Some Recent Developments in Voluntary Health Insurance

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IN CARRYING OUT its statutory mandate to make studies concerning the advancement or improvement of economic security, the Social Security Board has, from its inception, been deeply interested in the various methods that have been developed to prevent illness and disability, to maintain health and earning power, to protect workers and their dependents against the consequences of sickness and disability and, as far as possible, against the resultant economic losses.

One undertaking has been the accumulation of information on prepayment medical and hospital-service organizations in operation in various parts of the country to the extent possible without undue work on the part of those organizations or of the Board. A general statement describing the costs and benefits under 35 existing or projected prepayment medical-service plans was published at an earlier date.[1] The present article is based on information which has been obtained directly from 128 prepayment organizations and on information concerning the medical plans of the Farm Security Administration and the development of hospitalization insurance.

This compilation does not cover all projected organizations or even all in operation, but it is believed to include the large majority of organizations providing substantial amounts of service to any considerable number of persons. Industrial medical-care plans have been included and considered "voluntary" even in instances when employment is conditioned upon the participation of the employee in the plan. The medical-care plan covering the employees of the city and county of San Francisco has been excluded, on the other hand, because of the legal statute which makes participation in the plan compulsory. This study does not reflect the effect of coverage in prepayment plans of large numbers of workers in the rapidly expanding war industries.

Comparisons of costs under one type of organization in contrast to another must take account of many factors, such as variations in the characteristics of the group served, the scope of services provided, and the extent to which the premiums paid by subscribers are supplemented by funds or services from other sources. A company plan for medical services, for example, may be substantially subsidized by the employer, who meets administrative costs, provides offices and equipment, or carries other expenses of the organization. Costs to subscribers under such an arrangement will, of course, not be directly comparable with those under a completely self-supporting organization providing the same types of services for a group with similar age and sex composition. One organization may provide care to a selected group, widely different in age or sex composition from that covered by another organization; some exclude maternity care, and some include care for the dependents of subscribers, while others do not; limits imposed on duration of hospital care vary from one organization to another.

The following tabulation summarizes, for each type of plan discussed, the number of organizations that supplied information on charges, coverage, or services provided, and the total number of persons eligible for care under those plans that reported on coverage. The figures in the main refer to the year 1941. The number of persons that met the costs of their medical needs through prepayment was considerably larger than this tabulation indicates, especially in the industrial plans.

Type of organization	Total number of plans reporting	Number of plans reporting on membership	Membership
Industrial medical-service	59	47	700,000
State or county medical-society	28	17	577,000
Physician-owned	19	12	[1] 136,000
Consumer-sponsored	22	14	36,000
Farm Security Administration			[2] 682,000
Hospitalization insurance (Blue Cross)			8,500,000

[1] Includes 50,000 dependents of subscribers entitled to care at a reduced fee.
[2] Excludes medically indigent migrant farm families.

*Bureau of Research and Statistics, Division of Health and Disability Studies. The author wishes to acknowledge the assistance of Vincent V. Larson and Evelyn T. Borgen in preparation of the article.

[1] Reed, Louis S., "Costs and Benefits Under Prepayment Medical-Service Plans," *Social Security Bulletin*, Vol. 3, No. 3 (March 1940), pp. 13-26.

Industrial Medical-Service Organizations

Employer and employee medical services have been organized in a number of establishments in this country to furnish medical care for employees and, in some instances, also for their dependents. In some of these organizations, participation is optional with employees; often, however, it is a condition of employment and, so far as the employees are concerned, there is no real significance in labeling the plan as a "voluntary" prepayment undertaking. Some of the plans organized around an industry were initiated by employers, others by employees, and still others by joint employer-employee action.

The first criterion for including an industrial medical-care plan in this analysis was that it must provide a substantial amount of medical care. Excluded, therefore, are industrial plans which limit medical services to the care that can be given in an emergency room by a nurse or to care by a physician available only a few hours a week. Also excluded are medical-service organizations that provide only first aid and treatment of industrial accidents or injuries covered by State workmen's compensation laws.

Coverage and Services Provided

Forty-three of 59 organizations maintaining medical-service plans from which information has been received limit the provision of medical care to employees, while the remaining 16 provide care to both employees and their dependents. In the 47 organizations which have furnished data on coverage, almost three-fourths of a million persons are eligible to receive medical care—approximately 75 percent of them employees and 25 percent dependents.

Seventeen of the 47 organizations include medical care for accidents and injuries covered by workmen's compensation laws, as well as for nonindustrial illnesses and injuries; 16 definitely exclude care for accidents and injuries subject to workmen's compensation laws; and 14 have supplied no information on this point.

A large majority of the industrial medical plans provide medical and surgical care and hospitalization. Generally speaking, the inclusion of medical care among the services provided dependents of employees is not correlated with the type or scope of care provided. All but 16 of the 59 organizations provide "complete" medical services, i. e., medical and surgical care and hospitalization. Nine of the 16 organizations, with a total membership of approximately 140,000—half of them dependents—do not provide hospitalization; the remaining 7, with a membership of 50,000, of whom 2,000 are dependents, provide only surgery and hospitalization.

There is a wide variation in the amount of hospitalization provided by the industrial medical plans, but in general the provisions are more generous than in other types of plans. When the services include treatment for workmen's compensation cases, the extent of hospitalization allowed is generally a year or as long as the attending physician deems necessary. When care of such cases is not included, much less liberal hospitalization is provided, one plan allowing only 10 days per employee, several 1, 3, or 4 months, one limiting hospitalization to the total value of about $175, and only one providing the full amount deemed necessary.

About half of the plans, generally those which limit their services to employees, include provisions for special nursing service in the hospital, and an additional fourth of the plans provide services of a visiting nurse in the home.

Charges for Services Provided

Seven of the 59 plans studied are financed entirely by employers. These plans offer services much wider in scope and specify fewer conditions for which services are not allowed than plans financed in part or in whole by employees. Three provide hospital care for unlimited periods of time. Four provide service to dependents of employees.

In 19 organizations, all or the major part of the costs are borne by the employees alone. The monthly charges for membership in these plans vary from $1 to $2 in organizations providing services only to employees, and from $1 to $3 for a family of four in organizations which also provide care for dependents. Frequently, the amount is determined by the employee's salary. When care to dependents is also furnished, there is generally an increase of $1 per month in the cost; approximately the same services are available to the dependents as to employees. In about a third of these organizations, the employee's contribution includes a payment for death benefits and/or cash disability benefits.

When the employer and the employee share the cost, the contributions of employees approximate those in plans in which the employee pays the entire cost, but, in general, medical care for work accidents and injuries is included or the employee is entitled to cash disability or death benefits. The care provided usually includes physicians' services in the office, home, and hospital, and hospitalization; in the majority of cases, maternity care is excluded.

The methods of sharing the costs between the employer and employee are varied. In some instances costs are divided equally; in others the employer supplies certain services; in some plans the company contributes a definite sum of money for each employee member, while in others the company agrees to pay any deficit which may be incurred.

Since in many instances the exact sums contributed by the companies are not known, a complete cost picture is not available. In many of the organizations certain facilities, such as office space, light, heat, telephone service, secretarial service, and collection of dues, are provided by the employer, but in most instances the cash value of such facilities and the interest and depreciation on original capital investments made by the employer are not included when the contributions of the employer are reported. An even more serious lack of information on the employer's contribution arises from the fact that organizations which own and operate hospitals do not maintain separate cost accounting for the hospitals. There is also a lack of sufficient information on the relationship between the amount contributed by the employer and the cost of medical service provided by the organization for accidents and injuries covered by the workmen's compensation law.

Because of basic differences in financing industrial plans, as contrasted with the other types of medical-service organizations, comparable analysis of charges for services provided is often not feasible.

State or County Medical-Society Organizations

Plans sponsored by State or county medical societies provide medical service through participating physicians who agree to accept, on a fee-for-service basis, a prorated division of the funds contributed by subscribers during each month, after necessary administrative expenses have been met. Patients have a choice of physicians among those who participate. A characteristic of the plans is that the cooperating physicians continue in individual practice instead of practicing as a group. Membership is usually limited to persons with annual incomes under a specified amount, generally less than $2,000 for single individuals and less than $2,500 for families.

These prepayment medical-service organizations, financed jointly by employers and employees or by employees alone, were first developed in Washington and Oregon. The State and county medical societies were not closely affiliated with the earliest organizations, but in the early 1930's they began establishing medical-service bureaus—as administrative instruments of the societies—through which groups of workers arrange for medical care on a prepayment basis. Through contributions of employers and employees, members are eligible for medical, hospital, and nursing care for injuries covered by the workmen's compensation act, and through additional employee contributions they can receive similar care for sickness and injuries not connected with employment. Almost without exception, the service bureaus have followed the practice of earlier groups in making their agreements directly with the employers and groups of employees, using pay-roll deductions for collections, and restricting services to employees, i. e., not including dependents.

California and Michigan are among the States in which more recently formed State-wide plans are now in operation; a State-wide organization has been established in Utah, but no plans are in active operation. In New York, Colorado, North Carolina, Texas, Georgia, and Wisconsin a few county and city societies have sponsored plans. In Pittsburgh a plan to provide surgical care is functioning in close cooperation with a hospital-care insurance plan, and the State medical society is developing a State-wide plan to make care available in the office and the home. Under the spur of recently enacted enabling legislation, State and county organizations are being established in New Jersey, Ohio, and Massachusetts. Many of these organizations have completed preliminary work on plans, several of which are expected to begin operation during the current year.

Recent legislation.—The active participation of medical societies in the development of voluntary medical-care insurance is of importance for an estimate of the future progress and direction of prepayment medical-care organizations. The extent of the interest among medical societies in organizations of this type and the safeguards which they believe should be provided may be gathered from a review of recent legislation in this field.

Under an enabling act passed by the New Jersey Legislature in May 1940, prepayment medical-service corporations must be governed by boards of trustees whose nomination is approved by a recognized medical organization which has been incorporated for at least 10 years and includes at least 2,000 members licensed to practice medicine. Moreover, at least 51 percent of the physicians eligible to practice in the area to be served by the corporation must have agreed to participate in the plan. The effect of the legislation is that only the medical societies can sponsor or approve a corporation eligible to operate under this law.

Although the law specifies that "No person, firm, association or corporation other than a medical service corporation shall establish, maintain or operate a medical service plan," it does, however, allow medical care required under the State workmen's compensation law to be furnished by any person, firm, association, or corporation.

An interesting provision of this act is that medical-service corporations may accept funds from any governmental agency, or any private agency, corporation, or association, to provide medical services to needy persons.

Two enabling acts passed in Massachusetts in 1941 regulate the provision of medical services under prepayment plans, and it is interesting to note that, although passed in the same year, their provisions differ considerably. The Massachusetts (Medical Society) enabling act parallels the New Jersey law with respect to the requirement that a majority of the directors must be approved by a medical society which has been incorporated in the Commonwealth for not less than 10 years and has not less than 2,000 registered physicians as members. Every registered physician in the area covered by a corporation has the right to participate, on complying with rules and regulations.

The Massachusetts (White Cross) enabling act differs from the Medical-Society act on three important points. The licensing body for medical-service corporations organized under this law is the Department of Public Health, not the State insurance authorities. Directors do not have to be approved by a specified medical organization; in fact, any medical society or partnership of physicians whose members belong to the Massachusetts Medical Society, other recognized associations of physicians, or the staff of an approved hospital may form a medical-service plan. Only licensed physicians who comply with the rules, regulations, and qualifications laid down by the medical-service corporation are allowed to participate.

The Ohio enabling act, which became effective in August 1941, parallels the New Jersey act in that at least 51 percent of the licensed physicians in the territory to be served by a medical-service corporation must agree to render services under the plan, and any duly licensed physician or surgeon in the service area may participate. An interesting feature is that, on receipt of an application for a license under the act, the Superintendent of Insurance must give notice in writing to every corporation in the State holding such a license and hold hearings to determine whether the license shall be granted. The act also provides for payroll deductions for State employees who join such plans.

Coverage

Medical-care plans, in active operation or reported in the process of organization, are now sponsored by medical societies in 15 States—California, Colorado, Georgia, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, and Wisconsin. Medical societies in other States are considering plans of this type. Some organizations just beginning to function have not furnished information on membership. For 17 county or State-wide plans now in operation, available data indicate that more than half a million persons are eligible for care. Although this represents a considerable growth, these plans have not yet attained any large membership in relation to the population of the United States as a whole or to that of the States in which the plans are functioning.

Many of the newer medical-society plans, following the example of the older medical-society plans in Washington and Oregon and other types of medical-service organizations with respect

to enrollment policies, limit their membership to group enrollments. Of 24 medical-society plans which reported their policy in this regard, 17 accepted only group memberships, and 14 of the 17 accepted employee groups only, i. e., excluded dependents.

Services Provided

Except for surgery, which is included in all the plans which have furnished information, types of services offered by the various medical-society plans differ widely. The medical-service bureaus in Washington and Oregon which have furnished information on coverage report approximately 70,000 employees and 1,000 dependents eligible for physicians' care at home or in the office, surgery, laboratory services, X-ray, physiotherapy, the services of a special nurse, consultants' services, and hospitalization. The maximum hospital care varies among the plans from 90 to 180 days; the majority of the plans provide 180 days of ward care, and many plans allow a month in a private room, if necessary. The majority also provide ordinary drugs and medicines. These plans offer comprehensive care to the employees but usually make no provision for care to dependents.

The medical-society plans in other States tend to include dependents, but the care is less comprehensive than that provided in Washington and Oregon; maternity services are generally not included, nor are drugs and medicines, physiotherapy, or the services of a special nurse. About 49,000 persons are eligible under these plans for physicians' and surgeons' care and maternity services; 445,000 are eligible for surgical and maternity care only; while about 12,000 are eligible for hospitalization in addition to surgical and maternity care.

Plans which do not offer hospitalization benefits usually work in close relationship with already existing hospital-service associations. In Michigan, the Michigan Medical Service and the Michigan Society for Group Hospitalization operate jointly, using the same organization for enrollment in both. The California Physicians' Service has a working agreement with State hospitalization plans. In New York State, the law requires that medical and hospital-service organizations operate separately, but in the western part of the State two medical plans operate in close relation to hospital-service associations. The Medical Service Association, Inc., of Durham, North Carolina, operates a separate hospital plan of its own.

All plans which include maternity service impose a waiting period of from 9 months to 2 years—the most usual, a year—before such care is provided under a subscriber's contract. Many plans also stipulate waiting periods of a year for various types of surgical operations.

In common with most prepayment medical-service organizations, all these plans exclude services for certain diseases and conditions. The more usual exclusions are for preexisting diseases and conditions, mental diseases, venereal diseases, tuberculosis, and diseases and conditions due to drug addiction.

Charges for Services Provided

The plans in Washington and Oregon are fairly uniform with respect to services provided and charges; those in other States are characterized chiefly by their differences. One of the chief reasons for this variation is the introduction in many of the latter plans of a cash-deductible principle, under which the subscriber pays the first $5 or $10 of his doctor's bill, or pays for the first one or two calls by the doctor in any one illness or in any year.

Care restricted to subscribers.—The 11 medical-society plans in Washington and Oregon which restrict care to subscribers and furnish home and office care by physicians, surgery, and hospitalization, but not maternity care, charge each member $1.25–2.35 per month; four charge $1.25–2.00, six charge $2.00, and one $2.35.

In two other States, two medical-society plans which do not provide for the treatment of dependents charge $1.50 and $1.70 per month for physicians' and surgeons' services, including maternity care but not hospitalization. The plan which charges $1.70 does not restrict the amount of care a member may have during a year. Under the other plan, a patient pays for the first $5 of care incurred in any contract year, and the total value of medical care to which he is entitled during the contract year is limited to $325.

Care provided to subscribers and dependents.—In analyzing the charges made by organizations which provide care to members and their dependents, a family of four has been used as the unit. One plan in Washington which gives care

both to members and to their dependents charges $5 per month per family; this amount entitles the family to the services of physicians and surgeons, including maternity care and 6 months' hospitalization. Five medical-society plans in States other than Washington and Oregon furnish the services of physicians and surgeons, including maternity care; their charges for a family of four vary from a minimum of $3 to a maximum of $6 per month. The various restrictions in the different plans prevent a clear-cut analysis of charges. Three of the plans charge $3–4 per month; in one of these, the member pays half of the first $20 of care incurred in any contract year, with a maximum of $400 on the total amount of care provided; in another, the family pays for tonsillectomies and all maternity care; in the third, the total amount of care to which a family is entitled is limited to $1,000 and the premium rates range from $2.55 to $4.25 per month, depending on income. In this last, the family itself pays $5–10, depending on income, for the care first received in any illness or injury, exclusive of operations and fractures; such payment is required only once in any 90-day period, however.

Two plans charge $4–5 per month; in one, the family pays the first $5 of costs incurred in any year and is allowed services up to a maximum of $875; in the other, no extra charge is made for the first care received, but the total amount for a family is limited to $425.

Four of these plans limit services to surgery and maternity care and charge $1.38–2.75 per month for a family of four. One plan, which charges $1.70 per month, sets no maximum on the services which the family may receive during the year; one which charges $1.38 sets a maximum of $325; another, which charges $2, limits the value of care to $150 for any one illness of the member or any of his dependents in any year. The fourth plan, which charges $2.75 and limits the value of services to $425, also provides physicians' care for each person in the family for nonsurgical hospitalized cases, up to a total of $75 per year.

The one plan which provides the services of physicians and surgeons for hospitalized cases, maternity care, and hospitalization charges $2.75 per month for a family of four and places the following maximums per person per year: $100 for surgery, $25 for maternity care, $50 for other physicians' care, and 30 days for hospital care not to exceed $3 per day, plus other hospital charges for operating or delivery-room services, anesthetics, and ordinary laboratory services.

Associated Medical Services, Inc., Toronto, Canada

A Canadian medical-society plan, Associated Medical Services, Inc., which has been operating for 4 years in Toronto, developed as a result of a request by the Civil Service Association that a committee draw up a medical-service plan to operate within the Ontario civil service. The Ontario Medical Association approved the plan, recommended it for general use, and granted a loan of $3,800 for initial expenses. The Civil Service Association also lent $1,200, and the Government provided headquarters for 3 years. The growth in membership has been as follows: from 733 subscribers at the end of 1937, the rolls grew to 4,020 at the end of 1938 and to 29,000 by December 31, 1941. The number of participating physicians also increased, from 275 in the beginning to 1,000 at the end of 1938; and in June 1940 participating physicians numbered 1,676, or 92 percent of all physicians in the areas served.

The services provided by the plan include office, home, and hospital care and semiprivate hospital accommodation. There is a 2-month waiting period for all services except maternity, for which the waiting period is 10 months. A subscriber or dependent is allowed services up to a maximum value of $800 in any 12 consecutive months. Mental, tuberculous, and epileptic patients are cared for until institutionalized, but venereal and preexisting diseases are not covered.

The monthly charges are $2 for a subscriber, $1.75 for the first dependent, $1.50 for the second, $1.25 for the third, and $1 each for all additional dependents. This plan is unusual among medical-service plans in that there is no income limit or any requirement for group enrollments. The charges have been large enough to make prorating of fees unnecessary; in fact, the plan has been able to build up a reserve of $97,880 as of December 31, 1941.

Hawaii Medical Service Association

The Hawaii Medical Service Association of Honolulu undertakes to provide relatively complete medical care for the family. This association accepts only group enrollment. The smallest

number of employees of any one employer accepted is five, and, when the enrollment in any group reaches 75 percent of the total number of employees, dependents may also be included in the contract. The membership has increased from 600 to 5,000 within the last 3 years, as a result of the extension of the plan to industrial and low-salaried employees. On January 1, 1941, there were 184 physicians, surgeons, and specialists participating.

Individual subscribers or families are allowed five home or clinic calls in any contract year after the patient has paid for the first office or home call for each separate illness or injury. Treatment of certain gynecological conditions, mental, venereal, preexisting diseases, and drug addiction is excluded. However, the plan allows maternity care and treatment for tuberculosis and chronic diseases. The maximum care for an individual in a year is $300; for a subscriber and spouse, $400; for a family of three, $450; for a family of four, $475; and for a family of five or more, $500.

The monthly charge depends on income and ranges from $1.25 to $3.50 for a single employee; for a married employee, $1.10–3.00; for the spouse, $.90–2.25; and for the first child, $.75–2.00; the second child, $.60–1.75; and the third child, $.40–1.00. For a family of more than five the maximum monthly charges range from $4 for persons with monthly incomes of less than $100—a group to which many employees belong—to a maximum of $12 for persons with incomes between $251 and $350 a month.

Physician-Owned Organizations

In physician-owned organizations, medical services are provided for subscribers on a fixed monthly prepayment basis by a number of physicians who generally practice as a group, using joint office facilities and equipment. Usually the share of the total income which each member of the group receives is not strictly dependent on the amount of service he has rendered, as is commonly the practice among county medical-society plans, but represents either a salary or a salary plus a certain proportion of the balance after specified salaries and expenses are met. In most cases these organizations were developed by the physicians in response to requests of large employee groups, such as members of a police force, firemen, teachers, employees of a large industrial firm or a governmental agency. These organizations differ from the medical-society organizations mainly in that the subscribers must restrict their choice to physicians affiliated with the group, and that the physicians practice as a group and are under the supervision of a medical director.

Coverage and Services Provided

Approximately 136,000 persons are entitled to receive medical care from the 12 physician-owned organizations which have submitted information on this point. All groups but one reported more than 1,500 persons eligible for care, the largest reporting approximately 23,000.

Some 64,000 persons are eligible for comparatively complete care, that is, physicians' and surgeons' care in the home and office, and hospitalization; less than one-tenth of this number are dependents of subscribers. Under some of these 12 plans, however, about 50,000 dependents of subscribers are entitled to receive physicians' and surgeons' care and hospitalization at a reduced fee. The reduction in fee is substantial, usually 50 percent of the regular charge made in the locality for the same service. More than 7,000 persons, about two-thirds of whom are dependents, are eligible for hospitalization and for medical and surgical care in hospitalized cases; more than 15,000 persons, with the same proportion of dependents, are eligible for physicians' and surgeons' care only.

There is considerable uniformity among physician-owned organizations with respect to the diseases and conditions treated. In general, organizations which restrict their services to physicians' care treat cases of drug addiction and certain gynecological conditions, give care for preexisting conditions when the subscriber enrolls as a member of a group, and provide treatment for venereal diseases, and for mental disease and tuberculosis until the patient is institutionalized. The others, regardless of the extent of services provided, usually exclude the treatment of preexisting diseases and conditions, gynecological conditions, mental and venereal diseases, tuberculosis, and diseases and conditions due to drug addiction.

Charges for Services Provided

Care restricted to subscribers.—Seven of the 19 organizations which submitted information on

charges provide service only to subscribers. Those seven charge $1.25–2.50 per month and, except for some variations in items excluded or subject to extra charges, have in general the same pattern of services. These services include care by physicians and surgeons in the home, office, or hospital, hospitalization, laboratory services, ordinary drugs and medicines, physiotherapy, and X-ray examination and treatment. Two of the plans, one of which charges $1.25 a month and the other $1.75, provide for the services of a special nurse in the hospital. The amount of hospitalization provided by the seven plans varies from 45 days to 8 months, and the majority specify ward care; the maximum benefit period does not seem to be correlated with the size of the monthly charges.

Complete maternity care is not included in any of these plans, and three of the four plans which charge $1.25–2.00 per month specifically exclude maternity care. In the three plans which charge $2.10–3.00 per month, obstetrical care is excluded in one and is subject to an extra charge in the other two.

Three of these seven organizations furnish services to dependents of subscribers on a reduced-fee schedule, which represents in the main a fee approximately 50 percent less than the rate commonly charged in the community. One of the three charges the subscriber $1.50 per month, and two charge $2.50. The only other specified difference among these plans with respect to services provided is that the plan which charges $1.50 a month limits the maximum service to $800 in any one year.

Four of these seven plans accept only employees of a common employer who enroll as a group; three accept both group and nongroup enrollment, but two of the three charge an additional 50 cents per month for subscribers who do not join in a group; one plan makes an extra charge of 50 cents for subscribers who are over 40 years of age and an additional 50 cents when they reach 50 years of age.

Care given to subscribers and dependents.—Information on the charges made by physician-owned organizations indicates a wide variety of arrangements for providing medical services to families.

Two of these organizations limit their service to hospitalization, surgery, and medical care for hospitalized cases; both insist on group enrollment, and one will not accept groups of less than 200. For a family of four their charges are $1 and $1.60 per month; one organization writes that with the present charges it is necessary to exercise every known economy in order to break even. Both organizations provide ward care for an indefinite period at the discretion of the doctor. Home or office care in connection with the surgical, maternity, and hospitalized medical cases is not included in the contract, and one organization reports that a large proportion of these visits are given as free care.

Six of the 12 organizations provide physicians' care in the office, home, and hospital, but do not include hospitalization. All but one include complete maternity care. The monthly charges for a family of four vary from $2 to $4. The three plans which charge $2.00–2.50 provide services as inclusive as the two which charge $3 and $3.50, except that the former make an extra charge for each home call. The one organization which charges $4 per month also makes an extra charge for all home calls. The organization which charges $3.50 per month makes an extra charge for the first two home calls to any patient during any month, but charges are not made for more than four home calls in any month for any family, regardless of the number of persons who may have home calls. This organization is also the only one of this type that makes an additional charge for obstetrical cases. None of the six organizations provides drugs or medicines or the services of a special nurse; all provide ordinary laboratory service; four provide physiotherapy; three provide X-ray examination and treatment without extra charge.

Four organizations give comprehensive service, that is, physicians' care in the home, office, and hospital; surgery, maternity care, and hospitalization. Their monthly charges for a family are $3, $4, $4.50, and $8. The organization which charges $3 limits hospitalization to 28 days of ward care per person per year; the two which charge $4 or $4.50 make an extra charge for all home calls and provide as much as 6 weeks of hospitalization in a semiprivate room for each person in any one year. The organization which charges $8 provides a special nurse in hospitalized cases, 6 months of hospitalization in a ward in connection with any one illness, or 1 month in a private room if the condition of the patient requires it; it does not, however, provide maternity care. Except for

these variations, the services provided by the four organizations are relatively the same; all provide laboratory service, ordinary drugs, physiotherapy, and X-ray examination and treatment.

Consumer-Sponsored Organizations

The chief distinguishing feature of consumer-sponsored medical-service plans is organization and direction by lay groups which may be organized for this purpose or which maintain a medical-care program as only one of their activities. Physicians may be employed to administer a plan, but the policy-making power of the organization always rests with the membership or its representatives.

Coverage

Approximately 36,000 persons are eligible for some type of medical care in the 14 consumer-sponsored organizations from which information on coverage was received. About 10,000 persons, of whom approximately two-thirds are dependents, are eligible only for physicians' and surgeons' care; approximately 16,000 persons, about half of them dependents, are eligible for hospitalization as well; and about 10,000 persons are eligible for hospitalization and surgical care in the hospital, of whom about one-third are also eligible for obstetrical service and medical care in the hospital.

The consumer-sponsored organizations do not, in general, require group enrollment. Approximately 10,500 of the 36,000 persons eligible for care joined through group enrollment. Of this number, some 6,000 are dependents.

Charges for Services Provided

Information on medical services available to persons eligible for care under 22 consumer-sponsored plans indicates that all plans but one provide care for the dependents of subscribers; all but four include maternity service—usually after a waiting period of 8–12 months and, in almost half of the plans, on payment of an extra charge. Only three of the organizations differentiate in charge for subscribers who join as members of a group and for those who take out individual subscriptions; under these plans, the monthly charge for individual subscribers is 50–95 cents more than for group subscribers.

Hospitalization is provided by half the organizations. Some plans allow from 21 to 90 days, others provide hospitalization deemed necessary by the physicians, and a few limit the length by the total value of services to which a person is entitled. Eighteen plans provide physicians' care in the office or clinic, 15 provide home calls—with additional charges for all such calls in 5 plans, for the first home call in 2 plans, and for mileage in another. All the organizations include surgical care as a benefit; however, two plans charge extra for surgery. Care for maternity cases is provided by 18 organizations, 8 of which make an extra charge. All the plans include laboratory services; the majority provide physiotherapy and X-ray treatments and examinations; and about half treat patients with venereal diseases and tuberculosis, though some give such care only until the patient is institutionalized.

One consumer-sponsored organization, which includes dependents but gives them very limited care, charges the subscriber $2.00–2.50 per month, depending on his age, for visits to the home, office, and hospital by the physician and surgeon, and for hospitalization not exceeding 21 days. Care for maternity cases is not included. Only office calls are provided for dependents.

The other 21 organizations give more extensive care to dependents. Six organizations provide the services of physicians and surgeons and hospitalization to both subscribers and dependents, and charge from $2–6 per month for a family of four; three charge $2 for this care but make an extra charge for maternity cases and do not include home calls; and one plan gives hospitalization at reduced fees. The plan which charges $3.35 includes services in connection with maternity cases and home calls but provides hospitalization only on payment of reduced fees.

One plan charges $4.80–5.75 per month for a family of four, depending on type of enrollment. Subscribers are eligible for the service of physicians and surgeons and hospitalization; dependents are eligible for hospitalization, but they receive physicians' and surgeons' care on a reduced-fee basis. The plan covers only half of the hospital bill incurred in connection with maternity cases and dependents' gynecological cases and sets a maximum on the total care per year—$1,000 for the subscriber and $1,000 for all dependents.

One plan which charges $6 per month for a

family of four for physicians' and surgeons' services in the office, home, and hospital, and for hospitalization, makes an extra charge of $1 for the first home call in any illness and $50 for hospitalized maternity cases; it places no maximum, however, on the volume of care that the family may receive except by limiting hospitalization to 42 days per person per year. The benefits of the plan include laboratory services, X-ray examination and treatment, physiotherapy, and consultants' services. The majority of preexisting conditions are not treated without charge, but gynecological conditions and venereal diseases are treated, and mental and tuberculous patients and those suffering from any drug addiction are cared for until institutionalized.

Information on charges was received from 11 of the organizations in which the care provided consists of the services of physicians and surgeons and includes care for maternity cases. For these services, six of these groups charge $2–3 per month for a family of four; four make an extra charge for all home calls; one charges for the first home call in any illness; and two charge extra for maternity care. One of the organizations which charges $2 limits its members to group enrollees and makes an extra charge of $1 for each home call during the day and $2 for each night call.

One organization charges $3.00–3.75 (depending on the type of enrollment) for such care, and makes an extra charge for maternity care and for home calls in surgical cases; it does not provide X-ray, physiotherapy, or consultants' services. Three organizations which charge $3.70, $4, and $4.70 provide these services and make no extra charge for home calls, or surgical or maternity cases. One organization charges $6.00–6.50 (depending on the type of enrollment) for the same items of care and makes an extra charge for maternity care.

Four consumer-sponsored organizations which provide hospitalization and medical and surgical care for hospitalized cases charge $1.00–2.75 per month for a family of four. One which accepts subscribers only through group enrollment charges 40 cents a week for a family of any size but limits to $250 and 21 days of ward hospital care the maximum benefits that a family may receive; all benefits, however, are figured according to a fee schedule much lower than the usual charges. This organization gives obstetrical care for patients delivered in the hospital. Two groups charge from $1.00–2.90 a month, according to the value of the maximum annual amount of service for which the subscriber wishes to be insured (from $150 to $300) and the age of the dependents. These plans have a $30-deductible clause and do not pay for obstetrics or for physicians' services in nonsurgical hospitalized cases. One of the plans provides private hospital accommodations, and the other does not specify. The fourth organization, which charges $2.75 per month for a family of four, provides surgery and laboratory and X-ray examinations to ambulatory as well as hospitalized patients, and 21 days of ward hospitalization a year per individual covered by the contract, except for maternity cases, in which it assumes half the cost of hospitalization.

Farm Security Administration Plans

Since 1936, the Farm Security Administration (formerly the Resettlement Administration) has had medical-care plans under which specified amounts are included in the loans or grants made to Farm Security Administration clients to enable them to pay for their medical care on a fixed monthly basis. The FSA does not administer the medical-care plans directly. Its function is to reach an agreement with the State medical associations and with local medical societies, to advise on matters of organization, and to advance loans to its clients. Plans are developed only after satisfactory agreements with the local medical societies have been reached. The amounts paid by the families vary somewhat in different localities, but the usual payment is between $15 and $35 per family per year. The plans in general include home and office care by the physician, hospitalization, surgery, and drugs. Under the majority, the doctors agree to a uniform-fee schedule. If the bills for the month are less than the money set aside, the doctors and others who have rendered professional services are paid in full. If the bills amount to more than the funds allocated for the month, they are prorated.

Coverage.—On June 30, 1941, there were 881 counties in 35 States throughout the United States which had FSA medical-care programs in operation for rehabilitation borrowers, an increase of 242

counties during the year. Enrollment in these plans included about 104,000 families—approximately 546,000 persons—representing approximately 60 percent of all eligible FSA families in the areas covered and an increase of about 33 percent in enrolled persons over the previous year. In addition to these medical-care programs, the FSA makes provision for medical care in connection with the resettlement projects, and 75 such projects had medical-care groups in June 1941. In 37 of these projects, the families were participating in the groups organized for rehabilitation borrowers. The remaining 38 had their own medical-care groups, with a total membership of 4,000 families.

Since the spring of 1938 medical care has also been provided to medically indigent migrant farm families in California and Arizona through the Agricultural Workers Health and Medical Association, a nonprofit organization which is subsidized by FSA grants. During the past fiscal year medical-aid programs were established for migrants in Florida, the Rio Grande Valley of Texas, in Oregon, Washington, and Idaho. These programs function mainly through clinics established in each of the FSA migratory-labor camps. Provision is also made for referral of cases through these clinics or other referral offices to private physicians, hospitals, or dentists. The service of the referral offices is used relatively most extensively in California and Arizona, since these offices provide channels through which the program functions in areas widely removed from FSA camps.

Because of the rapid turn-over among the migrant families eligible for care it is difficult to give an accurate picture of the number of persons eligible to receive this service during a year. The extent of service is indicated, however, by the fact that in California and Arizona more than 4,000 applications for medical care were accepted in June 1941, and during the fiscal year ended June 30, 1941, approximately $1.5 million was expended for all purposes in connection with the medical program in these two States. Programs in the other five States have been organized so recently that comparable information is not available on persons served or expenditures.

Emergency or limited dental care is provided in 113 of the FSA medical-care programs; dental service is available to 15,000 families, composed of 79,000 persons. In addition, 159 units serving approximately 124,000 persons were in operation on June 30, 1941, under agreements to provide limited dental services.

The number of different physicians and dentists who have been compensated for medical and dental services to FSA clients cannot be accurately estimated, but it is known that most of the physicians and dentists living in areas where plans are in existence have approved the projects in principle even though they may not have participated in them.

Other Department of Agriculture Medical-Care Plans

The experimental rural health program which has been approved for six counties in the United States as part of the U. S. Department of Agriculture post-war planning program provides for prepaid health services on the basis of arrangements between a local health association, the county medical society, and other professional groups.

The health associations were organized through the efforts of the County Agricultural Planning Committees, which are made up of community leaders representing a cross section of the agricultural interest of the county. Community meetings were sponsored by these Committees and were attended by a large proportion of the farm families in each area. These meetings served as forums for the discussion of the health problems of the community, and the experience gained from this series of community meetings served as a basis for determining the type of health program later developed by the Committees. The plans reflected in large measure a "grass roots" demand. The local medical society and other professional groups have cooperated with these Committees in planning these programs. They were particularly helpful in working out the professional phases of the program.

Participation in the programs is voluntary, and all farm families residing in the area are eligible. The patterns which are being developed in setting up these health programs are not uniform, because it has been necessary to adjust them to conform with local conditions and needs. In general, however, all member families of an association pay 6 percent of their net cash income up to a maximum amount representing the full cost of providing

services, usually about $50 per year. The experimental program includes general-practitioner care, surgical and specialist care, hospitalization, prescribed drugs, limited dental care, and, in some cases, visiting-nurse service.

The Farm Security Administration is making grants to the associations participating in the experimental program to cover the deficit incurred by including families whose incomes are such that 6 percent is less than the annual family cost of participation. One of the purposes of the program is to ascertain what steps might be taken to raise the level of rural medical services after the war.

Hospitalization Insurance

The largest and most rapidly expanding type of voluntary prepayment for health services is hospitalization insurance. On January 1, 1942, there were 67 hospitalization insurance systems, almost all initiated within the past 10 years, which had been approved by the American Hospital Association. These systems reported 8.5 million subscribers, a gain of approximately 2.5 million since January 1, 1941.[2]

Two significant phases of the growth of hospital-service plans have developed during the past 2 years. The first was the cooperation of certain hospital associations with medical-care organizations or the addition of a new contract to the hospital-service plans to provide surgical or medical care in conjunction with hospitalization. The second was the inauguration and expansion of plans which provide ward service. It has been the belief of some persons that there was a need for service at a rate lower than that offered by contracts which provide care in a semiprivate room. It has been argued, on the other hand, that the majority of persons in the income groups for whom the provision of ward service at public expense—without direct charge to the patient—has been designed are unable to pay for hospital care, even on an insurance basis.

An example of both of these phases is the Community Ward Plan, a cooperative arrangement which is being worked out in New York City between Community Medical Care, Inc., and Associated Hospital Service. The plan provides for 21 days of ward hospitalization a year, of which only 10 may be for maternity care, and for payment of $4 a day to the attending physician. In maternity cases, the plan will pay the physician $3 a day and the subscriber is supposed to pay $1. The subscription rate is $12 annually for an individual and $27 for a family. Half of this amount covers hospitalization and half the physicians' care. Individuals with an income of more than $1,200, couples with more than $1,680, and families with more than $2,100 are not eligible for membership. Seventy hospitals and their staffs and more than 2,400 individual physicians are cooperating.

In connection with hospitalization insurance, it is of interest to note that in his Budget message of January 5, 1942, to the Congress the President recommended the provision of "hospitalization payments" through the Federal old-age and survivors insurance system. No specific plan has yet been advanced by the Government. Studies and discussion are proceeding, pointed toward legislative consideration of recommendations for expanding and strengthening the social insurances.

[2] In addition, an estimated 2 million employees are protected against hospital costs and some 1.4 million protected for surgical benefits by group policies sold by insurance companies. An unknown number of dependents of these employees are also eligible for care.