Voluntary Health Insurance on the National Scene

The Present Status of Voluntary Health Insurance *

MARGARET C. KLEM

Division of Industrial Hygiene, Public Health Service, Federal Security Agency, Washington, D. C.

A FEW years ago, a discussion of health insurance would have started with a statement as to the unpredictable nature of illness, the uneven distribution of medical costs among families, and the consequent need for insurance against unexpected medical bills. Today, there is little, if any, need for going into these "why's" of health insurance. Both the public and the professions concerned have accepted the fact that people should have advance protection against medical costs. The points now at issue are, "What form should health insurance take?" and "What services should be covered?" Two major forms have been proposed, both involving the prepayment principle—one, that membership in a prepayment health program be compulsory; the other, that membership be voluntary.

In its broader sense, the term voluntary health insurance can be used to denote both disability insurance, which provides reimbursement for wage loss in the event of illness, and medical care insurance which protects members against the direct cost of illness. The term, however, is now more commonly used to refer to medical care insurance, providing either cash or service benefits through insurance companies or nonprofit prepayment medical care plans, and that is the definition used here.

While this type of protection for some beneficiaries has been in existence for many years, the general public began to grow more aware of its existence in the 30's when Blue Cross hospital plans were inaugurated, when insurance companies began offering group coverage on an extensive basis to employed groups, and when state medical society plans in California and Michigan were organized and set the pattern for Blue Shield plans now found in most states. The rapid growth of membership in these three types of voluntary programs has coincided with extensive discussion of compulsory health insurance.

Membership in voluntary health insurance has grown rapidly, mainly in Blue Cross, Blue Shield, and insurance company coverage. Enrollment in the older programs, primarily the consumer-sponsored, the physician-owned, and the industrial plans, has not shown much change since 1943, when the first extensive study which took into consideration both the old and new types of prepayment medical care plans was made.

Despite considerable activity among consumer groups interested in forming prepaid medical care programs, only a few new plans with a relatively small

* Presented before the Medical Care Section of the American Public Health Association at the Seventy-seventh Annual Meeting in New York, N. Y., October 26, 1949.

The opinions expressed in this statement are those of the writer and do not necessarily represent the views of the Federal Security Agency.

total membership have been established. The importance of these plans, however, cannot be measured by membership alone because of their great educational value. They stimulate public discussion of the range of services to be provided; they encourage the use of preventive medicine and the early care of illness; they emphasize the importance of consumer representation in policy making bodies; and they have experimented with different methods of procuring medical personnel and facilities in areas where they are lacking.

Several factors have retarded the development of consumer-sponsored, industrial and physician-owned plans, namely, the shortage of medical personnel interested in salaried employment, the difficulties involved in the development of medical facilities, the rising and uncertain cost of providing medical and hospital service benefits, the existence of certain state legislation, and the availability of Blue Cross, Blue Shield, and group insurance contracts, which offer few, if any, enrollment difficulties to groups wishing protection.

The Health Insurance Plan of Greater New York, with a present enrollment of about 222,500 is one outstanding exception. This plan has attracted national attention because of the comprehensiveness of services provided, the distinguished and broadly representative board of directors, the exclusive use of medical group practice, the unique administrative relationships and professional controls, and the assistance given by the deans of the local medical schools in developing the plan and in setting up HIP group practice units in the schools.

Between 1943 and 1948 enrollment for hospital benefits under group contracts sold by insurance companies increased from almost 7 million to over 16.5 million. This represents an increase of 80 per cent in employee and over 250 per cent in dependent coverage. For the same period, the increase in the number eligible for surgical benefits was more than threefold, from 4.6 to 14.2 million. In this instance, employee coverage increased 100 per cent and dependent coverage 700 per cent.[1]

The more than 31 million people in the United States enrolled in Blue Cross hospital plans at the end of March, 1949, represent more than three times the number of persons enrolled in 1943, with plans operating in 47 states and the District of Columbia.[2] In 1943, prepayment plans sponsored by state and local medical societies covered about one million people, more than one-half of whom were in the Michigan Medical Service. At the end of June, 1949, medical society plans covered about 12 million persons in 40 states and the District of Columbia.[3]

Enrollment in voluntary health insurance for hospital and for medical benefits has tripled within a 5 year period. In 1943, approximately 20 million people had some form of hospital insurance, with almost two-thirds of the membership covered by prepayment plans and one-third by insurance company contracts. In the same year, between 9 and 10 million also had some form of protection against the cost of physicians' care, the number being about evenly divided between prepayment plans and insurance companies.[4] By the end of 1948, according to a generous estimate, approximately 61 million people were eligible for hospital care, 34 million for surgery, and 13 million for other physicians' services, principally in the hospital.[5] These figures were compiled by the Health Insurance Council, a body composed of insurance company representatives. The report attempted to make allowance for the number of persons eligible for the same type of benefits through more than one form of insurance, but this is extremely difficult to do because of the increasing tendency toward multiple enrollment.

What changes have taken place dur-

ing the past five years in the type of services provided? In most instances, the early programs were designed for a particular group or were developed by the beneficiaries themselves, and took into consideration the special needs and desires of each group to be served. These older programs have always tended to provide service benefits of a comprehensive nature, that is, hospitalization and physicians' care in the office, home, and hospital. Services are frequently given by physicians employed on a salary basis and in clinics or hospitals owned or operated by the plans. In addition to hospital and physicians' services, members are sometimes entitled to special duty nursing in home or hospital and to dental care. Most of the older, well established industrial, consumer-sponsored, and physician-owned plans are still operating without significant change in benefits provided. These older programs demonstrate what can be done by prepayment plans which include preventive medicine among their benefits and encourage early care for illness by providing home and office calls.

Unlike the earlier plans, the Blue Cross, Blue Shield, and insurance company group plans were organized to provide protection against the cost of hospitalized illness to any groups that cared to enroll. One of the principal reasons for limiting benefits to hospitalized cases is the fear of excessive demand for home and office calls, though recent substantial bodies of experience have indicated that when services are provided on a group practice basis this anticipated over-demand does not occur.[6] Some Blue Shield plans and insurance company group contracts offer coverage for home and office calls, but this protection has not been popular because of the cost and the fact that the patient generally must pay for the first few calls in each illness.

A survey of 56 medical society plans, made recently, showed that 7 plans provide service benefits; 1 provides service benefits except where the patient selects more expensive hospital accommodations than provided by the contract; 20 provide cash indemnity only; 28 of the plans provide service benefits to subscribers having annual incomes less than a stated amount and cash indemnity according to fee schedules to subscribers with higher incomes. The annual income limits specified by 28 plans vary from $1,500 to $3,000 for a single person and from $2,400 to $5,000 for a family.[7]

Originally, Blue Cross plans provided service benefits, but increased hospital costs have raised a serious problem for all prepayment plans operating on a service basis. To avoid raising premiums, some plans have given up their service benefits and now provide only a specified cash payment toward room and board. However, the plans continue to give other benefits in the hospital on a service basis, and the range of these services has increased somewhat. At the 1948 meeting of the American Hospital Association, a policy statement was approved which states, "The importance of maintaining service benefits is as great as ever. The basic strength of Blue Cross plans rests in their service benefits. . . ."[8]

The trend toward indemnity benefits among Blue Cross and Blue Shield plans has erased to some extent the line of demarcation between nonprofit plans and insurance companies. The benefits provided are now quite similar, namely, hospiltalization and in-hospital medical care, principally surgery. In several states, medical societies have organized plans with benefits underwritten by private insurance companies.

What in effect has been the result of the trend away from the provision of more comprehensive services and toward indemnity, largely limited to hospitalized illness? For example, to what extent do the limited benefits cover sur-

gical bills? A recent study by Martin Segal of insurance company group coverage based on more than 3,500 claims shows that in the New York area under policies providing a maximum of $150, the average surgical bill was $87, but the average patient received only $38. Even under the $225 policy schedule, under-insurance was still pronounced.[9] A study of a sample of 100,000 group surgical claims made under the auspices of the insurance companies showed that in 1947 the reimbursement paid by the companies under surgical insurance for non-obstetrical claims represented 55 per cent of the aggregate doctor's charge.[10]

To what extent is the total family medical bill now being met by voluntary insurance? Barkev Sanders, in material prepared for a report to be published by the Twentieth Century Fund, concludes that total payments in 1947 by both nonprofit programs and insurance companies to medical personnel and hospitals represented less than 10 per cent of the total cost of medical care to American families.

So much for the present situation. What about the future? Which major groups are not covered, and can the voluntary plans overcome the enrollment difficulties they now face? The rural population is an outstanding example. Dr. Hawley recently stated that Blue Cross rural enrollment is estimated at somewhat more than 2.5 million, but that no accurate figures on rural enrollment in Blue Shield are available. The chief difficulties encountered in rural enrollment are insufficient medical personnel and facilities, low cash incomes, and the problem of enrolling a scattered population, especially where group enrollment is required.[11] Lack of interest on the part of the rural population is not one of them. Rural interest is demonstrated by the number of rural groups attempting to solve their own medical problems through the formation of cooperatives and the enrollment activity of the Farm Bureau, the Grange, and the Farmers Union in the prepaid medical field.

How will voluntary health insurance be influenced by health and welfare programs established through collective bargaining? This type of arrangement did not become widespread and did not include medical services until the time of World War II and the concomitant wage stabilization program. At this time wage increases were limited, but employee benefit programs financed by employers were permitted. In the summer of 1948, the Bureau of Labor Statistics estimated that about 3 million workers were covered by some type of health, welfare, or pension plan under collective bargaining. About 45 per cent of these were covered for health and welfare benefits.[12] Many large unions are now asking for similar programs on a nation-wide basis.[13] These plans are important, both because of the large number of persons concerned and the wide geographic distribution of union membership.

What form will these new programs take? What will be the respective roles of labor and management in developing and administering them? Will benefits be provided through management, union, or jointly operated facilities, through direct contract with community hospitals and physicians in private practice, through Blue Cross, Blue Shield, or other nonprofit prepayment plans, or through the group contracts of insurance companies?

The health and welfare plans have brought out the need for a national contract that would provide uniformity in rates, benefits, and enrollment rules and procedures. The Blue Cross Commission recently announced that the Blue Cross Health Service had been incorporated to provide such national coverage.[14] The Blue Shield plans are in the process of developing an agency to do

the same thing for physicians' services.[15] Insurance companies operating on a national basis are the only ones now able to provide the uniform benefits throughout the country, that are being requested by particular unions, large employers, or other national groups.

Although striving for health protection through collective bargaining, unions have emphasized time and again that what they want is a national health insurance program and that they are particularly eager for a plan which will provide comprehensive medical services for themselves and their families.[16] In the meantime, they are accepting the group insurance contracts now available, arranging for coverage in local plans, or entering upon the difficult and time-consuming procedures of developing special facilities and services.

The Hoover Commission considered the problem of providing medical care to the million dependents of personnel in the armed forces who are now receiving or are considered eligible for substantially free medical care. Although the Commission itself made no specific recommendation directly related to the use of voluntary health insurance, one of the Task Force reports did. It recommended their use as one of two alternative solutions.[17] According to a newspaper story, the Air Force is now experimenting with a type of voluntary health insurance.[18]

Two other groups in the population hardly covered by voluntary prepayment plans are persons on relief and those with low incomes. Federal contributions toward the cost of dues in voluntary plans for the 5 million persons now receiving public assistance or general relief have been, and still are, practically impossible because of the provision of the Social Security law. If the relief agency and the local prepayment plans agreed upon an appropriate schedule of rates and wished to enroll the relief group, federal reimbursement could not be obtained unless the monthly dues were included in each recipient's grant which must be paid to him in cash. The Senate Advisory Council on Social Security, in commenting on this problem, agreed with the recommendation made many times by the Social Security Administration and the American Public Welfare Association that the federal government should participate in payments made directly to agencies and individuals providing medical care for relief recipients. The Council recommended that federal participation in medical costs should not exceed one-half of the total medical expenditures up to a monthly average of $6 per person receiving old-age assistance or aid to the blind, and $3 per person receiving aid to dependent children.[19] Such provisions were contained in H. R. 2892—the public assistance amendments introduced at the request of the President.

In the House Ways and Means Committee Report on H. R. 6000, "Social Security Act Amendments of 1949,"—the bill which the committee substituted for H. R. 2892—a step was taken toward prepaid medical care for public assistance groups. The recommendation was made "that the law be so amended that federal funds may be used to match such direct payments if these sums when added to any money paid directly to recipients do not exceed a monthly total of $50 for the aged or blind, $27 for the first child, and $18 for each additional child in Aid to Dependent Children families." In discussing the problem, the committee pointed out that some state agencies have wanted to insure their client's need for medical care with organizations such as the Blue Cross.[20] The bill, H. R. 6000, passed the House October 5, 1949, and will be considered in the Senate early in 1950.

Several states have already had experience in providing medical services to relief recipients through prepayment arrangements, and the proposed amend-

ment would encourage its expansion. A current study being made by the Bureau of Public Assistance, Social Security Administration, indicates the favorable attitude of public assistance officials in several states to using prepayment plans. In one state, all but one county included in the study reported that services to relief clients under prepayment arrangements are performed efficiently with minimum friction and misunderstandings, that the plan has made possible a considerable saving in administrative time, and that recipients can be assured that care is available when necessary and from a practitioner of their choice. One county gave major credit for the success of the arrangement to the effort made by the welfare agency staff to give recipients an understanding of the plan prior to its effective date.[21]

Closely associated with the enrollment of the relief population is the enrollment of the low income groups. The fact that rates charged by voluntary plans are usually flat amounts, not graduated to income, makes the enrollment of such groups difficult. The New York State Legislative Commission on Medical Care in its 1946 study report states that "upon analyzing the proposals made by persons interested in greatly extending coverage by voluntary insurance plans it was found that they entailed:

"*compelling* the payment of taxes to be used as a direct subsidy to the voluntary insurance plans, or
compelling the payment of taxes to be used as a direct subsidy to the low-income person or family wishing to enroll in a voluntary insurance plan, and for automatic enrollment of the indigent, or
compelling the employer to pay about one-half of the premium for persons wishing to enroll in a voluntary insurance plan. . . ." [22]

Several bills now before Congress under which care could be provided to relief and low income groups are of particular importance to voluntary health insurance programs.[23] The principle of compulsory contributions based on income is incorporated in a bill (S. 1679) which would make available physicians' care in the office, home, and hospital, and hospitalization to about 85 per cent of the population. This bill would permit the state agency to utilize voluntary insurance plans in providing personal health services. Four bills are based on federal subsidies from general revenues, one (S. 1456) would require and one (S. 1581) would permit the use of voluntary prepayment organizations in providing services to the neediest portions of the population, another (S. 1970) would subsidize voluntary plans to make their services more generally available at charges based on the income of subscribers, while a fourth (S. 1805) would assist coöperative and other nonprofit medical and hospital care plans (which so far as practicable provide for group practice and comprehensive medical care including preventive services) in the acquisition, construction, and equipment of needed facilities. Each bill would make federal funds available to pay part of the costs incurred.

As has been pointed out by persons recommending financial participation by the state or federal government, assistance of this type will give government a voice in making rules and regulations to insure that public funds are being expended properly.[24] Even if there is no financial participation by government, some people believe that the time may come when the magnitude of voluntary health insurance programs, both in numbers covered and moneys involved, will result in government inquiry into the quantity and quality of services provided.

To summarize: present enrollment, although large, is unequally distributed, leaving most of the rural population and a number of special groups, which present enrollment difficulties, without any type of protection. Many nonprofit organizations are now providing indemnity rather than service benefits, or a

combination of the two. The voluntary health insurance programs which now have the largest coverage show a decided tendency to concentrate their efforts on alleviating the financial burden of surgical-hospitalized illness. As a result, less than 10 per cent of the total family expenditures for medical care in 1947 is estimated to have been covered through voluntary health insurance.

The place of the voluntary programs will increase in importance to the extent that they follow the recommendations of the Medical Care Section of the National Health Assembly, namely, that they make available more comprehensive health services, that they encourage the development of a high quality of medical care, and that they provide such services on an economically sound basis for a major part of the population. Their ability to follow these recommendations raises the basic question of the adequacy of voluntary insurance and the need for compulsory insurance. Achievement of positive health involves many needs besides medical care, but a comprehensive medical care plan with broad coverage would be an important step toward that goal.

REFERENCES

1. Estimates for 1943 coverage furnished by Equitable Life Insurance Company. Nineteen hundred forty-eight figures from Kirkpatrick, A. L. The Extent of the Health Coverage of Insurance Companies, *American Economic Security,* Chamber of Commerce of the United States, VI:5 (July–August), 1949.
2. Blue Cross Commission. *Blue Cross Enrollment, First Quarter 1949,* (Special Study No. 114), 1949, pp. 6–7.
3. Associated Medical Care Plans. *Enrollment Reports, Blue Shield Plans, Second Quarter 1949.*
4. Reed, Louis. *Hospital and Medical Service Plans.* U. S Public Health Service 1947; and Klem, Margaret C. *Prepayment Medical Care Organizations,* Bureau Memorandum No. 55, 3d. ed. Social Security Administration, Bureau of Research and Statistics. Washington: Gov. Ptg. Office, 1945.
5. Health Insurance Council. *A Survey of Accident and Health Coverage in the United States.* New York, 1949.
6. Rothenberg, Robert E., M.D., and Pickard, Karl, M.D. *Group Medicine and Health Insurance in Action.* New York: Crown Publishers, 1949. See also: Klem, M. C., Hollingsworth, H., Miser, Z. A. *Medical and Hospital Services Provided Under Prepayment Arrangements, Trinity Hospital, Little Rock, Arkansas, 1941–42.* Social Security Administration, Bureau of Research and Statistics Memorandum No. 69. Washington: Gov. Ptg. Office, 1948.
7. *National Health Program, 1949* Hearings before a Subcommittee on Labor and Public Welfare, United States Senate, Eighty-first Congress, first session, on S. 1106, S. 1456, S. 1581, and S. 1679, Part 1, pp. 376–377. Washington: Gov. Ptg. Office, 1949.
8. American Hospital Association. *Proceedings of the House of Delegates,* Fiftieth Annual Convention, 1948, pp. 167–169.
9. "One Hundred Fifty Dollars Surgical Cover Inadequate for Many Operations." *Accident and Health Review,* 42:21 (Aug.), 1949.
10. "Report of Committee to Prepare Mortality and Morbidity Studies on Group Insurance." *Transactions of the Actuarial Society of America* Vol. XLIX, Part 1, No. 119 (May), 1948, p. 162.
11. Mott, Frederick D., M.D., and Roemer, Milton I., M.D., M.P.H. *Rural Health and Medical Care.* New York: McGraw-Hill. 1948. 562 pp. See also Johnston, Helen L. "Operation—Health," *New for Farmer Coöperatives* (October), 1949. U. S. Department of Agriculture.
12. U. S. Bureau of Labor Statistics. *Employee Benefit Plans Under Collective Bargaining,* Bull. No. 942. Washington: Gov. Ptg. Office, 1948, pp. 2–3.
13. *Report to the President of the United States on the Labor Dispute in the Basic Steel Industry by the Steel Industry Board.* Washington: Gov. Ptg. Office, 1949, p. 8.
14. *The Modern Hospital.* 72:140 (Feb.), 1949.
15. *J.A.M.A.* 140:693 (June 25), 1949.
16. *Report of the Executive Council of the AFL Sixty-Seventh Convention,* 1948, pp. 157–58; Murray, Phillip, *Report to the CIO, Tenth Constitutional Convention,* 1948, p. 38.
17. *Reorganization of Federal Medical Activities,* A Report to the Congress by the Commission on Organization of the Executive Branch of the Government, Washington: Gov. Ptg. Office (Mar.), 1949, pp. 13, 24.
    Task Force Report on National Security Organization (Appendix G). Prepared for the Commission on Organization of the Executive Branch of the Government. Washington: Gov. Ptg. Office, 1949, p. 81. Suggests that a system of Federal health insurance for service personnel and dependents should be studied.
    Task Force Report on Federal Medical Services (Appendix O). Prepared for the Commission on Organization of the Executive Branch of the Government. Washington: Gov. Ptg. Office, 1949, p. 44. Recognizes that provision of adequate care for dependents has been offered as an inducement to men in the service as part of their compensation. Persons formulating the latter report considered and rejected an increase in pay by an amount sufficient to meet a health-insurance premium; they offered two alternative solutions: (1) the government might contract directly for hospital care for acute cases and for outpatient care service with local community facilities and personnel; or (2) premiums for the dependents could be paid as part of the compensation of members of the armed forces, if a nonprofit or commercial health insurance plan was available which conformed to standards set by the Government.
18. Hinton, Harold B. Medical Economy in Services a Task, *New York Times,* Sept. 13, 1949, p. 21.
19. *Recommendations for Social Security Legislation,* The Reports of the Advisory Council on Social Security to the Senate Committee on Finance, Eightieth Congress (Doc. No. 208), Washington: Gov. Ptg. Office, 1949, p. 112.
20. *Social Security Act Amendment of 1949,* Report

No. 1300, House of Representatives, Eighty-first Congress, Washington: Gov. Ptg. Office, 1949, pp. 42, 152.
21. Bureau of Public Assistance, Social Security Administration. *Medical Care in Public Assistance—1946,* (No. 11, New Hampshire, p. 7) (No. 15, Minnesota, p. 11) (No. 17, Michigan, pp. 2, 5) (No. 19, Kansas, In press).
22. Report of the New York Legislative Commission on Medical Care. *Medical Care for the People of New York State.* (Feb. 15) 1946, pp. 358–360.
23. S. 1456, "Voluntary Health Insurance Act, 1949," sponsored by Senators Hill, O'Conor, Withers, Aiken, and Morse; S. 1581, "National Health Act of 1949," sponsored by Senators Taft, Smith and Donnell; S. 1679, "National Health Insurance and Public Health Act, 1949," sponsored by Senators Thomas, Murray, Wagner, Pepper, Chavez, Taylor, McGrath, and Humphrey; S. 1805, "Cooperative Health Act," sponsored by Senator Humphrey; S. 1970, "National Health Act, 1949," sponsored by Senators Flanders and Ives.
24. Sinai, Nathan, Anderson, Odin W., and Dollar, Melvin L. *Health Insurance in the United States.* New York: The Commonwealth Fund, 1946, p. 83. See also New York Academy of Medicine Committee on Medicine and the Changing Order, *Medicine in the Changing Order.* New York: The Commonwealth Fund, 1947, pp. 63, 97, 229. Also Goldmann, Franz, *Voluntary Health Insurance in the United States.* New York: Columbia University Press, 1948, p. 198.

Veterinary Public Health

In order to promote national programs in the veterinary aspects of public health and to coördinate the international phases of such programs, a Veterinary Public Health Section has been created by the Pan American Sanitary Bureau (regional office of WHO). The diseases known to be transmissible from animals to man include anthrax, brucellosis, tularemia, psittacosis, rabies, and trichinosis. However, animals are reservoirs of infection for many others such as jungle yellow fever, sylvatic plague, schistosomiasis, leptospirosis, Rocky Mountain spotted fever, and the various encephalitides. Other human infections are contracted through contaminated animal products.

One of the first steps to be taken by the new section is a campaign of rabies control along the United States-Mexican border. Technicians from Mexico, headed by Dr. Gerardo Varela, Director of the Institute of Tropical Medicine of Mexico City, recently came to the United States under the auspices of the PASB to study the latest rabies control methods developed by the U. S. Public Health Service.

Second, is a campaign against hydatidosis in the Rio de la Plata Area, which is said to be gradually extending to adjacent areas. An active public education project will be promoted along with a program for controlling the disease in animals.

Third, special brucellosis studies are now in progress; the Third Inter-American Brucellosis Congress is scheduled for November, 1950, in Washington, D. C., under the joint sponsorship of the Brucellosis Committee of the U. S. National Research Council and the PASB.

Chief of the new Section, is Benjamin D. Blood, D.V.M., an experienced public health veterinarian. He served with the armed forces during both the last war and post-war periods ending with a tour of duty as civilian consultant in Korea, where he organized the veterinary service and founded the first college of veterinary medicine of that country.