# *Independent Plans Providing Medical Care and Hospital Insurance: 1957 Survey*

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AT LEAST 120 million people in the United States today have some form of voluntary medical care insurance. This protection against the costs of hospital and medical care is provided by varied types of insurance. Some segments of the population are covered by more than one type—usually for different benefits but sometimes for the same benefit. The four generally recognized categories of insurers are (1) the Blue Cross and Blue Shield plans, (2) group insurance underwriters, (3) individual insurance underwriters, and (4) a group of plans usually referred to as the independent plans, since they are not associated with each other or with the other three types of insurers. The first three types of insurers report regularly to national associations that prepare summary information about their enrollment and finances. The Division of Program Research of the Social Security Administration has been collecting similar information periodically for the past 14 years about the fourth category, the independent plans. In each of the past 4 years, a canvass has been made by mail to obtain data on these plans. This article summarizes the findings of the 1957 survey, which collected data about the plans as of the end of 1956.

At about 5-year intervals an effort has been made in the survey to obtain information in considerable detail about the operation of the plans.[1] In the years since the last intensive survey in 1954, the plans have been asked to furnish only enrollment information and financial data and to supply any available literature describing each plan's benefits, dues, and the like. From one year to the next there is generally little change in a plan's basic structure and, particularly among the industrial plans, little change in enrollment, since the membership is derived from an employed group whose size varies only with employment conditions in the plant or industry concerned.

The independent plans vary widely in their approach to the provision of prepaid medical care. Some are comprehensive plans—for example, the Labor Health Institute of St. Louis, which through prepaid coverage provides hospitalization; medical and surgical care in the hospital; medical, diagnostic, and preventive services in the clinic; medical care in the home; and dental care. At the other end of the scale are such plans as the small hospital associations in Georgia that provide only cash indemnity benefits for a limited number of days in the hospital. A number of the plans are designed to round out the medical benefits already available to their membership through group insurance or the Blue Cross and Blue Shield plans; these plans may therefore omit hospitalization and/or surgical expense insurance and instead provide such items as outpatient physicians' services, diagnostic services, dental care, physicians' visits to the home, and drugs.

About two-fifths of the enrollment in the plans receive some benefits, if not all, through group-practice arrangements. About 4 million persons belong to plans[2] that do not differ in any appreciable degree from member plans of the Blue Cross or Blue Shield Commissions, although they are not affiliated with these national organizations. Indeed, several of the plans act as agents for the Blue Shield plan in their area,[3] and at least two medical-surgical plans (Medical Mutual of Cleveland and the Rhode Island Physicians' Service) are closely associated with a Blue Cross plan, though they are not members of Blue Shield. Occasionally in the past a plan has ceased to be an "independent" plan because it has become affiliated with the Blue Cross Commission, and an affiliated plan has become "independent."

## *Problems of Plan Classification*

A review of the problems encountered in compiling data about the independent plans affords some insight into their characteristics.

The Social Security Administration customarily reports the enrollment among independent plans to the Health Insurance Council so that the data may be included in the Council's annual summaries of enrollment under all forms of voluntary health insurance.[4] Since it is necessary to report the data on a State basis, problems arise from the fact that at least 30 of the reporting units have members in several States in addition to the State where their headquarters is located. The United Mine Workers' Welfare and Retirement Fund, for example, is centrally administered from its District of Columbia office but covers mining families in 21 States. The New York office of the International Ladies' Garment Workers Union furnishes reports on

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[1] See "Independent Plans Providing Medical Care and Hospital Insurance: 1954 Survey," *Social Security Bulletin*, April 1955; and "Group-Practice Prepayment Plans: 1954 Survey," *Social Security Bulletin*, June 1956. See also Margaret C. Klem, *Prepayment Medical Care Organizations*, Bureau Memorandum No. 55, Bureau of Research and Statistics, 3d ed., June 1945; and 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.

[2] Examples of this type of plan are Connecticut Blue Cross, Inc., the Rhode Island Physicians' Service, Medical Mutual of Cleveland, and Morgantown Hospital Service, Inc.

[3] The Intercounty Hospital Plan in Pennsylvania and Monongahela Valley Hospital Service in West Virginia are plans of this type.

[4] For 1956 data, see *The Extent of Voluntary Health Insurance in the United States, 1956*, Health Insurance Council. Because the Council reclassifies certain plans, their data differ from those presented in this article.

78 separate health and welfare funds located in 17 States; included are 19 union health centers. Several railway hospital associations operate hospitals and clinics along the right-of-way of the railroad line, which may stretch from California or the State of Washington to the Midwest or operate through the South. Frequently somewhat arbitrary decisions have been necessary to allocate enrollment among the States in such a way as to avoid distorting the proportion of persons in a given State who are eligible for benefits from these plans. (This problem also arises, though to a lesser degree, among Blue Cross and Blue Shield plans, both when the plan is located adjacent to other States, as is true for the New York City plan, or when a plan has a contract for national coverage of the employees of a business firm, but only the headquarters is located in the plan's jurisdiction.)

Another problem, not peculiar to the independent plans, arises from the fact that the number of dependents per subscriber or employee is not always a matter of record. Sometimes—especially in plans financed by employers, whether or not they have been collectively bargained—the number of employees or union members can only be approximated.

Duplicate reporting occurs with sufficient frequency among the independent plans to be a problem. A number of self-insuring union trust funds purchase some of the benefits provided their membership from other independent plans. Several union trust funds in New York City self-insure their hospitalization benefits, but their surgical and medical coverage is purchased through a contract with the Health Insurance Plan of Greater New York. A few union funds in the Philadelphia area self-insure their hospital and/or their surgical benefits and have joined with other unions to support the AFL Medical Center, where outpatient medical and diagnostic services are provided to the members of 25 unions. Both the Health Insurance Plan and the AFL Medical Center report their entire enrollment and finances in response to the Social Security Administration's request for data. The individual unions may also report on their whole welfare program and consequently duplicate that part covered by the Medical Center's reporting.

Interest in the extent to which prepaid medical care benefits are provided through group-practice clinics is increasing as this form of health insurance grows. Analysis of the enrollment eligible for benefits through group-practice arrangements entails a number of problems in classifying the plans and hence their enrollment. When the prepayment plan itself operates the clinic, few complications arise, but when the benefits are provided to members of the plan through a contractual arrangement with a separate group-practice clinic, various problems are encountered. The Health Insurance Plan of Greater New York, for example, enrolls its members through a single central organization, which in turn has arrangements with 30 group-practice clinics. The United Mine Workers' Welfare and Retirement Fund operates 10 hospitals with outpatient clinics and, in addition, has made arrangements with a number of group-practice clinics owned or operated by physicians; consequently a large proportion of the plan beneficiaries receive some or all of their benefits through genuine group-practice plans.

The independent plans, to a greater degree than the Blue Cross, Blue Shield, and insurance company plans, exhibit dissimilarities in the scope of the benefits they provide their membership. Some plans include hospitalization among their benefits, others furnish only hospital benefits, and still others do not provide this benefit. The same situation prevails with respect to surgical services, medical care in and out of the hospital, outpatient diagnostic benefits, and dental services. A fourth of the plans do not provide hospitalization benefits, and 20, including several large plans, confine their benefits to hospitalization. It is thus necessary to tabulate enrollments separately for each benefit.

Several difficulties that occur in analyzing the finances of a large segment of the independent plans do not arise in connection with insurance companies and the Blue Cross and Blue Shield plans. Prepayment group-practice plans usually receive from their members, in addition to "dues" or "premiums," sums representing charges or additional fees for certain services. In some plans, the dependents of members receive certain services at reduced fees rather than as fully prepaid benefits. Hospital care is sometimes available at a discount to members rather than as a fully prepaid benefit. Some clinics and hospitals also serve nonmembers on a fee-for-service basis, and this income is mingled with income from members. In these situations it is sometimes difficult to determine the portion of plan income

**Table 1.—*Enrollees eligible for one or more benefits in independent plans, by State, December 1956***

[In thousands]

| State | All types of sponsorship | | Industrial sponsorship | |
|---|---|---|---|---|
| | Total | Group-practice plans | Total | Group-practice plans |
| United States [1] | 8,944.1 | 3,430.1 | 3,383.1 | 1,967.5 |
| Alabama | 113.8 | 88.3 | 113.8 | 88.3 |
| Arizona | 11.0 | 11.0 | 11.0 | 11.0 |
| Arkansas | 37.8 | 32.8 | 37.5 | 32.5 |
| California | 927.1 | 887.3 | 217.3 | 188.6 |
| Colorado | 50.4 | 29.3 | 41.1 | 29.3 |
| Connecticut | 1,188.8 | .2 | .2 | .2 |
| Dist. of Col | 146.0 | 39.8 | 124.2 | 18.0 |
| Florida | 32.1 | 27.6 | 11.3 | 10.4 |
| Georgia | 45.5 | 4.8 | 4.8 | 4.8 |
| Idaho | 27.2 | | | |
| Illinois | 327.6 | 146.5 | 192.4 | 145.2 |
| Indiana | 26.8 | 12.0 | 24.0 | 12.0 |
| Iowa | 5.0 | | 5.0 | |
| Kansas | 6.0 | 3.0 | 3.0 | |
| Kentucky | 182.3 | 110.4 | 169.4 | 110.4 |
| Louisiana | 29.5 | 25.8 | 29.5 | 25.8 |
| Maryland | 4.1 | | 4.1 | 1.1 |
| Massachusetts | 27.3 | 21.2 | 27.3 | 21.2 |
| Michigan | 202.2 | | 65.6 | |
| Minnesota | 252.9 | 70.7 | 75.6 | 36.4 |
| Mississippi | 31.7 | 23.5 | 2.3 | 2.3 |
| Missouri | 111.6 | 103.1 | 103.1 | 103.1 |
| Montana | 8.0 | 4.0 | 4.0 | 4.0 |
| New Jersey | 111.4 | 12.1 | 73.7 | 10.2 |
| New Mexico | 3.0 | | 3.0 | |
| New York [2] | 1,617.1 | 999.6 | 662.8 | 445.8 |
| North Carolina | 52.6 | 30.7 | 52.6 | 30.7 |
| Ohio | 1,218.6 | 28.3 | 234.2 | 28.3 |
| Oklahoma | 13.4 | 10.3 | 6.0 | 3.0 |
| Oregon | 196.5 | 4.7 | 3.7 | .2 |
| Pennsylvania | 666.3 | 266.5 | 456.2 | 266.5 |
| Rhode Island | 503.1 | | (3) | |
| South Dakota | 8.2 | 8.2 | 8.2 | 8.2 |
| Tennessee | 16.4 | 1.4 | 16.0 | 1.0 |
| Texas | 49.5 | 45.2 | 40.4 | 39.9 |
| Utah | 64.9 | 64.9 | 64.9 | 64.9 |
| Vermont | 11.3 | 11.3 | 11.3 | 11.3 |
| Virginia | 75.2 | 75.2 | 75.2 | 75.2 |
| Washington [1] | 105.5 | 101.1 | 17.4 | 14.0 |
| West Virginia | 315.8 | 127.3 | 290.3 | 126.0 |
| Wisconsin | 95.9 | 2.2 | 93.7 | |
| Wyoming | 7.0 | | 7.0 | |

[1] Excludes an estimated 350,000 enrollees in those county medical service bureaus in the State of Washington not affiliated with Blue Shield.

[2] Excludes 90,000 employees and an unknown number of dependents in self-insured and partially self-insured employee welfare plans (see text footnote 5).

[3] Less than 500.

that stems from the prepayment relationship, the portion from other services—not necessarily prepaid—that enables plan members to obtain certain services at less than cost, and the portion that should be entirely divorced from the prepayment situation.

Other complicating factors arise when a hospital is operated as an integral part of the plan and is staffed by the same physicians who serve the members in the outpatient clinic. The expenditures reported by such plans for hospital care frequently include the salaries of these staff physicians. Every effort is made in analyzing plan finances to assign expenses for physicians' services to the cost column for physicians' services.

Financial reports received from union health and welfare funds frequently included the sums paid out as death benefits, cash sickness payments, and the like. The income reported by these plans must be adjusted to exclude an amount proportional to the expenditures they have reported for these nonmedical benefits. Administrative expenses of these plans must also be reduced proportionately.

An additional problem is inherent in reporting based on voluntary responses to mailed inquiries—that of nonresponse. The Division of Program Research has developed a variety of alternative sources for information concerning the plans.[5] In many instances, the Division can confirm the fact of a plan's continuing existence even though no direct reply to the questionnaire has been received. If the plan is known to be operating, the enrollment data furnished at an earlier date are sometimes used; the static nature of many of the smaller plans makes this treatment feasible. Since all the large plans provide accurate reports yearly, the amount of error produced by failure to obtain current enrollment figures each year for some of the smaller plans is felt to be negligible.

Earlier articles dealing with the independent plans have included figures on the number of plans furnishing each type of benefit, according to the type of sponsor and various other characteristics—for example, whether benefits were provided through group-practice arrangements. As indicated above, these counts of plans were not entirely meaningful and are therefore of doubtful value. Since enrollment data are of far more significance in observing trends, this year's article omits the tallies of the plans themselves. The number of plans has grown each year, however, with most new plans established by unions.

## *Enrollment*

The number of persons enrolled in the independent plans covered by the survey declined from 9,685,000 in 1954 to 8,944,000 in 1956. There are several reasons for the drop in coverage. The Washington State Physicians' Service, with an enrollment of more than 500,000 in 1954, has become a member of Blue Shield [5a] and is no longer considered an independent medical-society-sponsored plan. Coverage under the United Mine Workers' Welfare and Retirement Fund has fallen by half a million, as employment in the coal industry has declined. Enrollment in the railway hospital associations is also dropping, again due to employment conditions. A diagnostic clinic was operated in 1954 by the United Automobile Workers (CIO) and was credited with an enrollment of 300,000 in the 1954 survey; it has since been closed.[6] These shifts and drops reduced enrollment by almost 1.5 million so that the decline registered in total enrollment of nearly 750,000 from 1954 to 1956 means an actual increase among other plans of more than 750,000.

## *State Distribution*

Members of the independent plans reside in 41 States and in the District of Columbia (table 1). Some members of railway hospital associations may also be living in four other States — Nebraska, Nevada, North Dakota, and South Carolina. In Delaware, Maine, and New Hampshire, apparently no one is enrolled in an independent plan. Three States have more than 1 million persons enrolled. New York has 1.6 million, with more than half of them eligible for benefits through group-practice

[5] In the interval between the mailing of the questionnaire and the preparation of this report, the New York State Insurance Department has established its Welfare Fund Bureau. Preliminary data on a number of self-insured and partially self-insured employee welfare plans in New York State not included in the current survey were obtained from the Welfare Fund Bureau too late to consider in this analysis. Actual benefits paid were merely supplements to other forms of insurance in some of these plans. Future surveys will draw on this source when there has been an opportunity to reconcile its reports with data at hand.

[5a] Late information (not included in enrollment tables) shows an estimated 350,000 persons enrolled in the county medical service bureaus not affiliated with Blue Shield.

[6] A community plan with broad benefits is being developed in Detroit; it will serve automobile workers and others. Several locals of the United Automobile Workers (AFL-CIO) were instrumental in establishing a plan in Ferndale, Mich., in late 1957.

Table 2.—*Enrollees eligible for benefits in group-practice plans and in other independent plans, by type of benefit, December 1956*

| Type of benefit | Number (in thousands) | | | Percent in group-practice plans | Percentage distribution | | |
|---|---|---|---|---|---|---|---|
| | Total | In group-practice plans | In other plans | | Total | In group-practice plans | In other plans |
| Any benefit | 8,944 | 3,430 | 5,514 | 38.3 | 100.0 | 100.0 | 100.0 |
| Nonindustrial | 5,561 | 1,463 | 4,098 | 26.3 | 62.2 | 42.7 | 74.3 |
| Industrial | 3,383 | 1,967 | 1,416 | 58.1 | 37.8 | 57.3 | 25.7 |
| Hospitalization | 6,079 | 2,428 | 3,651 | 39.9 | 68.0 | 73.7 | 66.2 |
| Nonindustrial | 3,013 | 733 | 2,280 | 24.3 | 33.7 | 24.3 | 41.3 |
| Industrial | 3,066 | 1,695 | 1,371 | 55.3 | 34.3 | 49.4 | 24.9 |
| Surgical | 6,906 | 3,177 | 3,729 | 46.0 | 77.2 | 92.6 | 67.6 |
| Nonindustrial | 3,866 | 1,434 | 2,432 | 37.1 | 43.2 | 41.8 | 44.1 |
| Industrial | 3,040 | 1,743 | 1,297 | 57.3 | 34.0 | 50.8 | 23.5 |
| Medical | 6,125 | 3,399 | 2,726 | 55.5 | 68.5 | 99.1 | 49.4 |
| Nonindustrial | 3,184 | 1,457 | 1,727 | 45.8 | 35.6 | 42.5 | 31.3 |
| Industrial | 2,941 | 1,942 | 999 | 66.0 | 32.9 | 56.6 | 18.1 |
| Diagnostic | 5,194 | 3,396 | 1,798 | 65.4 | 58.1 | 99.0 | 32.6 |
| Nonindustrial | 2,447 | 1,456 | 991 | 59.5 | 27.4 | 43.0 | 18.0 |
| Industrial | 2,747 | 1,940 | 807 | 70.6 | 30.7 | 56.0 | 14.6 |
| Dental | 334 | 248 | 86 | 74.3 | 3.7 | 7.2 | 1.6 |
| Nonindustrial | 73 | 65 | 8 | 89.0 | .8 | 1.9 | .2 |
| Industrial | 261 | 183 | 78 | 70.1 | 2.9 | 5.3 | 1.4 |

arrangements. Ohio is second; Medical Mutual of Cleveland, the New York Central Railway Employees' Association, and the United Mine Workers' Fund largely account for its 1.2 million enrollment. Connecticut is third in enrollment; Connecticut Blue Cross, Inc., with more than 1 million members, accounts for nearly all of this number. Despite its name, this plan is not affiliated with the national Blue Cross Commission.

Most of the enrollment in California is found in group-practice plans. The Kaiser Foundation Health Plan has more than 500,000 members, and the Ross-Loos Medical Group, founded in 1929, has more than 130,000. The fact that several railway hospital plans have their headquarters in California adds to the coverage by group-practice plans in this State.

For the country as a whole, industrial plans include 38 percent of the enrollment in all plans and 57 percent of the enrollment in group-practice plans. They are responsible for 50 percent or more of the enrollment in 29 of the 42 jurisdictions. Notable exceptions are California, Connecticut, New York, Ohio, and Rhode Island, where some of the larger plans, already mentioned, are located. With 58 percent of the enrollment in industrial plans eligible for benefits through group-practice arrangements, it follows that in many States (26) 50 percent or more of the enrollment in industrial plans comes under group-practice arrangements. California, Illinois, Kentucky, Missouri, New York, Pennsylvania, and West Virginia lead with respect to enrollments in group-practice industrial plans; each of these States has more than 100,000 enrollees in this type of plan. In Kentucky, Missouri, and Pennsylvania, as well as in several other States with smaller enrollments, industrial plans are the only plans with group-practice arrangements.

**Table 3.—*Subscribers and dependents enrolled in independent plans, by type of benefit, December 1956***

| Type of benefit | Number of subscribers (in thousands) | Dependents | |
|---|---|---|---|
| | | Number (in thousands) | As percent of total eligible for benefit |
| Any benefit | 4,234 | 4,710 | 52.7 |
| Nonindustrial | 2,355 | 3,206 | 57.7 |
| Industrial | 1,879 | 1,504 | 44.4 |
| Hospitalization | 2,961 | 3,118 | 51.3 |
| Nonindustrial | 1,292 | 1,721 | 57.1 |
| Industrial | 1,669 | 1,397 | 45.6 |
| Surgical | 3,301 | 3,605 | 52.2 |
| Nonindustrial | 1,617 | 2,249 | 58.2 |
| Industrial | 1,684 | 1,356 | 44.6 |
| Medical | 3,045 | 3,080 | 50.3 |
| Nonindustrial | 1,309 | 1,875 | 58.9 |
| Industrial | 1,736 | 1,205 | 41.0 |
| Diagnostic | 2,677 | 2,517 | 48.5 |
| Nonindustrial | 1,016 | 1,431 | 58.5 |
| Industrial | 1,661 | 1,086 | 39.6 |
| Dental | 198 | 136 | 40.8 |
| Nonindustrial | 30 | 43 | 58.5 |
| Industrial | 168 | 93 | 35.9 |

## *Benefits Provided*

Table 2 shows the number of persons eligible for any type of benefit and for each of the five kinds of benefits the plans provide. Nearly 9 million different individuals are eligible for at least one or a combination of several types of benefits, but only 6.1 million are enrolled in plans providing hospitalization expense. In all, 6.9 million are eligible for surgical expense, with lesser numbers covered for medical and diagnostic benefits. Only a comparatively small number have prepaid dental care.

Enrollment is higher in nonindustrial plans than in industrial plans, chiefly because of the combined enrollment of 1.6 million persons in community hospitalization plans. More persons are entitled to diagnostic benefits from industrial than from nonindustrial plans.

About 3.4 million persons are enrolled in group-practice plans. Very few of them are in group-practice plans providing dental care exclusively. Plans of the latter type are under industrial sponsorship. Certain union health centers confine their services to diagnosis, without providing treatment—that is, medical care. These two situations account for the fact that less than 100 percent of the enrollment is eligible for medical and diagnostic benefits.

Among the nonindustrial plans, more dependents than subscribers are eligible for hospitalization and for surgical and medical expense benefits, as shown in table 3. Dependents are in the minority, however, among the industrial plans, where they make up 40–46 percent of total enrollment. Particularly in enrollment for medical and diagnostic benefits, subscribers outnumber dependents in the industrial plans. The reason is that dependents are not included in the enrollment of most of the railway hospital plans or in many of the union plans, which are among the main sources for prepaid medical and diagnostic services.

In table 4 the enrollment has been divided to show the proportions eligible for all or for various combinations

**Table 4.—*Enrollees* [1] *in group-practice plans and in other independent plans, by type of benefit provided and by availability of hospitalization, December 1956***

| Type of benefit | Number (in thousands) | | | | Percentage distribution | | | |
|---|---|---|---|---|---|---|---|---|
| | Group-practice plans | | Other plans | | Group-practice plans | | Other plans | |
| | With hospitalization | Without hospitalization | With hospitalization | Without hospitalization | With hospitalization | Without hospitalization | With hospitalization | Without hospitalization |
| Total | 2,435.5 | 994.6 | 3,654.1 | 1,859.9 | 100.0 | 100.0 | 100.0 | 100.0 |
| Surgical, medical, diagnostic, and dental | 224.9 | 58.9 | 49.2 | | 9.2 | 5.9 | 1.3 | |
| Surgical, medical, and diagnostic | 2,179.5 | 692.5 | 1,310.6 | 1,724.2 | 89.5 | 69.6 | 35.9 | 92.7 |
| Surgical, medical, and dental | | | 12.9 | 10.1 | | | .4 | .5 |
| Surgical, diagnostic, and dental | 25.0 | | 5.3 | | 1.0 | | .1 | |
| Surgical and medical | | | 491.6 | 50.8 | | | 13.5 | 2.7 |
| Surgical and diagnostic | | | 6.7 | | | | .2 | |
| Medical and diagnostic | .8 | 242.4 | | 6.1 | (2) | 24.4 | | .3 |
| Surgical | 5.3 | | 128.2 | 47.0 | .2 | | 3.5 | 2.5 |
| Medical | | | 3.7 | 4.2 | | | .1 | .2 |
| Hospitalization only | | | 1,646.0 | | | | 45.0 | |
| Dental only | | .8 | | 17.6 | | .1 | | .9 |

[1] Represents all persons enrolled in plans providing specified benefit; not all enrollees are eligible for all the benefits the plan provides—for example, 19,800 of the total number belonging to plans with hospitalization are not eligible for this benefit.

[2] Less than 0.05 percent.

of the five types of benefit. The enrollment eligible for benefits through group-practice plans has been differentiated from that in other types of plans, and the availability of hospitalization from the plan indicated. About 3.2 million persons are found in group-practice plans that provide combined surgical, medical, and diagnostic benefits, and about three-fourths of them—2.4 million persons—are also eligible for hospitalization benefits from their plan.

Three million persons are provided with combined surgical, medical, and diagnostic benefits in plans that use sources of service other than group-practice arrangements to provide benefits. Generally, when community facilities are used for the diagnostic benefits, the plan has a ceiling on the payment for the benefits, such as $25 or $50 for X-rays and $10–$25 for laboratory and other tests.

## *Plan Sponsorship*

Many of the independent plans confine their membership to a particular employee group, such as the members of a trade union, the employees of a railroad, or the employees of some other public utility or industrial concern. These plans constitute the group classed as "industrial." Other plans are open to the general public. They include the community plans, the medical-society-sponsored plans, and the prepaid private group clinics. Other nonindustrial plans require a more formal membership arrangement—for example, membership in the fraternal or consumer organization sponsoring the plan. Some of the consumer plans are organized as consumer cooperatives. The nonindustrial plans cover more persons than the industrial plans, but the latter afford hospital, diagnostic, and dental benefits to more individuals (table 5).

The 3.7 million persons in the community plans are dispersed among the plans providing hospitalization as the only benefit and the plans providing only surgical and medical benefits. Very few persons in these plans have benefits "across the board." In contrast, nearly the entire enrollment in the consumer plans has hospitalization and surgical benefits from the same plan, and more than half the enrollment has medical and diagnostic benefits. The entire enrollment of 554,000 in the medical-society-sponsored plans is entitled to surgical benefits, and nearly all enrollees are entitled to medical and diagnostic benefits; only three plans sponsored by medical societies include hospitalization. The fraternal plans are notable for the high proportion of their enrollment eligible for surgical benefits. There is more provision for dental benefits in the fraternal plans than in any other type of nonindustrial plan. The private group clinics, almost without exception, provide surgical, medical, and diagnostic benefits, and more than three-fourths of the enrollment in these plans is provided with hospitalization through the plan. No dental benefits are provided by this group of plans.

The combination of hospitalization, surgical, and medical expense is common among the union plans; in addition, a high proportion of their enrollment is also eligible for diagnostic services to some degree. Employee plans almost without exception include hospitalization and surgical expense insurance; only about half their enrollment is eligible for diagnostic benefits. Proportionately, more of the enrollment in employer plans than under other types of sponsorship is furnished with dental benefits.

The lowest section in table 5 shows in which type of independent plan may be found the bulk of the enrollment eligible for a particular benefit. Forty-one percent of the 8.9 million individuals eligible for benefits are found in the community plans. Sixty-four percent of the 6.1 million eligible for hospitalization benefits are found in community or union plans, with about equal num-

Table 5.—*Enrollees in independent plans, by type of sponsor and type of benefit, December 1956*

| Type of sponsor | Any benefit | Hospitalization | Surgical | Medical | Diagnostic | Dental |
|---|---|---|---|---|---|---|
| | Number enrolled for specified benefit (in thousands) | | | | | |
| Total | 8,944 | 6,079 | 6,906 | 6,125 | 5,194 | 334 |
| Nonindustrial plans | 5,561 | 3,013 | 3,866 | 3,184 | 2,447 | 73 |
| Community | 3,651 | 1,934 | 2,026 | 1,560 | 881 | 3 |
| Consumer | 379 | 365 | 371 | 216 | 194 | 7 |
| Medical society | 554 | 38 | 554 | 548 | 526 | ---- |
| Fraternal | 235 | 101 | 199 | 118 | 105 | 63 |
| Private group clinics | 742 | 576 | 716 | 742 | 741 | ---- |
| Industrial plans | 3,383 | 3,066 | 3,040 | 2,941 | 2,747 | 261 |
| Union | 2,215 | 1,972 | 1,944 | 1,822 | 1,833 | 51 |
| Employer-employee | 567 | 512 | 512 | 551 | 534 | 107 |
| Employer | 156 | 145 | 145 | 144 | 142 | 62 |
| Employee | 445 | 437 | 439 | 424 | 238 | 42 |
| | Percent eligible for specified benefit | | | | | |
| Total | 100.0 | 68.0 | 77.2 | 68.5 | 58.1 | 3.7 |
| Nonindustrial plans | 100.0 | 54.2 | 69.5 | 57.3 | 44.0 | 1.3 |
| Community | 100.0 | 53.0 | 55.5 | 42.7 | 24.1 | .1 |
| Consumer | 100.0 | 96.3 | 97.9 | 57.0 | 51.2 | 1.8 |
| Medical society | 100.0 | 6.9 | 100.0 | 98.9 | 94.9 | ---- |
| Fraternal | 100.0 | 43.0 | 84.7 | 50.2 | 44.7 | 26.8 |
| Private group clinics | 100.0 | 77.6 | 96.5 | 100.0 | 99.9 | ---- |
| Industrial plans | 100.0 | 90.6 | 89.9 | 86.9 | 81.2 | 7.7 |
| Union | 100.0 | 89.0 | 87.8 | 82.3 | 82.8 | 2.3 |
| Employer-employee | 100.0 | 90.3 | 90.3 | 97.2 | 94.2 | 18.9 |
| Employer | 100.0 | 92.9 | 92.9 | 92.3 | 91.0 | 39.7 |
| Employee | 100.0 | 98.2 | 98.7 | 95.3 | 53.5 | 9.4 |
| | Percentage distribution | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Nonindustrial plans | 62.2 | 49.6 | 56.0 | 52.0 | 47.1 | 21.9 |
| Community | 40.8 | 31.8 | 29.3 | 25.5 | 17.0 | .9 |
| Consumer | 4.2 | 6.0 | 5.4 | 3.5 | 3.7 | 2.1 |
| Medical society | 6.2 | .6 | 8.0 | 8.9 | 10.1 | ---- |
| Fraternal | 2.6 | 1.7 | 2.9 | 1.9 | 2.0 | 18.9 |
| Private group clinics | 8.3 | 9.5 | 10.4 | 12.1 | 14.3 | ---- |
| Industrial plans | 37.8 | 50.4 | 44.0 | 48.0 | 52.9 | 78.4 |
| Union | 24.8 | 32.4 | 28.1 | 29.7 | 35.3 | 15.3 |
| Employer-employee | 6.3 | 8.4 | 7.4 | 9.0 | 10.3 | 32.0 |
| Employer | 1.7 | 2.4 | 2.1 | 2.4 | 2.7 | 18.6 |
| Employee | 5.1 | 7.2 | 6.4 | 6.9 | 4.6 | 12.6 |

bers in each. More than a third of the 5.2 million persons eligible for diagnostic benefits are enrolled in union plans. The enrollment for dental benefits in employer-employee plans accounts for nearly a third of the total eligible for dental benefits.

## *Group-Practice Plans and Plan Sponsorship*

Because of special interest in the plans providing benefits through group-practice arrangements, these plans have been separately analyzed by the type of benefit and the type of sponsor (table 6). Had the plans providing solely dental benefits through a group-practice dental plan been omitted, nearly 100 percent of the remaining enrollment would have been registered as eligible for medical and diagnostic benefits. Among the employer, employee, and employer-employee plans with group practice, none confines itself to dental benefits; thus their entire enrollment is eligible for the full range of physicians' services and nearly all the enrollment is entitled to hospitalization. Since none of the community or private group clinic plans provides dental benefits exclusively or in combination, practically their entire enrollment is in plans providing medical and diagnostic benefits.

Of more significance is the lowest section of table 6, where the individuals eligible for each type of benefit are shown, according to plan sponsorship. More than a third of those eligible for hospitalization or for surgical, medical, or diagnostic services are found in union-sponsored plans, and more than a fifth are members of private group clinic plans. Community plans rank next (except for hospitalization), with 16–17 percent of the enrollment eligible for surgical, medical care, and diagnostic benefits. The employer-employee plans rank first in the provision of dental benefits.

Table 7.—*Coverage of retired workers and their dependents by independent plans sponsored by unions and by employers and employees, December 1956*

| Provision for retired members | Number of plans | Total number of members | Retired persons and dependents enrolled | |
|---|---|---|---|---|
| | | | Number | As percent of all members |
| Total reporting | 93 | 2,420,750 | 178,315 | [1] 7.4 |
| Plans not covering retirees | 16 | 120,398 | | |
| Plans reporting number of retirees covered | 77 | 2,118,988 | 178,315 | 8.4 |
| Retirees only | 36 | 522,549 | 49,275 | 9.4 |
| Retirees and dependents | 34 | 1,596,439 | 129,040 | 8.1 |
| Plans covering retirees but not reporting the number covered | 7 | 181,364 | | |

[1] Based on reported number of retired persons, as related to all persons in plans replying.

Table 6.—*Enrollees in independent plans providing benefits through group practice, by type of benefit and type of sponsor, December 1956*

| Type of sponsor | Any benefit | Hospitalization | Surgical | Medical | Diagnostic | Dental |
|---|---|---|---|---|---|---|
| | Number enrolled for specified benefit (in thousands) | | | | | |
| Total | 3,430 | 2,428 | 3,177 | 3,399 | 3,396 | 248 |
| Nonindustrial plans | 1,463 | 733 | 1,434 | 1,457 | 1,456 | 65 |
| Community | 530 | 32 | 529 | 530 | 529 | |
| Consumer | 88 | 80 | 86 | 87 | 87 | 8 |
| Fraternal | 103 | 46 | 103 | 98 | 98 | 57 |
| Private group clinics | 742 | 575 | 716 | 742 | 742 | |
| Industrial plans | 1,967 | 1,695 | 1,743 | 1,942 | 1,940 | 183 |
| Union | 1,229 | 1,014 | 1,060 | 1,204 | 1,202 | 29 |
| Employer-employee | 433 | 380 | 378 | 433 | 433 | 68 |
| Employer | 95 | 95 | 95 | 95 | 95 | 45 |
| Employee | 210 | 206 | 210 | 210 | 210 | 41 |
| | Percent eligible for specified benefit | | | | | |
| Total | 100.0 | 70.8 | 92.6 | 99.1 | 99.0 | 7.2 |
| Nonindustrial plans | 100.0 | 50.1 | 98.0 | 99.6 | 99.5 | 4.4 |
| Community | 100.0 | 6.0 | 99.8 | 100.0 | 99.8 | |
| Consumer | 100.0 | 90.9 | 97.7 | 98.9 | 98.9 | 9.1 |
| Fraternal | 100.0 | 44.7 | 100.0 | 95.1 | 95.1 | 55.3 |
| Private group clinics | 100.0 | 77.5 | 96.5 | 100.0 | 100.0 | |
| Industrial plans | 100.0 | 86.2 | 88.6 | 98.7 | 98.6 | 9.3 |
| Union | 100.0 | 82.5 | 86.2 | 98.0 | 97.8 | 2.4 |
| Employer-employee | 100.0 | 87.8 | 87.3 | 100.0 | 100.0 | 15.7 |
| Employer | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 47.4 |
| Employee | 100.0 | 98.1 | 100.0 | 100.0 | 100.0 | 19.5 |
| | Percentage distribution | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Nonindustrial plans | 42.7 | 30.2 | 45.1 | 42.9 | 42.9 | 26.2 |
| Community | 15.5 | 1.3 | 16.7 | 15.6 | 15.6 | |
| Consumer | 2.6 | 3.3 | 2.7 | 2.6 | 2.6 | 3.2 |
| Fraternal | 3.0 | 1.9 | 3.2 | 2.9 | 2.9 | 23.0 |
| Private group clinics | 21.6 | 23.7 | 22.5 | 21.8 | 21.8 | |
| Industrial plans | 57.3 | 69.8 | 54.9 | 57.1 | 57.1 | 73.8 |
| Union | 35.8 | 41.8 | 33.4 | 35.4 | 35.4 | 11.7 |
| Employer-employee | 12.6 | 15.7 | 11.9 | 12.7 | 12.8 | 27.4 |
| Employer | 2.8 | 3.9 | 3.0 | 2.8 | 2.8 | 18.1 |
| Employee | 6.1 | 8.5 | 6.6 | 6.2 | 6.2 | 16.5 |

## *Retired Workers*

A supplementary schedule was sent only to the industrial plans (plans sponsored by employers and/or employees and by union health and welfare plans), asking if the plan covered retired or pensioned workers and their dependents and, if so, how the benefits were financed. If the benefits differed from those available to active workers, the plans were asked to explain the differences.

Ninety-three respondents returned the "retired worker" schedule (table 7). The majority (77) reported that retired workers were included; 38 of the 77 also included dependents of retired workers. The returned schedules came from plans enrolling 2.4 million of the 3.4 million persons covered by industrial plans, or 73

Table 8.—*Sources of financing health insurance benefits for retired workers and their families, 77 independent plans, December 1956*

| Source of financing | Number of plans covering— | | Number of retired persons and dependents enrolled |
|---|---|---|---|
| | Retiree only [1] | Retiree and dependent [2] | |
| Total | 39 | 38 | 178,315 |
| Sponsor only [3] | 11 | 12 | 119,397 |
| Retiree only | 12 | 12 | 15,954 |
| Jointly by sponsor and retiree | 8 | [4] 12 | 19,451 |
| Sponsor and active employees | 6 | [5] 2 | 18,387 |
| Active employees only | 1 | ------- | 5,126 |
| Not reported | 1 | ------- | ([6]) |

[1] Includes 3 plans that could not report the number of retirees eligible for benefits.
[2] Includes 4 plans that could not report the number of retirees and dependents eligible for benefits.
[3] In most instances, the employer.
[4] Includes 3 plans where the sponsor pays for the retiree and the retiree pays for the dependent.
[5] Benefits for retired workers are specifically reported as financed from reserves.
[6] Not available.

percent of the entire enrollment in these plans. There is good reason to believe that the response was better from plans that could report coverage of retired persons than it was from plans whose replies would have been in the negative. Though some retired persons are undoubtedly included among the 961,000 persons in the plans that did not reply, their number is probably small.

In all, more than 178,000 retired persons and their dependents [7] were eligible for benefits from these plans. Eligible persons in pensioner families represented about 8 percent of the entire enrollment in plans covering retired persons, an interesting proportion in that it happens to correspond to the proportion of aged persons in the United States population.

Plans that have been in existence over a long period and that have always included pensioners in their program have a relatively high proportion of their membership among retired persons. The highest proportion was 27 percent, found in two of the large railway hospital plans. A few plans had only recently made retired workers eligible for benefits and as yet had none on the rolls. As time passes, the yearly accretion of retired workers probably will expand the proportion of plan enrollment among older persons. Periodic resurveys of the industrial plans should indicate the potential ratio of retired to active enrollees when more of the plans have "matured" in their coverage of retired workers.

The plans vary in the approach used to finance the retired enrollee's medical and hospital care (table 8). In general, coverage of the retired worker—and of his dependents when they too were included—was financed exclusively by the employer or jointly by the sponsor and the retired worker. Fewer than 20,000 of the retired workers and their dependents were bearing the entire cost of their protection.

Two-thirds of the plans did not reduce benefits after retirement, and only in a few instances did the same benefits cost the retiree more than they had cost him when he was working. In some plans the cost was actually less than before retirement. When the employer financed the plan exclusively, both before and after retirement, the cost to the employee, of course, remained at zero.

In the group of plans reducing benefits after retirement, the cost to the employee was, with four exceptions, either the same or less than before retirement. One plan covered workers for only 1 year after retirement.

No information was requested about older members of the nonindustrial plans, since these plans are usually unable to report the age of their members without undertaking special compilations. Since there is a need for more detailed data on the extent to which the aged have health insurance protection, it is hoped that the community, consumer, and other nonindustrial plans will consider undertaking such special tabulations to determine the age distribution of their membership.

## *Finances*

Two characteristics of the independent plans contribute to the fact that their income and expenditures differ from the general pattern found in health insurance. In the health insurance field as a whole, two-thirds

Table 9.—*Income and expenditures for medical care among independent plans, by type of expenditure and type of sponsor, 1956*

| Type of sponsor | Earned income | | | Benefit expenditures | | |
|---|---|---|---|---|---|---|
| | Total | For hospital services | For physicians' services | Total | For hospital services | For physicians' services |
| | Amount (in millions) | | | | | |
| Total | $289.9 | $145.3 | $144.6 | $253.9 | $128.4 | $125.5 |
| Nonindustrial plans | 136.9 | 63.7 | 73.2 | 122.0 | 56.1 | 65.9 |
| Community | 75.4 | 40.4 | 35.0 | 64.3 | 35.1 | 29.2 |
| Consumer | 11.1 | 6.2 | 4.9 | 9.0 | 4.8 | 4.2 |
| Medical society [1] | 16.3 | 3.8 | 12.5 | 14.2 | 3.3 | 10.9 |
| Fraternal | 2.1 | 1.2 | .9 | 2.1 | 1.2 | .9 |
| Private group clinics | 32.0 | 12.1 | 19.9 | 32.4 | 11.7 | 20.7 |
| Industrial plans | 153.0 | 81.6 | 71.4 | 131.9 | 72.3 | 59.6 |
| Unions | 92.3 | 46.1 | 46.2 | 73.4 | 37.4 | 36.0 |
| Employer-employee | 30.2 | 17.5 | 12.7 | 30.2 | 17.9 | 12.3 |
| Employer | 7.0 | 2.6 | 4.4 | 7.0 | 2.5 | 4.5 |
| Employee | 23.5 | 15.4 | 8.1 | 21.3 | 14.5 | 6.8 |
| | Percentage distribution | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Nonindustrial plans | 47.2 | 43.8 | 50.6 | 48.0 | 43.7 | 52.5 |
| Community | 26.0 | 27.8 | 24.2 | 25.3 | 27.4 | 23.3 |
| Consumer | 3.8 | 4.3 | 3.4 | 3.5 | 3.7 | 3.3 |
| Medical society | 5.6 | 2.6 | 8.6 | 5.6 | 2.6 | 8.7 |
| Fraternal | .7 | .8 | .6 | .8 | .9 | .7 |
| Private group clinics | 11.0 | 8.3 | 13.8 | 12.8 | 9.1 | 16.5 |
| Industrial plans | 52.8 | 56.2 | 49.4 | 52.0 | 56.3 | 47.5 |
| Unions | 31.8 | 31.8 | 32.0 | 28.9 | 29.2 | 28.7 |
| Employer-employee | 10.4 | 12.0 | 8.8 | 11.9 | 13.9 | 9.8 |
| Employer | 2.5 | 1.8 | 3.0 | 2.8 | 1.9 | 3.6 |
| Employee | 8.1 | 10.6 | 5.6 | 8.4 | 11.3 | 5.4 |

[1] Includes estimates for those county medical service bureaus in the State of Washington not affiliated with Blue Shield.

[7] Two plans reported that they included widows and their dependents; others may also include them but did not volunteer this information since it was not specifically requested.

of income and expenditures relate to hospitalization. Among the independent plans, only about half their income and expenditures relate to hospitalization. One reason for the difference is the broader scope of the medical benefits provided by the independent plans. A second reason is the fact that a number of these plans supplement the hospital, surgical, and in-hospital medical benefits of the other forms of insurance with benefits that are available outside the hospital. Outpatient services can account for as great or greater expenditures per capita than limited surgical and in-hospital medical benefits. Plans with a full range of services, such as Group Health Association of Washington, D. C., and the Labor Health Institute, may assign nearly 70 percent of their prepayment expenditures to medical services and only about 30 percent to hospitalization.

As shown in table 9, the independent plans received somewhat less than $300 million in income in 1956, an amount equal to about 8 percent of the entire amount of $3.6 billion going into voluntary health insurance in that year.[8] Income for hospitalization among these plans amounted to $145 million, 6 percent of the $2.4 billion going toward hospitalization through all forms of voluntary insurance. The $145 million received by independent plans for physicians' services was equivalent to 11 percent of the $1.3 billion spent for prepaid protection against the costs of physicians' services.

The industrial plans are responsible for more than half the aggregate income and expenditures for benefits among the independent plans. The union plans supply 32 percent of aggregate income and make 30 percent of aggregate expenditures for benefits. Community plans receive two-thirds of the income of the nonindustrial plans and spend a like proportion for benefits.

On the other side of the ledger, the independent plans spent about $254 million on benefits—$128 million for hospitalization and $126 million for benefits for physicians' and dentists' services. These expenditures were equivalent to 6 percent of the $2.0 billion used for all prepaid hospital benefits and 12 percent of the $1.0 billion spent for all prepaid benefits for physicians' services in 1956. As a group, the plans use 87 percent of income for benefits. The proportion varies with the different sponsors.

## *Growth in Income and Expenditures, 1949–56*

In spite of the decreases in enrollment noted earlier, there was a substantial increase in income and a corresponding increase in expenditures for benefits in the 3 years 1953–56 (table 10). During this 3-year period, expenditures for physicians' services increased more rapidly than expenditures for hospitalization. Since 1949, there has been a threefold increase in the amounts received and spent by the independent plans; the expansion was greater in the area of hospitalization than in the area of physicians' services.

These evidences of growth are significant, but the picture is considerably clouded by (1) the rising cost of medical care, particularly hospital care, (2) the addition and subtraction of plans as their affiliation with the Blue Cross and Blue Shield Commissions has changed from year to year, and (3) the development of the United Mine Workers Welfare and Retirement Fund and the changes in its impact on the total independent plan picture caused by reductions in its coverage. The community plans, the private group clinic plans, and the union plans have registered significant growth in the past 7 years. Consumer and fraternal plans, though only a small part of the total, have doubled their expenditures, but much of the expansion—like that in the employer plans—is attributable to rising costs of medical care rather than to increases in enrollment.

Table 10.—*Expenditures for benefits among independent plans, 1949, 1953, and 1956*

[In millions]

| Expenditures and type of sponsor | 1949 | 1953 | 1956 |
|---|---|---|---|
| Total expenditures | $75.6 | $200.9 | $253.9 |
| For hospitalization | 31.2 | 111.7 | 128.4 |
| For medical care | 44.4 | 89.2 | 125.5 |
| In plans sponsored by— | | | |
| Community | 10.3 | 48.0 | 64.3 |
| Consumer [1] | 4.8 | 7.7 | 11.1 |
| Medical society | 12.0 | 11.1 | 14.2 |
| Private group clinic | 8.8 | 16.5 | 32.4 |
| Union | 4.4 | 70.1 | 73.4 |
| Employer-employee | 12.6 | 24.4 | 30.2 |
| Employer | 4.4 | 4.4 | 7.0 |
| Employee | 18.3 | 18.7 | 21.3 |

[1] Includes fraternal plans.

FROM THE VANTAGE point of 1956, trends in enrollment and in income during the past 7 years indicate that the independent plans have shown a capacity for growth at least equal to that in other forms of voluntary health insurance. In the area of outpatient benefits and dental care, the independent plans have continued to set the pace.

[8] "Voluntary Health Insurance and Medical Care Costs, 1948-56," *Social Security Bulletin*, December 1957.