Independent Plans Providing Medical Care and Hospital Insurance: 1950 Survey

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Voluntary medical care insurance in the United States is, in general, provided through four kinds of insurers—Blue Cross hospitalization plans, Blue Shield surgical-medical plans, commercial insurance companies selling accident and health policies, and independent and nonaffiliated plans. For the first three groups, national or summary information is available through the Blue Cross and Blue Shield Commissions and the agencies that compile data on commercial insurance. But there is no regular or periodic reporting for the fourth group. This article summarizes the major findings of a survey made to fill this gap. A more detailed report will be published separately.

TO FILL out the national picture on voluntary medical care insurance, the Division of Research and Statistics in 1945 made a survey of independent prepayment plans providing medical care insurance[1] and has now completed a survey to ascertain their status at the end of 1949.

The 1950 survey covered independent plans that are self-insuring—that is, they do not contract with another agency for the provision of benefits. These plans operate without affiliation with any coordinating agency that customarily makes regular reports on enrollment and finances, or, if the plans are affiliated with a national agency, their enrollment and finances are not presented in regular reports. Part of the enrollment of a few plans with national affiliation was included in the survey because, while their medical care insurance is counted in the published national aggregates, their hospitalization insurance is not. Because the survey was designed with the additional purpose of determining the extent of comprehensive medical care insurance in 1949, five plans that have national affiliation but provide benefits of broad scope were also covered by the survey.

At the close of the survey, data were available for 251 independent prepayment plans furnishing medical care insurance through arrangements other than Blue Cross, Blue Shield, or commercial insurance.[2] The surveyed plans covered about 4.5 million persons, making the average enrollment about 18,000.

Large enrollments are precluded in most of the independent plans by the nature of their sponsorship and form of organization. They are generally confined to a specific group of persons associated in an industry or in a cooperative movement, and—since many of them provide service benefits to their membership through their own physicians, clinics, and hospitals—they cannot expand enrollment rapidly or cover a large number of persons.

In the aggregate, however, the 251 plans include substantially all insurers that provide more or less comprehensive—rather than limited—medical benefits. They return to their members so much for their premium payments or membership dues that their role is more important than may be inferred from their coverage alone. Their total income in 1949 ($93.8 million) and their expenditures for benefits ($82.5 million) represented about 9 percent of all voluntary medical care insurance premiums and about 11 percent of all benefit expenditures in that year.

Of the 251 independent plans, those providing insurance against the costs of physicians' services in the home and office (or clinic) and, in nearly all plans, also in the hospital, are called the "comprehensive plans"; those offering benefits restricted to hospitalization, or to in-hospital surgical and medical care, are called the "limited plans." The plans vary with respect to many important details of their medical benefits, and thus there is a range in the scope of "comprehensive" benefits from plan to plan, as there is in the scope of "limited" benefits. (Such variation also occurs among the other three kinds of insurers.)

The prepayment arrangements in the coal-mining industry (interrupted and reorganized in 1949) and the student health services of colleges and universities were excluded from the survey, as were all Blue Cross plans, all but seven plans on which the Blue Shield Commission reports, and

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

[2] There are seven plans included in the survey (because their hospitalization benefits are not reported elsewhere or their benefits are comprehensive) that present exceptions to the concept of "independence" or "nonaffiliation": (1) The hospitalization coverage (only) of California Physicians' Service, a Blue Shield plan. This part of the plan (covering 249,259 persons) is classified in the survey among plans providing hospitalization benefits only. Its enrollment for surgical-medical benefits and its finances are covered in Blue Shield reports. (2) Five Oregon Blue Shield plans, with an enrollment of 153,816, that provide hospitalization and comprehensive medical care. (3) The Washington State Medical Bureau plan; though enrollment is included among non-Blue Shield plans covered in *Blue Shield Enrollment Reports*, benefits are comprehensive and include hospitalization. Its enrollment for hospitalization is 310,738 and for medical care, 466,241.

Additional partial exceptions to the criterion about nonaffiliation are the inclusion of the member plans of the Cooperative Health Federation of America and the self-insuring member plans of the Federation of Employees' Benefit Associations. None of these plans is covered by national reporting.

all commercial group and individual insurance contracts for hospital, surgical, and medical expenses.

Method of Survey and Completeness of Returns

A 1-page questionnaire, sent to officers of the various plans, was used to obtain most of the data, and additional information was derived from correspondence with the plans and from State insurance commission reports and other sources.

The schedule was sent to 460 consumer groups, industrial establishments, private group clinics, and the like, which were reported to be operating independent medical care plans. When the survey was closed, information was available on all but 13 plans.

In terms of plans, 251 were within the survey's scope, 196 were not; no other source yielded information about the 13 who failed to reply. There were four principal reasons for exclusion: The plan had been discontinued by 1949 (53 plans); it was not yet in operation in 1949 (26 plans); other information to the contrary, it is not a prepayment plan (50 plans); or another insurance carrier was used—either one covered in the survey, or a Blue Cross, Blue Shield, or commercial group insurance plan (62 plans).

In general, the schedule asked for information on type of plan, enrollment, benefits, and premiums. It also asked for the 1949 prepayment financial statement, with a differentiation between (a) income and expenditures for hospitalization (room and board and other usual hospital charges), and (b) income and expenditures for in- and out-patient medical, surgical, and dental services and for out-patient X-ray and laboratory services. Forty-three of the plans furnished data on income and expenditures for both kinds of benefits combined but made no subdivision of their financial statements to show hospitalization and medical care insurance separately.[3] When the statistical analysis was begun, financial data had been received from all but 46 plans, and the required financial information about these plans had not been located in any insurance reports.

Enrollment data were available for all except five plans. Sufficient other information was available on these five plans, however, to provide a basis for an estimate of membership.

Table 1.—*Number and percentage distribution of surveyed plans and their membership, by region and by type of sponsorship, December 31, 1949*

Region and type of sponsorship or organization	Plans		Members	
	Number	Percent	Number	Percent
Total	251	100.0	4,459,260	100.0
Industrial plans	149	59.4	1,967,948	44.1
Employer	29	11.6	206,707	4.6
Employer-employee	45	17.9	435,585	9.8
Employer-union	2	.8	23,894	.5
Employee	59	23.5	868,111	19.5
Union	14	5.6	433,651	9.7
Consumer	47	18.7	294,309	6.5
Community-wide	25	10.0	814,299	18.3
Medical society	13	5.2	916,514	20.6
Private group clinic	17	6.7	466,190	10.5
New England	7	2.8	31,358	.7
Industrial	7	------	31,358	-----
Middle Atlantic	40	15.9	1,124,786	25.2
Industrial	34	------	581,790	-----
Consumer	1	------	971	-----
Community-wide	5	------	542,025	-----
East North Central	29	11.6	561,594	12.6
Industrial	22	------	464,237	-----
Consumer	2	------	2,077	-----
Community-wide	3	------	86,855	-----
Private group clinic	2	------	8,425	-----
West North Central	19	7.6	297,932	6.7
Industrial	14	------	182,878	-----
Consumer	5	------	115,054	-----
South Atlantic	42	16.7	271,736	6.1
Industrial	23	------	167,687	-----
Consumer	7	------	31,169	-----
Community-wide	11	------	60,380	-----
Private group clinic	1	------	12,500	-----
East South Central	13	5.2	216,270	4.8
Industrial	7	------	89,475	-----
Consumer	2	------	26,571	-----
Community-wide	3	------	57,724	-----
Private group clinic	1	------	42,500	-----
West South Central	38	15.1	181,049	4.1
Industrial	17	------	136,850	-----
Consumer	19	------	39,396	-----
Community-wide	2	------	4,803	-----
Mountain	19	7.6	145,590	3.3
Industrial	8	------	62,865	-----
Consumer	3	------	29,558	-----
Medical society	6	------	46,917	-----
Private group clinic	2	------	6,250	-----
Pacific	44	17.5	1,628,945	36.5
Industrial	17	------	250,808	-----
Consumer	8	------	49,513	-----
Community-wide	1	------	62,512	-----
Medical society	7	------	869,597	-----
Private group clinic	11	------	396,515	-----

General Characteristics of the Plans

Enrollment

As of the end of 1949, the surveyed plans covered 4.5 million different individuals[4] in plans ranging in size from 41 to 466,000 members. Of the 4.5 million persons, 3.9 million had hospitalization insurance in the 216 plans providing this benefit. Medical care benefits other than hospitalization were available to 3.5 million persons in 217 plans; benefits ranged from the limited surgical insurance of 33 plans to the provision of nearly all physicians' services in and out of the hospital in the 184 plans classified as comprehensive.

A total of 2.9 million persons were provided with both hospitalization and comprehensive or limited medical care insurance through plans providing both types of benefits. About 591,000 persons had only medical care insurance from these independent plans, while about 971,000 had hospitalization insurance alone—in the main from plans providing only this single benefit.

On the basis of the type of benefits provided, the independent plans fall into four major categories.

Type of benefit	Plans	Membership	
		Number	Percentage distribution
All independent plans	251	4,459,260	100.0
Physicians' services in the home, office (or clinic), and hospital, and generally providing hospitalization benefits	165	[1] 2,894,398	64.9
Physicians' services in the home, office (or clinic), but not the hospital, and generally providing hospitalization benefits	19	[2] 275,539	6.2
Hospitalization and/or surgical benefits (and very restricted medical benefits in a few plans)	33	[3] 423,310	9.5
Hospitalization-only benefits	34	866,013	19.4

[1] Includes 24,305 members eligible for hospitalization benefits only.

[2] Includes 264,700 persons covered under the International Ladies' Garment Workers Union plans, who receive medical attention at the Union Health Centers and are paid cash indemnity amounts for their hospitalization benefits.

[3] Includes 80,552 members eligible for hospitalization benefits only and 32,546 for surgical benefits only; the rest were eligible for both benefits.

Of the total membership of 4.5 million, 65 percent in 66 percent of the

[3] Special tabulations and analyses with respect to operating expenses, allocations to reserves, taxes, and the like will be presented in a more detailed report to be published separately.

[4] Duplication of coverage arising because of membership in more than one surveyed plan was slight. Known duplication applied to only 3,985 persons.

plans were eligible for a wide range of benefits, including, in addition to the services of physicians and hospitalization benefits, such items as laboratory and X-ray services, ambulance service, and—in 45 plans—certain dental services.

The 184 plans in the first two categories include all or substantially all the voluntary prepayment organizations in the United States that provide more or less comprehensive benefits and thus assure or encourage access to a physician early in an illness and offer preventive and diagnostic services, on a prepaid basis, without confinement to a hospital as a prerequisite.

There were approximately 2 dependents for every 3 subscribers in the surveyed plans, giving an average of 1.71 insured members per subscriber. Many of the plans, particularly a number of industrial plans, were open only to employees and not to their families. In plans covering dependents, there were 2.3 insured members per subscriber.

Sponsorship

The nature of the sponsorship or control has an important influence on the type of prepayment plan established and on the benefits provided. In the entire survey, 196 plans —classified as "industrial" or "consumer"—are controlled by the insured persons, by their employers, or by both; the others are controlled by the providers of the services (the plans sponsored by a medical society and the private group clinic prepayment plans) or by nonprofit organizations (the community-wide plans) (table 1).

Among the plans included in the survey, there are 149 industrial plans, some sponsored solely by employers, others solely by employees or unions, and still others jointly by employers and employees or unions. Industrial plans include such varied programs as the limited cash indemnity plans of some of the mutual benefit associations, the 28 railroad hospital plans providing service benefits for both hospitalization and medical care, and the union health center plans providing out-patient medical care. The distinction regarding sponsorship among industrial plans makes the type of control self-evident. It may be added, however, that plans are classified as consumer-sponsored in this survey only if they are nonindustrial plans in which the purchasers of the insurance control the over-all policies and direct the nonmedical aspects of the plan. Thus, employee- or union-sponsored plans might also be designated as consumer-sponsored, but the industrial classification seems more generally useful. There are 47 plans based on a cooperative form of organization and sponsored by consumers.[5]

Twenty-five of the surveyed plans are community-wide, with membership open to qualified groups or individuals in the community. Twenty of these offer hospitalization insurance as their sole benefit, three offer both hospitalization and surgical insurance, and two cover only medical care insurance.

Only 13 of the plans sponsored by medical societies qualified for inclusion in the survey.[6] The other 69 plans operating under the sponsorship of medical societies have limited benefits, and their enrollment and finances are reported by the Blue Shield Commission or are included in the aggregates of commercial health and accident insurance published annually.[7]

Geographic Distribution

Table 1 shows the regional distribution of the surveyed plans and their membership by type of sponsorship. The Pacific region, where prepaid medical care has had a long period of development, had the largest number of plans (44) and the largest enrollment of any of the nine regions. New England represented the other extreme, having only seven plans, all of them industrial, with less than 1 percent of the total enrollment. The three Southern regions taken together accounted for 93 plans; but since these plans are generally small, they covered in all only 669,000 persons—15 percent of the total enrollment.

In eight States there are no headquarters of any surveyed plan. In four of these States restrictive legislation may be at least partly responsible. Consumer-sponsored plans are more directly affected by such legislation than the other types included in the survey. Twenty-eight States have no consumer-sponsored plans; the majority of these States have legislation or court opinions that prevent the formation of the type of plan usually established by consumers.[8] These legal barriers make it impossible to form a plan controlled by the membership and providing service benefits to them through their own facilities.

Scope of Benefits

Of the total membership of nearly 4.5 million persons enrolled in all the independent plans, nearly 3 million had some measure of protection against the cost of physicians' services in the home, office (or clinic), and hospital (table 2). About 2.3 million persons in this group (81 percent) were also protected against the cost of hospitalization through the plan's own provisions. In all, 165 plans furnished these broad medical benefits, though 18 of them did not provide hospitalization.

Another 19 plans with 276,000 members provided insurance against the cost of physicians' services in the home and office, but not in the hospital. Twelve plans in this group, with only 21,000 members, did not provide hospitalization insurance.

Thirty-three plans limited their medical benefits to in-hospital surgery and obstetrics, with very limited medical care available in a few plans; about 343,000 persons were eligible for surgical benefits. Twenty-nine of

[5] Three plans having membership in the Cooperative Health Federation of America are not classified as "consumer plans." Two of these—Group Health Insurance of New York and the Health Insurance Plan of Greater New York—are classified as community-wide plans in the survey, because their enrollment is open to the public. The Labor Health Institute of St. Louis is included among union-sponsored plans.

[6] Six plans not reported by Blue Shield and the seven plans listed in footnote 2.

[7] Seven of these plans utilize commercial insurance carriers. They are not affiliated with the Blue Shield Commission.

[8] Horace R. Hansen, "Laws Affecting Group Health Plans," in "A Symposium on Laws Relating to Health Insurance Plans and Public Health," *Iowa Law Review*, Winter 1950, pp. 209-236.

Table 2.—*Number of members in surveyed plans, by major types of benefit and by type of sponsorship, December 31, 1949*

Major types of benefit provided [1]	Number of members in—								
	All plans	Industrial plans				Consumer plans	Community-wide plans	Medical society plans	Private group clinic plans
		Total	Sponsored by—						
			Employer	Employer-employee or employer-union	Employee or union [2]				
Total membership	4,459,260	1,967,948	206,707	459,479	1,301,762	294,309	814,299	916,514	466,190
Physicians' services in home, office (or clinic), and hospital	2,870,093	1,232,915	118,490	423,115	691,310	239,079	289,079	642,830	466,190
With hospitalization benefits from plan	2,331,758	1,178,999	118,490	421,123	639,386	223,167	----	487,327	442,265
Without hospitalization benefits from plan [3]	544,356	53,916	----	1,992	51,924	15,912	289,079	155,503	23,925
Physicians' services in home and in office (or clinic)	275,539	273,090	----	6,427	266,663	2,449	----	----	----
With hospitalization benefits from plan	254,973	254,973	----	----	254,973	----	----	----	----
Without hospitalization benefits from plan [3]	20,566	18,117	----	6,427	11,690	2,449	----	----	----
Surgeons' (including maternity) services only	342,758	225,341	35,199	29,880	160,262	30,962	66,015	20,440	----
With hospitalization benefits from plan	310,212	196,780	32,375	4,143	160,262	30,962	66,015	16,455	----
Without hospitalization benefits from plan [3]	32,546	28,561	2,824	25,737	----	----	----	3,985	----
Hospitalization benefits only	970,870	236,602	53,018	57	183,527	21,819	459,205	[4] 253,244	----
In more comprehensive plans	24,305	6,702	----	57	6,645	17,603	----	----	----
In limited hospital-surgical plans	80,552	11,770	----	----	11,770	----	68,782	----	----
In hospitalization-only plans	866,013	218,130	53,018	----	165,112	4,216	390,423	[4] 253,244	----

[1] Many of these plans also offer other benefits, not considered here, such as dentistry, nursing, X-ray services, laboratory services, and drugs. In some plans the benefits are provided as services and in others as cash indemnity payments.

[2] Such plans might alternatively have been classified as "consumer."

[3] Persons in these plans may have hospital benefits from organizations outside the scope of the survey.

[4] Surgical-medical benefits for 249,259 of these members included in Blue Shield enrollment reports; enrollment for hospitalization benefits, included here, not reported elsewhere.

these plans provided both hospitalization and surgical benefits to 310,000 members.

A total of 34 plans insured only the costs of hospitalization. They covered 866,000 persons and ranged in size from eight small Georgia community-wide plans[9] with an average enrollment of 4,645 to large plans whose enrollments average more than 200,000. In the surveyed plans, 971,000 persons in all were protected solely against hospitalization costs.

Finances

The present survey differed from earlier ones in that it sought income and expenditure data from all plans. The findings are presented here in two ways. In table 3, estimates of the total income and the expenditures for (a) all benefits, (b) hospitalization benefits, and (c) medical care benefits are shown separately for each type of plan sponsorship; in tables 4, 5, and 6, the actual per capita incomes and benefit expenditures are presented for each of the three categories of benefits, with the scope of the benefits indicated.

Estimated Income and Benefit Expenditures

As previously indicated, the financial reporting by the surveyed plans was nearly complete with respect to their entire prepayment balance sheet. Income and expenditure figures for all benefits taken together were furnished by plans covering more than 80 percent of the entire enrollment. It was necessary to make estimates for only 46 plans in order to cover 100 percent of the enrollment.

Of the 205 plans for which some financial data were at hand, 79 had been unable to separate income for hospitalization from other income; 43 of these 79 plans were unable to separate expenditures for hospitalization from total expenditures for benefits. In the tabulations confined to either hospitalization or medical care finances, estimates were made in more instances for income than for expenditures, and it was necessary to resort to estimating for more plans than was the case for the combined income or combined expenditure estimates. The estimates or projections were made plan by plan, on the basis of the findings for similar plans reporting all items.

The total income of the 251 plans was estimated to be $93.8 million in 1949; expenditures for all benefits were estimated to be $82.5 million. On the average, the members received in benefits 88 cents per $1 of premium. About two-fifths of total income and of benefit expenditures were used for hospitalization benefits, and three-fifths were used for medical care benefits, as shown in the following tabulation.

Item	Benefits		
	Total	Hospitalization	Medical care
Number of plans	251	216	217
Number of members	4,459,260	3,867,813	3,486,390
Income (in millions)	$93.8	$39.7	$54.1
Benefit expenditures (in millions)	$82.5	$36.4	$46.1
Benefits as percent of income	88.0	91.7	85.2

Table 3 indicates the estimated income and expenditures in 1949 for the plans of each type. The 149 industrial plans as a group had 46 percent of the estimated total income of all 251 plans and were responsible for 48 percent of expendi-

[9] One additional independent Georgia county plan had begun to cover surgical care in 1949. It is included among the plans mentioned in the preceding paragraph.

tures for all benefits, more than 50 percent of hospitalization expenditures, and 44 percent of medical care expenditures. The 59 employee-sponsored plans accounted for nearly half the entire income and expenditures of the industrial plans. The plans sponsored by a medical society received 24 percent of all income and made 23 percent of all benefit expenditures. Consumer-sponsored plans received only 6 percent ($5.6 million) of the total income and paid out a similar proportion of expenditures.

The table makes clear the differences in the proportion of income and expenditures assigned to hospitalization and to medical care insurance among the different types of sponsor. The community-wide plans, for example, used nearly as much money for hospitalization insurance as for medical care insurance, whereas the expenditures for medical care among consumer plans were double their expenditures for hospitalization.

Per Capita Income and Expenditures

On the basis of the estimates for all the surveyed plans, it appears that they collected about $10.25 per capita for hospitalization insurance, returning approximately $9.40 in benefits.[10] These amounts may be compared with per capita income of $11.18 and per capita expenditures of $9.50 for hospitalization among the 84 Blue Cross plans in operation in 1949.

Medical care benefits cost $15.52 per capita in premium income, and benefits amounted to approximately $13.22 per capita. These averages are less meaningful than those given for hospitalization because the medical care benefits varied more widely among plans. The ratio, however, of benefit expenditures to income—85.2 percent—may be compared with the benefit-expenditure ratio of 79.9 percent obtaining among all Blue Shield plans in the United States in that year.

The per capita data in tables 4, 5, and 6 are derived from the income and expenditure figures actually reported by a portion of the plans. The percentage of the total membership in the particular type of plan covered by actual reports is given to indicate the representativeness of each per capita figure. These figures are a guide to the relative costs of limited and more comprehensive medical care benefits in 1949.

Hospitalization and medical care in combination.—Per capita income and expenditure data are shown in table 4 for plans that provided both hospitalization and medical care benefits; the figures apply to the membership that received both. These data are derived from 122 reporting plans, which included 71 percent of all persons eligible for the combined benefits.

Per capita income for all plans covered in table 4, regardless of the precise scope of their medical benefits, equaled $23.15, and expenditures for the combination of benefits amounted to $21.18, or 91.5 percent of income.

Plans limiting their benefits to hospitalization and surgical care received $15.57 in income per capita and spent $13.96 in benefits. The proportion of income used for benefits is somewhat less (90 percent) than for all plans taken together.

The range in per capita income among the comprehensive plans is from $9.58 for the union plans to $35.40 for the employer-employee plans, with an average of $24.37. Per capita expenditures for benefits in these plans varied from $5.94 to $33.51, with the average $24.34. The variation in the proportion of income returned in benefits is from 49 percent for the one employer-union plan to 98.8 percent for the employee plans. The comprehensive plans, taken together, returned 92 percent of income in the form of benefits for hospitalization and medical care.

Hospitalization.—Per capita income for the hospitalization insurance provided by either the comprehensive or the limited plans varied, according to plan sponsorship, from $3 to $18 a year and averaged $9.18 for the 109 plans reporting this financial information (table 5).

These plans as a group returned 90 percent of income in the form of hospitalization benefits, or $8.28 per

Table 3.—*Estimates of total prepayment income and expenditures in the surveyed plans for all benefits and for hospitalization and medical care benefits, by type of sponsorship, 1949*

[In millions]

Type of sponsorship or organization	Total		Hospitalization		Medical care	
	Income	Expenditures for benefits	Income	Expenditures for benefits	Income	Expenditures for benefits
Total	$93.8	$82.5	$39.7	$36.4	$54.1	$46.1
Industrial plans	43.0	39.8	21.1	19.4	21.9	20.4
Employer	4.2	4.1	2.3	2.2	1.9	1.9
Employer-employee	13.9	13.3	6.7	6.5	7.2	6.8
Employer-union	.2	.2	.1	.1	.1	.1
Employee	20.4	18.3	10.8	9.5	9.6	8.8
Union	4.3	3.9	1.2	1.1	3.1	2.8
Consumer	5.6	4.6	1.9	1.6	3.7	3.0
Community-wide	11.1	8.8	5.1	4.3	6.0	4.5
Medical society	22.5	18.9	8.3	8.0	14.2	10.9
Private group clinic	11.6	10.4	3.3	3.1	8.3	7.3

Table 4.—*Per capita income and expenditures for hospitalization and medical care combined among 122 plans offering both benefits, 1949*[1]

Type of plan	Per capita[2]		Percent of income used for benefits	Percent of membership covered by reports
	Income	Benefit expenditures		
All plans	$23.15	$21.18	91.5	70.9
Hospitalization and surgical benefits	15.57	13.96	89.7	91.6
More or less comprehensive benefits	24.37	22.34	91.7	68.4
Industrial	23.85	22.71	95.2	73.9
Employer	30.19	29.74	98.5	82.3
Employer and employee or union	34.18	31.86	93.2	75.3
Employer and employee	35.40	33.51	94.7	74.2
Employer and union[3]	12.22	5.94	48.6	100.0
Employee	29.03	28.67	98.8	52.3
Union	9.58	8.68	90.6	100.0
Consumer	19.58	16.42	83.9	81.2
Medical society	32.22	27.24	84.5	35.7
Private group clinic	24.84	21.56	86.8	80.3

[1] Includes only plans providing both benefits to identical numbers of insured persons.
[2] May represent slight understatements because end-of-year enrollment was used instead of average enrollment for the year in computing per capita amounts. Based on data covering 2.1 million persons.
[3] Only 1 plan of this type.

[10] An average enrollment figure for 1949 is not available for use in determining per capita amounts; the use of the year-end enrollment figure may cause a slight understatement if enrollment in these plans expanded during the year. The figures are approximately correct, however, because it is known that growth was not substantial within the year.

Table 5.—*Per capita income and expenditures for hospitalization benefits among 109 reporting plans, 1949*

Type of plan	Per capita [1]		Percent of income used for benefits	Percent of membership covered by reports
	Income	Benefit expenditures		
All plans	$9.18	$8.28	90.2	63.8
Hospitalization only	10.13	8.34	82.2	100.0
Hospitalization and/or surgical benefits	9.35	8.45	90.4	90.3
More or less comprehensive benefits	8.76	8.50	97.0	45.1
Industrial	9.21	9.20	99.2	47.2
Employer	16.04	15.90	99.3	65.8
Employer and employee	18.00	16.99	94.4	15.1
Employer and union	[2]	[2]	[2]	[2]
Employee	16.87	17.33	102.7	32.2
Union	3.03	2.89	95.4	100.0
Consumer	7.73	8.18	105.8	20.7
Medical society	10.78	10.55	97.9	33.0
Private group clinic	6.78	6.21	91.6	36.5

[1] May represent slight understatements because end-of-year enrollment was used instead of average enrollment for the year in computing per capita amounts. Based on data covering 2.1 million persons.
[2] Insufficient data.

capita. Reporting was not complete for several groups that had large enrollments and relatively high per capita incomes and expenditures for hospitalization insurance; as a result the per capita figures in table 3, which are based on estimates for all plans, are slightly above the average per capita amounts shown in table 5.

There was a wide range in the proportion of hospitalization income returned as benefits among the different types of plans. Consumer plans appear to have lost money on hospitalizing their members, since expenditures exceeded income by 6 percent. Taken together, the comprehensive plans used 97 percent of reported hospitalization income in payment of benefits, while the limited plans used 85 percent.

Medical care.—Reported financial data, covering 52 percent of the persons eligible for medical care benefits in the survey, formed the basis for the figures in table 6. The coverage to which the data apply varied from small proportions of the private group clinic, medical society, and consumer-sponsored plans to 100 percent of the enrollment in some of the other groups.

For all these plans the average per capita income for medical benefits was $14.20; expenditures were $12.27. The corresponding income and benefit expenditures for the limited surgical plans were $7.87 and $7.04, respectively. In the comprehensive benefit plans the range in per capita income for medical care in 1949 was from $6.48 for the union plans to $22 for the consumer plans. The averages for all comprehensive plans were $15.44 for income and $13.30 for benefit expenditures—a ratio of benefit expenditures to income of 86 percent. The range in the proportion of income used for benefit expenditures was from 75 to nearly 100 percent, with four types of plans returning more than 90 percent of income in the form of benefits.

Premiums

Monthly subscription charges or insurance premiums varied so much among the surveyed plans that there were almost as many different rate structures as plans. Premiums reflected the scope of the benefits provided and, in industrial plans, the extent of the employer contribution.[11]

Most plans charge a fixed monthly premium adjusted, when dependents are covered, to the size of the family. A few plans relate the monthly charge to the amount of the employee's earnings, but only three of these plans provide benefits for dependents.

The premium most frequently cited for subscriber coverage only was between $2 and $3 a month, though it ranged from less than $1 to nearly $7. For family coverage (four persons), the range was from $1 a month to more than $10. Among the comprehensive plans, premiums between $5 and $6 a month for a family of four applied to more persons than other amounts in the range. A family of four could obtain more or less complete protection against the costs of hospitalization and medical care for an annual expenditure of $60-100.

Trends

In the absence of annual or even periodic data concerning the independent plans, two methods were used to measure trends. In table 7 the results of this 1950 survey are compared with those reported in the 1945 survey with appropriate adjustments for differences. Comparable groups of plans make up the first six items in the table. The comparison shows an increase of 56 in the number of plans and of 1.3 million in membership between the dates of the two surveys.

The number of consumer plans increased from 15 to 42 in the nearly 5 years between surveys, with a nearly proportionate increase in membership. Industrial plans remained relatively stable in number, with an increase in membership largely due to expansion of the coverage of dependents.

Table 6.—*Per capita income and expenditures for medical care benefits among 100 reporting plans, 1949*

Type of plan	Per capita [1]		Percent of income used for benefits	Percent of membership covered by reports
	Income	Benefit expenditures		
All plans	$14.20	$12.27	86.4	52.3
Surgical benefits	7.87	7.04	89.5	91.3
More or less comprehensive benefits	15.44	13.30	86.1	48.9
Industrial	11.18	10.82	96.2	48.7
Employer	15.26	15.19	99.5	65.8
Employer and employee	18.95	17.51	92.4	14.2
Employer and union	[2]	[2]	[2]	[2]
Employee	18.43	17.91	97.2	31.5
Union	6.48	6.26	96.6	100.0
Consumer	22.04	18.52	84.0	23.2
Community-wide	18.76	14.14	75.4	100.0
Medical society	21.44	16.69	77.8	25.0
Private group clinic	21.95	19.60	89.3	36.5

[1] May represent slight understatements because end-of-year enrollment was used instead of average enrollment for the year in computing per capita amounts. Based on data covering 1.8 million persons.
[2] Insufficient data.

Both the number of plans offering limited surgical and hospitalization benefits and membership in those plans increased markedly between the two surveys. Private group clinics with prepayment arrangements decreased, and their membership showed a slight decline. The increase in enrollment in the medical society plans with comprehensive benefits is almost entirely due to inclusion of dependents in the older plans, since the three new plans covered by the 1950 survey have small enrollments.[12]

[11] Details concerning the distribution of plans with respect to premium amounts are omitted here but will be included in a more complete report.

[12] Other plans with this type of sponsorship inaugurated since 1945 have benefits of limited scope and are included in Blue Shield reports or use commercial insurance carriers.

Another measure of trends is shown in table 8. Here 110 plans common to both surveys are compared as to enrollment and benefits in 1945 and in 1949. The plans have been classified as they were in 1945, so that union plans are included with consumer plans. Of the four major types of plans, only the private group clinics show a decline in membership. This decline is more than offset by the growth in enrollment in the consumer-sponsored plans and those sponsored by medical societies.

Discussion and Summary

This 1950 survey of the independent medical care insurance plans has compiled information on enrollment, premiums, benefits, income, and expenditures as of the end of 1949.

Of the 251 surveyed plans with nearly 4.5 million members, 165 are especially notable because they provide a wide range of benefits to their members, including physicians' services in the home, office (or clinic), and hospital. These "comprehensive" plans had an enrollment of 2.9 million persons, 80 percent of whom also had protection against hospitalization costs.

An additional 19 plans included in the survey, with 276,000 members, provide hospitalization and physicians' services in the home or office.

The 2.5–3.1 million persons insured for medical and hospital services by these 184 plans represent most—if not all—of the enrollment in this country eligible to receive more or less comprehensive care on a prepaid basis. These few millions are the only persons who have comprehensive insurance protection against medical costs—including care early in illness before it has become serious or costly or before its severity can be known, preventive and diagnostic services, and medical and hospital attention in a later or what may otherwise be a financially "catastrophic" stage.

Sixty-seven additional plans, covering 1.3 million persons for hospitalization and/or limited surgical benefits, were included in the survey. Information about their enrollment and finances (income of $12 million and benefit expenditures of $10 million in 1949) has not been assembled hitherto and represents a new segment of reporting on voluntary medical care insurance.

Table 7.—*Comparison of plans and membership in the 1945 and 1950 surveys of medical care organizations, by type of sponsorship*

Type of sponsorship or organization [1]	Number of plans		Number of members	
	1945	1949	1945	1949
Total	202	251	[2] 4,164,750	4,459,258
Comparable plans	161	217	2,297,589	3,593,245
Offering comprehensive benefits	156	184	2,264,807	3,169,935
Industrial	111	114	1,309,828	1,512,707
Consumer	15	42	110,731	259,131
Community-wide	1	2	9,352	289,079
Medical society	6	9	354,100	642,830
Private group clinic	23	17	480,696	466,190
Offering hospitalization and surgical benefits	5	33	32,782	423,310
Plans in 1945 survey only	41	----	1,867,161	----
Medical society	[3] 28	----	1,627,004	----
Governmental	11	----	135,004	----
Miners	2	----	105,153	----
Hospitalization plans in 1950 survey only	----	34	----	866,013

[1] By 1950 classification (some plans changed type of sponsorship). Union plans, formerly classified as consumer plans, here grouped with industrial plans.
[2] Differs from the total membership (4,975,850) shown in Bureau Memorandum No. 55 because of the following omissions: 600,000, overstatement of Washington State Medical Bureau coverage of dependents; 211,100, included in estimates for coverage of dependents in 1945 but not estimated for 1949.
[3] Now affiliated with the Blue Shield Commission, established in 1947.

The unusually high value of the insurance protection provided by the 251 independent plans is evident from the financial data. Their expenditures for benefits amounted to 11 percent of such expenditures for all voluntary medical and hospital insurance in the United States in 1949,[13] though their entire membership comprised a much smaller fraction of all persons said to have purchased some form of such insurance in that year. The 3.2 million persons in the 184 comprehensive independent plans (less than 5 percent of all who are said to have held some kind of voluntary medical care insurance in 1949) received benefits accounting for about 9 percent of expenditures for benefits made under all forms of voluntary medical care insurance in 1949.

With only minor exceptions the independent plans operated in 1949 with relatively high ratios of benefit expenditures to income. The estimates for all the survey plans show benefit expenditures equal to 88 percent of income. The comprehensive plans able to furnish detailed financial data applicable to a combined benefit structure had an average income of $24.37 and made average benefit expenditures of $22.34 per capita, for a benefit-expenditure ratio of 92 percent. Among these comprehensive plans, the industrial plans had a corresponding ratio of 95 percent.

These high ratios of benefit expenditures to income for a single year may or may not be precisely typical of other years. They are, however, highly indicative and worthy of note. Many of these independent plans have been in operation for a long time and have a stable financial structure. Their benefit-expenditure ratios are generally higher than the corresponding ratios recorded for Blue Cross, Blue Shield, and commercial insurance plans. There are several reasons for this difference. Presumably these plans do not spend any appreciable portion of their income for promotion of membership, and, of course, they do not pay brokerage fees or commissions; many rely heavily on voluntary services from their members, and the older and well-established plans apparently do not need to continue to accumulate reserves but instead can return most of their income in the form of benefits or even draw on reserves to pay for benefits in a period of rising costs.

The survey data show interesting relationships, among the independent plans, between type of sponsorship and scope of benefits. Approximately 48 percent of these plans are organized and controlled by the insured persons themselves, and about 78 percent by the insured persons and their employers. The provision of comprehensive benefits was one of the criteria for inclusion in this survey. The generally sharp contrast between the comprehensive protection provided by plans controlled by the insured persons (and employers) and the limited protection provided by plans otherwise controlled is therefore not clearly evident within the survey itself. The comparison has to be ex-

[13] For the 1949 figures for all voluntary medical care insurance see the *Bulletin*, March 1951, pp. 19-20; the figures for income and expenditures for the independent plans have since been revised on the basis of more complete returns.

Table 8.—*Comparison of plans and membership in 110 plans surveyed in 1945 and in 1950, by scope of benefits and by type of sponsorship* [1]

Type of sponsorship or organization [1]	Number of plans, 1945	Members		Members eligible for medical benefits									Members eligible for hospitalization benefits		
				At home, office (or clinic), and in hospital			At home and office (or clinic) only			In hospital only					
		1945	1949	Plans	Members		Plans	Members		Plans	Members		Plans	Members	
					1945	1949		1945	1949		1945	1949		1945	1949
Total	110	1,921,764	2,598,250	100	1,751,353	2,096,614	5	138,016	403,791	5	32,395	97,845	88	1,707,644	1,941,183
Industrial	[2] 76	984,157	990,450	68	958,047	[3] 962,531	4	6,967	[4] 8,389	4	19,143	19,530	60	953,366	960,538
Consumer	17	287,144	723,823	15	142,843	[5] 250,106	1	131,049	395,402	1	13,252	78,315	13	126,399	280,969
Medical society	6	[6] 354,100	[7] 620,338	6	354,100	[7] 620,338							6	354,100	464,835
Private group clinic	11	296,363	263,639	11	296,363	263,639							9	273,779	234,841

[1] By 1945 classification (some plans have changed type of sponsorship). Union plans classified in 1950 survey as industrial grouped here with consumer plans. Excludes the Health Insurance Plan of Greater New York since it was not included in the statistical tables in Bureau Memorandum No. 55; it began enrollment in 1947 and covered 229,200 persons on Dec. 31, 1949.

[2] Includes 1 plan for which there are no enrollment data; also includes 6 plans (1945) of 1 firm, which had 10 plans (counted as 6) as of Dec. 31, 1949.

[3] Includes 4 plans with an enrollment for 1949 of 26,247 members who are not covered for physicians' services in the home.

[4] Includes 1 plan with an enrollment for 1949 of 1,240 members having home services and hospitalization benefits only.

[5] Includes 3 plans with an enrollment for 1949 of 33,537 members who were not entitled to physicians' services in the home.

[6] 1945 data for Washington State Medical Bureau corrected for overstatement in Bureau Memorandum No. 55.

[7] Includes 155,503 State public assistance recipients who are not covered for hospitalization.

tended to plans outside the scope of this survey.

The 149 industrial plans—the principal type in the survey—had an enrollment of approximately 2 million persons. More than 75 percent of this enrollment was eligible for comprehensive benefits. Only among employer-sponsored plans was any appreciable portion of the membership limited in its benefits to hospitalization and surgical insurance.

The 47 consumer-sponsored plans had an enrollment of 294,000. Five-sixths of this membership was insured for comprehensive medical care, with benefits furnished in many cases through the plan's own medical facilities.

An examination of the data by region shows that the three Pacific States, where prepayment for comprehensive medical care was well-established long before the development of the Blue Cross-Blue Shield plans, had the largest number of plans and more than a third of the entire surveyed membership. The 1.6 million persons in the independent plans located in these States are almost all eligible under the plans for a wide range of benefits.

In eight States there were no independent plans, and in 28 States no plans sponsored by consumers, though an occasional industrial or community-wide plan was located in those States. Legal barriers erected in a majority of the 48 States and designed to favor plans sponsored and controlled by those who provide medical care have apparently been effective in these States in preventing the organization of plans controlled by the insured persons. This restriction, in turn, appears to have adversely affected the spread of plans offering comprehensive benefits, especially through service-benefit arrangements; in areas where control must rest with the providers of services the sponsors determine the benefit structure. They have made limited, and not comprehensive, medical care insurance the only form widely available.

The survey data show that, on the average, comprehensive medical care and hospitalization benefits provided by independent plans cost not much more than limited insurance benefits. For combined insurance against hospitalization and the costs of physicians' services in the home, office (or clinic), and hospital the member paid about $9 a year (about 75 cents a month) more per capita in premiums than for insurance confined to hospitalization and limited surgical-medical care (chiefly in the hospital).

In the 5 years between the surveys made in 1945 and 1950, some independent plans went out of existence, and some others ceased to be self-insurers and became purchasers of some other form of insurance. Plans newly established in the same period more than offset this loss; and the number of independent plans offering medical benefits increased by 56, and net enrollment expanded by 1.3 million. Plans common to the two surveys had a net addition of about 676,000 members.

Independent industrial plans remained substantially unchanged in number of plans and in enrollment, a finding of interest in light of the intensive promotional activities of Blue Cross, Blue Shield, and commercial accident and health insurance in industrial establishments.

Consumer-sponsored plans, though handicapped by limited financial resources, limited enrollment potentialities, and legal obstacles, more than doubled their enrollment and nearly tripled in number.[14]

The past 5 or 10 years have seen a very rapid increase in the number of persons having voluntary medical care insurance. Most of the increased coverage has been achieved in plans that provide benefits of limited scope. The existence—and the long history—of independent plans providing comprehensive benefits seems not to be generally recognized. The results of this survey invite renewed attention to these independent plans and to their demonstration that comprehensive insurance against the costs of medical care is feasible.

[14] This development was even more marked at the end of 1950, since the survey found that 24 consumer-sponsored plans started operations during 1950.