Independent Plans Providing Medical Care and Hospital Insurance: 1954 Survey

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In the United States voluntary medical care insurance is provided through four categories of insurers—Blue Cross hospitalization plans, Blue Shield surgical-medical plans, commercial insurance companies selling group and individual accident and health policies, and independent plans not associated with each other or with the other types of insurers. National or summary information about the first three types of insurers is available through the Blue Cross and Blue Shield Commissions and through various associations of commercial insurance carriers. There is, however, no regular reporting system for the fourth category of plans. For this reason, the Social Security Administration has made periodic surveys of the independent plans to round out the picture of enrollment, benefits, and financing in all forms of voluntary medical care insurance. The major findings of the 1954 survey are summarized in the following pages.

IN 1945 and again in 1950 the Division of Research and Statistics made surveys of prepayment plans providing medical care insurance[1]; it has now completed a third survey to ascertain their status in 1954.

Like the 1950 survey, the 1954 survey covered only independent plans that are self-insuring—that is, they do not contract with another agency for the provision of benefits.[2] Some of these plans are similar to the Blue Cross or Blue Shield plans for which national reporting is available, but most of them are characterized by being designed for the special groups they serve. They operate without affiliation with any national agency, or, if affiliated, their enrollment, benefit provisions, and financing are not presented in regular reports. Because, however, the surveys have been designed with the additional purpose of determining the extent of comprehensive medical care insurance, five comprehensive plans that are affiliated with the Blue Shield Commission and included in their reporting have also been included in the study.

The 1954 survey produced information on 309 plans—304 independent plans and the five Blue Shield plans offering comprehensive benefits. While there was a net gain of 58 plans between the time of the survey made in 1950 and the 1954 survey, actually more than that number were included for the first time among the independent plans in 1954. A few plans that had been active in 1950 were no longer in operation, but their loss was more than offset by 46 plans established since 1949. Moreover, some of the plans included for the first time in the 1954 survey were established before 1950. They include certain plans run by fraternal societies providing hospital and surgical benefits, only a few of which were covered in the earlier survey; certain nonprofit hospitalization and surgical-medical plans now counted among the independent plans but affiliated in the past with the Blue Cross or Blue Shield Commissions and by definition excluded from the 1950 survey; and a few plans that had been overlooked in 1950.

The surveyed plans covered 9.7 million persons at the end of 1953, while 4.5 million persons were covered by the plans counted at the end of 1949; average enrollment per plan was more than 31,000 in 1953 compared with 18,000 at the end of 1949. The median enrollment in December 1953 was only 5,250.

In comparison with the other three categories of carriers, most of the independent plans have small enrollments. Sizable enrollments are generally precluded by the nature of the sponsorship and the form of organization found to prevail among the independent plans. Only two plans had as many as a million persons enrolled; one of these was a Statewide nonprofit hospitalization plan, and the other was a Nationwide trade union plan. Membership in the plans is usually confined to a specific group of persons associated through their employment or in a cooperative or fraternal organization, and nearly half the plans provide service benefits through their own physicians, clinics, and hospitals. As a result, they cannot expand enrollment rapidly or cover a large number of persons. Table 1 shows how the plans were distributed by size of enrollment. The 203 plans with fewer than 10,000 persons enrolled accounted for only 6 percent of the total.

The 309 plans represent an extensive laboratory for the study of prepayment arrangements for hospital and medical care, since they use so many different approaches to providing prepaid services and offer such widely varying benefits. For the 1954 survey the mailed questionnaire was

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[1] See Margaret C. Klem, *Prepayment Medical Care Organizations,* Bureau Memorandum No. 55, Bureau of Research and Statistics, 3d ed., June 1945; Agnes W. Brewster, *Independent Plans Providing Medical Care and Hospitalization Insurance in 1949 in the United States,* Bureau Memorandum No. 72, Division of Research and Statistics, 1952; and Agnes W. Brewster, "Independent Plans Providing Medical Care and Hospital Insurance: 1950 Survey," *Social Security Bulletin,* May 1951.

[2] The 1945 survey covered all plans known to be furnishing medical care benefits, including all existing medical society plans that became affiliates of the Blue Shield Commission after it was established in 1946, and excluded plans providing only hospitalization benefits.

expanded so that information would be obtained in considerable detail on the benefits provided and on the methods by which they were made available; questions were also included to bring out differences between the benefit provisions for subscribers and for dependents. On the basis of the returns the plans have been classified as follows:

Total	309
Group-practice plans	140
Service benefits only	111
Some cash indemnity benefits	29
Nongroup-practice plans	169
Service benefits only	49
Some service and some cash indemnity benefits	23
Cash indemnity benefits only	97

As defined in this study, a service benefit entitles the member of the prepayment plan to receive the prepaid service without a large out-of-pocket expenditure for which he is later reimbursed by the insurance fund.[3] Service benefits may be direct or indirect. In the group-practice plans for medical care and/or diagnostic services benefits, the physicians' services are "direct," supplied by the plan's own staff of doctors; for hospitalization benefits the service may be either "direct" (furnished in the plan's own hospital) or "indirect" (obtained through arrangements with community hospitals). In the plans that do not have a group-practice clinic or hospital, or their own staff doctors, service benefits are necessarily "indirect"; the plan makes arrangements to reimburse physicians and hospitals in the community for services to its subscribers.

Table 1.—*Independent plans, by size of enrollment, 1954 survey*

Enrollment	Number of plans	Percentage distribution	Total enrollment (in thousands)	Percentage distribution
Total	309	100.0	9,685	100.0
Less than 500	46	14.9	14	0.1
500–999	22	7.1	17	0.2
1,000–2,499	36	11.6	57	0.6
2,500–4,999	46	14.9	164	1.7
5,000–9,999	53	17.2	376	3.9
10,000–24,999	48	15.5	749	7.7
25,000–49,999	29	9.4	1,015	10.5
50,000–99,999	11	3.6	745	7.7
100,000–499,999	15	4.9	3,452	35.6
500,000–999,999	1	.3	592	6.1
1 million or more	2	.6	2,504	25.9

Cash indemnity benefits are paid by the insurer to the insured person after he has received the service and paid for it himself.[4] The amounts may or may not be related to the charges he has incurred for the services.

Enrollment and Scope of Benefits

The survey shows 9.7 million persons enrolled in 309 plans in 1953 and thus eligible for at least one type of prepaid benefit from these plans. The number of those eligible for a specified benefit was, of course, less than this total because some plans provided only one or two of the following benefits: hospitalization, surgical care, medical care, diagnostic services, and dental care. Table 2 shows that 257 of the 309 plans offered hospital benefits, for which 7.1 million persons or three-fourths of the total enrollment were eligible. The 2.6 million persons in the 52 plans that did not provide hospitalization either obtained their hospital insurance from other carriers or were not protected against this insurance risk.

There were 7.2 million persons, or three-fourths of the total enrollment, eligible for surgical benefits in the 255 plans insuring against the costs of surgery. About 5.9 million persons or 61 percent of the entire enrollment were eligible for medical care benefits from the 213 plans providing prepaid benefits against the costs of physicians' services. More than half the plans (169) covered the costs of outpatient diagnostic X-rays, laboratory tests, and other services classified as diagnostic benefits; 3.7 million persons were eligible for such services. Dental services were seldom included among the benefits; 47 plans covering 0.6 million persons included dental care[5] on a prepaid basis.

Since all but 97 plans provided at least one type of service benefit and 160 plans offered only service benefits, it is clear that service benefits were more widely provided than cash indemnity benefits. This finding is especially true of the medical and

Table 2.—*Independent plans and their enrollment, by provision of service or cash indemnity and by type of benefit, 1954 survey*

Type of benefit	Plans: Total	Plans: With service benefits	Plans: With cash indemnity benefits	Enrollment (number in thousands): Total	Enrollment (number in thousands): With service benefits	Enrollment (number in thousands): With cash indemnity benefits
	Number					
All plans with any benefit [1]	309	212	149	9,685	6,322	4,831
Hospitalization	257	132	125	7,134	4,299	2,835
Surgical	255	132	123	7,161	4,360	2,801
Medical	213	169	44	5,918	4,864	1,054
Diagnostic	169	149	20	3,674	3,452	222
Dental	47	38	9	642	473	169
	Percentage distribution					
Hospitalization	100.0	51.4	48.6	100.0	60.3	39.7
Surgical	100.0	51.8	48.2	100.0	60.9	39.1
Medical	100.0	79.4	20.6	100.0	82.2	17.8
Diagnostic	100.0	88.2	11.8	100.0	94.0	6.0
Dental	100.0	77.1	22.9	100.0	73.7	26.3

[1] The 52 plans with some service and some cash indemnity benefits and their enrollment (1,468,000 persons) are included under both "service benefits" and "cash indemnity benefits" but appear once in the total figures.

[3] Some service plans make direct charges of varying amounts at the time the member receives the service.

[4] In some instances, it is possible for the insured person to sign over his indemnification to the provider of the service.

[5] To be counted as providing prepaid dental care a plan had to offer more services than routine X-rays of the mouth and periodic cleaning of the teeth; a plan was not counted solely because the surgical benefits that it provided included dental surgery for fractured jaws, etc.

diagnostic services. Because 52 plans provided some benefits as cash indemnity and some as services, these plans and their enrollment of 1.5 million persons are included under the classification "any benefit" in both the service and the cash indemnity columns of table 2. In this way the total number of persons eligible for any cash indemnity or any service benefit can be compared with the number eligible to receive a particular benefit as a service or as a cash indemnification.

Table 3 groups the plans and enrollment according to the combinations of benefits provided, thus indicating the scope of protection made available. As delineated in this table, the physicians' services that the plans provided could include: (1) surgical services, generally given in the hospital; (2) maternity or obstetrical care by the physician, also usually given in the hospital; (3) medical (nonsurgical) services in the hospital; (4) medical care in the clinic or physician's office; and (5) medical care in the patient's home. The table also shows whether hospitalization benefits were provided by the plan. Plans offering (a) only diagnostic services in the clinic, (b) only hospitalization, and (c) only dental care are shown in the table. The availability of diagnostic benefits is not indicated, unless it was the only medical benefit the plan provided; the extent to which diagnostic benefits were provided is shown in table 4 in relation to other physicians' services.

More than 2.5 million persons (26 percent of the enrollment in all the plans) were members of the 63 plans that offered all five of the specified medical benefits.[6] Fifty-two of these plans, with an enrollment of 1.9 million persons in 1953, also provided hospitalization as part of their benefit structure.[7] A number of the plans provided 365 days of hospital care, so that their benefit structure was very comprehensive. Thirty-five of the 63 plans provided medical benefits through the group practice of medicine, while 28 used other arrangements. Dependents were eligible for all the benefits provided by the 35 group-practice plans but not by some of the remaining plans.

Plans providing all the listed types of physicians' services except maternity care were even more numerous (91 plans) than the plans providing all five types of medical benefits, but their enrollment was considerably smaller since they covered just over a million persons. Most of the plans in this group were sponsored by employers, employees, or jointly by the workers and management; 10 percent were controlled by unions. Because employer-employee and union plans have historically

[6] While the 63 plans provided all 5 benefits and the enrollment data shown are of necessity related to the entire membership, less than the entire membership might actually be eligible for a specific benefit. Enrollment figures shown in table 2 provide the data for determining those actually eligible for medical services, while the figures in table 3 indicate the relative magnitude of coverage for different benefits.

[7] Laws in some States—New York, for example—prohibit a plan from furnishing both medical care and hospital benefits on a service basis.

Table 3.—*Independent plans by provision of hospital benefits and by type of medical benefit, 1954 survey*

Description of medical benefits [1]	Plans						Enrollment in plans					
	Number			Percentage distribution			Number of persons (*in thousands*)			Percentage distribution		
	Total	With hospital benefits	Without hospital benefits	Total	With hospital benefits	Without hospital benefits	Total [2]	With hospital benefits [3]	Without hospital benefits	Total	With hospital benefits	Without hospital benefits
All plans with any benefit	309	257	52	100.0	100.0	100.0	9,685	7,291	2,394	100.0	100.0	100.0
Surgical, maternity, and medical care in hospital, home, and clinic or doctor's office [4]	63	52	11	20.4	20.2	21.2	2,520	1,867	653	26.0	25.6	27.3
Surgical and medical care in hospital, home, and clinic or doctor's office	91	82	9	29.4	32.0	17.3	1,004	943	61	10.4	12.9	2.5
Surgical, maternity, and medical care in hospital and clinic or doctor's office	24	23	1	7.8	8.9	1.9	274	239	35	2.8	3.3	1.5
Medical care in hospital, home, and clinic or doctor's office	6	2	4	1.9	.8	7.7	8	2	6	.1	[5]	.3
Surgical care in hospital and medical care in clinic or doctor's office	6	6		1.9	2.3		269	269		2.8	3.7	
Medical care in hospital and clinic	1		1	.3		1.9	48		48	.5		2.0
Medical care in clinic and home	5		5	1.6		9.6	24		24	.2		1.0
Medical care in clinic or doctor's office	11		11	3.6		21.2	142		142	1.5		5.9
Surgical and medical care in hospital only	7	4	3	2.3	1.6	5.8	2,456	1,458	998	25.4	20.0	41.7
Surgical care in hospital and diagnostic services in clinic	13	13		4.2	5.1		94	94		1.0	1.3	
Surgical care only	50	46	4	16.2	18.0	7.7	852	777	75	8.8	10.7	3.1
Diagnostic services in clinic only	2		2	.6		3.8	351		351	3.6		14.7
Hospitalization only	29	29		9.4	11.3		1,642	1,642		17.0	22.5	
Dental care in dental clinic only	1		1	.3		1.9	1		1	[5]		[5]

[1] As used here, "medical benefits" applies to all services given by physicians, including surgical, maternity, and diagnostic services; "medical care" is confined to nonsurgical and nonmaternity services of physicians. Medical care services when given in clinic or doctor's office often include diagnostic services (see table 4).

[2] Enrollment for any benefit the plans provide; includes 602,000 members of plans providing medical care who are not eligible for medical care (see table 2).

[3] Total enrollment in any plan providing hospitalization benefits; includes 158,000 persons not actually eligible for hospitalization benefits (see table 2).

[4] Includes 5 Blue Shield plans whose enrollment of 151,000 is eligible for hospitalization.

[5] Less than 0.05 percent.

been designed to provide the employee with medical benefits, maternity services were the exception rather than the rule. Seventy-nine of the 91 plans were connected with industry, and only four industrial plans included dependents; consequently, employees made up nearly all the enrollment. Fifty-two group-practice clinics are represented here; 14 plans offered only cash indemnity benefits.

The third and fourth groups of plans did not provide for home visits by physicians. The remaining groups that provided some form of insurance for physicians' services had still other combinations of the five possible medical benefits. Nearly 2.5 million persons were found in the seven plans that provided in-hospital medical care and surgical care. Fifty plans offered surgical care as the only medical benefit but usually coupled it with hospitalization; such plans covered 9 percent of the enrollment in all the independent plans. Plans providing hospitalization as the sole benefit covered 17 percent of all enrollment and 23 percent of those eligible for hospital benefits. In the plans that did not provide surgical benefits or hospitalization benefits, it may in general be assumed that the membership was eligible for these benefits through some other form of insurance such as Blue Cross, Blue Shield, or a group insurance policy. Only enrollment for benefits provided as part of the plan's independent operations is shown.

Table 4 indicates in still another respect the comprehensive nature of the benefits provided by many of the plans. Eligibility for diagnostic benefits is shown in the second column, and the tabulation is confined to plans providing some medical care benefits in addition to surgery. A plan has been defined as offering diagnostic benefits only when it provided such services as diagnostic X-rays and laboratory tests on an outpatient basis; nearly all insurance relating to hospital care, of course, has provisions for some form of inpatient diagnostic benefits. A total of 169 plans reported insuring out-patient diagnostic benefits, and these plans had a total enrollment of almost 3.9 million. Slightly less than 3.7 million persons were eligible for the diagnostic benefits (table 2) in these 169 plans, and 211,000 were covered by the plans for some benefits but not for diagnosis. Fifty-two percent of the enrollment in plans furnishing diagnostic benefits was in the 63 plans providing the widest scope of physicians' services.

Group-Practice Prepayment Plans

Included in the 309 surveyed plans were 140 plans providing prepaid benefits through group-practice arrangements (table 5). These plans, which afford benefits through organized groups of doctors working together, provided one or more benefits to nearly 3.0 million persons. Again, because some plans did not include each of the five kinds of care, fewer than 3.0 million persons were eligible for any one benefit. A total of 2.5 million persons received medical benefits from 127 group-practice plans, and 2.4 million received surgical benefits from 123 such plans. That diagnostic benefits are characteristically provided by group-practice plans is, however, evident from the fact that 78 percent of all persons entitled to

Table 4.—*Independent plans with medical care benefits, by provision of diagnostic benefits, 229 plans, 1954 survey* [1]

Description of medical benefits [2]	Plans						Enrollment in plans					
	Number			Percentage distribution			Number of persons (in thousands)			Percentage distribution		
	Total	With diagnostic benefits	Without diagnostic benefits	Total	With diagnostic benefits	Without diagnostic benefits	Total [3]	With diagnostic benefits	Without diagnostic benefits	Total	With diagnostic benefits	Without diagnostic benefits
All plans with medical care and/or diagnostic benefits	229	169	60	100.0	100.0	100.0	7,190	3,885	3,305	100.0	100.0	100.0
Surgical, maternity, and medical care in hospital, home, and clinic or doctor's office [4]	63	45	18	27.5	26.6	30.0	2,520	2,007	513	35.0	51.7	15.5
Surgical and medical care in hospital, home, and clinic or doctor's office	91	71	20	39.7	42.0	33.3	1,004	732	272	14.0	18.8	8.2
Surgical, maternity, and medical care in hospital and clinic or doctor's office	24	15	9	10.5	8.9	15.0	274	231	43	3.8	5.9	1.3
Medical care in hospital, home, and clinic or doctor's office	6	3	3	2.6	1.8	5.0	8	1	7	.1	(5)	.2
Surgical care in hospital and medical care in clinic or doctor's office	6	6	----	2.6	3.6	----	269	269	----	3.7	6.9	----
Medical care in hospital and clinic	1	1	----	.4	.6	----	48	48	----	.7	1.2	----
Medical care in clinic and home	5	4	1	2.2	2.4	1.7	24	22	2	.3	.6	.1
Medical care in clinic or doctor's office	11	9	2	4.8	5.3	3.3	142	130	12	2.0	3.3	.4
Surgical and medical care in hospital only	7	----	7	3.1	----	11.7	2,456	----	2,456	34.2	----	74.3
Surgical care in hospital	13	13	----	5.7	7.7	----	94	94	----	1.3	2.4	----
Diagnostic services in clinic only	2	2	----	.9	1.2	----	351	351	----	4.9	9.0	----

[1] Excludes 80 surveyed plans with none of the specified benefits.
[2] See footnote 1, table 3.
[3] Enrollment for any benefit the plans provide; includes 827,000 persons not actually eligible for medical care benefits and 211,000 not eligible for diagnostic benefits.
[4] Includes 5 Blue Shield plans whose enrollment of 151,000 is eligible for diagnostic services.
[5] Less than 0.05 percent.

Table 5.—*Independent plans and their enrollment, by provision of benefit through group practice or other method and by type of benefit, 1954 survey*

Type of benefit	Plans			Enrollment (number in thousands)		
	Total	Group practice	Other [1]	Total	Group practice	Other [1]
	Number					
All plans with any benefit	309	140	169	9,685	2,984	6,701
Hospitalization	257	113	144	7,134	1,802	5,332
Surgical	255	123	132	7,161	2,410	4,751
Medical	212	126	86	5,918	2,507	3,411
Diagnostic	169	123	46	3,674	2,853	821
Dental	47	31	16	642	452	190
	Percentage distribution					
All plans with any benefit	100.0	45.3	54.7	100.0	30.8	69.2
Hospitalization	100.0	44.0	56.0	100.0	25.3	74.7
Surgical	100.0	48.2	51.8	100.0	33.7	66.3
Medical	100.0	59.6	40.4	100.0	42.4	57.6
Diagnostic	100.0	72.8	27.2	100.0	77.7	22.3
Dental	100.0	66.0	34.0	100.0	70.4	29.6

[1] Includes 5 Blue Shield plans whose enrollment of 161,000 is eligible for all benefits except dental services.

this benefit are found in group-practice plans. Some 2.9 million persons (in 123 plans) were entitled to prepaid out-patient diagnostic services, and they represented 96 percent of the entire enrollment in group-practice plans. It is nevertheless noteworthy that 46 plans, covering 821,000 persons, afforded diagnostic services through arrangements other than their own group-practice clinic.

Table 6 shows the relationship of group practice and the provision of service benefits; 28 plans with 475,000 members provided cash indemnity hospital benefits, but in nearly every instance the 140 plans provided medical care benefits as a service. The table also shows the extent to which hospital and surgical benefits were provided.

Many of the independent plans have been in operation for a number of years (table 7). Over half of the group-practice plans whose date of establishment is known began providing benefits before 1930. From 1850 through 1929 more group-practice plans than plans of other types were established, but in the period from 1930 to 1950 the other types of plans were established with greater frequency. Since 1950, however, more than two group-practice plans have been inaugurated for each independent plan of another type.

Coverage of Dependents

In comparison with the 41.6 subscribers and 58.4 dependents per 100 enrollees among Blue Cross plans,[8] there were 49.7 subscribers and 50.2 dependents per 100 persons eligible for one or more benefits in the independent plans surveyed. Only 61 percent of the plans provided any benefits to members' dependents. Many of the employee plans did not cover dependents for any type of benefits; in others, dependents were eligible for some benefits but not for all the services or benefits the plan made available to its subscribers. For these reasons, the aggregate number of dependents reported as eligible for "any benefits" or for hospitalization or for surgery was only a little larger than the aggregate number of subscribers (table 8). Fewer dependents than subscribers were eligible for medical, diagnostic, or dental benefits.

While eligibility of dependents varies according to plan sponsorship, the trend in all the plans not now completely insuring dependents appears to be toward gradual extension of benefits to them so that larger proportions can be expected to be insured in the future.

[8] *Financing Hospital Care in the United States*, Vol. 2, *Prepayment in the Community*, edited by Harry Becker (McGraw-Hill Book Co., Inc., 1955), page 27.

Type of Sponsorship

Nine different types of sponsorship or organization were differentiated among the 309 plans (table 9). Those not associated directly with the occupation of their members included prepayment plans sponsored by community groups, cooperative organizations, fraternal societies, and medical societies and by physicians practicing as a private group. The community plans in each instance were nonprofit plans sponsored by the public and open to groups or individuals in the community. Many of them were not distinguishable from the affiliates of the Blue Cross and Blue Shield Commissions. Plans classified as cooperatives in this survey invite more participation from their members in the affairs of the plan than holds true for community plans. In general, also, they require a membership fee on joining, and each member has one vote in running the nonmedical aspects of the plan. Fraternal society plans provide benefits that are in actuality but one form of the benefits that some fraternal societies make available to their members.

The medical society plans correspond to Blue Shield plans in having local or State medical society sponsorship, but, with the exception of the five plans already noted, none has become an affiliate of the Blue Shield Commission. Like the preceding plans, they are organized on a nonprofit basis.

Plans classified as sponsored by a private group clinic include only those prepayment plans operated and controlled by a group of doctors as their own enterprise; the health centers and other plans having a group-practice type of organization under another sponsorship are not counted among them. Of the 140 group-practice plans in the survey, only 15 were physician-sponsored. These plans were the only ones in the survey that might be considered as coming outside the "not for profit" concept.

Two-thirds of the surveyed plans were self-insuring arrangements under industrial sponsorship. The membership was restricted to the employees of a particular establishment

or union and to their dependents. Employee-sponsored plans—42 in number—were in most instances the outgrowth of an employee mutual benefit association. Plans run entirely by the employer and, nearly always, financed entirely by management number 26. Plans sponsored jointly by management and by the employees were relatively numerous. There were 63 of these plans, usually jointly financed, though the division of the costs between the employer and the employees varied. Some of the plans shown as employer-employee plans might have been designated as union-employer plans. Allocating such plans to the group of employer-employee plans rather than to a separate category was done more or less arbitrarily so that all the railway hospital plans, in many of which the railroad brotherhoods have a voice, would appear as having employee sponsorship. The classification of such plans as employer-employee or employee plans seemed to describe their sponsorship most accurately.

Plans classified as union-sponsored are controlled and operated directly by a union or group of unions. All of them self-insure the benefits provided; union-managed insurance companies that correspond in all respects to commercial group accident and health insurance companies have been excluded from the survey. As mentioned above, some plans in which a union participates have not been counted among the 73 union plans but as employer-employee plans, in order to restrict the category of union plans to those organized and operated entirely by trade unions.

Table 9 shows how many plans of each type of sponsor provided each of the five insurance benefits. The 37 community plans included 33 providing hospitalization benefits but only 13 offering medical care benefits. Nearly all the cooperatives had surgical and medical benefits, and all the plans sponsored by medical societies had both these benefits. All the plans sponsored by physicians in group practice (the private group-clinic plans) provided medical care and diagnostic services, but one of them did not cover surgery on a prepaid basis.

Most of the employer plans and most of the employee plans provided hospitalization, surgery, and medical care benefits. The widest variation in the benefits offered by the individual plans occurred among the union plans, many of which were designed to provide benefits that supplement coverage obtained from other forms of insurance carriers.

The plans are also grouped according to type of sponsorship in table 10, which shows the extent of coverage of their membership for each type of benefit. If this table is studied in relation to table 9, the fact that dependents are not always eligible for all benefits is evident. A total of 1,063,000 persons were enrolled, for example, in the 11 plans sponsored by medical societies; though all 11 plans provided medical care benefits, one plan limited these benefits to subscribers, and thus only 1,049,000 could have received medical benefits.

Plans of the community type covered the largest number of persons (3.3 million), but many of these plans offered only one or two of the listed kinds of benefits. While two-thirds of the enrollment was eligible for hospital care, less than half could receive surgical benefits, and even smaller percentages were eligible for medical or diagnostic benefits. About half the enrollment eligible for each

Table 7.—*Independent plans and their enrollment, by date of founding and by provision of benefit through group-practice or other method, 1954 survey*

Date of founding	Total		Group-practice plans		Other plans	
	Number of plans	Enrollment (in thousands)	Number of plans	Enrollment (in thousands)	Number of plans	Enrollment (in thousands)
Total	309	9,685	140	2,934	169	6,701
1850–79	6	156	3	149	3	7
1880–89	8	231	6	155	2	76
1890–99	7	117	6	87	1	30
1900–09	18	252	10	91	8	161
1910–19	42	676	28	460	14	216
1920–29	24	769	12	243	12	525
1930–39	40	1,933	8	66	32	1,867
1940–49	104	4,904	32	1,432	72	3,472
1950–54	48	462	34	299	14	163
Unknown	12	185	1	2	11	184

Table 6.—*Group-practice plans and their enrollment, by type of enrollee and by type of benefit (140 plans), 1954 survey*

Type of benefit	Plans		Number enrolled			Percent entitled to specified benefits		
	Number	Percent	Total	Subscribers	Dependents	Total	Subscribers	Dependents
All group-practice plans with any benefit	140	100.0	2,984	1,999	985	100.0	100.0	100.0
Service benefits only	111		2,453	1,601	852			
Some cash indemnity [1]	29		531	398	133			
Hospitalization	113	80.7	1,802	1,267	535	60.4	63.4	54.3
Service	85	60.7	1,327	891	436	44.5	44.6	44.3
Cash indemnity	28	20.0	475	376	99	15.9	18.8	10.1
Surgical	123	87.9	2,410	1,520	890	80.8	76.0	90.4
Service	100	71.4	2,007	1,173	834	67.3	58.7	84.7
Cash indemnity	23	16.4	403	347	56	13.5	17.4	5.7
Medical	127	90.7	2,507	1,574	933	84.0	78.7	94.7
Service	125	89.3	2,465	1,548	917	82.6	77.4	93.1
Cash indemnity	2	1.4	42	26	16	1.4	1.3	1.6
Diagnostic	123	87.9	2,853	1,964	889	95.6	98.2	90.3
Service	122	87.1	2,849	1,960	889	95.5	98.0	90.3
Cash indemnity	1	.7	4	4		.1	.2	
Dental	31	22.1	452	353	99	15.1	17.7	10.1

[1] Includes 1 plan whose only service benefit is dental benefits and 1 whose only service benefit is diagnostic services.

Table 8.—*Enrollment of independent plans, by type of enrollee and by type of benefit, 1954 survey*

Type of benefit	Number			Percentage distribution		
	Total	Subscribers	Dependents	Total	Subscribers	Dependents
With any benefit	9,685	4,822	4,863	100.0	49.8	50.2
Hospitalization	7,134	3,454	3,680	100.0	48.4	51.6
Surgical	7,161	3,465	3,696	100.0	48.4	51.6
Medical	5,918	2,982	2,936	100.0	50.4	49.6
Diagnostic	3,674	2,453	1,221	100.0	66.8	33.2
Dental	642	462	180	100.0	72.0	28.0

of the four major benefits was found among the industrial plans, but nearly a third of the total, or two-thirds of the enrollment in industrial plans, in turn derived from membership in union-sponsored plans. Most of the enrollment for dental benefits, however, was in the industrial plans, and 36 percent was in employer-employee plans.

The table also indicates differences among sponsors in the provision of the five kinds of benefits to the membership. For example, from 48 percent of those in fraternal plans to 97 percent of those in employer-sponsored plans were eligible for hospitalization benefits. Only 74 percent of those eligible for any benefit were entitled to surgical benefits. The range on medical care benefits was from 30 percent to 100 percent; it varied from 17 percent to 100 percent on diagnostic benefits. The small extent of provision for dental care on a prepayment basis is also apparent. Only 7 percent of those eligible for any benefit from the 309 plans received prepaid dental services.

Dependents.—Three-fifths of the plans made some or all of their benefits available to dependents of members (table 11). The practice varied according to the type of sponsorship, with the proportions including dependents ranging from 100 percent of the community, cooperative, and medical society plans to 31 percent of the employer plans. Dependents represented as much as 62 percent of the eligible enrollment in the cooperative plans but as little as 15 percent in the fraternally sponsored plans; they made up 55 percent of the enrollment in the nonindustrial plans but only 44 percent in the industrial plans. The discrepancy would be wider were it not for the fact that a few of the largest industrial plans, including the United Mine Workers fund with an enrollment of nearly 1.5 million, covered dependents for hospitalization, surgery, and in-hospital medical care.

Benefit provisions.—Some of the salient facts about the benefits made available by the independent plans to their members have already been brought out. The extent to which service benefits rather than cash indemnity benefits were provided was indicated in table 2. The provision of care in the doctor's office and the patient's home and the availability of diagnostic benefits were shown in tables 3 and 4, and the extent of provision for dental benefits has also been indicated.

Space does not permit tabulation of such measures of adequacy as the

Table 9.—*Independent plans, by type of sponsorship and by type of benefit, 1954 survey*

Type of sponsorship	Type of benefit					
	Any benefit	Hospitalization	Surgical	Medical care	Diagnostic	Dental
	Number of plans having specified benefit					
Total	309	257	255	213	169	47
Nonindustrial plans	105	80	74	69	50	8
Community	37	33	14	13	8	2
Cooperative	24	15	21	21	13	2
Fraternal	18	13	15	9	6	4
Medical society [1]	11	8	11	11	8	----
Private group clinic	15	11	13	15	15	----
Industrial plans	204	177	181	144	119	39
Employee	42	38	39	32	18	6
Employer	26	25	25	26	23	2
Employer-employee	63	58	59	46	37	17
Union	73	56	58	40	41	14
	Percent having specified benefit					
Total	100.0	83.2	82.5	68.9	54.7	15.2
Nonindustrial plans	100.0	76.2	70.5	65.7	47.6	7.6
Community	100.0	89.2	37.8	35.1	21.6	5.4
Cooperative	100.0	62.5	87.5	87.5	54.2	8.3
Fraternal	100.0	72.2	83.3	5.00	33.3	22.2
Medical society	100.0	72.7	100.0	100.0	72.7	----
Private group clinic	100.0	73.3	86.7	100.0	100.0	----
Industrial plans	100.0	86.8	88.7	70.6	58.3	19.1
Employee	100.0	90.5	92.9	76.2	42.9	14.3
Employer	100.0	96.2	96.2	100.0	88.5	7.7
Employer-employee	100.0	92.1	93.7	73.0	58.7	27.0
Union	100.0	76.7	79.5	54.8	56.2	19.2
	Percentage distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Nonindustrial plans	34.0	31.1	29.0	32.4	29.6	17.0
Community	12.0	12.8	5.5	6.1	4.7	4.3
Cooperative	7.8	5.8	8.2	9.9	7.7	4.3
Fraternal	5.8	5.1	5.9	4.2	3.6	8.5
Medical society	3.6	3.1	4.3	5.2	4.7	----
Private group clinic	4.9	4.3	5.1	7.0	8.9	----
Industrial plans	66.0	68.9	71.0	67.6	70.4	83.0
Employee	13.6	14.8	15.3	15.0	10.7	12.8
Employer	8.4	9.7	9.8	12.2	13.6	4.3
Employer-employee	20.4	22.6	23.1	21.6	21.9	36.2
Union	23.6	21.8	22.7	18.8	24.3	29.8

[1] Includes 5 Blue Shield plans.

amount of payment for hospital room and board charges or the length of stay provided, or the surgical fee schedules in force among the surgical plans. A few illustrations indicate the variety of the benefit provisions found. The length of hospital stay covered varied from 20 days to 365 days; 69 plans covering 2.1 million persons would take care of their members on a service-benefit basis for a full year. Occasionally, the hospital benefit was varied by length of employment. A few plans placed no ceiling on the number of days of care they would insure; instead they guaranteed to pay hospital bills up to a maximum amount, such as $500 or $600. Among plans paying fixed amounts for each day in the hospital, the per diem cash indemnification ranged from $4 to $18, but amounts of $7, $8, and $10 were most usual. In a few instances, the per diem benefit payable was $1 or $2 less for dependents than it was for subscribers.

Like hospitalization, surgical procedures were covered as a service benefit in some plans and according to a fee schedule of cash indemnification in others. The maximum indemnity amount paid for a surgical procedure varied from $25 to $375, but the most usual fee schedule called for $150 or $200. A few plans merely had a ceiling on all medical and surgical benefits payable in a year. One union plan undertook to insure its members for the difference between their cash indemnity benefits under their group insurance policy and the actual charges made by the surgeon. Some plans, particularly union plans, while classified as having cash indemnity surgical benefits, achieved the equivalent of a service benefit by arranging for panels of surgeons who would accept the amount of the indemnity as full payment; the union member was, however, free to select a nonpanel surgeon.

The provision of medical benefits in the form of a service was usually achieved through group-practice clinics. In the cash indemnity plans providing medical benefits, $3.00 was almost universally the amount of reimbursement for an office call, a home call, or a hospital call; the range was from $2.00 to $7.50. In those plans in which the amount was not uniform for all three types of calls, the indemnity for office calls was the lowest of the three amounts allowed, and home calls were sometimes reimbursed at a higher rate than hospital calls.

Most of the community plans providing hospitalization benefits continued to cover their members after age 65, if they had joined the plan

Table 10.—*Enrollment of independent plans, by type of sponsorship and by type of benefit, 1954 survey*

Type of sponsorship	Any benefit	Type of benefit				
		Hospitalization	Surgical	Medical care	Diagnostic	Dental
	Number of persons enrolled for specified benefit (in thousands)					
Total	9,685	7,134	7,160	5,918	3,674	642
Nonindustrial plans	5,462	3,593	3,644	2,900	1,850	207
Community	3,282	2,068	1,534	1,092	540	147
Cooperative	299	288	279	142	82	14
Fraternal	219	106	193	108	79	46
Medical society [1]	1,063	654	1,063	1,049	550	----
Private group clinic	599	477	575	599	599	----
Industrial plans	4,223	3,541	3,516	3,018	1,824	435
Employee	571	544	508	329	258	93
Employer	152	147	147	152	88	58
Employer-employee	727	615	629	576	502	234
Union	2,773	2,235	2,232	1,961	976	50
	Percent eligible for specified benefit					
Total	100.0	73.7	73.9	61.1	37.9	6.6
Nonindustrial plans	100.0	65.8	66.7	53.1	33.9	3.8
Community	100.0	63.0	46.7	30.5	16.5	4.5
Cooperative	100.0	96.3	93.3	47.5	27.4	4.7
Fraternal	100.0	48.4	88.1	49.3	36.1	21.0
Medical society	100.0	61.5	100.0	98.7	51.7	----
Private group clinic	100.0	79.6	96.0	100.0	100.0	----
Industrial plans	100.0	83.9	83.3	71.5	43.2	10.3
Employee	100.0	95.3	89.0	57.6	45.2	16.3
Employer	100.0	96.7	96.7	100.0	57.9	38.2
Employer-employee	100.0	84.6	86.5	79.2	69.1	32.2
Union	100.0	80.6	80.5	70.7	35.2	1.8
	Percentage distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Nonindustrial plans	56.4	50.4	50.9	49.0	50.4	32.2
Community	33.9	29.0	21.4	16.9	14.7	22.9
Cooperative	3.1	4.0	3.9	2.4	2.2	2.2
Fraternal	2.3	1.5	2.7	1.8	2.2	7.2
Medical society	11.0	9.2	14.8	17.7	15.0	----
Private group clinic	6.2	6.7	8.0	10.0	16.3	----
Industrial plans	43.6	49.6	49.1	51.0	49.6	67.8
Employee	5.9	7.6	7.1	5.6	7.0	14.5
Employer	1.6	2.1	2.1	2.6	2.4	9.0
Employer-employee	7.5	8.6	8.8	9.7	13.7	36.4
Union	28.7	31.3	31.2	33.1	27.1	7.8

[1] Includes enrollment of 5 Blue Shield plans (161,000 persons).

Table 11.—*Independent plans, by coverage of dependents and type of sponsorship, 1954 survey*

Type of sponsorship	Number of plans			Dependents as percent of total enrollment
	Total	Including dependents	Percent including dependents	
Total	309	188	60.8	50.2
Nonindustrial plans	105	95	90.5	55.0
Community	37	37	100.0	57.9
Cooperative	24	24	100.0	61.8
Fraternal [1]	18	11	61.1	15.5
Medical society	11	11	100.0	50.6
Private group clinic	15	12	80.0	58.0
Industrial	204	93	45.6	44.0
Employee	42	18	42.9	35.4
Employer	26	8	30.8	50.1
Employer-employee	63	32	50.8	34.3
Union	73	35	47.9	47.9

[1] Some fraternal societies count dependents as members in their own right and therefore do not show dependent coverage.

before their sixty-fifth birthday. In addition, 64 plans—most of them offering comprehensive benefits—continued protection after retirement; this feature was noted in particular among most of the railway hospital associations. Premiums for pensioned members of industrial plans varied from nothing to the same amount contributed before the member became a pensioner, but the amount was usually related to the size of the retirement income and was therefore lower than for employed members of the plan.

Financing the Plans

The premium charges or membership dues in a voluntary health insurance plan are meaningful only if related to the benefit structure of the plan. In plans with so much variety in the scope of the benefits, it is impossible to correlate premiums and benefits in brief form. In addition, the many industrial health insurance plans financed by employer and employee contributions require a different type of analysis, since the contributions are frequently based on a percentage of hourly wages and may cover more than the cost of the health benefits—fringe benefits, for example, such as vacation funds and life, cash disability, and, accidental death and dismemberment insurance.

The measurement of the significance of the independent plans and their place in the whole field of voluntary health insurance can, however, be shown in terms of their total income from premiums, dues, or contributions and their total expenditures for the benefits they furnish their members, without close attention to the content of the benefit structure.

All forms of voluntary insurance received $2,405 million in earned income in 1953 and expended $1,919 million for benefits, or 79.8 percent of earned income.[9] The prepayment income of the 304 independent plans amounted to $222.8 million or 9.3 percent of the aggregate income of all carriers. Expenditures for benefits came to $200.9 million or 90.2 percent of earned income. These expenditures equaled 10.5 percent of the total benefit payments made by all types of carriers. The union plans accounted for the largest segment of the income and expenditures of all independent plans; the community plans were next largest (table 12).

Income for medical benefits was responsible for 45.7 percent of the aggregate income of the independent plans and for 33.5 percent of that of the other three kinds of insurers; the difference indicates the role of medical benefits among the independent plans. In fact, 14.1 percent of all insurance benefits then available against the costs of physicians' and dentists' services derived from the independent plans, while only 8.7 percent of all insurance benefits for hospitalization came from them.

The independent plans are noteworthy because of their comparatively high ratio of expenditures for benefits to earned income (the "loss ratio"). The average was more than 90 percent for all plans combined; it was 93 percent among industrial plans and 87 percent among nonindustrial plans, as the following tabulation shows:

Plan sponsorship	*Loss ratio*
Total	90.2
Nonindustrial plans	86.2
Community	85.3
Cooperative	81.7
Fraternal[1]	100.0
Medical society	82.2
Private group clinics	92.7
Industrial plans	93.2
Employee	95.4
Employer	95.7
Employer-employee	96.8
Union	91.3

[1] Several fraternal society plans spent more than 100 percent of their income in 1953, and one that operated a hospital relied on outside patients for support, taking care of members at less than cost.

The independent plans generally operated with a loss ratio that provided their membership with better-than-average returns on their premium dollars, or contributions.

Summary and Conclusions

The survey conducted by the Social Security Administration in 1954 has resulted in information about 304 unaffiliated or independent prepayment plans and five Blue Shield plans in 1953. These plans provided 9.7 million persons with one or more of the following insurance benefits—hospitalization, surgery, medical care, diagnostic services, and dental services. Many of these plans are notable for the comprehensive scope of their benefits. Some of them provided all of the listed benefits, including home and office services of physicians; others were designed to supplement other forms of insurance to increase the comprehensiveness of the protection offered the plan members.

In all, 212 of the 309 plans offered at least one type of benefit on a service basis, while 97 provided only cash indemnification. Nearly half the plans (140) made the services of physicians for medical and/or diagnostic benefits available through group-practice arrangements. About 4.7 million persons were found in plans providing insurance for some or all of the costs of physicians' services outside the hospital; 3.8 million persons were eligible for diagnostic benefits on an outpatient basis in plans with a total enrollment of 3.9 million persons.

Of the nine types of sponsorship among the plans, two-thirds were associated with employment and classified as "industrial." Community plans—limited for the most part to the provision of hospital and surgical care—covered the largest number of persons (3.3 million). The second largest sponsoring group, consisting of 73 union plans, covered 2.8 million persons for one or more types of benefit. The 11 plans sponsored by medical societies included 1.1 million persons, and employer-employee plans covered 0.7 million persons. Smaller numbers of persons belonged to the cooperative, fraternal, group-practice, employee, and employer plans included in the study.

Less than half the industrial plans covered dependents, and even in these plans the dependents were sometimes not eligible for all the benefits provided to members. Among community, cooperative, and medical society plans, dependents were covered for the same benefits as members.

Less than 10 percent of the entire

[9] "Voluntary Insurance Against Sickness: 1948-53 Estimates," *Social Security Bulletin*, December 1954.

Table 12.—*Independent plans, by income and expenditures and by type of sponsorship (304 plans), 1954 survey*

[In millions]

Type of sponsorship	Income				
	Total	Non-earned	Earned		
			Total	Hospitalization	Physicians' services
Total	$229.8	$7.0	$222.8	$121.0	$101.8
Nonindustrial	100.6	4.0	96.6	49.0	47.6
Community	56.9	.6	56.3	33.1	23.2
Cooperative	7.9	.8	7.1	3.6	3.5
Fraternal	2.3	.4	1.9	1.0	.9
Medical society [1]	13.5	[2]	13.5	4.0	9.5
Private group clinic	20.0	2.2	17.8	7.3	10.5
Industrial	129.2	3.0	126.2	72.0	54.2
Employee	20.7	1.1	19.6	12.0	7.6
Employer	4.6		4.6	1.6	3.0
Employer-employee	27.0	1.8	25.2	13.6	11.6
Union	76.9	.1	76.8	44.8	32.0

Type of sponsorship	Expenditures				
	Total	Administrative	Benefit		
			Total	Hospitalization	Physicians' services
Total	$218.4	$17.5	$200.9	$11.7	$89.2
Nonindustrial	93.3	10.0	83.3	42.6	40.7
Community	54.4	6.4	48.0	29.0	19.0
Cooperative	7.6	1.8	5.8	2.9	2.9
Fraternal	2.2	.3	1.9	1.0	.9
Medical society [3]	11.5	.4	11.1	3.4	7.7
Private group clinic	17.6	1.1	16.5	6.3	10.2
Industrial	125.1	7.5	117.6	69.1	48.5
Employee	20.5	1.8	18.7	11.5	7.2
Employer	4.6	.2	4.4	1.6	2.8
Employer-employee	26.8	2.4	24.4	13.5	10.9
Union	73.2	3.1	70.1	42.5	27.6

[1] Excludes income of 5 Blue Shield plans ($6,100,000).
[2] Less than $100,000.
[3] Excludes expenditures of 5 Blue Shield plans ($5,900,000).

number of persons covered by voluntary insurance for hospitalization and surgical insurance benefits were enrolled in the independent plans, but these plans included 15 percent of those eligible for prepaid physicians' services other than surgery and a large (but unknown) proportion of all persons eligible for diagnostic services outside the hospital. These facts explain the finding that the independent plans were providing 14 percent of all insurance benefits against the costs of physicians' services, even though Blue Shield and commercial insurance companies covered more than 10 times as many persons as these plans for surgical and other services from physicians. As a group, the independent plans returned 90 percent of their members' contributions or premiums to them in the form of benefits.

Since the survey in 1950, several developments are sufficiently clear to be indicative of trends. The most outstanding is the development of self-insuring union-sponsored plans designed to provide their members with increasingly comprehensive benefits either through an integrated plan or as a supplement to other forms of insurance. The second development is the trend toward extension of benefits to dependents; the third is the expansion in the number of and membership in group-practice plans; a fourth is the increasing concern with provision of benefits to retired workers.

These developments are not separate and distinct trends; on inspection, their interrelationship is apparent. A logical step for the self-insured hospital and surgical plan organized for a group of employees is to extend its benefits to dependents and to retired workers so that the plan affords greater overall security. The group-practice diagnostic clinic established by a union to supplement the members' hospitalization and surgical insurance is equipped to provide dependents and retired persons with similar benefits at small additional cost, once the basic physical facility and staff are available, and this extension is occurring more and more.

With increased costs of medical and hospital care, the cash indemnity plans have had to revise their per diem benefits and their surgical fee schedules upwards and advance their premiums to meet added costs. To the extent that the independent plans provide service benefits rather than cash indemnification they have not been confronted with the need to enlarge existing benefits, but they have not escaped the necessity of raising dues or premiums. Moreover, both types of independent plans are constantly undertaking to broaden the scope of their benefits.

The survey has demonstrated that the independent plans cannot be overlooked in any assessment of the potentialities of voluntary health insurance in the United States today. Many of them are already furnishing the experimentation that may eventually lead to more widespread provision of comprehensive forms of protection. Among this group of plans, examples can be found of almost every conceivable variation in methods of furnishing benefits, in combinations of benefits, or in demonstrations of the feasibility of providing coverage of certain types or classes of risks.