*Voluntary Insurance Against Sickness: 1948-52 Estimates**

VOLUNTARY health insurance, which has been expanding rapidly in the United States, continued to grow in 1952. There were increases in the number of persons with insurance and in the amount of insurance premiums and benefits. The costs of sickness also continued to increase in 1952, resulting in larger benchmarks against which insurance protection may be measured.[1]

The direct and private costs of sickness are incurred mainly through (a) loss of earnings in periods of disability and the purchase of income-loss insurance, and (b) private expenditures for medical care and for medical care insurance. Taken together, these two private costs of sickness—restricted to loss of income from current incapacity, private expenditures for medical care, and the net costs of insurance—amounted to about $15.2 billion in 1952. This total represented an increase of about $1 billion from the 1951 total, or about the same annual increase as had been found for the two preceding years. Of the total cost for 1952, loss of current earnings accounted for $5.7 billion and private medical expenditures for $9.4 billion.

Premiums for insurance purchased against sickness costs amounted to about $2.8 billion in 1952—nearly $850 million for income-loss insurance and about $2.0 billion for medical care insurance. The losses or benefits paid by the insurance companies or plans equaled about $2.1 billion, with more than three-fourths ($1.6 billion) in the form of medical care indemnities or benefits.

* Prepared in the Division of Research and Statistics, Office of the Commissioner.

[1] This is the fifth article in a series analyzing the annual costs of sickness in the United States and the extent of voluntary insurance against these costs. For earlier estimates for 1948, 1949, 1950, and 1951 and subsequent revisions and refinements, and for an explanation of the methodology, see the *Bulletin* for January–February 1950, pp. 16–19; March 1951, pp. 19–20; December 1951, pp. 20–23; and December 1952, pp. 3–7.

Scope of the Estimates

The rapid growth of voluntary health insurance, especially during and after World War II, stimulated the need for periodic estimates of its size and achievements in providing protection against the costs of sickness. The first report in this series, dealing with insurance experience in 1948, defined the purpose and scope of these annual estimates and presented the basic methodology. Since each of the succeeding reports has included some revisions, based on experience in making these annual analyses, it is timely to recapitulate the scope of the estimates.

Voluntary health insurance may be assessed through various indexes—the number of insurance policies in force, the number of different individuals insured, the comprehensiveness of their insurance, and the value of their insurance protection. Each index presents difficulties, because current insurance contracts and practices are complex and because the required data are only partially available. The Health Insurance Council, composed of representatives from insurance companies, publishes annual estimates of health insurance coverage—the numbers of individuals having some kind or amount of insurance for hospital, surgical, or medical expense or for income loss—but the Council's Survey Committee does not evaluate the insurance protection actually provided.

Certain quantitative aspects of voluntary health insurance protection may be measured in dollar values. Substantial information is available annually on the amounts paid to insurance carriers as premiums and on the amounts paid out by them as cash indemnities or as expenditures for service benefits. These figures can be compared with estimates of the actual costs of sickness to obtain indexes of insurance protection. This method avoids the necessity of taking account of enrollment and multiple policyholding, diversity of insurance contracts, and changes in population and costs.

By definition, voluntary health insurance is concerned with insurance entered into voluntarily. The estimates on insurance operations therefore exclude private or public insurance and self-insurance resulting from the requirements of workmen's compensation and related public laws, and the estimates of sickness costs exclude the costs of work-connected income loss and medical care. Similarly, the data on both benefits and sickness costs exclude expenditures made through other government programs supported by taxation (such as veterans' programs, public health services, and public assistance provisions for subsistence or medical care), since these expenditures are in general outside the scope of voluntary health insurance.

Cash sickness or temporary disability insurance required by public law presents a mixed situation, in part like and in part unlike that of workmen's compensation. The temporary disability insurance programs are compulsory; they deal, however, with sickness costs that are generally personal losses and expenditures (not employers' costs of doing business). The operations of exclusive or competitive public insurance funds (in California, New Jersey, and Rhode Island and under the Federal program for railroad employees) are plainly not voluntary health insurance.[2] In California and New Jersey, however, private insurance companies carry part and in New York they carry practically all of the coverage determined by compulsory insurance. The figures on coverage, premiums, and benefits for voluntary health insurance operations ordinarily include this substantial volume of privately insured but compulsory insurance

[2] Alfred M. Skolnik, "Temporary Disability Insurance Laws in the United States," *Social Security Bulletin*, October 1952.

against sickness costs. Special attention will be given to this problem later in the article.

In general, the estimates of voluntary health insurance operations presented here undertake to show the dollar amounts that the population pays privately to all insurance carriers and the corresponding dollar amounts representing what the population receives in all insurance benefits with respect to sickness costs of the kinds that constitute personal loss of earnings and personal consumption expenditures (as defined below). The dollar estimates for insurance costs include premiums from individuals, groups, and employers in the stated year. The estimates for insurance benefits include losses incurred by insurance companies [3] and expenditures for benefits by nonprofit plans, health and welfare funds, self-insured employers, and the like—whether derived from current earned premiums or from reserves. The objectives are estimates of the amounts people paid privately for voluntary insurance during the year and what they received back in benefits during the same year.

The dollar estimates for sickness costs, similarly, include the amounts that employed persons lost in wages, salaries, and self-employment income during that year because of current incapacity, and the amounts the whole civilian population spent for medical care in the same year. These figures exclude income loss resulting from total incapacity beyond 6 months' duration (since most voluntary health insurance does not try to cover the more extended risk) and from death, dismemberment, or partial disability. They also exclude loss from war-risk incapacity and, as noted earlier, work-connected injury, as well as all payments by the public through taxes and all expenditures for medical care by governmental bodies and by private (noninsurance) community, charitable, philanthropic, and other agencies.

[3] "Losses incurred" as used here exclude adjustment expenses; it is recognized that this figure somewhat overstates current benefit payments to policy-holders by the amount of reserves set aside against future obligations resulting from current claims.

Table 1.—*Income loss due to illness,* [1] *1948–52*

[In millions, except average income loss per worker]

Item	1948	1949	1950	1951	1952
Average number of employed workers [2]	59	59	60	61	61
Average income loss per worker from illness [3]	$77.00	$78.75	$82.95	$89.32	$94.08
Total income loss from illness	$4,543	$4,646	$4,977	$5,449	$5,739
Net cost of income-loss insurance (addition) [4]	267	276	297	303	315
Paid sick leave (subtraction) [5]	291	298	314	334	347
Net income loss from illness	4,519	4,624	4,960	5,418	5,707
Potentially insurable income loss [6]	2,993	3,064	3,283	3,572	3,758
Potentially compensable income loss [7]	2,083	2,133	2,286	2,480	2,608

[1] Short-term or temporary non-work-connected disability (lasting not more than 6 months) and the first 6 months of long-term disability.

[2] Annual average of employed persons from Bureau of the Census, *Current Population Reports: Annual Report on the Labor Force*, Series P-50, Nos. 13, 19, 31, 40, 45, table 4.

[3] Average wage or salary for 7 workdays in a year, obtained by dividing the average annual earnings per worker (table 26, *Survey of Current Business*, National Income Number, July 1952 and July 1953) by 255 workdays in a year and multiplying this average daily wage by 7.

[4] The difference between premiums earned and losses incurred, from table 2. Data for 1948–51 revised.

[5] Based on estimated number of persons covered by paid sick leave and related provisions not treated as insurance in table 2. Assumes that 8.2–8.4 million persons with such coverage received the equivalent of 45 percent of their total income loss due to illness. See *Annual Survey of Accident and Health Coverage in the United States*, each year 1948–52; also, "Health Insurance for Workers and Their Families," by Barkev S. Sanders, in *Employment and Wages in the United States*, by W. S. Woytinsky and Associates, Twentieth Century Fund, New York, 1953, pp. 217–218.

[6] Total income loss reduced by 40 percent (to exclude both the first week of disability and otherwise insurable income loss covered by paid sick leave) and increased by the net cost of current income-loss insurance.

[7] Of the potentially insurable income loss (excluding net cost of income-loss insurance), two-thirds is assumed to be potentially compensable and then increased by net cost of income-loss insurance.

The primary measures of the risks to which people are exposed and against which they may seek insurance are the total income loss due to current incapacity and the total amount spent for medical care. Alternative measures of the risks may be confined to parts of these totals, in recognition of the specific risks against which insurance is currently purchased. The measures may deal, for example, with only part of the total wage loss or with only the costs of hospitalization or physicians' services. In the reports in this series, current insurance operations are related to, and measured against, alternative benchmarks to give various percentages of sickness costs met by insurance. These percentages measure how much of the stated total risk is met by insurance; they are not intended to measure how much of the total risk is met for those individuals who have any kind of voluntary health insurance or for those who have hospital, surgical, or some other particular kind of insurance (as distinguished from those who do not) or for those who have had some particular risk experience.

Income Loss Due to Illness

The estimate of income loss due to nonoccupational illness and injury used in this study is designed to reflect only current income loss from short-term or temporary disability and the first few months of extended disability. As noted earlier, it excludes loss of future earnings arising from extended or permanent disability or from premature death.

Table 1 shows the derivation of the estimate for each of the 5 years from 1948 through 1952. The gross figures (total income loss from illness) cover income loss for nonoccupational illness or injury, whether or not such losses are considered compensable under current insurance practice and whether or not they are covered by privately purchased insurance or by government programs.

Assuming that, on the average, 7 days were lost from work on account of illness during the year, the loss per worker equaled $94.08 in 1952. Applied to a labor force of 61 million, this figure yields a gross estimate of $5,739 million lost during the year. The gross figure was reduced by $347 million for paid sick leave (see table 1, footnote 5) and increased by $315 million for the net cost of income-loss insurance purchased in 1952 (table 2).

The resulting figure of $5,707 million represents the net income loss in 1952 due to non-work-connected short-term illness and the first 6 months of longer-term illness; it is 5 percent more than the 1951 figure

and 26 percent more than that for 1948.

Most accident and health insurance currently available for purchase ordinarily does not undertake to cover the first few days or the first week of sickness (though it may do so in the case of accidents). The potentially insurable portion of income loss is estimated as $3,758 million in 1952 (see table 1, footnote 6).

Potentially compensable income loss would be lower than either of the preceding estimates, since a guiding principle of current insurance practice is that benefits should not exceed 50–75 percent of actual income loss. For the purposes of these estimates it is assumed that two-thirds of the potentially insurable income loss is compensable. This assumption leads to an estimate of $2,608 million in 1952 (see table 1, footnote 7).

Insurance Against Income Loss

Most of the voluntary insurance against income loss is provided by accident and health policies sold directly by insurance companies on a group or individual basis; some of it is derived from membership in employees' benefit organizations and fraternal societies, from union health and welfare funds, self-insuring employers, and other sources.

Table 2 includes data for 1948–52 for all types of nongovernmental organizations insuring against income loss. Of the total of $533 million in income-loss benefits in 1952, only about $27 million appears to be derived directly from organizations other than insurance companies selling group and individual policies. Some health and welfare funds purchase their insurance from commercial companies or operate their own mutual insurance companies as separate corporations, and data for these funds are included, not in the $27 million, but in the other items in the table.

Income-loss insurance premiums increased $71 million between 1951 and 1952 (from $777 million to $848 million), or 9 percent. Benefits increased $59 million (from $474 million in 1951 to $533 million in 1952), or 12 percent. In the same period the overall net loss of income rose $289 million or 5 percent. The net cost of income-loss insurance—the difference between premiums earned and losses incurred—amounted to $315 million in 1952. The benefits equaled 63 percent of premiums and the net costs 37 percent.[4] In 1951, benefits were 61 percent of premiums; this proportion was only 51 per cent in 1948.

Private insurance company and self-insurance operations of the temporary disability programs in California, New Jersey, and New York are included in table 2 among the estimates for all private insurance provisions against income loss. These private operations under compulsory laws amounted to about 24 percent of all private insurance income-loss benefits in 1952. Since table 2 is restricted to private insurance, it does not include the operations of the public funds under the compulsory laws.[5]

Table 2.—*Premiums, benefit payments, and loss ratios for commercial and other private insurance against income loss, 1948–1952* [1]

[Amounts in millions]

Item	1948	1949	1950	1951	1952
	Premiums earned				
Total [2 3]	$545	$588	$671	$777	$848
Group insurance [2 4]	175	210	284	372	399
Individual insurance [3 4]	346	352	355	368	409
Other [5]	24	26	32	37	40
	Losses incurred				
Total [2 3]	$278	$312	$374	$474	$533
Group insurance [2 6]	124	147	203	295	327
Individual insurance [3 6]	139	148	151	155	179
Other [5]	15	17	20	24	27
	Loss ratios (percent)				
Total	51.0	53.1	55.7	61.0	62.8
Group insurance	70.9	70.0	71.5	79.3	82.0
Individual insurance	40.2	42.0	42.5	42.1	43.8
Other [5]	62.5	65.4	62.5	64.9	67.5

[1] Premiums and losses include accident only and travel accident insurance, and private insurance company operations and self-insured arrangements under compulsory cash sickness or temporary disability laws in California, New Jersey, and New York.

[2] Includes private insurance company operations under compulsory temporary disability insurance laws. Total losses paid by all private plans under these laws amounted to $9.3 million, $27.1 million, $54.6 million, $114.7 million, and $127.0 million in the years 1948–52, respectively; these aggregates include a small amount (8–10 percent) of self-insurance, shown as other private insurance, below.

[3] No reduction made in the premiums or losses of individual insurance for accidental death and dismemberment provisions in policies that insure against income loss. (Estimate by the Health Insurance Council indicates that such reductions on losses would be about $32 million for 1952.) Resulting overstatement of income-loss insurance is assumed to offset understatement arising from omission of current short-term income-loss insurance in automobile, resident liability, life and other policies.

[4] Premiums earned for income-loss and medical care insurance combined (separately for group and individual contracts), obtained from the *Spectator Accident Insurance Register*, 1949–52. Premiums for group policies were adjusted to eliminate Canadian business and to the level of total premiums according to Life Insurance Association of America charts (*Group Insurance and Group Annuity Coverage, Continental U.S.*, 1948–52) after excluding premiums for accidental death and dismemberment; premiums were then distributed between income-loss and medical care insurance on the basis of these charts. Premiums for individual policies were adjusted to eliminate life insurance and Canadian business and to the level of total premiums as derived from data in the U.S. Chamber of Commerce surveys (*American Economic Security*, July–August 1949–53); premiums were then distributed between income-loss and medical care insurance by reference to the mean amount of coverage shown in survey. Data include dividends and rate credits, mainly for group policies, and were adjusted for duplication within categories.

[5] Includes estimates for fraternal societies, union health and welfare funds, and employee mutual benefit associations, and for self-insurance under the California, New Jersey, and New York temporary disability laws and elsewhere. Information on fraternal accident and health business supplied by *The Fraternal Monitor*. Division between income-loss and medical care insurance estimated.

[6] Losses incurred, as reported by the *Spectator* for income-loss and medical care insurance combined, reduced by 1.9 percent (1.7 percent in 1952) of premiums earned for group policies and 3.2 percent for individual policies to eliminate adjustment costs. Loss ratios, furnished by the Health Insurance Council separately for group and individual insurance for hospital and surgical-medical care and for income loss, were used to derive losses incurred for each risk; these figures were then raised or lowered slightly to yield the aggregate losses for all three risks combined.

Private Expenditures for Medical Care

The Department of Commerce makes annual estimates of personal expenditures for medical care, as part of its annual report on national income and product. These data pro-

[4] For adjustments for accident and dismemberment insurance and offsets for income-loss insurance in automobile, resident liability, life, and other policies, see footnote 3 of table 2.

[5] Benefits paid by the public funds were $57.1 million in 1948, $62.1 million in 1949, $62.8 million in 1950, $59.5 million in 1951, and $73.1 million in 1952.

Table 3.—*Private expenditures for medical care, 1948–52* [1]

Item	Amount (in millions)					Percentage distribution				
	1948	1949	1950	1951	1952	1948	1949	1950	1951	1952
Total	$7,288	$7,658	$8,248	$8,816	$9,447	100.0	100.0	100.0	100.0	100.0
Physicians' services [2]	2,176	2,297	2,416	2,565	2,718	29.9	30.0	29.3	29.1	28.7
Hospital services [3]	1,663	1,858	2,121	2,283	2,561	22.8	24.3	25.7	25.9	27.1
Dentists' services	895	931	959	989	1,028	12.3	12.2	11.6	11.2	10.9
Nurses' services	200	207	225	239	245	2.7	2.7	2.7	2.7	2.6
Medicines and appliances	1,822	1,829	1,927	2,111	2,177	25.0	23.9	23.4	23.9	23.0
Services of miscellaneous healing and curing professions	272	283	297	318	319	3.7	3.7	3.6	3.6	3.4
Administrative and other net costs of medical care insurance [4]	256	249	299	307	394	3.5	3.2	3.6	3.5	4.2
Insurance for hospital services	192	168	189	188	233	2.6	2.2	2.3	2.1	2.5
Insurance for physicians' services	64	81	110	119	161	0.9	1.0	1.3	1.4	1.7
Student fees for medical care	4	4	4	4	5	(5)	(5)	(5)	(5)	.1

[1] Except where otherwise noted, data are from the Department of Commerce, *National Income and Product of the United States, 1929–50, Supplement to Survey of Current Business*, 1951, table 30, p. 195, and *Survey of Current Business*, July 1953, table 30, p. 22. Excludes medical care expenditures for the Armed Forces and veterans, those made by public health and other government agencies and under workmen's compensation laws, and direct expenditures for services by private philanthropic organizations.

[2] Addition made each year to figure reported in *Survey of Current Business* for salaries of physicians employed in prepayment medical service plans.

[3] Computed from data in *Hospitals*, June of each year 1949–53. Based on income from patients for each year ending September 30 in all types of general and special short-term hospitals. Data are projected to December 31 of each year, and additions have been made for (1) nonregistered hospitals, and (2) estimated income from patients received by general and special long-term hospitals, mental and allied hospitals, and tuberculosis sanitoriums.

[4] Data from table 4.

[5] Less than 0.05 percent.

vide the basis for the annual series used here, with the following adjustments and substitutions:

(a) An upward adjustment in the expenditures for physicians' services has been made to include the salaries of physicians employed by prepayment medical care plans.[6]

(b) A substitution for the figure on expenditures for hospital services has been made each year in order to have an estimate representing income from patients for care in both private and public hospitals for the calendar year (the Department of Commerce source data deal only with the private sectors of the economy).

(c) The net cost of medical care insurance, as determined from table 5, is substituted for the figures for insurance net costs; the Department of Commerce figures cover net cost of both income-loss insurance and medical care insurance and are somewhat less precise than the data obtained at a later date for this analysis.

Table 3 gives the data for private expenditures for medical care for each of the 5 years 1948–52. The civilian population spent about $9.4 billion in 1952. The increase for the year totaled about $630 million or about 7 percent, and each category of expenditure was higher in 1952 than in 1951. The 1952 total is nearly 30 percent higher than the total for 1948, giving an average annual increase of 6 percent. The annual increases reflect expansion in expenditures for medical services and goods concurrent with the increase in population, increases in prices, and growth of insurance and thus of total net cost of insurance. The largest items of expenditure have continued to be those for physicians' services, hospital services, and drugs and appliances. In 1948, private expenditures for hospital services were less than expenditures for physicians' services and for drugs and appliances; in 1952, they were almost as large as the former and nearly $400 million larger than the latter. The percentage distributions of the items making up the total of private expenditures for medical care has shown relatively little change from year to year, except for the rise in the proportion expended for hospital care.

[6] Similar adjustments for dentists and nurses employed in prepayment plans do not substantially alter the Department of Commerce figures, since the adjustments are less than $0.5 million.

Insurance Against Medical Care Costs

The financial operations of all voluntary medical care insurance in the 5-year period 1948–52 are summarized in table 4.

Earned insurance income increased by 132 percent during the 5 years; the increase was 101 percent for hospitalization insurance and 225 percent for insurance against the costs of physicians' services. Benefit expenditures advanced at an even faster rate; by 1952 they were 165 percent greater

Table 4.—*Premiums, benefit payments, and loss ratios for voluntary insurance against the costs of medical care, 1948–52* [1]

[Amounts in millions]

Item	1948	1949	1950	1951	1952
	Earned income				
Total	$862	$1,016	$1,291	$1,660	$2,002
Hospital services	647	707	869	1,085	1,303
Physicians' services	215	309	422	575	699
	Expenditures for benefits				
Total	$606	$767	$992	$1,353	$1,608
Hospital services	455	539	680	897	1,070
Physicians' services	151	228	312	456	538
	Loss ratios (percent) [2]				
Total	70.3	75.5	76.8	81.5	80.3
Hospital services	70.3	76.2	78.3	82.7	82.1
Physicians' services	70.2	73.8	73.9	79.3	77.0

[1] Data for 1948–51 summarize detailed presentations in earlier articles in this series; data for 1952 from table 5. The term "physicians' services" covers the services of surgeons (the largest component) and other types of physicians, including roentgenologists, and a small amount of dental, nursing, and related services and appliances. The term "hospital services" covers some services other than those received from hospitals, such as X-ray services not furnished as part of the hospital services and emergency accident care.

[2] A large proportion of commercial insurance companies had net losses from underwriting either their individual or their group accident and health insurance business, or both, in 1951 and 1952; more nonprofit insurance carriers reported in 1951 and 1952 than in 1950 an excess of benefit expenditures *plus* operating costs over total earned income.

than the 1948 amounts, with a higher rate of expansion for physicians' services than for hospital care benefits.

Table 5 gives in more detail 1952 financial data for all forms of medical care insurance by type of insurance or plan. The classification used in the 1952 table differs somewhat from that used in previous years, in order to meet requests for aggregates for the different classes of medical care insurance carriers or plans.

The proportion of total premium and of total expenditures assigned to hospitalization insurance did not change substantially from 1951 to 1952. Indeed, premiums for this insurance have accounted for about 65 percent and the benefits for about 66–70 percent of the totals since 1949. Hospitalization insurance continued in 1952 to be the leading form of medical care insurance being purchased.

In 1952, as in the four preceding years for which comparable data are available, Blue Cross plans were the largest single class of voluntary medical care insurance. Benefit payments under the Blue Cross plans accounted for 34 percent of all expenditures for benefits; their hospitalization benefits of $541 million accounted for more than half of all hospitalization benefits paid. Group commercial insurance was second to Blue Cross in both insurance premiums and benefit payments, with premiums also in excess of half a billion dollars. Commercial group companies were the leading insurers against the costs of physicians' services, slightly exceeding the Blue Shield plans; they provided about 36 percent of these benefits. Their benefit payments for physicians' services were, however, slightly less than the combined benefit payments made for physicians' services by Blue Cross, Blue Shield, and other nonprofit plans sponsored by medical societies, which together equaled 38 percent of the total. Plans not connected with Blue Cross, Blue Shield, or commercial insurance organizations provided only 8 percent of the total benefit expenditures for hospital services but as much as 17 percent of the benefit expenditures for physicians' services.

Table 5.—*Income and expenditures for medical care benefits of voluntary insurance, by type of carrier or plan, 1952*

[Amounts in millions]

Type of insurance carrier or plan	Earned income			Expenditures for benefits [1]			Benefits as percent of income
	Total	For hospital services [2]	For physicians' services [3]	Total	For hospital services [2]	For physicians' services [3]	
Total	$2,001.6	$1,302.7	$698.9	[4]$1,607.9	$1,070.2	$537.7	80.3
Blue Cross and affiliated organizations [5]	616.2	605.7	10.5	550.1	540.8	9.3	89.3
Blue Shield plans [6]	235.1	11.0	224.1	186.4	8.8	177.6	79.3
Other medical society-sponsored plans [7]	25.0	6.2	18.8	21.6	6.2	15.4	86.4
Other nonprofit plans:							
Community-wide plans	23.2	8.3	14.9	17.9	6.5	11.4	77.2
Consumer-sponsored plans	7.2	3.4	3.8	5.9	2.7	3.2	81.9
Fraternal societies [8]	7.9	3.7	4.2	5.3	2.5	2.8	67.1
Union health and welfare funds [9]	66.4	39.9	26.5	63.8	38.7	25.1	96.1
Employer and/or employee plans	47.2	23.6	23.6	43.8	21.5	22.3	92.8
Student health services [10]	5.0	2.0	3.0	5.0	2.0	3.0	100.0
Private group clinics with prepayment [11]	10.8	3.1	7.7	9.4	2.7	6.7	87.0
Commercial insurance: [12]							
Group	569.0	338.0	231.0	498.1	304.2	193.9	87.5
Individual	388.6	257.8	130.8	200.6	133.6	67.0	51.6

[1] Benefits paid, for nonprofit and other organizations; losses incurred, for commercial insurance.

[2] Includes some income or expenditures for outpatient services.

[3] Includes some income and expenditures for services other than those received from physicians (nurses, dentists, laboratories, etc.).

[4] Includes about $10 million paid under the State temporary disability insurance laws of California and New York. Hospitalization benefits through private carriers were $4.0 million in California; hospital and physician benefits through private carriers in New York were $6.1 million. Hospitalization cash benefits paid by the State fund in California (not included in the table) were $3.3 million.

[5] Addition made to the data reported for 81 plans by the Blue Cross Commission for one plan not reported and for Health Services, Inc. Data for medical-surgical insurance under 5 combined Blue Cross-Blue Shield plans shown under Blue Shield plans. Division between hospital and physicians' services estimated for 2 of the 6 Blue Cross plans that write both types of insurance on basis of enrollment and premiums.

[6] Excludes amounts for hospital insurance reported by Blue Shield Commission for 4 combined Blue Cross-Blue Shield plans (included in data reported by Blue Cross Commission, above). Division between hospital and physicians' services estimated for 6 plans on basis of enrollment and premiums.

[7] Covers 5 nonprofit plans sponsored or controlled by medical societies; excludes plans underwritten by commercial insurance companies.

[8] Estimated on basis of total accident and health insurance of such societies. Data on payments to lodge doctors not available.

[9] Covers only those funds or portions of funds used for the direct purchase of medical care without an intermediary insurance company or plan.

[10] Estimated.

[11] Not strictly comparable to 1951 data because 1 plan, previously classified as a private group clinic, has been reclassified as a community-wide plan.

[12] See footnotes 4 and 6 of table 2 for the method of developing these figures.

Trends in Insurance Protection

Tables 1–4 show the dollar amounts of income loss and of private medical care expenditures for the years from 1948 through 1952; they also show the dollar volume of voluntary insurance against these losses or expenditures. The relations between insurance benefits and sickness costs measure the accomplishment of voluntary insurance in providing against these risks. Table 6 (condensed by omitting the data in the preceding tables for 1949 and 1950) summarizes the basic data on sickness costs and insurance benefits and shows the value of the current insurance for each of the years 1948, 1951, and 1952 in terms of percentage of sickness costs met by insurance.

The first three lines of table 6 measure voluntary insurance protection against income loss due to sickness. Benefit payments for income loss in the 5-year period have risen 92 percent—from $278 million in 1948 to $533 million in 1952—while total (net) income loss rose 26 percent, from a total of $4,519 million ($2,993 million with a 1-week waiting period) to a total of $5,707 million ($3,758 million with a 1-week waiting period). Insurance met 6.2 percent of the total loss in 1948, 8.7 percent in 1951, and 9.3 percent in 1952 (line 1). When measured against the smaller index of income loss (total minus the loss resulting from 1 week of incapacity), the percentages were 9.3 in 1948, 13.3 in 1951, and 14.2 in 1952 (line 2). Measured against the index of potentially compensable income loss (line 3), benefits covered 13.3 percent of this loss in 1948, 19.1 percent in 1951, and 20.4 percent in 1952. In this third measure the net increase in protection in the 5 years has been at the rate of about 1.4 percentage points a year.

Table 6.—*Income loss, private expenditures for medical care, and insurance benefits through all voluntary insurance carriers, 1948, 1951, and 1952*

[Amounts in millions]

	Benchmark [1]	1948		1951		1952		Percentage of sickness costs met by insurance			
		Income-loss and/or medical care expenditures	Voluntary insurance benefits	Income-loss and/or medical care expenditures	Voluntary insurance benefits	Income-loss and/or medical care expenditures	Voluntary insurance benefits	1948	1951	1952	
1	Income loss only	$4,519	$278	$5,418	$474	$5,707	$533	6.2	8.7	9.3	1
2	Potentially insurable income loss (with 1-week waiting period)	2,993	278	3,572	474	3,758	533	9.3	13.3	14.2	2
3	Potentially compensable income loss	2,083	278	2,480	474	2,608	533	13.3	19.1	20.4	3
4	Total medical care expenditures	7,288	606	8,816	1,353	9,447	1,608	8.3	15.3	17.0	4
5	Physicians' services only	2,240	151	2,684	456	2,879	538	[2] 6.7	[2] 17.0	18.7	5
6	Hospital services only [3]	1,855	455	2,471	897	2,794	1,070	24.5	36.3	38.3	6
7	Physicians' and hospital services only [3]	4,095	606	5,155	1,353	5,673	1,608	14.8	26.2	28.3	7
8	Medical care expenditures currently insurable under some comprehensive plans [4]	5,067	606	6,301	1,353	6,919	1,608	12.0	21.5	23.2	8
9	Medical care expenditures potentially insurable under present forms of voluntary insurance [5]	5,798	606	7,087	1,353	7,672	1,608	10.5	19.1	21.0	9
10	Income loss plus total medical care expenditures [6]	11,807	884	14,234	1,827	15,154	2,141	7.5	12.8	14.1	10
11	Income loss plus physicians' and hospital services only [7]	8,614	884	10,573	1,827	11,380	2,141	10.3	17.3	18.8	11
12	Potentially insurable income loss and medical care expenditures [8]	8,791	884	10,659	1,827	11,430	2,141	10.1	17.1	18.7	12
13	Potentially compensable income loss and potentially insurable medical care expenditures [9]	7,881	884	9,567	1,827	10,280	2,141	11.2	19.1	20.8	13

[1] Except as noted, represents estimated income loss or private expenditure for medical care (from tables 1 and 3) *plus* appropriate addition for net costs of insurance (from tables 2 and 4).

[2] Slight overstatement because total benefit payments—but not the benchmark—unavoidably include some payments for services other than those received from physicians (nurses, dentists, laboratories, etc.).

[3] Both expenditures and insurance benefits contain some expenditures included as hospital services that were out-patient services.

[4] Includes total expenditures for services of physicians, hospitals, and dentists and one-tenth of the expenditures for drugs, *plus* the net cost of medical care insurance.

[5] Includes total expenditures for services of physicians, hospitals, dentists, and nurses *plus* one-third the expenditures for drugs and appliances *plus* the net cost of medical care insurance.

[6] Combines lines 1 and 4.

[7] Combines lines 1 and 7.

[8] Combines lines 2 and 9.

[9] Combines lines 3 and 9.

Included in the income-loss payments of $533 million in 1952 is an estimated $127 million paid by private insurance companies or self-insurers with respect to coverage under the compulsory temporary disability insurance laws of California, New Jersey, and New York; such payments under these programs accounted for 24 percent of all benefit payments by private carriers in 1952. The percentage was about the same in 1951. In 1948, when private insurance companies were writing insurance under the temporary disability insurance law of only one State (California), the amount of private income-loss benefits attributable to this law was approximately $9 million and made up about 3 percent of the total privately paid in that year.

If private insurance against non-work-connected income loss is regarded as only that insurance written entirely outside the provisions of compulsory public laws, the benefits paid in 1952 should be reduced by the $127 million attributed to private insurance under these laws. The benchmark may then be adjusted downward to exclude the income lost by those protected by the public laws, whether their coverage was effected by the public funds, by private insurance carriers, or by self-insurance. With such an adjusted benchmark and using only the entirely voluntary insurance benefit amount of $406 million (the total minus the $127 million), the percentages shown in the tabulation below are obtained; the corresponding unadjusted figures from table 6 are given for comparison:

Benchmark	Percentage met by insurance, 1952	
	Unadjusted [1]	Adjusted [2]
Total (net)	9.3	9.3
Potentially insurable income loss	14.2	13.8
Potentially compensable income loss	20.4	19.8

[1] From table 6.

[2] Excludes income losses for 12.3 million persons eligible for benefits under public temporary disability insurance programs, at an estimated $107 per capita. (Estimates of eligibles and of per capita loss were based on reports of coverage and of total covered wages under the five public programs.) Private insurance under public laws ($127 million) is assumed to have had a loss ratio of 82 percent in making the "adjusted" calculations, using the methodology in tables 1 and 6.

Thus, the effect of narrowing the benchmarks by excluding the entire coverage effected under public laws and taking account of only strictly voluntary private insurance reduces somewhat the indexes of income-loss protection achieved by private insurance. If it were assumed that persons eligible for benefits under public laws have some need for, and interest in, supplementary private protection, and that they are "at risk" for some private insurance, the reduction in the benchmarks would have been less and the adjusted percentages of income loss met by entirely private insurance, shown in the tabulation, would be lower.

Between 1948 and 1952, medical care insurance benefits expanded nearly threefold (line 4 of table 6). These benefits met 8.3 percent of total medical care expenditures in 1948 and 17.0 percent in 1952. Insurance protection increased at the rate of nearly 2 percentage points a year. Private expenditures for medical services of all kinds increased from $7.3 billion in 1948 to $9.4 billion in 1952 (29 percent); the corresponding insurance benefits increased from $606 million to $1,608 million (165 percent).

When insurance protection is measured against narrower benchmarks, it is seen from the table that in 1952 insurance met 18.7 percent of the cost for physicians' services (line 5), 38.3 percent for hospital services (line 6), and 28.3 percent for both (line 7).[7]

There are prepayment plans that provide a wide range of benefits, including physicians' services in the home, office, and hospital, diagnostic services, dental care, and drugs, as well as hospitalization, and the enrollment in these plans has been increasing. Table 6 therefore includes a benchmark that contains items potentially insurable under such comprehensive prepayment plans (line 8). Measured against this benchmark, insurance payments met 23.2 percent of costs in 1952, in contrast to 12.0 percent in 1948. While most of the increase in the 5-year period results from expansion of insurance against hospital costs and the costs of physicians' services in the hospital, some of it represents expansion in insurance against the cost of physicians' home and office calls, dental benefits, and the cost of drugs.

The benchmark in line 9 of the table most nearly represents the types of benefits available through the relatively new "major medical expense" insurance or the combination of the older forms of voluntary insurance and of "major medical expense" (or "catastrophic") insurance. The proportion of this benchmark met by insurance in 1952 was 21.0 percent; it had been 10.5 percent in 1948.

If total income loss and medical care expenditures are combined, 14.1 percent of the $15.2 billion private cost of sickness in 1952 was met by insurance benefits of $2.1 billion (line 10). If the measurement is made against a benchmark that includes only physicians' and hospital services plus income loss, insurance accounted for 10.3 percent in 1948 and for 18.8 percent in 1952 (line 11). If measurement is made against potentially insurable private medical care expenditures and income loss (line 12), the proportion of sickness costs met by insurance in 1952 was 18.7 percent; if made against potentially insurable medical costs plus potentially compensable income loss, insurance met 20.8 percent, nearly twice the achievement in 1948.

The data presented in this analysis provide a means of measuring the present extent and the growth of voluntary health insurance in the past 5 years. In terms of premium income and expenditures (as well as in population coverage), voluntary health insurance has been expanding rapidly. Increase in the dollar volume of insurance is partly offset by increase in population and in the costs of sickness. There has been a nearly threefold expansion in insurance benefit amounts for medical care between 1948 and 1952, yielding a twofold expansion in the effective insurance protection. Income-loss insurance has been growing more slowly, with a doubling in benefit amounts and a 50-percent increase in effective insurance protection over the same 5-year period. Most of the costs of sickness incurred annually by the civilian population as a whole are still being carried as private losses and expenditures.

[7] The insurance industry reports that, at the end of 1952, 57 percent of the population had some insurance protection against hospital expenses, 46 percent against surgical expenses, and 22 percent against medical expenses. (*Annual Survey of Accident and Health Coverage in the United States, as of December 31, 1952,* Health Insurance Council, Sept. 1953, p. 7.)