Group-Practice Prepayment Plans: 1954 Survey

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Current discussions of ways of extending voluntary health insurance to make benefits more inclusive tend to overlook one)orm of providing prepaid medical care benefits—through group-practice clinics. Though not widespread, since they reach only 3 million persons, such plans are well-established and provide a form of prepayment that lends itself readily to covering a variety of medical services. Prepaid group-practice arrangements are a'far from recent development; some plans have been in existence for nearly a century. Since World War II, however, new interest in the provision of medical care through organized groups of physicians, practicing together, has developed; more and more prepayment plans of this type are being established. Because they provide one approach to the problem of financing in advance preventive as well as curative medical care, they are worth examining.

GROUP practice was the form used to provide medical care benefits in about half the prepayment arrangements studied in the survey of all independent health insurance plans made by the Social Security Administration in 1954. The survey was designed to provide information about all types of hospital and medical care plans whose operations are not covered by national reports of accident and health insurance underwriters or the Blue Cross and Blue Shield Commissions. At the same time it afforded an opportunity to secure detailed information about the operations of 174 group-practice centers.

A report on all the 309 independent plans surveyed in 1954 appeared in an earlier issue of the BULLETIN (April 1955). The 174 plans whose enrollment, benefit structure, methods of providing benefits, and finances are considered in the current article generally provide comprehensive medical benefits, including office visits, home calls, and diagnostic and preventive services; 120 of them provide hospital care as an integral part of the plan.

The questionnaires returned by the 309 plans provided information about the methods of providing medical care and hospital benefits. The responses to the questionnaires were augmented by material previously assembled and by pamphlets, furnished by the plans, describing and explaining the organization and benefits afforded. Field visits to some of the group-practice clinics supplemented these materials.

A problem arose in deciding whether "the plan," as defined, was the organization making arrangements with a group-practice clinic to provide its members with medical benefits or whether it was in actuality the group-practice clinic. The latter interpretation was used in this analysis, except when the group-practice clinic was basically on a fee-for-service basis.

In the earlier article, the focus was on the organization making the arrangements with a clinic or group of clinics to furnish members with medical care. For this reason the number of plans using group-practice arrangements was reported as 140; this number included several group-practice dental plans, not considered here. In arriving at 174 as the number of plans in which group-practice arrangements are coupled with prepayment for medical care, the clinics of the Health Insurance Plan of Greater New York and of several of the railway hospital plans were considered as individual units—30 for the New York plan and 1–4 for the railway plans. In certain instances—for example, among the numerous clinics, branch clinics, and hospitals in California operating under the auspices of the Kaiser Foundation—the plan was considered as only one or two units, because of the organizational structure of the medical group.

Sponsorship

Twenty-five of the plans are directly sponsored by consumers, either as a cooperative or as a community or fraternal enterprise (table 1). Another 36 are also consumer-controlled, through unions. Of the 68 plans classified as industrial, 17 are controlled by the employer, 28 are jointly operated by employers and employees, and 23 are managed entirely by the employees. The 45 plans classified as private group clinics include the 30 medical centers of the Health Insurance Plan of Greater New York.[1] This method of classification places the private group clinics—with slightly less than 1 mil-

Table 1.—*Type of sponsorship, by number of members and dependents enrolled, 1954 survey*

Category and sponsorship	Number of plans	Number of persons enrolled		
		Total	Members	Dependents
Total	174	2,956,137	1,994,901	961,236
Nonindustrial plans	25	207,453	97,108	110,345
Community	7	45,300	13,750	31,550
Cooperative	12	81,576	27,537	54,039
Fraternal	6	80,577	55,821	24,756
Union plans	36	991,039	901,227	89,812
Industrial plans	68	758,386	578,571	179,815
Employer	17	101,628	54,294	47,334
Employer-employee	28	410,688	299,757	110,931
Employee	23	246,070	224,520	21,550
Private group-practice clinics [1]	45	999,259	417,995	581,264

[1] In general, plans having contracts with employee groups and unions; in some instances they provide membership throughout the community.

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[1] This plan was classified as a single community plan in the earlier article.

lion members—in the vanguard in terms of enrollment. Union plans are second; their enrollment was swelled by the inclusion of the UAW-CIO Diagnostic Clinic, which actually served only a fraction of that union's 350,000 members. Less than a tenth of the entire enrollment was in plans with community or cooperative sponsorship.

Forty-one separate clinics, operated by 26 railway hospital associations, are counted among the industrial plans. Nineteen of the clinics are employee-sponsored, and 22 are jointly sponsored by employers and employees. A number of these plans might have been classified as having union as well as employer and/or employee sponsorship; however, their relationship with the unions is not so direct as that of the plans classified as solely union-sponsored. The total enrollment in these plans is sizable (533,000), but it includes only 24,000 dependents, who are provided with service without extra charges in one railway hospital association that counts dependents in its enrollment.

Location

There was at least one prepayment group-practice clinic in 34 States and in the District of Columbia (table 2). New York, with 45 medical groups, and California, with 18, together take in 52 percent of the entire enrollment in the 174 plans.[2] The 13 plans located in Texas are comparatively small; only two have more than 10,000 persons enrolled. Regionally, the Middle Atlantic and the West Coast States account for 62 percent of the enrollment; the remaining enrollment of slightly more than a million is not concentrated in any one region. The smallest representation occurs in the New England States and the Northern Plains States rather than in the South, where smaller percentages of the population are enrolled in all forms of voluntary health insurance plans.

Table 2.—*Total enrollment, by State, 1954 survey*

State	Number of plans	Enrollment
Total	174	2,956,137
Alabama	3	71,500
Arizona	1	10,000
Arkansas	3	28,760
California	18	716,674
Colorado	4	25,690
Connecticut	----------	----------
Delaware	----------	----------
District of Columbia	2	41,446
Florida	5	14,800
Georgia	1	6,424
Idaho	----------	----------
Illinois	4	45,166
Indiana	1	3,000
Iowa	1	6,630
Kansas	2	35,040
Kentucky	2	17,426
Louisiana	3	38,609
Maine	----------	----------
Maryland	----------	----------
Massachusetts	2	25,697
Michigan	1	350,000
Minnesota	5	19,377
Mississippi	2	28,128
Missouri	11	118,957
Montana	2	10,300
Nebraska	----------	----------
Nevada	----------	----------
New Hampshire	----------	----------
New Jersey	2	30,775
New Mexico	1	4,250
New York	45	835,074
North Carolina	4	31,547
North Dakota	----------	----------
Ohio	1	5,000
Oklahoma	3	6,545
Oregon	1	5,500
Pennsylvania	10	137,801
Rhode Island	----------	----------
South Carolina	1	1,376
South Dakota	----------	----------
Tennessee	----------	----------
Texas	13	47,722
Utah	3	63,750
Vermont	----------	----------
Virginia	4	24,025
Washington	8	101,230
West Virginia	2	24,240
Wisconsin	3	23,678
Wyoming	----------	----------

Age of the Plans

The oldest prepaid group-practice plan still in existence is La Societe Francaise de Bienfaisance Mutuelle, established in San Francisco in 1851; this fraternal society is still operating both a clinic and a hospital. A number of the railway hospital plans also predate the turn of the century by many years. The "centros" of the Cuban and Italian cigarmakers of Tampa, Florida, originated early in the twentieth century. Seventy-seven plans were established before 1930. Of the 72 plans founded in 1946–53, 26 are sponsored by unions; only six of the 32 union health centers included in the analysis were established before the end of the war.[3]

Enrollment

A total of 2,956,000 persons were enrolled in the 174 plans. This figure is higher than the number eligible for any given benefit, because some plans provided only a few of the different types of benefits and because some plan members were not eligible for all the benefits a particular plan made available. Even though the plans do not provide this number of persons with every benefit, they affect almost 3 million persons.

Dependents.—In some plans, dependents were counted as members even though they made some payments whenever they received services. Other plans did not count such dependents as members. Either way, the plan's interpretation has been followed in the analysis. Slightly more than two-thirds of the enrollment was composed of primary members of the plans.

Plan coverage	Number of plans	Number of persons
Total	174	2,956,142
Covering members and dependents	92	1,640,513
Members	----------	679,277
Dependents	----------	961,236
Covering only workers	82	1,315,627
Only members covered	60	868,025
Dependents cared for at reduced fees	22	[1] 447,602

[1] An estimated 625,000 dependents of these persons might have been included as eligible for care at reduced fees.

This ratio compares unfavorably with the ratio of about 47 members to 53 dependents found in prepaid health plans generally. It reflects the fact that many of these group-practice plans, because of their history, are oriented toward furnishing benefits to the worker only.

In 82 of the 174 plans, dependents are not counted in the enrollment. The dues or contributions paid apply only to the primary members. The remaining 92 plans fix their premiums at a higher rate when the primary member includes his dependents

[2] The total enrollment of plans whose clinics were located in several States was arbitrarily divided among these States. No other attempt was made to distribute enrollment to a State other than that in which the clinic itself was located (for example, membership in the Group Health Association of Washington, D.C., is all assigned to the District of Columbia, even though some members live in Maryland or Virginia).

[3] Since 1954, 12 other union health centers have begun operations.

in his coverage. The latter type of plan averaged 41 members for every 59 dependents, or 2.4 persons per primary member.

While it is true that dependents are not counted in the enrollment in nearly half the plans, 22 of these plans reported that dependents could secure services by paying reduced fees at the time of receiving services. Probably there is not much difference between the way these 22 plans care for dependents and the method used by some other plans in which dependents paid small fees for services and have been counted in the total enrollment. The estimate that 625,000 dependents (not shown in the tables) would be eligible for services in the 22 plans was arrived at by assuming the same ratio of dependents to primary members in these plans as in the 92 plans covering dependents.

The extent to which dependents of members in the 22 plans use services at reduced fees is not, of course, known. Seventeen of the plans were organized by railway hospital associations, and travel to the hospital clinic's location would be required to obtain the service; five are union health centers located in New York City.

Size of the Plans

Students of group-practice clinics have found that, for efficient operation, the prepaid population served by a single clinic should include at least 10,000 persons. Enrollments of 20,000-30,000 afford a better base for providing a wide range of special services. The maximum for a plan housed under one roof is considered to be 40,000. The plans in the survey do not conform to these "rules of thumb."

Table 3 shows that plans with enrollments of less than 10,000 predominate. They number 97 and cover 390,000 persons; the average enrollment is only about 4,000, and 10 have fewer than 500 persons enrolled. The 44 plans that cover 10,000-19,999 persons have an average enrollment of about 13,000; the total enrollment is 583,000. The 33 plans with memberships of more than 20,000 cover nearly 2 million members and dependents and have an average enrollment of more than 60,000. This average is raised by the six largest plans, which have 125,000-350,000 members.[4] The median size of all plans was slightly less than 10,000, and the mean was almost 17,000.

Table 3.—*Size of plan and total enrollment, 1954 survey*

Size of plan	Number of plans	Enrollment
Total	174	2,956,137
499 persons or less	10	3,907
500-999 persons	11	8,497
1,000-1,999	10	12,696
2,000-3,999	16	50,311
4,000-5,999	24	114,944
6,000-7,999	13	86,038
8,000-9,999	13	113,287
10,000-19,999	44	582,738
20,000-39,999	23	638,816
40,000-59,999	4	194,774
60,000 and over	6	1,150,129

Clinic and Hospital Facilities

Since the essential feature of group practice is a setting in which the associated physicians may practice as a team, a health center or clinic and/or a hospital is included in all 174 plans. Eight different arrangements for providing their membership with clinic and hospital care have been developed (table 4). The most usual arrangement was ownership of both the clinic and the hospital by the plan. In most, but not all, of the 59 plans of this type the clinic was located within the hospital. In the second largest group, the clinic facility was owned by the plan; hospitalization benefits were not an integral part of the plan, and hospital care in most instances was made available through a separate group insurance policy or Blue Cross contract. Next in order of frequency was care in a clinic owned by the plan, with hospital benefits provided through a contractual arrangement with one or more outside hospitals. Still another variation was ownership of the clinic, with cash indemnity hospitalization benefits paid from the plan's own funds to the hospitalized member.

Table 4.—*Ownership of clinic and hospital facilities, 1954 survey*

Ownership of clinic and of hospital	Members		Dependents	
	Number of plans	Number of persons	Number of plans	Number of persons
Total	174	1,994,901	92	961,236
Clinic and hospital owned by plan	59	664,290	24	354,807
Clinic owned by plan:				
Hospital under contract	30	224,851	11	174,472
Cash indemnity benefits	22	362,492	5	59,060
No hospital benefits	53	712,130	46	348,347
Clinic and hospital under contract	6	12,188	3	6,250
Clinic under contract:				
Hospital service benefits	2	9,000	2	18,000
No hospital benefits	1	9,800	-----	-----
Hospital owned by plan	1	150	1	300

A brief explanation is necessary to bring out the distinction in classification between plans providing care in a clinic under contract arrangements and plans classified as sponsored by a private group clinic, since the latter also make contracts to provide prepaid medical care. A few plans have made arrangements with a group of doctors practicing together (but without a prepaid clientele) to take care of the plan's membership for a fixed monthly amount. In this analysis the plan making such a contract, rather than the clinic providing the services, is considered to be the prepayment group. A parallel situation is found in relation to hospitalization. The plan making an agreement with a hospital is looked on as the prepayment group, rather than the hospital.

Table 4 shows the distribution of the primary members and the dependents according to the ownership of the clinic and the hospitalization arrangements. When both clinic and hospital are owned by the plan, inclusion of dependents is far less frequent than when only clinic service is provided. The fact that so many railway hospital plans, which cover

[4] Four of the plans have more than one clinic center. The other two serve large union groups; one was the UAW-CIO Center, which offered diagnostic benefits only and is no longer in operation.

few dependents, fall in the first category largely explains the small number of dependents under plans owning both clinic and hospital.

Benefits

Since all the plans, whether or not they furnish medical treatment, provide diagnostic services, all of them are customarily classified as affording some form of medical care. Before examining in detail the nature of the medical benefits available in the clinics, their classification in terms of the benefits reported as provided by the more widely known forms of health insurance plans may be helpful. Table 5 permits such an assessment, in terms of both the primary members of the plans and their dependents.

Three of the 92 plans in which dependents are enrolled do not provide the dependents with diagnostic services. Eleven of the plans do not give any form of medical care other than diagnostic services to their membership; they refer the patient after diagnosis to his private physician. These 11 plans are under union auspices.

There are surgeons on the staff of 143 plans covering a total of 2 million members and dependents. Other arrangements—usually cash indemnification of the member according to a fee schedule—took care of members' surgical benefits in 29 plans; 20 furnished the cash indemnity surgical benefits from their own funds. All but 11 of the 92 plans that provide dependents with prepaid care included the services of surgeons for them. Four plans covered dependents for surgery from their own funds, by use of a fee schedule, and five others had Blue Shield or an insurance company policy that applied to dependents.

Among the groups that are shown as having alternative arrangements for surgical benefits, the clinic staff sometimes includes surgeons; the medical group may then agree to accept the surgical fee derived from the other form of prepaid coverage as full payment for the services of the group's surgeon. The equivalent of a service benefit is thus achieved by the combination of the two methods of providing prepaid benefits.

The plans present a considerably different picture in relation to obstetrical benefits. Only 79, with enrollments of less than 600,000 members and 800,000 dependents, provide obstetrical benefits directly to members. Three plans covering 83,000 persons make alternative arrangements (as for surgery) for such benefits, again usually through a cash indemnity arrangement. It is significant that, when dependents are regular participants in the plan, obstetrical benefits are generally made available through the clinic staff. Eighty-three percent of the 800,000 dependents eligible for any form of service are in plans providing obstetrical benefits.

In relation to hospitalization, none of the three approaches is predominant, either for primary members or for dependents. The details are discussed in the section on hospitalization.

Scope of services provided.—Table 6 shows the benefit structure of the plans as a whole. It indicates the number of plans and the number of persons eligible for a full range of benefits, as well as the number eligible for somewhat less, and it shows the benefits customarily omitted. Since all the plans provided diagnostic services, including routine laboratory examinations, these benefits are not shown.

Forty-nine plans covering 1.2 million persons provide a complete range of services, including medical care in the home, clinic, and hospital; surgical and obstetrical services; X-ray examinations and treatment; physiotherapy; basal metabolism tests; and electrocardiograms. Eleven omit medical care in the patient's home. Thirty-five plans, with a membership of 446,000, offer all the services, including home care, except those of an obstetrician. The other plans omit one or more of the benefits included in the analysis; they vary decidedly in the benefits that they omit or include and in the extent to which medical care is provided away from the clinic.

With table 6 for background, each of the benefits is considered separately. The extent to which the plan furnishes the particular benefits on a fully prepaid basis or requires extra payments at the time of receiving services varies widely for different benefits and differs somewhat for members and dependents.

Table 5.—*Type of service provided, by number and percentage distribution of members and dependents enrolled, 1954 survey*

Type of service	Number of plans covering—		Enrollment		Percentage distribution	
	Members	Dependents	Members	Dependents	Members	Dependents
Total	174	92	1,994,901	961,236	100.0	100.0
Diagnostic services:						
Provided by clinic	174	89	1,994,901	934,236	100.0	97.2
Not offered (or no information)	----------	3	----------	27,000	----------	2.8
Medical services:						
Provided by clinic	163	90	1,571,159	937,236	78.8	97.5
Not offered (or no information)	11	2	423,742	24,000	21.2	2.5
Surgical services:						
Provided by clinic	[1] 143	[2] 81	1,176,053	856,418	58.9	89.1
Patient reimbursed by plan [3]	20	4	365,843	50,038	18.3	5.2
Provided by other forms of insurance [4]	9	5	452,075	36,500	22.7	3.8
Not offered	2	2	930	18,280	(5)	1.9
Obstetrical benefits:						
Provided by clinic	[1] 79	[2] 75	593,095	783,627	29.7	81.5
Patient reimbursed by plan [1]	18	4	355,412	50,038	17.8	5.2
Provided by other form of insurance [4]	14	8	487,580	77,500	24.4	8.1
Not offered (or no information)	63	5	558,814	50,071	28.0	5.2
Hospitalization:						
In plan's own hospital	60	25	664,440	355,107	33.3	36.9
Provided by plan in other hospital	60	21	608,531	257,782	30.5	26.8
Provided by other forms of insurance [4]	54	46	721,930	348,347	36.2	36.2

[1] The United Mine Workers Health and Welfare Fund finances the benefits in 3 of these plans. The clinic is staffed with surgeons and obstetricians.

[2] Includes 2 plans financed by the UMW Health and Welfare Fund.

[3] According to a fee schedule, patient usually uses outside doctors, but in some instances the staff of the plans includes surgeons and/or obstetricians who perform the service for the amount of the benefit.

[4] Blue Cross, Blue Shield, or an insurance company policy.

[5] Less than 0.05 percent.

Physicians' services widely used.—The survey questionnaire attempted to distinguish between physicians' services widely used and those services infrequently called for, although it did not define precisely the meaning of the terms "widely used" and "infrequently used." Table 7 presents the results of each plan's own interpretation. Of the 174 plans, 164 operate their own clinics and 10 relatively small plans contract with another organization for the medical services they considered to be widely used by the membership. As already noted, 11 plans confine physicians' services to diagnosis and do not provide treatment.

The 164 plans providing physicians' services directly serve almost 2 million members; 86 of them also provide benefits to dependents of members and serve about 937,000. Ninety-two percent of the members and 70 percent of the dependents enrolled in the plans are entitled to fully prepaid medical services; the remainder either pay some extra charges or receive medical services at reduced fees.

Physicians' services infrequently used.—The plans are less apt to furnish the types of medical service required infrequently by the membership. Such services may include brain and nerve surgery, the services of a cardiologist, an allergist, a dermatologist, and the like. Indeed, 37 of the clinics make no provision for some of the more specialized services (table 7). There are 160 plans that offer fully prepaid benefits for medical services widely used, but only 112 have fully prepaid benefits for the less usual types of medical care. Seventy-four plans offer medical services widely used to dependents without extra charges, 57 provide the less common services as a fully prepaid benefit.

In this area of medical services a few plans make outside arrangements instead of having specialists on the regular staff; these specialists are either paid a retainer or reimbursed on a fee-for-service basis. Such specialists generally see patients in their own office rather than at the clinic.

Obstetricians' services.—The membership in 64 percent of the 174 plans is eligible for maternity or obstetrical benefits, provided in one of three ways (table 8). Seventy-nine plans include obstetricians on the staff, and 18 plans provide from their own funds for reimbursement of the patient for maternity services.

Together the two methods of covering maternity services apply to plans with more than a million members. The persons covered for these benefits under the remaining plans get their protection from Blue Shield or a commercial insurance policy. Many of the 63 clinics that do not offer obstetrical benefits are plans whose benefits have, since their founding, reflected the predominantly male employment of their particular industry; their benefits apply only to employees. When there is no care of any kind provided for dependents, the demand for maternity care is probably less than when dependents are eligible for some benefits.

Of the 92 plans that cover dependents, 87 offer obstetrical benefits; the 87 plans include 95 percent of all dependents enrolled in the plans.

Comparison of table 8 with table 7 brings out the fact that extra charges and reduced fees are more usual for maternity care than for services used by both sexes. Among the members entitled to obstetrical benefits, about 6 in 10 have fully prepaid maternity benefits; less than 7 in 10 dependents also have maternity care fully prepaid. In contrast, more than 9 out of 10 members and 7 out of 10 dependents receive widely used physicians' services on a fully prepaid basis.

Ancillary services.—Table 9 permits a comparison of the ways in which the plans finance certain diagnostic services and X-ray treatment. A few small plans make some charges for routine laboratory examinations to members, but in 97 percent of the plans such benefits are fully prepaid.

Table 6.—***Plans and total enrollment, by number of plans with specified benefits provided by the clinic, 1954 survey*** [1]

Number of plans with specified benefit provisions	Percentage distribution of plans	Total enrollment		Benefit provision						
		Number	Percentage distribution	Surgical	Medical	Obstetrical	X-ray examination	X-ray treatment	Physiotherapy	Basal metabolism and electrocardiogram
Total, 174	100.0	2,956,137	100.0	—	—	—	—	—	—	—
49	28.2	1,195,481	40.4	x	x	x	x	x	x	x
11	6.3	123,191	4.2	x	x [3]	x	x	x	x	x
10	5.7	73,629	2.5	x	x	x	x	—	x	x
1	.6	2,942	.1	x	x	x	x	x	—	x
1	.6	5,600	.2	x	x	x	x	x	x	—
4	2.3	24,684	.8	x	x	x	x	—	—	x
1	.6	26,000	.9	x	x	x	x	—	x	—
2	1.1	4,700	.2	x	x	x	x	—	—	—
2	1.1	3,328	.1	x	x	x	—	—	—	—
35	20.1	446,268	15.1	x	x	—	x	x	x	x
2	1.1	14,500	.5	x	x [2]	—	x	x	x	x
2	1.1	218,970	7.4	x	x [3]	—	x	x	x	x
2	1.1	27,495	.9	x	x	—	x	—	x	x
4	2.3	30,900	1.0	x	x	—	x	x	x	—
2	1.1	8,500	.3	x	x	—	x	x	—	x
4	2.3	35,416	1.2	x	x [3]	—	x	—	x	x
1	.6	27,280	.9	x	x [2]	—	x	—	x	x
1	.6	1,090	(4)	x	x	—	x	x	—	—
14	8.0	82,813	2.8	x	x	—	x	—	—	x
2	1.1	27,553	.9	x	x	—	x	—	x	—
1	.6	14,627	.5	x	x	—	x	—	—	—
3	1.7	2,338	.1	x	x	—	—	—	—	—
3	1.7	96,500	3.3	—	x [3]	—	x	x	x	x
1	.6	7,000	.2	—	x [3]	—	x	x	x	—
2	1.1	19,800	.7	—	x [3]	—	x	—	x	x
2	1.1	11,000	.4	—	x [5]	—	x	—	x	—
1	.6	790	(4)	—	x	—	x	—	—	—
3	1.7	30,879	1.0	x	—	—	x	—	x	x
5	2.9	41,599	1.4	x	—	—	x	—	—	x
1	.6	431	(4)	x	—	—	—	—	x	x
1	.6	833	(4)	x	—	—	x	—	—	—
1	.6	350,000	11.8	—	—	—	x	—	—	x

[1] Because all the plans provide diagnostic benefits, including routine laboratory examinations, this type of benefit is not shown here. When information was not available, the plan was classified as not providing the benefit.

[2] No home care.

[3] In clinic only.

[4] Less than 0.05 percent.

[5] Home and office, not in hospital.

Table 7.—*Provision of and method of financing physicians' services, by number of members and dependents enrolled, 1954 survey*

Method of financing services	Members							Dependents						
	Total			Services rendered in—				Total			Services rendered in—			
	Number of plans	Persons		Clinic operated by plan		Clinic with which plan contracts		Number of plans	Persons		Clinic operated by plan		Clinic with which plan contracts	
		Number	Percentage distribution	Number of plans	Number of persons	Number of plans	Number of persons		Number	Percentage distribution	Number of plans	Number of persons	Number of plans	Number of persons
Total [1]	174	1,994,901	100.0	164	1,963,763	10	31,138	92	961,236	100.0	86	936,686	6	24,550
Fully prepaid	160	1,825,300	91.5	152	1,802,312	8	22,988	74	669,642	69.7	71	663,642	3	6,000
Prepaid, but some extra charges	8	141,421	7.1	7	133,421	1	8,000	9	158,441	16.5	8	142,441	1	16,000
Reduced fees	5	27,680	1.4	4	27,530	1	150	7	129,903	13.5	6	129,603	1	300
No information	1	500	(2)	1	500	0	0	2	3,250	.3	1	1,000	1	2,250
Total providing specialized physicians' services [3]	137	1,322,290	100.0	127	1,212,317	10	109,973	75	861,648	100.0	71	835,751	4	25,897
Fully prepaid	112	1,090,555	82.5	105	1,006,082	7	84,473	57	584,427	67.8	56	582,030	1	2,397
Prepaid, but some extra charges	7	142,851	10.8	6	139,851	1	3,000	9	162,102	18.8	8	155,102	1	7,000
Reduced fees	6	47,126	3.6	5	25,126	1	22,000	4	108,871	12.6	3	93,371	1	15,500
No information	12	41,758	3.1	11	41,258	1	500	5	6,248	.8	4	5,248	1	1,000

[1] Ordinary physicians' services are made available to all members of the 174 plans and to all dependents covered in the 92 plans; in 11 plans the physicians confine their services to diagnosis and do not treat the patients.

[2] Less than 0.05 percent.

[3] Of the 174 plans, 37 plans covering 672,611 members do not provide specialized physicians' services to members; 17 plans covering 99,588 dependents do not provide specialized physicians' services to dependents.

Full prepayment is less general for dependents, 43 percent of whom must pay extra charges. The situation is similar for X-ray examinations.

X-ray treatment is not provided in about a third of the plans, with approximately a third of the membership. Where it is provided to members it is usually fully prepaid. In plans including dependents, proportionately more provide X-ray treatment, but only a little more than half the dependents eligible for X-ray treatment may receive the service without paying extra charges or reduced fees.

Basal metabolism tests and electrocardiogram examinations are generally provided except among a few small plans. Again, dependents usually pay extra charges while members do not.

The plans about which no detailed information was obtained were in all instances small, and it is probable that the scope of the services they could offer was restricted.

Special services.—In table 10, the methods of paying for physiotherapy, pharmacy, and ambulance services are shown, as well as the payment practices with respect to appliances.

Physiotherapy treatments were provided by the plans more often than were X-ray treatments; more than three-fourths of the plans, covering an equal proportion of the members, make physiotherapy services available. Plans that include dependents generally offer physiotherapy, but a large proportion of dependents pay extra charges or reduced fees at the time of receiving the services.

Appliances (crutches, wheel chairs, braces, and so on) are included as a prepaid benefit in only 25 percent of the plans, covering only a third of the members. Two-thirds of the members of these plans may obtain appliances without cost. The dependents are in a less favorable position than the members, since only 11 percent are covered by plans that fully prepay for appliances.

Forty-two percent of the plans reported that they have a pharmacy of some type. Half the members in plans with pharmacies paid reduced charges for the pharmaceutical items obtained. Interestingly enough, 55 percent of the dependents were in plans that had a pharmacy. As with

Table 8.—*Provision of and method of financing obstetrical benefits, by number and percentage distribution of members and dependents enrolled, 1954 survey*

Method of financing services	Members				Dependents			
	Number of plans	Number of persons	Percentage distribution		Number of plans	Number of persons	Percentage distribution	
			Plans	Persons			Plans	Persons
Total	174	1,994,901	100.0	100.0	92	961,236	100.0	100.0
Service provided	79	593,095	45.4	29.7	75	783,627	81.5	81.5
Fully prepaid	62	414,094	35.6	20.8	59	519,691	64.1	54.1
Prepaid, but some extra charges	8	124,942	4.6	6.3	9	145,148	9.8	15.1
Reduced fees	4	17,121	2.3	.9	5	118,206	5.4	12.3
Fee-for-service	5	36,938	2.9	1.8	2	582	2.2	.1
Cash benefits provided	18	355,412	10.3	17.8	4	50,038	4.3	5.2
Provided by other form of insurance	14	487,580	8.0	24.4	8	77,500	8.7	8.1
Not provided	61	557,224	35.1	27.9	4	49,071	4.3	5.1
No information	2	1,590	1.1	.1	1	1,000	1.1	.1

the other special services, charges were usually made for supplies furnished dependents.

In reporting on the ambulance service provided, the plans were not asked to specify if extra charges were made for patients living outside a given radius, so it is assumed that the reporting on fully prepaid ambulance service applies in general to the membership living fairly near the clinic or hospital. Provision of ambulance service was more extensive than might be expected. This service was generally provided through outside arrangements, and not by means of an ambulance owned by the plan.

Provision of Hospital Care

Some of the plans analyzed were, from their inception, designed to provide members with complete care in time of illness, and they included a hospital or hospitals as an integral part of their physical facilities. The railway hospital plans are almost all of this type, but some consumer plans and a few employer-employee plans also own their own hospitals. The union health plans that have developed so rapidly since World War II do not fall in this pattern.

The plans are about equally divided into three groups, according to the method used for providing members with protection against the costs of hospital care. Sixty of them operate their own hospitals, and 60 have made direct arrangements with hospitals in their communities to provide hospital services to their members. In the 54 that do not themselves provide hospitalization benefits directly, the members are eligible for these benefits through either a Blue Cross or a group insurance policy. In terms of the number of persons covered, the smallest group is the one eligible for care in hospitals operated by the plan itself and the largest is that which relies on an outside insurer.

Of the 92 plans providing dependents with some medical benefits, 25 have their own hospitals, 21 have contractual arrangements, and the balance use other insurers. It is probable that some dependents of members of the 60 plans that do not make their clinic facilities available to dependents and of the 22 admitting dependents as outside patients may have hospital insurance of the third type, so that in this group a large number of dependents are provided with hospital care through Blue Cross or group insurance policies.

Nearly 900,000 members, or 45 percent of the 2 million members of

Table 9.—*Provision of and method of financing specified diagnostic services, by percentage distribution of members and dependents enrolled, 1954 survey*

Method of financing services	Members								Dependents							
	Routine laboratory examinations		X-ray examinations		X-ray treatments		Basal metabolism tests and electrocardiograms		Routine laboratory examinations		X-ray examinations		X-ray treatments		Basal metabolism tests and electrocardiograms	
	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No provision for specified service	-------	-------	1.1	(1)	31.0	32.4	8.0	4.9	-------	-------	1.1	.8	22.8	14.1	5.4	1.9
Specified service provided	97.7	99.9	96.6	99.9	64.4	66.7	87.4	94.3	95.7	99.4	94.6	99.4	72.8	85.4	89.1	97.5
Fully prepaid	87.9	96.8	83.9	95.9	56.3	61.2	78.2	86.2	73.9	56.8	70.7	56.5	55.4	44.5	68.5	55.2
Prepaid, but some extra charges	1.1	.4	1.7	.5	2.3	3.3	1.1	5.4	5.4	26.3	6.5	26.6	4.3	26.1	5.4	26.3
Reduced fees	8.6	2.7	10.9	3.5	5.7	2.2	8.0	2.7	16.3	16.3	17.4	16.4	13.0	14.8	15.2	16.0
No information	2.3	.1	2.3	.1	4.6	.9	4.6	.9	4.4	.6	4.3	.5	4.3	.5	5.4	.6

[1]Less than 0.05 percent.

Table 10.—*Provision of and method of financing selected special services, by percentage distribution of members and dependents enrolled, 1954 survey*

Method of financing services	Members								Dependents							
	Physiotherapy		Appliances		Pharmacy		Ambulance		Physiotherapy		Appliances		Pharmacy		Ambulance	
	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons	Plans	Persons
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No provision for specified service	19.5	24.2	59.8	57.7	45.4	42.1	33.3	52.2	9.8	8.1	70.7	70.4	60.9	42.4	35.9	29.2
Specified service provided	77.6	75.7	25.3	34.1	42.0	52.1	51.7	39.6	84.8	91.3	22.8	26.4	33.7	54.8	57.6	67.7
Fully prepaid	70.1	72.6	17.2	19.3	24.1	20.1	46.0	34.8	66.3	48.8	9.8	11.1	15.2	11.8	52.2	55.0
Prepaid, but some extra charges	.6	.3	1.7	3.4	1.2	.5	3.4	2.8	5.4	26.3	3.3	10.5	1.1	.2	1.1	.2
Reduced fees	6.3	2.8	3.4	10.8	10.9	26.6	2.3	1.9	12.0	16.2	5.4	4.1	13.0	39.8	4.3	12.5
At cost	.6	(1)	2.9	.7	5.7	4.9	0	0	1.1	(1)	4.3	.7	4.3	3.0	0	0
No information	2.9	.1	14.9	8.2	12.6	5.9	14.9	8.2	5.4	.6	6.5	3.1	5.4	2.8	6.5	3.1

[1] Less than 0.05 percent.

the 174 plans, are eligible for fully prepaid hospital benefits either directly from the plan or through arrangements made by the plan (table 11). About 373,000 pay some extra charges when they receive hospital care. The remaining persons have other forms of hospital insurance. Only a few small plans, which operate their own hospitals, make any charges to members.

Dependents provided with some medical benefits by the plans numbered 961,000. About 400,000 of them are eligible for fully prepaid hospital benefits—333,000 in plans operating their own hospital facilities. More than 100,000 dependents were reported eligible for hospital care at reduced fees or at cost.[5] Of these, 86,000 dependents were enrolled in one plan that provided that they pay hospital charges at cost if admitted to the hospital with which the plan contracts for benefits. Seventy-seven percent of those who pay some extra charges are in plans that do not operate their own hospital.

Two plans not only operate their own hospital but reported that they also have arrangements with other hospitals to admit their members.

Days of hospital care provided.—Among the 120 group-practice clinics that included hospitalization as part of the plan, 87 provided service benefits and 33 indemnified members with cash when they were hospitalized (table 12). The most outstanding feature of the hospital care provided was the fact that more than half the plans (68) covered a full year of hospital care as a service benefit. Only five plans offering service benefits provided less than 90 days of care in a year. The 68 plans providing 365 days of care covered a total of 668,000 members and dependents.

Thirty or 31 days per illness was the most usual benefit among plans using cash indemnity paid from the plans' own funds as the method of taking care of members' hospital bills. Information was not collected on the nature of the hospitalization benefits for the group deriving their protection from a Blue Cross or commercial insurance policy.

Staffing

More than half the plans submitted information on their staffing. The information did not lend itself to statistical analysis that could be related to the plans' enrollment, as had been anticipated when the questionnaire was designed. The plans that had an integrated hospital and clinic facility had different personnel requirements from plans with only a clinic. Even plans with very small enrollments required the services of laboratory and X-ray technicians, and no conclusions could be reached about the prevailing ratio of technicians to enrollment. Furthermore, in some clinics and hospitals the staff furnished care for nonmembers so that it was impossible to relate staff to prepaid enrollment.

The use of physicians on a part-time basis was customary. Only 20 of the reporting plans limited their medical staff to full-time physicians. Part-time nurses were often employed, although all the clinics appeared to have at least one full-time nurse. Other staff personnel included a wide range of professional workers. In addition to physicians, more than one plan reported the following personnel: dentists, nurses, X-ray and laboratory technicians, physiotherapists, occupational therapists, medical and psychiatric social workers, pharmacists, anaesthetists, optometrists, medical record librarians, dental hygienists, podiatrists, visiting nurses, nutritionists, and health education specialists. Many plans also employed nurses' aides.

Premiums or Charges

Data submitted on the amount paid yearly for membership did not lend itself to statistical analysis, because of the variations in benefits, the inclusion or exclusion of hospital care as part of the plan, and the various practices regarding extra charges at the time service was rendered.

Information on premium charges was clear-cut for the consumer-sponsored plans. The industrial plans generally made their reports, however, in terms of the total contributions required for their entire health and welfare program. As a result, costs for life and cash sickness insurance and for other benefits were in-

[5] An estimated 300,000 dependents might be added to this number if the 17 railway hospital plans that care for dependents at cost but do not count them in their enrollment were to be included.

Table 11.—*Provision of and method of financing hospital care, 120 plans, by number of members and dependents enrolled, 1954 survey*

Method of financing hospital care	Members						Dependents					
	Total		Hospital owned by plan		Other hospitals [1]		Total		Hospital owned by plan		Other hospitals [1]	
	Number of plans	Number of persons	Number of plans	Number of persons	Number of plans	Number of persons	Number of plans	Number of persons	Number of plans	Number of persons	Number of plans	Number of persons
Total [2]	120	1,272,971	60	664,440	60	608,531	44	592,889	25	355,107	19	237,782
Fully prepaid	88	892,789	53	656,451	35	236,338	27	407,620	18	332,790	9	74,830
Prepaid, but some extra charges	26	373,283	1	1,090	25	372,193	9	76,952			9	76,952
Regular charges paid	5	6,399	5	6,399			7	107,317	6	21,317	1	86,000
No information	1	500	1	500			1	1,000	1	1,000		

[1] The plan may have contracts for service benefits with these hospitals or may indemnify the member if he is hospitalized.

[2] Of the 174 plans, excludes 54 whose members receive no hospital care or receive it through other resources than the plan, i.e., a Blue Cross or commercial insurance policy separate from the plan. Of the 92 plans providing dependents' benefits, 44 provide hospitalization; in another 44, dependents (and members) have alternate arrangements (through a Blue Cross or group insurance policy) for hospital care; 4 plans in which dependents were served in the clinic apparently have no arrangement for hospitalization coverage.

cluded in the contributions reported, and the portion applicable to the medical and hospital benefits frequently could not be separately determined.

In the most comprehensive plans whose prepaid monthly dues could be related to benefits, charges of about $60 a year for an adult member or adult dependent and $30 or less for child dependents were usual. The lowest charge was made by a rural Mississippi plan. A maximum charge of about $150 a year for hospitalization and medical care for a family of three or more was typical in comprehensive urban plans.

Finances

Estimated earned income in 1953 among the plans with group-practice arrangements amounted to $85.4 million (table 13). It is estimated that about $31.1 million of the total represented income for hospitalization and $54.4 million income for medical benefits (including dentistry). These figures relate not only to the clinics and hospitals run by the plan or with which the plan had arrangements but also to the cash benefits for hospitalization and surgery if they were an integral part of the plan.

Only the industrial plans appeared to place more emphasis on hospitalization than on medical care, but this finding results from the method of allocating expenses among the railway hospital plans. Frequently the cost of the salaried medical staff of the hospital was charged to hospital care and could not be entirely reassigned to medical care costs.

Table 13.—*Income and expenditure for hospitalization and medical services in 1953, by plan sponsorship, 1954 survey*

[In thousands]

Type of sponsorship	Income			Expenditures for benefits		
	Total	Hospitalization	Medical services [1]	Total	Hospitalization	Medical services [1]
Total	$85,455	$30,100	$54,355	$76,902	$29,308	$47,594
Consumer, community, and fraternal	5,212	1,946	3,266	5,466	2,235	3,231
Union	13,171	2,563	10,608	8,627	1,773	6,854
Employer and/or employee	36,792	19,255	17,537	35,665	18,998	16,667
Private group clinic	30,280	7,336	22,944	27,144	6,302	20,842

[1] Includes some dental services.

Expenditures for benefits amounted to $76.9 million or 90 percent of earned income. The ratio of benefits to income was 106 percent for the consumer, community, and fraternal group.[6] The ratio was 96 percent for the industrial plans, 65 percent for the union group, and 90 percent for the private group clinics.

Summary

Findings from the 1954 survey of 174 group-practice plans with prepaid benefits have been presented. These plans have an enrollment of about 3 million people, including nearly 2 million members and a million dependents. They are located in 34 States and the District of Columbia but are most numerous in New York and California.

A predominant characteristic of the plans is their control and sponsorship by consumers, either through consumer cooperatives, fraternal societies, unions, or employee organizations. Physicians directly control 45 of the 174 plans, if the 30 centers of the Health Insurance Plan of Greater New York are counted in this category rather than as one community-sponsored plan. Most of the enrollment derives from employed groups, either directly or through their union membership. Some of the membership of the cooperatives and all the membership in the fraternal plans, however, stem from sources other than attachment to the labor market.

The plans vary greatly in the size of their enrollment; 10 have less than 500 members and 10 have more than 40,000.

A total of 120 plans provide hospital care as part of their benefit structure, through either their own hospitals, arrangements with hospitals in their community, or cash indemnity benefits from the plan's funds. The coverage of hospital care is unusually comprehensive in many plans since 68 plans, covering 668,000 persons, provided 365 days of care on a fully prepaid basis.

All 174 plans offer diagnostic services; 11 of them do not go beyond diagnostic services to provide treatment, once a diagnosis is established. Less than half the plans provide obstetricians' services; plans affording

(Continued on page 31)

[6] Some of these plans make up the difference between expenditures and income by providing services to nonmembers on a fee-for-service basis; still others raise money through social activities.

Table 12.—*Number of days' hospital care furnished as service or cash indemnity benefits, 120 plans, by total enrollment, 1954 survey*

Number of days' care	Total		Service benefits in hospital owned by plans		Service benefits by contract with hospitals		Cash indemnity benefits	
	Number of plans	Number of persons	Number of plans	Number of persons	Number of plans	Number of persons	Number of plans	Number of persons
Total [1]	120	1,885,860	60	1,019,547	37	422,161	23	444,152
365	67	659,436	40	458,302	27	201,134		
180	7	110,077	6	95,050			1	15,027
120	2	9,379			2	9,379		
111	2	393,834	2	393,834				
90	4	173,267	1	3,424	2	144,843	1	25,000
35	3	55,697					3	55,697
30–31	14	112,644	1	1,092			13	111,552
Other	18	340,276	[2] 8	40,345	[3] 5	63,055	[4] 5	236,876
Not stated	3	31,250	2	27,500	1	3,750		

[1] Excludes 54 plans covering 722,000 persons that do not furnish hospitalization as an integral part of the plan.

[2] 182 days of full and 183 days partial benefits—8,235 persons; 111 full and 30 partial—22,166 persons; 90–365 days, depending on length of employment—6,500 persons; 62 days—444 persons; 50 days—880 persons; 28 days—1,200 persons; 10 full and 10 partial days (2 plans)—920 persons.

[3] 70 days—22,455 persons; 30 full and 180 partial or 90 full days—8,000 persons; 42 days—24,000 persons; 21 or 90 days (2 contracts offered)—3,000 persons; 21 days—5,600 persons.

[4] 105 days—10,000 persons; 100 days—22,354 persons; 75 days—199,912 persons; 14 full and 14 partial days—790 persons; no limit on days but $600 limit on benefit—3,820 persons.

Table 13.—*Public assistance in the United States, by month, March 1955–March 1956* [1]

[Except for general assistance, includes vendor payments for medical care and cases receiving only such payments]

Year and month	Total [2]	Old-age assistance	Aid to dependent children: Families	Aid to dependent children: Recipients: Total [3]	Aid to dependent children: Recipients: Children	Aid to the blind	Aid to the permanently and totally disabled	General assistance (cases)	Total	Old-age assistance	Aid to dependent children (families)	Aid to the blind	Aid to the permanently and totally disabled	General assistance
	Number of recipients								Percentage change from previous month					
1955														
March	------------	2,552,881	624,235	2,253,174	1,699,626	103,045	229,892	381,000	--------	(4)	+1.1	+0.2	+1.1	+0.3
April	------------	2,550,724	626,182	2,261,283	1,706,164	103,382	232,346	357,000	--------	−0.1	+.3	+.3	+1.1	−6.3
May	------------	2,547,965	625,430	2,260,962	1,705,832	103,654	234,649	330,000	--------	−.1	−.1	+.3	+1.0	−7.7
June	------------	2,548,503	620,303	2,239,328	1,691,613	103,902	236,828	310,000	--------	(5)	−.8	+.2	+.9	−5.9
July	------------	2,550,101	611,578	2,209,299	1,668,914	104,140	238,763	297,000	--------	+.1	−1.4	+.2	+.8	−4.1
August	------------	2,551,615	607,822	2,199,090	1,661,809	104,164	240,299	297,000	--------	+.1	−.6	(5)	+.6	−.1
September	------------	2,552,536	604,457	2,191,138	1,656,814	104,249	240,870	290,000	--------	(5)	−.6	+.1	+.2	−2.4
October	------------	2,552,991	598,459	2,171,169	1,642,869	104,444	242,320	286,000	--------	(5)	−1.0	+.2	+.6	−1.3
November	------------	2,554,709	598,112	2,173,222	1,644,728	104,718	242,122	297,000	--------	+.1	−.1	+.3	−.1	+3.8
December	------------	2,552,832	602,787	2,193,215	1,661,206	104,858	244,007	314,000	--------	−.1	+.8	+.1	+.8	+5.9
1956														
January	------------	2,545,576	605,674	2,205,913	1,670,728	104,947	245,210	331,000	--------	−.3	+.5	+.1	+.5	+5.1
February	------------	2,538,518	608,628	2,220,653	1,682,363	104,772	247,117	336,000	--------	−.3	+.5	−.2	+.8	+1.7
March	------------	2,535,419	613,246	2,240,856	1,698,296	105,083	249,118	336,000	--------	−.1	+.8	+.3	+.8	−.1
	Amount of assistance								Percentage change from previous month					
1955														
March	$232,724,000	$132,393,704	$54,078,960			$5,848,702	$12,647,701	$21,915,000	+1.0	+0.3	+1.7	+0.5	+1.8	+1.9
April	230,874,000	132,351,618	54,273,669			5,873,069	12,808,950	19,922,000	−.8	(4)	+.4	+.4	+1.3	−9.1
May	229,468,000	132,674,197	54,229,682			5,898,355	12,895,336	17,947,000	−.6	+.2	−.1	+.4	+.7	−9.9
June	228,480,000	133,292,041	53,830,416			5,964,848	13,009,522	16,675,000	−.4	+.5	−.7	+1.1	+.9	−7.1
July	227,683,000	134,267,369	52,998,023			5,906,557	13,188,555	15,941,000	−.3	+.7	−1.5	−1.0	+1.4	−4.4
August	226,881,000	133,649,806	52,770,265			5,888,035	13,300,930	15,717,000	−.4	−.5	−.4	−.3	+.9	−1.4
September	227,087,000	133,999,430	52,851,801			5,945,057	13,284,871	15,366,000	+.1	+.3	+.2	+1.0	−.1	−2.2
October	228,828,000	136,034,539	52,512,850			6,039,250	13,450,637	15,185,000	+.8	+1.5	−.6	+1.6	+1.2	−1.2
November	230,410,000	136,805,741	52,580,182			6,054,577	13,458,492	15,857,000	+.7	+.6	+.1	+.3	+.1	+4.4
December	234,133,000	137,666,717	53,415,398			6,090,772	13,709,025	17,293,000	+1.6	+.6	+1.6	+.6	+1.9	+9.1
1956														
January	235,480,000	138,276,533	53,474,008			6,100,996	13,784,271	18,012,000	+.6	+.4	+.1	+.2	+.5	+4.2
February	235,733,000	137,284,706	54,051,818			6,110,375	13,943,747	18,506,000	+.1	−.7	+1.1	+.2	+1.2	+2.7
March	236,918,000	137,091,819	54,818,312			6,144,744	14,082,132	18,567,000	+.5	−.1	+1.4	+.6	+1.0	+.3

[1] For definition of terms see the *Bulletin*, January 1953, p. 16. All data subject to revision.

[2] Total exceeds sum of columns because of inclusion of vendor payments for medical care from general assistance funds and from special medical funds; data for such expenditures partly estimated for some States.

[3] Includes as recipients the children and 1 parent or other adult relative in families in which the requirements of at least 1 such adult were considered in determining the amount of assistance.

[4] Decrease of less than 0.05 percent.

[5] Increase of less than 0.05 percent.

GROUP-PRACTICE PLANS

(*Continued from page 11*)

benefits only to employees and not to dependents frequently omitted this benefit. The enrollment in such plans is predominantly male because of the character of the industry in which the plan is established.

Surgeons are generally found on the staffs of the plans, but in many instances the surgical benefit was separately financed through another form of insurance, or through use of a fee schedule and cash indemnification to the patient of specified amounts.

A large number of plans provide their membership with a variety of outpatient diagnostic and therapeutic aids and services not ordinarily available on a prepaid basis. The following services are given on a fully prepaid basis for a large majority of the members: diagnostic X-rays, electrocardiograms, basal metabolism tests, physiotherapy, and ambulance. Extra charges are required of dependents—as distinguished from members—more frequently than of members. X-ray treatment is frequently not provided, but when offered it is usually fully prepaid for members and involves extra charges for dependents. The same is true of appliances and of the pharmaceutical items obtained from plans operating a pharmacy.

These group-practice prepayment plans, through the years in which they have been operating, have already produced a large body of experience in the provision of broad health benefits through periodic prepayment. In terms of coverage, their impact in the total voluntary health insurance field is small. It is evident that the number of these plans and the number of persons provided with medical services through group-practice arrangements will continue to expand. Whether this expansion will be in the direction of providing the membership with fully comprehensive benefits or of rounding out other forms of voluntary health insurance is problematical. At this time, the latter appears the more likely development.