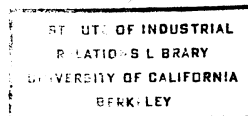


HEALTH INSURANCE

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INSTITUTE OF INDUSTRIAL RELATIONS
UNIVERSITY OF CALIFORNIA, (LOS ANGELES)

Los Angeles 2 1954



- *Major Types of Health and Welfare Plans*
 - *Principles of Health Organization*
- *Comprehensive Care through Prepayment Plans*

HEALTH INSURANCE

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In recent years, the American people have become increasingly preoccupied with the problem of medical care. The need has consequently arisen for more information on the development and scope of existing health plans, on the capacity of these plans to meet current needs and on possible future developments in health insurance.

The Institute of Industrial Relations, University of California at Los Angeles, has for the past two years conducted a health education program in the Southern California region.

This brochure is composed of materials developed by members of the Institute staff in connection with that program. These materials, it is hoped, will be of some assistance to members of the community in their search for adequate medical care.

MAJOR TYPES OF HEALTH AND WELFARE PLANS*

Insurance company, Blue Cross, and Blue Shield programs provide most of the protection that exists today against medical and hospital bills. These programs were originally designed primarily for coverage of hospitalized illness, therefore affording little opportunity for health education, early detection of disease, and treatment in the early stages of an illness. Unions have recognized these limitations and have worked with varying degrees of success with the voluntary programs in an effort to secure greater benefits through them.

In some instances, coverage under health and welfare plans has been obtained from cooperative prepayment organizations and from group-practice clinics. As a rule, these programs provide some preventive and diagnostic services and often physicians' services in the office and the home as well as in the hospital. The Kaiser Foundation Health Plan and Ross-Loos Medical Group are examples of group-practice programs serving union groups in California.

A limited number of union groups handle their own benefits. In some instances, reimbursement is made in cash, either from a fund or from an insurance company set up by the union; in others, the unions have established health centers to provide preventive, diagnostic, and various other services to their members. Services at the center are usually supplemented by some form of voluntary health insurance covering hospitalization and physician's care during hospitalized illness.

The selection of a particular type of program depends on many factors, including age, sex, marital status, geographical distribution, and socioeconomic characteristics of the employees to be covered, the amount and types of benefits to be provided, and the method of financing the program. These same factors influence the cost of the program as well.

INSURANCE COMPANY HOSPITAL AND MEDICAL CARE CONTRACTS

With only one or two exceptions, insurance-company contracts provide indemnity benefits. The provision of such benefits and the large areas covered by the companies have made it possible for them to assure uniform coverage to large and scattered union groups. Policies are adapted to meet the needs of special groups, and "package contracts" offer unions and other employed groups a chance to purchase hospitalization and medical coverage along with life insurance, sickness and accident, and various other health and welfare benefits. The fact that insurance-company plans may be administered in a union or trust-fund office has provided an additional advantage.

When the insurance company underwrites a hospitalization plan, it issues a group policy to the trust fund, setting forth in detail the terms of the contract. Each employee who is covered by the group policy receives a certificate summarizing the provisions of the group policy that principally affect him.

INSURANCE-COMPANY HOSPITALIZATION PLANS

*Adapted from *Management and Union Health and Medical Programs*, published by the Public Health Service of the U.S. Department of Health, Education, and Welfare, 1953.

daily benefits

The policies provide for reimbursement to the insured of a flat daily benefit for a stipulated number of days for continuous hospital confinement or for each admission for a different period of disability. Any daily benefit desired by the trust fund is available; the daily benefits may run for any number of days. Usually the payments range from \$8 to \$14 per day for 31 to 70 days for any one hospitalization period. There is usually no limit to the number of days that benefits are payable during the year if each hospitalization is for a different illness. A few policies provide for reimbursement up to a certain amount, the rate per day and the duration not being specified. The trend is to increase the benefits to meet union demands.

special hospital services

Cash-indemnity plans make a specific reimbursement for additional hospital charges. The amount is usually based upon the daily benefit, ranging from 5 to 35 times the daily indemnity.

choice of hospitals

The insured may be hospitalized in any legally recognized hospital located anywhere in the United States or Canada.

exclusions

Insurance company plans exclude hospitalization for industrial injuries or diseases for which the employee is entitled to benefits under workmen's compensation laws; hospitalization for military-service-connected disabilities; and for plastic operations for cosmetic or beautifying purposes. Maternity benefits are often not payable if pregnancy exists on the effective date of the policy.

dependents

Under almost all cash-indemnity plans, the daily-benefit allowance for dependents is less than that for the insured employee.

termination

All hospital-expense insurance underwritten by a regular insurance company automatically ceases on the date of the termination of employment.

**INSURANCE-COMPANY
SURGICAL AND MEDICAL-
CARE PLANS**

benefits

These policies vary widely in scope of benefits. The features that require special consideration are:

The indemnity policy most commonly written reimburses the insured for surgical expense only. The insured employee is reimbursed for the surgical fee up to the amount listed in the fee schedule, but in no event is the allowance more than the actual fee charged by the doctor. Typical schedules are the \$250-maximum plan and the \$350-maximum plan. Each specific operation in the higher-maximum plan is increased proportionately. The policies also specify a maximum amount that will be paid during any one continuous period of disability, should more than one operation be required.

Among the plans that provide reimbursement for medical nonsurgical expense, some are limited to reimbursement of costs of physician's visits while the patient is in the hospital, or to "in-hospital" benefits. Others provide for reimbursement of the cost of a physician's visit at the home of the insured or at the physician's office. Under a cash-reimbursement program providing nonsurgi-

cal care, payments to employees usually do not exceed \$3 for a hospital or office visit and \$5 for a home visit. Limitations are usually made on the number of such visits. Coverage usually excludes the first two or three visits in illnesses, but includes the first treatment in accident cases. Some policies also provide limited reimbursement for additional costs such as x-rays, electrocardiograms, laboratory analysis, etc.; but hospitalization is normally a condition of such coverage.

Medical-expense insurance written by insurance companies generally excludes occupational injuries or illnesses that entitle the insured to benefits under workmen's compensation or occupational-disease laws. It also excludes plastic-surgical operations for cosmetic or beautifying purposes if the condition existed at the time the policy was written. The coverage in the policies written by the large insurance companies is otherwise usually all-inclusive, even covering chronic conditions, alcoholism, heart disease, and nervous breakdowns. Some small companies, in an effort to get business, offer very limited policies for low premiums. In some cases, the exclusions in these contracts permit the carrier to evade almost any claim. (Groups should study the exclusions in a policy very carefully so that they will not be tempted by a cut-rate premium to buy a policy that is not satisfactory.)

exclusions

The employee may choose any legally qualified physician or surgeon.

*choice of
physician*

The indemnity policy reimburses the insured up to the amount listed in the schedule of operations for surgical fees for delivery, Caesarian section, abdominal operation for extrauterine pregnancy, and miscarriage. There is sometimes a waiting period before maternity benefits will be paid.

*maternity
benefits*

Insurance companies will underwrite surgical care plans or surgical and nonsurgical medical care plans with any reasonable benefits desired by the trust fund.

*uniformity of
benefits*

INSURANCE COMPANY MAJOR MEDICAL (CATASTROPHIC ILLNESS) CONTRACTS

Insurance companies have recently begun to issue group major medical expense contracts (usually referred to as "catastrophic" coverage) to cover unusually expensive or long-term illnesses. The contract is similar to other group-insurance contracts in that a master policy is issued to the employer and certificates are issued to the insured employees. No physical examination is required. The policy is designed to meet major costs (usually above \$300). It is anticipated that other health plans will cover the deductible amount, or that the patient will pay it himself.

The distinctive features of catastrophic health contracts are:

- deductible amount* A deductible amount of \$300 to \$500 is paid by the insured individual.
- coinsurance clause* The insurance company pays, for each separate illness or injury arising out of any one cause, 75 per cent of the expenses in excess of the deductible amount, to the maximum stated in the policy. The purpose of the coinsurance clause is to serve as a check on incurring needless expenses.
- maximum amount* The maximum amount of the policy varies between \$2,000 and \$5,000.
- income limits* Major medical policies once tended to impose a minimum-income limit for eligibility instead of a maximum-income limit. Early experience had suggested that employees earning less than \$5,000 were rarely interested in major medical policies; enrollment was mainly confined to personnel such as department heads, managers, executives, and salesmen. Recent experience now suggests that increasing numbers of employees earning less than \$5,000 per annum are interested in subscribing to plans providing major medical expense coverage. The minimum-income limit is thus being imposed with less frequency.
- benefits* Deductible and coinsurance factors have already been mentioned. Each new injury or illness is entitled to its own maximum. Coverage usually includes expenses for the diagnosis, treatment, or care of nonoccupational, accidental bodily injury or disease. This covers fees charged by physicians, surgeons, and nurses, hospital and clinic charges, x-ray examinations and treatments, laboratory tests, anesthesia, drugs and medicines, and all other therapeutic services and supplies.
- exclusions* All policies state that the charges must be reasonable and the services necessary. The reasonability of charges is gauged by comparison with practices by reputable persons and organizations in the area. Policy coverage is broad; only workmen's compensation cases are not covered. Pre-existing conditions are covered, provided the employee is at work when the policy is written. Psychiatric treatment is covered, and also dentistry if directed by a physician.
- choice of physician* The insured may choose any physician licensed to practice medicine.
- waiting period* There is no waiting period. All conditions are covered from the day the policy is written, provided the employee is at work that day.
- dependents* The plan may or may not cover dependents. The charge for each dependent is usually higher than that for the original subscriber.
- uniformity of benefits and premiums* Major medical plans are highly flexible. Coverage, premiums, and deductibles vary considerably with particular needs.
- claims* Major medical plans are indemnity plans, but companies will pay hospital and doctors' bills directly, if requested by the insured. In cases of prolonged illness, bills are paid from time to time as received.

Group catastrophe insurance terminates with employment. Unlike the usual group policy, a retiring employee may remain within the insured group and continue to pay the regular premium through the employer. The employee also has the opportunity of converting to an individual policy within 31 days.

termination and retirement

Interest in catastrophe coverage is growing. General Motors, Sears, Roebuck and Company, and Socony-Vacuum Oil Company are among the large business concerns which have recently adopted catastrophe policies for those of their employees earning \$5,000 or more a year. Other indications of interest in expanding catastrophe coverage have been the bills introduced in Congress providing for a Federal Reinsurance Service.

BLUE CROSS HOSPITAL PLANS

Blue Cross plans in California are almost entirely service programs. Outstanding features of Blue Cross contracts are summarized as follows:

Blue Cross plans usually provide for room and board, including special diets and general nursing, in a semi-private room or ward in a member hospital. Benefits are provided for a stipulated number of days, ranging from 35 to 120, for each separate period of disability. Blue Cross pays the ward allowance toward the room charges to subscribers who take a private room in the hospital.

daily benefits

Blue Cross plans provide for room and board, general nursing care, use of operating room, laboratory service, and medication and dressings. In addition to these basic services, plans provide for specified extra hospital charges, which vary with the plan. There is no limit on the cost of the services provided, but only those specified in the contract are allowed. Services usually allowed are the following:

special hospital services

Oxygen and use of equipment for administering oxygen.

Anesthesia supplies and use of anesthesia equipment—administration of anesthesia only if administered by an employee of the hospital.

Dressing and plaster casts.

Use of cardiographic equipment.

Basal metabolic examinations.

Use of physiotherapeutic equipment.

Laboratory and x-ray examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required.

Use of cystoscopic room and equipment.

Blue Cross plans require hospitalization in a local member hospital, that is, one with which the hospital association has a working contract. Almost all legally recognized hospitals are member hospitals. If all of these are occupied, the subscriber is put on a waiting list, or occupies a private room and pays the additional cost. Through reciprocity of services, Blue Cross plans provide hospitalization in member hospitals located out of the area covered by the hospitalized subscriber's plan.

choice of hospital

Maternity care requires a waiting period of nine months. In all other cases, benefits are available immediately after employment.

waiting period

maternity benefits

Blue Cross plans offer indemnity benefits (instead of service) only in maternity cases. Limitations exist on the number of days for which daily benefits are available, as well as on the total amount allowed.

out-patient service

Benefits for out-patient service are provided only in the case of emergency service obtained within 24 hours after an accidental injury.

exclusions

Broadly speaking, Blue Cross covers any illness that is treated in a general hospital. Benefits are not provided for workmen's compensation cases; hospitalization furnished under federal, state, or other laws; rest cures; and admissions primarily for diagnosis or physical therapy.

dependents

A family contract entitles dependents to the same benefits as the subscriber, except maternity benefits.

transfer and termination

When a subscriber changes his job, he may continue his membership by making payment directly to the plan at a slight increase in rate, or he may apply for a transfer to an existing Blue Cross group at his new place of employment. There need be no lapse of coverage. If the subscriber moves to another community, he may enroll in the Blue Cross plan there without a waiting period. He may continue his membership after retirement and after he reaches the age of 65, although he cannot enroll after the age of 65, except in large Blue Cross groups where the age limit is waived.

claims

A member need only show his Blue Cross identification card to be admitted to the hospital. No questions are asked; no financial references, no employer-verification of illness, no other claim forms are necessary. The member pays only the portion of his bill that is not covered by his contract; Blue Cross pays the balance directly to the hospital.

CALIFORNIA PHYSICIANS SERVICE (BLUE SHIELD)

Blue Shield has three classes of contracts: (1) individual, which cover only one person; (2) husband-and-wife, which cover the employee and his or her spouse; and (3) family, which cover the employee, his or her spouse, and all unmarried children under 19. The benefits under each are the same, except that the family contract offers maternity benefits. Features of these contracts are summarized as follows:

benefits

Hospital benefits are provided by C.P.S. Blue Shield in any licensed hospital in the world. In California, hospitals are paid directly their retail rates for listed services and for the three-bed ward rate. Benefits vary from 25-day contracts to 100-day contracts. In some contracts there is an additional rider for \$300 to provide for certain other hospital extras.

Surgical plans provide professional services in or out of the hospital. Surgery includes any cutting or incision, care of fractures or dislocations, suturing of wounds and lacerations or destruction of diseased tissue by such things as cautery, etc.

Ambulatory medical care is available to the employed member only. However, in-hospital medical care can be made available to all members. Most ambulatory medical contracts provide that the first two visits are deductible except in accident cases. There are no visits deductible on in-hospital medical-care contracts. In complicated and serious illnesses, there is no limit to the amount of service being rendered, or to the number of doctors necessary for the care.

Claims are paid from a fee schedule developed for C.P.S. by the California Medical Association and is administered on a service basis, which means that the fee schedule is not governed by flat fixed amounts.

In ordinary procedures wherein the postoperative course is normal, a total item is paid. In cases where it is anticipated that normal after-care is a matter of about two weeks, the fee for the procedure is total, except that, when the after-care extends beyond this period, all services are paid for additionally. In cases where the postoperative course is completely unpredictable — such as the treatment of certain traumatic wounds, fractured skulls, burns, etc. — the fee schedule provides payment for the primary procedure, and all after-care is paid for additionally.

The services of certain other doctors, such as assistants, anesthetists, and surgical consultants, are also provided.

Doctors belonging to Blue Shield agree to accept the fees paid by the plan as total payment for professional services if the patient's income falls below a certain limit. The usual limit in California is \$3,600 for a single person and \$4,200 for a family. The physician may charge an additional fee to patients whose income exceeds this limit.

income limits

Some efforts are being made to increase the income limit to a higher figure or to eliminate the limit altogether. The last convention of the California Medical Association authorized the individual county medical associations to increase the family-income limit to \$6,000 if they so wished. Recently, the doctors in the San Pedro-Wilmington area of Los Angeles agreed to abolish the limit entirely for groups enrolling in C.P.S. in that area.

The subscriber may choose either a "participating" or a "nonparticipating" physician (either doctors of medicine or doctors of osteopathy). A participating physician is one who has entered into a service agreement with the organization. A nonparticipating physician is paid the same allowances, but he may make an additional charge to the subscriber, regardless of the income status of the subscriber. Many of the best physicians in a community participate in C.P.S.

choice of physician

Allowance is not made for the first two visits to the doctor, even in plans including medical coverage. Some plans exclude all medical care, or require that the patient must be hospitalized to receive benefits for nonsurgical medical treatment.

exclusions

Plans exclude industrial injuries or diseases that are covered by workmen's compensation laws and care furnished under federal, state, or other laws. Also excluded are functional disorders of the mind or nervous system, rest cures, cosmetic surgery, etc.

*maternity
benefits*

Although most plans provide a nine-month waiting period for maternity cases, this may be waived. Maternity cases are given virtually the same benefits as other conditions.

*transfer and
termination*

Blue Shield plans have generally the same provisions for transfer of membership and change of contract as do Blue Cross plans.

claims

Blue Shield pays the doctors the scheduled allowance directly, and the subscriber pays any difference between the doctor's fee and the allowance.

THE KAISER FOUNDATION HEALTH PLAN

The Kaiser Foundation Health Plan was started during the 1930's for the purpose of providing health care to employees in the Hoover Dam and other Kaiser projects in that area. Later, the Plan was extended to cover Kaiser employees in the Grand Coulee Dam project and in the Oakland shipyards. At the end of World War II, the Plan was made available to the public through both group and individual family enrollment. The Plan has now been extended to other areas along the West Coast, with a total enrollment at the present time of about 450,000.

The Kaiser Foundation Health Plan is a group-practice, service-benefit organization. Health services are rendered by Permanente Medical Groups, which are partnerships of general physicians and specialists organized on a regional basis. All the major specialties are represented in each group. Hospital care is provided through hospitals built and owned by the Kaiser Foundation; the hospitals are operated by the Kaiser Foundation Hospitals, a nonprofit organization.

The Kaiser Foundation Health Plan has the following general characteristics:

income limits

There are no income limits.

benefits

This is a service-benefit program. Service benefits are provided in greater or lesser degree, depending on the type of contract taken out by the subscriber. In the most comprehensive type of contract, complete medical, surgical, and hospital care (with certain customary exclusions) are provided without extra cost to the subscriber. Other types of contracts entail supplemental payments by the subscriber at the time he receives the services, such as a fee of \$1 for each office visit, or payment of a sum roughly equivalent to one-half the cost of x-ray and laboratory services. Among the total membership in Southern California, about one-half have the type of contract covering all costs; the rest are enrolled under contracts with several different types of supplementary payment arrangements. Cash benefits up to a maximum of \$250 are awarded in the event of accidental injury sustained more than 30 miles away from a Kaiser Foundation Health Plan center, to cover emergency expenses.

A "multiple choice" arrangement is now being offered in many cases by the Kaiser Plan in cooperation with commercial and nonprofit health insurance

organizations. For a given premium, a "package" is offered to interested groups; if the "package" is purchased by the full group, each individual in the group may then choose between the various plans included in the "package"—usually representing the full range of choice from fee-for-service, individual-practice plans to service-benefit, group-practice plans. The Kaiser Foundation has expressed the hope that this "multiple choice" system will become standard practice in the future.

Exclusions from benefits are the same for all contracts, and are generally as follows: attempts at suicide and other intentionally self-inflicted injuries or illnesses; tuberculosis; alcoholism; conditions covered by workmen's compensation; service-connected conditions; dental care; corrective appliances; conditions resulting from a major disaster or epidemic; contagious diseases and diseases requiring isolation; mental disorders. The Plan formerly excluded poliomyelitis, but with the development of the Kabat-Kaiser Institutes, which furnish special physical therapy care, the Plan has been able to provide rehabilitation services for polio victims among its subscribers.

exclusions

Persons covered by the Kaiser Plan are treated by physicians who are members of the Permanente Medical Groups. The subscriber may choose his personal physician from the larger departments such as internal medicine, pediatrics, and others. The patient can also change physicians within a department; he can transfer, for example, from one internist to another. This arrangement, the Kaiser organization holds, offers as effective a free choice of physician as is available under other types of plans. Opponents of the Kaiser Plan contend that the real choice of physician under the plan is necessarily restricted because of the limited size of the Permanente Medical Groups.

choice of physician

The only waiting period requirement in the Kaiser Foundation Health Plan contracts is that related to maternity care. A higher supplementary payment is required from the member receiving maternity care benefits during the first ten months of membership.

waiting period

Full coverage is provided, subject to the extra charges mentioned above.

maternity benefits

There are no special rates for female members of the Plan. Equal services are provided for equal premiums.

female employees

Services are offered in all contracts on the same basis as those for the employee. There are reduced rates for families.

dependents

There are, as previously mentioned, a number of variations in Kaiser Foundation Health Plan rates, depending on the coverage provided and the size of enrolling groups. Individuals may also enroll. Large groups may also negotiate special contracts whereby the Kaiser Plan will supplement Blue Cross or insurance company benefits.

rates

transfer

Any subscriber leaving his place of employment may transfer from a group contract to an individual contract. There are no obstacles to the transfer of a subscriber from one Kaiser group to another in a different area.

procedure for receiving service

A subscriber needs only to show his health plan identification card when receiving service.

THE ROSS-LOOS MEDICAL GROUP

The Ross-Loos Medical Group is a copartnership of physicians and surgeons licensed to practice in the State of California. The plan has been in operation for over 25 years. At the present time, a full-time staff of 125 doctors is providing health care for over 125,000 persons in Los Angeles County. The Group occupies a 13-story building in downtown Los Angeles and has 13 offices in outlying areas of the county. The plan has the following general characteristics:

income limits

There are no income limits, no extra charges because of income.

benefits

The Group provides such medical care and treatment as is necessary in the case of injury or illness, including office consultations, house calls, physical examinations, eye examinations and refractions for glasses. The Group also provides all surgical operations necessary in the case of illness or injury, including the services of an assistant and anesthetist; pre- and post-operative care is also provided. In maternity cases, complete pre- and post-natal care is given, including office and home calls, all necessary tests during pregnancy, delivery, and associated surgical procedures, and other services required in the event of miscarriage, ectopic pregnancy, or Caesarian birth. Laboratory procedures, x-ray examinations, and physiotherapy are given when ordered or approved by the attending Ross-Loos physician.

World-wide hospital benefits for Ross-Loos subscribers and dependents are provided by the Independence Insurance Company on an indemnity basis. An amount, not in excess of a specified amount per day, is payable for room and board for each day of confinement and continues for a specified number of days. The same is true of charges made by the hospital for necessary services and supplies, as well as charges made for ambulance transportation to or from the hospital. The plan also provides emergency accident out-patient coverage.

A "dual choice" group policy is offered by Ross-Loos in cooperation with the Independence Insurance Company. Under this arrangement, any individual in the subscribing group may choose between (1) medical services with Ross-Loos and hospital services with the Independence Insurance Company, or (2) medical and hospital services with the insurance company. The premium in both cases is the same; medical benefits, however, vary.

exclusions

There are some customary exclusions from the benefits provided to Ross-Loos subscribers and their dependents. They include service-connected disabilities, mental illness, and conditions arising from acts of war or catastrophes. Medical care and services to which the subscriber or dependent is not entitled as a regular service may be rendered in certain cases, when ordered by the attending physician, on a fee basis.

In the case of individual policies, all individuals are required to undergo a physical examination prior to enrollment; coverage for pre-existing conditions is then sometimes waived. In group enrollment, the physical examination is frequently omitted, and pre-existing conditions frequently included in the benefits. Pregnancy is never treated as a pre-existing condition.

The subscriber may choose any Ross-Loos doctor when service is required within the Ross-Loos service area. Supplemental benefits are provided outside this area by the Independence Insurance Company.

*choice of
physician*

There are no waiting periods.

waiting period

As previously mentioned, complete maternity coverage is provided, even when the subscriber is pregnant at the time of enrollment.

*maternity
benefits*

Female employees receive the same benefits as male employees for the same monthly payment.

*female
employees*

Dependents are entitled to receive the same care and service as is available to subscribers at special rates and fees prescribed in advance.

dependents

All group contracts in Ross-Loos offer identical coverage at varying rates depending upon the average age of the group. All individual policies are offered at the same rate with varying coverage depending upon age and other factors.

rates

When a subscriber is no longer eligible through his group he may transfer to an individual policy and continue the combined plan at a slightly higher cost.

transfer

In the case of medical and surgical care provided by the Ross-Loos Group, the patient is provided with an identification card; the presentation of this card, or a check with the Group records, is sufficient so far as the provision of service benefits is concerned. In the case of hospitalization and other benefits by the Independence Insurance Company, the patient signs an authorization whereby the hospital or other agency providing the care is authorized to bill the Company for the services; no other action on the part of the patient is required.

*procedure for
receiving service*

PRINCIPLES OF HEALTH ORGANIZATION

Recommendations of the President's Commission on the Health Needs of the Nation

The provision of adequate health services at reasonable cost to all American citizens is clearly a problem of national importance. With this in mind, President Harry S. Truman appointed, in December of 1951, a Commission on the Health Needs of the Nation. The task of the Commission was to survey the present and prospective health needs of the United States, and to make appropriate recommendations. The Commission reported back to the President in December of 1952. Its findings and recommendations are of fundamental importance to those interested in improving, in particular, the health plans to which they are presently committed, and in general, the health standards of the American people.

The Commission accepted the principle that all persons should have access to comprehensive health services of high quality. Popular demand for such services is, in fact, constantly increasing. They are available to most people, however, only through special financial arrangements. The old system of direct payment from the patient to the physician is therefore rapidly being replaced, because of the high costs of medical care, by prepayment plans. These plans have, indeed, been the medical success story of the past fifteen years.

prepayment

Hospital insurance plans are by far the most prevalent form of medical insurance in the United States. As of July, 1953, they were subscribed to by about 87.4 million people; 43.3 million were in individual and group insurance company plans; 41 million were in Blue Cross plans; 10 million subscribed to other plans. Some 74.5 million also had surgical or medical insurance with varying degrees of coverage. Only about 5 million people were covered by prepayment plans described as comprehensive, and even in some of these plans there were considerable limitations in the benefits provided.

The Commission concluded that the present system of payment for medical care is deficient. Voluntary insurance has solved some but by no means all problems in the field. The gains in enrollment have been impressive, the extension of services less so. The average coverage provided is inadequate: in one study made in New York, one-third of the families questioned reported that they had paid medical bills of \$100 to \$400 *above* the costs of their insurance; some families reported *additional* expenditures of over \$600. As already shown, only a fraction of the people are covered by comprehensive prepayment plans.

The Commission recommended that prepayment be accepted as the most feasible method of financing the cost of medical care. It urged, further, that prepayment plans be developed which provide more adequate coverage. This can best be done through the association of prepayment plans with group practice, where the system of cash indemnities is replaced by that of service benefits. Under this system, a group of physicians would provide comprehensive health services to a group of patients, receiving a fixed amount per patient at regular intervals irrespective of the services rendered.

group practice

Group practice is the association of a number of physicians to use their combined skills and resources in the provision of health services. The group practice of medicine is a long-established institution in the United States. It is, according to the Commission, "a curiously American phenomenon," almost unique to this country.

Medical groups vary in size, organization and purpose. Some groups are operated by one individual who employs the other physicians in his group; many groups are partnerships, sometimes hiring extra physicians as employees; other groups are set up by consumer organizations, employers, and/or unions.

There is a sharp division of opinion on the value of group practice. Its supporters say that no individual physician can master all the complexities of diagnosis and treatment; that many sick people, if they are to receive the best care, must be seen by more than one physician; and that group practice is the only way to do this efficiently and economically. Groups of physicians, by pooling their financial resources, can maintain equipment for diagnosis and treatment that none of them could afford as individuals. The incomes of physicians in group practice are more stable and in many cases higher than incomes in individual practice; financial security enables the physicians to concentrate more on their work. The patient receives better service at lower cost through group practice. Group practice, in general, raises community health standards by good example, frees the physician of all but medical duties, provides better preventive medicine, and assists in the development of prepayment plans.

The opponents of group practice assert that most of its "advantages" are theoretical only. The primary criticism is that most patients can be adequately treated by an individual practitioner; and that group practice in this respect is "inefficient, time-consuming and unduly expensive." The physician loses some of his independence of judgment and action in a group, and his development is retarded by constant supervision. Group practice isolates members of the groups from the profession as a whole; the individual physician, associating with the profession in general, receives more stimulus through contact with his colleagues than the member of a group. Higher incomes in group practice are earned only by inferior physicians who could not succeed in individual practice. The ability of the group to provide expensive equipment is becoming progressively less important as regional specialist, hospital and laboratory services expand. Group practice results in excessive referral to specialists; the important patient-physician relationship is impaired. Many groups employ inadequately trained physicians as "specialists," thus lowering professional standards.

The Commission, while admitting the possibilities of abuse, supported group practice. Group practice is, the Commission stated, a practical answer to the problems of complexity and high cost in modern medicine. Groups can give more comprehensive and specialized care than the individual physician; they provide better value for the dollar. The concentration of health services in one place gives greater unity and continuity to the care of patients, encourages consultation and minimizes travel. Physicians working in groups receive continuous stimulation from their colleagues, have immediate access to a wide field of specialized knowledge, and are able to devote more time to study. The Commission agreed that group practice provides stable incomes generally higher than those in individual practice, and that this financial security enables physicians to concentrate more on professional matters.

The Commission applauded the recent trend of combining group practice with prepayment, and suggested that it be further developed. In particular, the system of per capita payments for service benefits through group practice offers many advantages. As the physician receives the same income irrespective of the number of patients he treats, an incentive is provided for preventive medicine and thorough care; unnecessary operations and treatment, often given for financial reasons under other systems of payment, are eliminated. Fee-splitting and overcharging are no longer possible. The heavy administrative expenses of the cash indemnity system are greatly reduced. Above all, specialized medical care is continuously available to the patient at a predictable cost.

Some opposition to the spread of prepayment-group practice plans may, the Commission observed, be expected from the medical profession.

The Commission suggested that organized medical bodies review their attitudes towards group practice in a spirit of tolerance. On the other hand, proponents of group practice should pay careful attention to the objections of the medical profession; the Commission noted that there had been a high mortality rate amongst medical groups, and that special care should be taken to ensure sound financial and administrative arrangements to preserve high medical standards. Group practice should, however, be encouraged, and the Commission recommended the provision, where required, of federal loans to local organizations for this purpose.

The report of the Commission stated that present-day deficiencies in health organization cannot be met by prepayment and group practice alone. These deficiencies are said to be considerable. They begin with the general, severe shortages in modern equipment and trained personnel. Personnel and equipment are, in turn, inefficiently used. Public health services, medical schools and research are all inadequately provided for. Medical centers, especially those in rural areas, are too often isolated from the mainstream of medical developments. Health education of the public is inadequate. The existing pattern of health services in many areas tends to confuse the patient and leads to much delay and unnecessary expense.

*regional
organization*

These deficiencies in the organization of health services have prompted many health agencies to cooperate on an area basis. Regional cooperation has emerged as a definite trend in the organization of health services. Regional organization — in which prepayment-group practice plans would clearly play an important part — is recommended by the Commission in the provision of more comprehensive health services.

The regionalization of health organization, the Commission adds, “means cooperation between all responsible agencies in ways that best meet the needs of each region.” The Commission goes on to emphasize that:

- (a) One of the best, least radical and least expensive ways of improving medical care is to organize better what we already have. We should therefore get all local health agencies and personnel to work more smoothly together.
- (b) Regionalization does not discourage individualism in the practice of medicine. It actually enhances individual effort.

- (c) Regionalization preserves the American tradition of local autonomy, customs and characteristics, while seeking greater comprehensiveness and efficiency in medical services.

Regionalization of medical services has been widely discussed throughout the nation, although its application has been "slow and fragmentary." Progress has been slow for several reasons: lack of general knowledge of the problem, the misgivings of the medical profession, the difficulty of adopting new organizational and administrative methods to cope with the complexity of regional health services, and the problem of obtaining adequate finances.

Several regional programs appear to have been successful. The reasons given for their success are that regional programs improve health organization by integrating hospitals, medical schools and personnel over a wide area. The joint use of resources reduces costs and helps to avoid duplication and waste. Improved organization equalizes the standard of treatment throughout the area, this being particularly important in outlying districts. More post-graduate training and education for the individual practitioner is made available, enabling him to keep abreast of medical developments. Preventive medicine is practiced on a wider scale.

Provision can be made in all regions for the initial and continuing education of all health personnel. Advisory services can be provided for those institutions unable to afford them. Services such as blood bank operations and the purchasing of hospital supplies might best be conducted on a regional basis.

comprehensive health services

The Commission's report thus advocates three principles which it considers vital to the provision of more comprehensive health services. The principles are *prepayment*, *group practice*, and *regional organization*. The first puts adequate health care within the means of the average citizen. The second is to provide the care on a basis which combines high professional standards with personal service. The third is to supply the scale of organization necessary to cope with the increasing cost and complexity of health services while retaining local independence.

Recognizing the financial and organizational problems involved in establishing new health programs, the Commission recommended the institution of federal-state cooperation to assist in health planning. A single health authority would be set up in each state, and would draw up a plan for comprehensive health services within the state. Existing resources would be used where possible. Federal funds would be provided if state plans complied with broad federal standards, but actual federal supervision would be minimized. Where there was no federal-state cooperation, federal grants would be made direct to local or regional organizations for the establishment of pilot health plans.

The Commission, however, laid constant emphasis on the need for flexibility and variety in organization according to local circumstances. In his final letter to the President, the Chairman of the Commission stated the belief of himself and his associates that "good health care starts at the grass roots." The report itself said that the local community or regions should be the focus for the administration of health services. Local voluntary action should provide much of the initiative for the planning of adequate health organization. Federal and state funds should be used to encourage rather than administer, to promote

rather than control, the local and regional organizations to which they are given. In every case, the final form of organization should be determined by local needs and desires.

"We believe," said the Commission, "that access to the means for the attainment and preservation of health is a basic human right." Throughout the report, the Commission worked on the assumption that the goal should be comprehensive health care for all. According to the Commission, the achievement of that goal depends in large measure upon the widest possible application, preferably in concert, of the three principles here discussed — prepayment, group practice, and regional organization.

PREPAYMENT FOR COMPREHENSIVE MEDICAL SERVICES

The principle of prepayment for medical expenses is now broadly accepted throughout this country. The number of persons covered by health insurance plans continues to grow rapidly, so that in 1954 over 90 million persons have some type of insurance. At the same time, the scope of services furnished under prepayment plans is increasing, but it still falls far short of meeting the need.

A number of recent studies, including those of the President's Commission on the Health Needs of the Nation and the Health Information Foundation, have pointed out that existing plans cover only 15 percent of private expenditures for medical care, and that at any one time over 8 million families are in debt for medical expenses. As a result, despite the encouraging expansion of health insurance, there remains an insistent demand for more comprehensive coverage.

Most existing plans do not offer comprehensive service; generally they limit their benefits to hospital and surgical care, and make no provisions for preventive care. Many of them offer only cash indemnity for medical expense, a method of compensation which often does not cover the full charge. Prepayment plans currently available often exclude pre-existing conditions needing care, and do not adequately cover catastrophic illnesses.

For these reasons, the average health plan subscriber does not have assurance that his policy will cover the whole cost of whatever health services he may need. The Health Information Foundation survey showed that while for families with hospital insurance the median percent of hospital charges covered by the plan was 89, and for families with surgical insurance the median percent of surgical costs covered was 75, the median percent of gross medical costs of subscribers covered by insurance was only 32.

The attention of groups interested in health insurance has thus turned increasingly to the means of expanding the coverage under prepayment plans. At present, only 5 million persons, or 3 percent of the population, have substantially comprehensive coverage. As a result, a great deal of experimentation is taking place with various methods of providing as comprehensive coverage as possible to a larger number of persons. Some examples of these new developments are discussed in the following pages.

MEDICAL-SOCIETY-SPONSORED HEALTH PLANS

The claim is sometimes made that comprehensive medical care can be provided only through group-practice plans organized on a service-benefit basis. The experience of lay organizations in sponsoring such plans has also, on occasion, given rise to the belief that such sponsorship is necessary if comprehensive care is to be provided. Services provided through the familiar techniques of individual medical practice and payment according to fee schedules, it is sometimes said, must necessarily be subject to severe limitations in coverage. Even relatively comprehensive coverage, it is held, can be provided under this system only at a cost prohibitive to the average citizen.

It should, therefore, be of interest to examine at least one plan which is based on individual practice and the fee schedule method of payment, and is providing what may reasonably be termed comprehensive health care for its subscribers.*

This plan, Windsor Medical Services, was founded in 1939 by the Essex County Medical Society in Ontario, Canada. Windsor is an industrial city situated in Ontario Province, across the river from Detroit, Michigan. According to a recent report published in the *American Journal of Public Health*, single individuals and family heads are enrolled in groups of ten or more having a common employer, or as 75 percent or more of the workers in larger employed groups. Dependents, including children under the age of 21 and adult relatives under 60 years of age, are covered. The plan has shown a progressive increase in membership and by May, 1951, there were over 100,000 subscribers. This enrollment represents over 50 percent of the total population of the Windsor metropolitan area.

benefits

The Windsor health plan contract provides general practitioner and specialist care for subscribers and dependents at the home, office, and hospital. The benefits include complete maternity service with pre- and post-natal care, well-baby care, immunizations, annual physical examinations, x-ray examinations and treatment, and refractions. There are no age limits, no exclusions of pre-existing conditions, and no extra charges. Waiting periods are, however, required in certain cases: 10 months for maternity cases, 6 months for pre-existing conditions, and 12 months for annual physical examinations and refractions.

exclusions

Laboratory services other than those performed by a physician in his office are not covered. There are no nursing, dental, or drug benefits. There is no coverage for workmen's compensation cases, drug addiction, acute alcoholism, and chronic cases requiring care in an institution other than a general hospital. Hospitalization benefits are not provided. (Blue Cross coverage is available locally, and used by a majority of the members of the Windsor plan.)

rates

The monthly premium (as of 1952) for the Windsor comprehensive contract was \$1.85 for a single employee, \$3.70 for a man and wife, \$5.00 for a family with one child, \$6.10 for a family with two children, and \$7.00 for a family with three or more children.

*This section is adapted from an article by S. J. Axelrod, M.D., and Robert E. Patton, M.P.H., appearing in the *American Journal of Public Health*, May, 1952.

More than 95 percent of the doctors in the Essex County Medical Society participate in the Windsor plan. Doctors are paid according to a fixed fee schedule for each service rendered. Each participating doctor agrees to accept the Windsor plan fees as full payment for services rendered to single subscribers with an annual income of \$3,000 or less, and to families earning \$6,000 or less. In terms of the level of income in the Windsor area, this means that almost the entire enrolled population receives medical care without extra charges.

*medical society
participation*

One of the charges most frequently made against comprehensive medical plans is that they are open to abuse, particularly through over-utilization. In a survey of the Windsor plan a number of facts regarding utilization during 1950 were established. Some of them are enumerated below.

utilization

1. On the average, 3,940 physician's services per 1,000 subscribers were rendered during the year.
2. Annual services amounted to about three for males, four for females.
3. Fewer than 3 percent of the subscribers received night calls (no charge) during the year.
4. "Shopping around" from one doctor to another occurred only to a very slight degree. Only 1 percent of the subscribers saw more than four doctors during the year. Nine percent saw three, 15 percent saw two, and 36 percent saw only one; 39 percent of the subscribers saw no physician at all.
5. There was little difference in utilization of services between subscribers under 50 and those over that age.
6. There was no appreciable difference in utilization between those who had recently joined the plan and those who had been members for longer periods. There was no evidence that the plan had been "swamped" by new members owing to a backlog of unremedied sickness. In no case does there seem to have been utilization in excess of generally accepted standards.

The Windsor plan provides comprehensive medical services of apparently high quality at low cost to more than half the population in the area in which it operates. There appears to be no precise information available on the quality of care offered by the plan, although the indications are that it is high. There is no evidence of substantial dissatisfaction with the plan. Further, such abuses as do occur do not constitute a major administrative or medical problem; the main problem, indeed, seems to be one of under- rather than over-utilization. Nor, finally, does there seem to be cause to believe that the experience of the Windsor plan is in any way necessarily unique. Windsor is an average industrial community; and there is probably good reason to expect that its experience could be repeated in other communities where comparable conditions exist.

summary

Perhaps the major significance of the Windsor plan is its remarkable success in providing comprehensive medical coverage at low cost to the subscriber while still retaining the traditional type of medical practice.

CONSUMER-SPONSORED HEALTH PLANS

Consumer-sponsored health plans are responsible for most of the comprehensive health care now available in the United States. In 1930, there was only one such plan in the entire country, serving a few thousand people. Today there are scores of them scattered throughout the United States, with an estimated membership of between 3 and 4 million. Most of this growth has taken place in the past five years.

The distinctive idea behind such plans is that general policy should be in the hands of lay persons — the consumers or their representatives. Lay jurisdiction is not meant, however, to extend beyond financial and administrative matters; it is not intended that laymen should exercise control over the actual practice of medicine and the doctor-patient relationship. In every case, it appears, an attempt has been made to ensure that professional matters shall remain completely in the hands of the medical staff concerned. In some cases, there is a difference of opinion as to whether this separation of functions has been successfully achieved.

Consumer-sponsored health plans represent every type of health care. Some of them provide indemnity benefits; some, service benefits. Some are based on solo practice, others on group practice. Some provide services only for particular groups, such as cooperatives or labor unions; others impose no restrictions on membership. The range of benefits also varies: some plans provide only out-patient care; others provide comprehensive medical services. It is with two examples of the latter type that this section is concerned.

LABOR HEALTH INSTITUTE

The Labor Health Institute is a group-practice, service-benefit health plan with an enrollment of about 14,000. It was set up in 1945 for what is now Local 688 of the Teamsters Union in St. Louis.

In the early 1940's, studies made by the union revealed that its members lacked adequate medical care for three general reasons: inability to pay, non-availability of health services, and unawareness of the importance of medical care. In 1943, the union entered into negotiations for a health plan which would meet the health needs of the membership. After two years of planning, the Health Institute was established, with Elmer Richman, M.D., as its first medical director.

organization

Policy control of LHI is vested in the membership, and general policy is established at the annual membership meetings. Administration is the responsibility of a board of trustees elected by the membership. This board meets quarterly. An executive committee elected by the board of trustees meets monthly.

The 24 members of the board of trustees, under its own bylaws, are representative of the sponsoring unions, the managements under contract, and the general public of St. Louis. (There are 16 union representatives, 6 management, and 2 general-public representatives.) The president of the Institute, elected by the trustees, supervises all nonmedical activities. A medical director is in charge of all medical staff and activities. Nine standing advisory committees assist the trustees in various aspects of administration. A medical conference committee, composed of five outstanding local authorities in medicine and dentistry, gives professional advice to the medical director and to the president.

The professional staff at LHI numbers over 80, of whom about 20 percent are general practitioners; 60 percent, specialists; and 20 percent, dentists. Except for the medical director, all are engaged in private practice in the community, and work for LHI on a part-time basis. All specialists at LHI are diplomates of specialty boards or board-qualified. All are paid at "going rates" agreed upon between LHI and the medical staff — at hourly rates for services rendered at LHI and hospitals; at fixed fees for home and office calls.

medical staff

The medical staff is under the direction of a full-time medical director. The medical director is selected by the board of trustees and reports regularly to the president of the board. The director initiates the appointment of all physicians, dentists, technical assistants, and other professional personnel, under policies established by the board of trustees. He supervises the functioning of the Medical Center and has final authority on the extent of medical services to be rendered to any individual. The medical director makes monthly reports to the board of trustees and represents LHI at professional meetings and in contacts with both local and national health agencies.

Coverage under LHI may be obtained as a union member, as a dependent of a covered union member, or through a cooperative community group. Although any group in the community may participate, less than 2 percent of the membership has joined in this manner.

eligibility

Waiting periods for benefits vary from 30 to 60 days. Eligibility for benefits continues from 60 to 180 days during sickness and temporary layoffs. Eligibility as a group member terminates immediately upon resignation or dismissal from employment. Employees re-hired within a year after termination are re-eligible immediately.

The entire cost for regular members is paid by the employer under collective bargaining agreements; the amount is fixed as a percentage of payroll. In the great majority of cases, the premium is 5 percent, representing an average monthly expenditure of \$5.10 for each member and each dependent. The average monthly payment for members under the 3.5 percent contract is \$4.89.

rates

Dependents of union members covered by the 3.5 percent contracts may receive limited medical and surgical benefits for a monthly fee of 31 cents. Individual members who continue payment after leaving their place of employment pay \$3.53 monthly. Members of affiliated community groups pay \$2.58 per month; dependents eligible for hospitalization pay only \$1.35 per month. The average cost to employers per employee in the financial year 1951-52 was \$130.05. In 1951-52, about 83 percent of the medical dollar was spent in benefits. The average cost of comprehensive health care to LHI was thus about \$50 per person per year.

LHI offers preventive services and comprehensive medical care at the center, home, and hospital. General medical care is provided by a personal physician selected by the patient from the LHI group; the physician is also responsible for periodic physical examinations and for referral to specialist and ancillary services.

the consumer

Specialist care is provided by doctors in 14 different specialties, including radiology and dentistry. In the latter case, each patient is assigned, after an initial examination, to a personal dentist. Dental services are free of charge. Drugs and materials are provided at cost. Hospitalization benefits are provided up to 90 days each year.

Some services are not provided by LHI. These include care for conditions requiring treatment in a sanitarium or public institution; care for tuberculosis, mental or nervous disorders, and alcoholism; blood, blood plasma, surgical supplies and appliances; illegal operations and plastic surgery; care for patients still under treatment with outside physicians; care for patients who will not follow instructions or who refuse treatment; and care for pre-existing chronic conditions of employees hired after the original contract was signed, unless the medical director agrees to accept the condition for treatment.

LHI employs a full-time educational director. The main duty of this director is to educate the membership in the advantages and full use of the services offered by LHI

evaluation

There have been several impartial surveys of the operation of the Labor Health Institute.

In a poll of LHI membership conducted by Washington University, 65 percent of those responding expressed unqualified approval of the plan; 21 percent said they were satisfied with the plan but had some criticisms of it; 7 percent expressed marked dislike of LHI; and 7 percent had no opinion.

In the same poll, 90 percent of the respondents who had used LHI physicians said that the quality of service was as good or better than they could get elsewhere; that the LHI doctors showed the appropriate amount of interest in them; and that they were treated as private patients.

There were some complaints against LHI, mainly about long waiting periods for appointment and treatment; and only 65 percent of the respondents thought they had found a "family doctor" at LHI. In general, however, the poll showed an overwhelming approval by the members of the plan.

In 1948, at the request of the St. Louis Planning Council and the Labor Health Institute, an evaluation of the plan was made by two eminent American physicians. The evaluation was based on standards accepted by the medical profession. The conclusion was reached that "the amount of service actually received by the persons covered by regular payment plans is such as to place the Labor Health Institute in the top bracket of group-practice prepayment health plans and comes close to ideal standards."

HEALTH INSURANCE PLAN OF GREATER NEW YORK

The Health Insurance Plan of Greater New York is a voluntary nonprofit corporation providing comprehensive health services to some 420,000 persons in the New York area. It was organized in 1944 by the late Mayor Fiorella LaGuardia and other prominent citizens to provide adequate medical care for people in low-income groups. HIP has grown approximately tenfold since it began providing services in 1947.

organization

HIP is a nonprofit corporation headed by a board of directors, 24 in number, including the mayor of New York, high officials of local government, heads of several of the largest banks, leaders of business and industry and labor (both AFL and CIO), and a number of doctors chosen for their professional and administrative experience. The board operates the Plan as a community trusteeship.

In addition to the board of directors, there is a medical control board of 15 physicians which determines the professional standards to be met by participating medical groups. The professional qualifications of every HIP

physician must be approved by the medical control board, and each medical group must possess the minimum physical facilities required by the board.

The medical group council is composed of delegates from the medical groups affiliated with HIP. The council selects a committee of five doctors which meets monthly with representatives of the board of directors and of the administrative branch of HIP to discuss important problems and to outline general policies.

The HIP office staff is headed by a medical director and a general manager. Each medical group also has its own office staff. Each group is subject to inspection by representatives of the central HIP administration. When requested, HIP headquarters sends out office staff to assist member groups.

There are 30 medical groups, representing nearly 1,000 doctors, affiliated with HIP. Each group is required to have a medical center capable of providing comprehensive medical care to at least 10,000 patients. Each group is autonomous, and itself determines the distribution of salaries among its member physicians. Most participating doctors continue to engage in some private practice. Full-time HIP physicians, however, earn as much as non-HIP physicians in the area.

medical groups

The membership of HIP is confined to employed persons, but there are no restrictions by reason of age, sex, pre-existing illness, injury, physical defects, or pregnancy. Enrollment is open to groups of ten or more.

eligibility

City employees and their families constitute a large percentage of the total HIP enrollment, but the Plan also serves employees of the United Nations and of many firms, unions, private schools, and social welfare agencies.

HIP regulations require that employers pay at least half the HIP premium. In some cases, the entire premium is paid by employers or by union welfare funds. A number of unions have won HIP in individual shop agreements.

A recent exception has been made to the rule requiring employers' contributions. Families in several low-cost cooperative housing projects are now allowed to pay the full premium with their monthly rents. Similarly, since neither the New York State nor the federal government has the authority to contribute toward health-plan premiums, state and federal employees are allowed to pay their HIP premiums in full.

There are two subscription rates in HIP. The base premium rate is paid by individuals with salaries up to \$5,000 and families with incomes up to \$6,500. Individuals and families earning more than these respective maximum salaries must pay a premium rate 20 percent above the base. The latter group comprises only 7 percent of HIP's total enrollment. All subscribers are required, as a condition of membership, to carry their own hospitalization insurance.

rates

HIP's annual premium is \$42.72 for one person, \$85.44 for a married couple, and \$128.16 for families of three or more. Subscriptions are paid direct to HIP, which in turn remits capitation fees to each medical group at the rate of \$28.80 per subscriber registered with that group. The remainder is used for administrative purposes, insurance reserves, and retirement benefits for physicians.

HIP subscribers and their families are entitled to health care by general physicians and specialists in homes, doctors' offices, group medical centers, and hospitals. Services include general medical care, specialist and surgical care,

the consumer

maternity and pediatric care, diagnostic laboratory services of all kinds, x-ray examinations and treatment, radium, radon, and radio-isotope treatment, physical therapy, administration of blood and plasma, visiting nursing services, and private ambulance transportation. Services also include psychiatric consultation, although not prolonged psychiatric treatment.

There are no waiting periods for service, no time limitations on duration of medical care. The only extra charge by participating doctors is a \$2 fee for night calls requested and made between 10 p.m. and 7 a.m. Many groups do not, however, levy this charge.

The principal exclusions in HIP are dental care, drugs and appliances, treatment for alcoholism and drug addiction, and conditions the treatment of which is a governmental responsibility.

The subscriber selects the medical group most convenient to him. From that group he chooses one of the general physicians as his personal or family doctor. Occasionally, where it is more convenient for the patient, the doctor provides general services from offices nearer the home of the patient.

HIP attempts to acquaint each new subscriber with the services available and with the way to use them to maximum advantage. The subscriber is encouraged to discuss complaints with medical group officials, and offer suggestions for improvement. HIP itself maintains a Subscriber Service Division for dealing with inquiries, complaints, and suggestions. Each complaint is considered individually and discussed with the group director concerned. According to HIP statistics, the average number of complaints is two per month per 10,000 subscribers, or one complaint for every 2,000 medical services rendered.

HIP conducts an extensive health education program among its subscribers. HIP and the medical groups publish bulletins and arrange lectures on health matters in general and HIP in particular. The medical groups hold periodical evening meetings with subscribers. The main purpose of these educational efforts is to encourage preventive medicine, early diagnosis, and the proper use of HIP's facilities.

evaluation

HIP is a widely known program and has been controversial since its inception.

There seems little doubt that HIP satisfies most of its subscribers as to price, quality and range of benefits. Frequent public pronouncements by organizations affiliated with HIP strongly support it in these terms. And while there was some protest at a recent substantial rise in HIP's rates, there was no suggestion of secession from the plan or of dissatisfaction with its services.

HIP has, however, encountered stiff opposition from organized medicine in the New York area, particularly from the Kings County Medical Society. The Society has accused HIP of lay domination of medical personnel, of preventing effective free choice of doctor, of unethical advertising, and of perpetuating a structure unfavorable to a proper doctor-patient relationship. The Society has proposed the establishment of a "Golden Rule Medical Aid Committee" in Kings County in opposition to HIP, and is currently supporting legislation in the New York legislature allegedly aimed at curbing HIP's activities. The Society's actions appear to be opposed by all consumer groups affiliated with HIP.

A SPECIFIC PROPOSAL FOR CALIFORNIA*

The most important development in recent years in the field of prepaid medical care plans is the increased interest in such plans on the part of organized labor. Hardly a labor contract is written today which does not contain some health and welfare provision. The number of people involved when one considers dependents as well as the actual union members is very large. In the past a good many plans have been tried. None have yet proven wholly satisfactory to either the unions receiving the service nor to the doctors who furnish it. A great deal of the money has apparently been wasted, and the situation calls for a new approach which takes cognizance of the various interests involved and of the mistakes of the past.

Generally speaking, the working man desires for himself and perhaps even more for his family the assurance that when the need comes he will have access, under financial conditions which he can afford, to medical and hospital care of the highest quality. In general he wants "comprehensive care," i.e., coverage for all or practically all hazards and provision for preventive and diagnostic services as well. He wants to be sure that when he has paid his premium that will be all, or substantially all, of the money he will be called upon to furnish for medical care. In the first place he wants quality; in the second, financial security against the hazards of illness.

Organized medicine, on the other hand, has certain strongly held convictions on this matter and certain criteria which it insists must be met. In the first place it insists that the physician shall not be under the control of any outside authority whether that be a lay group, an institution, a labor body, or the government, particularly not the government. It insists upon a "free choice of physician," it frowns upon anything resembling a closed panel and indeed upon any panel arrangement whatsoever, it does not like groups of patients being delivered en masse to any particular plan. While it is officially tolerant toward groups, there is quite widespread hostility on the part of many doctors and medical societies to the whole concept of group practice. In order to get truly first-class medical care, it is necessary to have the cooperation of the organized medical bodies. Therefore, in formulating a plan it is most important to get the approval of organized medicine.

The following plan is proposed as one which seems to meet the needs of the insured upon one side and the stipulations of organized medicine upon the other.

It is proposed that these plans be established on a regional basis in order that the special conditions of each separate community may be met with local control and local responsibility. The first step would be the formation of a local or regional health council which should be a nonprofit foundation with a board of directors composed of men and women of unimpeachable integrity and with keen interest in the field. This body should act in the capacity of trustee for all funds in the area which are to be expended for prepaid medical and hospital services. It would be, in effect, the broker for the purchase, in behalf of the beneficiaries, of the best coverage available in the area. But in addition to this function of brokerage it would be charged with the task of developing new plans for

*A proposal made to the Health Plan Consultants Committee by Russel V. Lee, M.D., Clinical Professor of Medicine, Stanford University School of Medicine; Director, Palo Alto Clinic; Member, House of Delegates, American Medical Association; and Member, President's Commission on the Health Needs of the Nation.

prepayment of medical services if no satisfactory ones are available. Groups, unions, employers, individuals, anyone desiring health coverage would turn the funds they had available for such services into the health council which in turn would make the best deal possible in behalf of the clients.

For the special problem of union welfare funds there is suggested an arrangement which might give the unions what they want in the form of comprehensive care and still meet the stipulations of the medical societies. This would involve the collection of a certain sum per month from each prospective beneficiary. From this sum the council would first purchase hospital insurance from presently available Blue Cross plans or recommended insurance companies. (Or when the membership became large enough it might pay the hospital charges directly.) The hospitalization being provided for, it would then contract for comprehensive medical service to be furnished to its clients by groups of doctors already existing or formed for the purpose of furnishing such care. These groups would be required to meet certain standards as to the number of specialists on their staffs and the proper distribution of them, and would be limited in the number of patients they could take to the number they could properly care for. But for those clients who desired the services of a doctor who was not in a group and for those doctors who did not care to enter into group practice a special arrangement would be made. For every patient who chose a nongroup doctor to be his medical adviser, the monthly fee would be deposited with a fund under the custody of the county medical society. The participating doctors who rendered service would put in bills based upon an agreed fee schedule to this fund and would be reimbursed as they are now on a fee-for-service basis. The same arrangement would be invoked when a patient who was signed up with a group chose a nongroup doctor for some special service. This doctor would bill the group for the agreed-upon fee in accordance with the schedule. If the aggregate of the bills presented to the county society fund exceeded the funds available they would be prorated, as CPS has done under some circumstances. Special arrangements, not difficult to devise, can be made for x-ray and laboratory services to the insured. In this way both those who favor capitation group practice and those who prefer fee-for-service could be accommodated. There is complete freedom of choice to the patient and no outside control of the physician. And the patients have the assurance of comprehensive coverage at an agreed-upon fee.

An additional and very important feature of this plan would be for the health council to contract with a medical school (or schools) to furnish overall consultation service to all the doctors who participate in the plan. For this service a fixed percentage of the premium would be paid to the medical school, which in turn would make its staff available for such procedures as neurosurgery, heart surgery, etc., which might be beyond the competence of the individual group or doctor and would also make its staff available for any difficult or special problem which might arise. In this way the beneficiaries would be assured of medical care of the highest order, the standards of practice in the community could be raised, and the medical school would have an assured income to meet its deficits. This feature would add greatly to the attractiveness of the plan to the patients.

It is not possible to say offhand what the cost of such services should be. Quality should be stressed before cheapness. Most people would pay more for health coverage if they were assured of such quality. But some approximations can be made. The hospitalization should be about \$1.25 per month per person.

The medical services might well be furnished for an average of \$5 per month per person. The medical school should get \$.50 per month per person. The overhead of such a plan should be very small indeed, as there would be no commission, no sales expense, no reports to be filed, etc. Only a careful actuarial study could show just what the charges would be. The availability of union funds, of course, might limit the benefits which could be purchased. There are many administrative details to be worked out but no serious obstacles are likely to be encountered.

The plan provides most of what is desired by all parties interested in pre-paid medical plans.