

Private Health Insurance

Part Two†

PROBLEMS, PRESSURES AND PROSPECTS

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Between 1940 and 1957, annual premium payments for voluntary health insurance increased from about \$100 million to \$4.2 billion,¹ a rate of growth unprecedented in the history of private insurance. During the same period the proportion of Americans with hospitalization coverage, the most prevalent form of health insurance, rose from 10 percent to 71 percent.² Nearly $\frac{2}{3}$ also have some protection against surgical costs. More people now have health insurance than any other form of private insurance.³

Not unnaturally, growth of this magnitude has been accompanied by an exceptionally high degree of instability and uncertainty as to the future. The late Professor C. A. Kulp, one of the nation's leading authorities on casualty insurance, was referring primarily to the health insurance business of the commercial carriers when he said that "it has yet to stand the test of adversity,"⁴ but the same caution applies to the entire business, whether sold by commercial companies, the professionally-sponsored "Blue" organizations, or the minority group of "independents," such as Health Insurance Plan of Greater New York (HIP) and the Kaiser Foundation Health Plans.

The carriers have exhibited great energy and ingenuity, but equally important is the extraordinary degree to which the industry is conditioned by a variety of technological and economic developments outside its control. As Kulp put it, the health insurance industry has been "both the beneficiary and victim of these events. It has had presented to it not only a group of potential buyers commanding the largest volume of mass purchasing power in our history but, for a considerable part of the decade [during World War II] buyers with few other goods or services on which to spend

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¹ Estimates furnished authors by Health Insurance Council. For 1948-56 premiums, see Part One, 46 CALIF. L. REV. 376 (Table I).

² *Id.* at 376 n.1.

³ Health Insurance Institute, Press Release, Sept. 26, 1957.

⁴ KULP, CASUALTY INSURANCE 335 (3d ed. 1956).

this purchasing power, and—very importantly—official . . . encouragement of the purchase of group insurance. . . . In large part . . . this new business has been manna from heaven or Washington or Mars”⁵

The manna has continued to descend, but growth is slowing down and now the difficulties, internal contradictions, and external pressures besetting the industry are daily more prominent. The current rapid changes in both the technology of medical care and the sociology of medical demand are major sources of the instability of the industry. Like a circus rider, trying to keep his balance with one foot on one horse, the other on a second, the animals both galloping forward but not necessarily in step, health insurance must seek to keep its balance astride these two rapidly changing movements. Moreover, all three areas—consumer demand, the organization of supply, and the insurance programs themselves—are affected by cultural and institutional pressures and resistances which further complicate the problem of adjustment.

In Part One the changing patterns of medical care demand and supply, in relation to health insurance, were described. The threefold objective in this Part is to summarize the principal recent developments in health insurance institutions, discuss some of the major problems confronting private health insurance today, and assess the prospects of private health insurance in the light of these problems and the changing social environment.

I. MAJOR HEALTH INSURANCE PROGRAMS AND TRENDS

Space permits only a brief summary of the vast and complex health insurance industry.⁶ Table III indicates the number of persons with hospital, surgical and “regular medical”⁷ expense coverage in the different types of insuring organizations at the end of 1957. Table IV gives the distribution of premium income and benefit expenditures in 1956, as well as the average loss ratio or retention rate for each type of carrier. The continued predominance of hospital coverage, both in terms of enrollees and volume of business, is obvious, although surgical coverage does not lag far behind. Hospital coverage was the first to achieve national prominence.

The Blue Cross idea started in Texas in 1929 and spread with surprising speed throughout the nation. Blue Shield surgical care plans had their beginnings in California and Michigan in the late Thirties and achieved their maximum rate of growth during the immediate post-war years, when the medical profession was most concerned with counteracting the possibil-

⁵ KULP, *CASUALTY INSURANCE* 335 (3d ed. 1956).

⁶ For a brief bibliography, see Part One, 46 CALIF. L. REV. 376, 377 n.2. See also the annual December issue of the Social Security Bulletin, published by the U.S. Soc. Sec. Admin., Dept. Health, Educ. & Welfare; *PREPAYMENT & THE COMMUNITY* (Becker ed. 1955).

⁷ This term is rather misleading. The great majority of such policies apply only to in-hospital, non-surgical, doctors' visits.

ity of national health insurance. There are now nearly ninety state or community Blue Cross plans and over seventy Blue Shield organizations, frequently conforming to the same geographic areas.⁸

Both are incorporated under special state enabling acts relating to non-profit medical-service corporations, which grant tax-exemption but require that all contracts with subscribers and hospitals be approved by the state insurance commissioner.⁹ Both are generally controlled by the providers of service, although in different degrees. Blue Shield plans are usually controlled by state or local medical societies. Blue Cross plans are usually controlled by local hospitals although minority representation of community and consumer interests is frequent and increasing.¹⁰

Nationally, B.C. plans are loosely coordinated by the Blue Cross Commission of the American Hospital Association and the B.S. plans by Blue Shield Medical Care Plans (Blue Shield Commission). Both are primarily geared to group insurance but most plans accept groups as small as five,¹¹ and nongroup subscribers at a higher rate in terms of price and/or services. Conversion from group to nongroup policies upon retirement or otherwise leaving the enrollment-group is usually permitted on liberal terms. As a result, the proportion of nongroup subscribers in Blue Cross is steadily increasing.¹²

Commercial insurance companies have sold medical care insurance, along with the associated disability coverage for loss of income due to illness or accident, for many years on an individual policy basis. But it was not until they were "half-dragged, half-lured" into the group hospitalization business by the amazing expansion of Blue Cross and other community hospital benefit plans that they became a serious competitive factor. As

⁸ For description of individual B.C. plans—benefits, enrollment regulations, etc.—see BLUE CROSS COMMISSION, BLUE CROSS GUIDE (rev. annually); for B.S. plans, see BLUE SHIELD COMMISSION, BLUE SHIELD MANUAL (rev. annually); AMA COUNCIL ON MEDICAL SERVICE, VOLUNTARY PREPAYMENT MEDICAL BENEFIT PLANS (rev. annually) (hereinafter cited as AMA, VOLUNTARY BENEFIT PLANS).

⁹ For a brief summary of their legal status, see SERBEIN, PAYING FOR MEDICAL CARE IN U.S. 192-94 (1953); for historical background, Rorem, *Enabling Legislation for Non-Profit Hospital Service Plans*, 6 LAW & CONTEMP. PROB. 528-44 (1939).

¹⁰ Atypically, in Massachusetts, medical professional interests are in the minority among both B.C. and B.S. directors. Of the 31 B.C. directors, only 6 are doctors, 10 lay hospital trustees. The remainder represent labor, other subscribers and the general public. Of 18 B.S. directors, only 6 are physicians. The demand for greater consumer and public representation was a major issue in the New York and Pennsylvania 1958 rate increase hearings, discussed *infra*.

¹¹ Group enrollment regulations usually increase participation requirements as the size of the group diminishes. Thus a group of 5 may be eligible only if all join. But a group of 80 may be admitted with only 50% participation.

¹² For example, the Philadelphia B.C. has shown a slow but steady rise in proportion of nongroup subscribers to over 27% of the total in 1957. E. A. van Steenwyk, executive vice-president, Associated Hospital Service of Philadelphia, Statement before the Insurance Commissioner of Pa., Jan. 1958, Exhibit I, p. 2.

TABLE III

DISTRIBUTION OF HOSPITAL, SURGICAL, AND REGULAR MEDICAL EXPENSE COVERAGE
BY TYPE OF INSURING ORGANIZATION (DECEMBER 31, 1957)

Type of Insuring Organization	Number of People Protected		
	Hospital Expense	Surgical Expense	Regular Medical Expense ^a
Insurance Companies:	(000 omitted)		
Group Insurance	48,439	48,955	28,317
Individual-Policy Insurance	28,673	24,928	7,371
Unadjusted Total	77,112	73,883	35,688
Deduction for Duplication in Persons with Insurance- Company Protection	6,920	6,427	2,448
Net Total for Insurance Companies.....	70,192	67,456	33,240
Blue Cross, Blue Shield and Medical Society Plans.....	54,923	45,383	36,926
Independent Plans ^b	4,947	5,597	6,019
Deduction for Duplication	8,630	9,505	4,372
Net Total	121,432	108,931	71,813

^a Mostly in-hospital non-surgical benefits. Includes about 13 million with "major medical" coverage and 6 million with "comprehensive" coverage.

^b The Social Security Administration estimates the total number of "independent" enrollees, Dec. 1956, at 8.9 million, with about 6 million each for hospital and medical coverage and 7 million for surgical. Soc. Sec. Bull., April 1958, p. 7. The difference is due primarily to the fact that the above table classifies HIP and some other "independents" in the BC-BS category.

Source: Derived from HEALTH INSURANCE COUNCIL, *EXTENT OF VOLUNTARY HEALTH INSURANCE COVERAGE IN U.S.*, Sec. 3 (1958).

late as 1949 more people had individual commercial health insurance policies than group policies, but in 1957 there were nearly seventy percent more commercial group-enrollees than individual subscribers. (See Table III.) Once the insurance companies had aggressively launched their group insurance campaign, it did not take them long to overtake Blue Shield in the field of surgical care. By 1950, their combined group and individual coverage exceeded Blue Cross in hospital enrollment and by 1956 they had a twenty-five percent lead. In the same year, they achieved a slight edge in volume of premiums. (See Table IV.)

Unlike the "Blue" plans, commercial group and individual insurance are separate businesses and the differences in benefits, rates and loss ratios are very great. (See Table IV.) Conversion from group to individual coverage is not permitted or is almost prohibitive in price.¹³ Commercial group

¹³ "With Blue Cross or Blue Shield, conversion typically entails an increase of approximately 20% in premium; with commercial insurance, it entails an increase of as much as 300% for a constant benefit level." Estimates given at N.Y. State Conference on Financing Health Costs for the Aged, 1956, cited by H. E. Klarman, *Changing Costs of Medical Care and Voluntary Health Insurance*, p. 42 (address to Amer. Econ. Ass'n and Amer. Ass'n of Univ. Teachers of Insurance, Cleveland, Dec. 1956, mimeo.).

TABLE IV

INCOME AND EXPENDITURES FOR MEDICAL CARE OF VOLUNTARY HEALTH INSURANCE PLANS,
BY TYPE OF CARRIER (1956)

Carrier	Income ^a			Expenditures for benefits ^b			Benefits as percent of income
	Total	For hospital services	For physi- cians' services	Total	For hospital services	For physi- cians' services	
Amount (in millions)							
Total	\$3,623.0	\$2,367.4	\$1,255.6	\$3,014.7	\$2,021.8	\$992.9	83.2
Blue Cross	1,046.6	1,021.7	24.9	968.1	946.9	21.2	92.5
Blue Shield	446.9	19.3	427.6	385.6	18.9	366.7	86.3
Insurance Companies	1,839.1	1,176.1	663.0	1,410.6	927.0	483.6	76.7
Group	1,216.3	734.8	481.5	1,082.5	688.5	394.0	89.0
Individual	622.8	441.3	181.5	328.1	238.5	89.6	52.8
Independent Plans—Total	289.9	145.3	144.6	253.9	128.4	125.5	87.6
Nonindustrial plans	136.9	63.7	73.2	122.0	56.1	65.9	89.1
Community	75.4	40.4	35.0	64.3	35.1	29.2	85.3
Consumer	11.1	6.2	4.9	9.0	4.8	4.2	81.1
Medical Society	16.3	3.8	12.5	14.2	3.3	10.9	87.1
Fraternal	2.1	1.2	.9	2.1	1.2	.9	100.0
Private group clinics....	32.0	12.1	19.9	32.4	11.7	20.7	101.3
Industrial plans	153.0	81.6	71.4	131.9	72.3	59.6	86.2
Unions	92.3	46.1	46.2	73.4	37.4	36.0	79.5
Employer-employee	30.2	17.5	12.7	30.2	17.9	12.3	100.0
Employer	7.0	2.6	4.4	7.0	2.5	4.5	100.0
Employee	23.5	15.4	8.1	21.3	14.5	6.8	90.6
Percentage Distribution							
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Blue Cross	28.9	43.2	2.0	32.1	46.8	2.1	
Blue Shield	12.3	.8	34.1	12.8	.9	36.9	
Insurance Companies	50.8	49.7	52.8	46.8	45.9	48.7	
Group	33.6	31.0	38.3	35.9	34.1	39.7	
Individual	17.2	18.6	14.5	10.9	11.8	9.0	
Independent Plans	8.0	6.3	11.2	8.3	6.4	12.2	

* Earned income for Blue Cross, Blue Shield and similar plans and insurance companies; total income for other plans. Division of income between hospital and physicians' services estimated in some cases.

^b Benefits paid for nonprofit organizations; losses incurred for insurance companies.

Source: Derived from Social Security Bull., Dec. 1957, p. 5, Table 3; April 1958, p. 9, Table 9. Footnotes omitted or abbreviated.

insurance also aims at larger groups, usually requiring at least 25 or 50, and 75 percent participation.

The legal status of the commercial carriers is, of course, different from that of the noncommercial plans,¹⁴ but the increasing competition between the two types of carriers and the growing body of state regulation affecting

¹⁴ For a brief summary of regulations governing the accident and health insurance business, see KULP, CASUALTY INSURANCE 407-11 (3d ed. 1956); SERBEIN, PAYING FOR MEDICAL CARE IN THE U.S. 190-92 (1953).

both suggest that the *de facto* difference, at least with respect to group insurance, is rapidly narrowing. Differences in benefit and rate structures, historically so great, also appear to be narrowing with a general trend to indemnity benefits and experience rating.

A. Service vs. Indemnity Benefits

Health insurance plans are usually classified as either service or indemnity. A service plan provides specified services when required by an insured person. The insured receives no bill since the plan pays the hospital or doctor directly. Under an indemnity plan, specified amounts of money are provided to reimburse the insured, usually in part only, for the cost of the services he purchases. Most B.C. plans provide service benefits, usually a semi-private or ward room for a specified number of days—now typically seventy for group, thirty for nongroup subscribers—and all or most “extras” such as use of the operating room, prescribed drugs, etc.¹⁵ They reimburse the hospital, rather than the insured, in accordance with a contract which may be based on hospital costs or charges, in the latter case usually with a “wholesale discount,” or a formula combining elements of both. In turn, the hospitals guarantee fulfillment of B.C. subscriber-contracts.

By contrast, commercial carriers usually have no contractual relations with the providers of service—hospitals and doctors—and their benefits are almost always in the form of indemnity. Their hospitalization policies usually provide a specified number of dollars a day—now typically \$10 or \$12—for a specified number of days, typically thirty per year or per illness.¹⁶ The allowance for hospital extra charges is typically ten (sometimes twenty) times the per diem.

Surgical and medical plans usually indemnify, according to a specified fee schedule, a list of allowances payable for different surgical procedures. The maximum allowance has increased steadily to a current average of about \$250. The first B.S. plans were primarily service contracts, and the attached fee schedules constituted full payment for the various surgical

¹⁵ There is a trend toward longer durations. Some group plans now provide full coverage up to 120 days. Others may provide half-benefits for a period, often 90 days, additional to the full-service period. Anesthesia is usually covered only if administered by a hospital employee. Blood is almost never covered. A few plans have dollar limits on drugs and other supplies. For benefits under employee group insurance, see FOUNDATION ON EMPLOYEE HEALTH, MEDICAL CARE & WELFARE, INC., *SERVICE BENEFITS—AND HOW TO COMPARE SERVICE VS. INDEMNITY BENEFITS* (Study No. 1, Parts B & C, 1958); U.S. BUREAU OF LABOR STATISTICS, DEPT. OF LABOR, *HEALTH & INSURANCE PLANS UNDER COLLECTIVE BARGAINING LATE 1955* (1957) (hereinafter cited as B.L.S., *HEALTH AND INSURANCE PLANS*).

¹⁶ According to the Life Insurance Ass'n of America, the average daily allowance for an employee under commercial group insurance in 1956 was \$10.26. Cited in Skolnik & Zisman, *Growth in Employee-Benefit Plans*, Soc. Sec. Bull., Mar. 1958, p. 7. Allowances for dependents are usually a little lower. As with Blue Cross, there is a trend to longer duration but rarely over 70 days. Allowances for hospital “extras” are now frequently \$150.

procedures by the insured to his doctor. If the insured earned more than a stated amount, the doctor was permitted to charge more than the scheduled fee—presumably on the basis of ability to pay—but in California, for example, the income limit in the early California Physicians Service (CPS) plan excluded only about ten percent of the population from full service benefits.

The doctors found this type of contract unsatisfactory and gradually abandoned the service principle, primarily by permitting income limits to become obsolete in the face of rising incomes,¹⁷ but also by switching to straight indemnity insurance. A 1957 survey of B.S. and other prepayment medical benefit plans (not including any commercial insurance) by the AMA found less than 3 percent of enrollees with full service benefits, about 30 percent with straight indemnity, and 68 percent with combination service and indemnity.¹⁸ B.S. surgical schedules are about the same as those of the insurance companies.

B. Pricing Policies and Costs

It is virtually impossible to summarize actual premium costs today. Among the many variables affecting the price of health insurance are 1) type of carrier, 2) type of policy, *i.e.*, group or non-group, 3) range of benefits, 4) geographic differences in hospital charges and doctors' fees, and 5) characteristics of the particular group or individual risk. The last factor has become especially important in recent years. Accompanying the relative expansion of commercial insurance and the trend to indemnity benefits there has been a movement away from community-wide pricing, originally employed by all the Blue plans, to differential pricing or experience rating, techniques developed by the insurance companies.

Under community rates, premiums are set on the basis of the medical costs of a cross-section of the community—the good risks help pay for the poor risks. Differential or experience rating means that good risks—*e.g.*, a group of younger-than-average employees with fewer-than-average women in a non-hazardous occupation—are rewarded for their own anticipated or actual low claims experience by lower initial rates, annual refunds, dividends or other downward adjustments from the standard premium. The result is lower prices for preferred risks and higher prices for poorer risks. It increases the difficulty of covering the aged, the self-employed, and those workers employed in small groups or in dangerous occupations.

Despite this drawback, the intense pressure of competition for the big

¹⁷ Income limits for single subscribers in 1958 varied from \$1,500 (Colo.) to full service (*e.g.*, Iowa); median, \$4,000. For families, from \$2,400 (*e.g.*, Fla.) to full service (*e.g.*, Iowa); median, \$6,000.

¹⁸ AMA, VOLUNTARY BENEFIT PLANS 14 (Supp. 1957).

and profitable group-policies has resulted in a steady trend to experience rating.¹⁹ Many B.C. and other nonprofit plans have reluctantly fallen in line.²⁰

Table VI gives some indication of average "standard" premiums for group enrollees in 1956-57. Where experience rating is applied, the actual cost would be more or less than the standard rate. The average cost of typical hospital and surgical-medical coverage under commercial insurance was \$26 for an individual, \$114 for a family. Roughly similar benefits under the Blue plans cost \$38 for an individual, \$97 for a family, reflecting the B.C. principle of deliberately favoring large families. The additional annual cost for nongroup subscribers under B.C.-B.S. averaged about \$9 for an individual, \$14.40 for a family.²¹ The cost of individual commercial insurance, for comparable benefits, was nearly 70 per cent higher than group premiums. (See comparative retention rates of commercial group and individual insurance, Table IV.)

C. The "Independents"

The "independents" constitute a third category of insurance carriers, including some 300-odd plans with a total enrollment variously estimated at 5 to 9 million, or 4 to 7 percent of all U.S. health insurance enrollment.²² The strength of the "independents" is greatest in 4 states—New York, Ohio, Connecticut and California. About the only characteristics they have in common are: they are self-insurers, they are nonprofit, and they are not part of a national organization like B.C. or B.S.²³ They are generally classified as industrial or nonindustrial. The former confine their membership to a particular employee group, *e.g.*, members of a union, employees of a rail-

¹⁹ For simplicity, the term "experience rating" will be used herein to cover both practices—differential pricing based upon characteristics of the group and upon actual experience of the group.

²⁰ "The forces of competition and pressures to substitute expediency for principle in order to get or keep an account, tend to force Blue Cross to identify itself more and more as an insurance company operation rather than as a service plan to meet community needs." J. E. B. Stuart, exec. dir., Blue Cross of Cincinnati, in *Hospitals*, Jan. 16, 1956, p. 46.

²¹ BLUE CROSS COMMISSION, *BLUE CROSS GUIDE* (1957); BLUE SHIELD COMMISSION, *BLUE SHIELD MANUAL* (1957); computed by Social Security Administration, U.S. Dept. Health, Educ. & Welfare, Research & Statistics Note 33, p. 3 (1957).

²² For the low estimate, see Table III. The Social Security Administration, principal source of information on the "independents" today, sets the 1956 figure at 8.9 million. Brewster, *Independent Plans Providing Medical Care & Hospital Insurance—1957 Survey*, Soc. Sec. Bull., Apr. 1958, p. 4. The difference is due primarily to the Health Insurance Council classification of HIP and some other "independent" plans in the BC/BS category. See Table IV for Social Security Administration classification. Social Security Administration estimates are used throughout this section.

²³ Some 20-odd of the "independents," which are committed to comprehensive group practice, are members of the Group Health Federation of America (formerly Cooperative Health Federation of America). The union health centers have recently started a national organization, American Labor Health Ass'n.

road, public utility or other industrial concerns. The nonindustrial plans are open to the general public and include community plans such as HIP²⁴ and Kaiser,²⁵ private group-practice clinics such as Ross-Loos,²⁶ and a number of smaller consumer-sponsored plans. The vast Washington Physicians' Service, with its 23 county bureaus and 700,000 enrollees, long an independent, has recently joined Blue Shield.²⁷ The experience of Windsor Medical Services, a Canadian independent sponsored by the Ontario Medical Association, is frequently included due to its geographic and cultural relevance.²⁸

Both types of plans have increased their membership during the past decade, but nonindustrial plans have done relatively better and now account for over $\frac{3}{4}$ of the total. Within the nonindustrial group, community plans are by far the most significant, accounting for over $\frac{3}{4}$ of "independent" enrollment. Union plans are dominant in the industrial group and account for $\frac{1}{4}$ of the total.²⁹

The most significant distinguishing aspect of this type of carrier is the extent to which "comprehensive" benefits are provided. About 3.5 million enrollees have hospital, surgical, medical and diagnostic benefits and another 2.4 million have comprehensive outpatient services without hospital benefits. The latter generally have B.C. or other hospital coverage. Nearly 4 percent have dental insurance. These proportions contrast conspicuously with the usual hospital-surgical coverage available through "Blue" or commercial insurance. It is related to the fact that nearly $\frac{3}{4}$ of independent enrollees receive medical care through group-practice.³⁰

As indicated in Table IV, the "independents" accounted for 6 to 11 percent of total health insurance premiums in 1956 and 6 to 12 percent of

²⁴ The most extensive study of HIP is COMMONWEALTH FUND, HEALTH AND MEDICAL CARE IN NEW YORK CITY (1957). See also, HEALTH INSURANCE PLAN OF GREATER NEW YORK, TEN YEARS OF SERVICE: 1947-1956 (1957).

²⁵ See, H. J. Kaiser et al, statement and additional information re Kaiser plans, *Hearings on Health Inquiry (Voluntary Health Insurance) Before the House Committee on Interstate & Foreign Commerce*, 83d Cong., 2d Sess., pt. 6, at 1341-1450 (Jan. 1954). For a brief report, see Deutsch, *Group Medicine, Part 3*, Consumer Reports, Mar. 1957, p. 135.

²⁶ See, Dr. H. C. Loos, statement, *Hearings on Health Inquiry (Voluntary Health Insurance) Before the House Committee on Interstate & Foreign Commerce*, 83d Cong., 2d Sess., pt. 6, at 1451-98 (Jan. 1954). For a brief recent report, see Deutsch, *Group Medicine, Part 2*, Consumer Reports, Feb. 1957, p. 83.

²⁷ AMA, VOLUNTARY BENEFIT PLANS 99-100. Health Information Foundation (H.I.F.) is sponsoring a major study of Washington Physicians' Service (W.P.S.) under direction of G. A. Shipman, Institute of Public Affairs, Univ. of Washington.

²⁸ See DARSKY, SINAI & AXELROD, COMPREHENSIVE MEDICAL SERVICES UNDER VOLUNTARY HEALTH INSURANCE (1958); Health Information Foundation, Progress in Health Services, Nov. 1957.

²⁹ Brewster, *Independent Plans Providing Medical Care and Hospital Insurance: 1957 Survey*, Soc. Sec. Bull., Apr. 1958, p. 7.

³⁰ *Id.* at pp. 3, 6, 7.

total benefits, in each case the larger percentage referring to physicians' and the smaller to hospital services. Both percentages are substantially smaller than in 1949.³¹ The reasons for this relative decline in volume of business are too numerous and complex to list here. As primarily service plans, there has probably been less price inflation than in health insurance in general. The concentration on outpatient services means relatively lower overall costs. Among other limiting factors have been the general lack of enthusiasm among "health and welfare" plan negotiators, the determined opposition of influential sections of organized medicine and the resulting legal and institutional barriers which have been erected in many states against their expansion.³² This opposition is directed primarily, but not exclusively,³³ at the nonindustrial plans which are not limited to special categories of low-income groups and are attracting regular middle-class consumers. Among the independents the primary concern of this article is with the most controversial group—those which challenge traditional methods of organizing as well as financing medical care—the comprehensive prepayment group-practice plans such as HIP, Kaiser, Ross-Loos and the Labor Health Institute of St. Louis.

II. MAJOR PROBLEMS TODAY

The history of voluntary health insurance during the past fifteen years might be summarized briefly in these terms: phenomenal overall growth accompanied by rapid changes in underwriting practices, a *de facto* rapprochement among the principal types of carriers under the impact of common problems and pressures, with a current lead for the commercial companies, and now deep foreboding about the future. The reasons for this foreboding can be subsumed under three major problems which embody the principal challenges to the industry today. These are whether the enrollment gap can be significantly reduced, whether benefits to the insured can be made adequate in relation to the enlarged concept of medical needs, and whether these goals can be achieved at a practical price. The answer to these questions may determine the future, not only of individual health insurance carriers, but of the business as a whole.

A. *The Enrollment Gap*

Current health insurance enrollment has already exceeded the predictions of the most optimistic and confounded the pessimists. The rapid rate of growth has, however, slowed down markedly and appears to be moving

³¹ Brewster, *Independent Plans Providing Medical Care and Hospital Insurance in 1949*, Soc. Sec. Admin., Bureau Memorandum No. 72, 1952, p. 32. Mrs. Brewster has surveyed these plans at 4-year intervals for the past 14 years.

³² See Part One, 46 CALIF. L. REV. 376, 407 nn.98 & 99.

³³ An example of opposition to an industrial plan is the current fight against the Miners Welfare Fund by medical societies in several states (see text at note 114 *infra*).

towards a plateau—although absolute increases will continue even if the proportion of population covered is stabilized since the nation's population is increasing almost two percent annually. Hospitalization insurance is approaching the limits of feasible enrollment, a goal which has been set by various experts in medical economics at 75–85 percent of the population.³⁴ The extent to which surgical and other medical insurance will follow the trend of hospitalization insurance is still an open question among the crystal gazers. There is some evidence that these two series are already lagging behind hospital insurance at a corresponding phase of development.³⁵

In any event, about 29 percent of the civilian population, some 49 million people, still have no health insurance of any sort. Well over half are limited to hospital-surgical protection and only about 5 percent of the population are enrolled in plans which provide comprehensive physicians' services.

1. Characteristics of the Enrolled

Estimates of future growth potential involve many factors including developments in underwriting techniques, long-run shifts in employment, *e.g.*, from agriculture to manufacturing or from self-employment to employee status, family income levels, general business conditions, and patterns of collective bargaining, as well as the complex cultural forces influencing the demand for, and supply of, medical care which were discussed in Part One.

The relative decline in individual insurance is one of the most significant recent trends. According to the Health Information Foundation's (H.I.F.) nation-wide survey, 77 percent of all families who had any health insurance in 1953 got it originally through their employer, union, or other group enrollment. Eight percent had converted to a non-group policy. Only 32 percent had nonconverted individual policies.³⁶ This trend to group insurance is likely to continue due to lower cost and greater value. Since eligibility for

³⁴ Serbein estimated a maximum potential of 75–80%. SERBEIN, *PAYING FOR MEDICAL CARE IN THE U.S.* 392 (1953). Eli Ginzberg set the ultimate goal for hospital insurance in New York State at 85%. *PATTERN FOR HOSPITAL CARE* 289–90 (Final Report of New York State Hospital Study, 1949). Odin Anderson assumes that about 15% of the population cannot or need not be covered, *i.e.*, recipients of public assistance, those in the armed forces and in institutions. ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE: A NATIONWIDE SURVEY* 82 (1956) (hereinafter cited as ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS*).

³⁵ The concept of lead-lag relationship among the three types of coverage was developed by SERBEIN, *PAYING FOR MEDICAL CARE IN THE U.S.* 385–86 (1953).

³⁶ ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS* 18–20 (percentages total more than 100 because some families had more than one type of policy). Unless otherwise noted, all data in this section are from this source at pp. 12–20 and related appendices. Although the data are for 1953, Dr. Anderson believes most of the proportions are still essentially accurate. Interview, New York City, Sept. 6, 1957.

group coverage depends primarily on employee status this factor has achieved paramount importance.³⁷

Among the other major factors affecting health insurance enrollment, H.I.F. found that families with incomes over \$5,000 are twice as likely to have some form of health insurance as families under \$3,000, 80 percent and 41 percent respectively. The latter group contains a disproportionate number of old people and farmers. After 65, coverage declines to about half the national average. In urban areas 70 percent of families have some protection. Among rural nonfarm groups the percentage is 57, and among farm groups only 45. The higher the level of education of the main wage-earner, the greater the likelihood of insurance coverage.

The excluded are thus characterized by lack of employee status, advanced age, low income, little education, and rural residence—frequently overlapping categories—as well as higher than average medical needs and costs. The difficulty of selling health insurance on a voluntary basis to these people is obvious.

2. Maintenance of Insured Status

Just as important as initial enrollment is the maintenance of continuous coverage. For the great majority of group-enrollees coverage is dependent upon current employment status. The loss of a job for whatever reason—old age, retirement, serious disability, or business shutdown—will, in most instances, automatically cancel health insurance, frequently at the very time when need is greatest. During the 1957-58 layoffs in the automobile industry, for example, a UAW spokesman reported a twenty percent monthly decline in the insured status of unemployed auto workers. After six months of unemployment, virtually all laid-off workers had lost their insurance, despite the fact that most auto workers have B.C. and B.S. coverage, permitting easier conversion to nongroup status than would indemnity insurance.³⁸

For most of those with individual policies, health insurance is also of a "term" character, running on a year-to-year basis and cancellable at the option of the carrier. These factors give the protection a high degree of instability and, for most enrollees, partial unreality.

³⁷ 78% of families where the main breadwinner works for a private employer have some type of health insurance, but only 46% of the self-employed do. Among corporate managerial staffs and unionized employees, the concentration is exceptionally high. In California, for example, in January 1957, 83% of all employees working under union agreements had some form of medical care insurance. In at least 14 different industry categories, the coverage was 95% or higher. Calif. Div. Labor Statistics & Research, Dept. of Industrial Relations, Industrial Relations Reports, May 1957, p. 8. In highly unionized Michigan, 81% of the entire population were reported to have some form of health insurance in 1957. 166 J.A.M.A. 84 (1958).

³⁸ Interview with Jerome Pollack, consultant, UAW Social Security Dept., June 22, 1958. For a survey of group insurance provisions with respect to unemployed workers, see U.S. Soc. Sec. Admin., Dept. Health, Educ. & Welfare, Research and Statistics Note 11, May 1958.

3. *Carrier Efforts to Extend Enrollment*

The health insurance industry is earnestly trying to cope with both problems—initial enrollment of those who have not yet been reached and continuous maintenance of benefit status for all. The least promising avenue for large-scale progress is individual commercial insurance. Efforts are being made to develop practical “guaranteed renewable” policies, “non-cancellable” policies, or policies paid up by retirement age. There is considerable interest in establishing statutory standards in this respect. New York has already made a beginning.³⁹ The actuarial problems are formidable, however, and thus far no satisfactory way has been found to reconcile adequacy of benefit, voluntary coverage, and a price low enough to sell to a significant number of people.

Professor Kulp no doubt expressed a minority view when he warned the carriers against the inherent weaknesses in current non-group insurance, but he was probably correct in urging them to abandon irresponsible attempts to capture a mass-market and instead concentrate on producing a high-class product for their logical clientele.⁴⁰

An entirely different approach, utilizing some of the intrinsic economies of group insurance, is represented by the development of conversion contracts to enable those who have employment-connected group-coverage to continue their protection at somewhat higher but not impossible premiums. There has been some real progress in this respect. The spread of group conversion plans⁴¹ probably accounts for most of the recent increase in enrollment of the aged.⁴² However, these plans are largely confined to big corporations. The problem of financing health benefits for the much more numerous pensioners of smaller companies will be far more difficult.⁴³ Obviously,

³⁹ See, for example, the 1957 and 1958 legislative recommendations of the N.Y. Joint Legislative Committee on Health Insurance Plans, headed by Sen. Metcalf (Rep.) and somewhat similar recommendations by Gov. Harriman (Dem.). A modified version of the Metcalf proposals was enacted in 1958, including a ban on cancellation of individual policies in effect for two years, because of physical or mental deterioration of the policyholder.

⁴⁰ KULP, *CASUALTY INSURANCE* 391-407 (3d ed. 1956).

⁴¹ A 1955 study of 300 large collectively bargained health and welfare plans, covering 5 million workers, shows that 23% of the plans, accounting for 38% of the workers, extended some form of health benefits to employees after retirement. Most of these included dependents of retired employees and, in most cases, the benefits were the same as immediately prior to retirement. B.L.S., *HEALTH AND INSURANCE PLANS* 6-11. For carrier efforts with respect to insuring the aged, see FOLLMANN, *VOLUNTARY HEALTH INSURANCE AND MEDICAL CARE* 28-41 (Health Insurance Ass'n of Amer. 1958); articles in *HEALTH AND HEALTH SERVICES, II, STUDIES OF THE AGED AND AGING* (Sen. Comm. on Labor and Public Welfare, 1956).

⁴² In 1956, 37% of those 65 and over had some insurance, 10% more than in 1952. U.S. Soc. Sec. Admin., Dept. Health, Educ. & Welfare, Research & Statistics Note 13, p. 6 (1958).

⁴³ The U.S. Chamber of Commerce recently presented a terrifying, even if exaggerated, picture of the possible increase in costs to employers who undertake to provide post-retirement health benefits. It predicted that a firm of 500, which is now paying \$1,200 a year for hospital and surgical benefits for 13 pensioners, could find itself, in 15 years, with a cost of \$38,000 a

too, this approach cannot help those aged persons who are already retired. And physical examinations often eliminate those who need protection most.

Blue Cross and other community-oriented carriers have tried to meet this problem from the beginning by permitting non-group enrollment and by setting premium rates on a community rather than experience rating basis. The great difficulty of holding to this approach in a competitive situation is forcing B.C. plans to adopt experience rating, in which case they too must discriminate against the aged, those with serious chronic conditions, and other "poor risks." Otherwise, they will be left with a disproportionate number of the poorer risks—as is already happening—and could eventually be forced out of business.

Blue Cross is well aware of the dilemma⁴⁴ and there is evidence that public authorities, as well as medical consumers, are beginning to take note of it. In his 1958 decision on the Philadelphia B.C. rate increase, the insurance commissioner of Pennsylvania tried to protect the interests of non-group subscribers by approving proportionately smaller increases for them than for group subscribers.⁴⁵ The ultimate logic of this public policy, however, seems to lead to a general statutory ban on experience rating, but the industry does not appear ready to accept this degree of discipline.

It is difficult not to agree with Odin Anderson that "as for enrollment, despite the evidence to the contrary, I would say that the coverage of individuals, *i.e.*, self-employed, and others outside of the employed group labor market, have not even been covered in principle even though there may be evidence in fact. This is to say that no overall workable technique or techniques have been devised in the same sense as group insurance."⁴⁶

It would appear that voluntary health insurance still has an opportunity to increase enrollment of the aged who have not yet retired, the self-employed and rural residents, if it can devise practical group-insurance tech-

year for the same benefits. The rise is based on the following assumptions: 1) a 10-fold increase in number of pensioners, 2) 170% increase in unit cost of benefits, 3) a 3-year or 20% increase in retirement-life expectancy. *Nation's Business*, Nov. 1957, p. 43.

⁴⁴ The executive director, Blue Cross of Cincinnati, painted this gloomy picture of the consequences of experience rating: "Having no community responsibility, the insurance companies can pinch-off, through group experience rating, the best risk groups in the community—the groups which are contributing to Blue Cross reserves—the groups which are carrying their responsibility for financing the hospitals of the community If this trend should become a national pattern, the risk covered by Blue Cross would progressively deteriorate, the rates charged the remaining subscribers would become higher and higher to the point of diminishing return, and voluntary prepayment will cease to exist." *Hospitals*, Jan. 16, 1956, p. 46.

⁴⁵ *In re Associated Hospital Service of Philadelphia 22*, adjudication of F. R. Smith, Insurance Commissioner, Commonwealth of Pennsylvania (April 15, 1958).

⁴⁶ *Your Product in the Next Five Years—Will it Measure Up?*, Blue Cross-Blue Shield Executive Training Course, Univ. Mich., p. 3 (mimeo, 1957). See also ANDERSON & LEVINE, *BLUE CROSS EXPERIENCE WITH NON-GROUP ENROLLMENT* (Health Information Foundation, 1956); ANDERSON, LEVINE & GORDON, *NON-GROUP ENROLLMENT FOR HEALTH INSURANCE* (1957).

niques for them and if the trend to experience rating can be reversed. The potential adequacy of such protection is another question—part of the overall issue of benefits to be discussed below. With respect to some other categories of the excluded, those with serious chronic diseases, most of the institutional population, and public assistance recipients, there seems to be no way of providing health insurance on a voluntary basis. Public responsibility for the two latter groups, as well as for the mentally ill and the tubercular, is already clearly established in law. This necessity is acknowledged by even the firmest opponents of public health insurance.

It is unlikely, however, that government participation can be rigidly confined to these categories. The concept of "indigence," especially if broadened to include "medical indigence," is as difficult to define as it is to confine.⁴⁷ It may not be possible to prevent the "medically indigent" from including a larger and larger proportion of all the aged.⁴⁸ If it wishes to avoid even greater government participation in this field, voluntary health insurance will not only have to enroll a substantial portion of the excluded but will have to give thought to the sort of public instrument best suited to the needs of that residual percentage which cannot be insured through voluntary methods.

B. The Challenge of Comprehensive Coverage

1. Current Adequacy of Benefits

Health insurance protection is not measured by enrollment figures alone. Equally important is the extent to which insurance benefits cover medical expenditures, both of those who are insured and of the nation as a whole. As already noted, the ratio of insurance benefits to total private expenditures increased from about 8 percent in 1948 to 25 percent in 1956.⁴⁹ Since 1951, the increase has been at a rate of about 2 percentage points a

⁴⁷ The "medically indigent" are generally defined as those low-income families who have enough income or resources to make them ineligible for public assistance but not enough to pay for needed medical care. In a recent study of a program for the medically indigent in Maryland, Odin Anderson found that families earning up to \$1,000 or \$2,000 a year were eligible for public assistance, depending upon size of family. In the U.S., about 14% of all households earn less than \$1,000 a year; 26% less than \$2,000. ANDERSON & ALKSNE, AN EXAMINATION OF THE CONCEPT OF MEDICAL INDIGENCE 2, 13, 14 (Health Information Foundation, 1957).

⁴⁸ Already, public outlays for medical care of the aged are estimated at about 38% of total medical expenditures for this age group. Their total medical expenditures (excluding philanthropic contributions) in 1955-56 were an estimated \$2.34 billion. Of this, 33% was expended under public programs and 5% was subsidized under federal tax-savings provisions. U.S. Soc. Sec. Admin., Dept. Health, Educ. & Welfare, Research & Statistics Note 3 (1958). In New York State, the medical care component in old age assistance rose from 14% in 1951 to 28% in 1956. FINANCING HEALTH COSTS FOR THE AGED 16 (1956 N.Y. State Conf., Albany) (1957).

⁴⁹ Part One, 46 CALIF. L. REV. 376 (Table I).

year. The remainder of the large dollar increase in benefits was absorbed by the increase in population and rises in the cost of medical care.⁵⁰

This type of measurement has been criticized by those who think the ratio is too high. For example, it is pointed out that current figures on consumer expenditures do not reflect the increasing amount of personal medical care now being financed by government which might, if an adequate voluntary mechanism existed, be financed by consumers. It is also criticized by those who think the results are too low since consumer expenditures include the cost of many items which are frequently alleged to be "uninsurable," e.g., mental disease and other long-term illness, and a considerable proportion of drug and regular doctors' bills.⁵¹

The concept of "potentially insurable expenditures" was developed by the Social Security Administration to meet the latter criticism. This measurement includes only items which are in fact currently covered by some existing insurance or prepayment plan. By this criterion, voluntary insurance is meeting about thirty-one percent of potentially insurable costs.⁵² This figure is, in some ways, a more telling criticism of the dominant patterns of health insurance benefits than the unadjusted benefit-expenditures ratio.

There are no comparable trend figures for the proportion of the medical costs of individual families being met by insurance. The only national data on this question have been provided by the Health Information Foundation's 1953 survey. Following are the major findings, adjusted by later published figures.⁵³ For all families insurance paid about 15 percent of total private medical bills; for the insured 19 percent. By 1957, the latter proportion had risen to an estimated 25 percent or more.⁵⁴ Among the insured who actually received benefits⁵⁵—about $\frac{1}{3}$ of all insured families—payments averaged 35 percent of total charges.

⁵⁰ A 16% rise in 1955 in the dollar volume of benefits increased the actual coverage of medical bills by only 1.8 percentage points. Soc. Sec. Bull., Dec. 1956, p. 13.

⁵¹ For examples of these and other criticisms from two different points of view, see Klarman, *Changing Costs of Medical Care and Voluntary Health Insurance*, pp. 8-10 (address to Amer. Econ. Ass'n and Amer. Ass'n of Univ. Teachers of Insurance, Cleveland, Dec. 1956, mimeo), and FOLLMANN, *VOLUNTARY HEALTH INSURANCE AND MEDICAL CARE* 13-24 (Health Insurance Ass'n of Amer. 1958).

⁵² Soc. Sec. Bull., Dec. 1957, p. 6.

⁵³ ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS* xiii-xiv, 24, 48-50, and *passim*; ANDERSON AND STAFF OF NATIONAL OPINION RESEARCH CENTER, *VOLUNTARY HEALTH INSURANCE IN TWO CITIES*, *passim* (1957); also, Health Information Foundation, *Progress in Health Services*, Feb., June 1957; various papers by George Bugbee, president, and O. W. Anderson, research director, Health Information Foundation.

⁵⁴ Anderson, *Issues in Voluntary Health Insurance*, INDUSTRIAL RELATIONS RESEARCH ASS'N PROCEEDINGS, 1957, 117.

⁵⁵ Not everybody who is insured receives a benefit even though he utilizes a normally insured service. There may be a waiting period, a specific exclusion for a pre-existing condition, limitation of benefits to inpatients, or the absence of a charge when workmen's compensation or other third party payments take precedence.

From the Social Security Administration data in Part One, together with the H.I.F. findings, this pattern emerges: for general hospital care, insurance is now paying about 50 percent of the private expenditures incurred by all families, 75-80 percent for the insured; for surgery, 40-45 percent for all, 76 percent for the insured; for all physician services, 13-28 percent for all families.⁵⁶

By every measurement there has been progress and in one segment of the field, coverage of hospitalized illness, very substantial and perhaps adequate protection is now available to group insurance subscribers in many parts of the country. On the other hand, there is still very inadequate protection in the area of nonhospitalized illness and this omission is clearly the major factor in holding down the record of voluntary health insurance with respect to overall benefit adequacy. This omission is becoming more conspicuous as the new consumer demand for "comprehensive" coverage, discussed in Part One, becomes stronger.

The limitations of present benefit patterns are becoming clearer. We now know that about $\frac{2}{3}$ of the annual charges for all personal health services to insured families are incurred for services not covered under typical forms of health insurance. Among the uncovered services, physicians' home and office calls account for somewhat over $\frac{1}{5}$ of total costs, medicines and dentistry for just under $\frac{1}{5}$ each.⁵⁷ Continued progress with respect to benefit adequacy thus does not depend primarily on a gradual extension of present benefit patterns, *e.g.*, more liberal hospital per diems or surgical schedules, but on some major changes in that pattern—first upon a solution to the problem of insuring outpatient physician's care and then dental care and drugs.

2. *The Trend to Comprehensive Coverage*

The commonly used term "comprehensive coverage" has no uniform meaning and can be quite misleading. No insurance plan in the U. S. undertakes to cover all medical expenses, nor do Americans expect 100 percent protection.⁵⁸

Even the so-called comprehensive prepayment plans limit their liability through consumer controls of many types. Every plan has some limit on

⁵⁶ Social Security Administration ratios are based on Dept. of Commerce income reports from suppliers of medical services; H.I.F. ratios on reported expenditures by consumers. Some discrepancy is not surprising. It is far more conspicuous, however, in the case of physician services than hospital services.

⁵⁷ Health Information Foundation, *Progress in Health Services*, June 1957, pp. 1, 3.

⁵⁸ In a 1953 poll of subscribers in Boston and Birmingham, Health Information Foundation and the National Opinion Research Center found that while the majority wanted far more coverage than they had, only 6-7% wanted 100% coverage. ANDERSON AND STAFF OF NATIONAL OPINION RESEARCH CENTER, *VOLUNTARY HEALTH INSURANCE IN TWO CITIES* 43 (1957).

hospital benefits. Drugs are almost universally excluded (except when used by hospital inpatients)⁵⁹ as are most mental conditions,⁶⁰ tuberculosis and other long-term illnesses which require special institutional care. Insurance of dental care is still in the experimental stage.⁶¹ Waiting periods are common for treatment of pre-existing conditions and maternity cases. Small deductibles on hospital coverage and coinsurance in the form of small charges for home visits, the less common laboratory procedures, maternity care and tonsilectomies, appear to be becoming more common as alternatives to raising premiums.⁶²

Indeed the restrictions in all such plans have led H.I.F. to estimate that even this relatively broad type of insurance usually covers only about half of the average family's medical costs.⁶³ Plans which include dental insurance, such as the St. Louis Labor Health Institute, probably cover an additional 15-20 percent. And those which have generally resisted the imposition of extra charges, *e.g.*, HIP and Group Health Cooperative of Puget Sound, also cover a substantially larger proportion of their members' total costs, perhaps 70 percent or more. This 50-70 percent protection should be compared with the average of 25 percent which H.I.F. estimates for families insured under dominant patterns of health insurance.

The currently central distinction is that the comprehensive plans have undertaken to provide substantial coverage of the costs of physicians' services outside the hospital, which are second only to hospital costs in the consumer's medical bill and clearly the next big hurdle on the path toward really comprehensive benefits. The "challenge of comprehensive coverage" must be conceived relatively at any given time. For the immediate future,

⁵⁹ Windsor Medical Service is running a test plan on drug insurance. One thousand subscribers pay 95 cents a month per individual up to \$3.55 a month per family. They also pay the druggist 35 cents for each prescription. The rest is paid by the plan. *Medical Economics*, Dec. 1957, p. 17.

⁶⁰ Partial insurance of mental ills is feasible, according to Dr. L. S. Reed, *PRESENT PRACTICES OF HEALTH INSURANCE PLANS IN COVERING PSYCHIATRIC ILLNESS* (Amer. Psych. Ass'n, 1957). One B.C. plan now covers mental cases for 120 days in general hospitals and 30 days in other hospitals. The costs amount to only 3.2% of total inpatient payments. Dr. Reed estimates that an average of 45 days of care per admission in any mental hospital would increase total hospital prepayments costs by only 10%. *Medical Economics*, Apr. 14, 1958, pp. 45-48. This became an issue in the 1958 N.Y. Blue Cross hearings.

⁶¹ For description of the pioneer dental prepayment programs conducted by several independents, see H. R. Abrams, M.D., *The Closed Panel Clinic in a Health Service*, 54 J. AM. DENTAL ASS'N 205-11 (1957).

⁶² Kaiser makes a number of extra charges: \$1 for each office visit, \$3.50 for day home calls, \$5 for night calls, \$15 for a tonsilectomy for subscribers, \$35 for dependents. Among the Washington, D.C. Group Health "extras" are \$3 for the first home call, \$125 deductible in maternity cases and a general \$15 deductible for any hospital bill. Such coinsurance features appear to add about 20-25% to the subscriber's premium costs of these plans.

⁶³ ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS* 24.

it means substantial coverage of doctors' office and home services in addition to hospital and surgical charges.

As already indicated in Part One, widely differing types of prepayment organizations have clearly demonstrated the fallacy of the old view that such services, rendered outside the hospital, are uninsurable. This is true not only of group-practice plans such as HIP, Ross-Loos, and Kaiser, but of a number of medical society-sponsored fee-for-service plans, including Washington Physicians' Service and Windsor Medical Service.

This impressive experience has inspired a good deal of consumer interest but even more professional opposition. As a result, there have been a variety of less direct approaches, designed to meet the new demand for comprehensive care without antagonizing organized medicine.

Although most of the 74 million persons now reported to have "regular medical" insurance (see Table III) are covered only for non-surgical in-hospital doctors' care, there is a persistent, albeit halting, trend toward coverage of outpatient services, even among the professionally-controlled plans. Outpatient accident treatment and minor surgery are now generally included in B.C. contracts. Since 1954, the Massachusetts B.C. and B.S. have jointly written a "prolonged illness certificate" as a supplement to their standard contracts. This now covers 400,000 persons.

In 1958, the Philadelphia B.C. added outpatient diagnostic services, up to a limit of \$75, to its new "comprehensive" and "cooperative" contracts and even its standard contract will provide visiting nurse services for those over sixty five. The San Joaquin County (Calif.) Medical Society now sponsors an individual policy which goes considerably beyond the usual California Physicians' Service (Blue Shield) contract, including outpatient diagnostic x-ray and laboratory benefits, and full payment for up to fifty home or office visits per year for a list of catastrophic diseases.⁶⁴

Another manifestation has been the rapid extension of various types of "supplementary" medical benefits to the "health and welfare" package. A 1955 Bureau of Labor Statistics study of 300 large health and welfare plans found that nearly $\frac{1}{3}$ provided some coverage for outpatient diagnostic procedures, usually a cash allowance varying from \$10 to \$100.⁶⁵ Where union pressure for expanded outpatient benefits has been both strong and effectively applied, some outstanding examples of comprehensive health insurance have resulted. For example, the coverage provided by the San

⁶⁴ Progress Report of the San Joaquin County Foundation for Medical Care, pp. 5-6 (Stockton, mimeo. 1955).

⁶⁵ B.L.S., HEALTH AND INSURANCE PLANS 86-87. For an optimistic view of this trend and the ability of presently constituted employee benefit plans to include post-retirement benefits, psychotherapy, prepaid dental care, physical exams, etc., see WERMEL, PROBABLE FUTURE TRENDS IN HEALTH AND WELFARE PROGRAM EXPENDITURES (Cal. Inst. of Tech., Industrial Relations Sec., Benefit & Insurance Research Center Publ. 7, 1957). Mr. Wermel warns, however, of the need for adequate cost controls.

Joaquin Medical Association under the International Longshoremen's & Warehousemen's Union—Pacific Maritime Association Welfare Fund is far more complete than under its individual policies, including almost full coverage of office and home medical visits, maternity and well-baby care.⁶⁶ The Michigan State Medical Society, faced with the threat of a general withdrawal of UAW members, has approved a new Blue Shield contract to cover all surgery, wherever performed, and considerably liberalized medical benefits.

3. *Major Medical Insurance*

The most widely-discussed response to the new demand, however, is the new type of commercial insurance, now known as "major medical" and its even newer off-shoots, "comprehensive" or "semi-comprehensive."⁶⁷ Starting from scratch in 1949, major medical now has an estimated enrollment of 13 million, and is currently growing at a faster rate than any other type of health insurance. Its distinguishing features include: 1) Broad coverage of almost every kind of medical expense for both short-term and long-term illness—hospital, surgical and physician charges of all types, nursing fees and prescriptions. Some policies even cover dental care and mental illness. 2) The carrier pays only when the total cost of such expenses for an insured individual exceeds a specified "deductible" amount, which has been steadily lowered. It now varies from \$25 to \$500, most commonly \$100. 3) In addition to the "deductible," the insured pays an agreed portion of the remaining amount, commonly 20-25 percent. 4) A maximum limit on what the insurer will pay is set, usually at \$3,000-\$10,000, most commonly \$5,000. The maximum may apply for a year, for the duration of a given illness, or be absolute.

Proponents of major medical claim that it meets the challenge of comprehensive insurance. It covers physicians' services and either does or could cover most other forms of medical costs, and it avoids the previous over-concentration on hospitalized illness. They claim that the co-insurance and deductible features provide the necessary controls on consumers and permit the carrier to sell the policy at a practicable price. Equally important, they point out that the doctors are enthusiastic about it. Unlike Blue Shield or Windsor Medical Service, there are usually no fee-schedules, and since major medical is indemnity rather than service insurance, the doctor has no commitment of any sort.⁶⁸

⁶⁶ ILWU-PMA Welfare Fund, *Your Welfare Program* 9-10 (Stockton, 1955).

⁶⁷ Major medical policies may be added to "basic" hospital and surgical insurance with the deductible as a "corridor" from one coverage to the other. Or, the entire package may be incorporated into one "comprehensive" or "integrated" policy. In this discussion the more general term, "major medical," is used to apply to both.

⁶⁸ For an optimistic report on one of the largest and most comprehensive major medical programs, see Willis, *GE's Experience with Comprehensive Health Insurance*, 81 MONTHLY LABOR REV. 621-25 (1958).

Critics of major medical allege that it fails to offer or encourage one of the most important aspects of proper medical care—early preventive services, that it is highly inflationary and that as far as the average worker is concerned the cost is too high to be generally useful.⁶⁹

Major medical's highly inflationary potential is generally recognized by both proponents and opponents. The problem is that the cost controls imposed on consumers in the effort to limit the carrier's liability have no counterpart in controls on the price charged by vendors; and the knowledge that a patient has insurance, up to \$5,000 for example, without any item control, has been affecting the doctors' bills.⁷⁰

So great is this problem that, despite its phenomenal growth, the future of major medical is very much in doubt. Indeed, some experts see it as the possible swansong of the voluntary health insurance movement. The executive director of Connecticut's Blue Shield plan has said it "may well provide the easiest method by which voluntary medical practice can lose its fight against government control."⁷¹ A leading insurance executive alleges that it promotes abuse by patients, doctors and hospitals. "I am afraid this will result in losses to insurance companies, increases in rates and possible restrictive action. . . . Government control could be a result."⁷²

While such dour statements may not represent majority opinion, there is indeed a growing recognition that major medical may be a testing ground for something much bigger than itself, the issue which goes to the heart of the future of voluntary health insurance: can the insistent new consumer demand for broadened protection, especially from regular doctors' bills, be met by voluntary health insurance at a saleable price?

C. What Price Comprehensive Coverage?

The average overhead costs of health insurance are not excessive—with the exception of commercial nongroup policies where only about half of total premiums are returned to policy-holders in benefits. (See Table IV.) Blue Cross' average seven percent retention rate compares favorably, for so complex an operation, with any form of insurance, public or private. This

⁶⁹ The Bureau of Labor Statistics found, in 1955, that only 14 of the 300 large plans studied provided major medical but these covered about a million workers, $\frac{1}{6}$ of the total. Dependents were covered in only 8 plans, and in no case were retired workers. B.L.S., *HEALTH AND INSURANCE PLANS* 83-84.

⁷⁰ The medical director of the Equitable Life Assurance Society recently made public these examples of fees their major medical policy-holders had been asked to pay: Dilation, curettage, and cauterization of the cervix—\$1,200 (patient's annual income—\$6,000). Excision of semilunar cartilage of the knee—\$1,000 (patient's income—\$4,000). Gastrectomy—\$1,500 (patient's income—\$3,000). Lobectomy—\$2,500 (patient's income—\$2,500). *Medical Economics*, Feb. 17, 1958, pp. 30, 36.

⁷¹ W. H. Horton, M.D., quoted in H. C. Sherwood, *Fastest-Growing Health Insurance Today*, *Medical Economics*, July 1957, p. 129.

⁷² W. A. Henning, Jr., State Mutual Life Assurance Co., quoted, *Id.* at 129.

is particularly striking when one considers that a substantial and growing proportion of Blue Cross enrollees have non-group policies. Commercial Group—eleven percent—and Blue Shield—fourteen percent—do not have as good a record in spite of the fact that indemnity insurance is obviously easier to administer than service plans. Still, they compare well with the record of the community plans and most of the nonprofit “independents.”⁷³

Indeed, group health insurance appears to be approaching a “cost plus” pricing system: the cost of the covered medical care plus a percentage for operating overhead, reserves and, in the case of stock insurance companies, profits. Possibilities for acquisition and administrative economies certainly exist⁷⁴ and the question of reserve policy is now undergoing extensive study by the National Association of Insurance Commissioners.⁷⁵ But, in general, the problem of health insurance costs is primarily the problem of medical care costs. Hence, the question “What price comprehensive medical insurance?” means, primarily, “What price comprehensive medical care?”

1. Insurance and the Costs of Medical Care

The problem of medical costs is exceedingly complex. We may distinguish over-all costs, per capita costs, and unit costs, *i.e.*, the price of a particular service such as a hospital room, a tonsilectomy, or a doctor's office visit. The rise in over-all costs reflects the rise in per capita costs plus the rise in total population. Per capita costs reflect both the change in unit costs and the extent and character of utilization. Quite aside from the impact of health insurance, there are numerous basic factors which have raised per capita costs. Many have already been discussed in Part One: On the one hand there is the increasing proportion of the aged and of long-term chronic disability, and rising levels of income, education, health consciousness, and other factors increasing health needs and demands. On the other hand, there have been scientific and technological improvements leading to a better but more expensive product, a gradual ending of the large element of charity formerly associated with medical care, and the price consequences of failure of supply factors to expand and adjust in keeping with demand.

Some waste and faulty utilization—especially with respect to hospital services and drugs—are undoubtedly associated with the great upsurge

⁷³ Historically, the carriers have shown real progress. The net cost of the nation's health insurance declined from 30% of total premiums in 1948 to 17% in 1956. This is due almost entirely to the improved efficiency of group insurance.

⁷⁴ See, for example, Senate Comm. on Labor & Public Welfare, *Welfare & Pension Plans Investigation*, S. REP. No. 1734, 84th Cong., 2d Sess. 25-40 (1956).

⁷⁵ Indicative of the increasingly critical attitude taken by insurance commissioners toward large reserves was the 5% cut in B.S. rates ordered by the N.J. Commissioner of Banking and Insurance in August 1958. His decision was based on the existence of “unnecessarily high” reserves of about \$10 million. N.Y. Times, July 23, 1958.

of demand. But even if all such abuses could be eliminated, there are sound reasons which lead experts in medical care and medical economics alike to believe that per capita as well as over-all medical costs will continue to rise.

Moreover, health insurance is an important cost factor in at least three ways. The net cost of insurance overhead has added about five percent to the nation's medical bill;⁷⁶ the pattern of health insurance affects the rate and type of utilization; and there is evidence that the availability of insurance has contributed to price inflation of unit costs.

Unit costs cannot be measured precisely for many reasons, including the fact that they too reflect, in part, advances in technology and improved product. But a comparison of unit prices of medical services with the prices of other items in a society wherein other commodities and services similarly reflect scientific and technical advances throws some light on relative price trends. The Bureau of Labor Statistics' Consumer Price Index is cited both by those who believe medical prices have risen inordinately and those who say they have lagged behind increases in other living costs. Each can make a case depending upon the time period used. Over a 20-year period, 1936-1956, medical prices have increased less than living costs as a whole, 85 percent as compared to 98 percent. But during the 5 years, 1951-56, the price of medical care rose five times as fast as the general cost of living.⁷⁷ (See Table V.) The explanation lies partly in the typical lag in the price of services as compared to commodities in responding to general economic developments, and partly in the fact that the inflationary potential of current health insurance practices has only recently reached impressive dimensions outside the area of hospital costs.

TABLE V
COMPARATIVE INCREASES IN MEDICAL PRICES AND GENERAL LIVING COSTS,
1936-56 AND 1951-56

	Percent Increase, 1936-56	Percent Increase, 1951-56
All items	98	5
All commodities	110	-1
All services (except rent).....	88	16
All medical services.....	85	28
Hospital room rates.....	264	37
Dentists' fees	82	12
General practitioners' fees.....	72	19
Surgeons' fees	59	10

Source: E. A. Langford, *Medical Care in the Consumer Price Index, 1936-56*, and Tables D-1, D-3, Monthly Labor Rev., Sept. 1957, pp. 1053, 1055, 1162, 1163.

⁷⁶ See Part One, 46 CALIF. L. REV. 377 (Table I).

⁷⁷ The Univ. of Calif.'s Heller Committee for Research in Social Economics, which publishes annual family budgets for families in the San Francisco Bay Region, revealed that while family living costs as a whole rose 1-3% between 1955 and 1956, medical and dental care costs rose 7.3% for the average salaried family and 7.9% for the wage earner. Press Release, March 3, 1957.

a. Hospital Costs.

The major factor in raising medical charges all along has been the spectacular rise in hospital rates, which started up steeply in the early forties and have continued to rise ever since. During one year, 1956, rates jumped an average of ten to twelve percent. And yet many hospitals are still operating at a loss which must be made up by government aid and private philanthropy. The average paying patient in short-term general hospitals in 1956 was charged \$22.40 a day and actually cost the hospital \$24.15.⁷⁸ Many institutions also operate at a net loss in their outpatient departments.

The rise in hospital unit costs reflects primarily higher operating costs, especially long-overdue increases in wages and salaries. The traditional underpayment of nurses and other hospital labor, in the name of charity, is coming to an end. Even that dependable source of "slave labor," young hospital interns and residents, is finally in revolt. Many hospitals now pay interns \$25 to \$75 a month, or more. If the drive to put hospital specialists on a fee-for-service basis is successful, total costs will again shoot up.

Under the typical hospital-surgical indemnity policy, the commercial carriers are relatively protected against these increases in hospital costs by the dollar limits, at least in the short run. The result is likely to be a decline in the value of the consumer's protection rather than an immediate rise in premium costs. This is particularly true of individual insurance where one now finds such unrealistic hospital per diems as \$4 and \$5 a day, amounting in many cases to $\frac{1}{4}$ or less of the actual room rates, and even more unrealistic allowances for other hospital expenses.

But Blue Cross, as a service plan, has to absorb the increases. As a result, many B.C. plans, which had accumulated substantial reserves during the lush post-war years, are now operating with serious deficits and claim that their whole financial structures are threatened. During the year ending July 1958, 34 plans in 22 states raised premiums as much as 60 per cent.⁷⁹ Leading eastern B.C. plans filed requests with state insurance commissioners for large increases: Philadelphia—53 per cent, New York City—40 percent, Massachusetts—about 25 percent, and New Jersey—29 percent, following a 17 percent rise in 1956.

Resistance turned out to be unexpectedly great. Protracted, sometimes bitter, public hearings were held. The New York application was first

⁷⁸ This includes laboratory, drugs and other "ancillary" services as well as room, board and general nursing. Nearly half the average hospital bill is composed of such "extra" charges. Anderson, *Hospital Charges in the U.S.*, Hospitals, May 16, 1957, p. 49, Table I.

⁷⁹ R. L. Brenner, *Why Blue Cross is in Trouble*, Medical Economics, Aug. 4, 1958, pp. 157-58. New York City's Blue Cross is reported to have lost \$2.5 million in 1956 and more than \$9.5 million during the first 9 months of 1957. Medical Economics, Feb. 3, 1958, p. 54. The Philadelphia Blue Cross had a \$3.3 million underwriting loss and a \$2.8 million reserve decrease in 1957. E. A. van Steenwyk, executive vice-president, Associated Hospital Service of Philadelphia, Statement before the Insurance Commissioner of Pa., Jan. 1958, p. 10. Reserves of both organizations are considered inadequate.

denied but later a 22 percent increase was granted. The New Jersey increase was cut to 19 percent. In Philadelphia, rises averaging 39 percent were granted effective July 1958, but the insurance commissioner added many reservations and directives to B.C. organizations and hospitals. Extensive studies of the entire B.C. system are being made in New York, Michigan, Massachusetts, and Pennsylvania.

There is wide difference of opinion as to whether the continuing increase in hospital costs and hence in B.C. rates is inevitable. Authoritative accusations have been made that the hospitals have done little to bring about efficient and economical service. However, hospital administrators, now an established profession, point to significant "productivity" improvements, such as shorter average stays⁸⁰ and earlier ambulation during convalescence which reduces personnel-hours of care per patient. They have undertaken critical self-examination and encouraged public scrutiny of their operations.⁸¹

Room for improvement there certainly is: more imaginative hospital architecture and ward design, consolidation of some of the many small institutions, sharing of specialized equipment, joint purchase of drugs and other supplies, further emphasis on self-care and self-help, *e.g.*, in maternity wards, and more uniform methods of accounting and statistics to permit appraisal of comparative experience—all of these could indeed produce needed savings. But they are not likely to offset the continued upward pressure on the price of medical supplies and wages. On the contrary, the country's leading hospital administrators anticipate a continuing minimal five percent increase per year.⁸²

It would seem that any significant reduction in hospital costs will have to come from a reversal of the present trend toward ever-greater utilization

⁸⁰ The average length of stay in general and special hospitals (other than mental and tuberculosis) declined from 15 days in 1935 to 9.7 in 1956.

⁸¹ See, for example, the 3 volume report of Commission on Financing Hospital Care (1955). Vol. II is PREPAYMENT AND THE COMMUNITY; Vol. III is FINANCING HOSPITAL CARE FOR NON-WAGE AND LOW-INCOME GROUPS. The Commission was sponsored by the American Hospital Association and financed by it, H.I.F., John Hancock Mutual Life Ins. Co., Mich. Med. Service, and a number of private foundations.

⁸² H. E. Klarman, asso. dir., Hospital Council of Greater N.Y., points out "that the hospital as a personal-service institution has little room for gains in productivity. Yet it must continually lift salaries and working conditions to competitive levels, which are geared to such gains. . . . Services for the long-term patient, whether in mental hospitals, nursing homes or chronic disease facilities, are under-staffed, and they operate at low cost because they are of low quality. Substantial improvement in services will not be bought cheaply." *Changing Costs of Medical Care and Voluntary Health Insurance*, p. 5 (address to Amer. Econ. Ass'n and Amer. Ass'n of Univ. Teachers of Insurance, Cleveland, Dec. 1956, mimeo). The average patient day of care in a general hospital involves about two "personnel days" of professional, administrative, and institutional services. Rorem, *What Hospitals Can Do About Rising Costs*, Hospitals, March 1, 1957, pp. 35-36.

of inpatient services rather than from any substantial reduction in unit prices. "Abuse" is virtually built into the present insurance pattern. When the patient has insurance only for hospitalized illness, and the doctor's convenience is also served by sending him to the hospital, and the hospital itself has no control over admissions, what incentive or instrument is there for substantial reform of admissions policy? Some tightening up there may and probably will be. But it is not likely that any substantial results will be achieved until there is a basic reorientation of health insurance away from its present over-concentration on hospitalized illness. As noted in Part One, the hospital utilization rate for members of comprehensive plans averages only 60-80 percent of that for members of the "Blue" plans.

Some change is beginning to take place as indicated by the gradual trend to comprehensive coverage,⁸³ including such useful experiments as outpatient diagnostic benefits and post-hospitalization home care programs.⁸⁴ The Philadelphia B.C. and Hospital Council agreed, in May 1958, on a new reimbursement formula intended to provide incentive to reduce hospital stays. The per diem reimbursement to hospitals declines from a maximum for the first day to a minimum six to ten days later. These are hopeful developments.

But progress is very slow. Contributing to the delay are the many unresolved issues in the organization of medical care discussed in Part One. Doctors in solo practice are loath to see the prepayment mechanism used to stimulate group practice, either in private clinics or hospital outpatient departments. The battle over "corporate medicine" has slowed down coverage of outpatient diagnostic services. Until the question whether x-ray and laboratory technicians are to be hospital employees or contractors or independent practitioners is settled, it will not be clear whether their services should be insured by B.C. or B.S. If voluntary health insurance is to be saved from the soaring costs of hospital care, more determined action than is now in sight will probably be needed.

b. Physicians' Fees.

Viewed over a generation, the rise in physicians' fees appears moderate. Judging by the past five years, however, the picture is quite different. Be-

⁸³ A spokesman for the new GE Comprehensive Plan has compared the current frequency of hospital admissions—91 per 1000 insured employees—with the 116 per 1000 the company had in 1954 under its former standard plan. Willis, *Controlling Fringe Benefit Costs—Major Medical Insurance*, p.14 (address to the Natl. Industrial Conf. Bd., New York City, Jan. 1958, processed).

⁸⁴ The substantial economy, as well as other beneficial results, of an early discharge home-nursing plan was established by a recently concluded 5-year experiment sponsored by Blue Cross of N.Y. which hopes to make this a permanent part of its program. About 10% of all non-maternity patients in 4 participating hospitals could, in the judgment of their doctors, profit by home-nursing services. ASSOCIATED HOSPITAL SERVICES OF N.Y., REPORT OF A STUDY CONCERNING FEASIBILITY OF PROVIDING VISITING NURSE SERVICE FOLLOWING HOSPITALIZATION FOR B.C. SUBSCRIBERS (1957).

tween 1951-56, surgeons' fees rose twice as much as the general cost of living; G.P. fees rose almost four times as much.⁸⁶ (See Table V.) There is reason to believe that the more recent trend is the relevant one for future projection. It is only recently that health insurance has begun to exercise an inflationary effect upon physicians' fees as it has on hospital charges for over a decade. The trend from service to indemnity insurance, the generally unrealistic B.S. income levels, and the popularization of major medical insurance with its absence of item control, will augment the tendency to raise prices, as the complaints of the carriers already indicate.⁸⁶

One answer is simply to abandon the effort to insure outpatient services. This is, no doubt, the solution that some parts of the medical profession would prefer. But this begs the question. If health insurance is to maintain its position in the financing of medical care, it must find a means to meet the expectations it has helped to create and to answer the insistent new demand for medical care. Moreover, failure to provide insurance for outpatient care may mean failure to cope with the rising costs of hospital insurance and threaten survival of that part of the business as well.

2. *Costs under Comprehensive Prepayment Plans*

A 1954 Social Security Administration survey of all group-practice prepayment plans in this country found that those which provided both hospital and physician' services, and a few with dental as well, charged an average of about \$60 a year per adult member and \$30 or less for child dependents. About \$150 a year for hospital and medical care for a family of three or more was typical in comprehensive urban plans.⁸⁷ Table VI gives

⁸⁶ G.P. fees are still relatively modest, averaging, in 1956, about \$3-5 for office visits, \$4-7.50 for home visits.

⁸⁶ M. E. Segal, one of the country's best known health and welfare consultants, has said, "In most health and welfare programs there is nothing to prevent a surgeon from charging more than the amount allowed under the surgical schedule . . . [i]n many instances the patient is charged a fee which is from 25% to 100% or more higher than the benefit which the patient gets from his health and welfare program . . . This would suggest that an increase in the surgical indemnity schedules will remove the burden of the additional charges . . . However, studies have indicated that this is not the answer to the problem. Regardless of the increase in . . . fee schedules, many surgeons charge more than . . . the schedule allows. In fact, some . . . have been frank enough . . . to say that they charge . . . not on the basis of the patient's economic status or the complexity of the surgical operation but simply on the basis of what kind of insurance benefits the patient has—and what the patient might be able to pay over and above the benefits received from the health and welfare program." *Reforms in Health and Welfare Funds*, pp. 4-5 (paper presented Univ. Cal. Conf. on Industrial Relations, mimeo. 1957). At the 1957 meeting of the American College of Surgeons, President W. L. Estes, Jr. said that "a surgeon should base his fee upon the patient's 'ability to pay' without regard to how the patient will pay: that is, whether or not one or more insurance payments will be involved." R. K. Plumb, *N.Y. Times*, Oct. 19, 1957, p. 40, col. 1. But, of course, the insurance benefit has become part of "ability to pay."

⁸⁷ Brewster, *Group-Practice Prepayment Plans*, Soc. Sec. Bull., June 1956, p. 11.

TABLE VI

ILLUSTRATIVE ANNUAL PREMIUMS, MAJOR GROUP HEALTH INSURANCE PLANS 1956-57^a

	<i>Individual</i>		<i>Family^b</i>	
	Month	Year	Month	Year
A. Hospital, Surgical and In-Hospital Medical Coverage				
1. Blue Plans ^c				
Blue Cross ^d	\$ 2.10	\$ 25.20 ^e	\$ 5.00	\$ 60.00 ^f
Blue Shield ^g	1.10	13.20 ^h	3.12	37.40 ^j
B.C.-B.S. Combined	3.20	38.40 ^k	8.12	97.40 ^l
2. Commercial Insurance ^m				
Hospitalization ⁿ	1.53	18.36	6.33	75.96
Surgical ^o	.53	6.36	2.73	32.76
In-Hospital medical ^p	.13	1.56	.46	5.52
Combined	2.19	26.28	9.52	114.24
B. Selected Comprehensive Prepayment Plans				
1. Solo, fee-for-service Plans				
a. Windsor Medical Services ^q	2.30	27.60	7.90	94.80
W.M.S./B.C. Combined	4.40	52.80	14.20	170.40
b. ILWU-PMA (San Joaquin County, Calif.) ^r	13.00	156.00 ^s	13.00	156.00 ^s
2. Group Practice Plans				
a. Kaiser (San Francisco Area) ^t	5.50	66.00	13.20	158.40
b. HIP ^u	3.56	42.72	10.68	128.16
HIP/B.C. Combined	5.16	61.92	15.04	180.48
c. Group Health Asso. (Wash., D.C.) ^v	4.50 ^w	54.00	15.00 ^{wx}	180.00

^a Figures not strictly comparable. Additional variations not included in notes, relate to benefit eligibility and exclusions.

^b Some plans have an intermediate rate for a couple or smaller family. Rate given here is maximum, unless otherwise indicated.

^c Typical benefits; see text at notes 15-18 *supra*.

^d Median of 80 plans—reported in *Blue Cross Guide*, Jan. 1957.

^e Range: \$13.80-\$42.00.

^f Range: \$37.80-\$88.08.

^g Median of 51 plans—reported in *Blue Shield Manual*, July 1957.

^h Range: \$7.80-\$35.40.

^j Range: \$24.00-\$70.80.

^k Range: \$24.60-\$72.00.

^l Range: \$67.80-\$145.80.

^m Typical "standard" premiums subject to rate credits or adjustments as reported in Soc. Sec. Bull., Dec. 1956, p. 10.

ⁿ Up to \$10 per diem for 70 days; 10 times daily rate for "extras."

^o \$200 maximum fee schedule. ^p \$4 maximum per visit for up to 70 days.

^q Complete surgical-medical coverage; income limits of \$4,000 for individual, \$6,500 for family.

^r Includes hospitalization up to 70 days for employee, 35 for dependents; complete surgical; virtually complete medical for employee, small charges for dependents; complete maternity.

^s Employer pays same rate per employee regardless of size of family.

^t Includes up to 111 days hospitalization for subscriber, 60 plus 51 at half-rate for dependents; complete surgical and medical with about 20% coinsurance in form of charges.

^u Complete surgical and medical. Only charge: \$2 for night calls. Individuals with incomes over \$6,000, families over \$7,500, pay 20% higher rates. One-half premium must be paid by employer.

^v Includes up to 180 days hospitalization, with \$15 deductible; complete surgical and medical with about 20% coinsurance in form of charges.

^w Same rate for non-group members. \$50 membership fee additional.

^x No family rate. Rate cited is for 2 adults and 2 children, average size of G.H.A. family. Third child costs \$3 a month additional.

1956-57 premiums for several of the larger comprehensive plans, which have demonstrated that employed families can be insured against 50-70 percent of all their medical costs for \$180 or less a year, even in high cost medical areas such as San Francisco and New York. One plan, Group Health Association of Washington, D.C., applies this rate to non-group members. The difference between 25 percent protection for \$100-\$114 in the conventional plans and 50-70 per cent protection for \$180 is a significant improvement in itself. Moreover, the techniques of such economy may point the way to resolution of present dilemmas, if the economies can be obtained without sacrificing quality.

The economy does not appear to be primarily related to underwriting costs. The independents as a whole appear to have higher retention rates than either the "Blues" or commercial group insurance. The difference may be due in part to variations in accounting and reporting but the general point is still valid. Three factors appear primarily responsible for the greater economy of the comprehensive plans:

1. A smaller proportion of their income and expenditures goes for hospital services, the most expensive form of medical care. In the health insurance field as a whole, hospital services account for nearly two-thirds of total income and expenditures. (See Table IV.) But among the independents nearly half goes for outpatient services. Plans with a comparatively full range of benefits, such as Group Health of Washington, D.C., and the Labor Health Institute, assign nearly 70 percent of their income to medical services, only 30 percent to hospitalization. Their members are hospitalized less because their insurance covers outpatient service as well.

2. All five plans listed in Table VI are service plans which means that they must exercise some control over the cost as well as utilization of the services provided. This is presumably true of B.C. and B.S. too—to the extent that they operate as service plans. But there is an important difference due primarily to the differing type of sponsorship. As Odin Anderson has pointed out, B.C. hospital plans were "grafted on, so to speak, to the existing structure of hospital service" and B.S. plans were "grafted on the present practice of medicine."⁸⁸ B.C. subscribers generally receive a wholesale discount from the hospitals but there is nothing in most plans inherently designed to promote economy in hospital service or to discourage over-utilization.

The B.S. formula for dealing with increasing costs has simply meant allowing old income limits to become obsolete or switching outright to indemnity contracts. While B.S. and commercial surgical insurance have not risen greatly in price, the value of the protection has declined.

By contrast, the comprehensive plans, whether sponsored by consum-

⁸⁸ ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS* 7.

ers or independent groups of doctors, have accepted the commitment of a service contract and have tried to cope with the problem of rising medical costs by various types of professional restraints and organizational reforms. In the case of the fee-for-service plans listed, the doctors have not imposed unrealistic income schedules. The ILWU-PMA contract has no income limits. The \$6,500 limit in Windsor is said to exclude very few families, and, where it does, local professional tradition is against charging higher fees. The Windsor doctors, ninety percent of whom belong to the Service, apparently feel that the success of their plan justifies this degree of self-restraint.

3. Among the larger hospitals and group practice plans, there is the additional opportunity to control costs of outpatient services by taking advantage of the efficiency and economy of large scale organization. Improvements in productivity are not alien to medical practice as is so often assumed. Although the traditional image of the individual family doctor as the embodiment of medical care, and the lack of newspaper headlines heralding the change, have impeded public realization of the fact, medical technology is already moving into the electronic and nuclear age. In the new era of automatic testing, recording and computing, the expensive time of physicians can be greatly conserved by use of less expensive paramedical aides and technicians.⁸⁰ But such specialized skills and expensive equipment are economically feasible only for doctors working in large groups or hospitals serving a good-sized population.

Admittedly the full impact of the "technical revolution in medicine" is still in the future. But the economies which may already be realized in the provision of routine outpatient services, by taking advantage of large-scale production methods, are striking.

Donald Straus, vice-president of HIP, has provided some provocative calculations based on HIP experience plus theoretical assumptions. Assuming an average of 6 enrollee-services per year (HIP members actually average 5.4) and an average time consumption of 20 minutes per service, the average person consumes two hours of physician-care per year or 1,000 people need 2,000 physician-hours a year. Assuming the desirability of a 40-hour week for doctors for 48 weeks a year or 1,920 hours a year—far less than is common practice—this means a need for one doctor for each 1,000 enrollees. Assuming a goal of average earnings of \$18,000 net per year or \$30,000 gross—it is estimated that 40% of gross income is required for expenses although small groups may have an even higher expense ratio—the average doctor with 1,000 patients should gross \$15.60 per hour of practice. On the calculated basis of two hours of service per enrollee-year

⁸⁰ See, for example, V. K. Zworykin, *Magic Eyes for Medicine*, Sat. Eve. Post, May 31, 1958, pp. 27, 50.

the cost would be \$31.20 per person.⁹⁰ This is the per capita payment HIP makes to its participating groups. HIP doctors are reported to earn \$18,000-\$20,000 a year net.

The views of Dr. Russell Lee, head of the 80-physician Palo Alto Clinic, on the subject of group practice indicate its inherent economies:

"I know from experience that a group can profitably give complete medical service at \$5 per person per month. The Palo Alto Clinic has such a deal with the Masons. We take care of all their old people at that price. Old people, remember, aren't supposed to be insurable. And these Masons are from 65 to 105 years old. Yet we give them complete care for \$5 a month.

"Q. And you don't lose money?

"A. One year . . . We kept a careful check. At \$5 a month we took in \$234 more from them than we would have earned on a straight fee-for-service basis. If it can be done for old folks, it can be done for anybody.

"Q. Can a solo practitioner do it?

"A. The solo practitioner can't offer complete prepayment because he can't give comprehensive care. He may be a good internist; but if the patient gets pregnant, he has to call in an obstetrician. If the patient gets a brain tumor, he has to call in a neurosurgeon. About the only way solo practitioners' services can be prepaid is through Blue Shield or some other middleman. And when you bring in middlemen, you begin to get inefficiencies and conflicts."⁹¹

The economies of this type of organization of medical care so impressed the Twentieth Century Fund that it predicted the private medical needs of the American people in 1960 could be met for approximately half the cost of providing them under presently prevailing methods of organization—\$16 billion as compared to \$30 billion.⁹²

D. Costs, Quality, and Freedom

The fact that comprehensive health insurance can be provided at a price feasible for most of the population does not prove that it generally will, or should, be done. Economy at the expense of quality is false economy. Moreover, many believe that in the American context cost is not a central problem. As already noted, in 1957 medical care consumed only five percent of average family expenditures, about \$280 per family.

The nation as a whole can surely afford to pay more for health and an

⁹⁰ A Framework for Developing a National Policy on the Financing and Organization of Physicians' Services, 70-71, 75 (HIP mimeo, 1957).

⁹¹ Medical Economics, Nov. 1957, p. 141.

⁹² DEWHURST & ASSOCIATES, AMERICA'S NEEDS AND RESOURCES 344 (1955). Starting with \$50 per person as a typical 1952 cost for insuring hospital and physicians' services under group practice prepayment plans, assuming an average family of 3.1 persons, and allowing an additional \$35 per family per year for additional medical items not usually insured, the Fund arrived at a total cost of \$190 per family.

increased allocation of the national income for this purpose would probably be justified. But for individual families the burdens of medical care continue to fall with great inequality, despite the growth of health insurance. In 1953, 58 percent of all families incurred charges of less than 5 percent of their incomes for medical care, while for 7 percent, charges exceeded 20 percent, and for 2 percent, more than half.⁹³ While it can be assumed that health insurance has "cut the top off" the extreme peaks of medical expenditures, great unevenness continues to prevail.

Moreover, these costs customarily fall inversely to capacity to pay. For some sectors of the population, including the aged and the seriously disabled, the growth of health insurance, from which they are generally excluded, has actually aggravated their difficulties. They suffer the rise in costs associated with insurance but obtain none of the advantages.

All parties—consumers, carriers, and employers, whose contributions have made possible the main growth of group insurance—are beginning to balk at these rising costs. Almost all elements of the community complained volubly at B.C.'s 1958 rate requests. Jerome Pollack, spokesman for the United Automobile Workers, one of the nation's largest participants in group health insurance, said recently: "For a time, labor was not especially concerned with the rising cost The impressive improvements in hospital care were bound to cost money But the unrelenting increases over a long period of time and the abandoned manner with which some plans accept the inevitability of every element of increase and attempt to pass them on to the consumer are beginning to undermine confidence in hospitalization insurance Workers are now concerned with an out-of-hand trend."

With special reference to major medical plans, he added, "Labor fears that for lack of adequate controls, the cost of this new coverage may get out of hand in a few years, and that pressures will arise to retreat from more comprehensive coverage, not because it was truly uninsurable but because proper safeguards were not taken."⁹⁴

The uncritical days of easy expansion are over. Yet voluntary health insurance must expand or face decline. Viability depends upon finding means to furnish more adequate protection for a larger proportion of the population. This must mean, among other things, a concern with the costs of care which so largely determines the price of insurance. This, in turn, means concern with efficiency, or medical "productivity."

1. Relationship of Quality and Cost

Economy is not the enemy of quality. Logic and evidence indicate that many of the same factors which promote economy and efficiency also result

⁹³ ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS* 36, 38.

⁹⁴ *Health Insurance Today and Tomorrow: A Labor View*, pp. 5-6, 9 (address to Health Insurance Ass'n of America, mimeo, 1958).

in improved quality. Prevention—early diagnosis and treatment—which is advanced by comprehensive protection is generally recognized as both economical and conducive to better care. Ready accessibility of the wide range of specialized skills in modern medicine, which group and institutional practice offer, is clearly helpful to quality and can be generally brought within feasible price range only through such methods of organization. The same is true of the elaborate and costly equipment of present-day medical technology. In short, these and other elements of quality care can be made generally available only if costs are controlled and very broadly spread through the population.

2. Quality and Comprehensive Prepayment Plans

The main issue is whether comprehensive care, especially physicians' outpatient services, can be organized and marketed extensively through the mechanism of private health insurance, at a practical price, without injury to quality. The concept of quality is as elusive and complex as it is crucial but this paper can only deal with a few general points.

Advancing technology also brings better means of measurement, testing and control. These are becoming increasingly recognized and utilized. The history of organized medicine in this country includes a succession of successful attempts to raise qualitative standards by improving medical education, and also by applying institutional or structural safeguards to practice.⁹⁵ The long struggle, started in 1918 by the American College of Surgeons, to improve the quality of hospital care culminated in the establishment, over three decades later of the Joint Commission on Accreditation of Hospitals in which the AMA, AHA, the American College of Physicians, and the College of Surgeons all participate. "Quality controls" of hospital and surgical care are now applied through "medical audits" and "tissue committees."

Such examples are plentiful. The point is that the health professions have developed and can further develop criteria for objective control of quality. With the cooperation of the professions it is possible to evaluate and control the quality of medical care purchased through health insurance, including that rendered through comprehensive plans where the issue has been most prominently raised.

The comprehensive plans have had a heavy public relations handicap to overcome in this respect due to widespread recollection of the far-from-admirable care often dispensed in the past through "contract practice,"

⁹⁵ For an historical account of the AMA's activities in promoting qualitative standards in medical practice, see Comment, *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 937, 959-76 (1954).

"company doctors," workmen's compensation programs,⁹⁶ and charity clinics of various sorts. But the leading comprehensive prepayment plans of the Fifties are as different from the charity clinics of the past as the new University of California Hospital in San Francisco from the 19th century alms houses. In part, perhaps, because of their awareness of the handicap of the old image, there is, among them, exceptionally high self-conscious concern with quality. The eagerness with which some of these plans submit themselves to "quality studies"⁹⁷ is impressive and bespeaks a conviction that the care they provide at an insurable price is as high in quality as can be purchased at any price. The first public act of the UAW sponsored Community Health Association of Detroit was to hold a conference on "Quality of Medical Care" attended by 44 doctors from Michigan and other parts of the country.⁹⁸

Wherever recent quality studies have been made, the results have been generally favorable to the comprehensive plans. A 1955 comparative study of maternity cases in New York City showed that women who received their care from HIP had a lower perinatal death rate (infant deaths under one week plus fetal mortality) than private patients generally. Since the study eliminates the major nonmedical factors (although some subtle socioeconomic distinctions may remain) the conclusion was that differences in the medical care available had a significant influence.⁹⁹ Similarly, the favorable results to HIP of a study of comparative hospital utilization rates in New York City have already been cited in Part One.¹⁰⁰ In an impartial survey, 84 percent of Windsor Medical Service subscribers termed themselves "highly satisfied" or "generally satisfied" while only about half the

⁹⁶ The story of compensation medicine provides an interesting and disturbing case study in the problem of reconciling "free choice," quality and economy in a medical care program. See SOMERS & SOMERS, *WORKMEN'S COMPENSATION* 166-76 (1954); also *Rehabilitation: Challenge to Compensation Medicine*, Social Service Rev., Dec. 1955, pp. 383-94.

⁹⁷ See, for example, GOLDMANN & GRAHAM, *QUALITY OF MEDICAL CARE PROVIDED AT LABOR HEALTH INSTITUTE* (1954). HIP reports a "continuing" series of quality studies conducted in cooperation with U.S. Public Health Serv., N.Y. City Health Dept., Commonwealth Fund and Rockefeller Foundation. See notes 24 *supra*, 99 *infra*. The Windsor study (note 28 *supra*) also emphasized quality and the doctor-patient relationship.

⁹⁸ The program adopted by the board of directors provides the following quality controls: "Standards of qualifications for physicians in the groups which serve CHA members. Standards for hospital and medical group facilities and equipment. Standards of medical practice to be set with competent medical advice and enforced by the medical director and his staff. Provision for continuing education of professional personnel. Periodic evaluation of quality." Community Health Ass'n Program and Development, Detroit, May 1957, p. 3. Similar standards are now applied at HIP by a central Medical Control Board, made up of a representative body of physicians.

⁹⁹ Shapiro, Weiner & Denson, *Comparison of Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice Medical Care Plan*, 48 *AM. JOUR. PUBLIC HEALTH* 170-87 (1958).

¹⁰⁰ 46 *CALIF. L. REV.* 376, 392 n.50 and accompanying text.

subscribers to other plans in the area felt that way. Among participating doctors, almost one-half judged the effect on the quality of medical care to be favorable; only fifteen percent thought the results unfavorable.¹⁰¹

Those who believe this type of medical service is conducive to high quality stress the importance of "structural elements"—built-in factors that protect quality, such as group practice, medical center organization, group standards of professional procedure, promotion of preventive services, etc. The generally beneficial effect on quality of medical care of hospital practice, group practice, and other forms of combined practice is widely accepted. It is apparent that close working relations among doctors, as among other professionals, impose an effective, even if informal, professional discipline.

3. *Freedom and Quality*

Methods of organizing and financing medical care are as subject to technological and social obsolescence as the substantive medical arts themselves. Methods which conduce to high quality today differ from those of yesterday and may prove quite inadequate for tomorrow. Similarly, no one method is "best" at any time in all circumstances or for different communities.

The most effective safeguard of quality is freedom—the spirit of free inquiry and experimentation, the freedom to launch new methods of practice, new forms of organization and financing. But free experimentation and free competition are now severely restricted by arbitrary prohibitions. As already noted in Part One, in about half the states, comprehensive prepayment plans are virtually outlawed by statute and, in most of the others, institutional barriers—guild restrictions by medical societies—preclude fair competitive tests.¹⁰² The apparent fear of opponents of comprehensive plans to submit to the competition of the market-place and to objective quality tests casts doubt on the validity and motivation of their criticism.

At the moment it appears that the advocates of hospital and group practice and comprehensive insurance are displaying more concern with the quality of care than their opponents. But this is not universal. It has not always been the case in the past and it may not be so in the future. The basic safeguard of freedom must be preserved. In the immediate future, this requires removal of legislative and other barriers. The capacity of voluntary health insurance to meet the growing challenge of comprehensive coverage may depend upon the extent to which this freedom is achieved.

The opponents of comprehensive plans also champion the cause of freedom, claiming that such plans, especially where combined with group

¹⁰¹ Health Information Foundation, *Progress in Health Services*, Nov. 1957, pp. 4-5.

¹⁰² 46 CALIF. L. REV. 376, 407-08 n.99 and accompanying text.

practice, violate the principle of "free choice" of physicians and damage "doctor-patient relationships." The medical societies employ the invidious terms "corporate medicine" and "closed panels." In organizations like Windsor Medical Service and the Washington medical bureaus, most doctors in the community participate and "free choice" is not a real issue. Indeed, forty percent of Windsor Medical Service doctors believe that the plan has had a stabilizing effect on "doctor-patient" relationships. Ninety-two percent of the subscribers have a "regular doctor" as compared to seventy-six per cent of the uninsured in Windsor.

Where prepayment is combined with group practice, however, some restriction of choice is inevitable, just as denial of the right to join such a plan is also a restriction on free choice. Several of the large plans have indicated their willingness to meet this criticism by offering "dual choice" or "dual insurance" contracts. Enrollees are given an opportunity to opt, individually and usually annually, between the comprehensive plan and an indemnity plan of approximately the same price. General Motors, Ford, New York state employees, and other large contracts now have such provisions. An increasing proportion of Kaiser and HIP enrollment is on this basis.¹⁰³ This innovation could turn out to be one of the most significant recent developments in health insurance, not only reconciling considerations of quality and efficiency with "free choice" but also serving as a discipline upon the service of both competitors.

The extent to which the issue of "free choice" can, however, be made false and even serve as a drag on quality is indicated by the attempts of several medical societies to obstruct the efforts of the United Mine Workers Welfare Fund to raise quality and reduce unnecessary utilization under its medical program. After nine years of permitting consumers unrestricted choice of physicians, the Fund now maintains that the quality of care received, as well as the Fund's solvency, can be protected only by imposing administrative controls. For example, it proposed that surgery be performed only by a doctor certified by one of the surgical boards or by a Fellow of the College of Surgeons.¹⁰⁴ Such minimal standards, established

¹⁰³ The experience is too brief to provide firm conclusions on shifts of membership. In general, the majority of subscribers tend to abide by their original choice. Where there has been attrition in the membership of comprehensive plans, a net gain is reported as a result of new contracts which could only be obtained on a dual choice basis. For the origin and development of "dual choice," see A. Yedidia, *Health and Welfare Funds* (Kaiser, mimeo. 1956). H.I.F. is currently sponsoring a study of consumer attitudes in one important dual choice area, New York City.

¹⁰⁴ L. R. Chevalier, Interview with Dr. W. Draper, executive medical officer, UMW Health and Welfare Fund, "Free Choice Has Failed," *Medical Economics*, Jan. 20, 1958, p. 76. See also, W. H. Potter, M.D., *Experiment in Elevating Standards of Medical Care*, Harvard Med. Alumni Bull., July 1958, pp. 34-37.

as quality safeguards by the profession itself, are opposed by the medical societies in the name of "free choice!"

III. THE CHANGING SOCIAL ENVIRONMENT

Thus far powerful psychological and institutional resistances have deterred health insurance from adequate exploitation of the new productivity potential in modern medical care as well as the economy inherent in service plans and wide risk-sharing. Perhaps the most dramatic example of this seemingly perverse phenomenon is the expansion of indemnity insurance at the expense of service plans. But there is evidence that such forces may be in a state of transition. Two decades of direct experience and increasing knowledge are influencing the attitudes of consumers, employers, carriers, hospitals and physicians while the inadequacies of private insurance produce a continuing expansion of public medical care programs.

A. The "Health and Welfare" Influence

The vast majority of insured persons owe their protection to an employee benefit plan, paid for in full or in part by employers, and often negotiated on their behalf by a union. Some employers, recognizing the inherent economy of a service program, and some labor officials committed to the service ideal, have insisted upon this type of insurance. But in the main both groups have accepted the trend to indemnity. Some of the reasons are easy to recognize.

The vocabulary of collective bargaining is generally dollars and cents. It is entirely feasible to convert negotiated dollars-and-cents or percentages-of-pay into service benefits, and it is frequently done. But management and union leaders often found it easier to negotiate, to explain, and to administer a program defined in money terms rather than services for whose quality they preferred not to take responsibility.

The development of multi-employer, industry-wide bargaining patterns also furthered this trend. It was easier to provide at least the appearance of uniformity among workers in different parts of the country by stating benefits in dollars rather than in services, especially when the latter required organizational structures which did not already exist.

The skeptical attitude of the newly insured industrial worker toward group clinics has already been mentioned. This feeling often carried over to service plans in general. The newly-enfranchised patient often preferred cash which he could spend on whatever doctoring he wished as compared to the restricted choice, implicit in most comprehensive service programs, and which, in the light of his own past, seemed to him to have overtones of charity. Moreover, the industrial worker, to whom it was a new boon, was less likely to find fault with the typical cash-benefit hospital-oriented

policy than the more educated professional or management family.¹⁰⁵ Interest in preventive medicine and regular care usually comes only after protection against the possibility of catastrophic cost has been secured and with increasing education.

The attitudes here described, however, now appear to be in gradual decline. New forces and new experiences are being felt. Health insurance itself, the expectations it has given rise to, its cost and problems, and its administrative history, are important parts of that experience. For example, B.C. has demonstrated, through its National Health Service, Inc. and its various inter-plan transfer agreements, that a service plan can operate on a national basis as well as can indemnity plans. Similarly, Washington Physicians Service has demonstrated that an entire state can be covered by a combination of county-based service plans supplemented by centrally-administered indemnity benefits.

Employers, once relatively indifferent to the forms of health insurance, are feeling the pressures of expanding benefits and rising costs and thus are being forced to a more critical cost-consciousness which concerns itself with value as well as price. Union negotiators are also becoming better informed on health matters. One of the most striking examples of the new sophistication in collective bargaining circles is the Foundation on Employee Health, Medical Care and Welfare, Inc., sponsored jointly by the International Association of Machinists and U.S. Industries.¹⁰⁶ The recent federal legislation requiring public disclosure of health and welfare fund financing should augment this trend.¹⁰⁷

In the changing environment, the advice of the top labor leadership may have more influence. The first AFL-CIO convention went on record in favor of "actual prepaid health services (as distinguished from cash payments covering an unpredictable portion of actual medical bills)." The

¹⁰⁵ H.I.F.'s survey revealed that low income families had a higher proportion of charges paid by insurance—26% for those with incomes below \$2,000 compared to 15% for those over \$7,500. "At first sight it may seem that insurance carried by low-income families was more 'adequate' than that carried by upper income families. Actually, low-income families are less likely to utilize and incur charges for services other than hospital care and surgery, the services most likely not to be covered by insurance . . ." ANDERSON & FELDMAN, *FAMILY MEDICAL COSTS* 50. For importance of income differences and social stratification on attitudes towards health, see KOOS, *HEALTH OF REGIONVILLE* (1954).

¹⁰⁶ The Foundation's second report, *SERVICE BENEFITS—AND HOW TO COMPARE SERVICE VS. INDEMNITY BENEFITS* (1958), contains detailed recommendations for eliminating waste and providing more comprehensive services. It estimates that at least \$50 million a year could be saved by more careful "comparison shopping" among various plans (at p.3).

¹⁰⁷ Pub. L. No. 836 (1958). Officers of health and welfare plans, whether administered by employers, unions or jointly, are required to make annual reports of assets and operations to the U.S. Secretary of Labor. Willful violation constitutes a federal offense. In addition, any covered worker denied access to such information may sue the administrator who is subject to a \$50-a-day penalty for each day of refusal to furnish the facts.

Federation is now actively supporting the American Labor Health Association, a group of labor sponsored direct-service plan executives dedicated to furthering that form of insurance. The Detroit Community Health Association, sponsored by the UAW, an ambitious plan for bringing prepaid comprehensive service on a group practice basis to the entire community could, if successfully put into effect, alter the whole health and welfare picture.

B. Attitudes of Carriers

The position of the carriers is also subject to alteration in response to accumulating pressures to reconcile new demands with mounting costs, while they face increased public controls. The very success and enormous enrollment of Blue Cross plans are bringing them closer to a public utility status. Their recent tribulations in seeking rate increases indicate that subscriber criticism and state supervision are no longer perfunctory.

Insurance companies are finding themselves threatened with enlarged public regulation which may extend far beyond the traditional boundaries of state action in the insurance field.¹⁰⁸ Their response to this prospect, however, has had many constructive results. They have demonstrated a capacity for great flexibility and imaginative improvisation.

Under present arrangements, however, their future is largely dependent upon the adaptability of the medical profession. The carriers wish no battle with the medical societies. But the stakes are high. If it becomes clear that uncontrolled medical costs are a threat to successful continuation of their health insurance business, their traditional alliance with organized medicine is likely to be under severe strain.¹⁰⁹ Even among the commercial car-

¹⁰⁸ See, for example, 1957 and 1958 legislative recommendation of the N.Y. Joint Legislative Comm. on Health Insurance Plans. Pennsylvania has a unique law requiring approval of health and accident policy rates which the commissioner and attorney general have indicated they intend to use. California has a statute which requires that the commissioner must disapprove a policy if its benefits are "not sufficient to be of real economic value to the insured." CAL. INSURANCE CODE § 10291.5(b) (7).

¹⁰⁹ In an article addressed primarily to the medical profession, Dr. G. W. Wheatley, vice-president, Metropolitan Life Insurance Co., said, "In setting his fee, the physician should know the effect of raising it merely because insurance benefits are available. This is one of the most potent inflationary factors in the rising cost of professional care. Insurance plans can never hope to keep pace with this escalator technic. The danger that such a practice can price the voluntary plans out of the market is very real . . . if this should happen, national compulsory health insurance . . . will rush into the vacuum so made. Employers may also become discouraged in their efforts to solve this problem by voluntary means . . . [T]hey could find it very easy to throw in the sponge and let the Government—meaning all the taxpayers—meet the cost of medical care . . . It can happen here, if individual physicians and other interested parties do not assume their proper responsibility for the success of present private efforts." *Voluntary Health Insurance—Progress & Problems*, 257 N.E. JOUR. MED. 118-20 (1957).

riers, one large company has announced a policy of promoting service-type health insurance in the face of medical opposition.¹¹⁰

C. Hospitals and Doctors

Tighter regulation of the carriers almost inevitably implies closer public scrutiny of the suppliers of care. This was illustrated in the Philadelphia Blue Cross rate decision. Most of Commissioner Smith's strictures on economy were directed not at Blue Cross but at the hospitals. Harry Becker of the National Blue Cross Association has pointed out that "public hearings and legislative investigations [of hospital costs] have become common occurrences. Since . . . January [1958] these hearings and investigations have been newspaper copy in at least one out of [every] five states. Before the end of the year, the costs of hospital care may well be a subject for public review in well over half the states." He explains, "Hospitals have entered a new economic era. The costs of hospital care are no longer financed by the sick paying for care . . . but by the well making budgeted monthly payments throughout their adult life." Thus, "hospital costs have shifted from a private matter to one of general public concern, with public officials expressing a vested consumer point of view."¹¹¹

The responsible attitude of the AHA towards hospital costs and their relation to the future of voluntary health insurance has been indicated. Health insurance now pays fifty percent or more of all general hospital bills.¹¹² Leaders of American Dental Association have also displayed receptivity to change in the organization and financing of medical care.¹¹³ The main resistance now appears to come from state and local medical societies.

In earlier years when the threat of governmental health insurance was imminent, the medical profession played an affirmative and constructive role in creating B.S., W.P.S., HIP, W.M.S., and other voluntary institutions which helped persuade the American people that physicians' services could be satisfactorily insured through private instrumentalities. All of these early programs were based on the "service" principle.

But the doctors now feel they have eliminated the threat of govern-

¹¹⁰ Nationwide Mutual Insurance Co. has adopted the following policies: "[A] development program for encouraging and developing comprehensive medical care prepayment plans, under which medical care would be provided by doctors associated together in group practice" and a policy of taking mortgages on property of and making loans to "cooperatively organized medical care plans." The company has already taken a mortgage on a Detroit hospital. Interview, R. A. Rennie, vice-president, Dec. 6, 1957.

¹¹¹ *Hospital Care Becomes a State-Regulated Industry*, Medical Economics, April 28, 1958, pp. 47-48.

¹¹² In many short-term general hospitals it accounts for two-thirds of all payments.

¹¹³ See, for example, keynote address by Dr. H. Hillenbrand, secretary, Am. Dental Ass'n, at 7th Natl. Dental Health Conf., 1956, *Dentistry's Responsibility in the Changing Socio-economic Pattern*, 54 J. AM. DENTAL ASS'N 164-67 (1957).

mental health insurance. They have prospered under present arrangements and they are highly confident. Many state and local societies are taking an uncompromising position for return to traditional fee-for-service practice and, gradually, are sloughing off the responsibilities they assumed earlier. Many appear determined to abandon the service principle in favor of indemnity. Fee schedules, the one device which might give indemnity insurance a chance to work, are increasingly opposed. Presumably they see immediate financial advantages while overlooking long-term hazards.

The societies also seem to have redoubled efforts to prevent the spread of lay-sponsored prepayment plans. In Kentucky, Colorado, Pennsylvania, and Illinois, state societies are locked in combat with the UMW Fund ostensibly over the "free choice" issue. But, again, more than one "freedom" is involved. In Colorado, two doctors, who were denied membership by the county society because of their UMW practice, have sued for \$75,000 each for "compensatory and punitive damages." They are charging the society with a conspiracy to "restrain trade in the practice of medicine."¹¹⁴

There are powerful counter-forces within the medical profession and many influential voices have been raised in warning against the pitfalls inherent in adamancy.¹¹⁵ And there are signs that an increasing sector of the profession is not in accord with "official" views.¹¹⁶ For many doctors, as with the hospitals, insurance has become an indispensable financial underpinning. Over forty percent of all surgeon fees and perhaps one-fifth of private expenditures for all doctor bills now come from health insurance. With so large a stake in insurance the doctors, who are realists, may again, as in past crises, embark upon a policy of "enlightened self-interest." Dr. Lowell Coggeshall, president, Association of American Medical Colleges, anticipates this:

"Originally group practice prepayment plans were . . . actively opposed by organized medicine. Although there is still opposition . . . there is every reason to believe that prepaid group practice will continue to grow. Some

¹¹⁴ Medical Economics, Feb. 3, 1958, pp. 44-49.

¹¹⁵ In an impassioned warning to his medical colleagues, Dr. L. J. Raider, vice-president, United Medical Service of N.Y., biggest Blue Shield plan in the country, compared voluntary health insurance to the "phililoo bird," a mythical creature that flies forward but looks backward and always ends in trouble. The doctors, he said, are so bemused with victory over compulsory health insurance that they fail to see the danger ahead. Blue Shield is threatened with collapse. Indemnity insurance can be sold cheaper through experience rating. If service plans go, he added, consumers will never be satisfied with indemnity and this will lead to government in medicine. Medical Economics, Sept. 1957, p. 274.

¹¹⁶ For example, in a 1954 AMA survey of doctors, on a question regarding control of society-approved plans, a surprising 49% of respondents said there should be as many laymen as doctors on boards of directors. COMM. ON PREPAYMENT MEDICAL & HOSPITAL SERVICE, SUMMARY OF PHYSICIANS' ATTITUDES TOWARD VOLUNTARY HEALTH INSURANCE 20 (1955). In other situations, the AMA appears as a moderating influence on embattled local societies. See, e.g., J. R. Lindsey, *Medicine vs. The Mine Workers*, Medical Economics, July 21, 1958, pp. 73-160.

opponents have viewed it as a road to 'socialized medicine.' Actually . . . such plans have been conducted with a maximum of professional independence Prepayment, with restrictive provisions to prevent abuse, will be more and more the pattern. Rather than establishing an opening wedge for 'socialized medicine' professional groups by sharing in the planning or management, will be safeguarding against such an eventuality."¹¹⁷

Dr. Russell Lee of Palo Alto, long-time leader in the field, has even more firmly predicted organized medicine's acceptance of the inevitable: "Within twenty-five years almost all the medicine in the country will be practiced in prepayment groups."¹¹⁸ As if to fortify Dr. Lee's appraisal of the trend, only a month later Dr. Blasingame, the new general manager of the AMA, lifted many an eyebrow among the state societies by saying, "I believe in experimentation. I'm not opposed to group practice plans with prepayment arrangements. I'm not opposed to lay-sponsored plans. I'm not opposed to labor plans. In the long run, they'll *all* help to solve medicine's economic problems."¹¹⁹

Clearly there is a ferment in medical opinion as the facts of medical economics penetrate the doctors' busy daily routines. It is too early to predict which attitude will prevail. But the factors favoring the more flexible position are legion. Paramount among these is the influence of science and technology. "The form of medical practice is ultimately shaped by the technical facts."¹²⁰ The trends described with respect to the technology of medicine indicate that the views of state and local societies are less and less consonant with actual practice and it is unlikely that this can continue indefinitely.

Equally important are the basic intellectual traditions of the profession. The "great tradition" in medicine is associated with men like Paré, Harvey, Pasteur, Lister, Semmelweis, Osler, and Gregg, men who demonstrated the capacity and the courage to move forward in the face of the hostility or indifference of their colleagues. "The great tradition in medicine is in large part a tradition of commitment to the search for improved, and therefore *changing*, ways of coping with the problems of the sick."¹²¹

¹¹⁷ *National Health—Sociological Aspects*, pp. 66-67 (1956, mimeo.).

¹¹⁸ "The pressure for comprehensive care on a prepaid basis is going to be impossible to resist. That's the way the customers want it and that's the way they're going to get it. If organized medicine doesn't accept the idea, you'll see a lot of M.D. mavericks who will. But organized medicine is smart. It's slow and conservative, but it's not stupid. In time it's sure to accept some modified pattern of prepaid group practice. I feel certain that within twenty-five years almost all the medicine in the country will be practiced in prepayment groups. If it isn't, we'll have state medicine." *Medical Economics*, Nov. 1957, p. 144.

¹¹⁹ *Medical Economics*, Dec. 1957, p. 140.

¹²⁰ S. TAYLOR, *GOOD GENERAL PRACTICE* 550 (Oxford, 1954). Dr. Taylor adds, "[I]n the long run, man's desire for self-preservation forces through the necessary alterations."

¹²¹ R. K. MERTON in MERTON, READER & KENDALL, *THE STUDENT-PHYSICIAN* (Bureau of Applied Social Research, Columbia Univ., 1957).

D. Expansion of Public Medical Care Programs

While private health insurance has been burgeoning in spectacular fashion, publicly financed medical programs have also continued to expand. Considering the field of personal health services alone—excluding all community public health activities—the rate of government increase has slowed down markedly since the Depression years and, in the past few years, voluntary health insurance has increased at a faster rate than public expenditures. However, in 1956, the latter still accounted for 21.4 percent of all personal health services as compared to 18.9 percent for private insurance.¹²²

Few people would maintain that either government or voluntary health insurance should finance the entire cost of personal medical care. In a high income economy such as ours consumers may rightly be expected, and will wish, to pay directly a portion of the costs just as they do in connection with other contingencies in which they are protected by social and private insurance. However, the pieces must add up to a satisfactory composite. To the extent that the major current problems of medical care financing are not met through voluntary health insurance, that is, through voluntary spreading of costs, we can expect increasing pressures for compulsory spreading of costs through the use of governmental powers. The relationship between the adequacy of private insurance and popular demand for public intervention has repeatedly been demonstrated.

There are many other forces continually pressing government toward action in the health field. Many essential medical services already depend on the government for indispensable financial aid. These include education, research, hospitals for mental and most long-term chronic illness, and, to an increasing extent, even the short-stay general hospitals, those which have most profited from voluntary insurance.¹²³

Of paramount significance to the role of government is the fact that we are living in a quasi-mobilized society. There are now 23 million veterans and a military establishment of more than 2½ million with 2 million

¹²² In 1929, about 8.7% of personal health services was financed by government; in 1940, 16.9%; and in 1949, 19.4%. The proportion met by private insurance in 1949, the first period for which comparable data are available, was 7.4%. Merriam, *Social Welfare Expenditures in the U.S., 1955-56*, Soc. Sec. Bull., Oct. 1957, p. 11.

¹²³ In 1955, nearly 44% of all U.S. hospital income came from tax sources. W. J. Cohen, *The Forand Bill*, 58 AM. JOUR. NURSING 702 (1958). In his 1957 presidential address to the American Hospital Ass'n, Dr. A. W. Snoke advocated additional government payments for the "indigent and medically indigent." Hospitals, Oct. 16, 1957, pp. 42-43. Dr. Rufus Rorem, exec. sec., Phila. Hospital Council, places major reliance upon increased government payments for public assistance beneficiaries as a means of stabilizing hospital income. Hospitals, March 1, 1957, p. 36.

dependents.¹²⁴ We have established a tradition of "socialized medicine"¹²⁵ for those with past or present military connections. The proportion of the population made up of veterans and their families will continue to grow, and their privileges are not likely to be reduced.

Meanwhile, as almost every proposal to permit government to employ or encourage the insurance mechanism¹²⁶ is defeated,¹²⁷ programs financed out of general revenues expand. These include public health programs, in which over half the expenditures now go for personal health services,¹²⁸ medical care for public assistance recipients,¹²⁹ and vocational rehabilitation.¹³⁰ Indeed, the conspicuous trend toward liberalized interpretation of

¹²⁴ Expenditures for veterans' hospital and medical programs amounted to \$730 million in 1955-56. Soc. Sec. Bull., Oct. 1957, p. 11. Defense Dept. expenditures for medical care for armed forces, retired military personnel and members of Congress now average \$260-270 million per year. *Id.* at 10. Medicare costs for dependents of military personnel reached an unexpected \$87 million in fiscal 1958, the first full year of operation. Office for Dependents' Medical Care, U.S. Dep't of Defense, *Distribution of Hospital and Physicians' Claims by State*, Aug. 1958, p. 3.

¹²⁵ This controversial term is generally used by experts in medical economics to refer to medical care paid for in full or in large part by tax funds and usually dispensed by salaried government doctors. The veterans' medical care program is the outstanding example in the U.S. It may be contrasted with public health insurance, which is financed in full or in large part by contributions by or on behalf of the patient. The insured care is usually provided by private physicians generally reimbursed on a contractual basis.

¹²⁶ There are a few non-federal public health insurance programs: the medical care provisions of workmen's compensation laws; the provision in the California temporary disability law for partial reimbursement of hospital costs; a little-used provision in the N.Y. temporary disability law permitting the substitution of "actuarially equivalent" hospital or medical benefits for a portion of the statutory cash wage loss payments; and public employee programs in a few cities and states. One of the most interesting is the New York State program (N.Y. INSURANCE LAW § 461 (1956) for its 80,000 employees and their dependents. See U.S. Soc. Sec. Admin., Dept. Health, Educ. & Welfare, Research and Statistics Note 32, Sept. 1957. Most of these are financed through private carriers.

¹²⁷ Among these were the \$25 million reinsurance corporation proposed by the Eisenhower Administration in its first term, proposals for federal participation in financing construction costs of private medical clinics and health centers with prepaid membership, and federal subsidies to private health insurance carriers to help them to cover the poorer risks. For a digest of all proposed federal legislation in this field in recent years, see BREWSTER & ORTMAYER, *HEALTH INSURANCE AND RELATED PROPOSALS FOR FINANCING PERSONAL HEALTH SERVICES* (U.S. Soc. Sec. Admin., Dept. Health, Educ. & Welfare, prelim., mimeo., 1957).

¹²⁸ Public health expenditures in 1955 were \$3.3 billion of which \$3 billion came from state and local funds. Almost \$1.8 billion went for hospital and medical care in mental, tuberculosis and general hospitals. Soc. Sec. Bull., Oct. 1956, pp. 4, 6.

¹²⁹ 1956 amendments to the Social Security Act (Pub. L. No. 880, 84th Cong., 2d Sess., codified in scattered sections 42 U.S.C. (Supp. V, 1958)) include extension of federal funds to encourage expanded state medical care for the 6 million beneficiaries on grant-in-aid programs, the aged, the blind, the permanently and totally disabled, and dependent children. In 1955-56, before the amendments, combined expenditures for this purpose were \$253 million. For a state-by-state analysis, see GREENFIELD, *MEDICAL CARE FOR WELFARE RECIPIENTS* (Univ. Cal., Bur. of Publ. Adm., 1957). For California's new implementing program, see tenBroek, *California's New Medical Care Law and Program*, in this issue of the California Law Review.

¹³⁰ The main civilian vocational rehabilitation program is operated under 29 U.S.C. §§ 31-38, 41-44. Federal-state expenditures for medical rehabilitation under this program were \$11 million in 1955-56.

"medical indigency"¹³¹ and greater use of tax funds have led the past president of the American Economic Association, a distinguished specialist in this field, to claim that in the effort "to avoid compulsory health insurance" the U.S. is "moving rapidly in the direction of socialized medicine."¹³²

E. A Pluralistic Approach

As in all American social security patterns, the ultimate design in the financing of medical care will remain highly pluralistic. Even the old age field, where the federal government conducts what is probably the largest social insurance operation in the world, is widely shared by a variety of public and private instrumentalities: the Old-Age, Survivors, and Disability Insurance program (OASDI), a national system of federal-state old-age assistance, individual private life and retirement insurance, industrial group life insurance and pension systems, and a host of other public and private programs. Such diversity is typical of most aspects of American life.

The participation of government does not necessarily diminish the role of private agencies but may, on the contrary, create possibilities for general expansion. Insurance officials acknowledge, for example, that the basic security offered by public programs has greatly contributed to the growth of private retirement and life insurance.¹³³ Various experts have suggested that private health insurance might profit in the same manner from the institution of a limited system of public health insurance which, by means of compulsory contributions, could finance economically the minimal health needs of the aged and other "poor risks," leaving to private insurance the job for which it is better equipped, more comprehensive care for the bulk of the population.

One widely discussed possibility was the recent congressional proposal

¹³¹ According to the Pennsylvania Secretary of Welfare, considerably more than half of those who need help in paying for hospital care have adequate income for other needs and are not eligible for public assistance. A University of Pennsylvania Committee set up to study this problem recommended a state-supported program for the purchase of hospital care for this group of "medically needy." *TAX-SUPPORTED MEDICAL INSTITUTIONAL CARE FOR THE NEEDY AND MEDICALLY NEEDY OF PENNSYLVANIA* 11 (1957), and introductory letter therein from H. Shapiro.

¹³² E. E. Witte, *The Future of Social Security*, p. 6 (address, Mich. State Univ., Jan. 1957, mimeo.).

¹³³ The Director of Life Insurance Information of the Institute of Life Insurance writes: "The creation of the government benefit program has not diverted large segments of the insuring public away from insurance but has on the contrary increased the number of persons turning to insurance for amplification of the sustenance base provided by the plan. This trend has been seen with the introduction of each new project for mass protection. When the Social Security Act was adopted in 1935 it was widely predicted that life insurance, especially industrial life insurance, would be seriously curtailed. In fact, the life insurance in force has more than tripled in the intervening years, and even industrial insurance has increased to 2½ times the 1935 aggregate." C. C. Nash, *The Contribution of Life Insurance to Social Security in the United States*, 72 *INTERNATIONAL LABOUR REV.* 24-25 (1955).

to add insurance against the costs of hospital, nursing home and surgical care to the OASDI program. Insured men over 65 and women over 62, whether retired or not, and surviving dependents of insured workers would be eligible. Services would be provided on a "free choice" basis by institutions under contract with the U.S. Department of Health, Education and Welfare.¹³⁴

Opinion on the Forand Bill was sharply divided. The AFL-CIO, the American Public Welfare Association and other social work groups enthusiastically endorsed it. The AMA issued a call to arms against it.¹³⁵ The American Hospital Association, caught in a difficult position, issued an ambiguous policy statement opposing the Forand Bill and "the use of compulsory health insurance for financing hospital care even for the retired aged." At the same time, it reiterated its 1955 stand that "federal legislation will be necessary to solve the problem" of financing the hospital needs of the retired aged satisfactorily, and that "the use of Social Security to provide the mechanism to assist in the solution . . . may be necessary ultimately."¹³⁶

If some such limited public insurance is not eventually made available and private carriers fail to meet the major challenges described, far-reaching alterations in the financing and organization of medical care seem inevitable. Most likely, and already under way, is a rapid increase in public regulation and control of health insurance. Another possibility is its transformation into the workmen's compensation pattern, combining compulsory coverage and statutory benefits with private financing.¹³⁷ Always in the background is the possibility of renewed demand for general compulsory public health insurance, whose potential attraction will continue to vary with the demonstrated capacity of private health insurance to meet conspicuous needs.

¹³⁴ H.R. 9467, 85th Cong., 1st Sess. (1957) (Forand Bill). This bill proposed up to 60 days of hospital care in any 12 month period plus nursing home care, after hospital discharge, up to a combined total of 120 days. Surgical benefits included all in-hospital procedures and minor surgery on an outpatient basis. The medical aspects of the Forand Bill died in the House Ways and Means Committee, July 1958.

¹³⁵ "The president of the AMA described as 'socialized medicine' today plans to provide hospital and medical benefits for the aged under the Social Security program. Dr. David B. Allman . . . AMA president, called for the nation's physicians to fight against this [proposal] just as they had fought Oscar Ewing's national compulsory health insurance a decade ago." R. K. Plumb, New York Times, Dec. 4, 1957, p. 32, col. 4.

¹³⁶ *Statement on Financing of the Hospital Needs of the Retired Aged*, approved by Board of Trustees, AHA, Nov. 27, 1957. There was some insurance carrier support for a program which would utilize OASDI machinery for collection of premiums but would provide benefits on a cost-plus basis through existing insurance institutions.

¹³⁷ Among those who foresee this line of development, albeit with grave misgivings, is Dr. Dean A. Clark, director, Mass. General Hospital. See his *Where does the Nation's Health Stand Today?* MILBANK MEMORIAL FUND, SELECTED STUDIES OF MIGRATION SINCE WORLD WAR II at 236 (1958).

In any case, it may be reiterated, short of atomic attack or other major catastrophe which might force government to mobilize all private resources, neither voluntary nor public institutions can preempt the field. The nature of the relationship between the public and private sectors is still very much an open question.

CONCLUSIONS

While most health insurees are compensated for only a moderate proportion of their medical expenditures, about one-quarter on the average, the importance of this protection has been very great in supplying to the insured population a sense of basic security in regard to the most dreaded of unpredictable family costs. In recent years Americans have become more intelligently health conscious than ever before and a greater proportion have become acquainted with good medical care. Whatever the present shortcomings of voluntary health insurance, there should be no depreciation of the substantial achievements to date.

But these very achievements, together with changing demographic and morbidity patterns, are rapidly altering the need and demand for medical care. Arrangements which represented progress only a few years back are no longer adequate nor appropriate. The currently dominant pattern of health insurance—hospital plus surgical coverage on an indemnity basis—is becoming obsolete. This is one reason that health insurance is becoming inordinately expensive.

The rising demand for more "comprehensive" benefits is consonant with the needs of a population with an increasing number of aged, increasing incidence of chronic illness, and a growing recognition of the need for continuous health maintenance as opposed to concentration on episodic care. In the nature of our society, it can be predicted that in one way or another this demand will eventually be met. If voluntary health insurance is to survive as a major instrument for financing medical care it must solve the problem of providing more extended services and means must be found, either through private insurance or otherwise, to furnish protection to the aged, the chronically ill and other "poor risks," as well as the short-term unemployed.

The principal barriers to such goals now appear to be primarily cultural and political rather than technological or economic. From the actual operational experience of private health insurance a number of facts, which were unknown or in question only a few years ago, have clearly emerged:

1. The hospital utilization rate, which has a crucial effect on the cost of hospital insurance and which has been accelerating at a disturbing pace, can be kept within insurable bounds without artificial restrictions or damage to medical care, by avoiding the present built-in incentives for non-

essential utilization. Health insurance enrollees with comprehensive coverage utilize only 60–80 percent as many hospital days as those with hospital-surgical coverage only. The comprehensive plans have demonstrated that the present distorted two to one ratio of hospital to medical insurance expenditures can be substantially reversed. If the minority pattern could be generalized, the problem of hospital insurance costs might be solved on a voluntary basis, while simultaneously serving other desirable objectives, *e.g.*, more prevention and rehabilitation.

2. Recognition of the desirability of moving toward the goal of comprehensive medical care insurance implies no neglect of hospital-surgical coverage. On the contrary, the great progress achieved in this area in the past two decades must be preserved, not frittered away, through abuse, inflation or public misunderstanding. Institutions like Blue Cross, which have demonstrated their social utility, will be strengthened by a closer attention to overutilization, costs and the promotion of outpatient insurance. Of primary importance is the recognition of B.C.'s "public utility" role and the needed increase in public and consumer representation on its policy-making bodies. This should help to strengthen B.C.'s control over costs, its ability to preserve its service-benefit structure and to expand its benefit coverage.

3. The next step toward the goal of comprehensive medical care insurance—coverage of outpatient physicians' services—is clearly feasible. Such insurance can be provided at a price which the average consumer can and is willing to pay.¹³⁸ Consumers are willing to accept co-insurance, extra charges, and other reasonable cost controls if the suppliers of services demonstrate equal willingness to accept some controls and economy measures.

At the heart of the matter lies the development of service as opposed to indemnity plans. The former provide the better means for quality as well as cost controls. Group practice, either in private clinics or hospital outpatient departments, today offers the best promise of combined efficiency and quality in medical care. In some parts of the West and North Central states, it is already the dominant form of medical organization and it lends itself well to prepayment service programs. However, solo fee-for-service practice, which will continue to attract many doctors and patients, although probably as a minority pattern,¹³⁹ can also be satisfactorily organized on a prepayment basis provided the profession is willing

¹³⁸ In the early days of Windsor Medical Service, the directors feared that the comprehensive plan might seem too expensive to most people and offered a limited plan for \$30 a year per family of four compared to the \$95 premium for the comprehensive plan. By 1955, the comprehensive plan had 191,000 enrollees; the limited plan about 1,000. N. Sinai in *HEALTH INFORMATION FOUNDATION—ITS EIGHTH YEAR—1957*, 24.

¹³⁹ See, for example, Dr. Gunnar Gunderson (incoming president, AMA), *Groups Give Patients More for Their Money*, *Medical Economics*, May 26, 1958, pp. 84–90.

to accept and abide by fixed fee schedules and effective professional supervision. Essential to the successful coverage of physicians' services on a voluntary basis is professional self-discipline by doctors and other suppliers of services through formal or structural means.

4. The fast changing technology and environment of medical care will continue to require continuous adjustments in organization and financing. No particular forms will prove universally and perpetually correct. It is therefore indispensable for success that freedom for experimentation in the application of technological and administrative advances be assured. The present legislative and other restrictions on such freedom are creating an impasse which threatens the capacity of voluntary health insurance to cope successfully with its present challenges. In fact, positive incentives and aids to advance the development of new types of outpatient institutions and services may now be necessary to help overcome the effects of the long hostile environment. Financial aid, in the form of governmental or foundation grants or loans is needed for the construction of such new facilities, including group practice clinics.

5. There is still an opportunity for private health insurance to cover a substantial proportion of those now excluded from protection if the overall benefit emphasis is shifted from hospitalized to non-hospitalized illness, as suggested, if group insurance techniques can be further extended to these groups, *e.g.*, through group conversion policies for the retired and longer coverage for the temporarily unemployed, and if costs are better spread through wider risk-sharing. Essential to success in this respect is the curtailment of experience rating and a deliberate return to the principle of community rates.

If this cannot be done and if the coverage of the aged and other "poor risks" is indeed unfeasible under voluntary insurance methods, then the sooner acknowledgment of that limitation is made and other desirable means of filling the gap are found, the better private health insurance will be able to do the remainder of the job.

If the aged and other excluded groups continue to be squeezed between the mounting costs of health care and the non-availability of voluntary health insurance it seems probable we will move towards some form of public social insurance for this segment of the population. The most likely immediate approach appears to be extension of the OASDI program to provide hospital and surgical care for the aged and dependent survivors, and perhaps eventually to the disabled. Self-interest may induce the private carriers to endorse such a public program as a way "off the hook." If a limited program is denied and the vacuums remain, the pressures for a more extensive government program may multiply.

In the crucial stage of evolution immediately ahead voluntary health insurance may determine its own role and, indirectly, the role of government for many years to follow. If the voluntary programs can succeed in taking the bold steps which offer some promise for coping with current and increasingly apparent inadequacies, the government role may continue in more or less the same pattern as at present. Otherwise the growing volume of consumer demand coupled with the financial crises of hospitals, medical schools, and other branches of medicine will lead to greater government intervention. At the moment the power of decision still rests to a major extent with the providers of service and the insurance carriers. If they default or fail, the major influence in public policy determination may move into other hands.