*Voluntary Insurance Against Sickness: 1948–53 Estimates**

THE year 1953 saw a continued expansion in voluntary health insurance, both in terms of the number of persons with some protection against the costs of sickness and the dollar value of the protection provided. This growth in insurance accompanied (1) an increase in population that resulted in greater expenditures for medical care and for medical care insurance and (2) rising costs. Nevertheless the growth in insurance protection from 1952 to 1953 was at a more accelerated rate than that of the other factors, so that again there was a net gain in the protection the population received through voluntary health insurance.

Voluntary health insurance takes such diverse forms in the United States today that lengthy documentation is required to delineate the types of benefits or the number of persons covered for each of these benefits. A summary of the main forms of voluntary insurance and the main categories of insurers may, however, be useful here.

Voluntary health insurance falls primarily into two broad classifications—cash indemnity insurance and service benefit insurance. Under cash indemnity insurance the insured person who suffers the loss files a claim and receives indemnification up to the amount stated in his policy, which is, however, not necessarily equivalent to the total amount of his loss. With service benefit insurance it is usual for the insured person to receive the benefit (the "service"), without paying the bill directly and without subsequently filing a claim. This procedure is possible either because the insurer has made financial arrangements with the providers of services, such as the hospital in the case of Blue Cross plans or the physician in the case of Blue Shield plans, or because the plan itself provides the services through its own staff of physicians and/or hospital facilities.

In the order of availability to the public, insurance providing cash indemnification to the insured person ranks foremost. Such insurance is provided by commercial group and individual accident and health and life insurance companies, including both stock and mutuals. It is also made available by some nonprofit hospitalization and/or surgical plans and by some employers, employee groups, unions, and fraternal societies. The insurance may provide protection against one or more of the following risks: loss of income, hospitalization, surgical operations, medical care, and—to a limited degree—dental and nursing care. The maximum amount of indemnification for the particular benefit is usually stated in the policy.

Service benefit insurance is applicable to medical care costs but not to income loss. It is usually subdivided into "indirect" and "direct" service types. Blue Cross and Blue Shield plans are of the indirect type, since they contract with a third party—the hospitals or the physicians—to provide the service benefits. In some Blue Cross and Blue Shield plans the arrangements to make the payment to a third party are the only inherent difference between their form of insurance and cash indemnity insurance, since their contracts do not

IN OUR STUDIES of the economic status of old-age and survivors insurance beneficiaries and our analyses of the reasons for persons coming on the public assistance rolls, we frequently find that sickness and its attendant costs are one of the major causes for economic insecurity. The Social Security Administration has observed the progress of prepayment for medical care and income loss with interest, and I believe that our findings, as presented in this annual series, will be of use to all who are concerned with the economic security of the American people.

CHARLES I. SCHOTTLAND
Commissioner of Social Security

Table 1.—*Income loss due to illness, 1948–53* [1]

[In millions, except average income loss per worker]

Item	1948	1949	1950	1951	1952	1953
Average number of employed workers [2]	59.7	59.1	60.4	61.4	61.7	61.9
Average income loss per worker [3]	$76.65	$78.26	$82.60	$89.11	$94.68	$98.56
Total income loss from illness	$4,576	$4,625	$4,989	$5,471	$5,805	$6,101
Net cost of income loss insurance (addition) [4]	267	276	297	303	317	374
Paid sick leave (subtraction) [5]	290	296	312	333	347	350
Net income loss from illness	4,553	4,605	4,974	5,441	5,775	6,125
Potentially insurable income loss [6]	3,013	3,051	3,290	3,586	3,800	4,047
Potentially compensable income loss [7]	2,099	2,127	2,293	2,493	2,640	2,824

[1] Short-term or temporary non-work-connected disability (lasting not more than 6 months) and the first 6 months of long-term disability. Data for years before 1953 revised to reflect newly available data from the Bureau of the Census on annual average number of employed persons.

[2] Annual average of employed persons, from Bureau of the Census, *Current Population Reports, Labor Force*, Series P–57, No. 19, table 1, and No. 45, table A; Series P–57, Nos. 127–129, table 1.

[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 1953, and unpublished data for 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.

[5] Estimated number of persons covered by paid sick leave and related provisions from *Annual Survey of Accident and Health Coverage in the United States*, Health Insurance Council, each year 1948–53. Assumes that this number of persons (8.4 million in 1948–50, dropping to 7.9 million in 1953) received the equivalent of 45 percent of their total income loss due to illness.

[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 ⅛ 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.

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

Table 2.—*Premiums, benefit payments, and loss ratios for commercial and other private insurance against income loss, 1948–53*

[Amounts in millions]

Item	1948	1949	1950	1951	1952	1953
	Premiums earned [1]					
Total [2]	$545	$588	$671	$777	$853	$975
Group insurance [3]	175	210	284	372	399	448
Individual insurance [3] [5]	346	352	355	368	409	474
Other [4]	24	26	32	37	45	53
	Losses incurred [1]					
Total [2]	$278	$312	$374	$474	$536	$601
Group insurance [5]	124	147	203	295	327	364
Individual insurance [3] [5]	139	148	151	155	179	202
Other [4]	15	17	20	24	30	35
	Loss ratios (percent)					
Total	51.0	53.1	55.7	61.0	62.8	61.6
Group insurance	70.9	70.0	71.5	79.3	82.0	81.3
Individual insurance	40.2	42.0	42.5	42.1	43.8	42.6
Other	62.5	65.4	62.5	64.9	66.7	66.0

[1] Premiums and losses include accident only and travel accident insurance. They also include private insurance company operations and self-insured arrangements under public laws but exclude payments from public funds. (See table 3 for details.)

[2] 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 $36 million for 1953.) 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.

[3] Premiums earned for income-loss and medical care insurance combined (separately for group and individual contracts), obtained from the *Spectator Accident Insurance Register*, 1949–54. 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.*, 1948–53) 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 1949–54); 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.

[4] 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 insurance laws and elsewhere. Information on fraternal accident and health business supplied by *The Fraternal Monitor*. Division between income-loss and medical care insurance estimated.

[5] Losses incurred, as reported by the *Spectator* for income-loss and medical care insurance combined, reduced by 1.9 percent (1.6 percent in 1953) of premiums earned for group policies and 2.8 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.

attempt to guarantee that the payment to the physician or the hospital will cover most or all of the charges made to the patient. Other Blue Cross and Blue Shield plans do make such a guarantee, subject to the limits of their contractual obligations—that is, the benefits they agree to furnish. Blue Shield plans providing service benefits guarantee, however, that the amount they pay the physician after he has provided the service will cover the entire bill only if the patient's income is less than a specified limit, which varies among the plans. In other words, the physician agrees that his charges will amount to no more than the payment set forth in the fee schedule of the policy only if the patient's income is under the "ceiling." When the patient's income is more than this stated amount, the payment of the fee schedule amount to the physician becomes in effect a cash indemnification even though made to the physician rather than the patient; the physician may bill the patient directly for the difference between his actual charges and the fee schedule.

Direct service plans, as their name implies, furnish the insured person with medical and/or hospital services. They show less uniformity in the benefits they provide than do the cash indemnity or indirect service plans, which confine their benefits to cash sickness, hospitalization, surgical and maternity care, and a limited amount of medical care, mainly in connection with a hospitalized illness. The direct service benefit plans vary in the scope of their benefits from the provision of complete hospital care, medical care in the hospital, clinic, and patient's home, and dental care to the provision of diagnostic and preventive care only, or only dental care, hospital care, or ambulatory medical care. They likewise vary in the extent to which they make extra charges to the patient at the time he receives services.

The differences among companies and plans in the method of providing protection against the costs of sickness and the differences in the scope of the protection—whether geared to meet the entire cost of the illness or indemnify a part of the loss—are two of the elements making evaluation of health insurance in terms of persons protected or types of risks covered less meaningful than they appear to be on casual inspection.

Starting in 1950 with data for 1948, the Social Security Administration has measured certain quantitative aspects of voluntary health insurance by an appraisal technique based on the dollar value of the protection afforded, measured against the current costs of sickness in the United States. This article—the sixth in the series—covers the 6 years 1948–53 and incorporates the results of a special survey, made in 1954 by the Division of Research and Statistics, of the prepayment income and expenditures for medical care among 306 providers of health insurance benefits who are neither affiliated with the Blue Cross or Blue Shield Commissions nor classified as commercial insurance carriers.[1] As a result, data on the independent plans are more exact for 1953 than for the years between this survey and one made by the Division of Research and Statistics in 1950; the 1951 and 1952 figures for independent plans as they appear in this year's article have been revised to bring them in line with the findings for 1953.

[1] The results of this survey will be published early in 1955 in the *Bulletin* and more fully at a later date in a monograph.

Table 3.—*Temporary disability insurance under public laws, 1948–53*

[In millions]

Benefits, net cost, and income loss	1948	1949	1950	1951	1952	1953
Cash sickness insurance:						
Benefits, total	$66.4	$89.2	$117.4	$174.2	$202.3	$231.8
Public plans [1]	57.1	62.1	63.2	60.9	74.5	91.6
Private plans [2]	9.3	27.1	54.2	113.3	127.8	140.2
Net cost, total	30.2	32.6	28.4	40.1	35.9	35.9
Public plans [3]	27.5	24.5	13.0	16.6	12.9	9.7
Private plans [4]	2.7	8.1	15.4	23.5	23.0	26.2
Income loss under public provisions (estimated) [5]	455.0	595.0	1,053.0	1,167.0	1,243.0	1,327.0
Hospital and medical care insurance:						
Benefits, total			6.5	11.0	13.4	16.2
Public plans [6]			2.7	2.6	3.3	3.7
Private plans [7]			3.8	8.4	10.1	12.5

[1] Under the Railroad Unemployment Insurance Act and the laws of Rhode Island, California, New Jersey (beginning 1949), and New York (beginning 1950). Not included in data in table 2.

[2] Under laws of California, New Jersey (beginning 1949), and New York (beginning 1950). Group insurance plans except for 8–10 percent that are self-insured. These amounts are included in data in table 2.

[3] In the early years of the programs in California and New Jersey some of the excess of contributions over expenditures was used to establish a reserve.

[4] Assumes that the loss ratio for group insurance and self-insurance under the public laws is the same as that shown in table 2 for group insurance each year.

[5] Adjusted for paid sick leave in the covered population.

[6] Hospital benefits in California.

[7] Hospital benefits in California and hospital, surgical, and medical benefits in New York.

Income Loss Due to Illness

In thinking of the costs of sickness to an individual, there is a tendency to consider only expenditures for medical and hospital care and for insurance against these two types of costs, and to overlook the cost occurring through loss of income and the purchase of income-loss insurance. Actually income loss due to illness, if it is broadly enough defined, can become the largest item in the personal costs of sickness. As used in this study, however, the estimate of income loss is confined to that attributed to nonoccupational illness and injury and reflects only current income loss from short-term or temporary disability and the first 6 months of extended disability. It does not therefore encompass the loss of future earnings arising from extended or permanent disability or premature death. As thus defined, it accounts for about two-fifths of the annual costs of sickness.

The derivation of the estimate of income loss for the 6 years 1948–53 is shown in table 1. The gross figures cover income loss from nonoccupational illness and injury, whether or not such losses were compensable. The table shows that, assuming an average of 7 days lost from work on account of illness during the year, the loss per worker amounted to $76.65 in 1948, $94.08 in 1952, and $98.56 in 1953. When the 1953 figure is applied to the 1953 labor force of nearly 62 million, it yields a gross estimate of $6,101 million in lost income, which may be compared with a loss of $4,576 million in 1948. The gross figures require adjustment each year (table 1) for paid sick leave and for the net cost of income-loss insurance purchased (table 2).

After these subtractions and additions, the net income loss due to non-work-connected illness and the first 6 months of longer-term illness was $6,102 million in 1953. The 1953 figure represents a rise of 6 percent from 1952, an increase of the same magnitude as occurred the preceding year; it was 35 percent greater than the 1948 total.

The figure on potentially insurable income loss takes into account the fact that most accident and health insurance policies currently available for purchase restrict their benefits by not undertaking to cover the first few days or the first week of sickness (though they may do so in the case of accidents). The potentially insurable portion of the net income loss is estimated to have been $4,047 million in 1953 (see table 1, footnote 6).

A guiding principle of current insurance practice is that compensation should never represent more than 50–75 percent of actual income loss. By assuming that on the average the potentially compensable loss amounts to two-thirds of the potentially insurable loss, the estimate for 1953 equals $2,814 million (see table 1, footnote 7).

Insurance Against Income Loss

Ninety-five percent of current protection against income loss is provided by accident and health policies sold on a group or individual basis by commercial insurance companies. The remaining 5 percent is derived from self-insured plans of employers, employees, and unions, and from employee benefit organizations and

Table 4.—*Private expenditures for medical care, 1948–53* [1]

[In millions]

Item	1948	1949	1950	1951	1952	1953
Total	$7,193	$7,552	$8,117	$8,586	$9,236	$9,866
Hospital services [2]	1,663	1,858	2,121	2,283	2,561	2,825
Physicians' services [3]	2,233	2,342	2,467	2,562	2,718	2,859
Dentists' services	833	857	869	888	906	943
Other professional services [4]	423	448	476	498	532	562
Medicines and appliances	1,785	1,798	1,885	2,048	2,130	2,192
Administrative and other net costs of medical care insurance [5]	256	249	299	307	389	485
Insurance for hospital services	192	168	189	188	232	284
Insurance for physicians' services	64	81	110	119	157	201

[1] Except where otherwise noted, data are from the Department of Commerce, *1954 National Income Supplement to Survey of Current Business*, table 30. 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. Includes expenditures by industry for the employers' share of health insurance premiums.

[2] Computed from data in *Hospitals*, June of each year 1949–54. 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. Amount of private expenditures is overstated by an unknown amount representing payments to nonprofit hospitals on behalf of individual patients by government and welfare agencies and workmen's compensation funds. Data are understated in that no estimate has been included for private expenditures for care in private nursing homes.

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

[4] Comprises services of osteopathic physicians, chiropractors and podiatrists, private duty trained nurses, and miscellaneous curative and healing professions.

[5] Data from table 5.

Table 5.—*Premiums, benefit payments, and loss ratios for voluntary insurance against the costs of medical care, 1948–53* [1]

[Amounts in millions]

Item	1948	1949	1950	1951	1952	1953
	Earned income					
Total	$862	$1,016	$1,291	$1,660	$1,993	$2,405
Hospital services	647	707	869	1,085	1,306	1,572
Physicians' services	215	309	422	575	687	833
	Expenditures for benefits					
Total	$606	$767	$992	$1,353	$1,604	$1,919
Hospital services	455	539	680	897	1,074	1,287
Physicians' services	151	228	312	456	530	632
	Loss ratios (percent)					
Total	70.3	75.5	76.8	81.5	80.5	79.8
Hospital services	70.3	76.2	78.3	82.7	82.2	81.9
Physicians' services	70.2	73.8	73.9	79.3	77.1	75.9

[1] Data for 1948–51 summarize detailed presentations in earlier articles in this series; data for 1952 revised; data for 1953 from table 6. 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.

Table 6.—*Income and expenditures for medical care benefits of voluntary insurance by type of carrier or plan, 1953*

[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	$2,404.6	$1,571.3	$833.3	[4] $1,919.2	$1,287.0	$632.2	79.8
Blue Cross plans [5]	708.4	693.0	15.4	626.8	613.8	13.0	88.5
Blue Shield plans [6]	280.2	11.3	268.9	224.7	9.9	214.8	80.2
Other medical society sponsored plans [7]	10.0	4.0	6.0	9.0	3.4	5.6	90.0
Other nonprofit plans:							
Community	56.3	33.1	23.2	48.0	28.9	19.1	85.3
Consumer-sponsored	7.8	4.0	3.8	5.8	2.9	2.9	81.7
Fraternal society [8]	12.1	5.6	6.5	10.8	6.1	4.7	89.3
Employer and/or employee	49.6	26.9	22.7	47.7	26.3	21.4	96.2
Union health and welfare [9]	76.7	44.8	31.9	70.2	42.7	27.5	91.5
Student health services [10]	5.0	2.0	3.0	5.0	2.0	3.0	100.0
Private group clinics with prepayment	17.8	7.3	10.5	16.5	6.3	10.2	92.7
Commercial plans: [11]							
Group insurance	722.6	432.7	289.9	625.8	384.6	241.2	86.6
Individual insurance	458.8	307.0	151.8	228.9	160.1	68.8	50.0

[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 or expenditures for services other than those received from physicians (nurses, dentists, laboratories, etc.).

[4] Includes amounts paid through private plans under the State temporary disability insurance laws of California and New York (see table 3).

[5] Addition made to the data reported by the Blue Cross Commission for Health Services, Inc. Data for medical-surgical insurance for 5 combined Blue Cross-Blue Shield plans shown under Blue Shield plans. Division between hospital and physicians' services estimated for 3 of the 9 Blue Cross plans that write both types of insurance on the basis of enrollment and premiums for each type.

[6] Excludes amounts for hospital insurance of 5 Blue Cross-Blue Shield plans. Includes hospital insurance among 7 Blue Shield plans; division between hospital and physicians' services estimated for 1 of these plans on basis of past reporting.

[7] Covers 4 nonprofit plans sponsored or controlled by medical societies; excludes plans underwritten by commercial insurance companies.

[8] Represents amounts reported in 1954 survey of such plans by Social Security Administration and estimates for nonrespondents.

[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] See footnotes 3 and 5 of table 2 for the method of developing these figures.

fraternal societies. Table 2 shows data for the years 1948-53 for all types of nongovernmental organizations insuring against income loss. A total of $975 million is estimated to have been paid for income-loss premiums in 1953, and $601 million was received in benefits. The net cost of income-loss insurance—the difference between premiums earned and losses incurred—amounted to $374 million in 1953; the benefits amounted to 62 percent of the premiums. In comparison with 1952, benefits had increased by $65 million, or 12 percent, and the premium cost had gone up $122 million or 14 percent.

Private insurance company and self-insured operations of the State temporary disability insurance programs in California, New Jersey, and New York are included in the estimates in table 2. These private operations under public laws accounted for 24 percent of the total benefits paid for income loss in both 1952 and 1953. Publicly provided insurance is not included in these data. To permit consideration of the significance of both publicly and privately provided insurance under these public laws, and publicly provided insurance under the Rhode Island temporary disability insurance law and the Railroad Unemployment Insurance Act, table 3 has been prepared. These data permit adjustment of the private insurance benefits under public laws, as well as the adjustment of the income loss due to sickness, so that the results may, if desired, be confined to the entirely voluntary field or alternatively encompass the public provisions. If the benefits under public laws are excluded, the adjustment reduces the percentage of potentially insurable and potentially compensable income loss met by voluntary insurance by less than 1 percent, and so it is not shown in this year's analysis.[2]

Private Expenditures for Medical Care

The Department of Commerce makes annual estimates of personal expenditures for medical care, revising the data periodically for its annual reporting of national income and

[2] See the *Bulletin* for December 1953 for a detailed explanation of the adjustments.

Table 7.—*Income loss, private expenditures for medical care, and insurance benefits through all voluntary insurance carriers, 1948, 1952, and 1953*

[Amounts in millions]

	Benchmark [1]	1948		1952		1953		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	1952	1953	
	Income loss:										
1	Income loss only	$4,553	$278	$5,775	$536	$6,125	$601	[2] 6.1	[2] 9.3	[2] 9.8	1
2	Potentially insurable income loss (with 1-week waiting period)	3,013	278	3,800	536	4,047	601	14.1	14.1	14.9	2
3	Potentially compensable income loss	2,099	278	2,640	536	2,824	601	13.2	20.3	21.3	3
	Medical care:										
4	Total medical care expenditures	7,193	606	9,236	1,604	9,866	1,919	8.4	17.4	19.5	4
5	Hospital services only [3]	1,855	455	2,793	1,074	3,109	1,287	24.5	38.5	41.4	5
6	Physicians' services only	2,297	151	2,875	530	3,060	632	[4] 6.6	[4] 18.4	[4] 20.7	6
7	Hospital and physicians' services only [3]	4,152	606	5,668	1,604	6,169	1,919	14.6	28.3	31.1	7
8	Medical care expenditures currently insurable under some comprehensive plans [5]	5,164	606	6,787	1,604	7,331	1,919	11.7	23.6	26.2	8
9	Medical care expenditures potentially insurable under present forms of voluntary health insurance [6]	5,780	606	7,528	1,604	8,092	1,919	10.5	21.3	23.7	9
	Combined income loss and medical care:										
10	Income loss plus total medical care expenditures [7]	11,746	884	15,011	2,140	15,991	2,520	7.5	14.3	15.8	10
11	Income loss plus hospital and physicians' services only [8]	8,705	884	11,443	2,140	12,294	2,520	10.2	18.7	20.5	11
12	Potentially insurable income loss and potentially insurable medical care expenditures [9]	8,793	884	11,329	2,140	12,139	2,520	10.1	18.9	20.8	12
13	Potentially compensable income loss and potentially insurable medical care expenditures [10]	7,879	884	10,169	2,140	10,916	2,520	11.2	21.0	23.1	13

[1] Except as noted, represents estimated income loss or private expenditure for medical care (from tables 1 and 4) *plus* appropriate addition for net costs of insurance (from tables 2 and 5).

[2] If the benefits from public funds under the temporary disability insurance laws had been included in the benefits and the net costs of operating public funds added to the benchmarks (using data in table 3), these percentages would be 7.3 (1948), 10.6 (1952), and 11.3 (1953).

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

[4] 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.).

[5] 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.

[6] 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.

[7] Combines lines 1 and 4.

[8] Combines lines 1 and 7.

[9] Combines lines 2 and 9.

[10] Combines lines 3 and 9.

product. The data that furnish the basis for most of the figures shown in table 4 for 1948–53 were extensively revised by the Department of Commerce in 1954, and items previously shown separately have been grouped and consolidated. As in previous articles in the series, certain adjustments and/or substitutions have been made in these data for (1) expenditures for physicians' services, (2) expenditures for hospital services, and (3) the net cost of medical care insurance (see footnotes to table 4 for details).

Table 4 gives the revised figures for expenditures for medical care for each of the 6 years 1948–53. The civilian population spent about $9.9 billion for medical care in 1953—an increase from 1952 of $630 million or 6.8 percent; the expansion was slightly less than that in the preceding year, when expenditures rose 7.9 percent. Since 1948, expenditures for medical care have gone up 37 percent and expenditures for hospital services have shown a 70-percent increase. Expenditures for physicians' services, on the other hand, rose only 28 percent in the 6 years.

Insurance Against Medical Care Costs

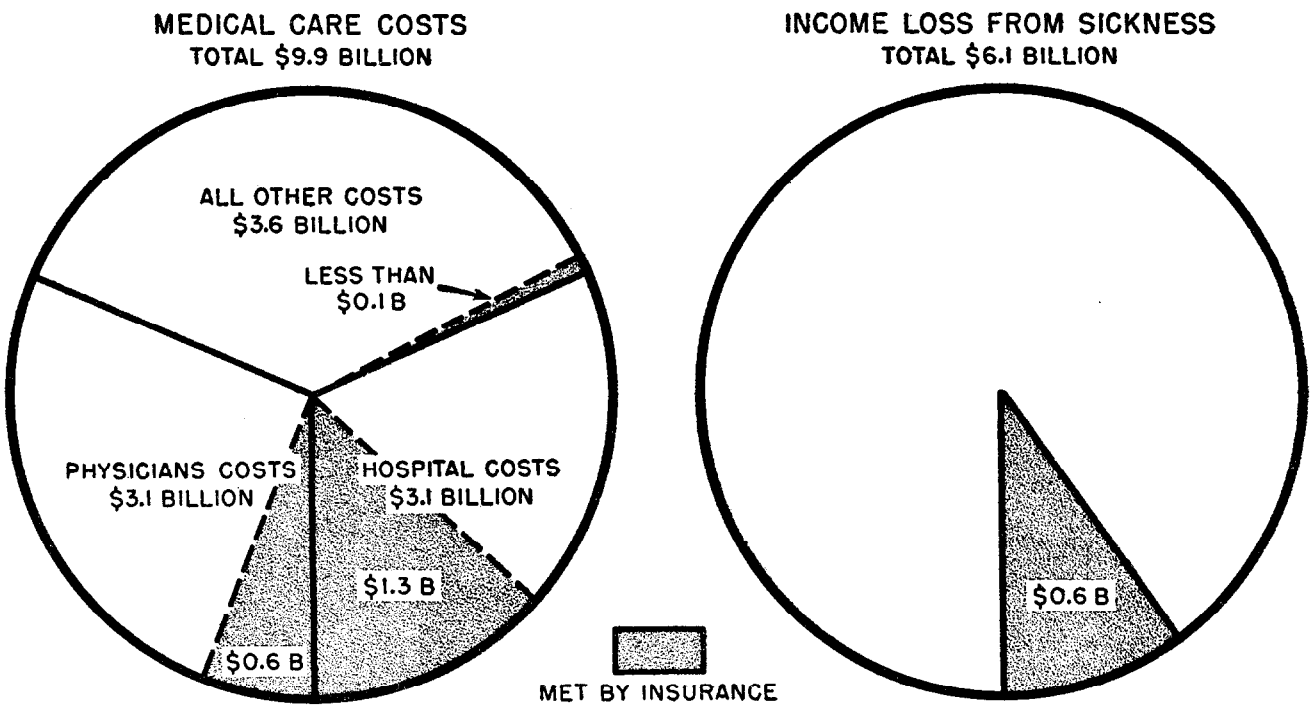
The financial operations of all voluntary medical care insurance during the 6-year period 1948–53 are summarized in table 5. Earned insurance income increased by 180 percent; hospitalization insurance income increased by 143 percent; and that for physicians' services, which was relatively low in the first year reported by the series, went up 289 percent. The increases reflect the addition of many more insured persons, improvements in benefits, and the rising costs of premiums and benefits in this far from static field. The net costs of medical care insurance (shown in table 4) have increased less rapidly than either income or benefits; the ratio of expenditures for benefits to earned income has risen in the 6 years so that about 10 cents more per dollar of premium was returned as benefit payments in 1953 than in 1948.

Table 6 provides a more detailed analysis of the 1953 financial data on voluntary medical care insurance, by type of insurance carrier or prepayment plan.[8]

Among all insurance carriers and plans, hospitalization insurance accounted for 65 percent of the total premium income in 1953 and 67 percent of the expenditures for benefits, with the balance applicable to insurance against physicians' services. There has been no material change in this distribution between hospitalization insurance and that for physicians' services since 1949 — an

[8] For corresponding data for earlier years, see the *Bulletin* for December 1953, December 1952, December 1951, and January–February 1950.

Chart 1.—*Costs of sickness and voluntary health insurance benefits, 1953*



indication that the expansion of the two types has been at a similar rate.

In 1953, for the first time, the total earned premiums of group accident and health insurance companies exceeded those of plans affiliated with the Blue Cross Commission; their total benefit expenditures, however, were just below those of the Blue Cross plans. In the field of provision of hospitalization insurance Blue Cross maintained its leadership. Benefit payments of Blue Cross plans accounted for 48 percent of all hospitalization benefits paid in 1953 and 44 percent of total hospitalization income. Commercial group insurance was the leading provider of insurance against the costs of physicians' services, with Blue Shield ranking second. These two types of insurers accounted for roughly 70 percent of the insurance provided in 1953 against the cost of physicians' services. Since, of course, much of the insurance purchased from Blue Shield or commercial companies applies to surgical services, the small extent to which nonsurgical medical care is covered by insurance is readily apparent. Plans not connected with Blue Cross, Blue Shield, or commercial insurance organizations made about 15 percent of the benefit payments for physicians' services; it is this group of plans that provides most of the insurance for home and office and diagnostic and preventive services.

The data in table 6 include about $15 million in premium income and $12.5 million in expenditures for benefits resulting from insurance provided through private carriers under the public temporary disability insurance laws in California and New York relating to medical care benefits. The table does not show the $3.7 million paid from the State fund in California for hospitalization under its temporary disability insurance law.

Trends in Insurance Protection

The dollar amounts of income loss and of private medical care expenditures for 1948–53 are shown in tables 1 and 4. Tables 2 and 5 give the dollar volume of voluntary insurance against these losses or expenditures. Table 7 summarizes the basic data on sickness costs and insurance benefits and shows the value of the prevailing insurance for each of the 3 years 1948, 1952, and 1953 in terms of the percentage of sickness costs met by insurance.

The first section of table 7 measures voluntary insurance protection against income loss due to sickness. Benefit payments for income loss in the 6-year period have risen 116 percent—from $278 million in 1948 to $601 million in 1953—while total (net) income loss increased 34 percent. Insurance, which met 6.1 percent of the income loss in 1948, was meeting 9.8 percent in 1953 (line 1). Had the data not been confined to protection furnished through voluntary (private) provisions, and had payments from public funds been included in the benefits, the percentage of income loss met by insurance would have been 11.3 (see footnote 2 of table 7). When measured against potentially insurable income loss, the percentage met by insurance was 14.9 in 1953, nearly 6 percent higher than in 1948. If the index is further narrowed to include only potentially compensable income loss, 21.4 percent was covered by insurance benefits in 1953 and 13.2 percent in 1948.

The figures in table 7 include the income loss of persons protected by the public laws and the amounts paid by private insurance companies or self-insurers with respect to coverage under the compulsory temporary disability insurance laws. The adjust-

ments necessary to exclude these amounts may be made from data presented in table 3. These adjustments reduce by less than 1 point the percentage figures for 1952 and 1953; the volume of compulsory income-loss insurance was negligible in 1948 so that the adjustments would not alter the earlier figures.

The second section of table 7 includes six alternative benchmark figures for expenditures for medical care against which voluntary medical care insurance may be measured. Private expenditures for medical services of all kinds increased from $7.2 billion in 1948 to $9.9 billion in 1953. The benefits provided by insurance covered 19.5 percent of the 1953 expenditures and 8.4 percent of those in 1948; the increase has thus been at an average rate of nearly 2 percentage points a year. The percentage of physicians' bills met by insurance has gone up slightly more than 2 points a year and that of hospital costs slightly less than three points a year.

Certain prepayment plans, including those classified as private group practice plans in table 6 and, in addition, a few of the consumer, community, union, and employer-employee plans, provide a wide range of prepaid benefits, such as physicians' services in the home, office, and hospital, diagnostic services, dental care, and drugs, as well as hospitalization. Line 8 of table 6 gives a benchmark made up of items potentially insurable under such comprehensive prepayment plans. Insurance payments met 26.2 percent of this total in 1953, in contrast to 11.7 percent in 1948.

As nearly as possible the benchmark in line 9 of the table represents the types of benefits available through the relatively new "major medical expense" policies or through a combination of the more usual forms of voluntary insurance and of "major medical expense" (or "catastrophic") insurance; under either of these arrangements, some insurance protection would be provided for the costs of nursing services, expensive drugs and appliances, and physical restoration. By 1953 voluntary insurance benefits were meeting nearly 24 percent of this benchmark.

To complete the picture of the extent of sickness costs met by insurance, the third section of the table contains four benchmarks combining income loss and medical care expenditures. If total income loss and total medical care expenditures are combined, it appears that 15.8 percent of the $16 billion private cost of sickness in 1953 was met by insurance benefits of $2.5 billion (line 10). The average increase in percentage points in the 6 years has been less than 1.5 percent annually. When the benchmarks are narrowed the proportion met by insurance increases, but the rate of expansion has remained at 2 percent or slightly less each year.

This yearly analysis affords a means of measuring the present extent and growth of voluntary health insurance divorced from considerations of population growth, changes in the cost of medical care and the level of income, and the adequacy of the particular benefits for which insured persons are eligible. In terms of premium income and expenditures for benefits, voluntary health insurance has shown a remarkable growth, but as chart 1 shows, the extent of insurance protection currently provided varies markedly according to the risk.

Recognizably, increase in the dollar volume of insurance is partly offset by increases in the population and in the costs of sickness. The more than threefold expansion in insurance benefit amounts for medical care has therefore yielded in the past 6 years only slightly more than a twofold expansion in the effective insurance protection (a 217-percent increase in benefits and a 133-percent increase in the percentage met by insurance). Income-loss insurance has expanded more slowly than medical care insurance so that benefits have increased 116 percent, while the effective protection has risen only 61 percent in the 6-year period.

Chart 2 shows 6-year trends in the percentages of various sickness costs met by insurance. It is only in the field of hospital costs that voluntary insurance benefits have begun to reveal a significant relationship between the proportion of the population insured and the proportion of the Nation's medical bills met by insurance. On balance, even though more than half the population reportedly has some kind or amount of voluntary health insurance, most of the costs of sickness incurred annually by the civilian population as a whole are still met at the time they occur and not through prepayment.

Chart 2.—*Percentage of costs of sickness met by voluntary health insurance benefits, 1948–53*