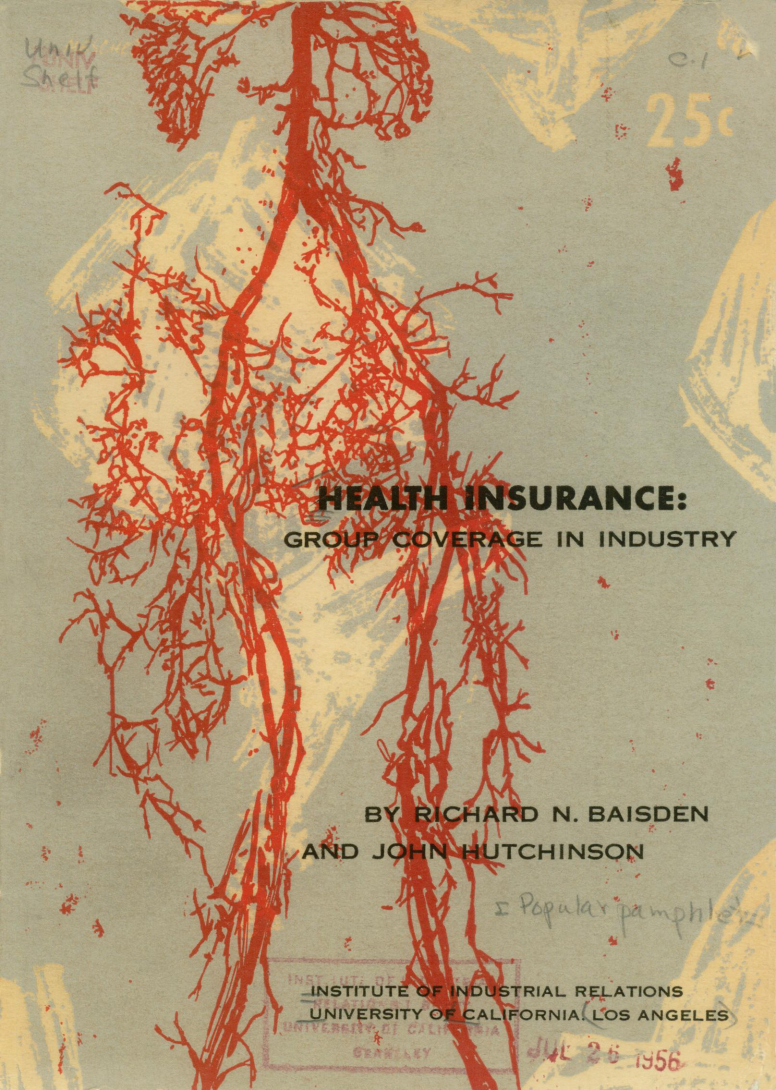


HEALTH INSURANCE:

GROUP COVERAGE IN INDUSTRY

BY RICHARD N. BAISDEN
AND JOHN HUTCHINSON

INSTITUTE OF INDUSTRIAL RELATIONS
UNIVERSITY OF CALIFORNIA, LOS ANGELES

HEALTH INSURANCE:

Group Coverage in Industry

HEALTH INSURANCE:

GROUP COVERAGE IN INDUSTRY

By
RICHARD N. BAISDEN and
JOHN HUTCHINSON,

Edited by Irving Bernstein

INSTITUTE OF INDUSTRIAL RELATIONS
UNIVERSITY OF CALIFORNIA, LOS ANGELES

POPULAR PAMPHLETS OF THE INSTITUTE OF INDUSTRIAL RELATIONS

Southern Division:

Collective Bargaining, by Edgar L. Warren and Irving Bernstein
Making Grievance Procedures Work, by Abbott Kaplan
Employing the Seriously Impaired, by Robert D. Melcher
Wages: An Introduction, by H. M. Douty
Union Security, by Orme W. Phelps
Wage Structures and Administration, by H. M. Douty
Health Insurance: Group Coverage in Industry, by Richard N. Baisden and John Hutchinson

Northern Division:

Pensions under Collective Bargaining, by William Goldner
Strikes, by William Goldner
Hours of Work, by William Goldner
Productivity, by Peter O. Steiner and William Goldner
Guaranteed Wages, by J. W. Garbarino
The Business Agent and His Union, by Wilma Rule Krauss and Van Dusen Kennedy
Local Employers' Associations, by William H. Smith

Copies of these pamphlets may be purchased at the following rates:
1 to 9 copies—25c per copy
10 to 99 copies—20c per copy
100 or more copies—15c per copy

Order from the

INSTITUTE OF INDUSTRIAL RELATIONS

Southern Division:
Business Administration–Economics Building
University of California
Los Angeles 24, California

Northern Division:
201 California Hall
University of California
Berkeley 4, California

Foreword

THE INSTITUTE OF INDUSTRIAL RELATIONS of the University of California was created for the purpose, among others, of conducting research in industrial relations. One of its basic tasks is to convey the results of this research to the people who need it and can use it. The Institute seeks to do this in part through popular pamphlets, designed for the use of labor organizations, management, government officials, schools and universities, and the general public. A list of the pamphlets already published appears on the preceding page. The Institute's publishing program has resulted also in a substantial number of monographs and journal articles, a list of which may be obtained by interested persons upon request.

As the authors of *Health Insurance: Group Coverage in Industry* point out, a marked feature of American society in the past decade has been the extraordinary development of health insurance plans by voluntary initiative. This growth, the types of plans, the effectiveness they have demonstrated, and the challenging issues they raise for the future are dealt with in the pamphlet. Primary attention is given to the economic problem of financing medical care for workers and their dependents and to the variety of plans that have been devised for this purpose. The authors have analyzed the alternatives in relation to the needs they fill and have avoided endorsing any particular type of plan.

Health Insurance: Group Coverage in Industry grew out of a combination educational and research project run by the Southern Division of the Institute between 1951 and 1955, generously financed by the Inter-University Labor Education Committee and the Rockefeller Foundation. Richard N. Baisden served as Project Director and John Hutchinson participated in the program. They have distilled the results of their rich experience in this pamphlet. Mr. Baisden is now Principal Extension Representative for the Southern Division and Mr. Hutchinson is Coordinator of Labor Programs for the Northern Division of the Institute.

Appreciation must be expressed by the Institute to the following individuals for their review and constructive criticism of the manuscript: Mr. Arthur Carstens, Dr. George A. Pettitt, Dr. Irving Pfeffer, and Dr. J. Fred Weston of the University of California; Dr. Lester Breslow, Chief of the Bureau of Chronic Diseases of the California Department of Public Health; Dr. Maurice I. Gershenson, Chief of the Division of Labor Statistics and Research of the California Department of Industrial Relations; and Mr. Ted Ellsworth, Administrator of the Motion Picture Health and Welfare Fund. Arnold Mesches prepared the cover. Mrs. Anne P. Cook assisted with the editing.

The viewpoint expressed is that of the authors and may not necessarily be that of the Institute of Industrial Relations or the University of California.

GEORGE H. HILDEBRAND, *Acting Director*
Southern Division

ARTHUR M. ROSS, *Director*
Northern Division

Contents

I. Introduction

DURING the first half of the twentieth century, the American worker has obtained protection against a wide variety of causes of insecurity. As early as 1910, workmen's compensation laws began to provide the worker with medical care, compensation, and sometimes rehabilitation if he were injured during employment. Since the passage of the Social Security Act in 1935, he has generally been assured of income when he retires in old age or when he becomes unemployed, and of survivors' benefits for his family when he dies. These benefits and many others have been provided through government action.

Another major cause of insecurity—illness and injury not connected with the job—was to receive later and somewhat different treatment. Prior to World War II, frequent attempts were made to pass legislation supplementing existing social security measures with a program of national health insurance. None of these attempts met with success.

1. NEED FOR HEALTH INSURANCE

Nevertheless, there has been a growing awareness of the need to develop some method of assisting the worker with his health problems and those of his family.

Both the annual manpower loss to our economy due to ill health and the large number of young men rejected for military service for health reasons during recent national emergencies have underlined the importance of good health to our national welfare.

It is true that the last half century has witnessed a phenomenal improvement in our nation's health. Much of this is attributable to our rising standard of living—better diet and housing and shorter working hours—and to improvements in personal hygiene and public health services. Much progress in health is also due to recent advances in the field of medical science.

However, the availability of good medical care has depended to a large extent on the patient's ability to pay for it. This fact undoubtedly accounts in part for the findings of recent studies that there is a direct relationship between health and family income. The mounting costs of medical services and the unpredictable nature of illness often make it impossible for individual families to finance medical needs out of their own income and savings. Illness strikes a double blow at the worker, since at the same time that he faces high medical costs he often experiences loss of income due to disability.

Management and labor have both recognized the need to safeguard the health of the worker. Numerous studies have shown that poor health is an important cause of accidents on the job, absenteeism, and employee turnover. Anxiety about ill health reduces plant morale and lessens efficiency.

Thus, the past twenty years have witnessed a growing agreement that there is need for a better way of meeting sickness costs. The traditional device whereby the individual paid for medical care at the time of receiving service imposed difficult burdens on large segments of the population. Under that system workers in the low and middle income groups often did not obtain medical services when the need arose because they did not have the money to pay for them.

Today there is wide acceptance of the principle that for most workers the medical costs and income loss resulting from sickness must somehow be distributed among groups of people and over periods of time. Health insurance is the term which we use for this principle. As used in this pamphlet, health insurance includes protection against both medical expense and wage loss resulting from nonoccupational sickness or injury.

Beyond the general agreement on the broad objective of health insurance, there remains sharp disagreement as to the extent to which medical costs and wage losses should be insured and as to whether insurance coverage should be provided through private arrangements on a voluntary basis or through government programs involving compulsion. At the same time that many European countries have been adopting national health insurance programs financed by taxation, this country has experienced a phenomenal growth of voluntary health insurance plans. In a few cases, however, the voluntary programs which provide protection against medical

costs have been supplemented by government programs alleviating the problem of income loss due to disability: four state nonoccupational disability laws and the railroad temporary disability program.

2. GROUP HEALTH INSURANCE

Although for many years health insurance coverage has been available to workers who wish to purchase individual policies from insuring organizations, this method of enrollment has not been particularly successful. Insurance premiums for persons covered as individuals are costly, the benefits provided tend to be restricted, the prospective insured person is required to pass a physical examination, and his policy may be canceled by the insurer for a variety of reasons. In addition, the insured is "on his own" in his negotiations with the physician, the hospital, and the insuring organization.

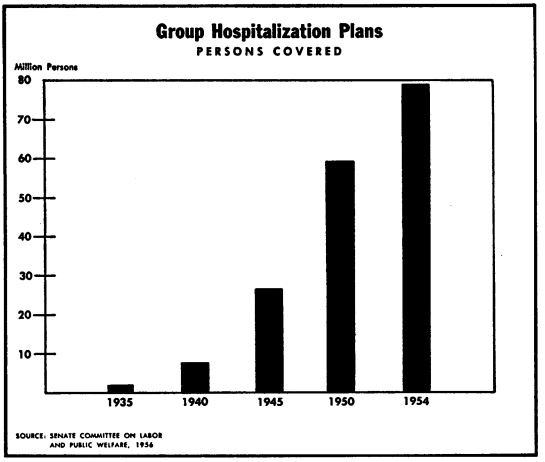
In contrast to the individual policy, group coverage has opened the channels of insurance to all wage earners, regardless of age, sex, or physical condition. A master group policy covering all members is issued by the insuring organization to an employer, trustees of a welfare fund, a labor union, or a trade association, as the representative of the workers to be covered. The individual remains insured so long as the master policy remains in force and so long as he continues to be a member of the covered group.

Group policies are less expensive, provide more exten-

sive benefits, and do not make bad health a barrier to membership. These advantages are made possible by the fact that if the group represents a fairly good sample of the population, the "poor risks," while not excluded, are not unduly numerous and they are balanced by the "good risks," who probably will not utilize the plan excessively. Commercial insurance companies usually offer this advantageous coverage to groups of 25 or more, while Blue Cross and Blue Shield organizations permit enrollment of even smaller groups.

In its earliest stages group accident and health insurance, as offered by commercial insurance companies, provided weekly benefits indemnifying workers for lost wages due to disability. In the early 1930's, commercial carriers as well as hospitals operating through their newly formed Blue Cross plans began to provide protection against the costs of hospital care. A few years later, the insurance companies added surgical benefits and by 1944 began to offer a more general medical expense insurance against the cost of physician's services other than surgery. Beginning in 1939, they were joined by Blue Shield plans, sponsored by medical societies, and other service type plans which offered surgical and medical coverage. In the meantime, group coverage was also broadened to include the dependents of wage earners, thus multiplying the number of eligibles.

The Health Insurance Council has estimated that by the end of 1954 over 101 million persons had hospital protection. Approximately 75 to 80 percent of this num-



ber were members of group plans. The remarkable rise in the popularity of group health insurance is underscored by the chart which depicts the growth in the number of workers and dependents covered by group hospital insurance from 1935 to 1954.

II. Health and Welfare Plans in Industry

THE RAPID INCREASE in the number of workers covered by health insurance in the United States has stemmed primarily from the development of health and welfare plans in industry. These plans have developed in a variety of ways: union sponsorship, management sponsorship, and as a result of negotiations between unions and management. They have also been financed by different methods: benefits paid directly out of the union treasury, noncontributory plans where the entire cost of the premiums is borne by the employer, and contributory plans where the employer and the employee each pay a portion of the premium. Finally, there are alternative methods whereby the plans are administered: unilaterally by the union, unilaterally by the employer, and through a trust fund jointly controlled by union and management representatives. The following pages will describe the development of these various types of plans.

1. UNION PLANS FOR SICKNESS BENEFITS

Unions have traditionally been concerned with the health needs of their members, and sick benefit programs were among their first welfare activities. The railroad brotherhoods established such programs after the Civil War, and some other unions followed their lead in the eighties and nineties. Benefits usually took the form of payments to protect members against wage loss due to illness. They were financed out of union dues and assessments, the payments usually coming from the common funds in the unions' treasuries.

Even though the amounts provided by these benefit programs were relatively small, the plans were in constant financial trouble. They suffered from both lack of expert administration and the absence of actuarial planning. As a result of these experiences, most unions have ceased to provide sickness benefits out of union funds.

Not all early union plans were restricted to income maintenance benefits. A few unions provided medical services to members through union-operated health facilities. The International Ladies' Garment Workers' Union pioneered in this type of benefit in 1913, when a number of New York locals joined in financing a clinic which later developed into the Union Health Center.

2. EMPLOYER-SPONSORED PLANS

Management has also long recognized the importance of providing some protection to workers against injury and illness. Many employers have maintained that the increased productivity made possible by a healthy work force justified considering the cost of health benefits as a legitimate business expense. Particularly in hazardous occupations or industries requiring employees to work in remote areas, such as lumbering, mining, construction, and railroading, employers have for decades provided medical services.

In the latter part of the nineteenth century, mutual benefit associations, which usually provided sickness (wage loss) and death benefits, were organized in many firms. These were financed from employer contributions and/or employees' dues. Although many of these associations were initiated by the companies, some were organized by the employees themselves. Employer-sponsored plans reimbursing employees for hospital and doctor bills appeared following the development of group health insurance plans by the insurance industry and other organizations in the thirties.. .

3. NEGOTIATED HEALTH AND WELFARE PLANS

Significant though the early unilateral efforts by labor and management may be, the real growth of health insurance coverage awaited the acceptance of the idea that health benefits should be made an aspect of collective bargaining. The depression period of the 1930's generally convinced unions of their inability to cope independently with their members' health needs. When it became clear that the government was not likely to establish a health insurance plan by law, the unions turned to the employer as a source of financial support for health plans.

a. *Labor's position.* Unilateral management plans had been established in only a small proportion of industry and, with a few exceptions, were limited in their benefits. Unions had other objections to management plans. One was that they offered no real security since the employer could withdraw the benefits at will. Another was that unions had no voice in the level of benefits provided or in the choice of plan. Thus, the inability of unions to finance their own programs, lack of governmental action, and dissatisfaction with management arrangements led organized labor to include health and welfare plans among their collective bargaining demands.

Although one collectively bargained plan dates back to 1926, the recent trend of unions to negotiate employer-financed programs was initiated by the Amalgamated Clothing Workers in 1942. In industries where no plan had been in existence, unions tried to establish plans through collective bargaining. In cases where employers had developed unilateral programs, labor began to insist that the benefits be made an employee right, that the number of benefits be increased, that the employer pay a larger share of the costs, and that the plans be administered jointly by labor and management.

Many employers opposed these efforts by unions on the ground that welfare plans were not proper subjects for collective bargaining. In 1949, the courts ruled in the W. W. Cross and Co. case that group insurance programs were forms of compensation under the Taft-Hartley Act and, therefore, employers were required to bargain with unions concerning them.

b. *Recent advances.* The major development of negotiated health and welfare plans has come since World War II. One powerful influence was the national wage stabilization program established during the Korean emergency in 1951–1952. Restrictions on wage and salary increases led employers and unions to substitute a number of fringe benefits, including health plans. Another incentive for stressing health benefits was provided by the tax laws. From the standpoint of the employee, if an increase in his compensation took the form of higher wages, part of the increase would go to the gov-

ernment in taxes. On the other hand, increases in compensation in the form of health and welfare benefits were not subject to taxation. From the standpoint of the employer, the cost of supplying medical benefits could be deducted as a business expense in computing federal taxes on earnings. Since the excess profits tax was in effect during wartime, only a small portion of the cost of such benefits came out of company profits.

The rapid increase in the number of workers covered by negotiated health and welfare plans between 1945 and 1955 was one of the major social developments of this mid-century period. In early 1954, nationwide figures showed that two-thirds of the workers covered by union contracts were protected—an increase of 55 percent since mid-1950. A California study found that more than 80 percent of all employees working under union contracts in that state at the end of 1954 were entitled to such benefits—an increase of 400 percent between 1950 and 1954. These negotiated plans have tended to emphasize hospitalization and life insurance benefits. The majority also include surgical, wage loss or temporary disability, and accidental death and dismemberment benefits. The actual percentages for 1954 are shown in Table 1, based on the reports of 173 unions concerning plans covering 8.7 million workers of all types exclusive of government and railroad employees. In recent years more and more plans have provided coverage for dependents as well as for the employee.

TABLE 1

TYPES OF BENEFITS PROVIDED TO WORKERS COVERED BY NEGOTIATED HEALTH AND WELFARE PLANS

Benefits provided	*Percentage of workers covered*
Life insurance	93%
Hospitalization	88
Surgical	83
Accident and sickness (temporary disability)	73
Accidental death and dismemberment	54
Medical benefits	47

SOURCE: Bureau of Labor Statistics, U. S. Department of Labor.

4. FINANCING THE PLAN

Under a negotiated plan the labor contract specifies the method by which the plan will be financed. The extent of the financial obligation of the employer is stated in specific terms, usually on the basis of a fixed amount per worker. This contribution may be specified as a monthly amount per employee or as cents per hour. Some contributions, however, are expressed in terms of cents per day or shift, dollars per week, a percentage of the total payroll, or a royalty on production.

An alternative to fixing the employer's financial obligation in terms of money is the device whereby the contract lists the specific health and welfare benefits which the employer is to provide. The employer is then obligated to purchase these benefits regardless of cost.

A health and welfare plan may be contributory or noncontributory. In a contributory plan, the employee shares the cost of the plan with the employer. Here it is customary for the employee to authorize the employer to deduct his portion of the premium payment from his wage or salary check. Such an authorization may be voluntary or it may be required as one of the terms of employment. The majority of the plans today are noncontributory, and even in the contributory plans the trend is toward the employer's bearing an increasing proportion of the cost, although this is less true of dependent coverage than of employee coverage.

The question of whether a plan should be financed on a contributory or noncontributory basis has often arisen in the course of labor-management negotiations. Some management officials have argued that the employee should contribute so that he will have a greater sense of identification with the plan and therefore will be less inclined to abuse it. Many employers have also held that although they are willing to pay the bill for insuring the employees, dependents are the responsibility of the employees themselves and insurance for dependents should not be charged to the company. Finally, employers have argued that when employees contribute, the amount to be spent on health and welfare is increased and more comprehensive coverage can be purchased.

Unions have generally fought for noncontributory plans, taking the position that fringe benefits merely

represent wages in another form and are alternatives to increases in monetary compensation. Thus they argue that it is preferable to have the employer put the money into insurance directly rather than to follow the roundabout route of deducting it from the workers' paychecks. They point out that the latter method has the disadvantages of subjecting the money to the income tax and of requiring the additional administrative expense involved in payroll deduction. It is also argued that the employee is just as likely to abuse the plan if he puts his "own" money into it, and that where employee participation is voluntary, many workers who will need coverage may not join the plan.

5. SELECTING AND ADMINISTERING THE PLAN

Although the agreement to set up a health and welfare plan and the arrangements for financing are included in the labor contract, the decisions as to the kind of plan to be adopted and as to administrative arrangements are normally delegated. The contract may specify that the plan will be administered by either the union, the employer, or the carrier. Usually, however, it will establish a trust fund controlled by trustees selected from both management and labor. The trustees are empowered to receive the contributions to the fund, purchase benefits from insuring organizations, and invest any surpluses.

a. *The trust fund.* The use of the trust fund device permits great flexibility in the development and administration of the health and welfare plan. There are few legislative limitations, with the exception of a provision of the Taft-Hartley Act. This requires that the fund be for the sole use of employees and their dependents, that payments from the fund must be for specified welfare purposes, and that employers and unions must be equally represented on the board of trustees.

One great advantage of the fund device is that it permits a number of small employers to pool their employees into one group, thereby overcoming the disadvantages of higher premiums and restricted benefits faced by small units. In the case of many pooled funds a number of employers pay their contributions to a single fund covering all of the workers in a given area who are members of the same union. This device is used frequently in the construction and garment industries.

Once the fund has been established, the trustees contract with an insuring organization for the purchase of benefits or arrange to provide the benefits directly from the fund without a carrier as intermediary. Usually, unless the trustees decide to self-insure, they will permit a number of insurance companies and service plans such as Blue Cross and Blue Shield to submit bids. In soliciting bids, the trustees will provide information relative to the amount of money available to pay premiums, the

size and composition (age, sex, and number of dependents) of the employee group to be covered, and the kind of benefits desired.

The insuring organizations will then each offer a plan for the consideration of the trustees based upon the information submitted to them. Due to higher utilization by groups with a large percentage of older members and females, they normally receive less liberal benefits than those composed predominantly of young males.

Upon receipt of the bids, the trustees evaluate them and presumably choose the insurer whose offer most adequately meets the health needs of the employees. An insurance contract is then drawn up between the insurer and the trustees, and booklets listing the benefits are issued to all employees.

b. *Possible abuses.* As an unfortunate consequence of the rapid, comparatively unregulated development of health and welfare plans involving huge amounts of money, certain abuses have occurred. Investigations by government, labor, and management groups have uncovered a number of undesirable practices. One of these is a collusive arrangement between negotiators and favored brokers or carriers so that the choice of plan is made without open bids or fair competition. Such an arrangement may result from either nepotism or "influence" payments.

These practices may lead to the payment of excessive commissions and retention rates. They may also result in the workers being handed a plan which does not prop-

erly meet their needs or which does not provide the maximum quantity and quality of benefits for each premium dollar. Investigations have also found cases where trust fund monies have been allocated for other than health plan purposes and where refunds or dividends have been withheld from the fund.

Courses of action tending to reduce these evils include legislation requiring that health and welfare funds be open to public scrutiny, more active participation in the direction of the fund by both management and labor representatives, and education of the plan members as well as the trustees about the responsibilities implied by the concept of trusteeship.

Lack of knowledge and proper advice has, however, probably been more responsible than bad faith for errors in the development of health and welfare plans. It is vitally important that, before adopting a plan, officials of labor and management know the health requirements of the employees and that they select a plan only after careful study.

III. Types of Health Insurance Plans

UNION AND MANAGEMENT officials in most communities today may choose from a relatively wide range of plans providing protection against the costs of medical care. Since these alternative types vary considerably in their methods of providing benefits, the choice of plan is important. It is the purpose of this chapter to discuss briefly the characteristics of each type of plan.

1. CASH INDEMNITY AND SERVICE PLANS

Health insurance plans may be roughly divided into two kinds: cash indemnity and service. A cash indemnity plan reimburses the subscriber in cash when he incurs expenses for medical treatment. The liability of the plan for each item of service—hospital room and board, surgery, doctor's visits—is limited to a schedule of fees listed in the insurance policy. The cash indemnity plan does not guarantee that the amount of reimbursement will cover the actual medical expenses

of the patient. Most of the health plans underwritten by insurance companies fall in the cash indemnity category.

Other health insurance plans agree to provide services instead of cash. Blue Cross plans guarantee to provide a specified list of hospital services, without any cost to the subscriber beyond the insurance premium. The hospital providing services to a Blue Cross patient will bill Blue Cross direct, and will charge the patient only for services not covered by the health plan. The same principle applies to low-income subscribers to Blue Shield plans and members of certain medical center plans.

Two types of service plan may be distinguished. In one type, including Blue Cross and Blue Shield, the insuring organization is separate from the doctors and hospitals providing services to plan members. Here the insuring organization reimburses the doctors and hospitals for each service rendered to members on a fee-for-service basis. A second type goes one step further and either has its own doctors and hospitals or makes arrangements with a medical group to provide services to the members. Under this system, sometimes referred to as the medical center type, physicians are not reimbursed on a fee-for-service basis. They receive either a regular salary or capitation payment (a fixed amount from each subscriber to the plan). Examples of the medical center approach include the Kaiser Foundation Health Plan and the Health Insurance Plan of Greater New York.

2. INSURANCE COMPANY PLANS

Insurance companies today offer a wide variety of health insurance coverages. It is possible to purchase almost any type and amount of benefits desired, with policies adapted to meet the needs of the purchasing groups. "Package contracts" are featured which combine hospital, surgical, and out-patient medical benefits with life insurance, disability, and accidental death and dismemberment benefits. Insurance company plans permit free choice of doctor and hospital, since they reimburse subscribers for services rendered by any legally qualified physician or hospital.

a. *Benefits.* Insurance company policies provide indemnity (cash) benefits. The amount of the indemnity is usually specified in the policy, with the patient being reimbursed for medical or hospital expenses according to a specific schedule of fees established by agreement between the insurance company and the policyholder.

Hospital benefits usually consist of a flat daily allowance for a stipulated number of days of continued hospital confinement. Any daily benefits desired by the policyholder are available and they may run for any number of days. Usually the benefits range from $8 to $16 per day for 31 to 70 days for any one hospital confinement. Reimbursement is also provided for additional hospital charges (X-ray, laboratory, and operating-room costs) up to a maximum amount per hospital confine-

ment, usually ranging from 5 to 35 times the daily benefit. Several insurance companies now write plans in which they accept liability for the full cost of a specified type of hospital room, and some also accept unlimited liability to reimburse subscribers for hospital "extras."

Insurance company plans usually offer reimbursement for surgical costs. Surgical fees are covered up to the amount listed in the policy fee schedule, but the allowance is seldom permitted to exceed the actual fee charged by the surgeon. Schedules are usually designed according to the highest amount payable for any operation on the schedule. Typical schedules provide maximum payments of from $250 to $350 for the most costly operations.

Among the plans that reimburse medical (nonsurgical) expenses, some are limited to in-hospital physician's visits, while others include visits to the home as well as services rendered by a physician in his office. Such payments to subscribers usually range from $3 to $5 for a hospital or office visit, and $3 to $7 for a home visit. There are usually limits on the number of such visits covered during the course of one year or of any one illness, and the first two visits are often excluded. More liberal plans, however, may include not only the first two visits but also limited reimbursement for X-ray and laboratory services rendered in the doctor's office.

In addition to the "basic" coverages described above, insurance companies have begun to write major medical or "catastrophic" policies. These are designed to meet

major medical bills falling within specified lower and upper limits. The lower limit is usually $100 or more; the upper limit may vary between $5,000 and $15,000. It is the responsibility of the patient to pay the deductible amount himself. Major medical policies also usually include a coinsurance clause, which provides that the insured individual will pay a certain percentage (usually 25 percent) of the major medical expenses.

Major medical policies provide a relatively wide scope of benefits including hospitalization, surgery, medical visits, nursing care, X-ray and laboratory services, and other therapeutic services and supplies, as long as the treatment is necessary and the charges reasonable.

b. *Exclusions.* Unlike individual policies, group health insurance plans do not usually require a physical examination or exclude preëxisting illnesses. They do, however, in addition to the restrictions noted above, exclude occupational injuries or illnesses that entitle the insured to benefits under workmen's compensation laws. They also exclude plastic surgery for cosmetic purposes, and many plans exclude military service-connected illnesses which can be treated at veterans' hospitals, as well as mental illness, alcoholism, and narcotic addiction. Policies vary in their coverage of maternity and polio benefits.

c. *Premiums.* Premium rates charged to policyholders depend on a number of factors: the liberality of benefits provided, the age and sex composition of the group, the size of the group, etc. An insurance company sets rates

to cover the anticipated claim losses for the year, both cash and incurred. In addition, the gross premium will include a certain percentage referred to as the retention rate. This is the amount that the insurance company keeps over and above its benefit payments to pay taxes, commissions, and operating and acquisition costs, and to provide profits. Premium rates are usually also set to give a margin of safety to the insurance company by assuring that there will be money left after the claims are paid, reserves are set aside, and company costs are met. Part of this overage is usually returned to the policyholder at the end of the year in the form of a dividend.

d. *Payment of claims.* Subscribers to insurance company plans are provided with forms which they and the doctors or hospitals rendering services must fill out before indemnity payments will be made. Workers submit their completed claim forms either directly to the carrier or to the employer's personnel office, the union office, or a separate office designated by the trustees of the plan. In some cases these offices will merely transmit the forms to the insurance company for payment. In other instances the policyholder may be permitted to accept claims, process them, and pay benefits on behalf of the insurance carrier.

e. *Eligibility for coverage.* Most health insurance plans in industry provide that a worker becomes eligible for benefits after he has been employed for a stated period. Once covered, the worker must continue to work for a contributing employer for at least a minimum number

of hours in order to retain his benefits. When his number of hours of employment falls below the minimum, or when he is laid off or retired, he usually loses his insurance coverage. Insurance companies often do not permit persons enrolled under a group policy to continue their coverage upon leaving the group by converting to an individual payment basis.

3. BLUE CROSS HOSPITAL PLANS

Blue Cross hospital plans are nonprofit, sponsored by the hospitals in a given geographical area for the purpose of providing hospital benefits through the insurance mechanism. Blue Cross organizations belong to a national Blue Cross Commission of the American Hospital Association, which has the power to review all local arrangements.

Although there is considerable variation among the Blue Cross plans throughout the country, most of them are service plans in that they agree to cover the full cost of a hospital bed in a ward, in addition to many other hospital services, for a specified period. In an effort to provide uniformity of benefits to workers covered by industry-wide negotiated health and welfare plans, a standardized National Blue Cross Plan has been developed.

Since most hospitals in the country have working agreements with Blue Cross, the subscriber has much freedom in his choice of hospital.

a. *Benefits.* Blue Cross plans provide room and board, including special diets and general nursing, in a ward in a member hospital. If the subscriber takes a private room, Blue Cross will pay the ward allowance and the subscriber pays the difference. These benefits are provided for a stipulated number of days, ranging from 35 to 120 for each separate period of disability. In addition to room and board, the Blue Cross plans provide operating-room and laboratory services, medications and dressings, and other hospital "extras." Services are usually provided without additional cost to the subscriber unless specifically excluded by the terms of the policy.

Some Blue Cross plans offer hospital benefits on a cash indemnity basis only. Where, as in California, Blue Cross is not integrated with Blue Shield, it may indemnify for medical and surgical expenses.

b. *Payment of claims.* In most cases a member need only show his Blue Cross identification card to be admitted to the hospital. The hospital bills Blue Cross for the services rendered to the subscriber, and Blue Cross pays the hospital direct. The member receives a bill only for those services not covered by his contract.

c. *Conversion privilege.* When a subscriber leaves his job, he may continue his membership by making payment directly to Blue Cross at a slight increase in rate. The new arrangement will usually provide somewhat less liberal benefits.

4. BLUE SHIELD PLANS

Blue Shield is a network of nonprofit corporations sponsored by state or local medical associations for the purpose of providing insurance against the costs of surgery and medical care. Blue Shield combines both the service and the cash indemnity approach to providing benefits. Subscribers to Blue Shield may utilize the services of any licensed physician or surgeon. In most states Blue Shield coverage is sold together with Blue Cross as one "health package."

a. *Benefits.* The benefits provided by Blue Shield plans vary widely throughout the country. All Blue Shield plans provide coverage for surgical costs. Surgeons are reimbursed according to a schedule of fees which participating physicians agree to accept as full payment in the case of subscribers with low incomes. Some plans require that the patient be hospitalized to receive benefits for nonsurgical medical care; others also pay for home or office visits. Most plans limit the fee per visit and the number of visits, in addition to excluding the first two or three visits. The California Physicians' Service, since it is not integrated with Blue Cross, provides hospital service benefits as well as medical care.

b. *Claims.* To receive service, a Blue Shield subscriber must show his identification card to his doctor. Blue Shield pays the doctors according to the schedule of fees. If the subscriber goes to a doctor who has signed an

agreement with Blue Shield and if his income falls below the income limit set by the local Blue Shield plan, he will be required to pay only for services not covered by the plan. On the other hand, if the physician used does not have an agreement with Blue Shield or if the patient's income exceeds the income limit, the physician may bill the patient for the difference between his fee and the Blue Shield allowance, if any. Income limits vary from plan to plan, but range from $1,500 to $3,600 for a single subscriber and from $2,500 to $7,500 for a family. Some local experiments are being tried which would either raise the income ceilings or eliminate them altogether.

c. *Conversion privilege.* When a subscriber leaves his job due to layoff or retirement, he may continue his membership by making payment directly to Blue Shield at a slight increase in rate. He will usually be required to accept a reduction in benefits.

5. MEDICAL CENTER PLANS

Early in this chapter, two types of service plans were distinguished. In one type, exemplified by Blue Cross and Blue Shield, the plan is an insuring organization which reimburses the doctors and hospitals, already existing in the community, for those services rendered to plan subscribers. In the second type, the plan not only acts in the capacity of an insurer, but also provides the medical services through professional staff and facilities organized by the plan itself. The doctors,

in such an arrangement, usually work together as a group in one or a number of medical centers. Instead of being paid on a fee-for-service basis, the doctors receive either a salary or a fixed payment per subscriber.

One of the key features of the medical center is the possibility of the doctors working together as a group and combining their skills and resources. Medical groups vary in size, organization, and purpose. The number of physicians in a group may vary from a few to several hundred. Some groups are operated by one doctor who employs the other physicians; some are partnerships of doctors, with the partnership in turn hiring other doctors. Others are organized on the initiative of lay persons or groups—employers, unions, or consumer organizations.

Some of these plans provide only diagnostic services on an ambulatory basis at the medical center. Others provide comprehensive care including hospitalization, surgery, medical services at the center, home, and hospital, and even eye and dental care.

Examples of doctor-sponsored, group practice prepayment plans are the Ross-Loos Medical Group in Los Angeles, the Palo Alto Clinic in Palo Alto, and the Labor Health Plan in Baltimore. These groups are organized as individual proprietorships, partnerships, or corporations by doctors who provide their own facilities and retain control over the administrative and financial as well as the medical aspects of the plan.

In the case of lay-sponsored medical center plans, the

plan is organized and the facilities supplied by an employer, a union, or a consumer group. The main distinction between lay-sponsored and doctor-sponsored plans is the locus of policy-making in the areas of finance and administration. Lay-sponsored plans are normally controlled by a board of directors on which the medical profession, if represented at all, has a minority voice. Efforts are made, however, to leave medical decisions to the medical director of the plan and his group of professionals.

a. *Company-sponsored medical centers.* A large number of companies have established medical centers for their employees at or near the place of work. These centers are staffed by doctors employed by the companies on a full- or part-time basis. Some of them are providing employees with comprehensive medical care for nonoccupational as well as occupational diseases and injuries, and a few have also included the workers' dependents.

An outstanding example is the medical care program sponsored by the Endicott-Johnson Corporation, shoe manufacturers in New York State. This program, established in 1918, provides comprehensive medical, surgical, hospital, and dental benefits to 50,000 employees and dependents. Service is provided on a group practice basis in two clinics staffed by 45 doctors, 7 dentists, and a large complement of auxiliary personnel. Drugs are dispensed from the program's own pharmacies, there are no restrictions on the type of disease covered, the serv-

ices offered are complete and unlimited, and the cost is borne entirely by the company.

The Kaiser Foundation Plan on the west coast was begun as an employer-sponsored plan for employees of various Kaiser enterprises. Since the end of World War II, however, this group practice program has been offered to industrial groups generally, and now provides comprehensive care to approximately half a million persons. The Kaiser Plan is relatively unique in that it has constructed its own hospitals in addition to a large number of medical centers.

b. *Union-sponsored medical centers.* Among the earliest of the union-sponsored medical center plans are those in the garment trades. Starting with the Union Health Center in New York in 1913, the International Ladies' Garment Workers' Union has expanded its program to a number of urban areas throughout the country. The Amalgamated Clothing Workers have also organized several Sidney Hillman Medical Centers. A number of other unions have developed group practice prepayment programs, the best known of which is the Labor Health Institute of Teamsters Local 688 in St. Louis.

The Labor Health Institute, established in 1945, now has an enrollment of 14,000. Policy control of the Institute is vested in a 24-member board of trustees composed of 16 union representatives (elected by the members of the union), 6 management, and 2 public representatives. The president of the Institute, elected by

the trustees, supervises all nonmedical activities. A medical director supervises a medical staff of over 80 professionals, of whom about 20 percent are general practitioners, 60 percent are specialists, and 20 percent are dentists. The full-time medical director receives a salary; the other doctors and dentists, all of whom work only part time, are paid on an hourly basis for services rendered at LHI. LHI offers comprehensive medical care (including diagnosis, treatment, and surgery) at the center, home, and hospital. General medical care is provided by a personal physician selected by the patient from the LHI group; this physician is also responsible for periodic physical examinations and for referral to specialists and ancillary services. Routine dental care is provided without charge, and drugs are supplied at cost. The LHI medical center is located in the Teamsters Union building.

c. *Consumer-sponsored medical centers.* The best known of the general consumer-sponsored medical center plans is the Health Insurance Plan of Greater New York. HIP is a nonprofit corporation currently providing comprehensive health services to some 420,000 persons in the New York area. It was organized in 1944 by the late Mayor La Guardia and other prominent citizens to provide adequate medical care for people in low-income groups. Heading the corporation is a 24-member board of directors composed of the mayor of New York and other city officials, leaders of business, industry, and labor in the city, and a number of doctors. Affiliated with

HIP are 30 medical groups, operating in medical centers in various parts of the city and representing nearly 1,000 doctors. The subscriber chooses the medical center most convenient for him, and a percentage of his premium is allocated by HIP to that center. Each medical group is autonomous and itself determines the allocation of group income among the member doctors. HIP subscribers and their families are entitled to care by general practitioners and specialists in the medical centers, homes, and hospitals.

Other consumer-sponsored plans have been developed by cooperative movements in Washington, D.C., Seattle, and several communities in the Middle West.

Although the medical center prepayment plans differ widely as to organization, sponsorship, and benefits, some general observations may be made.

d. *Benefits.* While insurance company and Blue Cross–Blue Shield plans tend to emphasize hospitalization and surgery, the medical center plans stress diagnostic services and out-patient medical care. Some of these plans, particularly those in the garment industries, limit their services to this area. Others, such as Ross-Loos and HIP, also provide surgery but not hospitalization. The Kaiser Foundation Health Plan provides hospitalization for its members in its own hospitals. A few of these plans go a step further in providing dental care.

e. *Cost to the subscriber.* In most cases, medical center plans agree to provide the services listed in the contract without cost to the patient other than his prepayment

premium. The patient only needs to show his membership card to receive service. Since doctors are not paid on a fee-for-service basis, no financial record need be kept of each service performed, and doctors and patients need not bother with claim forms.

f. *Choice of doctor.* The very nature of the medical center plan requires it to restrict subscribers to the use of doctors belonging to the group, with the possible exception of emergency treatment outside the service area. Where the plan has its own hospital, patients are normally required to use that hospital.

6. CHOOSING THE PLAN

According to the most recent study (as of December 31, 1954) of the Health Insurance Council, of the more than 101 million persons in the United States with some form of health insurance, 51 percent belong to insurance company plans, 44 percent belong to Blue Cross–Blue Shield plans, and 5 percent belong to other plans. The fact that each of these types has substantial numbers of adherents would seem to indicate that each is satisfying needs.

The needs of groups of workers tend to vary from industry to industry, and the whole field of health insurance is still too new for anyone to say with certainty that any one type of plan is best for all groups at all times. It is in the public interest that each type of plan be encouraged to compete for public favor without being hindered

by unnecessary restraints, and that each consumer group be permitted to choose from the total array of plans.

Some labor and management officials responsible for developing health and welfare plans have concluded that they should not attempt to impose one type on all the workers in an industry. Instead they have developed an arrangement whereby the final selection of the most suitable plan can be left to the individual subscriber. This "dual" or "multiple" choice arrangement involves enrolling the group in two or more plans and then permitting each member to select the plan he prefers. Under this system the member usually has an opportunity to change his selection at stated intervals.

IV. Our Progress to Date: An Evaluation

Now that the initial stage of rapid enrollment in group insurance plans is drawing to a close, subscribers, employers, and labor union officers are beginning to take a second look at what they have purchased. Workers and their families, while certainly pleased with the medical benefits available to them, are also becoming aware of the shortcomings of their plans. Their dissatisfactions are transmitted to those who provide services as well as to the union and management representatives responsible for the initiation of the programs. As a result, many groups are now reëvaluating group health insurance in terms of extent of coverage, size of benefits, quality of care, problems of administration, and methods of organization.

Many studies have been made which have pointed out weaknesses in existing plans. The following problems have been among those most frequently cited:

1) Voluntary plans tend not to cover those segments of the community most in need of health insurance.
2) The exclusions and limitations under most existing

plans are relatively numerous and some of the most important kinds of treatment are not covered.

3) Even in the case of procedures which are covered by the plans, there is often no assurance that the payments (under the plans) will be sufficient to pay the full bill.
4) Satisfactory arrangements have not been developed for evaluating and improving the quality of care.

Each of these points will be discussed in turn.

1. PERSONS NOT COVERED BY HEALTH INSURANCE

No exact figures are available on the number of workers insured for some of the costs of medical services. The U. S. Bureau of Labor Statistics estimated that in 1954 approximately 11 million out of the 16 million workers covered by union contracts (exclusive of railroad and government workers) had some form of health insurance. The great majority of workers are not covered by union contracts. While no statistics exist on the proportion of this group which has health insurance through employer-sponsored plans, estimates indicate that the percentage is much lower.

A substantial number of occupational groups are virtually excluded from group insurance plans. This is true of the self-employed and of the employees of very small businesses, farm laborers, and domestic servants. Per-

sons in these categories may, of course, subscribe to individual policies, but often find them unsatisfactory due to high costs, waiting periods, limitations on benefits, and restrictions based on age and health.

Before these occupational groups can be enrolled in large numbers, it will be necessary to devise means whereby people without a common employer or in very small businesses can be grouped together for enrollment in plans with similar premiums and as few limitations in benefits as those now available to large employed groups. Some experiments are now being made with enrolling whole communities in group plans.

A growing number of labor and management leaders are concerned that a worker's protection usually ceases when he loses his job or retires—at the very time when he is least able to pay for medical care. Many plans have rather strict eligibility provisions which require that the worker, though still working, be dropped when his hours fall below a designated minimum. Although an increasing number of plans are providing a worker with continued coverage following retirement, the great majority provide no such protection. In addition, many plans do not permit an unemployed or retired person to convert to an individual policy even if he is able to pay his own premiums. Where conversion is permitted, the insured person is usually required to pay a higher premium and to accept less comprehensive benefits. As a result, many health and welfare plans are now seeking more generous conversion features.

For workers with dependents, the bulk of the family's medical expense bills are incurred by the wife and children—the average is approximately 75 percent according to one estimate. Although more and more health and welfare plans now include dependents, dependent coverage is often optional with the total cost borne by the employee. A study of all negotiated health and welfare plans in northern California in 1955 indicated that while 58 percent of the workers were covered by plans in which employers contributed to dependent coverage, 29 percent had to purchase this coverage at their own expense and 13 percent were enrolled in plans which made no provision for dependents.

2. THE EXCLUSIONS AND LIMITATIONS

If the medical services provided on a prepayment basis are to be comprehensive, there is still a long way to go. Most workers with minimum coverage have some type of hospital insurance. Important as this coverage is, expenditures for hospital services represent less than 30 percent of the total private medical bill. As a result, there has been an increasing demand for surgical and medical coverage also.

A typical group insurance plan in California in 1955 included limited hospital room and board benefits for 70 days; X-ray and laboratory payments and surgical and in-hospital medical benefits, with maximum payments according to a fee schedule; and out-patient medical

benefits of $4 for an office visit and $6 for a home call beginning with the third visit. Under this typical plan the member is not usually covered for routine visits to the doctor involving a checkup or treatment which requires less than three calls, he must assume the costs after the hospital and medical benefits have become exhausted, and if any benefits are provided for dependents, they are usually more limited than those of the worker.

Most health insurance programs provide very little coverage for out-patient treatment. Some do not cover it at all; others exclude at least the first two visits to the doctor. Spokesmen for insurance company, Blue Cross, and Blue Shield plans justify this omission on the basis that out-patient benefits are too open to abuse by both patients and doctors. In addition, they point out that covering numerous doctors' bills adds substantially to the administrative cost of the plan, and that most persons are able to pay these small amounts out of their own pockets.

Nevertheless, medical experts have been putting more and more emphasis on the importance of early diagnosis of illness because of the substantial rise in the incidence of chronic diseases: diseases that can be effectively treated only in their early stages. It is important, therefore, that people be encouraged to have periodic physical examinations, even if they have no specific complaints. Many health insurance leaders maintain that the likelihood of persons doing so is greatly reduced when insurance does not relieve the costs of a physical exami-

nation, and that, as a result, the omission of out-patient care materially reduces the effectiveness of health plans.

Group insurance plans often require that the patient be hospitalized before they will cover the cost of laboratory tests. This safeguard backfires where doctors permit patients to be hospitalized unnecessarily so that laboratory tests, which could have been given in the doctor's office, will be paid for by the plan. In such cases, the plan not only must pay for the tests but is also billed for hospitalization.

Another serious limitation of most health insurance is that benefits are exhausted before treatment involving extensive hospitalization and medical care is completed. This occurs particularly in chronic disease cases where allowance for, say, 31 days in the hospital and a limitation on medical payments to six months per disability may represent only a small part of the total costs.

In order to fill this need, insurance companies have recently begun making catastrophe or major medical health insurance available to groups. Catastrophe insurance is designed to meet major costs, taking up where the usual group insurance coverage leaves off. However, most major medical policies still require the patient to pay a percentage of the bill himself, the so-called co-insurance feature. The very rapid recent increase in the number of persons covered by major medical expense insurance would seem to indicate that it will soon become a popular type of coverage.

Most health insurance plans do not cover a number of

kinds of health care which represent a substantial portion of the average family's medical bill. Among the most important of these are dental care, eye examinations and the fitting of glasses, psychiatric treatment, and medicine and drugs purchased outside the hospital. While some notable efforts are being made in various parts of the country to provide some of these services on a prepayment basis, they are still in the experimental stage.

3. INABILITY TO ASSURE PAYMENT OF ENTIRE BILL

Voluntary health insurance plans have made much progress in safeguarding patients from excessive financial burdens due to hospital, surgical, and medical expenses. However, the rising costs of medical and hospital care, the inadequacy of the fee schedules of many insurance policies, and the methods of fee determination traditionally used by doctors have often left a sizable gap between the actual charges made to the patients and the reimbursements provided by cash indemnity plans.

The period that witnessed the most rapid expansion of health insurance coverage also saw considerable increases in medical and hospital costs. As a result, the surgical fee schedules and hospital allowances provided by cash indemnity plans, though perhaps sufficient when established, became less adequate to pay the bills presented to subscribers as time went on. As a result, subscribers often had to supplement the insurance pay-

ments with substantial sums out of their own pockets. Persons thus affected soon began to complain to union officials and employers about the inadequacy of their group plans, and to demand the purchase of plans providing higher benefits. Thus the fee schedules purchased by health and welfare funds were steadily raised from a maximum of $250 to $300 and $350, with corresponding increases in premiums paid by the employer and/or the employee.

The problem was intensified by the tendency of many doctors to use the same standard of fee determination with insured patients that they traditionally used with uninsured patients: charging on the basis of ability to pay. When applied to patients with insurance, this concept results in negating much of the value of coverage, since a doctor can assume that by virtue of such coverage the patient's ability to pay has increased. Carried to the extreme, this concept means that the higher the fee schedule, the higher the fee; thus any effort on the part of an insurance plan to keep up with doctors' charges would be doomed to failure.

Subscribers have assumed that their insurance should pay virtually the entire bill for services which are covered. Doctors and hospitals have argued that they should not be expected to hold the line on medical costs in a period when all other costs are rising. They contend that cash indemnity plan fee schedules are unrealistic and that if they were to accept these fee schedules as full payment, they would in effect be turning the right to

determine their charges over to third parties. At the same time, responsible officers of the American Medical Association have been urging doctors to seek ways of cooperating with insurance plans to the end that costs can become more predictable.

These difficulties have led some union and management representatives to seek prepayment plans which provide service benefits rather than cash reimbursement. Other health plan administrators have attempted to persuade doctors either to accept existing plans' fee schedules as total payment or to establish reasonable fee schedules that physicians would be willing to accept.

The doctors frequently reply that Blue Shield plans, sponsored by the medical associations, represent the closest thing to a service plan that they will support. Although many industrial groups are members of Blue Shield plans, unions generally are dissatisfied with the income ceilings which prevent many of their members from receiving full coverage for their medical care costs.

4. THE QUALITY OF CARE

The three problems discussed above have been primarily economic ones, relating to the cost and *quantity* of medical benefits. A growing body of critics has begun to argue that health plans have been negligent in not also giving more attention to the *quality* of care provided to subscribers. These observers view the role of the health plan as providing positive leadership in

safeguarding health, rather than merely paying claims.

It is true that frequent charges are made against one type of plan or the other, challenging the quality of care provided. One often hears allegations that one kind of plan encourages unnecessary operations and services, or that another attracts inferior doctors who provide poor care. Certainly, an unnecessary operation, no matter how well performed, is a disservice to the patient; and an incorrect diagnosis resulting in an improper course of treatment is usually worse than no treatment at all.

Unfortunately, however, arguments based on the criterion of quality have seldom been founded on careful research. Almost no health plans have really attempted objectively to evaluate the kind of care being rendered to subscribers. Until they do so, efforts to improve the quality of care will be hampered, and union and management officials will continue to be greatly handicapped in making more intelligent decisions in their choice of plan.

5. CONCLUSION

The foregoing account has shown that in spite of the impressive strides which have already been made, there is still considerable room for improvement in existing health plans. Progress in overcoming these deficiencies will depend upon the extent to which all of the groups involved in the success of voluntary health insurance are willing to cooperate. There seems to be

general agreement among organized labor, management, the medical profession, hospital and health plan administrators, and insurance companies that voluntary insurance should be improved and expanded. However, these groups still tend to approach problems from widely divergent points of view, and substantial differences exist among them, and even within them, on what constitutes an ideal health plan.

V. Some Unresolved Issues

VOLUNTARY HEALTH INSURANCE PLANS in the United States are constantly being improved to the end that they will serve more people and provide increased protection. It may be, however, that we shall soon reach the point where further steps in the direction of providing a greater quantity and quality of benefits in the most efficient way will require all of the groups interested in health plans to reconsider their positions on some of the basic issues that presently divide them. This chapter discusses the most controversial issues.

1. THE PURPOSE OF HEALTH AND WELFARE PROGRAMS

Probably the most basic difference of opinion relates to what the major objective of health plans should be.

One viewpoint holds that the role of health insurance is to indemnify the insured for cash losses due to sickness. Spokesmen for this position argue that insurance is a means of spreading the risk, and that the insurance mechanism is most appropriate when applied to the more unpredictable and costly contingencies, since em-

ployed persons can bear the cost of predictable expenses. Conversely, they contend that the insuring of "routine" items, such as physical examinations and dental and eye care, merely creates added administrative expense without providing any substantial risk-sharing and encourages abuse of the plan.

The opposite point of view holds that the purpose of a health program should be to make comprehensive medical care available to the subscriber, so that his health may be maintained at an optimum level at a cost that is reasonable and predictable. This approach insists upon the inclusion of "routine" services within the coverage of the plan, since they play a crucial role in the overall maintenance of good health and represent a substantial part of the worker's expenditures for medical care.

2. COMPLETE COVERAGE VS. COINSURANCE AND A DEDUCTIBLE

The argument is often made that a plan which provides virtually complete coverage encourages abuses by subscribers and doctors. It is claimed that when services are available at no added cost to the patient, there is little incentive for either the patient or his attending physician to exercise restraint, and the consequent overutilization will result in higher premiums paid by the insured population.

For insurance written on the indemnity basis, controls are being sought through a method commonly called

coinsurance, whereby the insured receives substantial but not complete reimbursement of expenses incurred. For example, in the typical major medical expense policy, which becomes effective after the benefits in the basic plan are exhausted, the insurance covers 75 or 80 percent of the actual expenses. The theory of the coinsurance provision is that if the insured pays 20 or 25 percent of each bill, he will be more interested in keeping the cost of his medical care at a minimum. Another device often used for the same purpose is the deductible amount. Examples of this are found in policies which cover visits by a physician after excluding the first two visits and in policies which exclude from reimbursement the first $100 to $500 of expenses incurred.

Those who oppose the introduction of coinsurance and deductible features do so on the ground that these devices are not proper ways to eliminate whatever abuses have crept into present plans. They argue that although a few abuses by patients may be corrected, the net result is likely to be that some who urgently require care and treatment are kept away from the doctor and out of the hospital. The deductible and coinsurance amounts may put an excessive burden on lower-income families, while at the same time the actual abuses or unnecessary procedures may still remain. Thus, it is claimed that the use of these devices may harm the prepayment system without achieving an ultimate solution in terms of doctor and hospital cooperation with the plans. A medical-association-sponsored health plan in

Windsor, Ontario, providing comprehensive benefits on a fee-for-service basis, seems to have overcome the problem of overutilization through strict medical association control of participating doctors.

3. INDIVIDUAL PRACTICE VS. GROUP PRACTICE

Another sharp division of opinion has arisen over whether medical care should be provided by doctors practicing individually, each with his own office, equipment, financial arrangements, and medical records, or by medical groups whose members join together to use their combined skills and resources to provide services.

Proponents of solo practice believe that most patients can be adequately treated by an individual practitioner, that in group practice the physician loses some of his independence, and that group practice results in excessive referral to specialists, thus impairing the patient-doctor relationship.

Advocates of group practice assert that this method results in both greater economy and higher quality of care, because groups of physicians, by pooling office space, equipment, and auxiliary personnel, can greatly increase the efficiency of their work. Furthermore, supporters of group practice maintain that since no individual physician can master all the complexities of diagnosis and treatment, many sick people must be seen by

more than one doctor, and group practice assures that this can be done in an efficient way.

The controversy over the relative merits of individual and group practice becomes particularly warm when group practice is combined with a prepayment plan. A prepayment plan based on group practice generally entitles the patients to seek medical care only from doctors who are members of the group. This arrangement is often referred to as a closed-panel plan.

Opponents of the closed-panel arrangement argue that it restricts too severely the freedom of the patient to choose his physician. They claim that doctors practicing in these plans tend to be inferior since highly qualified doctors prefer solo practice. Opponents also contend that since the doctors in group practice prepayment plans are reimbursed on a capitation or salaried basis, rather than on a fee-for-service basis, they have little incentive to provide maximum service to members and are tempted instead to "cut corners" by spending too little time with each patient and by not providing essential services.

Proponents of group practice prepayment plans reply that adequate freedom of choice is permitted within the group of participating doctors, and that actually this choice may be a more meaningful one, since patients are choosing from only well-qualified physicians. They also argue that doctors in group practice are not burdened with the administrative and financial problems that plague the individual private practitioner, and that re-

imbursement on a capitation basis provides an incentive to keep patients well and to diagnose disease in its early stages in order to avoid later expensive surgery and hospitalization.

Each of the above positions has its confirmed believers, and it is probable that within almost any group of workers some will strongly favor one type of plan as against the other. Consequently, there is a growing tendency toward enrolling groups in two or more plans so that the individual subscriber may decide for himself which type of plan best suits his needs.

4. LAY SPONSORSHIP OF HEALTH PLANS

In a number of communities, groups dissatisfied with existing insurance programs have sponsored plans of their own. In some cases, a union or a company has been the sole sponsor; in others, consumer groups have joined together to establish a plan. The main feature of these plans is that basic policy decisions—particularly those involving finances—are placed in the hands of representatives of the consuming group or groups. Most of these consumer-sponsored programs are based on the group practice or medical center approach.

Advocates of lay sponsorship maintain that medical- and hospital-association-sponsored plans tend to be operated primarily in the interest of the providers of services. They feel that only lay control of basic policies relating to finance, organization, and administration will assure operation of the plan in the consumer interest. It

is generally agreed that lay control must not extend to any of the medical decisions.

Since most lay-sponsored plans have utilized the medical center, closed-panel approach, they have often been faced with determined opposition from medical societies. Organized medicine has insisted that both the standards of medical care and the terms of physician participation in any program should be strictly retained in the hands of the profession. Thus medical societies have objected to these lay-sponsored plans on three grounds. First, they have argued that lay control of the health plan brings lay control of medical care. Second, they have objected to the methods of reimbursing participating doctors (salary or capitation) employed by lay-sponsored plans. Third, they dislike the requirement that subscribers be restricted to the use of medical center doctors, branding this requirement as "panel medicine."

Medical societies have utilized a number of devices for discouraging lay sponsorship. They have supported legislation which would make such plans illegal. They have attempted to discipline physicians who join by expelling them from medical societies. Finally, the societies have sponsored their own competing plans.

Despite these objections to lay-sponsored plans, it is generally conceded that some of them are offering comprehensive benefits at a relatively low cost. In addition, at least one of them has taken the unique step of permitting studies of the quality of care provided and of subscriber satisfaction.

5. PREVENTION AND EARLY DIAGNOSIS OF DISEASE

The promotion of good health involves more than furnishing medical care to the sick. Good health involves proper diet, a healthful environment, good living habits, health education, and early diagnosis of disease. There is considerable disagreement, however, concerning the proper role of health insurance in this area. Insurance companies and medical associations put much time, effort, and money into campaigns for health education. But they contend that it is economically unsound to include provisions for early diagnosis in the health insurance plans which they sponsor, feeling that the individual should be expected to budget the costs of periodic physical examinations.

Comprehensive group practice plans do include periodic checkups within their range of services, and they often sponsor programs of health education. However, even when physical examinations are offered free of charge, not all members of the group take advantage of the service.

One possible answer to this problem may be found in a technique known as "multiphasic screening," which consists of a series of simple tests, administered rapidly and on a mass basis, directed at the early detection of disease. Experience with multiphasic screening has shown that, where this series of tests is made available

in or near the place of employment, close to 100 percent of the workers will participate voluntarily. If industrial groups make extensive use of the personnel and equipment of voluntary and public health organizations and agencies, their costs can be held to a low figure, even if some time off the job is given for taking the tests.

Among the tests which may be conveniently included are height and weight, vision, chest X-ray, blood pressure, hemoglobin, blood sugar, electrocardiogram, serologic test for syphilis, and a health questionnaire. While a number of diseases may be detected as a result of the use of this procedure, it should be emphasized that multiphasic screening is not a substitute for a thorough physical examination by a physician.

In addition to its potential for disease detection, multiphasic screening provides an excellent opportunity for the development of a concurrent program of health education.

6. THE ROLE OF THE GOVERNMENT

Governmental activities in the field of public health have steadily increased. These activities have grown to include not only the area of sanitation but also programs of diagnosis, treatment, and hospitalization in the fields of communicable disease control, mental health, maternal and child health, and indigent care. The federal government has appropriated large sums of money for medical research, hospital construction,

and care of veterans, dependents of military personnel, merchant seamen, and Indian tribes. As a rule, however, organized medicine and some other groups have opposed measures to provide public medical care directly to persons able to pay for private services.

a. *Legislative proposals.* Their opposition has also extended to proposals to establish compulsory health insurance programs under either state or federal government auspices. In 1935, thought was given to including health insurance as part of the federal social security program. However, the first serious legislative proposal for a national health program, introduced in 1939 by Senator Robert Wagner, would have provided grants-in-aid to the states to enable them to develop plans of their own choosing—subject to basic standards set by the federal government. This proposal was followed in 1943 by the first Wagner-Murray-Dingell bill, which provided for a federal system of medical and hospital benefits, financed by equal payroll contributions from employer and employee. This bill died in committee, and a similar bill introduced in 1945 met the same fate.

The last major health insurance bill was inspired by the Ewing Report of 1948. Federal Security Administrator Oscar R. Ewing's proposals for a national health program were backed by President Truman; but a bill similar to the Wagner-Murray-Dingell proposals, introduced in 1949, received little support in Congress.

In 1954, the Eisenhower Administration, while opposing any programs for compulsory health insurance,

proposed the establishment of a Federal Health Reinsurance Service which would "encourage private and nonprofit health insurance organizations to offer broader health protection to more families." The bill would have set up a $25 million fund designed to stimulate voluntary insurance plans to "reinsure" themselves against the risks involved in giving increased coverage to more people and in improving benefits. The insurance carriers were to pay premiums for this reinsurance, thus building up a revolving fund which would ultimately carry the program without federal subsidies.

The reinsurance proposal received little support from any quarter, most groups feeling that it would not provide any real assistance in broadening health insurance protection. Neither this bill nor a slightly revised version proposed in 1955 was adopted.

b. *Views of labor and organized medicine.* Organized labor has in the past supported bills aimed at the establishment of compulsory health insurance. Most unions are still officially on record as favoring a national program over the voluntary plans now in existence. Two labor representatives—Walter Reuther (Automobile Workers) and Albert J. Hayes (Machinists)—served on the President's Commission on the Health Needs of the Nation which submitted its report in December, 1952. They dissented from the Commission's recommendation that health plans be coordinated through local regional health authorities established in each state by state health authorities. Their dissent stated that the objective

"of giving all persons in the country ready access to high quality comprehensive personal health services" could be attained only if "the participation of every State is assured by Federal statute." If this cannot be assured, the objective should be accomplished "through a National Health Insurance Act supported by joint employer-employee contributions and tax revenues."

Organized medicine, on the other hand, has opposed national intervention in the health insurance field. The California Medical Association also strongly opposed attempts by Governor Earl Warren to establish a state compulsory health insurance program both in 1945 and 1947. All such legislative programs have been called "socialized medicine" or an "opening wedge to socialized medicine." Organized medicine particularly objected to provisions in the Wagner-Murray-Dingell bills which would have limited workers to the selection of doctors who had agreed to participate in the national program and which would have given the Surgeon General powers to set fee schedules and limit the size of a doctor's panel of patients.

In general, even the proponents of national health insurance see little possibility that their proposals will be enacted in the near future. While this may be attributed in part to the spirited campaigns waged by medical and other groups against governmental programs, there is little doubt that the rapid growth and the growing effectiveness of voluntary plans have contributed greatly to the decreased emphasis on legislative solutions.

VI. Insurance Against Wage Loss

ALTHOUGH in recent years discussions about health insurance have tended to center around protection against hospital, surgical, and medical bills, insurance against loss of income caused by illness or injury constitutes a vital part of the whole picture. Earlier chapters have pointed out that most health and welfare plans established in industry prior to 1930 stressed income-loss benefits almost exclusively. Certainly, this type of benefit is of great importance since, where sickness or accidents cause loss of income, the amount involved is frequently much greater than the hospital and doctor bills which result; in addition, it is the worker's income that must meet his family's expenses.

There are two important factors which must be considered in any discussion of disability benefits. The first is the cause of the disability—whether or not it is related to the job. The second is the duration of the disability—whether it is temporary or permanent. If the accident causing the disability occurred on the job, the worker is eligible for workmen's compensation benefits. Workmen's compensation laws provide protection against both temporary and permanent disability. If the dis-

ability is due to sickness or injury totally unrelated to the job, the worker may be covered by some type of temporary disability program. If his nonoccupational disability should turn out to be permanent, he is largely unprotected unless his pension plan happens to have a special provision covering this contingency.

Since health insurance plans exclude industrial accident cases from the scope of their coverage and in almost all cases provide only temporary benefits in the case of nonoccupational disabilities, most of this chapter will be devoted to temporary, nonoccupational disability plans.

According to the 1954 survey of the Health Insurance Council, approximately 42 million workers have some form of coverage against loss of income due to disability. This figure represents around three-fifths of the total civilian labor force.

Group disability coverage has developed in a number of ways. The oldest types of plans are the union-sponsored sick benefit programs and the employee mutual benefit association plans first developed around the turn of the century. A second type includes the formal or informal, contractual or discretionary arrangements developed by many employers which permit their employees through paid sick leave to continue their wages in full or in part for varying periods during absence on account of disability. A third type of program is based on the voluntary purchase of disability insurance from insurance companies. These policies may be bought

either by individual workers or by employers or trust funds to cover an entire group of employees. The final type of disability program has developed as a result of legislation. There are five statutory plans: a federal one for railroad employees and four state plans for employees generally in Rhode Island, California, New Jersey, and New York.

1. VOLUNTARY GROUP DISABILITY INSURANCE PLANS

Group disability insurance is often provided for workers as part of an industry's health and welfare program. It may be offered as a result of collective bargaining agreements or of unilateral management action. It may be entirely employer-financed, or the employee may be required to pay a portion of the premium. The provisions of such insurance vary widely from plan to plan depending on the eligibility requirements, the amount and duration of the benefits provided, and the length of the waiting period, if any.

The eligibility of the worker for disability benefits is usually dependent upon his having worked a specified length of time, although in some cases he is entitled to coverage as soon as he is hired. In some industries, such as construction, he is required to work a given number of hours during a certain time span. Other industries merely require that he be on the payroll of a company for between one and six months.

The benefits paid may be graduated on the basis of the employees' normal earnings or they may provide a flat sum for all wage earners. Although the benefits provided by the graduated plans vary widely, the tendency is to set the benefits at approximately half or more than half of the weekly compensation of employees in the lower income brackets. For workers whose income exceeds $75 per week, however, the benefits tend to average around $40 per week. As of 1954, the average weekly benefit was between $28 and $29 for all covered workers.

Disability insurance benefits are usually paid only for nonoccupational illnesses or injuries, although in some cases the plans pay the difference between the company's nonoccupational benefits and whatever the employee injured on the job receives under workmen's compensation. Most disability insurance plans provide benefits for six weeks to female employees unable to work because of pregnancy.

Payments commonly begin on the first, fourth, or eighth day of the disability. A distinction is commonly made in the waiting period depending on whether the disability is due to illness or accident. One reason for the waiting period is to discourage malingering and abuse. In addition, it reduces costs by eliminating a large number of small payments, thereby cutting administrative expense. Finally, cash compensation is not as urgent in brief illnesses. Since it is assumed that the possibility of abuse is not as serious in accident cases, the most

common provision is to pay benefits from the first day of an accident and the eighth day of an illness.

The duration of the benefits is usually expressed as a maximum number of weeks (13, 26, or 52) for a single disability. Probably the majority of plans provide benefits for 26 weeks. However, other disabilities arising from different and unrelated causes usually entitle workers to additional benefit periods, except in a number of plans which provide that employees 60 years of age or older are entitled to only one maximum period of disability benefits in any one calendar year.

2. COMPULSORY GROUP DISABILITY INSURANCE PLANS

Five programs providing cash benefits in case of loss of income due to nonoccupational sickness or accident have been established by compulsory legislation. Four of these have been created by the passage of state temporary disability laws, and the fifth was provided for railroad employees through federal legislation. The Rhode Island, California, and New Jersey plans were established in 1943, 1946, and 1949, respectively, as supplements to state unemployment insurance benefits. The New York law was passed in 1950 as an amendment to workmen's compensation.

These state programs are financed from contributions of 1 percent or less of the first $3,000 of an employee's income. In Rhode Island and California the tax is levied

against the employee alone. In New Jersey and New York the employer shares the burden of the contributions.

The most controversial issue connected with the development of state disability programs has been whether all employers should be required to participate in the state plan, or whether they should have the option of requesting substitution of a private plan. Only Rhode Island requires that all benefits be paid from the public fund. The other three permit employers either to act as self-insurers or to engage approved private insurance companies, providing these private plans at least equal the benefits provided by the state program. In California private plan benefits must exceed those provided by the state fund.

All of the state laws specify a waiting period between the time the worker is first disabled and the time he may begin to collect benefits. In each case, benefits begin on the eighth day of the disability after a waiting period of one week. However, the California law provides that if the worker is hospitalized, benefits may be paid from the first day of hospitalization.

The amount and duration of benefits vary among the state laws. In each state, however, the weekly benefits are paid on a graduated scale based on the worker's past earnings. Table 2 shows the benefit provisions as of December, 1955.

TABLE 2

	Weekly benefit payments	*Maximum duration of benefits*
California	Range from minimum of $10 to maximum of $40. If hospitalized, worker gets additional $10 per day for 12 days.	26 weeks per period of disability.
New Jersey	From minimum of $10 to maximum of $35.	26 weeks per period of disability.
New York	50% of base pay to maximum of $33.	13 weeks in a year.
Rhode Island	From minimum of $10 to maximum of $30.	26 weeks in a year.

It is surprising that more states have not followed the lead of Rhode Island, California, New Jersey, and New York in passing temporary disability laws. Once unemployment is accepted as a contingency requiring insurance, it is difficult to understand the logic of making a distinction between unemployment caused by economic conditions and unemployment caused by sickness or injury. Yet this is precisely what is done in 44 states which, while having unemployment insurance laws for the able-bodied, exclude from coverage workers who become unemployed due to disability.

The other compulsory disability insurance program, covering approximately 2 million railroad employees throughout the country, is unique in that it provides benefits for both temporary and permanent disability. The temporary coverage was instituted in 1946 through an amendment to the Railroad Unemployment Insurance

Act, benefits being financed by payroll taxes on the employer. Permanent disability pensions have been provided through the Railroad Retirement Act since 1935. Both of these programs are administered by the U. S. Railroad Retirement Board.

Temporary disability benefits averaged about $38 weekly in 1954 and were paid for maximum periods of six months. Permanent disability payments are made to workers who have been shown by competent medical examinations to be suffering from a disease or injury that cannot be corrected by medicine or surgery and prevents them from engaging in any gainful work.

3. SUMMARY

In spite of the spectacular advances made in recent years in alleviating the financial burdens imposed by disability, it is essential to point out the size of the problem which is yet to be faced. The U. S. Department of Health, Education, and Welfare estimated an income loss during 1954 of $6.2 billion due to short-term disability. All types of protection combined met only 24 percent of this loss. The average weekly temporary benefit of somewhat in excess of $28 would seem insufficient to provide even a minimum subsistence level for a majority of the families it is intended to protect. Perhaps of even greater importance is the fact that probably 80 to 90 percent of the existing disability plans provide benefits for only 13 or 26 weeks. This is in spite of actu-

arial figures which show that of 1,000 persons aged 35, nearly one-third will suffer prolonged disability before age 65, and 30 percent of this one-third will be permanently disabled.

It would appear that there is need for a change in attitude toward the problem of permanent or prolonged disability. The insurance industry has traditionally entertained skepticism toward its ability to cope with the problems posed by this kind of coverage. The result has been that no type of voluntary insurance up to now has even begun to measure up to the needs of workers in the area of permanent or prolonged loss of income.

There are about 2 million individuals under 65 years of age who have been in the labor force and who are now permanently and totally disabled. Because they are under 65, they are not eligible for old age benefits. To give some protection to these persons, the Social Security Act Amendments of 1954 provided for freezing their benefit rights as of the time they became permanently and totally disabled. They thus are protected from losing whatever rights they have acquired. In addition, the House of Representatives in 1955 passed a bill changing the existing social security law to make fully-insured persons who are over 50 years of age eligible for retirement benefits six months after they become permanently and totally disabled. The Senate, as of the time of writing, has taken no action.

VII. The Outlook for Health Insurance

THE TWENTIETH CENTURY has been characterized by a quest for security. A significant role in this search has been played by labor, management, and other groups which have experimented with various methods to protect the worker against problems created by ill health: both the need for medical care and the loss of income due to disability.

In most cases, the methods adopted have taken the form of insurance or prepayment programs, and except for the temporary disability legislation in four states and the railroad industry, these programs have developed through voluntary arrangements. The rapid growth of voluntary health insurance reflects widespread agreement on the need for and desirability of this form of protection.

The achievements to date have been laudable, but they should not blind us to the needs that remain. The partial satisfaction of needs has resulted in increased consumer expectations. The earlier demand for *some* protection is giving way to the expectation of *comprehensive* protection. Millions of workers have very lim-

ited coverage; recent estimates indicate that only 5 million persons are enrolled in plans providing comprehensive medical benefits.

There are and there will remain large numbers of workers not covered by industrial health insurance plans. These persons are primarily in the income groups which are in greatest need of protection. However, as individuals, they do not possess the means to purchase health insurance, no matter how attractive and reasonable the plan may be. The problem of group insurance for these workers is yet to be solved.

It may be assumed that increases in coverage for those now under private plans will require the allocation of larger amounts of money for health insurance purposes. In the case of workers covered by industrial plans, this will mean increases in employer contributions to these plans.

However, before labor and management decide to allocate increasingly greater amounts for this type of protection, it will be appropriate for them to make a thorough comparison of alternative methods of financing and organizing medical services. Events of the past have shown that the mere act of providing more money for medical care does not necessarily result in an increase in either the quantity or quality of services. Labor and management as negotiators and administrators of health and welfare plans have assumed new and perplexing responsibilities. They are required as trustees of a health and welfare fund to safeguard it against abuse. It is only

one step further for them to assume the role of consumer representative in the field of medical care.

Trustees of health and welfare plans have an obligation to assure that every dollar they put into health insurance results in the covered workers receiving a dollar's worth of medical benefits. This will require them to know more not only about medical care organization, but also about health needs.

In terms of medical care organization, it will be well for them to make an intensive study of some of the unresolved issues mentioned in Chapter V: group practice versus individual practice, closed panel versus free choice of doctor, fee-for-service payment versus salary or capitation payment, and lay versus professional control of financial and administrative matters.

In terms of the health needs of the worker, it will be necessary for labor and management to evaluate the desirability of preventive and diagnostic services as well as coverage of catastrophic illness and permanent disability. Their decisions on these matters will depend in part on their attitudes toward the role of insurance, their willingness to allocate increased funds for health and welfare purposes, and their ability to cut administrative costs and to deal with the problem of abuse.

Informed decisions on these weighty matters can come only from continued study and experimentation with all of the alternative methods by which health protection can be organized and financed. If all groups concerned with the success of voluntary health insurance continue

their efforts to provide comprehensive protection—without excluding the possibility of additional governmental assistance in some areas—there is no reason to believe that voluntary insurance plans will be replaced as the predominant device for providing health protection to the American worker within the foreseeable future.

VIII. Suggestions for Further Reading

THE BEST recent source of information on health needs, including problems of health insurance, is still the five volume report of the President's Commission on the Health Needs of the Nation (U. S. Government Printing Office, 1952). This report, entitled *Building America's Health,* was issued in December, 1952. The findings and recommendations included in Volume 1 are of particular interest since they represent the thinking of a representative group of 16 leaders of medical, management, labor, and consumer groups. Volume 2 expands on the recommendations and the reasoning on which they were based. Volume 3 consists of a statistical appendix documenting America's health status, needs, and resources. Volume 4 contains a number of excellent essays by representatives of a number of points of view discussing various aspects of the problem of financing medical care, with emphasis on both health expenditures and various methods of prepayment. Volume 5 is composed of selections from the testimony of the nearly 400 witnesses who appeared at the eight public hearings held by the President's Commission.

Although the statistical information included in *Building America's Health* was complete as of 1951, annual up-to-date reports are available from a number of sources. The Health Insurance Council makes an annual survey, the results of which are published under the title *The Extent of Voluntary Health Insurance Coverage in the United States.* These reports, the most recent of which has the figures as of December 31, 1954, have coverage statistics for various forms of protection—hospital, surgical, medical, major medical, and disability—as well as the distribution of such protection among insuring organizations and geographical areas. The Division of Research and Statistics of the Social Security Administration (U. S. Department of Health, Education, and Welfare) periodically releases a study of the total costs of sickness during a 12-month period, along with the extent to which such costs are being met by voluntary health insurance. These reports are published in the December issue of the *Social Security Bulletin.*

National figures on the number of workers covered by some type of negotiated health insurance plan frequently appear in articles in the *Monthly Labor Review* of the Bureau of Labor Statistics (U. S. Department of Labor), the most recent of which may be found in the September, 1955, issue. State governmental departments at times also issue reports on health insurance coverage within their borders, a notable example of which is the publication of the Division of Labor Statistics and Research of the California Department of Industrial Relations en-

titled *Labor-Management Negotiated Health and Welfare Plans, Northern California* (as of May 1, 1954). This California survey provides detailed figures on the benefits and limitations of the plans studied in addition to the number of workers covered.

Additional valuable information is provided by the *National Family Survey of Medical Costs and Voluntary Health Insurance,* published in 1954 by the Health Information Foundation. Statistics in this survey, based on interviews of 2,809 families, provide needed information on enrollment in health insurance by family income, age, and rural-urban areas, as well as on debt among families due to costs of personal health service.

A thorough analysis of the field of group insurance is provided in a book by Louise Ilse entitled *Group Insurance and Employee Retirement Plans* (New York: Prentice-Hall, 1953). Perhaps the best history of the development of sickness benefit plans by labor unions and the subsequent early stages of health and welfare plan negotiation may be found in *Group Health Insurance and Sickness Benefit Plans in Collective Bargaining,* published in 1945 by the Industrial Relations Section of Princeton University. For a discussion of both early union- and management-sponsored plans, see *Labor's Risks and Social Insurance* by Harry A. Millis and Royal E. Montgomery (New York: McGraw-Hill, 1938), and articles by Harry Becker and Dr. William Sawyer in the January, 1951, issue of *The Annals of the American Academy of Political and Social Science.*

Descriptions of existing types of health insurance—cash indemnity, Blue Cross, Blue Shield, and medical center plans—are available in a number of publications. One of these is *Management and Union Health and Medical Programs* by Margaret C. Klem and Margaret F. McKiever of the U. S. Department of Health, Education, and Welfare (Public Health Service Publication No. 329, 1953). See also *A Look at Modern Health Insurance* published by the Chamber of Commerce of the United States (Washington: 1954). A survey entitled *Union Health Centers* (Chicago: American Medical Association, 1953) outlines the main features of 12 such programs.

An excellent survey of the entire field, which includes a discussion of the basic issues in medical organization and finance—individual and group practice, compensation of professional persons, freedom of choice, cash indemnity and service plans—is provided in *Voluntary Medical Care Insurance in the United States* by Franz Goldmann, M.D. (New York: Columbia University Press, 1948).

An analysis of various insurance company practices in underwriting group insurance, as well as of legislative proposals for meeting the problem of health and welfare plan abuses, is included in *Welfare and Pension Plans Investigation,* Final Report of the U. S. Senate Committee on Labor and Public Welfare (U. S. Government Printing Office, 1956).

The most recent thorough presentation of the case for

a program of national health insurance may be found in the report by Oscar R. Ewing, former Federal Security Administrator, entitled *The Nation's Health, a Ten Year Program* (U. S. Government Printing Office, 1948). Reactions by medical associations to this and other kinds of programs which they view with disfavor may be found in the following publications of the American Medical Association: *An Analysis of the Ewing Report* (August, 1949), *A Brief History of the Attitude of the American Medical Association toward Voluntary Health Insurance* (October, 1949), and "Building Health by Commission," *Journal of the American Medical Association* (March 21, 1953). Another account of the role of organized medicine may be found in the May, 1954, issue of the *Yale Law Review*, by David R. Hyde and Payson Wolff, entitled "The American Medical Association: Power, Purpose, and Politics in Organized Medicine."

Up-to-date statistics on the extent of protection against income loss due to disability are now published in January issues of the *Social Security Bulletin*, beginning with January, 1956. The same source has published articles describing the experience under the disability insurance programs established by state laws. An excellent evaluation of the disability programs covering railroad employees is provided by a paper entitled "Experience under Social Insurance Programs for Permanent and Temporary Disability in the United States," presented by Jerome Pollack, UAW consultant, before the 1955 spring meeting of the Industrial Relations Research Association.

PRINTED IN THE UNITED STATES OF AMERICA

BY THE UNIVERSITY OF CALIFORNIA PRINTING DEPARTMENT


141