Independent Plans Providing Medical Care and Hospital Insurance: 1959 Survey*

THE DIVISION of Program Research of the Social Security Administration has been collecting information for nearly 20 years about a group of prepaid medical care and hospital plans usually referred to as "the independent plans." The designation of these plans as "independent" has been used for at least 10 years in the absence of a better short descriptive word. The essential feature of the plans is that they are not underwritten by insurance companies or affiliated with the Blue Cross or Blue Shield associations. Their one common trait is that they have not jointly associated in any larger organization to which they regularly make statistical reports. Hence their status as "independent plans."

Periodically the Division surveys this group of nearly 300 plans, mainly through a mailed questionnaire supplemented by information from such other sources as the Welfare Fund Bureau of the New York State Insurance Department and the new Division of Welfare and Pension Reports in the Bureau of Labor Standards of the U.S. Department of Labor. A few plans report their financial operations to State insurance departments. As a result, their income and expenditures (but not their enrollment) appear in national compilations, where they are usually referred to as "other hospital and medical plans" to distinguish them from the three major categories: plans underwritten by insurance companies, Blue Cross plans, and Blue Shield plans.[1]

ENROLLMENT

The number of persons enrolled in the independent plans was slightly less than 10 million in 1959 (table 1), nearly 1 million more than the total reported at the end of 1956. Forty percent were in plans directly connected with employment, with the benefits sponsored by unions, employers or employees, or jointly by labor and management. The other 60 percent were found in community-sponsored or physician-sponsored

TABLE 1.—Enrollees eligible for one or more benefits in independent plans, by State, December 1959

[In thousands]

State	All types of sponsorship		Industrial sponsorship	
	Total	Group-practice plans	Total	Group-practice plans
United States	9,876.2	3,929.2	3,831.7	2,227.4
Alabama	112.4	86.9	112.4	86.9
Alaska				
Arizona				
Arkansas	31.3	28.8	31.3	28.8
California	1,027.6	983.0	185.3	149.6
Colorado	63.7	27.0	38.5	27.0
Connecticut	1,213.8	.4	.4	.4
Delaware				
District of Columbia	249.2	69.1	215.6	35.4
Florida	26.4	25.6	13.5	12.7
Georgia	34.9	3.9	4.1	3.9
Hawaii	21.7	21.7		
Idaho	33.6			
Illinois	264.3	112.8	192.9	111.6
Indiana	24.0	12.0	24.0	12.0
Iowa	5.0	2.5	5.0	2.5
Kansas	38.5	37.0	37.0	35.5
Kentucky	159.7	80.2	159.7	80.2
Louisiana	31.3	26.4	31.3	26.4
Maine				
Maryland	34.3	32.8	19.3	17.8
Massachusetts	26.0	22.7	26.0	22.7
Michigan	147.6	.8	3.8	
Minnesota	98.2	57.0	70.5	29.3
Mississippi	27.8	16.5	2.0	2.0
Missouri	112.7	89.5	105.9	89.5
Montana	8.0	4.0	8.0	4.0
Nebraska				
Nevada				
New Hampshire				
New Jersey	98.6	1.1	65.6	1.1
New Mexico	3.0	1.5	3.0	1.5
New York	2,261.3	1,203.4	1,018.1	599.3
North Carolina	34.5	17.8	34.5	17.8
North Dakota				
Ohio	1,399.3	183.5	329.7	183.5
Oklahoma	14.0	11.0	6.0	3.0
Oregon	295.3	40.9	2.9	.1
Pennsylvania	673.7	311.6	455.5	309.5
Rhode Island	560.2		.4	
South Carolina				
South Dakota	7.6	7.6	7.6	7.6
Tennessee	16.3	8.0	16.3	8.0
Texas	46.6	43.3	41.2	40.6
Utah	63.4	57.9	63.4	57.9
Vermont	13.4	12.8	13.4	12.8
Virginia	70.7	49.7	68.7	47.7
Washington	93.2	90.3	14.6	11.8
West Virginia	319.9	143.5	292.4	143.5
Wisconsin	106.0	1.1	104.9	
Wyoming	7.0	3.5	7.0	3.5

* Prepared in the Division of Program Research, Office of the Commissioner, by Agnes W. Brewster, who is now on the staff of the Public Health Service.

[1] See Agnes W. Brewster, "Voluntary Health Insurance and Private Medical Care Expenditures, 1948–59," *Social Security Bulletin*, December 1960.

plans available to the public generally or in plans run by consumer groups or fraternal societies.

Two in 5 members of the plans received benefits through group-practice arrangements. Among the plans under industrial sponsorship, more than half the enrollment (2.2 million) had some or all benefits provided through the group practice of medicine or dentistry. Since 1956—the year of the last survey of the independent plans—growth in group-practice plans has been slightly larger numerically and considerably larger relatively than that in plans not using group-practice arrangements. Enrollment in group-practice plans expanded by about 500,000 or 15 percent compared with 433,000 or 8 percent for the remaining plans.

STATE DISTRIBUTION

Members of the independent plans are found in 41 of the 50 States and in the District of Columbia. Some members of railway hospital associations may also be found in five other States—Arizona, Nebraska, Nevada, North Dakota, and South Carolina—since certain railroads whose employees belong to a railway hospital plan have rights-of-way that pass through these States. Organizations such as the Rural Letter Carriers Hospital Plan probably have members in every State. Group-practice prepayment plan headquarters are located in 39 States, and there are branch centers in several other States.

Four States, each with more than 1 million persons enrolled, account for more than half the enrollment in independent plans. In two of them—California and New York—the enrollment in group-practice prepayment plans exceeds that in other independent plans and, in addition, represents more than half the national enrollment in prepaid group-practice plans. The Kaiser Health Plan in California and the Health Insurance Plan of Greater New York, each with more than 500,000 members in 1959, are responsible for this concentration in two States.

Connecticut's inclusion among the States with more than a million members results from the large enrollment in the Connecticut Blue Cross Plan—a hospitalization plan that, despite its name, is not an affiliate of the Blue Cross Association. Ohio's enrollment of more than a million stems mainly from the enrollment in Medical Mutual of Cleveland, a plan resembling the typical Blue Shield plan except that it is under community sponsorship rather than medical-society sponsorship.

In 22 States all the enrollment in group-practice plans is derived from the industry-oriented plans.

BENEFITS PROVIDED

The benefits provided by the plans range from very limited to almost complete coverage of medical care. Some plans provide both medical and hospital benefits, others either one or the other. Relatively few plans provide dental benefits that

TABLE 2.—Enrollees eligible for benefits in group-practice plans and in other independent plans, by type of benefit, December 1959

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	9,876.2	3,929.2	5,947.0	39.8	100.0	100.0	100.0
Nonindustrial	6,038.6	1,701.8	4,336.8	28.2	61.1	43.3	72.9
Industrial	3,837.6	2,227.4	1,610.2	58.0	38.9	56.7	27.1
Hospitalization	6,085.6	2,525.7	3,559.9	41.5	61.6	64.3	59.9
Nonindustrial	2,932.3	906.0	2,026.3	30.9	29.7	23.1	34.1
Industrial	3,153.3	1,619.7	1,533.6	51.4	31.9	41.2	25.8
Surgical	7,494.5	3,279.9	4,214.6	43.8	75.9	83.5	70.9
Nonindustrial	4,356.3	1,620.5	2,735.8	37.2	44.1	41.2	46.0
Industrial	3,138.2	1,659.4	1,478.8	52.9	31.8	42.2	24.9
Medical	6,786.0	3,399.9	3,386.1	50.1	68.7	86.5	56.9
Nonindustrial	3,984.7	1,640.1	2,344.6	41.2	40.3	41.7	39.4
Industrial	2,801.3	1,759.8	1,041.5	62.8	28.4	44.8	17.5
Diagnostic	5,701.7	3,694.9	2,006.8	64.8	57.7	94.0	33.7
Nonindustrial	2,595.8	1,673.5	922.3	64.5	26.3	42.6	15.5
Industrial	3,105.9	2,021.4	1,084.5	65.1	31.4	51.4	18.2
Dental	500.4	317.7	182.7	63.5	5.1	8.1	3.1
Nonindustrial	58.9	36.4	22.5	61.8	.6	.9	.4
Industrial	441.5	281.3	160.2	63.7	4.5	7.2	2.7

go beyond paying for inhospital oral surgery (not treated as a separate dental benefit in this study).

Table 2 groups the 9.9 million persons eligible for one or more types of benefit according to their eligibility for each type and indicates the numbers enrolled in nonindustrial and in industrial plans. Three out of 5 members of these plans (6 million persons) may obtain hospitalization through the plans. The proportion is somewhat less than that 3 years earlier, but the number is about the same. Surgical coverage, available to 76 percent of the enrollees in these plans, increased 580,000 in the 3 years.[2]

Medical benefits, as distinct from surgical benefits, are available to two-thirds of the nearly 10 million members of the independent plans, a higher ratio than among insurance company policyholders or members of Blue Cross-Blue Shield plans. In addition, a larger proportion of the 6.8 million persons with coverage for the costs of physicians' nonsurgical services are entitled to services outside a hospital. Half of those eligible for medical benefits secure their medical care through group-practice plans, all providing care in the office and many care in the patient's home. The industrial plans lead in using organized groups of doctors for the provision of medical benefits.

In the past 3 years enrollment among independent plans for medical benefits has increased 11 percent—1 percent more than the increase in enrollment for any type of benefit. A corresponding growth has occurred in the enrollment eligible for diagnostic benefits. In 1959 a total of 5.7 million persons could look to the independent plans for such prepaid services as laboratory tests, X-rays, and basal metabolism and electrocardiograph tests.[3]

Half a million persons had dental benefits through membership in the independent plans. Nearly two-thirds of the dental-plan enrollment is found in prepaid group-practice dental plans; 88 percent of those eligible for dental care are members of industrial plans. Since 1954, enrollment for dental benefits has risen sharply; the growth has been among plans relying on other than group-practice arrangements.

Enrollment of primary members and dependents is summarized in table 3. In nonindustrial plans, dependents outnumber subscribers, particularly among enrollees eligible for diagnostic benefits. Though dependents are still in a minority among the industrial plans, their proportion has increased slightly since 1956 and decidedly since 1949. Dental benefits are extended to proportionately fewer dependents than other types of services.

TABLE 3.—Subscribers and dependents enrolled in independent plans, by type of benefit, December 1959

Type of benefit	Number of subscribers (in thousands)	Dependents	
		Number (in thousands)	As percent of total eligible for benefits
Any benefit	4,551.8	5,324.4	53.9
Nonindustrial	2,519.9	3,518.6	58.3
Industrial	2,031.9	1,805.8	47.1
Hospitalization	2,925.9	3,159.7	51.9
Nonindustrial	1,273.6	1,658.7	56.6
Industrial	1,652.3	1,501.0	47.6
Surgical	3,449.1	4,045.4	54.0
Nonindustrial	1,792.7	2,563.6	58.8
Industrial	1,656.4	1,481.8	47.2
Medical	3,260.3	3,525.7	52.0
Nonindustrial	1,620.9	2,363.8	59.3
Industrial	1,639.4	1,161.9	41.5
Diagnostic	2,719.3	2,982.4	52.3
Nonindustrial	1,012.4	1,583.4	61.0
Industrial	1,706.9	1,399.0	45.0
Dental	296.9	203.5	40.7
Nonindustrial	33.4	25.5	43.3
Industrial	263.5	178.0	40.3

Some plans provide hospitalization, medical, surgical, diagnostic, and dental benefits, as well as other types of prepaid medical goods and services (prescriptions, nursing-home care, home nursing, physiotherapy, and the like). Others provide only one or two of the five main benefits.

Table 4 shows the extent of enrollment eligible for the full range of the five main benefits and for various combinations, separately for the group-practice plans and the other plans. More than a third—3.5 million—of the enrollees are eligible for surgical, medical, and diagnostic benefits, plus hospitalization. An additional 2.5 million are enrolled for these medical benefits but not for hospitalization. The Health Insurance Plan of Greater New York is the largest and most

[2] Enrollment in the independent plans of the nonindustrial type may register a decline in 1960 because the Rhode Island Physicians' Service, with 500,000 enrolled for surgical and medical services, has become a Blue Shield affiliate.

[3] For a detailed description of the availability of the diagnostic and other special services in group-practice plans, see Agnes W. Brewster, "Group-Practice Prepayment Plans: 1954 Survey," *Social Security Bulletin*, June 1956.

widely known of the group-practice plans not providing hospitalization benefits. Members of this plan carry hospitalization insurance either through Blue Cross or an insurance company policy.

When diagnostic benefits are provided under other than group-practice plans, the usual practice is to indemnify the enrollees for at least a part of the costs of X-rays, electrocardiographs, basal metabolism readings, laboratory work, and so forth. The amount of reimbursement is usually specified or subject to a ceiling.

PLAN SPONSORSHIP

Many independent plans confine their membership to a particular employee group—the members of a trade union, for example, or the employees of a railroad or some other public utility. Some of the nonindustrial plans also operate through a formal relationship, such as membership in the sponsoring fraternal society or the consumer organization operating the plan. The community plans, on the other hand, are open to most persons in an area, in much the same manner as a local Blue Cross plan.

The majority of those enrolled in the independent plans, especially for hospital, diagnostic, or dental benefits, are in plans developed with consumer backing, either community plans or union plans (table 5). In the future, when enrollment in the Rhode Island Physicians' Service is counted

TABLE 5.—Enrollees in independent plans, by type of sponsor and type of benefit, December 1959

Type of sponsor	Any benefit	Hospitalization	Surgical	Medical	Diagnostic	Dental
	Number enrolled for specified benefit (in thousands)					
Total	9,876.2	6,085.6	7,494.5	6,786.0	5,701.7	500.4
Nonindustrial plans	6,038.6	2,932.3	4,356.3	3,984.7	2,595.8	58.9
Community	4,201.8	1,957.7	2,609.4	2,264.7	1,456.4	37.6
Consumer	137.7	126.1	130.9	127.3	127.3	10.9
Medical society	618.4	42.3	618.4	617.8	41.7	----
Fraternal	141.4	72.0	113.8	70.4	32.6	5.8
Private group clinics	939.3	734.2	883.9	904.4	937.8	4.6
Industrial plans	3,837.6	3,153.3	3,138.2	2,801.3	3,105.9	441.5
Union	2,832.8	2,274.0	2,207.9	1,909.6	2,228.4	223.3
Employer-employee	509.4	429.1	448.9	489.5	486.6	141.5
Employer	123.8	83.9	118.9	120.7	115.8	49.4
Employee	371.7	366.3	362.6	281.5	275.1	27.3
	Percent eligible for specified benefit					
Total	100.0	61.6	75.9	68.7	57.7	5.1
Nonindustrial plans	100.0	48.6	72.1	66.0	43.0	1.0
Community	100.0	46.6	62.1	53.9	34.7	.9
Consumer	100.0	91.6	95.1	92.4	92.4	7.9
Medical society	100.0	6.8	100.0	99.9	6.7	----
Fraternal	100.0	50.9	80.5	49.8	23.1	4.1
Private group clinics	100.0	78.2	94.1	96.3	99.8	.5
Industrial plans	100.0	82.2	81.8	73.0	80.9	11.5
Union	100.0	80.3	77.9	67.4	78.7	7.9
Employer-employee	100.0	84.2	88.1	96.1	95.5	27.8
Employer	100.0	67.8	96.0	97.5	93.5	39.9
Employee	100.0	98.5	97.6	75.7	74.0	7.3
	Percentage distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Nonindustrial plans	61.1	48.2	58.1	58.7	45.5	11.8
Community	42.5	32.2	34.8	33.4	25.5	7.5
Consumer	1.4	2.1	1.7	1.9	2.2	2.2
Medical society	6.3	.7	8.3	9.1	.7	----
Fraternal	1.4	1.2	1.5	1.0	.6	1.2
Private group clinics	9.5	12.1	11.8	13.3	16.4	.9
Industrial plans	38.9	51.8	41.9	41.3	54.5	88.2
Union	28.7	37.4	29.5	28.1	39.1	44.6
Employer-employee	5.2	7.1	6.0	7.2	8.5	28.3
Employer	1.3	1.4	1.6	1.8	2.0	9.9
Employee	3.8	6.0	4.8	4.1	4.8	5.5

TABLE 4.—Enrollees in group-practice plans and in other independent plans, by type of benefit provided and by availablity of hospitalization, December 1959

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	2,571.5	1,357.7	3,559.9	2,387.1	100.0	100.0	100.0	100.0
Surgical, medical, diagnostic, and dental	243.3	40.5	160.4	----	9.5	3.0	4.5	----
Surgical, medical, and diagnostic	2,231.6	828.1	1,283.5	1,671.8	86.8	61.0	36.1	70.0
Surgical and medical	18.8	15.6	191.2	616.7	.7	1.1	5.4	25.8
Surgical, diagnostic, and dental	34.4	----	----	----	1.3	----	----	----
Surgical and diagnostic	36.0	----	34.6	----	1.4	----	1.0	----
Surgical and dental	----	----	14.6	----	----	----	.4	----
Medical, diagnostic, and dental	----	15.9	----	----	----	1.2	----	----
Medical and diagnostic	.6	156.2	1.7	24.2	(1)	11.5	(1)	1.0
Surgical	6.8	----	316.2	36.2	.3	----	8.9	1.5
Diagnostic	----	244.3	8.8	1.7	----	18.0	.2	.1
Hospitalization only	----	----	1,548.9	----	----	----	43.5	----
Dental only	----	57.1	----	36.4	----	4.2	----	1.5

[1] Less than 0.05 percent.

with Blue Shield, consumer-oriented membership will probably be predominant in relation to all five types of benefit.

Patterns of benefits tend to vary according to plan sponsorship even more than is evident from the data in table 5. Among community plans—few of which furnish more than one or two benefits—the distinction between plans providing only hospitalization and those providing only surgical-medical benefits is pronounced. Fraternal plans tend to focus on surgical benefits, and there is more extensive coverage of dental benefits by employee-benefit plans. The concentration of coverage for diagnostic benefits among union and community plans is clear from the enrollment data in table 5.

Group-Practice Plans

Plans using group practice for some or all of their benefits are separately analyzed in terms of plan sponsorship in table 6. (Plans sponsored by medical societies are not shown because they are all on a fee-for-service basis.) Of the 617,000 enrollees in group-practice plans available on a community basis, 560,000 do not have hospital benefits through the plan and 37,000 have hospitalization as well as surgical, medical, and diagnostic benefits. Almost all the 21,000 persons eligible for dental benefits have dental care as their only prepaid benefit from an independent plan.

More than 90 percent of the total enrollment in consumer-sponsored, group-practice plans is eligible for hospitalization benefits from the plan. This proportion is higher than that among private group clinic plans. Almost all the employee plans provide hospitalization benefits.

Union plans, private group clinics, and community plans, ranked in that order, together account for 80 percent of the enrollment eligible for at least one benefit through the group-practice mechanism. Dental benefits are almost entirely confined to industrial-plan enrollment, as shown in the third section of table 6.

TABLE 6.—Enrollees in independent plans providing benefits through group practice, by type of benefit and type of sponsor, December 1959

Type of sponsor	Any benefit	Hospitalization	Surgical	Medical	Diagnostic	Dental
	Number enrolled for specified benefit (in thousands)					
Total	3,929.2	2,525.7	3,279.9	3,399.9	3,694.9	317.7
Nonindustrial plans	1,701.8	906.0	1,620.5	1,640.1	1,673.5	36.4
Community	617.2	36.6	597.1	597.1	597.1	20.9
Consumer	108.7	98.6	102.9	108.7	108.7	8.0
Fraternal	36.6	36.6	36.6	29.8	29.8	3.0
Private group clinics	939.3	734.2	883.9	904.4	937.8	4.6
Industrial plans	2,227.4	1,619.7	1,659.4	1,759.8	2,021.4	281.3
Union	1,603.5	1,093.5	1,095.5	1,145.3	1,406.9	114.1
Employer-employee	373.1	313.9	316.6	363.7	363.7	110.1
Employer	66.8	31.8	66.8	66.8	66.8	47.1
Employee	184.0	180.5	180.5	184.0	184.0	10.0
	Percent eligible for specified benefit					
Total	100.0	64.3	83.5	86.5	94.0	8.1
Nonindustrial plans	100.0	53.2	95.2	96.4	98.3	2.1
Community	100.0	5.9	96.7	96.7	96.7	3.4
Consumer	100.0	90.7	94.7	100.0	100.0	7.4
Fraternal	100.0	100.0	100.0	81.4	81.4	8.2
Private group clinics	100.0	78.2	94.1	96.3	99.8	.5
Industrial plans	100.0	72.7	74.5	79.0	90.8	12.6
Union	100.0	68.2	68.3	71.4	87.7	7.1
Employer-employee	100.0	84.1	84.9	97.5	97.5	29.5
Employer	100.0	47.6	100.0	100.0	100.0	70.5
Employee	100.0	98.1	98.1	100.0	100.0	5.4
	Percentage distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Nonindustrial plans	43.3	35.9	49.4	48.2	45.3	11.5
Community	15.7	1.4	18.2	17.6	16.2	6.6
Consumer	2.8	3.9	3.1	3.2	2.9	2.5
Fraternal	.9	1.4	1.1	.9	.8	.9
Private group clinics	23.9	29.1	26.9	26.6	25.4	1.4
Industrial plans	56.7	64.1	50.6	51.8	54.7	88.5
Union	40.8	43.3	33.4	33.7	38.1	35.9
Employer-employee	9.5	12.4	9.7	10.7	9.8	34.7
Employer	1.7	1.3	2.0	2.0	1.8	14.8
Employee	4.7	7.1	5.5	5.4	5.0	3.1

INCOME AND EXPENDITURES FOR BENEFITS

The data in table 7 cover slightly less than 100 percent of the medical dollars channeled through the independent plans in 1959. The various sources of funds and the bookkeeping methods of a number of the group-practice plans present certain problems in any attempt to adhere to the concept of earned income and thus to come up with income data analogous to those of the insurance companies, Blue Cross plans, and Blue Shield plans, whose operations involve only cash and not direct services.

In addition to premiums or dues, almost all the independent group-practice plans make small charges for some of the services provided. These charges may relate to a relatively minor item, like a home call at night, or to a more significant item, such as each visit to the clinic; or the benefit structure may call for payment of part of the charges for hospital care. Such charges are a form of coinsurance but, unlike the coinsurance

or deductible features of other forms of health insurance, they are usually in the form of money actually received by the plan and so are shown in its accounts as income from patients. To omit them would understate the dollar volume of medical care provided by the group-practice plans, and they are therefore included as income.

A few of the plans, however, receive additional income from nonmembers for services provided in the plan's hospital and/or by its medical staff. These charges to outsiders are sometimes so important as a source of revenue that without them the plan could not continue to serve the prepaid members at the premiums being charged. This form of plan income—whenever it was reported—has been omitted from the data in table 7 in order to confine income and expenditures to the prepaid segment of the patient load.

A few fraternal plans augment their income from dues with money-raising social activities among their members, such as the fiestas of the Spanish-speaking fraternal organizations in Florida. Though this income should perhaps conceptually be included as derived from members, it has been omitted, along with income from investments, coke machines, hospital gift shops, and the like. In relation to total earned income (as defined), the volume of such revenues is small.

A few employee plans, again those with their own medical facilities, provide the employee members with prepaid care but offer care—particularly hospital care—at a discount to dependents. The financial data do not permit a determination of the value of the discounted services. Since this practice occurs only among membership organizations, and the membership ultimately finances the costs of the services, any increase in costs reverting to the member from the provision of services below cost to his nonmember dependents is reflected in his subscription charges. In such instances, per capita expense would be somewhat inflated since dependents are not included in enrollment aggregates.

To the extent possible the financial data submitted by the plans were confined to income from premiums (subscription charges or dues) and to those additional charges paid by members for services not covered by prepayment. The prob-

TABLE 7.—Income and expenditures for medical care among independent plans, by type of expenditures and type of sponsor, 1959

Type of sponsor	Earned income									Benefit expenditures								
	All			For hospital services			For physicians' services			All			For hospital services			For physicians' services		
	Total	Group practice	Other	Total	Group practice	Other	Total	Group practice	Other	Total	Group practice	Other	Total	Group practice	Other	Total	Group practice	Other
	Amount (in millions)																	
Total	$336.8	$180.8	$156.0	$153.7	$64.4	$89.4	$183.1	$116.4	$66.7	$318.3	$175.3	$143.0	$147.4	$64.2	$83.2	$170.9	$111.1	$59.8
Nonindustrial plans	168.2	79.2	89.0	69.1	20.0	49.1	99.1	59.3	39.9	155.1	75.2	79.8	64.6	19.4	45.2	90.5	55.9	34.6
Community	99.4	21.8	77.6	47.9	.5	47.4	51.5	21.3	30.2	88.5	19.4	69.2	44.3	.5	43.8	44.3	18.9	25.4
Consumer	5.5	4.8	.7	1.6	1.3	.3	3.8	3.5	.3	5.1	4.5	.6	1.6	1.2	.3	3.6	3.3	.3
Medical society	9.4	-------	9.4	.9	-------	.9	8.5	-------	8.5	9.0	-------	9.0	.8	-------	.8	8.2	-------	8.2
Fraternal	2.4	1.1	1.3	1.1	.6	.5	1.3	.4	.8	2.3	1.1	1.1	1.1	.7	.4	1.1	.5	.7
Private group clinics	51.5	51.6	------	17.6	17.6	------	34.0	34.0	------	50.2	50.2	------	17.0	17.0	------	33.2	33.2	------
Industrial plans	168.6	101.6	67.0	84.6	44.4	40.2	84.0	57.1	26.8	163.3	100.1	63.2	82.8	44.8	38.0	80.4	55.2	25.2
Union	106.4	56.5	49.9	55.9	24.9	31.0	50.5	31.7	18.9	101.8	54.2	47.7	54.6	24.8	29.8	47.2	29.3	17.9
Employer-employee	33.8	26.8	6.9	13.0	10.0	3.0	20.8	16.8	3.9	34.2	27.7	6.5	13.1	10.3	2.8	21.1	17.4	3.7
Employer	5.3	2.7	2.6	1.7	.4	1.3	3.6	2.3	1.4	5.2	2.7	2.5	1.6	.4	1.2	3.6	2.2	1.3
Employee	23.0	15.5	7.5	14.0	9.1	4.9	9.0	6.4	2.6	22.1	15.5	6.5	13.5	9.3	4.2	8.5	6.2	2.3
	Percentage distribution																	
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	100.0	100.0
Nonindustrial plans	49.9	43.8	57.1	45.0	31.1	54.9	54.1	50.9	59.8	48.7	42.9	55.8	43.8	30.2	54.3	53.0	50.3	57.9
Community	29.5	12.1	49.7	31.2	.8	53.0	28.1	18.3	45.3	27.8	11.1	48.4	30.1	.8	52.5	25.9	17.0	42.5
Consumer	1.6	2.7	.4	1.0	2.0	.3	2.1	3.0	.4	1.6	2.6	.4	1.0	1.9	.4	2.1	3.0	.5
Medical society	2.8	-------	6.0	.6	-------	1.0	4.6	-------	12.7	2.8	-------	6.3	.5	-------	1.0	4.8	-------	13.7
Fraternal	.7	.6	.8	.7	.9	.6	.7	.3	1.2	.7	.6	.8	.7	1.1	.5	.6	.5	1.2
Private group clinics	15.3	28.5	------	11.5	27.3	------	18.6	29.2	------	15.8	28.6	------	11.5	26.5	------	19.4	29.9	------
Industrial plans	50.1	56.2	42.9	55.0	68.9	45.0	45.9	49.1	40.2	51.3	57.1	44.2	56.2	69.8	45.7	47.0	49.7	42.1
Union	31.6	31.3	32.0	36.4	38.7	34.7	27.6	27.2	28.3	32.0	30.9	33.4	37.0	38.6	35.8	27.6	26.4	29.9
Employer-employee	10.0	14.8	4.4	8.5	15.5	3.4	11.4	14.4	5.8	10.7	15.8	4.5	8.9	16.0	3.4	12.3	15.7	6.2
Employer	1.6	1.5	1.7	1.1	.6	1.5	2.0	2.0	2.1	1.6	1.5	1.7	1.1	.6	1.4	2.1	2.0	2.2
Employee	6.8	8.6	4.8	9.1	14.1	5.5	4.9	5.5	3.9	6.9	8.8	4.5	9.2	14.5	5.0	5.0	5.6	3.8

lem of handling sources of income other than monthly premium income does not arise for the non-group-practice plans that account for 46 percent of the total independent plan income ($337 million) and 58 percent of income for hospital services.

More than a third of the benefit expenditures ($318 million) of the independent plans related to the provision of medical services by the group-practice segment.

Union plans accounted for more than 30 percent of the total income and total benefit expenditure, the highest proportion for any type of plan. Community plans other than those using group practice, with $78 million in earned income and $69 million spent for benefits, accounted for nearly a fourth of the respective totals.

The percentage distribution of all earned income (table 7) differs noticeably from the distribution of enrollment in all the independent plans shown in table 5. The nonindustrial plans account for 50 percent of the income but 61 percent of the enrollment. The percentage distributions of income and of enrollment for hospital benefits correspond fairly closely, however, since some plans provide only hospitalization. The same is true if enrollment for medical services and income for physicians' services are compared.

TRENDS IN VOLUME OF EXPENDITURES

The Social Security Administration has conducted four complete surveys of the independent plans in the past 11 years. Table 8 summarizes the expenditures made under the different types of sponsor for hospitalization and for medical care benefits separately. The expenditures data reflect rising costs for both medical and hospital care over the years. As shown in the table, benefit expenditures were more than four times larger in 1959 than in 1949. Expenditures for hospitalization showed a somewhat greater growth than those for medical care, a finding corresponding to medical costs generally. The expenditures data reflect rising costs for both medical and hospital care over the years.

The composition of the group of plans has shifted from survey year to survey year. Only 56 percent of the plans surveyed in 1949 were included in the 1959 survey. New plans were added each survey year, and other plans dropped out because they went out of existence or failed to respond to the mailed inquiry, or their classification was changed to that of a Blue Cross or Blue Shield plan or an insurance company.

Some of the industrial plans have experienced decided declines in enrollment, stemming from drops in employment. The most notable declines were in the plans covering railroad workers and mine workers. Expansion in enrollment in other independent plans—particularly community and private clinic plans—has more than offset these losses.

The community-sponsored plans had an eightfold increase in expenditures from 1949 to 1959. Nearly half the growth occurred between the first survey and the second, largely because of the fact that the Connecticut Blue Cross Plan came within the definition of an independent plan by 1953, when it was no longer affiliated with the Blue Cross Association. Another factor was the expanded enrollment in the Health Insurance Plan of Greater New York, which had more than half a million members by 1959.

The higher expenditures among private group clinic plans reflects in part the postwar expansion in the Kaiser Health Plan. Almost 600,000 persons are now enrolled in this plan.[4]

The phenomenal growth in self-insured union operations, particularly between the first survey and the second, was caused by the establishment of the United Mine Workers Health and Retirement Fund in 1950 and the establishment in the early years of the decade of a number of large union health centers. The decline in benefits stemming from medical-society-sponsored plans is attributable to the affiliation of the King County (State of Washington) Medical Service Plan with Blue Shield after 1956. Had there not been a rise in medical care costs in the period, the drop in expenditures among plans in

[4] The Kaiser Plan's unique organizational structure explains why it has been classed as a private group clinic plan in all the Social Security Administration surveys. Medical services are provided by the Permanente Medical Group, an organization of doctors. Hospital services are furnished by the nonprofit Kaiser Hospital Plan. The enrollment, which is handled by a third administrative arm—the Kaiser Health Plan—could be equally appropriately assigned to community-plan enrollment. For comparability with past surveys, however, the Kaiser enrollment is assigned to private group clinics.

this category would have been more pronounced and the gains registered among consumer and employee plans would have been negligible.

CONCLUSIONS

Prepaid health care in the United States had its beginning among plans of the kinds still found exclusively in the independent category. These laboratories for testing various alternative methods of prepayment and demonstrating the feasibility of prepayment for medical services other than hospitalization continue to have a vitality and value greater than their weight in the universe of health insurance enrollment and health insurance expenditures would imply. When, under the Federal Employees' Health Benefits Act, they were placed in a position to compete on an even footing with other forms of health insurance, they appeared to have decided attractions, since they doubled their enrollment of Federal workers. The trends shown by the 1959 survey indicate that continued attention to all the independent plans is warranted in the decade ahead because their willingness to experiment continues in areas of prepayment not yet fully charted.

TABLE 8.—Expenditures for benefits among independent plans, 1949, 1953, 1956, and 1959

[In millions]

Expenditures and type of sponsor	1949	1953	1956	1959
Total expenditures	$75.6	$200.9	$253.9	$318.3
For hospitalization	31.2	111.7	128.4	147.4
For medical care	44.4	89.2	125.5	170.9
In plans sponsored by—				
Community	10.3	48.0	64.3	88.5
Consumer [1]	4.8	7.7	11.1	7.5
Medical society	12.0	11.1	14.2	9.0
Private group clinic	8.8	16.5	32.4	50.2
Union	4.4	70.1	73.4	101.8
Employer-employee	12.6	24.4	30.2	34.2
Employer	4.4	4.4	7.0	5.2
Employee	18.3	18.7	21.3	22.1

[1] Includes fraternal plans.