LEGISLATIVE PROPOSALS FOR COMPULSORY HEALTH INSURANCE

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The Wagner National Health Bill¹ provides in Title XIII for federal aid to state general medical care programs. The language of this title is sufficiently broad so that states setting up compulsory health insurance or comprehensive tax-supported public medical care systems (or more limited programs) would be entitled to financial assistance from the federal government in carrying on these programs provided certain specified requirements are met. This financial assistance would amount to between one sixth and one third of the total expenditures under the state program depending upon the relative financial resources of the state.

The purpose of this article is to examine legislative proposals which have been made for state compulsory health insurance and to discuss certain of the issues involved in programs of this type.

During the past three years, bills for compulsory health insurance have been introduced in a considerable number of states. The majority of these bills are identical, or approximately so, with the "model" state bill for health insurance prepared by the American Association for Social Security. In the writer's opinion, only four state bills for compulsory health insurance have thus far been introduced which are sufficiently different to warrant separate examination and discussion. These are the "model" bill of the American Association for Social Security;² the bill drawn up in California by the Governor's Committee on Health Insurance and introduced jointly by a considerable number of the members of the legislature;³ the bill introduced in the New York Assembly in 1939 by Assemblyman Robert F. Wagner, Jr.;⁴ and the bill introduced in the Wisconsin Assembly in 1937 and, with a few slight changes, in 1939, by Mr. Andrew Biemiller.⁵

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The opinions expressed in this article are the writer's and are not to be taken as representing the views of the Social Security Board.

¹ S. 1620, 76th Cong., 1st Sess. (1939).

² The bill was prepared by the Association in cooperation with leading authorities, including interested practitioners. The drafting of the bill was done principally by Professor Herman A. Gray of the New York University Law School.

³ Calif. Ass. B. No. 2172, as amended April 14, 1939.

⁴ N. Y. Ass. B. No. 2726. Assemblyman Wagner first introduced his health insurance bill in 1938. The 1939 bill differs from the earlier bill in some important respects.

⁵ Wis. Ass. B. No. 807A.

These four bills will now be examined in detail. Parenthetically, it may be said that none of them has been enacted and only one—the California bill—received detailed legislative consideration. This bill had the support of the Governor and was actively debated in the legislature. It was defeated in the Assembly by a vote of 48 to 20.

THE "MODEL" BILL OF THE AMERICAN ASSOCIATION FOR SOCIAL SECURITY

The "model" bill of the American Association for Social Security would establish a state-wide system of compulsory health insurance covering all employees subject to the state's jurisdiction except (a) those engaged at other than manual labor receiving in excess of sixty dollars a week, and (b) farm laborers, and domestic servants in households having less than three servants.

The cost of this system, equivalent to a total of 6% of pay rolls in covered employments, is to be borne jointly by employers, employees and the state. Employers contribute 3½% of wages in the case of employees receiving \$20 a week or less, 2½% in the case of employees receiving more than \$20 but not exceeding \$40 a week, and 1½% in the case of employees receiving over \$40 a week. The contributions of employees vary in reverse fashion. Employees receiving less than \$20 a week pay 1% of wages, those receiving \$20 to \$40 a week pay 2%, and those receiving over \$40 a week, 3%. These contributions are to be deducted from wages by the employer. It is seen that in each case the total of employer and employee contributions amounts to 4½% of wages and that, on the whole, employers pay slightly higher contributions than employees. The state government is to contribute to the system an amount equal to 1½% of pay rolls.

Three types of benefits are provided: medical, disability and maternity benefits. The first consists of medical services provided in kind; the last two of cash payments.

Medical benefits consist of the services of general practitioners and specialists, laboratory and clinic services, hospital care including nursing service in the hospital, and dental care—the latter being limited to extractions, plastic fillings, prophylactic care and such other services, including restorative work, as may be necessary to correct conditions seriously prejudicial to health. These services, available to both qualified employees and their dependents, are denoted as the "regular" medical benefits. The Health Insurance Commission, at its own discretion and to the extent it deems advisable, may also provide drugs and medicines, nursing service outside the hospital, institutional care for convalescents, eyeglasses, orthopedic and other appliances, and other forms of dental care beyond those included under the "regular" benefits. The Commission may provide these "additional" benefits without charge to insured persons and their dependents, or may require that part of the cost shall be borne by them.

The furnishing of medical benefits begins three months after contributions accrue and become payable. After the system is in operation, an employee is entitled to medical benefits for himself and his dependents if he has had not less than 10 days of employment or voluntary medical insurance within the three months preceding

the day on which he or any dependent requests medical attention. Eligibility continues so long as the employee remains in covered employment. If he leaves covered employment or becomes unemployed, he and his dependents remain qualified for medical benefits for a period equal to one day for every five days of employment or of voluntary medical insurance during the preceding five years.

Certain restrictions are laid down concerning the length of time for which medical care will be provided in any one illness. Hospital care will not be furnished for any one illness or injury for more than 111 days in all, of which the first 21 are to be without charge, the recipient thereafter paying 15% of the cost. With respect to disabling illnesses, employees are entitled to receive general practitioner care and the stipulated dental services for a maximum of 26 weeks in any one illness, but specialist, laboratory and clinic services for not more than 12 weeks. Apparently, there are no restrictions on length of care in non-disabling illnesses. Nor apparently are there any restrictions on the length or amount of care, except hospital care, which dependents may receive so long as the employee remains in covered employment. After leaving covered employment, the period of time for which an employee or his dependents may receive care in connection with any one illness or injury is limited to 26 weeks for general practitioner medical and dental care and 12 weeks for specialist, laboratory and clinic care.

The bill also provides for the payment of cash benefits in the event of disability or maternity.

Cash benefits, payable for each day of wage loss due to disability after a waiting period of five working days, are to be paid at a rate of 50% of the employee's full-time daily wages but with a maximum of \$15 a week. The benefit would be increased by an amount equal to 10% of the full-time daily wages but not beyond \$3 per week if the employee had a dependent spouse; and 5% of the full-time daily wage but not beyond \$1.50 a week, for each dependent child not exceeding three. An employee with a dependent spouse would thus receive a benefit equal to 60% of full-time wages but with a maximum of \$18 per week, and one with a dependent spouse and three or more dependent children would receive a benefit equal to 75% of full-time wages but with a maximum of \$22.50 a week.

To qualify for these cash benefits, an employee must have had not less than 104 days of employment or of voluntary cash insurance within the 12 months preceding the day on which cash benefits are to commence or not less than 160 such days within the 24 months preceding that day.

The employee would be entitled to cash benefits for a maximum of 156 cumulative days of wage loss within any period of 52 consecutive weeks. When the right to benefits has been exhausted on account of this provision, the employee cannot draw further benefits unless he has had 60 days of employment or of voluntary cash insurance subsequent to the termination of his benefits and, in addition, is able to meet the original qualifying conditions.

When an employee becomes unemployed or ceases being engaged in covered

employment, his qualification for benefits remains effective for an extended period equal to one day for every five days of employment or of voluntary cash insurance during the preceding five years. If he becomes disabled during this extended period, he is eligible for benefits on the same basis as an employee who had continued in covered employment.

The furnishing of cash benefits begins six months after the date on which contributions accrue and become payable.

Maternity benefits equal in amount to the benefits payable in disability would be paid to qualified women for six weeks before and six weeks after the birth of a child. To obtain this benefit, the woman must abstain from gainful work during the period for which it is payable and must have had not less than 250 days of employment or of voluntary cash insurance during the two years preceding the day on which the benefit is to commence. This regular maternity benefit is to be payable even though an employee has exhausted her rights to cash disability benefits and receipt of the former benefit does not exhaust her rights to the latter. A woman employee who becomes unemployed or leaves covered employment remains qualified for maternity benefits on the same basis as for disability benefits.

An added maternity benefit of \$15, payable on the birth of the child, is also given on condition that proper prenatal care shall have been received. This added benefit would be payable to a qualified woman employee, to the wife of a qualified employee, or the widow of such employee providing the child be born within 10 months of his death.

It will be remembered that contributions aggregate 6% of covered pay rolls. Of the funds thus raised, three fourths are earmarked for provision of medical care and the remaining one fourth (*i.e.*, 1½% of pay rolls) is to be used to pay the disability and maternity benefits.

Systems of voluntary disability and medical care insurance are set up for persons with limited incomes who are not covered by the compulsory system. Employees in noncovered employments whose wages are \$60 a week or less, and who have not reached 65 years of age, are entitled to subscribe for voluntary cash disability and maternity benefits. Such persons pay contributions equal to 1½% of their wages and may receive in return the same disability and maternity benefits as compulsorily insured persons, and under the same provisions with respect to qualifications, waiting period, duration of benefits, etc. Employees voluntarily subscribing to disability and maternity benefits may be required to pass a health examination; however, no examination is to be required of any person who, within the preceding three years, has had not less than 260 days of covered employment or of voluntary cash insurance.

On a somewhat similar basis, a system of voluntary insurance for provision of medical care is established. This system is open to self-employed persons, not merely to those working as employees as in the case of the voluntary disability and maternity benefit insurance. Entitled to subscribe to this insurance are any residents of the state whose net income from whatever source is \$60 a week or less, or whose net income

does not exceed \$100 a week, provided they have had within the three preceding years not less than 260 days of covered employment or of voluntary medical insurance. Persons also may subscribe, regardless of income, who are at the time unemployed but who have had not less than 260 days of covered employment or voluntary medical insurance within the preceding three years. Voluntary subscribers pay contributions equal to $3\frac{3}{8}\%$ of their income—in the case of unemployed persons, $3\frac{3}{8}\%$ of average weekly income during the preceding three years. Eligible also are any residents receiving old-age or unemployment benefits, or relief, from any governmental or public agency. Each such agency may insure their beneficiaries by paying such amounts as the Commission may fix.

Those taking out this voluntary medical insurance and their dependents are entitled to medical benefits on the same basis as compulsorily insured persons and their dependents.

These voluntary insurances are subsidized to the same extent as the compulsory system, *i.e.*, the state is to contribute amounts equal to one third of the aggregate contributions paid by voluntarily insured persons.

For an additional premium, the Commission may provide additional medical benefits to voluntary subscribers. The premium for these additional benefits is to be fixed so that the persons desiring them will pay the full cost of these benefits.

The health insurance system is to be administered by a "Health Insurance Commission" composed of five persons: the Commissioner of Health Insurance, the State Commissioner of Health, and one representative each of employers, of employees, and of the professions engaged in furnishing the medical benefits. The Commission is to be advised by a State General Advisory Council representative of employers, employees, the public and the professions rendering service, and in addition by a State Medical Advisory Council representative of the main professions or groups concerned with the provision of medical care.

The bill does not specify closely the arrangements for the provision of medical care. It is specified that all duly qualified *general* medical and dental practitioners are to be entitled to render services under the system, and that insured persons are to be free to choose from amongst the participating practitioners in each locality, the physicians or dentists by whom they wish to be attended. General medical and dental practitioners may be remunerated in several ways: by salary, by a per capita payment for each person on their list, by fee, or by any combination of these. No mode for remunerating these practitioners shall be adopted for any local area without the consent of a majority of the general medical and dental practitioners furnishing insurance services in that area.

With respect to the provision of specialist services, nursing care, hospital care, laboratory services, etc., no precise arrangements are stipulated and each local council, subject to the supervision, direction, control and approval of the Commission, may furnish these services through such arrangements as it deems best.

The Commission is required to divide the state into a number of health insurance

districts, each with its district financial supervisor and district medical supervisor—the latter a physician. In turn each district is to be divided into a number of local areas, each managed by a local finance manager, and a local medical manager who must be a physician. Each local area is to have a local council composed of the local finance manager, the local medical manager, the local public health officer, one representative of the professions furnishing medical benefits, one representative of employers, and two representatives of employees. Each local council may appoint, with the advice and consent of the Commission, such local advisory committees as it deems necessary. The local councils, under the direction and subject to the review, approval and control of the Commission, shall supervise and direct the payment of disability and maternity benefits and the furnishing of medical benefits.

THE CALIFORNIA BILL

The California bill⁶ has two distinctive features which may be remarked upon at the outset. First, being drafted after the Wagner National Health Bill had been introduced, it was designed so as to take advantage of federal aid under the terms of that bill. Secondly, since California has a functioning system of unemployment compensation, the drafters of this bill faced the concrete and practical problems of coordinating the projected health insurance system, particularly on its cash benefit side, with the existing unemployment compensation system. Whereas the "model" bill had to be general in order to be a model, the California bill represents an attempt to establish a health insurance system coordinated with the particular unemployment insurance system of a particular state.

The bill amends the State Unemployment Reserves Act so as to establish a "system of social insurance, consisting of unemployment and health insurance." The health insurance system embraces both "disability unemployment" and "medical" benefits, and the bill provides that one part of the system is not to be operative without the other. However, the medical benefit part of the system covers a wider population than the disability unemployment benefit plan and, administratively, the former is set up pretty much as a separate unit while the latter is conjoined with the unemployment compensation system. Accordingly, an understanding of the projected health insurance system may best be gained by considering its two parts separately.

The medical benefit part of the system embraces all employees within the state, including state and local government employees, domestic servants, farm laborers and those of high incomes. (The unemployment compensation system excludes domestic servants, farm laborers and employees working for employers with less than 4 workers, as well as a number of other numerically less important occupational groups.) Employees contribute 1% of taxable wages, employers 1% and the state 1%. In each case, taxable wages do not include that part of an individual's remuneration in excess of \$3,000 a year. The amount contributed by the state is to be reduced by any amount received as federal aid from the federal government.

⁶ All the following relates to the amended (April 14, 1939) draft of the bill.

Medical benefits—available to the covered employee and his dependents⁷—are of two kinds: “service benefits” and “reimbursement benefits.” The first are provided to those earning less than, the second to those earning more than \$3,000 a year. Service benefits consist of general practitioner care; stipulated specialist services to the extent permitted by the financial resources of the fund, but in any event to include major surgery, emergency specialist and obstetrical service; laboratory and X-ray diagnostic services; hospitalization up to a maximum of 12 weeks in any year for any one illness; and all drugs and medicines. In addition, nursing care and certain limited dental services are to be provided to the extent permitted by the funds available, and after these services are provided other additional services may be furnished as funds permit.

Reimbursement benefits consist of cash payments to eligible persons in reimbursement of expenditures for medical services. (Presumably the idea of such benefit is that physicians would object to serving persons with incomes over \$3,000 on the same basis and for the same fees as those with incomes under this figure. Under this arrangement, physicians would be free to charge persons with incomes over \$3,000 such fees as were mutually agreeable and the insured person would be reimbursed for part of this cost.) The bill does not specify closely how the medical reimbursement plan is to operate, but leaves it to the governing authority to work it out. Claims for reimbursement benefits are to be filed and such claims allowed in accordance with a prescribed fee schedule. If the total claims in a period exceed the amount set aside for reimbursement benefits, all claims are to be prorated equally. The total funds available for medical benefits are to be apportioned between service benefits and reimbursement benefits on the basis of the number of insured persons eligible to each.⁸

The provisions for determining eligibility for medical benefits are clear. To be eligible for medical benefits in any given “benefit” year, which runs from July 1 to June 30, an individual must have earned at least \$300 in covered employments during the applicable base period, which is the preceding calendar year. In other words, an individual would be eligible for medical care during the period of, say, July 1, 1941, to June 30, 1942, if he had earned \$300 or more in covered employments in the calendar year 1940. He would continue to be eligible during the next “benefit” year if he had earned \$300 or more in 1941.

The bill provides that a system of voluntary insurance may be established for self-employed persons earning less than \$3,000 a year. Voluntarily insured persons are to be entitled to the same service benefits as those compulsorily insured. The rates which they are to pay are to be determined by the governing authority. Persons over 50 would not be eligible to insure voluntarily on an individual basis but such persons may enroll on a group basis. The voluntary system would be subsidized as in the

⁷ “Dependents” are defined to include only the dependent spouse and dependent children under the age of 21.

⁸ I presume this is the intention; the formula set forth in the bill is obscure.

case of the compulsory system—the state contributing amounts equal to 1% of the earnings of voluntary subscribers.

With respect to the arrangements for the provision of medical care, the apparent intention of the bill is that general practitioner service should be rendered through an open panel system, *i.e.*, patients would have free choice of physician for general practitioner service, and all qualified physicians would be eligible to participate. For these services, physicians are to be paid on a per capita basis, *i.e.*, a fixed amount for each person for whose care they have assumed responsibility. In addition to, or possibly in conflict with, the above, the medical director is given express authority to employ a salaried medical service for any part of the state when necessary for securing the rendition of service benefits.

Specialist and consultant services are to be provided in public diagnostic centers to be organized throughout the state as adjuncts to public hospitals. Such services may also be rendered in approved private diagnostic centers coordinated with approved private hospitals. There is no stipulation of “free choice” as regards specialist services. Both public and approved private hospitals may be utilized, private hospitals being compensated at stipulated rates comparable to the costs of efficiently operated public facilities.

The bill gives encouragement to the development of group practice of medicine by providing that any beneficiary may choose a non-profit group of physicians practicing on a group practice basis. Such a group is to be paid on the basis of a fixed amount per annum for each individual upon its list, the amount of such remuneration to be dependent upon the scope of the medical services rendered.

The medical care insurance plan is to be administered by a Bureau of Medical Service established in a projected “Division of Social Insurance” in a state “Department of Social Insurance and Employment Service.” A single agency within this Department is to collect the contributions, maintain the records and do the disbursing for unemployment benefits, disability unemployment benefits and medical benefits. The head of the Bureau of Medical Service must be a physician; he is appointed by the governing authority of the “Department” with the approval of the Advisory Council.

Much authority is given to an Advisory Council to be composed of 8 members appointed by the Governor, three of whom are to represent labor, two employers, and one each the physicians giving service, the Department of Health and the medical schools, respectively. All basic policies must have the approval of the Council.

So much as regards the medical care insurance plan.

The bill provides for “disability unemployment benefits” to be payable at the same rate as unemployment benefits under the state unemployment compensation system. The waiting period for these benefits is to be one week and their duration and the conditions of eligibility for them are to be the same as for unemployment compensation benefits. The coverage for the two types of benefits is the same and the funds for payment of disability unemployment benefits are obtained by diversion of the

present 1% of wages which employees in California now pay for unemployment insurance to a special disability unemployment benefit account. Essentially, disability unemployment benefits are provided through expansion of the existing unemployment compensation system, the Bureau of Medical Service being responsible for certification of disability.

THE WAGNER-NEW YORK BILL

In drafting this bill, Assemblyman Wagner drew heavily upon the "model" bill of the American Association for Social Security. Many provisions of the two bills are alike and in some places the language is identical. The Wagner-New York bill is very much shorter than the "model" bill, this brevity being obtained to a considerable extent by leaving details to administrative discretion.

The health insurance system set up by this bill applies to all employees excepting those engaged in nonmanual work earning over \$2,500 a year. The contributions from employers and employees are identical with those in the "model" bill. However, the state's contribution is to be equal to only 1% of taxable wages (making the total revenues of the system 5½% of wages) and is to be reduced by the amount of any aid received from the federal government.

Both medical and disability benefits are provided. Medical benefits consist of the services of general practitioners and specialists, laboratory and clinic service, hospital care and certain limited types of dental care. These services are available both to the insured person and his dependents. To be eligible for them, the employee must have had 100 days of covered employment or voluntary medical insurance within the 12 months, or 150 days within the 24 months, preceding the day on which the furnishing of medical benefits is asked for himself or his dependents. Care is furnished without time limit so long as the person through whose eligibility they are granted remains insured for such benefit.

Cash benefits are to be paid to compensate for wages lost on account of disability at the rate of 50% of full-time wages with a maximum of \$20 a week. This benefit is to be increased by an additional 10% of full-time wages up to \$5 a week for a dependent spouse, and an additional 5% of the employee's full-time wages up to a maximum of \$3 a week for each dependent child not exceeding four. Such cash benefit is to be payable for a maximum of 156 accumulated days of loss due to disability in each consecutive 52 weeks. The qualifications for this benefit are approximately the same as those of the "model" bill, with the difference that during the so-called extended period of qualification the employee remains entitled to benefits at half rate.

Cash maternity benefits are to be paid to a woman employee for 6 weeks prior and 6 weeks after the birth of a child, in amounts equal to the cash disability benefit to which the employee would be entitled. The qualifying and other conditions for receipt of this benefit are approximately the same as in the "model" bill.

Persons not covered by the compulsory plan are entitled to insure voluntarily for either cash or medical benefits or both, in accordance with conditions formulated by

the Board. Such persons are to be required to pay four fifths of the appropriate contribution for their insurance, and the state is to pay the remaining one fifth. In other words, the voluntary system is to be subsidized by the state to the extent of 20%.

The system is to be administered by a Health Insurance Board of five members, established as a division in the State Department of Health. The members of the Board are to be appointed by the Governor, and at least two must be physicians. As in the case of the "model" bill, provision is made for state general and medical advisory councils.

The bill stipulates that there is to be "free choice" of physician and dentist for general practitioner service. Similar specifications are not made with respect to specialists' care. Physicians may be remunerated by salary, by fee for service, or by per capita system or by any combination or modification of these. The Board is to fix in each district the manner of remunerating physicians and dentists for their services, but no mode of remunerating physicians and dentists in general practice is to be adopted for any local area without the consent of the majority of such physicians or such dentists respectively in that locality.

Unlike the "model" bill, no provision is made for apportioning the funds available between medical and cash benefits.

THE BIEMILLER-WISCONSIN BILL

This bill differs from all the others previously described in that there is no provision for disability benefits; medical care only would be provided.

The system applies to all employees except those engaged in agricultural labor or domestic service (the latter, where the employer has fewer than four persons in such service) and except persons engaged in nonmanual labor who are paid at the rate of more than \$60 per week.

Employers and employees alike are to contribute 2% of wages paid or received. There is no contribution from the state. The system would provide general practitioner and specialist service, nursing care, hospital care, drugs and dressings, laboratory and clinic services, optometrist services, and emergency dental care. These services would be available alike to insured persons and their dependents.

To be entitled to medical care, an individual must have had at least four weeks of covered employment within the 26 consecutive weeks immediately preceding the day on which health benefits are first provided. The covered person remains eligible so long as he is employed and for 26 weeks after the last week of employment. In no case will health benefits be available to an eligible person for more than 26 weeks in any one illness.

The health insurance system is to be administered by a Health Insurance Division of the State Board of Health. This Division is to function under the supervision and control of the State Health Insurance Council appointed by the Governor and consisting of an equal number of representatives of each of the following: employees, employers, physicians, dentists, optometrists, pharmacists, hospitals and the general

public. The representatives of the professional groups are to be selected from panels proposed by their state associations.

The Health Insurance Division is to be administered by a director appointed by the State Health Insurance Council, and he is to be assisted by a medical officer also appointed by the Health Insurance Council from a panel of six or more physicians proposed by the state medical society.

Insured persons are to have free choice among the physicians—both general practitioners and specialists—dentists and optometrists electing to provide insurance services, and all members of these professional groups are to have the right to furnish services under the health insurance plan.

SOME PROBLEMS INVOLVED IN FORMULATING HEALTH INSURANCE PLANS

Against the background of these four bills, we may briefly discuss a few of the more important problems in health insurance.

Who Should Be Covered Under Compulsory Health Insurance?

It is assumed that the purpose of health insurance is to provide adequate medical care and to spread the burden of sickness costs. Insurance is made compulsory primarily in order that the whole of the population covered may participate in these benefits. All four of these bills limit compulsory insurance to a part of the population; all of them exclude from compulsory coverage the self-employed, and two of them exclude in addition farm workers and domestic servants. Finally, all except the California bill limit compulsory coverage to manual workers and to nonmanual employees earning less than \$2,500 or \$3,000 a year.

It may be questioned whether some of these limitations are altogether necessary or desirable. The social problem of medical care is a community problem. It is not limited to persons working for wages or salary. The position of farmers, small shopkeepers, etc., and their dependents, with respect to need for more adequate medical care and protection from medical cost burdens, is more or less the same as that of employed persons. Distinctions with respect to need are not primarily along occupational but along income lines. By their exclusions, these health insurance bills attempt to solve the medical care problem for only a portion of the population.

Presumably, these bills exclude the self-employed and, two of them, domestic and agricultural workers, not because of a desire to do so, but because it is considered impractical or inexpedient to do otherwise—the compelling factors being very much the same as those which resulted in the exclusion of these groups from the federal old-age insurance system. Inclusion of domestic and agricultural workers may be initially inexpedient, but coverage of these workers is possible as is shown by European experience. With respect to the self-employed, the main obstacle to their coverage is the difficulty of collecting contributions geared to income. To include these persons on the same basis as employees would require the collection from them of what would be essentially special flat-rate income taxes earmarked for health insurance. Whether or not such income taxes can be collected from the self-employed of low

income at a reasonable cost and with reasonably accurate accounting and reporting of income, is a question which requires careful study and consideration.

The fundamental factors involved here are very much the same as in old-age insurance. Old age comes to the self-employed as well as to employees, and both groups need insurance protection. Certainly in health insurance and probably in old-age insurance, government contributions are desirable. The self-employed may feel that it is inequitable for them to pay their share of these taxes and also as consumers to bear indirectly some share of the pay-roll taxes on employers, and yet to derive no benefit from these insurances.

There is also the question of whether health insurance should be limited to those with incomes under a given limit, say \$3,000. On the one side there is the consideration that the medical profession will strongly desire such a limitation. Also, inclusion of the high income group is by no means as imperative as inclusion of the self-employed of low incomes. On the other side there is the consideration that non-inclusion of this group might have unfortunate consequences for the system as a whole. It might be argued that it is inconsistent with American traditions of equality and democracy to have one medical service for the low or moderate income groups and another for the well-to-do. Also, restriction of health insurance to those under a given income level might give the system an inferiority complex, so to speak—to cause all to believe, whether or not there are any real grounds for such an opinion, that insurance medical care is never quite as good as the service obtained by the well-to-do under private practice.

Eligibility Requirements

The provisions in these health insurance bills with respect to the determination of eligibility for medical care raise complex and important questions. The problems to be faced are these: Assuming the medical insurance system is in current operation, how soon after a person newly enters covered employment do he and his dependents become eligible for medical care? By what procedures is the eligibility of insured persons to be indicated to doctors, hospitals, etc., so that the one may obtain and the other provide service without delays, inconvenience and red tape? Are any restrictions to be set on the volume of service which a covered person may obtain so long as his eligibility continues? If so, how are these to be administered? If a covered person becomes disabled or unemployed or leaves covered employment, for how long do he and his dependents remain eligible for medical care? In the case of such persons, how is the physician to be notified that they are no longer eligible for free care under the insurance plan?

Of the four bills, the California bill seems to contain the least complex provisions on these points. It provides that persons are eligible for medical care during a "benefit year" lasting from July 1 to June 30, if during the preceding calendar year they earned \$300 or more in covered employment. Thus, eligibility for care runs in year intervals—the intervals being the same for all workers. During the period of his eligibility, the worker is entitled to medical care without limitations, except with

respect to hospital care, as to volume of service or length of care in any illness. When his year of eligibility is up, he forthwith ceases to be entitled to medical care unless, of course, he has gained eligibility for the new year by having had sufficient earnings in the applicable base period. Under this arrangement it would be possible to provide all persons having the requisite earnings in the base period with cards, good for the ensuing benefit year and for that year only, which would indicate their eligibility to physicians, hospitals, etc.

With these eligibility provisions, it would be possible for the health insurance system to utilize for the determination of eligibility the same employment and wage records which are now obtained from the employer under the unemployment compensation system; one may judge that it was the desirability of this that led to the adoption in the bill of these particular eligibility arrangements. However, while these arrangements seem administratively feasible, the precise requirements laid down have certain undesirable consequences. Thus, a person newly entering covered employment would have to wait six months to almost a year and a half before he would be entitled to medical care. It would seem preferable, if it were administratively possible, to make the period of eligibility for medical care coincide more nearly with the period of covered employment.

The eligibility arrangements in the other three bills follow a quite different pattern than those of the California bill. Under these bills, the worker becomes eligible for medical care soon after entering covered employment (10 days in the "model" bill, 4 weeks in the Biemiller-Wisconsin bill, and 100 days in the Wagner-New York bill), he continues to be eligible as long as he works in covered employment, and upon leaving covered employment he remains eligible for a certain period *which is measured from the last day of his employment*. There is thus a different period of eligibility for each worker. These provisions would require reports from employers quite different from those now common under unemployment compensation. (It might be more desirable for eligibility to run in fixed intervals of time. Then, periodically, lists could be furnished to physicians or cards to insured persons indicating eligibility for a future quarter, half year or year.)

Two of the three bills place certain limitations on the number of weeks for which an eligible worker may obtain medical treatment in any one illness—one of the bills limits duration of medical benefits only in the case of disabling illnesses. Methods would thus have to be devised for keeping track of the number of weeks for which medical care was provided in any one case. Although the administrative problems seem complex, European experience indicates that they can be solved.

In all of this it needs to be remembered that eligibility requirements are important in proportion to the limitations in coverage. If the insurance system is made universal in coverage, eligibility requirements to all practical purposes can be dispensed with. This is desirable because socially the aim of health insurance is to provide medical care.

Coordination of Disability and Unemployment Benefits

Temporarily disabled and unemployed workers are suffering the same wage losses and it would seem logical that both should be compensated alike for such losses. Accordingly, it would seem desirable that disability and unemployment benefits should be paid at the same rate and that the waiting periods and eligibility requirements should be the same. However, there are factors in the situation which may make some differences unavoidable. It would also be desirable on some counts to have the benefit duration period the same, though this is complicated by the exigencies of coordinating temporary disability insurance with invalidity insurance, on the one hand, and of coordinating unemployment insurance with work relief or relief on the other.

The California bill compensates disability and unemployment at the same rate, and provides for identical waiting and benefit periods and eligibility requirements. Indeed it goes further and provides for joint administration of disability and unemployment benefits with, however, a separate fund for each. The joint system is then administratively coordinated with the medical care insurance system by placing both within a "Department of Social Insurance and Employment Service," and by providing that the same agency shall collect contributions, maintain accounts and records and disburse for all three benefits.

The other bills follow a different line. The Wisconsin bill does not provide disability benefits. The "model" bill and the Wagner-New York bill both follow European precedents in that they provide for joint administration of medical care and disability benefits. Neither of these bills provide for coordination of disability and unemployment benefits. Indeed, the "model" bill was prepared before there was an unemployment compensation law, except in Wisconsin, and the Wagner-New York bill was written without attempt to take account of New York's unemployment compensation system. It would necessitate employer reports and wage records independent of those now required by that system.

Coordination or Integration of Health Insurance and Other Governmental Health Services

It is imperative to coordinate or possibly to integrate health insurance medical services with other governmental health services. In general, it may be said that the wider the population covered by health insurance the greater the desirability of correlating or integrating the system with public health work, provision of care to the indigent, and other public medical services.

All of these health insurance bills provide in various degrees for the coordination of their limited coverage systems of health insurance with public health activities. The "model" bill does this by making the health commissioner a member of the Health Insurance Commission; the California bill by making the health commissioner a member of the all-important Advisory Council. The Wagner-New York and Biemiller-Wisconsin bills go further and set up the health insurance system as a division within the state board of health.

None of the four bills makes mandatory the coordination of insurance medical services and services for the indigent. The "model" and Wagner-New York bills, however, do provide that public unemployment and relief agencies may insure their clients for medical care by paying the appropriate premium.

There are excellent reasons for integrating the provision of medical services to insured and indigent persons so that both groups are served by the same physicians and facilities. This can be achieved by having the appropriate governmental agency insure the indigent under the health insurance system by paying the contributions on their behalf. To do otherwise—to have separate systems for the poor and for the self-supporting, with each group served by more or less different sets of physicians, would have many obvious disadvantages.

Organization for the Provision of Medical Care

The correction of the present lacks and inadequacies in our national medical care situation may be said to involve two main problems: first, that of fashioning a system of payment for medical care which will enable people to purchase the service they need at a cost they can afford; and second, that of fashioning arrangements for the provision of care which will assure high standards of quality of service and the delivery of service efficiently and at reasonable cost. The two problems, of course, interlock.

What is rapidly becoming a voluminous literature attests to a growing opinion to the effect that the individual physician practicing by himself labors under handicaps in the provision of adequate care. The growth of medical knowledge has necessitated the development of specialism. The provision of an integrated service to the patient is held to require the coordination of the service of specialists and of general practitioners and specialists through organization. Thus, the primary recommendation of the majority of the Committee on the Costs of Medical Care was that "medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel. Such groups should be organized preferably around a hospital for rendering complete home, office and hospital care. . . ."⁹ Recently, the Committee of Physicians for the Improvement of Medical Care, in giving its views with respect to the Wagner National Health Bill, stated as a general principle, which should be incorporated in any such legislation, that "Complete medical services, including prevention, are no longer obtainable through the individual practitioner alone. The rapid development of modern medical science has made it impossible for the individual doctor to provide all the facilities needed for modern scientific medical care. Good medical care now requires the integrated service of the individual doctor, the laboratory and the hospital."¹⁰

How do these health insurance bills propose that medical care shall be provided? How is the provision of medical care to be organized? All of the bills under con-

⁹ MEDICAL CARE FOR THE AMERICAN PEOPLE (1932) 109.

¹⁰ Proposals for Amendment of the Wagner Bill S. 1620, Hearings before a Subcommittee of the Senate Committee on Labor and Education, on S. 1620, 76th Cong., 1st Sess. (1939) 951, 955.

sideration are content to handle this problem in terms of broad principle. They do not go into details. One finds no detailed blue prints as to how the system is to be administered on the ground.

All four bills stipulate that every insured person is to have the right to select the physician from whom he wishes to receive *general practitioner* care from among the physicians in each locality or area who have signified their willingness to render this service under the insurance plan;¹¹ and that every qualified physician shall have the right to participate in the provision of *this type of service* to insured persons, provided he agrees to accept remuneration at the stipulated rates and to abide by the other necessary conditions of the plan. This would mean that every insured person could continue to have the same family physician or general practitioner, as at present, provided his physician wishes to give service under the insurance plan. Thus, for general practitioner care, a "free choice" open panel system is stipulated.

The "model" and Wagner-New York bills provide that physicians rendering general practitioner care may be remunerated in any of the following ways: (a) by salary, (b) by a fixed payment per quarter or year for each insured person on their lists, *i.e.*, for whose care the physician assumes responsibility, and (c) by a fee system, or (d) by any combination of these methods. Both bills also provide that no method of remuneration for general practitioner service shall be adopted for any locality or area which does not have the approval of a majority of the physicians in that area giving this service.

The Biemiller-Wisconsin bill restricts the mode of remuneration of general practitioners to a per capita or fee system or any suitable combination of these two. The California bill, aside from stipulating that patients shall have free choice of general practitioners and that all qualified physicians shall be entitled to provide this type of service, does not specify the mode of remuneration.

All of the above concerns simply general practitioner service. As regards the provision of specialist services, the "model" and Wagner-New York bills leave the matter open, *i.e.*, they do not stipulate "free choice" and they give the administrative authority *carte blanche* to organize such services as it finds best. The California bill, provides that specialist and consultant services are to be rendered by public and approved private diagnostic centers, the services of which are to be coordinated with public or approved private hospitals. In addition, it stipulates that insured persons, when entitled to choice, may choose any nonprofit group practice unit of physicians on the same basis as an individual physician. The Biemiller-Wisconsin bill makes the greatest concession to expediency. It provides for a "free choice" panel system for specialist as well as for general practitioner service.

Thus, of the four bills, only the California bill stipulates that medical service shall be provided through group practice units—and this only as regards specialist services. The "model" and Wagner-New York bills would permit the health insurance

¹¹ The "model" and Wagner-New York bills also stipulate free choice for general practitioner dental services.

authorities to develop group practice arrangements for the provision of specialist care, but do not require this.

An open panel system, as is stipulated by all four bills for general practitioner care and by the Biemiller-Wisconsin bill for specialist service, does not in itself provide any certain guide as to whether insurance medical practice would be primarily *individual* practice or *group* practice. It leaves the question up to the physicians themselves. If they wish to practice *solo* they can do so; if they should wish to come together into group practice units, they can do so. As physicians learn the technique of group practice and as they become familiar with its professional advantages and financial economies, group practice may be expected to develop of its own accord under insurance, just as it has developed to a certain extent under private practice of the present day.

Is compulsory health insurance likely to "freeze" the individual private practice of medicine and retard the development of group practice? One may venture to think not.

It seems probable that we must solve our problems one at a time and build on what we have. The solution of the "payment" problem through health insurance will be a great step forward, and one which should lead toward the evolution and development of group practice. Presumably under health insurance, a central authority is created which, on behalf of the insured population, is interested in seeing that the quality of service delivered is as good as possible, and that care is provided as economically and efficiently as possible. Under such a system, interests now diffused and scattered are concentrated and can thus be made effective. Given this situation, comparisons of the quality and cost of medical service under group and individual practice will have an obvious moral.