*Voluntary Health Insurance and Medical Care Costs, 1948–55**

Private expenditures for medical care in the United States in 1955 amounted to more than $11 billion, or $69 for each person in the population. Expenditures of such magnitude, representing as they do 2.9 percent of the total national output and 4.1 percent of disposable personal income, deserve careful study. Study of the costs of medical care in the United States cannot be divorced from an examination of voluntary health insurance, used by two-thirds of the population to assist them in financing a part of their medical bills in advance of sickness. In 1955 the American people paid $3.2 billion or 29 percent of their total medical bills to the health insurance industry. The interest—both of groups and individuals—in voluntary health insurance is continuing to grow. This year's article therefore includes a brief description of the various types of insurance available, the benefits, and the costs.

THE extent to which voluntary health and accident insurance benefits have replaced direct expenditures for medical care and income loss due to sickness has been the subject of regularly scheduled articles in the BULLETIN.[1] The distribution of the medical care dollar to hospitals, physicians, dentists, and nurses and for drugs and prescriptions, ophthalmic products, and so forth has been recorded and the growth of health insurance followed for the past 8 years.

In recognition of the growing interest among all segments of the population in health insurance as a means of prepaying at least a part of their medical care costs, this year's article contains a section describing the available types of health insurance and the kinds of benefits provided; it includes some discussion of individual and family health insurance premiums.

The interest of government agencies, at both the Federal and State levels, in approaches to the problems of providing prepaid protection for health care is indicated by recent legislative action. Laws were enacted this year providing for medical care for the dependents of members of the Armed Forces and of State Department employees overseas, and there have been various legislative proposals in recent years at the Federal and State levels, as well as recommendations of State conferences and commissions. Private groups, too, have a concern with the scope of insurance now available in relation to health and welfare plans and the needs of certain population groups, such as the aged and those living in rural areas. Visitors from abroad find the complexities of the voluntary approach to prepayment of medical care in the United States hard to grasp. It is hoped that this general, though necessarily brief, picture of the scope and costs of the major benefits available from voluntary health insurance companies and plans will provide a useful source document.

A discussion of private expenditures and their relation to health insurance benefits follows the material describing health insurance. Only a brief description of the tables that have become a regular part of the annual series is given this year. The subject of income loss due to sickness and the amount of insurance against this loss will be treated, as in 1955, in a separate article.[2]

* Prepared in the Division of Program Research, Office of the Commissioner.

[1] For the previous articles in this series, beginning with data for 1948, see the *Bulletin* for January-February 1950 and December of 1951, 1952, 1953, 1954, and 1955. Details of the methodology will be found in these articles.

[2] See the *Bulletin*, January 1956, and the forthcoming *Bulletin* for January 1957.

Data for each year from 1948 to 1955 have been slightly revised in the tables that follow. Newly available estimates prepared by the Public Health Service for a single year (1955) have made it possible to include an item for nursing-home care, a recognized omission in the earlier reports. An addition has been made to expenditures for physicians' services and hospital services to cover the cost of student health services, which were not represented in the expenditure series in earlier years.

I. Description of Voluntary Health Insurance

In 1955 voluntary insurance against the costs of hospital and medical care provided more than $2.5 billion in benefits to insured persons, a sum representing about 23 percent of their aggregate personal expenditures for medical care and health services. Table 1 shows both the amounts the population paid to the various providers of health insurance for this protection and the amounts returned as benefits in 1955. The table gives an indication of the many different forms of health insurance found in the United States and shows also their relative importance.

Prepayment or health insurance is a method of averaging medical care expenditures among groups of persons over a period of time. In the United States, individuals, families, and groups of people associated together for some purpose other than the purchase of insurance may buy such insurance from various types of commercial and nonprofit insurance organizations. For various reasons, a group that is a cross section of the population can collectively purchase protection at lower rates than individuals. Their experiences are pooled, the costs of collecting the premiums are lower, and the costs of marketing the "product" are less.

Expenditures for Medical Care

To understand the mechanism of spreading the risk, it is helpful to keep in mind that the ordinary family may expect to spend, on the average, between 4 percent and 5 percent of its annual income on all forms of medical care and on health insurance. For lower-income families more than 4–5 percent of income is usually required, and for higher-income families slightly less than this proportion.

A family's expenditures vary, of course, from year to year and according to the size of the family, the age of the family members, and other characteristics. Expenditures for a child are less, on the average, than those of an adult. Largely because of childbearing, expenditures are greater for married women than for men or single women. Were older persons able to afford all the medical care they need, their expenditures, which are higher than the average for all ages, would increase more sharply with age than they actually do. The different rates of using medical services and supplies, taken together, nevertheless result in average expenditures of about 5 percent of family income a year.

Various studies have shown that a family consisting of more than one person spends, on the average, about $200–$225 a year for medical care, distributed roughly as follows:

Total percent	100
Physicians	25
Surgeons and obstetricians	13
Hospitals	26
Dentists	18
Other	18

This distribution of the medical care dollar does not include expenditures for health insurance premiums. Had it done so, payment of premiums would have replaced at least a part of the cost shown for hospital care and the services of surgeons, obstetricians, and physicians, but it also would have added an item for the cost of operating the health insurance arrangements. The overhead costs of insurance account for nearly 6 percent of the Nation's total expenditures for all forms of medical care.

The Nation as a whole distributes its medical care dollar among the items in the medical care bill in slightly different fashion from the family units (table 2). Families appear to spend a larger percentage for physicians' services and dentists and less for hospital care and other items than do all persons—families, single persons, and unattached individuals—together.

In addition to showing how the Nation's payments for medical care are distributed among hospitals, physicians, dentists, and other practitioners and for services and supplies, table 2 indicates the shift from 1948 to 1955 in the method of paying for hospital care and physicians' services. In 1948 only 8.3 percent of the total bill was derived from insurance benefits—6.2 percent for hospitals and 2.1 percent for physicians' services. By 1955 a total of 22.3 percent of the payments for medical care came from insurance benefits. There were other significant changes in the distribution of the total bill. Hospital services, which amounted to 23 percent of the total bill in 1948, accounted for more than 30 percent in 1955. The share going to physicians and dentists decreased 2 percent. Expenditures for drugs and appliances represented 21 percent in 1955, compared with 24.5 percent in 1948. As the extent of prepaid protection increased, the expenditures for obtaining it rose to 5.5 percent of the total.

Utilization of Medical Care

In any one year, among 100 middle-income families about 77 will have expenditures for doctors; 74 will have

Table 1.—*Earned income and expenditures for medical care benefits of voluntary insurance, by type of carrier or plan, 1955*

[In thousands, except for average benefit; data corrected to Nov. 8, 1956]

Type of insurance carrier or plan	Earned income: Total	Earned income: For hospital services [1]	Earned income: For physicians' services [2]	Expenditures for benefits [3]: Total	Expenditures for benefits [3]: For hospital services [1]	Expenditures for benefits [3]: For physicians' services [2]	Benefits as percent of income
	Amount (in millions)						
Total	[4]$3,149.6	$2,017.8	$1,131.8	[4]$2,535.7	$1,678.4	$857.3	80.5
Blue Cross plans [5]	910.7	891.2	19.5	832.2	815.7	16.5	91.4
Blue Shield plans [6]	381.7	16.9	364.8	314.5	15.9	298.6	82.4
Other medical-society-sponsored plans [7]	6.4	.6	5.8	5.6	.5	5.1	87.5
Other nonprofit plans	199.3	108.7	90.6	180.8	99.6	81.2	90.7
Community	68.3	39.4	28.9	57.1	33.8	23.3	83.6
Consumer-sponsored	8.9	5.1	3.8	7.2	3.9	3.3	80.9
Fraternal societies	2.3	1.3	1.0	2.2	1.3	.9	95.7
Employer and/or employee	52.6	29.8	22.8	54.9	30.1	24.8	104.4
Union health and welfare [8]	67.2	33.1	34.1	59.4	30.5	28.9	88.4
Student health services [9]	5.5	2.2	3.3	5.4	2.1	3.3	98.2
Private group clinics with prepayment	19.1	6.7	12.4	18.2	5.8	12.4	95.3
Insurance companies [10]	1,626.9	991.5	635.4	1,179.0	738.8	440.2	72.5
Group	1,022.5	620.0	402.5	858.0	535.0	323.0	83.9
Individual	604.4	371.5	232.9	321.0	203.8	117.2	53.1
	Percentage distribution						
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Blue Cross plans	28.9	44.2	1.7	32.8	48.6	1.9	
Blue Shield plans	12.1	.8	32.2	12.4	.9	34.8	
Insurance companies	51.7	49.1	56.2	46.5	44.1	51.4	
Group	32.5	30.7	35.6	33.8	31.9	37.7	
Individual	19.2	18.4	20.6	12.7	12.2	13.7	
All other plans	7.3	5.9	9.9	8.3	6.4	11.9	

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

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

[3] Benefits paid, for nonprofit and other organizations; losses incurred, for insurance companies.

[4] Includes premiums or benefits for hospitalization and physicians' services among private plans under the State temporary disability insurance laws of California and New York (see table 6).

[5] For the 5 combined Blue Cross-Blue Shield plans, data for medical-surgical insurance shown under Blue Shield plans. Distribution between hospital and physicians' services for these combined plans and for the 7 Blue Cross plans that write both types of insurance furnished by the Blue Cross Commission. Addition made for Health Services, Inc.

[6] Addition made for Medical Indemnity of America. Excludes hospital insurance of the 5 Blue Cross-Blue Shield plans. Includes 8 Blue Shield plans that also furnish hospital insurance. Data supplied by Blue Cross Commission.

[7] Excludes plans underwritten by insurance companies.

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

[9] Estimated.

[10] Estimated by Health Insurance Council and adjusted for plans shown here as "other nonprofit plans."

expenditures for such items as drugs and appliances; 41, for dentists; 26, for hospitals; and 17, for surgery and obstetrics.[3] These ratios are in terms not of individuals but of families, some of whose members may incur heavy medical expenses and some little or none. The family's income must be spread over the large and the small expenditures.

In terms of individuals in any group of 100 persons, 90 will not need hospital care during a year. About 10 will go into the hospital and spend, on the average, about 10 days there; approximately 100 days of hospital care will thus be needed for each 100 persons, provided they are a cross section of children, working adults, housewives, and older persons.

It can therefore be expected that, to prepay for all the hospital care its members will need, any group will find it necessary to spend the equivalent of the cost of a day of hospital care for each individual in the group. A lower rate of expenditure for prepayment will make it necessary to exclude from the benefits some of the hospital care the group will use. The cost of providing the prepaid benefits must be added to the total.

If any physicians' and surgeons' services other than those provided as an integral part of hospital care are also to be prepaid, additional funds will be required, and a choice must be made among the kinds of insurance protection available against these costs. The choices at present include insurance against surgical expense, obstetrical expense, in-hospital medical expense, and outpatient physicians' services. The costs of dentistry, nursing, drugs, and appliances can seldom be insured.

Types of Plans and Policies

Because most families use physicians' services more often than they do surgeons' services or hospitals, a prepayment plan that provides some benefits for physicians' services will assist more families to spread their medical care costs over a period of years than will a plan that provides only for prepaid hospitalization and surgery. Furthermore, prepayment plans that provide diagnostic benefits and care in the physician's office and patient's home encourage preventive medical care and care early in sickness and may therefore reduce the impact of more costly illnesses for the group as a whole.

Plans that furnish benefits outside the hospital are not widely available, however, and the prospective purchaser of prepaid medical care may be limited by his location or his financial means to insurance covering only in-hospital illness.

The major forms of protection available to the general public are listed below.

1. Hospitalization expense insurance—available from Blue Cross plans, a few Blue Shield plans, commercial insurance companies, and, where they exist, some group-practice plans.

2. Surgical expense insurance—available from Blue Shield plans (usually affiliated with Blue Cross plans, so that the coverage is sold

[3] See the *Bulletin*, November 1956.

Table 2.—*Private expenditures for medical care and insurance benefits, 1948–55* [1]

[Amounts in millions]

Expenditure or insurance benefit	1948		1949		1950		1951		1952		1953		1954		1955	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$7,298	100.0	$7,662	100.0	$8,232	100.0	$8,711	100.0	$9,363	100.0	$10,109	100.0	$10,476	100.0	$11,198	100.0
Direct and third-party expenditures [2]	7,042	96.5	7,413	96.8	7,933	96.4	8,404	96.5	8,974	95.8	9,611	95.1	9,899	94.5	10,584	94.5
Hospital services	1,665	22.8	1,860	24.3	2,123	25.8	2,285	26.2	2,563	27.4	2,922	28.9	3,038	29.0	3,365	30.1
Direct	1,210	16.6	1,321	17.2	1,443	17.5	1,388	15.9	1,489	15.9	1,649	16.3	1,596	15.2	1,686	15.1
Insurance benefits	455	6.2	539	7.1	680	8.3	897	10.3	1,074	11.5	1,273	12.6	1,442	13.8	1,679	15.0
Physicians' services [3]	2,236	30.6	2,345	30.6	2,470	30.0	2,565	29.5	2,721	29.1	2,865	28.4	2,966	28.3	3,123	27.9
Direct	2,085	28.5	2,117	27.6	2,158	26.2	2,109	24.3	2,191	23.4	2,217	22.0	2,229	21.3	2,266	20.2
Insurance benefits [4]	151	2.1	228	3.0	312	3.8	456	5.2	530	5.7	648	6.4	737	7.0	[1] 857	7.7
Dentists' services	833	11.4	857	11.2	869	10.6	888	10.2	906	9.7	943	9.3	975	9.3	1,017	9.1
Other professional services [5]	423	5.8	448	5.8	476	5.8	498	5.7	529	5.6	559	5.5	583	5.6	610	5.4
Medicines and appliances	1,785	24.5	1,798	23.5	1,885	22.9	2,048	23.5	2,130	22.7	2,192	21.7	2,197	21.0	2,319	20.7
Nursing homes [6]	100	1.4	105	1.4	110	1.3	120	1.4	125	1.3	130	1.3	140	1.3	150	1.3
Expenditures for obtaining prepayment insurance [7]	256	3.5	249	3.2	299	3.6	307	3.5	389	4.2	498	4.9	577	5.5	614	5.5
For hospital services	192	2.6	168	2.2	189	2.3	188	2.1	232	2.5	283	2.8	325	3.1	339	3.0
For physicians' services	64	.9	81	1.0	110	1.3	119	1.4	157	1.7	215	2.1	252	2.4	275	2.5

[1] Except where otherwise noted, data are from the Department of Commerce, *1955 National Income Supplement to Survey of Current Business*, table 30, and *Survey of Current Business*, July 1956, table 30. Consumer expenditures include employer contributions to health insurance premiums. 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. No attempt has been made to identify and exclude expenditures made by individuals from payments received by them under the public assistance programs.

[2] Computed from data in *Hospitals*, June of each year 1949–54 and September 1955 and 1956. 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 received from patients by general and special long-term hospitals, mental and allied hospitals, and tuberculosis sanitoriums. Amount of private expenditures is overstated by an unknown amount recorded by the hospital as patient income in some instances where a government or welfare agency or workmen's compensation carrier actually made payment or reimbursed the patient. Addition made each year for hospital care in student health services.

[3] Addition made each year to figure reported in *Survey of Current Business* for salaries of physicians employed in prepayment medical service plans, and for physicians' services in student health services. Excludes amounts private practitioners received from nonconsumer sources (equal to about 10 percent of the amounts shown) such as those for workmen's compensation cases, physical examinations connected with writing life insurance, and so forth.

[4] Overstated because prepaid dental benefits are included.

[5] Services of osteopathic physicians, chiropractors, podiatrists, private-duty trained nurses, and miscellaneous curative and healing professions.

[6] Estimate for 1955 by the Public Health Service, adjusted for earlier years.

[7] Data from table 1. Represents the difference between expenditures for health insurance premiums and amounts returned to consumers as benefits.

jointly); from insurance companies (where it also is usually combined with hospital insurance in one policy); directly, in a few instances, from Blue Cross plans; and, where they exist, from group-practice plans.

3. Maternity expense insurance—available from all the sources mentioned and ordinarily combined with basic hospital or surgical coverage.

4. In-hospital medical care expense insurance—available from the same organizations that provide surgical insurance and usually sold as a "rider" to hospitalization and surgical expense insurance except in group-practice plans.

5. Outpatient physicians' services—attention from the physician in the doctor's office or the patient's home, which may include physical examinations, preventive services, diagnosis, and treatment of nonhospitalized illness. Group-practice prepayment plans, union health centers, and a number of Blue Shield plans provide some or all of these benefits. Policies that include limited outpatient benefits may also be purchased from insurance companies. In addition, a relatively new form of insurance, called major medical expense insurance and offered by insurance companies and an occasional Blue Shield plan, can be applied to this type of medical care.

The purchaser of insurance against the costs of medical care usually considers each of these five types of protection separately, with hospitalization and surgical insurance generally given priority. An exception occurs in group-practice plans, which are ordinarily organized around outpatient physicians' services.

Group-practice plans have been mentioned under each type of protection because in their most highly developed form they can cover the full range of physicians' services (including those of surgeons), both in and out of the hospital, and provide prepaid hospitalization as well. Services are provided through a group of physicians practicing together—hence the term "group practice." An outpatient medical clinic forms the nucleus of these plans. The benefits provided vary widely, however; they may be limited to treatment and/or diagnosis at the medical clinic (as an augmentation to the in-hospital expense benefits of other forms of insurance), or they may cover some or all of the other benefits, including doctor's visits to the patient's home, surgery, and hospitalization.

Many of the existing group-practice plans provide prepaid benefits only to the members of the sponsoring union or the employees of a particular industrial establishment. Railway employees, for example, belong to the hospital association of the railroad for which they work. Relatively few group-practice plans are open to the general public. (Examples of plans that the public may join are, on the West Coast, the Ross-Loos Medical Group, the Kaiser Foundation Health Plan, and Group Health Cooperative of Puget Sound, and in the East the Health Insurance Plan of Greater New York and the Group Health Association in Washington, D.C.)[4]

Health insurance plans fall into two broad categories—plans or policies providing service benefits and those providing cash indemnity benefits. Members of plans or holders of policies in the first category receive the service (hospital care or physicians' or surgeons' services) without having to pay the provider of the service at the time they receive the service; the insuring organization pays the provider of the services or provides the services directly. In the second category, the insured person pays the provider of the service, receives a receipted bill, and then submits a claim to the insurer, who indemnifies the insured person. Group-practice prepayment plans are essentially service plans, although there may be occasional charges at the time a particular service is received.

Most of the insurance plans or policies do not provide benefits for conditions resulting from work-connected illness or injury; the exceptions are individually purchased insurance company policies. Care in tax-supported institutions (such as mental hospitals, tuberculosis sanatoriums, veterans' hospitals, and hospitals of the Public Health Service) is also usually not covered. Adult dependents (persons aged 18 or 19 and older) are usually excluded from policies covering a family. Persons who have already attained age 65 are ordinarily not eligible to join a plan unless they are employed and come in as a member of an employed group.[5] Preexisting conditions and pregnancies predating the effective date of the policy are subject to special rules, spelled out in each policy. The plans vary in their coverage of newborn infants; some cover them from birth, and others not until they are 5 or 6 months of age.

While there are numerous exceptions and special provisions, it is possible to present a general picture of the several types of insurance that are available.

Blue Cross Plans

Among the distinctive features of a Blue Cross hospitalization plan is the ease with which the insured person is admitted to a member hospital. No down payment is required; he simply shows his membership card at the admitting office. In addition, he makes no large payment to the hospital when he is discharged, since Blue Cross pays the hospital directly; the patient pays only the difference between the hospital's charges and the Blue Cross benefits. The patient does not have to submit the hospital bill to the insurer to have the claim honored, as he does with an insurance company.

Most Blue Cross plans provide service benefits—that is, they pay the cost of a semiprivate or ward room, rather than a fixed amount (such as $10 a day) toward the hospital's charges for room and board. The plans also pay most or all extra charges, such as those for use of the operating room or for anaesthesia,

[4] For a detailed study of group-practice plans see the *Bulletin*, June 1956.

[5] Blue Cross and Blue Shield plans make special provisions for persons who have been covered and who leave employment at retirement. Their group protection may be converted into an individually held policy. Group policies sold by insurance companies may be written to permit conversion on retirement. Most group-practice plans continue coverage of retired members. Through special arrangements, retired persons may also be continued as part of the whole group under any form of insurance.

dressings and casts, and prescribed medicines, during the period the patient is covered for room and board charges. If charges for X-rays are not covered, they usually are included in the companion Blue Shield plan.

The insurance principle of spreading the risk over a large group is usual in the Blue Cross plans. While some plans have a variety of policies, most provide identical benefits to all members of the community they serve so that all share the risk equally. Any subscriber may convert to an individual policy if he has to give up membership in a group, either because of retirement or change of employment. While policies are legally cancellable at a plan's discretion, it is a widely accepted principle of the plans not to cancel a policy even though claims have been heavy or the insured person has reached age 65 or some other specified age.

Blue Cross plans are sponsored by the American Hospital Association and by local hospitals. Any excess of income over expenditures not allocated to reserves is divided among the hospitals serving the particular plan; it is not returned to subscribers in the form of dividends or rate credits.

Most Blue Cross plans act as the agent for the Blue Shield plan in their area, handling the sales of the Blue Shield policies and the records, claims payments, and so forth. In several States the Blue Cross plan provides surgical insurance as well as hospital insurance.

Blue Shield Plans

In its usual form, surgical insurance provides that the insurer—whether a Blue Shield plan, another type of medical-society-sponsored plan, an insurance company, a Blue Cross plan, or a consumer-sponsored plan—pay the surgeon or the patient a specified amount for a given operation. The stipulated amounts are set forth in a "fee schedule of surgical procedures." It is recognized that the indemnification made by the insurer will not necessarily coincide with the charges made by the surgeon in the individual case. If the surgeon's charge is less than the fee schedule allows, the insurer pays only the amount of the charge. All Blue Shield plans provide surgical insurance and all except seven provide in-hospital medical expense insurance.[6]

In typical Blue Shield plans the surgeon is paid directly by the plan. The insured person is responsible for paying only that portion of the surgeon's charges that exceeds the reimbursement provided by the fee schedule.

Many Blue Shield plans have agreements with "participating physicians," under which the amount of reimbursement shown in the surgical fee schedule will be considered as payment in full for the charges to those patients whose income is less than a specified amount. The maximum income varies from plan to plan; it is as low as $2,400 a year in some plans and as high as $6,000 in others. Since low-income members of these Blue Shield plans know in advance that their bills for surgery will be paid in full, they have, in effect, a "service benefit."

The plans are under the aegis of local or State medical societies. As a result, they can sign up members of the medical societies as participating physicians and have a mechanism for agreements on fee schedules, on income ceilings for service benefits, and on methods of handling complaints about excessive charges.

Like Blue Cross plans, Blue Shield plans also have provisions for converting group policies to individual policies. Their policies afford identical benefits to the whole community they serve, and they seldom cancel policies because of age or heavy claims. They are nonprofit plans, and any excess of income over expenditures is not distributed to physicians or to subscribers but is allocated to reserves. The reserves may ultimately be used to increase benefits or delay a rise in premiums.

Insurance Company Policies

Insurance company policies may cover only hospital expense, surgical expense alone, in-hospital medical expense alone, or any combination of the three. A combined hospitalization-surgical expense policy is most common.

Insurance company policies usually take the form of cash indemnification of the insured person, after he has paid the bill. The claim may be assigned by the insured to the hospital, surgeon, or doctor, or the policy may include a provision that the insurance company will arrange with local hospitals to admit patients on evidence that they are covered by insurance.

Some insurance companies sell policies only on a group basis, usually to a group of employees whose employer takes out the policy; others sell only to individuals—for themselves and their families. Some companies do both, but the two forms are kept separate and distinct. The descriptions that follow apply to both forms, although group insurance, which is spread over more people, ordinarily costs less per dollar of benefit than individual insurance.

Group policies cover the insured person only while he is a member of the group. When he changes employment or retires, his coverage stops. Some policies contain special provisions for continuation or conversion of the protection. These provisions are being more widely incorporated now than they were in the past because of the realization that retirement and the termination of group coverage usually occur at an age when it is difficult or expensive to purchase an individual policy.

Individual policies, unless specifically purchased on a noncancellable basis, may be canceled at the discretion of the insurance company. Group policies have an annual renewal rate on the anniversary of the effective date of the policy, at which time the net premium is recomputed.

Hospital expense insurance.—This form of insurance as provided by insurance companies has several distinctive features, one of which is flexibility. The companies design benefit specifications, for example, to suit the wishes of the group buying the insurance. The insurance usually pays up to a fixed amount, such as

[6] The Oregon and Washington Blue Shield plans include as standard benefits for employees (but not dependents) home and office services in addition to hospital and surgical care; four other plans offer home and office benefits in addition to their in-hospital benefits for dependents as well as employees.

$10 a day, for room and board in the hospital; the amount may be selected by the policyholder. (Policies paying the cost of a semiprivate room may also be obtained from some companies.) The maximum allowance for hospital extras is generally determined by multiplying the daily rate for room and board by a specified figure—usually from 5 to 20. (With an allowance of $10 a day for room and board, for example, a "10 times" allowance for the hospital extras would pay up to $100 for other hospital charges, including use of the operating room, diagnostic X-rays, laboratory tests, and so forth.)

Members of the group may be scattered in different areas, but the policy provides the same dollar benefit for all members of the group. Under a Blue Cross contract the group might have to be divided among several different Blue Cross plans—some with better benefits than others.[7]

Both group and individual policies can be priced at the amount the purchaser is willing to pay, since the benefits may be adjusted up or down. If experience is favorable, some of the premiums may be recovered—through dividend payments or experience-rating refunds—at the end of the policy year. In periods when hospital costs are rising, the premium rates do not require adjustment to reflect increases in hospital charges as often as policies paying the cost of a semiprivate room and all extras, since the rates are based on a maximum fixed amount per day. The dollar maximums will then meet less of the cost, however, leaving more for the insured person to pay out of pocket.

Frequently the only form of insurance available to persons living in isolated places is an individually purchased accident and health policy sold by an insurance company. Premiums for such policies may appear relatively expensive in relation to the benefits offered and to the costs of group policies, but the greater cost of marketing individual policies and the likelihood of unfavorable selection make the higher cost understandable.

Surgical expense insurance. — Insurance companies sell policies that provide for cash indemnification of the insured person according to a "fee schedule for surgical procedures." The distinctive features of this type of surgical expense insurance are similar to those relating to insurance company hospitalization policies: (1) flexibility of benefits and premium costs that may be adapted to the particular group purchasing the policy; (2) uniform benefits regardless of the location of the insured; (3) availability to individuals who are not part of an employed group; (4) termination on separation from the group unless the individual is disabled, in which case coverage is extended for 3 months; and (5) cancellability.

Maternity and Obstetrical Expense Insurance

Blue Cross plans usually provide 10 days of hospital care for a confinement. Blue Shield plans provide specified amounts in their surgical fee schedules for a normal delivery and other specified amounts for complications resulting from pregnancy. Under both Blue Cross and Blue Shield plans, benefits are usually paid only if the mother has been a member for at least 9 or 10 months, but this rule is sometimes waived for members of a large group. Payments are made by the plans directly to the hospital or to the doctor. If family income is less than a specified amount the Blue Shield plan's payment to the obstetrician is accepted as full payment.

Insurance companies may provide a flat maximum amount, such as $100 or $150, toward the combined cost of the hospital confinement and the fee of the obstetrician, or they may have separate hospital and obstetrical benefits corresponding to Blue Cross-Blue Shield benefits, except that a fixed dollar amount per day for room and board is provided. Payments are made to the insured or may be assigned to the providers of the services. Some policies call for a waiting period before the mother is eligible for maternity benefits, while others may waive this requirement; the premium for the latter type is higher.

Generally, among Blue Cross plans, Blue Shield plans, and the insurance companies, if the woman is pregnant when the insurance is terminated (for whatever reason), the maternity benefits are honored. The various insurers differ on the amount of coverage given the newborn infant.

Medical Care in the Hospital

Most Blue Shield plans and insurance companies offer insurance to pay part of the costs of nonsurgical attendance by physicians to hospitalized patients. These benefits are sometimes included in a rider to the hospital and surgical policy.

The Blue Shield plans seldom pay benefits for the first day or two, and insurance company plans may be tailored to suit the wishes of the insured. Both usually pay $3–$5 a day for the same number of days as are covered for hospital expense. Extra amounts are sometimes allowed for a consultant. As in surgical insurance, Blue Shield plans pay the doctor directly and insurance companies usually pay the insured person, unless he has assigned his claim to the doctor. The Blue Shield plans have no agreements for this type of benefit that correspond to those for surgical benefits for low-income families, under which the doctor's charge is no more than the insurance benefit.

Other Benefits

As already indicated, the only insurance benefits that can be purchased for such services as home and office care and diagnosis are limited in scope, except in a few States and in localities where there are group-practice plans.[8] An exception occurs in major medical expense insurance, discussed below. Insurance companies offer riders to hospitalization and surgical expense policies that pay up to a specified amount, such as $25 or $50, toward the cost of diagnostic X-rays and certain other diagnostic procedures.

[7] A Blue Cross plan may also write national contracts either directly or through Health Services, Incorporated—the Blue Cross organization established to handle national contracts.

[8] Because of their flexibility in writing insurance to suit the purchaser, insurance companies can, however, write this coverage if the purchaser is willing to pay the cost.

Major Medical Expense Insurance

Insurance specifically against major medical expenses has been available only a relatively short time. (Most group-practice prepayment plans cover major medical expenses in their standard provisions.) Offered first by insurance companies, major medical expense insurance is now also sold by some Blue Cross-Blue Shield plans on a group basis. It has two special features—a deductible amount, which the insured person must pay before he can collect a claim, and "coinsurance" on the part of the insured. It is sometimes likened to automobile collision insurance, in which the car owner pays any claims up to the deductible amount ($50 or $100) and the insurance company pays anything over such an amount up to the maximum set forth in the policy.

Unlike collision insurance, however, major medical expense insurance does not provide complete coverage for charges above the deductible amount. The insured person pays directly, in addition to the deductible amount, 20-25 percent of the remaining amounts up to specified maximums—usually $5,000 or $10,000. The purpose of this stipulation, called the coinsurance feature, is to give the insured person an incentive for holding down the bills, since it means that he must meet a fourth or a fifth of the cost above the deductible amount (which he also pays directly).

If major medical expense is the only policy held, in its most usual form it provides that the insured person pay the first $50, $100, $200, or a higher figure (the deductible amount) of a large medical bill. The insurance company will then pay 75 percent or 80 percent of the remainder—up to the stated maximum—for expenses covered by the policy. Not all expenses incurred are necessarily covered.

If the insured person has basic coverage, such as Blue Cross-Blue Shield or an insurance company policy providing hospitalization and surgical or surgical-medical expense insurance, the major medical expense policy generally takes the following form: (1) All basic benefits are deducted from the total expenses; (2) the insured person pays directly, out of pocket, $100-$200, depending on the policy (an expense sometimes referred to as "the corridor"); and (3) the insurance company pays 75-80 percent of the remainder.

Experience has shown that illnesses causing large expenditures are generally those requiring hospital care and often the services of a surgeon. Though adequate basic insurance may be expected to cover a large proportion of the bills for these services, major medical expense insurance can be helpful when large amounts must be spent for such items as special nursing and expensive drugs. In the absence of such benefits in the basic insurance policy, this type of insurance is also helpful in meeting some of the costs of nonsurgical physicians' services, especially those not incurred in the hospital. It can (after application of the rules about deductible amounts and coinsurance) assist with hospital costs and surgeons' fees not fully met by the basic insurance.

Cost of Health Insurance Protection

The costs of obtaining health insurance protection depend partly on the characteristics of the individuals or the group seeking insurance, on the specific benefits they want or can obtain, and on their geographic location.

It is a cardinal principle of insurers that an acceptable group, for the purposes of group insurance, must have banded together for some reason other than to buy health insurance. The exception to this rule is the consumer-sponsored plan, which self-insures either through establishment of a clinic or otherwise. If group enrollment is out of the question, the individual selecting an insurer may be restricted to the Blue Cross-Blue Shield plan serving the area and then only during a community enrollment drive, which many Blue Cross-Blue Shield plans conduct periodically. Because enrollment on an individual basis is not provided by some Blue Cross-Blue Shield plans, purchase of an individual policy from an insurance company may become the only alternative.

Since doctors' fees and hospital charges vary in different localities and insurance benefits vary from policy to policy, it is not possible to state categorically what the premium for a particular type of benefit is likely to be. The Blue Cross and Blue Shield plans usually set their premiums for a single individual at a slightly higher figure than the anticipated cost of care; their premiums for family coverage are more nearly at expected cost. In addition, all the younger members of Blue Cross-Blue Shield plans are bearing some of the extra costs incurred by older members, since premiums are graduated only slightly, if at all, for advancing age. Consequently, for young persons, the higher costs of protection in their own later years are spread throughout their period of coverage under the plan.

A few generalizations about benefits and costs are possible and will illustrate the kinds of choices available to purchasers of insurance.

Hospitalization Insurance

A rough yardstick of hospitalization insurance premiums is readily available. For one person, the yearly cost should be approximately equivalent to the average cost of a day of general hospital care in the area, plus about 10 percent for the operating costs of the plan.[9] For a family, the cost would be two and one-half to three times the figure for one person.

To some extent, premium costs reflect the number of days of hospital care the plan provides. Benefit days vary among the plans from 21 to 365, and they may be days per illness or per year. Some plans provide a specified number of "full benefit" days, such as 30, and additional days of partial benefits, such as 90, making them equivalent usually to 50 percent of the full benefit offered for the first part of a prolonged period in the hospital. The premium will also reflect the number of hospital extras provided.

---

[9] For State data on approximate costs for a day of hospital care, see *Hospitals*, Administrator's Guide issue; for a particular locality, data may be available from the hospitals about costs under the Reimbursable Cost Formula used by public agencies in buying hospital care.

Table 3.—*Blue Cross and Blue Shield annual premiums, average among all plans and range*

Type of contract	Group		Nongroup	
	1-person	Family	1-person	Family
Blue Cross:				
Average	$23.12	$56.22	$29.86	$65.60
Range	13.20–42.00	36.00–102.48	16.80–54.00	39.60–108.00
Blue Shield:				
Surgical-obstetrical expense:				
Average	10.32	31.44	12.40	35.24
Range	7.20–15.00	22.80–48.60	8.40–16.20	22.80–49.80
Surgical-medical expense:				
Average	13.20	36.84	15.28	39.76
Range	7.56–19.80	24.00–59.40	12.00–23.40	28.80–57.00

Source: Blue Cross data from *Blue Cross Guide*, Blue Cross Commission, January 1956; Blue Shield data from *Voluntary Prepayment Medical Benefit Plans*, American Medical Association, Council on Medical Service, 1954.

Blue Cross plans.—Current figures on the yearly charges made by Blue Cross plans for group enrollment under their "standard" and "comprehensive" plans are shown in table 3. Persons enrolling on a nongroup basis usually pay additional amounts, averaging almost $7 a year for individuals and more than $8 for families; benefits may be somewhat less broad for nongroup than for group members.

Insurance company group policies.—Insurance companies set their group rates in terms of the employee, adding separate amounts for wives and children. Table 4 indicates the group rates, which are subject, however, to various plus and minus factors, including the age and sex and occupational characteristics and size of the group and the experience under the policy (which may produce dividends). The details of rate fixing are too complex to be considered in a summary description.

A typical policy providing reimbursement of up to $10 a day for 70 days, with 10 times the daily rate for "extras" and maternity benefits available immediately, might at present involve premiums in the amounts listed in table 4. The premium for any dependents would be added to that for the employee to show the full premium.

Insurance company individual policies.—Rates for individual policies vary according to the benefits selected, the purchaser's age and sex, and the methods used by the insuring organization to market its policies. When agents who sell the policy receive a commission, the costs must cover the commission. If the policy is sold by mail the cost of advertising is a factor. The probability of a selection of risks unfavorable to the insurance company enters into the determination of costs when the insured person is electing to be covered.

Surgical Insurance

Surgical fee schedules are usually referred to according to the maximum amount payable for any one operation. There are fee schedules of $150, $200, $300, and occasionally higher amounts; the first two are the most common.

Since the top figures in the fee schedules apply to rather infrequently encountered surgical procedures, a more useful measure of the value of the surgical insurance offered is the amount of benefit paid for (1) a tonsillectomy, (2) an appendectomy, and (3) a normal delivery. It is not possible here to present such detail, but it can be obtained for individual plans. The benefits paid by a particular plan may also be related to the usual charges made by the physicians serving members of the group in the community.

Blue Shield plans.—The premiums under group policies for surgical contracts that included obstetrical services ranged, according to the latest available information, from $7.20 to $15.00 annually for a one-person policy and from $22.80 to $48.60 for a family policy (table 3). The rates for nongroup policies are slightly higher.

Insurance company group policies.—For group surgical policies as for group hospital expense insurance, insurance companies quote a rate for the employee, to which are added separate rates for dependents. Typical charges for a $200 surgical fee schedule, including obstetrics, are shown in table 4. The illustrative rates are those applying to a "standard" group. Actual quotations would vary from these rates according to the size of the group, the number of women employees, and other factors.

Medical Care Insurance

The type of insurance that is applicable to physicians' nonsurgical services and that is generally available from Blue Shield plans usually covers only visits made by physicians while the patient is in the hospital. For such insurance, benefits starting the first or second day in the hospital

Table 4.—*Typical insurance company premiums for group hospitalization and health insurance policies*

[Initial rates, subject to rate credits or dividends]

Coverage	Hospitalization [1] policy		Surgical and obstetrical expense policy [3]		In-hospital physicians' services policy, monthly premium			
	Monthly premium	Annual premium [2]	Monthly premium	Annual premium [2]	31-day maximum with benefits per visit of—		70-day maximum with benefits per visit of—	
					$3	$4	$3	$4
Employee	$1.53	$18.36	$0.53	$6.36	$0.090	$0.120	$0.099	$0.132
Dependents: [4]								
Family, combined rate [5]	3.92	47.04	1.84	22.08	.180	.240	.198	.264
Wife only	3.05	36.60	1.40	16.80	.117	.156	.129	.172
Child or children only	1.75	21.00	.80	9.60	.108	.144	.117	.156
Wife and children	4.80	57.60	2.20	26.40	.225	.300	.246	.328

[1] Providing up to $10 a day for 70 days with 10 times the daily rate for "extras" and maternity benefits.
[2] Shown as 12 times the stated monthly amount. In practice an annual rate might be slightly less.
[3] With a $200 surgical fee schedule.
[4] The amounts below should be added to the employee rates to obtain the combined rates for the family.
[5] Covers all dependents, regardless of family size.

will, of course, cover more of the actual expenditures (and usually cost a little more) than those starting the third or fourth day. An allowance for a consultation is frequently included. In most communities a benefit of $5 a visit or a day will be closer to the physician's usual charge than $3.

Blue Shield plans.—Among the Blue Shield plans that provide some in-hospital expense insurance, annual premiums under group policies (on the basis of the latest figures that are available) for a combined surgical-medical contract for one person ranged from about $8.00 to $20.00, with an average of $13.20; for a family the range was from $24.00 to $59.00, and the average was $37.00 (table 3).

Insurance company group policies.—Typical monthly rates for a commercial insurance company policy providing payments of $3 and $4 for in-hospital doctor's visits are shown in table 4. These amounts (on an annual basis) should be added to the appropriate premium for group surgical policies to obtain a comparison with the Blue Shield combined surgical-medical premium.

Group-practice plans. — Prepaid costs of the care afforded by group-practice plans necessarily vary widely, according to the inclusiveness of the benefits. If the benefits are comprehensive (including hospitalization and surgical as well as other medical care benefits), the annual cost may approximate average annual family expenditures for the services provided ($150 or more a family per year).

Major medical expense policies.—These policies are so relatively new that no two companies appear to calculate premiums in the same fashion, and widely divergent rates may be quoted to a group seeking bids for a specific set of benefits.

II. Growth of Voluntary Health Insurance, 1948–55

The complex nature of existing voluntary health insurance is evident from the description of the various types of plans and of the diverse types of benefits they provide. Measurement of the value of voluntary health insurance in terms of the number of persons with some kind or amount of insurance ignores the great differences in the benefits they are purchasing and in the amounts they are paying for premiums.

Starting in 1950 the Division of Program Research has measured each year certain quantitative aspects of voluntary health insurance. The appraisal technique that is used gives simultaneous recognition to changes in (1) the costs of medical care, (2) the size of the population, (3) the number of persons covered by one or more types of voluntary health insurance, and (4) the insurance benefits made available to insured persons. All these factors influence the volume of medical and hospital care received by the civilian population and result in changes in direct consumer expenditures for health purposes and in insurance offsetting these expenditures.

In this series, the relation between civilian expenditures for health and insurance benefits received in connection with these expenditures provides the basis for the year-to-year comparisons of the extent to which voluntary health insurance is affording a mechanism for paying for medical care.

Insurance Against Medical Care Costs

In 1955 the public spent $3.15 billion to purchase voluntary health insurance and received in benefits $2.54 billion—the equivalent of 80.5 percent of the total amount spent to purchase the insurance. Put another way, of each dollar spent to purchase insurance, 19.5 cents was used to operate the insurance plans, make additions to reserves, and pay sales costs and the like, and 80.5 cents was paid directly or indirectly to hospitals, physicians, dentists, and so forth (table 5).

Table 5.—*Earned income, benefit payments, and loss ratios for voluntary insurance against the costs of medical care, 1948–55*

[Amounts in millions]

Year	Earned income [1]	Benefit payments	Loss ratio (percent)
1948	$862	$606	70.3
1949	1,016	767	75.5
1950	1,291	992	76.8
1951	1,660	1,353	81.5
1952	1,993	1,604	80.5
1953	2,420	1,921	79.4
1954	2,756	2,179	79.1
1955	3,150	2,536	80.5

[1] Represents benefit payments plus expenditures for obtaining prepayment insurance; for detail, see table 2.

As in the immediately preceding years, 64 percent of the total amount of earned income of all forms of health insurance was identified as applying to hospitalization and 66 percent of all benefits represented hospitalization benefits. The loss ratio for hospitalization insurance was 83 percent in 1955, compared with 82 percent in 1954. The loss ratio for insurance against physicians' services was 76 percent in 1955 and 75 percent in 1954.

The sources of the insurance protection provided in 1955 have been shown in table 1. Blue Cross plans were the major providers of insurance against the costs of hospital care, since they provided 49 percent of all hospitalization expense payments made by all types of carriers and a third of all benefit payments. Group policies sold by commercial insurance companies for the second year in succession exceeded the Blue Cross-Blue Shield plans in the amount of benefits paid against the costs of physicians' services. In fact, insurance companies, through both group and individual policies, furnished 51 percent of all such benefits and 44 percent of all benefits for hospitalization. The combined premiums of the insurance companies made up 51 percent of the total earned income of all forms of prepayment insurance; their benefits represented 46.5 percent of all health insurance benefits paid.

Prepayment plans other than Blue Cross, Blue Shield, and the insurance companies received $2.7 million less in income and paid out $1.3 million less in benefits in 1955 than in 1954. Because of the growth of other forms of insurance they represented a smaller segment of the total in 1955 than in the preceding year. Primarily responsible for this shift is the fact that one large and several small medical-society-sponsored plans became affiliated with the Blue Shield Commission in the period under review, and a hospital plan classified as a community plan for the past several years renewed its affiliation with the Blue Cross Commission. As a result, data for these plans have been assigned to Blue Cross or Blue Shield for 1955. In addition, the United Mine Workers Health and Welfare Fund, the largest of the union-sponsored plans, paid out less in benefits than in earlier years; the lower payments reflect the decline in coverage resulting from a drop in employment in the mining industry.

The data in tables 1 and 5 do not, in the strictest interpretation, represent exclusively private or consumer purchases of health insurance. Employers are responsible for a large and expanding contribution to the financing of health insurance. The expenses of industry for this type of cost are borne only indirectly by the consumer as they become part of the costs to him of other types of goods and services that he buys. An estimate[10] for 1954, when health insurance premiums or earned income amounted to $2.8 billion, placed the contribution of employers at $656 million; this figure is equivalent to 24 percent of total premiums in that year. The percentage was probably somewhat higher in 1955.

In still another respect the data in tables 1 and 5 are not confined to wholly voluntary expenditures, since they include a small amount of health insurance resulting from the compulsory temporary disability insurance laws in New York and California. The extent of medical care benefits provided under the two State laws is shown in table 6, separately for private carriers and for the public program in operation in California. In 1955 a total of $15 million in hospitalization and medical-surgical benefits was paid through private carriers writing insurance under the temporary disability insurance laws. Another $6.3 million in hospitalization benefits was derived from the public plan in operation in California and would also offset private expenditures for hospital care. An adjustment for the California public plan can be made in table 2 for the years 1950–55 by decreasing private expenditures or increasing insurance benefits by the amounts shown in table 6.

Expenditures for medical and hospital care arising from work-connected injuries and illnesses are not included in the data in table 2. Consequently workmen's compensation payments for hospital and physicians' services are omitted from the aggregates of insurance benefits paid by insurance companies.

[10] *Welfare and Pension Plans Investigation: Final Report of the Committee on Labor and Public Welfare Submitted by Its Subcommittee on Welfare and Pension Funds* (S. Rept. 1734, 84th Cong., 2d sess., 1956), page 84.

Table 6.—*Benefits from hospital and medical care insurance under California and New York State temporary disability insurance laws, 1950–55*

[In millions]

Year	Total	Under public plans [1]	Under private plans [2]
1950	$6.5	$2.7	$3.8
1951	11.0	2.6	8.4
1952	13.4	3.3	10.1
1953	16.2	3.7	12.5
1954	19.2	5.7	13.5
1955	21.3	6.3	15.0

[1] Hospital benefits in California.
[2] Hospital benefits in California; hospital, surgical, and medical benefits in New York.

Trends in Insurance Protection

The value of the prevailing insurance each year from 1948 through 1955 is measured in table 7. The percentage of private expenditures for

Table 7.—*Private expenditures for medical care and the percentage met by voluntary health insurance, 1948–55*

[Amounts in millions]

Year	Total medical care expenditures		Hospital services only		Physicians' services		Hospital and physicians' services		Currently insurable expenditures		Potentially insurable expenditures	
	Amount	Percent met by insurance	Amount [1]	Percent met by insurance	Amount	Percent met by insurance [2]	Amount	Percent met by insurance [2]	Amount [3]	Percent met by insurance	Amount [4]	Percent met by insurance
	With expense to obtain insurance included											
1948	$7,298	8.3	$1,857	24.5	$2,300	6.6	$4,157	14.6	$5,169	11.7	$5,727	10.6
1949	7,662	10.0	2,028	26.6	2,426	9.4	4,454	17.2	5,491	14.0	6,063	12.7
1950	8,232	12.1	2,312	29.4	2,580	12.1	4,892	20.3	5,950	16.7	6,553	15.1
1951	8,711	15.5	2,473	36.3	2,684	17.0	5,157	26.2	6,250	21.6	6,903	19.6
1952	9,363	17.1	2,795	38.4	2,878	18.4	5,673	28.3	6,792	23.6	7,476	21.5
1953	10,109	19.0	3,205	39.7	3,080	21.0	6,285	30.6	7,447	25.8	8,158	23.5
1954	10,476	20.8	3,363	42.9	3,218	22.9	6,581	33.1	7,776	28.0	8,498	25.6
1955	11,198	22.6	3,704	45.3	3,398	25.2	7,102	35.7	8,351	30.4	9,110	27.8
	With expense to obtain insurance excluded											
1948	7,042	8.6	1,665	27.3	2,236	6.8	3,901	15.5	4,913	12.3	5,471	11.1
1949	7,413	10.3	1,860	29.0	2,345	9.7	4,205	18.2	5,242	14.6	5,814	13.2
1950	7,933	12.5	2,123	32.0	2,470	12.6	4,593	21.6	5,651	17.6	6,254	15.9
1951	8,404	16.1	2,285	39.3	2,565	17.8	4,850	27.9	5,943	22.8	6,596	20.5
1952	8,974	17.9	2,563	41.9	2,721	19.5	5,284	30.4	6,403	25.1	7,087	22.6
1953	9,611	20.0	2,922	43.6	2,865	22.6	5,787	33.2	6,949	27.6	7,660	25.1
1954	9,899	22.0	3,038	47.5	2,966	24.8	6,004	36.3	7,199	30.3	7,921	27.5
1955	10,584	23.9	3,365	49.8	3,123	27.3	6,488	39.0	7,737	32.7	8,496	29.8

[1] Expenditures include outpatient services provided by hospitals. Insurance benefits are applicable to such services when service is given in an emergency.
[2] Slight overstatement because the data used for insurance benefits include some payments to nurses, dentists, and laboratories.
[3] Includes total expenditures for services of physicians and hospitals and one-tenth of the expenditures for drugs and appliances.
[4] Includes total expenditures for services of physicians, hospitals, dentists, and nurses and one-third of the expenditures for drugs and appliances.

medical care that was met by insurance benefits is shown for the total and under five different groupings. The benchmarks representing expenditures have been calculated both to include and to omit the expenditures incurred in the purchase of the insurance protection being measured, so that the reader may select the concept of expenditures best suited to his particular needs.

Insurance was meeting 8.3 percent of the Nation's medical bill in 1948 and 22.6 percent 7 years later. Since 1951 this percentage has increased about 2 points a year; 1955 was no exception.

In the field of hospital care costs the peak year of growth in insurance protection was 1951 (6.9 percentage points); for each of the other years in the series about 2 percentage points of growth have been registered. The rate of expansion in providing protection against the costs of physicians' services was more rapid in the earlier years of the series—with 1951 again a peak year (5.2 percentage points)—but this rate too has leveled off to about 2 percentage points of increase a year.

Since most of the health insurance available today applies to the costs of hospitalization and physicians' services, the measurement of the impact of insurance benefits on the expenditures for these two items provides an index of the value of insurance where it has been most successful. The rise from 15 percent in 1948 to 36 percent (or 39 percent, if the expense to obtain insurance is omitted) is evidence of the spread of voluntary insurance in these two fields.

In recognition of the fact that there are many items included in the Nation's medical care bill that are covered by few forms of health insurance, the present report includes two additional benchmarks, which have been prepared for each year in the series. The first of these—the amount "currently insurable under existing forms of health insurance"—omits the services of dentists, nurses, and other practitioners and nine-tenths of the Nation's expenditures for drugs and appliances. If prepaid dental care expands as much as it has in the past year or two, this benchmark may need revision. Insurance benefits were equivalent to 30–33 percent of this benchmark in 1955, and the index was two and one-half times what it had been in 1948.

The final benchmark provides a hypothetical measure of expenditures that may be considered potentially insurable; in this measure the items of expenditure included are those covered on a prepaid basis by some comprehensive plans and under some forms of insurance company policies —that is, major medical expense policies and comprehensive expense policies. Today all forms of health insurance are, by one or more approaches, meeting only 30 percent of this benchmark of potentially insurable costs.

What of the future? Is voluntary insurance going to continue its net expansion in the protection it provides at the rate of 2 or 3 percentage points a year, with the remainder of its growth dollarwise absorbed by increases in population and rises in the cost of medical care? Are improvements in benefits, the newer forms of insurance—such as dental care, outpatient services, benefits payable in nursing homes, and the like—and the broader forms of coverage represented by the establishment of health centers and the sale of major medical expense insurance going to close the gap between actual and potential protection more rapidly than has been the case in the past 8 years?

The dollar volume of voluntary health insurance benefits—which rose 16 percent in 1955—must increase about 2 percent each year merely to keep up with population growth. If the costs of medical care continue to rise, the volume must increase even more if the same level of protection previously afforded is to be continued. To cover a greater proportion of the medical care bill than in the immediately preceding year, there must be an increase in the dollar volume of benefits paid over and above these two requirements. The 16-percent increase in 1955 in the dollar volume of health insurance benefits was only sufficient to increase by 1.8 percentage points the coverage of the national medical care bill. More rapid closing of the gap will require that the Nation assign still more of its medical care dollar to the insurance industry in return for prepaid protection for those parts of the medical bill inadequately insured at the present time.

Notes and Brief Reports

Money Income Sources for Persons Aged 65 and Over, June 1956*

By mid-1956, it is estimated, 9 out of 10 aged men in the United States and 2 in 3 of the aged women had some money income from employment, social insurance, and/or a program for veterans. When those receiving public assistance are taken into account, it appears that substantially all the 6.7 million aged men in the United States and more than four-fifths of the 7.8 million women aged 65 and over had some earnings or money from a public income-maintenance program (table 1). Since women outnumber men in the aged population, with about 116 women to every 100 men, one-tenth of all aged persons were still without income from employment or a public income-maintenance program in June 1956.

Almost all the married women had income from one or more of the sources under consideration, either in their own right or as wives of earners or of beneficiaries. Most of those without any money income of the types specified were widowed before their husbands had been able to earn insured status under old-age and survivors insurance; some of them had income from private insurance policies, some were supported by relatives and some were maintained in institutions.

*Prepared by Lenore A. Epstein, Division of Program Research, Office of the Commissioner.