TABLE 3.—Administrative expenses of the combined old-age, survivors, and disability insurance program in relation to contribution income, benefit payments, and taxable payroll, 1940–62

| Calendar year | Total amount [1] (in millions) | As percent of— | | |
|---|---|---|---|---|
| | | Contributions | Benefit payments | Taxable payroll |
| 1940–62 | $2,490 | 2.4 | 2.8 | 0.09 |
| 1957 | 164 | 2.2 | 2.2 | .09 |
| 1958 | 207 | 2.4 | 2.4 | .11 |
| 1959 | 234 | 2.6 | 2.3 | .12 |
| 1960 | 240 | 2.0 | 2.1 | .12 |
| 1961 | 303 | 2.5 | 2.4 | .14 |
| 1962 [1] | 322 | 2.5 | 2.2 | .15 |

[1] Preliminary estimates.

gram, which costs relatively more to administer than old-age and survivors insurance.

For the entire period (1940–62) that monthly benefits have been payable, administrative expenses have represented 2.4 percent of contributions, 2.8 percent of benefit payments, and 0.09 percent of taxable payroll. It is clear that, whatever base is used, administrative expenses paid out of the trust funds—in other words, out of the contributions of workers and employers—are relatively low. By far the greatest part of such contributions is thus available for benefit payments.

## Independent Health Insurance Plans, 1962*

"Independent" group health insurance plans in the United States had an estimated enrollment at the end of 1962 of 7 million persons for hospital care, about 8 million for surgical-obstetrical service and for in-hospital medical service, and somewhat more than 7 million for in-hospital medical service and office, clinic, and home visits. The plans had a total income of $475 million in 1962 and expended $430 million for benefits and $32 million for administrative expenses.

The "independent" health insurance plans are all private organizations that are not Blue Cross plans, Blue Shield plans, or insurance companies and that provide specified health services and/or supplies or make benefit payments for them on a group prepayment, risk-spreading basis. If the plan does not itself provide the services, it may make payment directly to the supplier of the services or it may reimburse the covered individual for his expenditures for them.

The plans are of five main types: (1) community plans, serving the general community or a consumer group and controlled by persons selected to represent the community or consumer group; (2) employer-employee-union plans, set up to serve a particular group of employees or union members (and usually their dependents) and operated by a jointly managed (employer-union) welfare fund or less frequently, by an employer, an employee association, or a union; (3) medical-society plans, serving the general community and sponsored by State or local medical societies but not affiliated with the National Association of Blue Shield Plans; (4) dental-society plans, serving the general community and sponsored by State or local dental societies; and (5) private group clinic plans, operated and owned by private physicians and/or dentists functioning as a group.

The Division of Research and Statistics makes annual surveys (in some years on an all-inclusive basis, in others on a sample basis) of independent health insurance plans in order to obtain information on their enrollment and finances. The data are then combined with similar data from the Blue Cross-Blue Shield plans and insurance companies to develop national estimates of the number and proportion of the population having health insurance coverage and of the total income and benefit expenditures of all health insurance organizations.[1]

The survey made in 1963 was on a sample basis. Questionnaires were sent to a few (32) of the larger plans of each type, and replies were received from 27. These responding plans in 1961 had more than half the enrollment in all independent plans; they had 80 percent of the total enrollment in community plans, about 40 percent of the enrollment in employer-employee-union plans, 52 percent of that in private group clinic plans, and 97 percent of the enrollment in medical-

* Prepared by Louis S. Reed, Division of Research and Statistics.

[1] For summary findings of the latest comprehensive survey of all independent health insurance plans, see Donald G. Hay, "Independent Health Insurance Plans, 1961 Survey," *Social Security Bulletin*, February 1963. More detailed findings are presented in Research Report No. 2, *Independent Health Insurance Plans, 1961*, by Donald G. Hay, Louis S. Reed, and Robert E. Melia, which is about to be released by the Division of Research and Statistics.

society plans not affiliated with Blue Shield. No questionnaires were sent to dental-society plans, but comprehensive data on the enrollment and finances of the five plans in operation during 1962 were obtained from the Division of Dental Public Health and Resources of the Public Health Service, which each year surveys these plans.

Estimates of the enrollment as of December 1962 in all independent plans (other than dental-society plans) and of their 1962 income and benefit expenditures were made by assuming that for all plans of each type the changes from 1961 to 1962 were similar to the changes in the responding plans.

## ENROLLMENT

It is estimated that as of December 31, 1962, there were 7.0 million persons enrolled in the independent plans for hospital care, 8.3 million enrolled for surgical-obstetrical service, 7.8 million for in-hospital medical services, and 7.4 million for physicians' visits (office, clinic, and home).[2] Enrollment for these services by type of plan is shown in table 1. Estimates of enrollment at the end of 1962 for other services—dental care, drugs, special- and visiting-nurse services, and nursing-home care—were not made because the available data were incomplete. In any case, the figures would probably show little change from those for the end of 1961, as shown below.

TABLE 1.—Estimated enrollment in independent health insurance plans for hospital and physicians' service benefits, by type of plan, December 31, 1962 [1]

[In thousands]

| Type of plan | Hospital care | Physicians' services | | |
|---|---|---|---|---|
| | | Surgical-obstetrical | In-hospital medical | Office-clinic-home |
| Total | 6,959 | 8,308 | 7,808 | 7,428 |
| Community | 1,837 | 3,010 | 2,904 | 2,641 |
| Medical society | 344 | 346 | 346 | 342 |
| Private group clinic | 60 | 243 | 249 | 255 |
| Employer-employee-union | 4,718 | 4,709 | 4,309 | 4,190 |

[1] Excludes college and university health services; also excludes dental-society plans, which had 78,000 enrollees for dental care benefits.

[In thousands]

| Type of benefit | All plans | Type of plan [1] | | | | |
|---|---|---|---|---|---|---|
| | | Community | Medical society | Dental society | Private group clinic | Employer-employee-union |
| Dental | 1,124 | 195 | ------- | 162 | 7 | 760 |
| Nursing | 3,864 | 2,572 | 4 | ------- | 9 | 1,279 |
| Drugs outside hospital | 1,417 | 125 | 4 | ------- | 23 | 1,265 |
| Nursing-home care | 526 | ------- | ------- | ------- | ------- | 526 |
| Other health benefit | 3,027 | 1,880 | 8 | ------- | 11 | 1,128 |

[1] Excludes college and university health services.

Source: Donald G. Hay, "Independent Health Insurance Plans, 1961 Survey," *Social Security Bulletin*, February 1963, p. 11.

The estimated enrollment in all plans for hospital care and the three types of physicians' services is slightly less than it was at the end of 1961. There are two reasons for the decrease: (1) The small gains in some plans were more than canceled by a downward readjustment, based on more accurate information for one large employer-employee-union plan, and (2) another sizable organization, formerly considered to be an independent plan of the community type, was found to be an insurance company and hence was dropped from the independent group.

The community and private group clinic plans had a small increase in enrollment. The medical-society plans had no change. Employer-employee-union plans showed a drop in enrollment because of the readjustment of data for one large plan; there was relatively little change in the enrollment of the other plans of this type. The dental-society plans had 78,000 persons enrolled at the end of 1962. This was less than half the enrollment (162,000) reported for 1961. That figure, it now appears, was an overstatement, since it included for one plan a large number of welfare recipients served under a contract between the plan and the State welfare department.

Table 2 shows estimated enrollment in all independent health insurance plans for hospital care and surgical and in-hospital medical physicians' service, by region and State. These estimates are based on those for the year 1961,[3] with adjustments made on the basis of the changes in enroll-

[2] A small number of those shown as enrolled for physicians' visits (office, clinic, and home) are entitled only to service at a clinic or health center; all others are entitled to service in the office, clinic, and home. It may be assumed that all persons covered for office-clinic-home visits are covered for X-ray and laboratory examinations in physicians' offices or at a clinic or health center.

[3] Estimated enrollment in all independent plans at the end of 1961, by region and State, are shown in the February *Bulletin* (see footnote 1).

TABLE 2.—Estimated enrollment in independent health insurance plans for specified types of benefits, by region and state, December 31, 1962

[In thousands]

| Region and State | Number enrolled for specified benefit | | |
|---|---|---|---|
| | Hospital care | Physicians' services | |
| | | Surgical | In-hospital medical |
| United States | 6,959 | 8,308 | 7,808 |
| New England | 129 | 127 | 125 |
| Maine | 7 | 8 | 8 |
| New Hampshire | 5 | 5 | 5 |
| Vermont | 7 | 6 | 6 |
| Massachusetts | 71 | 70 | 69 |
| Rhode Island | 8 | 8 | 7 |
| Connecticut | 31 | 30 | 30 |
| Middle Atlantic | 2,177 | 3,403 | 3,102 |
| New York | 1,326 | 2,783 | 2,545 |
| New Jersey | 163 | 134 | 130 |
| Pennsylvania | 688 | 486 | 427 |
| East North Central | 958 | 1,001 | 824 |
| Michigan | 90 | 90 | 86 |
| Ohio | 377 | 342 | 254 |
| Illinois | 292 | 368 | 297 |
| Indiana | 50 | 49 | 45 |
| Wisconsin | 149 | 152 | 142 |
| West North Central | 329 | 361 | 344 |
| Minnesota | 64 | 96 | 103 |
| Iowa | 29 | 29 | 25 |
| Missouri | 169 | 169 | 155 |
| North Dakota | 2 | 2 | 2 |
| South Dakota | 11 | 10 | 10 |
| Nebraska | 14 | 14 | 8 |
| Kansas | 40 | 41 | 41 |
| South Atlantic | 661 | 580 | 568 |
| Delaware | 3 | 3 | 3 |
| Maryland | 37 | 37 | 36 |
| District of Columbia | 113 | 111 | 110 |
| Virginia | 127 | 103 | 102 |
| West Virginia | 234 | 201 | 201 |
| North Carolina | 43 | 43 | 41 |
| South Carolina | 17 | 17 | 13 |
| Georgia | 43 | 21 | 21 |
| Florida | 44 | 44 | 41 |
| East South Central | 280 | 270 | 309 |
| Kentucky | 127 | 127 | 125 |
| Tennessee | 45 | 44 | 42 |
| Alabama | 72 | 63 | 107 |
| Mississippi | 36 | 36 | 35 |
| West South Central | 157 | 159 | 147 |
| Arkansas | 31 | 31 | 25 |
| Louisiana | 35 | 35 | 35 |
| Oklahoma | 19 | 19 | 15 |
| Texas | 72 | 74 | 72 |
| Mountain | 207 | 206 | 200 |
| Montana | 4 | 4 | 4 |
| Idaho | 5 | 5 | 5 |
| Wyoming | 4 | 4 | 4 |
| Colorado | 77 | 76 | 72 |
| New Mexico | 6 | 6 | 6 |
| Arizona | 35 | 35 | 34 |
| Utah | 66 | 66 | 65 |
| Nevada | 10 | 10 | 10 |
| Pacific | 2,039 | 2,180 | 2,170 |
| Washington | 460 | 452 | 447 |
| Oregon | 328 | 326 | 326 |
| California | 1,178 | 1,329 | 1,324 |
| Alaska | [1] | [1] | [1] |
| Hawaii | 73 | 73 | 73 |
| Outlying | 22 | 21 | 19 |
| Puerto Rico | 22 | 21 | 19 |
| Guam | | | |

[1] Less than 500.

ment of the larger plans as found by the current survey.

## FINANCES

Total income of all independent plans in 1962 is estimated at $475 million, 9.4 percent more than in 1961. Total benefit expenditures amounted to $430 million, an increase of 8.3 percent. Administrative expenses were not shown as a separate item in the previous survey reports. It is estimated that in 1962 they amounted to $32 million, bringing total expenditures to $462 million, and that net income (surplus of total income over total expenditures) amounted to $12 million (table 3). For all plans, benefit expenditures amounted to 90.5 percent of total income, administrative expenses to 6.7 percent, and net income[4] to 2.8 percent.

TABLE 3.—Estimated income, expenditures for benefits and administration, and net income of independent health insurance plans, 1962 [1]

[In millions]

| Type of plan | Income | Expenditures | | | | | Net income [2] |
|---|---|---|---|---|---|---|---|
| | | Total expense | Benefit expense | | | Administrative expense | |
| | | | Total | Hospital care | Physicians' and other service | | |
| All plans | $474.5 | $462.3 | $430.4 | $185.1 | $245.3 | $31.9 | $12.2 |
| Community | 164.0 | 160.2 | 151.2 | 50.0 | 101.2 | 9.0 | 3.8 |
| Medical society | 19.2 | 18.9 | 17.6 | 7.7 | 9.9 | 1.3 | .3 |
| Dental society | 2.4 | 2.5 | 2.3 | ------ | 2.3 | .2 | −.1 |
| Private group clinic | 10.6 | 10.4 | 8.7 | 1.0 | 7.7 | 1.7 | .2 |
| Employer-employee-union | 278.3 | 270.3 | 250.6 | 126.4 | 124.2 | 19.7 | 8.0 |

[1] Excludes college and university health services.
[2] Difference between total income and total expenses; represents addition to reserves for plans operated on a nonprofit basis.

Data on expenditures for benefits separate from those for administration are not apt to be meaningful, however, for group practice plans providing direct service. (In 1961 the income of these plans equaled approximately 71 percent of aggregate income for all community plans, 100 percent of that for all private group clinic plans, and 41 percent for all industrial plans.) When a plan provides services through its own facilities and staff, it is difficult to separate expenditures for administration of the medical program from expenses incurred in administering the prepayment aspects of the plan. Similarly, expenses incurred in providing service cannot well be separated from the expenses of administering the clinic—all are parts of the cost of providing service. (The problem does not arise for a plan, such as the Health Insurance Plan of Greater New York,

[4] For all plans other than private group clinic plans, net income means additions to reserves.

that provides benefits through a number of autonomous group practice units and is thus mainly a prepayment organization.) The breakdown of expenditures of independent plans between benefits and administration must therefore be used with caution.

## Ontario's "Portable Pension" Law*

The Legislature of Ontario Province, Canada, recently passed the Pension Benefits Act, 1962–63, to remedy some of the shortcomings found in employee-pension plans. The principal aims of the new law, which was proclaimed June 1, 1963, are to extend the coverage of the plans, to improve their financial soundness, and to facilitate the transfer of pension credits when workers move from one plan to another. Passage of the bill climaxed a legislative history that began in the spring of 1960 with the appointment of a group of experts to the Ontario Committee on Portable Pensions.

Ontario's Prime Minister, John Robarts, in introducing the bill on March 19, 1963, referred to the January 1962 announcement of the Canadian Government that it was seeking a constitutional amendment to establish a nationwide, contributory, wage-related pension plan with survivor benefits attached. He indicated then that the Pension Benefits Bill or similar Provincial legislation would still be needed to regulate employee pension plans and to improve their "portability."

### COVERAGE AND MEMBERSHIP

The Pension Benefits Act requires that every employer with 15 or more employees in Ontario Province set up at least a minimum pension plan by January 1, 1965. Plans that are already in existence but fall short of the minimum pension standards are to be amended. All Provincial and local government agencies are included. In determining the number of employees, casual and certain part-time workers are excluded. Certain types of employment will be excluded from coverage by regulation.

An employee who has reached the age of 30, who has had 6 months' continuous service, and who has worked an average of at least 24 hours a week during the 6 months must become a member of the firm's pension plan. The effect of this provision is to exclude seasonal, part-time, and other temporary workers. Workers aged 70 or over are also excluded. In addition, workers who are already aged 65 when they become members of an eligible group of employees have the option of abstaining from plan participation.

### MINIMUM BENEFIT STANDARDS

The minimum benefit standards that will go into force when the law takes effect in 1965 are lower than those commonly found in established plans. They were scaled low in recognition of the cost burden on employers already committed to heavy expenses for fringe benefits. These minimum benefits are payable for life starting at age 70. (The actuarial equivalent is to be payable for benefits commencing earlier than age 70, for joint and survivorship benefits, and for benefits that assume a fixed number of payments.)

Since existing plans use a variety of benefit formulas, the law gives employers several alternative ways of providing the minimum benefits:

1. A unit-benefit plan, under which the minimum monthly benefit is to equal ½ of 1 percent of the first $400 of monthly pay for each year of employment.

2. A flat-benefit plan, under which the minimum is $2 a month for each year of employment. According to a proposed schedule in the preliminary draft regulations, the annual contribution needed to pay this amount to workers starting at age 70 would be as follows:

| Age | Annual contribution | |
|---|---|---|
| | Men | Women |
| 30 | $53 | $58 |
| 40 | 78 | 86 |
| 45 | 95 | 105 |
| 50 | 115 | 127 |
| 55 | 140 | 155 |
| 60 | 170 | 188 |

3. A money-purchase plan, under which the minimum must be the amount purchasable with total employer-employee contributions, based on the follow-

* Prepared in the Division of Research and Statistics. This explanation of the law (Bill 110) is based in part on the Introductory Statement of the Prime Minister of Ontario delivered in the Provincial Legislature on March 19, 1963.