses for a reasonable period. Dues may be deducted from State government's pay rolls.
Wisconsin (Ch. 494) Approved: July 19, 1945.	Amends statutes and provides for care during sickness by State medical society.	State society, or county society in manner approved by State society, may establish plans.	Not specified.....	Sickness care of indigents, low-income groups, and others.	Participating physicians; subscribers have free choice of physician.	Commissioner of Insurance.	Corporation is exempt from State insurance laws except those relating to nondiscriminatory rates, investments, and premium reserves, as specified.

than the commercial insurance companies can provide at similar rates. Since the majority of the subscribers to medical society plans receive care for catastrophic illness only—a benefit quite similar to that provided by the average insurance company—the development of prepayment plans along these lines has been ground for causing both the general public and the commercial companies to question the right of these organizations to special privileges.

Effect on Development of Plans and on Medical Services

The effect of recent legislation, both on the types of plans contemplated under this enabling legislation and on the types of services that will be provided, will be obvious to those familiar with prepayment medical care plans. Most of these State plans will either be operated directly by State or county medical societies (or by organizations which they establish and control) or will follow such patterns as they prescribe.

The medical services afforded will provide the type of care now being given by medical society plans, which operate on the principle that the public is primarily interested in protecting itself against the costs of particular classes of catastrophic illness. Only a very small percentage of the membership in plans of this type now in operation is eligible for more than surgical, and in some instances medical, care (including obstetrical care) when hospitalized. Preventive care and care early in the course of illness, therefore, have largely been excluded. Services in most medical society plans may be provided by any licensed physician in the area who chooses to participate in the plan and who agrees to care for beneficiaries on a fee-for-service basis; the plan pays full or partial remuneration for services.[6]

Since the laws provide that all or a large percentage of the physicians in the area may provide service under the plan, group practice plans are, in effect, excluded because such plans provide service through a limited number of physicians working either full time or part time in an organized group under medical supervision.

The advantages of group practice were interestingly presented in a recent Senate subcommittee interim report on health insurance. The report stated that "Most of the plans offering comprehensive prepaid medical care are group practice plans . . . There is evidence, both qualitative and quantitative, that well-organized group practice can offer better medical care than individual practice."[7] The preference of physicians, particularly young physicians, for this type of practice was indicated in a survey among medical officers in the armed forces, sponsored by the American Medical Association, which showed that more than half the doctors replying wanted to enter private group practice after their discharge.[8]

An additional indication that prepayment plans in most States that have recently enacted legislation will be under strong pressures to follow the medical society pattern is found in the fact that four of these States—Illinois, Kentucky, North Dakota, and Tennessee—specify that every licensed physician in the area where the plans operate has a right to participate in providing services. Alabama requires that the beneficiary shall have the right to select any member of the county medical society; and Minnesota not only provides that the patient may select his physician but, as a further guarantee of free choice, forbids any contracts or agreements between physicians and plans with respect to rendering service to subscribers and states that the selection of a physician "shall be a matter of agreement directly between the patient and the doctor of medicine selected by the patient to treat him." Plans in all these States have no choice regarding the manner in which services will be provided. The medical society practice of using a participating physician must be followed.

The restricted nature of the services now being provided by medical society plans under most recent legislation will be of concern to all persons interested in the establishment of comprehensive medical care programs. Such an authority as Louis H. Pink, president of the Associated Hospital Service of New York and former Superintendent of Insurance of the State of New York, has recognized the weakness of voluntary plans with too limited services and has advised against them. At a recent meeting of the Medical Society of the County of New York, Mr. Pink emphasized the responsibility of voluntary plans to the public as a result of the special privileges granted them. He pleaded for the enrollment of a substantial percentage of the population and for a broad health program adaptable to the needs of each community. He emphasized particularly the value of stressing and developing preventive measures.

Attitude of State Medical Societies Toward Recent Legislation

To determine the attitude of the medical societies toward recently enacted legislation, a review was made of the official publications of societies in States where laws were enacted. In a number of instances the societies not only approved this type of legislation but were actually responsible for its passage. While some of the journals have merely referred to the laws briefly with such comments as "our medical and hospital prepayment insurance bill," others have discussed the acts in detail and have taken full credit for framing them and assuring their passage.[9]

[6] Full or partial payment depends on several factors. In medical society plans, physicians are paid by the plan according to a specified fee schedule, if funds are ample. If the plan cannot meet the physicians' bills in full, they are prorated. Some plans provide that the physician may charge the patient a fee in addition to that received from the plan if the latter's income is above a specified amount or if he uses a private room while hospitalized.

[7] Senate Committee on Education and Labor, *Health Insurance*, Subcommittee Report No. 5, July 1946, pp. 10–11.

[8] Based on data in the *Journal of the American Medical Association*, June 24, 1944, pp. 558–560.

[9] *Journal of the Medical Association of the State of Alabama*, June 1945, pp. 285–287; *Journal of the Kansas Medical Society*, April 1945, pp. 119–120; *Illinois Medical Journal*, August 1945, pp. 58–60; *Journal of the Iowa State Medical Society*, March 1945, pp. 89–90; *Minnesota Medicine*, June 1945, pp. 470–471; *Journal of the Tennessee State Medical Association*, March, pp. 76–79, and May 1945, pp. 121–125; *West Virginia Medical Journal*, April 1946, pp. 84–88; and *Wisconsin Medical Journal* (Medical Forum), July 1945, pp. 1–2.