Private Health Insurance in the United States: An Overview

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Each December the Bulletin has published a summary article presenting data on private consumer expenditures for medical care and on the financing of voluntary health insurance organizations. This year the material on health insurance and expenditures has been reorganized. Two articles instead of one will be presented. The first, which appears below, deals exclusively with private health insurance. It continues the series on finances and adds a new series on enrollment.

The second article, which will appear in the Bulletin for January 1966, will present data on total national health expenditures, public and private, giving an overall picture by type of service and sources of funds. The article will include data, formerly appearing in the December issue, on private consumer medical expenditures and the proportion of such expenditures being covered by voluntary health insurance.

WITH THE INTRODUCTION of a public program of health insurance for the aged, it is appropriate to review and take stock of the development and accomplishments of the private health insurance movement. Private health insurance plans now provide some measure of health protection to more than 4 out of 5 persons under age 65. This article reviews the development of health insurance in this country, describes the various types of health insurance organizations, and gives data on enrollment and finances.

History

Although the main development of health insurance in this country began in the 1930's, organizations of varying types had begun to make arrangements for prepayment of medical care as early as the middle of the last century. Among the earliest plans were the "hospital associations" developed by the railroads, particularly those serving the West. Many of the railroad companies served unsettled country and had to build their own hospitals and employ physicians to assure that care would be available for sick or injured employees. To finance the care, the companies organized hospital associations, which provided comprehensive care to employees in return for fixed periodic payments deducted from pay. The Southern Pacific organized its association in 1869, the Missouri Pacific in 1876, the Northern Pacific in 1881—to cite the earlier ones. In 1930, there were 27 steam railroads with hospital associations or relief departments that provided medical care to more than 500,000 employees.[1]

About the same time, various companies in the logging, coal, and metal mining industries developed similar arrangements. Frequently, because of the isolation of the enterprise, these plans were the only way of assuring that hospital facilities and doctors would be available. By 1930, about 540,000 mining and lumber employees were covered by payroll deduction medical service plans of one type or another.[2]

Similar medical care prepayment arrangements were developed by various concerns or employee benefit associations in the textile, steel, and other industries. In the 1920's a number of private group medical clinics—such as the Ross-Loos plan in California—made arrangements to serve groups of patients on a prepayment basis. A few hospitals here and there developed similar arrangements.

Commercial accident and health insurance was first written in the United States in 1847, largely in the form of accident insurance. Later, this protection was extended to cover disability caused by sickness, and some companies added provisions for reimbursement of medical care expenses. Such benefits were relatively unimportant, however, in comparison with the cash disability or accident

*Office of Research and Statistics.

[1] Pierce Williams, *Medical Care Through Fixed Periodic Payments*, National Bureau of Economic Research, 1932, page 4.

[2] *Ibid.*, page 3.

benefits, representing less than 10 percent of the $200 million in benefits paid under all accident and health insurance in 1930.[3]

All told, by 1930 probably about 1½ million or 2 million persons were covered under medical prepayment or health insurance arrangements.

BLUE CROSS AND BLUE SHIELD PLANS

The beginnings of the Blue Cross plans are usually traced to an experiment of the Baylor University Hospital in Texas in 1929. The school teachers of Dallas asked the hospital if it could provide them with hospital care on a prepayment basis. The hospital evolved a plan under which each teacher would be eligible for 3 weeks of hospital care in return for a payment of $3 a semester or $6 a year. The experiment was successful, and soon other employee groups in the city requested similar privileges.

In the early 1930's, with the deepening of the depression, charity cases increased and income from paying patients declined. Hospitals throughout the country began to pay attention to the Baylor plan and to consider starting similar plans. It was soon apparent that there would be many problems if each hospital operated its own plan, in competition with other hospitals, and that it would be far better if all the hospitals of a community could get together and jointly offer a plan. Soon plans of this nature, offering free choice among the participating hospitals, made their appearance.

The first citywide plan was that offered by the hospitals of Sacramento, California, in July 1932. Then in January 1933 the hospitals of Newark, New Jersey, started a plan, and in July 1933, those of St. Paul, Minnesota. Most of the earlier plans initially were set up to serve a city or a metropolitan area and later expanded to serve the entire State. There were 10 plans with 54,000 participants at the end of 1934, 26 plans with 600,000 participants by the end of 1936, and 59 plans with more than 4 million participants by the end of 1939.

In 1933 the hospitals and civic groups in New York City found that their proposed plan would constitute insurance and be prohibited under the insurance law. The backers of the plan therefore pressed for legislation that would enable it to operate. The necessary legislation was passed in May 1934, and from then on the passage of similar legislation tended to be a prerequisite for the establishment of plans elsewhere.

Early in the thirties the American Hospital Association adopted principles "for an acceptable plan for group hospitalization" and encouraged the organization of plans along these lines. A formal program for approval of plans meeting specified standards was adopted by the Association in 1937. Shortly thereafter the Blue Cross insignia was adopted, and the plans began to call themselves Blue Cross plans.

Many of the earlier plans offered 21 days of hospital care in semiprivate accommodations at a subscription cost of about 75 cents a month for a single person, $1.50 for a couple, and $2.00 for a family. At first the plans covered only employees; later coverage was extended to dependents.

The Blue Shield plans had a somewhat analogous history, but with the backing coming from the organized medical profession. In the 1910's, the 1920's, and the early 1930's, many county medical societies in the State of Washington and in Oregon established county "medical bureaus" that offered rather comprehensive medical care coverage, with a free choice of physician. These plans were organized largely because of the profession's dislike for various contract medical arrangements that had developed in the logging and other industries and that seemed likely to spread unless alternative prepayment arrangements were made available.

In 1939 the California Medical Association, motivated by a desire to meet the public's demand for prepaid medical service, established California Physicians' Service. (In the preceding year the Governor had sponsored a bill for compulsory health insurance.) In 1939, also, the Michigan State Medical Society, convinced that the public wanted medical service on a prepayment basis and that the profession should assume leadership in developing such arrangements, started a plan. Both plans originally offered contracts providing for virtually complete medical service, but they did not sell well and had adverse financial results. Subsequent contracts were limited mainly to surgical, obstetrical,

[3] *Ibid.*, pages 256 and 258.

and anesthesia service and were more successful.

The growing interest of the public and the medical profession in prepaid medical service soon led to the establishment of similar plans elsewhere, sponsored and backed by the State or local medical societies. By the end of 1941 there were 10 plans with 800,000 participants, and by the end of 1946 there were 44 plans with 4.4 million participants.

Undoubtedly one factor in the medical profession's interest in starting these plans was the belief that, unless voluntary insurance met the need, a compulsory government medical care program would be established. As in the case of the hospital service plans, in most States the passage of special enabling legislation was a necessary prelude to the organization of a plan.

After the early, rather unsuccessful experimentation with broader coverage, the plans generally offered only surgical and obstetrical benefits, plus coverage of X-ray and laboratory services in the hospital if they were not offered by the affiliated hospital plan. A little later the contracts were broadened to include physicians' services in the hospital for nonsurgical cases.

The American Medical Association began in the forties to encourage the establishment of medical-society-sponsored plans. In 1946 the Association set up a program for approval of medical service plans. The Blue Shield insignia was adopted, and the plans became known as Blue Shield plans.

INSURANCE COMPANIES

In the early and middle 1930's the insurance industry did not show much interest in hospital or surgical-medical expense insurance. Many insurance executives believed that the field should be left to the nonprofit plans. However, as the rapid growth of the Blue Cross plans showed the strong public desire for health protection, more and more companies began to consider entering the field.

Group coverage took the lead. At first coverage was offered only for employees, but later it was extended to dependents. By 1935, insurance companies covered 38,000 employees under group hospital expense contracts. By the end of 1938, the number had grown to 300,000 and by the end of 1940 to 1.8 million. Soon surgical coverage was also offered. By the end of 1938, under group policies 94,000 persons had surgical coverage; 2 years later, 1.3 million had such coverage.

Unlike the Blue Cross plans, which generally provided specified services, hospital expense policies generally took the form of reimbursement of charges for room and board and ancillary services up to specified amounts. Surgical expense policies provided for reimbursement of surgical charges up to a specified allowance for each operation.

A number of companies soon began writing similar insurance under individual policies. By 1951, the insurance companies were covering as many persons under hospital expense policies—group or individual—as Blue Cross. From the start, surgical insurance by insurance companies grew faster than the medical service prepayment plans.

OTHER PLANS

Besides the Blue Cross and Blue Shield plans and the policies sold by insurance companies, there are prepayment plans or arrangements sponsored or operated by (a) community-consumer groups, (b) employer-employee-union groups, (c) medical societies, (d) dental societies, and (e) private group medical clinics. Frequently these "other" types of plans are called independent plans. Some predate the Blue Cross-Blue Shield plans, as noted earlier. The medical society plans consist of the few not yet affiliated with Blue Shield, and their enrollment is negligible. From a historical standpoint the only plans that need be considered here are the community-consumer plans, the postwar industrial plans, and the dental society plans.

The common denominator of the community-consumer plans is organization by the "consumers" of medical care, rather than the "producers." Most of the enrollment is in the 20 or so plans that provide service through group practice and that are bound together by a conviction that high quality of care at reasonable cost can be assured only through arrangements combining prepayment, group or team practice of physicians, and the provision of comprehensive medical care.

Among the leading members of this group are the Kaiser plans of California, Oregon, and Hawaii (which largely grew out of programs established by the Kaiser Company to serve its employees), the Health Insurance Plan of Greater New York (organized in 1945), Group Health Cooperative of Puget Sound (1947), Community Health Association of Detroit (organized in 1960 largely by the United Auto Workers), and Group Health Association of Washington, D. C. (1937). Largely because of the public's attachment to traditional arrangements and opposition from the organized medical profession, these plans have had a relatively slow growth yet have had significant impact upon the thinking of the public and the medical profession.

Mainly under the impetus of collective bargaining, a considerable number of new employer-employee-union plans have been established since the war. Some of the plans developed by labor unions and union-management welfare funds provided for labor health centers, where care typically was provided through part-time salaried physicians. More recently, a number of unions have developed plans providing a comprehensive health service—for example, the Labor Health Institute of St. Louis and the Family Medical Fund of the Hotel Industry of New York City. Other plans provide benefits mainly in the form of indemnity allowances against hospital charges and those of doctors. These plans prefer to self-insure rather than purchase coverage.

State dental societies began a few years ago to organize nonprofit dental service corporations to provide dental care benefits with a free choice of dentist; the first was organized in 1954. They are similar to the Blue Shield plans.

Description of Health Insurance Organizations

BLUE CROSS PLANS

At present there are 76 Blue Cross plans in the United States, not including the one in Puerto Rico. (Four are also operating in Canada, and one in Jamaica.) Each of these plans is an independent, locally governed nonprofit corporation, serving the general community. Thirty-one plans each serve an entire State. Thirty-three serve parts of States in such a way that a whole State is covered; eight local plans thus cover New York and seven cover Ohio. One plan serves two States (New Hampshire and Vermont), and in North Carolina two plans serve the State in competition.

Contracts.—All Blue Cross plans offer hospital benefits. A few, not affiliated with a Blue Shield plan, offer surgical-medical benefits as well.

Most plans offer several group and individual contracts; some offer as many as 15, 20, or 30. The contracts differ widely from plan to plan. Individual contracts tend to be less varied than group contracts and generally offer less comprehensive benefits.

All contracts provide room and board in specified accommodations or dollar room allowances and include special diets, the hospital's general nursing service, use of operating room, anesthesia materials and anesthesia service provided by hospital employees, routine laboratory service, and drugs (with dollar limits for drugs imposed by some plans under some contracts). Coverage of pathology and X-ray diagnosis and therapy varies with the judgment of hospitals and physicians in the plan's area on whether these are hospital or medical services. If not covered in whole or in part by Blue Cross as hospital services, they will be covered as physicians' services by the affiliated Blue Shield plan.

Probably most plans under their most widely held group contract provide at least 60 days of coverage at full benefits and usually additional days at part benefits. A study of the Blue Cross Association as of December 31, 1962, showed that of all Blue Cross members in the United States, 7 percent were entitled to 365 or more days of full benefits under basic certificates, 42 percent to 120–180 days, 23 percent to 70–100 days, 2 percent to 55–60 days, and 26 percent to 40 days or less.[4]

The same study showed that 64 percent of the members covered under basic certificates were entitled to care in semiprivate accommodations, 6 percent in ward accommodations (3 or more beds), 6 percent required the patient to pay so much per day or per admission, and 24 percent were entitled to dollar allowances against the

[4] Blue Cross Association, *Special Blue Cross Enrollment Report*, March 5, 1964 (Statistical Bulletin No. 2B, table 1).

cost of room and board. Such allowances may approximate the cost of semiprivate accommodations or be considerably less.

Virtually all the plans provide emergency outpatient services. Most also provide outpatient service for minor surgery. A growing number of plans go further and under basic certificates provide some coverage of diagnostic X-ray and laboratory services for outpatients. As of December 1962 approximately 9 million members were covered for these services.

Maternity cases are covered after a waiting period of 9 or 10 months. Some plans under some contracts do not cover maternity care in full but only up to a maximum dollar amount, and many limit paid stays for normal deliveries to a specified number of days.

Where a patient uses better accommodations than those to which he is entitled by his contract, most plans give him a dollar allowance against the cost of the better accommodations equal to the hospital's usual charge for the entitled accommodations.

Initially most Blue Cross plans excluded mental illness and tuberculosis, but gradually they have extended coverage to include care for these conditions in general hospitals on the same basis as other illnesses. Most plans, however, still exclude coverage of these cases in mental or tuberculosis hospitals or provide this coverage only for relatively short stays. Some plans, under some contracts, exclude pre-existing conditions; most plans cover them.

Benefits in noncontracting or nonmember hospitals in or out of the plan area are generally limited to per diem dollar allowances that are less than the amount that would be paid to member hospitals.

Within the past 15 years an increasing number of plans have developed supplementary contracts, variously known as "extended benefit," "major medical," "prolonged illness," or "catastrophic illness" contracts. They are usually written in cooperation with the affiliated Blue Shield plan.

"Extended benefit" contracts generally provide additional hospital coverage for days beyond the basic contract and coverage of physicians' services and, possibly, drugs after hospitalization. Often they also provide some coverage of outpatient diagnostic X-ray and laboratory service, private-duty nursing service, visiting-nurse service, and, in lesser degree, nursing-home care. (About half the plans under their nongroup contracts for older persons cover nursing-home care.)

Supplementary "major medical" contracts are similar to those sold by insurance companies. They provide coverage of hospital care and physicians' services in the office, home, and hospital (in addition to benefits under the basic Blue Cross-Blue Shield contract), drugs, appliances, private-duty and visiting-nurse service, and sometimes nursing-home care—all on a deductible and co-insurance basis (that is, payment, after an initial deductible, of 75 percent or 80 percent of covered expenses).

Blue Cross subscription charges vary from plan to plan and among the contracts of each plan, depending upon the benefits offered. Until 10 or 15 years ago, most Blue Cross plans charged all groups alike for identical contracts. Now, virtually all plans operate on an experience-rating basis—that is, all groups of more than a specified size are charged on the basis of their experience. The plans, in general, came to this practice reluctantly; they were forced into it by the competition of insurance companies, which had always rated according to experience.

Member hospitals and their reimbursement.—The plans provide their contractual services through participating or member hospitals—generally all recognized or licensed general hospitals in the plan's area. A few plans have standards for member hospitals that go beyond licensure. Member hospitals contract with the plan to provide the contractual services or benefits to subscribers and to accept the plan's remuneration as full payment for such services.

The majority of the plans, with most of the members, pay hospitals on a basis related to each hospital's cost of providing services. The definition of cost varies for such items as depreciation, interest, and any "plus" factor for improvement. Reimbursable cost may be "historic" (based on an earlier period) or "current" (reflecting cost during the period being paid for). Most plans using a cost-related basis reimburse hospitals at a rate equal to their full charges but not exceeding the amount allowable under the cost formula. Some plans place a ceiling on allowable cost for any individual hospital—for example, 110 percent or 115 percent of the weighted average of allowable costs of comparable hospitals. A

minority of the plans pay hospitals on the basis of their regular charges or some combination of charges and cost.

Enrollment.—All plans enroll both groups and individuals. Most group policies are sold to employee groups, and employers help to finance the plan. Groups are enrolled only if a certain percentage of the membership—which varies with the size of the group—enrolls. All plans allow persons leaving groups to convert to individual contracts. Most plans have two methods of individual enrollment. Under one they will accept enrollment of individuals at any time but may reject persons who, on the basis of their health history, are poor risks. Under the other they advertise from time to time in given communities that enrollment will be open during a given period to all individuals without regard to health status. Pre-existing conditions are usually excluded, or covered under individual contracts only after a waiting period.

Legal status.—The great majority of the plans operate under State enabling legislation, which exempts nonprofit hospital service plans from the provisions governing insurance companies but provides for regulation or supervision by a State agency, usually the insurance department. Supervision generally includes review of financial status and approval of contracts and of rates charged and, in some cases, rates of payment to hospitals. Most laws stipulate that the boards of directors of such corporations must include a certain number or proportion of hospital trustees or administrators and that there must be some representation of the medical profession and the public. Most acts exempt the plan from all taxes, with the possible exception of local taxes on real estate.

Control.—Each plan is controlled by a board of directors or trustees appointed or elected in accordance with the plan bylaws. The American Hospital Association standards of approval require that at least one-third of the members of the nonprofit hospital service plan's governing board represent the contracting hospitals and at least one-third represent the general public. Most plans also provide for representation of the medical profession. A recent survey of the Blue Cross Association showed that in 1964, of all the members of Blue Cross governing boards, 41 percent represented the public, 16 percent the medical profession, and 43 percent hospital trustees and administrators.[5]

Utilization of hospital care.—To slow down the rise in subscription costs, the plans in recent years have increasingly acted to prevent unnecessary utilization of hospital care by their subscribers. Typical activities include: Encouraging hospitals to establish utilization committees; review of cases staying longer than a certain period, with the attendant physician asked to certify that further care is necessary; and support of local or statewide hospital planning agencies to plan for community facilities and prevent overbuilding.

National coordination.—All approved plans belong to the Blue Cross Association, which coordinates them, undertakes research and various service activities, and is their national spokesman. All approved plans must participate in interplan arrangements for transfer of membership, without loss of status, for a member who moves into another plan's area and for provision of service benefits to members hospitalized in another plan's area.

The plans have also developed various ways of handling so-called national accounts—that is, enrolling and providing uniform benefits for the employees of employers with plans and offices in different parts of the country. Thus far the best example of Blue Cross and Blue Shield interplan coordination is the provision of nationally uniform Blue Cross and Blue Shield benefits at a uniform rate to Federal employees under the Federal Employee Health Benefits Plan.

The American Hospital Association and the Blue Cross Association jointly operate a program for approval of plans as members of Blue Cross if they meet specified standards. In addition to the standards for composition of the governing board, the following standards, among others, are applied: The plan must have nonprofit sponsorship and control; cover under its most widely held certificate not less than 75 percent of hospital billings; maintain adequate reserves; contract with a majority of the hospitals qualified to provide service in the area; and maintain adequate accounting and statistical records.

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[5] *Medical Economics*, June 28, 1965. A confirming letter from the Blue Cross Association indicates that plan executives who are also board members are classed as public representatives.

BLUE SHIELD PLANS

There are 74 Blue Shield plans serving the United States, excluding the one in Puerto Rico. (Canada has six plans, and Jamaica one.) A little less than half the plans serve entire States; most of the others serve parts of States; one plan serves two States (New Hampshire and Vermont); and two plans serve one State in competition.

Contracts.—All Blue Shield plans write contracts providing surgical, obstetrical, and anesthesiology services (in or out of the hospital), and physicians' care for nonsurgical cases in the hospital. About two-thirds of the plans also cover X-ray examinations and therapy for inpatients or outpatients. These services are covered by Blue Cross or Blue Shield, or both cooperatively, depending upon prevailing practices in the area. A growing number of plans provide some coverage of X-ray diagnosis and therapy and laboratory service in the office or home; about 20 give some coverage of office and home calls, but the number of persons affected is relatively small.

The benefits provided by Blue Shield plans may be on a service, indemnity, or a mixed service-indemnity basis. As of October 1965, six plans, small in membership, provided service benefits to all subscribers regardless of income.[6] Thirteen plans were on an indemnity basis—that is, the participating physicians do not undertake to accept the plan's payments as full payment for their services.

The largest number of plans (55), with about three-fourths of the total membership, provide mixed service-indemnity benefits. The participating physicians agree to accept the plan's scheduled payments or allowances as full payment for their services to subscribers with incomes under specified ceilings; the benefits for these subscribers are thus on a service basis. To subscribers with higher incomes the physicians, if they wish, may make additional charges; for these subscribers, benefits are on an indemnity basis.

The ceilings or limits for service benefits under the mixed service-indemnity plans are typically $4,000 for a single person and $6,000 for a family. As of October 1965, the limit for a single person was under $4,000 in 12 plans, $4,000–$5,999 in 29, and $6,000–$12,000 in 14. For a family, it was under $6,000 in 12 plans, $6,000–$7,999 in 33, and $8,000–$12,000 in 10.[7]

Thirty-four of these plans have two sets of ceilings for their service benefits (that described and one or two lower ones); they also have two (in a few instances, three) schedules of allowances or fees. The ceilings under the lower schedules are generally $2,500–$3,000 for a single person and $4,000 for a family.[8]

Fee or allowance schedules.—Each plan has its own schedules of fees or allowances for the different operations, procedures, etc., developed by negotiation with the representatives of the medical society or societies of the area. Since the plan's board of trustees is, in effect, designated by the same society or societies, the same party is likely to be at both sides of the negotiation table. In the development of fee schedules the plans tend more and more to use "relative value scales" that indicate the value of each procedure in terms of a single unit.[9]

Participating physicians.—The plans operate through agreements with participating physicians. All licensed physicians in a plan's area are eligible to participate, and in most plans almost 100 percent of all physicians do participate. They agree to bill the plan for services to subscribers and, in plans with service features, to accept the scheduled allowances as full payment for their services to subscribers entitled to service benefits.

Legal status.—Most plans operate under special enabling legislation that exempts them from the

[6] Based on data for early October from the Blue Shield Manual.

[7] *Ibid.*

[8] A recent nationwide study by the National Association of Blue Shield Plans found that, for all plans and all certificates, in 67 percent of all claims the Blue Shield payment covered the doctor's charge in full and that plan payments met 77 percent of total charges under all claims. (Testimony of Blue Shield representatives before Senate Committee on Finance, *Social Security, Hearings. . . . on H.R. 6675,* April 29–May 7, 1965, Part II, page 405.)

[9] A recent development that deserves notice is one in which a plan dispenses with a formal fee schedule. Physicians are asked to file with the plan their customary or regular charges for the procedures they perform. If a physician's charges are within the ninth decile of the charges of all physicians in the area, then the plan will pay him his regular charges for each procedure, and he in turn agrees to accept these as full payment for all patients, regardless of income. The National Association of Blue Shield Plans is encouraging all plans to adopt this arrangement.

insurance code, generally specifies what practitioners may participate, frequently requires that a majority of the board must be physicians, provides for regulation of contracts and subscription rates by the insurance department, and exempts the plans from taxation other than local taxes on real estate.

Control.—Virtually every Blue Shield plan is, in effect, controlled by the State or local organized medical profession of the area in which it operates. The bylaws of most plans specify that most of the board members must be physicians appointed by the medical society or societies of the area. In recent years there has been some movement towards more lay representation on such boards. A study by the National Association of Blue Shield Plans showed that, in 1964, 63 percent of the members of Blue Shield governing boards were from the medical profession, 31 percent represented the public, and 6 percent represented hospitals.[10]

National coordination.—The plans have the National Association of Blue Shield Plans as their national coordinating agency; it does for them what the Blue Cross Association does for Blue Cross plans. Requirements for approval as a Blue Shield plan include nonprofit status, approval by the State medical society or the county medical society or societies of the area, provision for free choice of physician, maintenance of adequate statistical and accounting records, and adequate reserves.

Relationships with Blue Cross.—Generally the Blue Cross and Blue Shield plans serving the same area are affiliated. Probably the most common arrangement is as separate corporate entities, each with its own board, but with both plans having the same executive director and administrative staff. Less frequently, each plan has its own executive director, and the medical plan has its own staff for handling medical claims, but the Blue Cross plan does the enrollment and billing for both plans. In seven instances the Blue Cross and Blue Shield organizations are identical; there is a single corporation, board of directors, and staff. At the opposite extreme is the situation in which the Blue Cross and Blue Shield plans serving an area are competing organizations, as in California, Idaho, Oregon, Montana, Washington, and, to some extent, Minnesota and Wisconsin. In Alaska, Hawaii, and Louisiana there is only a Blue Cross or a Blue Shield plan, which writes both hospitalization and surgical-medical benefits.

[10] *Medical Economics*, June 28, 1965, page 75. Plan executives who are members of the board of trustees are classed as "public" representatives in this accounting.

INSURANCE COMPANIES

Medical care expense insurance by insurance companies is one part of so-called health and accident insurance; the other part is accident and disability (wage replacement) insurance.

In 1963 a total of 903 insurance companies wrote health and accident insurance—609 life companies, 252 casualty companies, and 42 companies offering health and accident insurance only.[11] Of these companies, 588 wrote group insurance, 821 individual insurance, and 506 wrote both group and individual insurance. Not all write medical care expense insurance; some write only accident or disability policies.

Group Policies

Most companies writing group medical care expense insurance offer "basic" hospital, surgical, and "regular medical" expense policies, and probably a majority also write "major medical" policies.

Basic hospital policies usually provide for reimbursement of the hospital's daily room and board charges up to a specified amount per day for a specified number of days and reimbursement of miscellaneous hospital expense (charges for use of operating room, drugs, X-ray and laboratory examinations, etc.) up to a specified amount, frequently 10, 15, or 20 times the daily room allowance. Frequently there will be further coverage of the miscellaneous expense on a co-insurance basis. A popular variant provides complete reimbursement of all hospital charges (but including room and board charges only up to a specified amount per day, not in excess of cost of a semiprivate room) with a maximum of, say, $500 or $1,000 and then payment of 80 percent of all charges beyond

[11] Health Insurance Institute, *Source Book of Health Insurance Data, 1964*, page 55.

that amount. Policies are available in varied combinations of room and board allowances, days of coverage, allowances for special services, etc.; they may include or exclude maternity cases and may cover them with or without a waiting period, as the purchaser prefers. Generally all illnesses are covered without restriction; mental illness, for example, is covered on the same terms as other conditions and without regard to type of hospital.

Basic surgical expense policies provide for reimbursement of surgical expense in accordance with a schedule set forth in the policy. Policies with different levels of reimbursement for the various operations are offered. The allowances for all the different operations are scaled in proportion to the largest amount payable for any operation.

"Regular medical" expense policies cover physicians' visits (other than for surgery or obstetrics) in the hospital or—much less frequently—in the hospital, office, and home, paying so much per visit up to a stated maximum. Policies covering office and home visits frequently exclude the first two visits in each illness. Regular medical policies may also include coverage of the expense of X-ray and laboratory examinations in the outpatient department or doctors' office or the home. Most policies reimburse up to a set maximum in any one illness—$25, $50, $75, or higher.

Not infrequently levels of benefits under all the basic coverages will be higher for employees than for dependents.

In 1948, insurance companies began to write a new type of medical care expense insurance known as "major medical" policies. Sales of these policies have increased rapidly, and total group premiums for major medical coverage amounted in 1964 to 33 percent of all group medical care expense premiums.

The concept behind these policies is that it is relatively more important for health insurance to meet or "break the back" of the catastrophic expenses arising from serious, costly illness than to give "first dollar" coverage of the cost of hospital care or physicians' service in relatively minor episodes of illness. Accordingly, the distinctive features of such policies are: (1) they cover almost all illness expense, but not dental care (except for accidents), health check-ups, eye refractions, eyeglasses, and hearing aids; (2) there is an initial "deductible" amount, which the insured person must first pay out of pocket; (3) the insurance pays 75 percent or 80 percent of all remaining allowable expense up to high benefit maximums. The purpose of reimbursing only 75 percent or 80 percent of allowable expense is to assure that the insured person has an interest in the prudent use of service and in reasonable charges.

Major medical policies are of two types: supplementary and comprehensive. The first type supplements basic coverage (from an insurance company or Blue Cross-Blue Shield). The second type gives integrated comprehensive coverage in itself.

Supplementary policies usually provide for a "corridor" of expense, in addition to the expenses covered under the basic coverage, which the insured meets out of pocket, and then pay 75 percent or 80 percent of all remaining allowable expense. Typical "comprehensive" policies have an initial deductible of $50, $100, $200, or $500 and meet 75 percent or 80 percent of all remaining expense. (Supplementary policies are more popular by a margin of almost 3 to 1 in terms of the number of persons covered.) Both types meet allowed expenses up to high benefit maximums for each covered person, frequently $10,000, $25,000, or $50,000, in any illness, during a year, or for life. In the last case, provision is made for restoration of the maximum when the insured person incurs no allowable expense within a certain period.

Within recent years the line between basic coverage and major medical coverage has tended to become blurred. Thus, policies are written that provide for (a) 100-percent reimbursement of all hospital expense, up to a certain amount—say, $1,000—and for 80-percent reimbursement of all remaining hospital expense, all without a deductible, and (b) 80-percent coverage of all other illness expense after a deductible of, say, $50 or $100.

Most major medical policies cover psychiatric care in a hospital on the same basis as other expense but provide for only 50-percent reimbursement of psychiatric expense outside the hospital.

No information is available on the levels of benefits under all group contracts of insurance companies, but some light on this is shed by the Health Insurance Institute's periodic surveys of new group cases. Its 1964 survey showed that

of all employees in its sample of new cases, 65 percent were covered for basic hospital benefits, the same percentage for surgical benefits, 48 percent for in-hospital medical visits, 4 percent for physicians' services in the office and home, 22 percent for diagnostic X-ray and laboratory benefits, 50 percent for supplementary major medical, and 15 percent for comprehensive major medical.[12]

Of the employees insured for basic hospital benefits alone or plus supplemental major medical coverage, 40 percent were covered for daily room and board allowances of less than $16.00, 22 percent for allowances of $16.00–$19.99, 24 percent for allowances of $20.00–$24.99, 6 percent for allowances of more than $25.00, and 8 percent were covered for full payment of semiprivate or ward accommodations. Approximately 36 percent of the same employees were covered for 31 or 35 days of hospital care, 36 percent for 70 days, 19 percent for 100, 120, or 150 days, and 3 percent for 180 days or more. Five percent were covered for other durations or for no specified number of days, but up to a dollar maximum. It is possible that the levels of benefits in these newly written cases are higher than those under all policies currently in effect.

Rates.—The initial rate (the rate for the first year of coverage) at which the companies write basic hospital, surgical, and regular medical policies varies with the percentage of women in the covered group and is increased for employees in industries with above-average health hazards. Rates may also vary with the percentage of persons in the covered group who are aged 65 and over.

After the first year, premiums are experience-rated—at least for all groups of more than a specified size. In other words, the company agrees in effect to provide the specified insurance for what it pays out in benefits, plus a specified retention to cover administrative expense, reserves, and underwriting gain. Thus, the premium rates for any given year are based on the preceding year's experience. If benefit expenditures are less than the amount calculated, the difference is returned to the insured organization in the form of a policy dividend or retrospective rate reduction. If the cost is greater than calculated, the insurance company raises the rate in the next policy year.

Continuation of coverage on termination of employment.—Until the past 10 years or so, most group policies contained no provision under which an employee whose job is terminated could continue to receive coverage. Provisions that give such an employee a right to convert to an individual policy without regard to the state of his health at time of termination, but at a premium appropriate to his age, are now becoming common. Many policies include special provisions for continuation of coverage, on one basis or another, for employees retiring because of age. New York has a law requiring that all group hospital and surgical policies provide a right of conversion to comparable individual policies, without evidence of insurability, for persons who cease to be members of the group.[13]

Administrative practices.—Group policies are contracts between the insurance company and the insured organization, by which the insurance company agrees to reimburse each covered person for covered expenses in accordance with the terms of the policy. It is becoming more and more common for the insured person to assign his benefits to the hospital or physician, and the insurance company then pays them directly. Frequently large employers or welfare funds perform much of the work of claims administration, such as determining eligibility, approving claims, and paying benefits by a draft drawn on the insurance company.

Individual Policies

Policies sold on an individual basis follow the same general lines as group policies. In general, these policies tend to cover hospitalization and surgical expense only; there is relatively little coverage of physicians' in-hospital, office, and home visits. The relatively small volume of major medical coverage is mainly of the supplementary type.

Benefits under individual policies are, in general, markedly lower than those under group policies, as a comparison of the per enrollee premiums or benefit expenditures shows. One reason

[12] Health Insurance Institute, *Group Health Insurance Policies Issued in 1964.*

[13] O. D. Dickerson, *Health Insurance,* Richard D. Irwin, 1963, page 623.

for the low benefit levels is that about half the premiums go for selling and other operating expense. Another is the need of keeping premiums to levels that individuals can afford without employer contributions. Some companies sell policies with such low levels of benefits—the $100 a week, for example, provided by one large writer—that only token protection against today's hospital costs is given.

Individual policies are much more hedged about with restrictions and exclusions than group policies. Pre-existing conditions are almost always excluded, at least for the first 1 or 2 years of coverage. There are frequently waiting periods for specified conditions—such as hernia, heart disease, and tuberculosis. Mental illness is commonly excluded. Some companies provide coverage for accidents from the inception of the policy but not for sickness until after a month or two has elapsed.

Individual policies are generally sold on a basis that permits the company to select its risks. The company may refuse to accept an applicant whose health history or physical examination indicates that he would be a poor risk, or it may accept him subject to a waiver of coverage for one or more specified conditions.

An important feature of individual policies is the reliability of the coverage—whether they can be cancelled or not renewed by the company. The value of coverage to an insured person is obviously much impaired if, following a claim in a serious illness, the company cancels the policy or at the next renewal date refuses to renew at all or only subject to waiver of coverage for one or more specified conditions. Such practices on the part of some insurance companies led to much public dissatisfaction some years ago and to investigations and remedial legislation in some States. Nine States do not permit cancellation of a policy within the term of the policy, and several restrict cancellability by stipulating a period of notice (1 year or two) before a policy can be cancelled or not renewed.[14] New York specifically prohibits refusal to renew because of deterioration of the insured person's health.

In recent years there has been a considerable growth in the number of noncancellable or guaranteed renewable policies covering health care expense. Typically under these policies the company cannot cancel or refuse to renew but may change the premiums for classes of insured persons. The premium volume, however, would represent not more than a fourth of the total under individual health care expense policies.

Regulation of Insurance Companies

Although insurance is held to be interstate commerce, Federal law provides for regulation of insurance by the States and not the Federal Government. All States regulate accident and health insurance, along with other types of insurance, to some degree. Such regulation provides for licensure of companies doing business in the State; sets up standards of solvency including reserves and permissible investments; requires annual statements and periodic financial examinations; and provides for approval of policy forms and rates, licensure of agents, and investigations of complaints, etc. The emphasis is on making sure that companies are and will be solvent—able to meet obligations to policyholders.

In the field of accident and health insurance there has been considerable recognition of the need for protecting holders of individual policies. Most States require individual policies to contain certain uniform provisions designed to protect the interests of the insured person. About a third of the States have laws providing that policies shall not be approved if the benefits provided are unreasonably low in relation to the premium charged. The State laws with respect to cancellations have been noted. One persistent and difficult problem is the lack of any adequate regulation of companies that sell by mail and are not licensed in most of the States in which they do business.

INDEPENDENT PLANS

Of the total enrollment in all independent plans for any benefit, 39 percent is in the community-consumer plans, 54 percent in the employer-employee-union plans, 3 percent in the private group-clinic plans, and 4 percent in the dental society plans. The enrollment in medical society plans (not Blue Shield) is negligible. In 1961, 44 per-

[14] Dickerson, *op. cit.*, pages 622–623.

cent of the enrollment in independent plans was in plans that provided service through group practice; the proportion today is probably a little higher.

Of the community-consumer plans, nine of the larger plans account for about three-fourths of the total enrollment for physicians' service; all but one of the nine provide service through group practice.

The four Kaiser Health Plans (in Northern California, Southern California, Oregon, and Hawaii) together have over more than 1.1 million participants. Each plan has its own hospital or hospitals (more than twelve) and provides hospital care and comprehensive physicians' services (care in the hospital, clinic, and home) through an organized group of physicians. A similar plan is the Group Health Association of Puget Sound (with more than 70,000 participants).

The Health Insurance Plan of Greater New York (with approximately 700,000 subscribers) provides comprehensive physicians' services through about 30 medical groups. The medical groups in all but a few cases are owned and controlled by the member physicians; each group is paid a set amount monthly for every participant who has elected to receive care from the group. Formerly each group provided its own physical facilities; recently the plan has begun to assume some responsibilities for financing and providing facilities. This plan does not provide hospitalization; the subscribers must have coverage through Blue Cross or some other carrier.

Group Health Association of Washington, D.C. (having about 56,000 participants), provides hospital care and complete physicians' services and pays part of the cost of drugs under some contracts. It contracts with Blue Cross for hospital care for its members but provides physicians' care through its own salaried medical staff. Similarly, the Community Health Association of Detroit (which has more than 60,000 participants) provides service through contract with a hospital and two ancillary clinics, all served by a full-time medical staff.

These and other community-consumer group practice plans (as well as some union-sponsored plans providing care through group practice) are members of the Group Health Association of America. This organization serves as their national spokesman, conducts research and statistical activities, and endeavors to promote their growth and development.

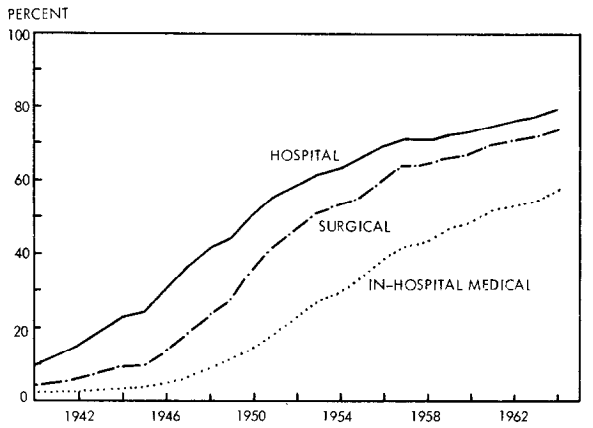
One large consumer-sponsored plan — Group Health Insurance of New York City (which has about 800,000 participants)—provides benefits on an individual practice basis. Alternative contracts are offered. One covers comprehensive physicians' services; the other offers surgery, in-hospital medical care, and X-ray and laboratory service. The majority of subscribers have the more com-

TABLE 1.—Number of persons reported enrolled for hospital, surgical, and in-hospital medical benefits by private health insurance organizations, and Health Insurance Association of America estimate of net number of persons enrolled, as of December 31, 1964

Type of organization	Hospital care		Surgical service		In-hospital medical care	
	Number (in thousands)	Percentage distribution	Number (in thousands)	Percentage distribution	Number (in thousands)	Percentage distribution
Gross total	162,598	100.0	152,491	100.0	112,934	100.0
Blue Cross-Blue Shield plans, total	62,429	38.4	54,473	35.7	49,800	44.1
Blue Cross	60,478	37.2	3,222	2.1	3,200	2.8
Blue Shield	1,951	1.2	51,251	33.6	46,600	41.3
Insurance companies:						
Total, unadjusted	104,230	-------	99,714	-------	59,764	-------
Group policies	64,506	-------	64,939	-------	47,446	-------
Individual policies	39,724	-------	34,775	-------	12,318	-------
Net total [1]	93,209	57.3	89,558	58.8	55,174	48.9
Independent plans, total	6,960	4.3	8,460	5.5	7,960	7.0
Community	2,090	1.3	3,400	2.2	3,300	2.9
Employer-employee-union	4,800	3.0	4,800	3.1	4,400	3.9
Medical society	10	[2]	10	[2]	10	[2]
Private group clinic	60	[2]	250	.2	250	.2
HIAA estimate of enrollment:						
Net total [3]	151,123	-------	140,667	-------	108,717	-------
Percent of civilian population	79.2	-------	73.7	-------	57.0	-------

[1] With deduction for duplication of members among insurance companies.
[2] Less than 0.05 percent.
[3] Number of different persons enrolled.

CHART 1.—Percent of civilian population with specified types of health insurance coverage, 1940–64, as estimated by the Health Insurance Association of America



prehensive coverage. This plan has more than 10,000 participating physicians who agree to accept the plan's fees as full payment for their services, regardless of what the subscriber's income may be.

Of the 4.8 million persons enrolled in the employer-employee-union plans, somewhat more than a third are in plans that provide service through group-practice arrangements — some through health centers that provide care only at the center. The others mainly provide indemnity allowances against expenses incurred for hospital care, physicians' services, and/or other items of care.

Where employers, employee benefit associations, unions, and union welfare funds provide service on a free-choice, fee-for-service or indemnity basis they do so largely because they think they can provide benefits more cheaply through self-insurance than through purchasing coverage from a carrier. Frequently they provide types of care—physicians' services in the office and home, dental care, eyeglasses, and drugs, for example—that are as yet somewhat experimental and for which they find that insurance cannot be purchased advantageously.

Enrollment

Because some individuals are enrolled in more than one of the three types of organizations—Blue Cross-Blue Shield plans, insurance companies, and independent plans—the gross number with coverage[15] is substantially larger than the actual (net) number of different persons covered (table 1).

The data for Blue Cross and Blue Shield have been compiled by the Office of Research and Statistics from information furnished by the Blue Cross Association and the National Association of Blue Shield Plans. The insurance company data are estimates of the Health Insurance Association of America (HIAA), based on its annual surveys. The data for independent plans are based on the periodic surveys made by the Office of Research and Statistics.

It will be seen that the net number of different persons covered by insurance companies is materially larger than enrollment in the Blue Cross-Blue Shield plans, and enrollment in the inde-

[15] See Louis S. Reed, *The Extent of Health Insurance Coverage in the United States* (Research Report No. 10, Office of Research and Statistics, Social Security Administration), 1965.

TABLE 2.—Number of persons reported enrolled for hospital benefits by private health insurance organizations, and Health Insurance Association of America estimate of net number of different persons enrolled, end of year, 1940–64

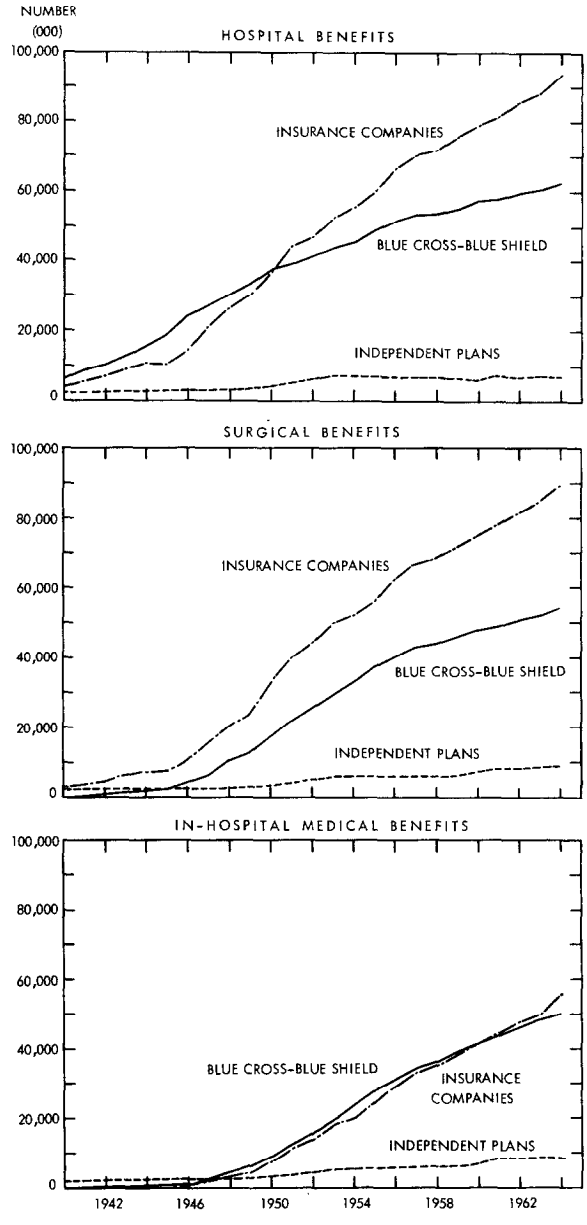
End of year	Gross total, all organizations	Blue Cross-Blue Shield plans			Insurance companies				Independent plans					HIAA estimate of net number of different persons enrolled	
		Blue Cross-Blue Shield	Blue Cross	Blue Shield	Total, unadjusted	Group	Individual	Net enrollment [1]	Total	Community-consumer	Employer-employee-union	Medical society	Private group clinics	Number	Percent of civilian population
1940	12,022	6,072	6,012	60	3,700	2,500	1,200	3,700	2,250	140	1,560	110	440	12,312	9.3
1941	16,089	8,469	8,399	70	5,350	3,850	1,500	5,350	2,270	140	1,560	130	440	16,349	12.4
1942	19,465	10,295	10,215	80	6,880	5,080	1,800	6,880	2,290	140	1,560	150	440	19,695	15.2
1943	23,915	12,696	12,600	96	8,900	6,800	2,100	8,900	2,319	144	1,560	170	445	24,160	18.9
1944	29,123	15,828	15,748	80	10,800	8,400	2,400	10,800	2,495	280	1,610	185	420	29,232	22.9
1945	32,135	18,961	18,881	80	10,504	7,804	2,700	10,504	2,670	420	1,660	200	390	32,068	24.0
1946	41,477	24,342	24,250	92	14,315	11,315	3,000	14,315	2,820	560	1,700	200	360	42,112	29.9
1947	51,813	27,646	27,489	157	21,774	14,190	7,584	21,127	3,040	700	1,760	250	330	52,584	36.4
1948	60,685	30,619	30,448	171	28,027	16,741	11,286	26,786	3,280	840	1,810	330	300	60,995	41.5
1949	67,415	33,576	33,381	195	32,426	17,697	14,729	30,216	3,623	977	1,870	508	268	66,044	44.2
1950	79,045	37,645	37,435	210	39,601	22,305	17,296	36,955	4,445	1,445	2,280	500	220	76,639	50.7
1951	88,990	39,412	38,424	988	47,465	26,663	20,802	44,288	5,290	1,910	2,700	500	180	85,348	55.9
1952	94,315	41,353	40,495	858	50,867	29,455	21,412	46,842	6,120	2,380	3,120	490	130	90,965	58.5
1953	102,875	43,684	42,857	827	57,050	33,575	23,475	52,218	6,973	2,851	3,541	493	88	97,303	61.5
1954	107,317	45,355	44,243	1,112	60,428	35,090	25,338	55,282	6,680	2,890	3,380	340	70	101,493	62.9
1955	115,123	48,924	47,719	1,205	65,735	39,029	26,706	59,654	6,545	2,920	3,220	360	45	107,662	65.4
1956	124,144	51,455	50,108	1,347	72,840	45,211	27,629	66,259	6,430	2,956	3,066	388	20	115,949	69.1
1957	129,885	53,282	51,869	1,413	77,112	48,439	28,673	70,192	6,411	2,920	3,090	371	30	121,432	71.1
1958	13,810	53,623	52,258	1,365	78,880	49,508	29,372	71,798	6,389	2,880	3,120	354	35	123,038	70.8
1959	136,891	55,054	53,673	1,381	82,973	51,255	31,718	75,457	6,380	2,846	3,153	337	44	127,896	72.3
1960	142,343	57,464	55,938	1,526	88,120	55,218	32,902	78,885	5,994	1,604	4,000	340	50	131,962	73.4
1961	146,431	57,960	56,489	1,471	90,887	57,013	33,874	81,369	7,102	1,851	4,850	344	57	136,522	74.8
1962	151,729	59,618	58,133	1,485	95,214	59,153	36,061	85,174	6,937	1,830	4,703	344	60	141,437	76.3
1963	155,990	60,698	59,141	1,557	98,612	60,547	38,065	88,127	7,165	1,947	4,814	344	60	145,329	77.3
1964	162,598	62,429	60,478	1,951	104,230	64,506	39,724	93,209	6,960	2,090	4,800	10	60	151,123	79.2

[1] Less deduction for duplication.

pendent plans is relatively small. The share of insurance companies in the total is larger for surgical benefits and least for in-hospital medical benefits. The reverse holds for the Blue Cross-Blue Shield plans. The independent plans, with their emphasis on comprehensive coverage of physicians' services, make their best showing in this area.

According to HIAA estimates of the net number of different persons with coverage at the end of 1964, some protection against hospital care cost was held by 79 percent of the civilian population, 74 percent had some surgical expense protection, and 57 percent were protected to some extent against the cost of in-hospital medical visits.[16]

CHART 2.—Enrollment under private health insurance organizations, by type of care and type of organization, 1940–64



During the period 1940–64, the estimated percentage of the population with hospital insurance has increased continuously, but in recent years the rate of increase has slowed down (chart 1). Thus, in the 6 years from 1951 to 1957 the percentage of the population with some hospital insurance (as shown by the HIAA enrollment data) increased by almost 15 percentage points, from 55.9 percent to 71.1 percent. By contrast, from 1958 to 1964 the percentage increased by only 8.4 points. It is evident that almost as many persons now have surgical insurance as have hospital insurance, but the number with in-hospital medical coverage still lags considerably behind.

Enrollment for hospital care under the Blue Cross-Blue Shield plans was greater than that of the insurance companies until 1950 (table 2 and chart 2). Since then the net enrollment of insurance companies, as estimated by the HIAA, has exceeded that of the Blue Cross-Blue Shield plans by an increasing margin. Surgical coverage by insurance companies has always been greater than that of the Blue Cross-Blue Shield plans, and the gap has been consistently widening (chart 2). The Blue Cross-Blue Shield plans were leaders in the development of in-hospital medical coverage and had the largest enrollment until 1961, when the insurance companies took the lead. The independent plans have also grown, but slowly.

The number of enrollments under group policies of insurance companies covering hospital care has consistently been larger than the number under individual policies, and since 1952 the gap has widened. The same pattern holds, but to an even greater degree, for the surgical and hospital medical coverages (tables 2, 3, and 4 and chart 3).

In connection with the HIAA estimates of the number of different persons with coverage, it should be borne in mind that the estimates based on the enrollment reports of health insurance

[16] For a description and analysis of the method used by the HIAA in estimating duplicatory coverage, see Louis S. Reed, *op. cit.*

TABLE 3.—Number of persons reported enrolled for surgical benefits by private health insurance organizations, and Health Insurance Association of America estimate of net number of different persons enrolled, end of year, 1940–64

End of year	Gross total, all organizations	Blue Cross-Blue Shield plans			Insurance companies				Independent plans					HIAA estimate of net number of different persons enrolled	
		Blue Cross-Blue Shield	Blue Cross	Blue Shield	Total, unadjusted	Group	Individual	Net enrollment [1]	Total	Community-consumer	Employer-employee-union	Medical society	Private group clinics	Number	Percent of civilian population
1940	4,790	260	----------	260	2,280	1,430	850	2,280	2,250	200	1,480	110	460	5,350	4.0
1941	6,215	645	----------	645	3,300	2,300	1,000	3,300	2,270	200	1,480	130	460	6,775	5.1
1942	7,580	815	----------	815	4,475	3,275	1,200	4,475	2,290	200	1,480	150	460	8,140	6.3
1943	9,488	1,065	11	1,054	6,100	4,700	1,400	6,100	2,323	205	1,481	170	467	10,069	7.9
1944	11,183	1,583	65	1,518	7,225	5,625	1,600	7,225	2,375	280	1,470	185	440	11,713	9.2
1945	12,092	2,335	127	2,208	7,337	5,537	1,800	7,337	2,420	350	1,460	200	410	12,890	9.7
1946	17,357	4,236	332	3,904	10,661	8,661	2,000	10,661	2,460	430	1,450	200	380	18,609	13.2
1947	24,295	6,187	455	5,732	15,978	11,103	4,875	15,558	2,550	500	1,450	250	350	26,247	18.2
1948	33,565	10,516	631	9,885	21,143	14,199	6,944	20,379	2,670	580	1,440	330	320	34,060	23.2
1949	39,749	12,842	907	11,935	24,905	15,590	9,315	23,881	3,026	653	1,438	643	292	41,143	27.5
1950	54,441	17,253	1,151	16,102	34,937	21,219	13,718	33,428	3,760	940	1,950	600	270	54,156	35.8
1951	66,842	22,052	1,806	20,246	41,999	26,376	15,623	40,280	4,510	1,230	2,470	570	240	64,892	42.5
1952	75,952	25,775	2,190	23,585	47,975	29,621	18,354	44,919	5,258	1,520	2,990	538	210	72,459	46.6
1953	85,998	29,527	2,625	26,902	54,251	34,039	20,212	50,464	6,007	1,803	3,516	502	186	80,982	51.2
1954	91,857	33,081	2,923	30,158	57,165	35,723	21,442	52,806	5,970	1,970	3,350	470	180	85,890	53.2
1955	99,970	37,395	3,194	34,201	62,170	39,725	22,445	56,645	5,930	2,130	3,200	430	170	91,927	55.8
1956	109,437	40,542	3,502	37,040	68,980	45,906	23,074	62,996	5,899	2,298	3,040	401	160	101,325	60.4
1957	116,751	43,305	3,801	39,504	73,883	48,955	24,928	67,456	5,990	2,360	3,070	390	170	108,931	63.8
1958	119,536	44,331	3,927	40,404	75,736	49,917	25,819	69,125	6,080	2,430	3,100	370	180	111,435	64.1
1959	124,837	46,386	4,129	42,257	79,212	51,756	27,456	72,263	6,188	2,496	3,138	360	194	116,944	66.1
1960	130,907	48,266	3,773	44,493	83,713	55,504	28,209	75,305	7,336	2,760	4,020	346	210	121,045	67.3
1961	136,729	49,374	3,048	46,326	87,775	57,373	30,402	78,861	8,494	3,026	4,891	346	231	126,940	69.6
1962	141,146	50,876	2,814	48,062	91,230	59,787	31,443	81,983	8,287	3,003	4,695	346	243	131,185	70.8
1963	145,937	52,371	2,740	49,631	94,689	60,944	33,745	84,958	8,608	3,206	4,806	346	250	134,908	71.7
1964	152,491	54,473	3,222	51,251	99,714	64,939	34,775	89,558	8,460	3,400	4,800	10	250	140,667	73.7

[1] Less deduction for duplication.

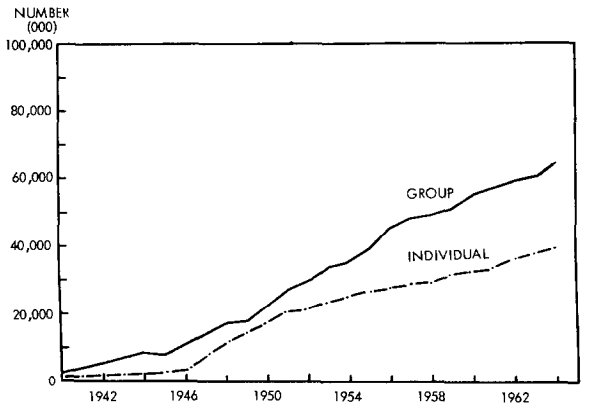
TABLE 4.—Number of persons reported enrolled for in-hospital medical benefits by private health insurance organizations, and Health Insurance Association of America estimate of net number of different persons enrolled, end of year, 1940–64

End of year	Gross total, all organizations	Blue Cross-Blue Shield [1]	Insurance companies				Independent plans					HIAA estimate of net number of different persons enrolled	
			Total, unadjusted	Group	Individual	Net enrollment [2]	Total	Community-consumer	Employer-employee-union	Medical society	Private group clinics	Number	Percent of civilian population
1940	2,265	65	----------	----------	----------	----------	2,200	170	1,430	110	490	3,000	2.3
1941	2,390	170	----------	----------	----------	----------	2,220	170	1,430	130	490	3,100	2.4
1942	2,470	230	----------	----------	----------	----------	2,240	170	1,430	150	490	3,200	2.5
1943	2,591	320	----------	----------	----------	----------	2,271	178	1,432	170	491	3,411	2.7
1944	3,000	500	200	100	100	200	2,300	265	1,390	185	460	3,840	3.0
1945	3,640	770	535	335	200	535	2,335	350	1,360	200	425	4,713	3.5
1946	4,637	1,480	867	567	300	867	2,290	370	1,330	200	390	6,421	4.6
1947	6,856	2,400	2,209	1,098	1,111	2,116	2,340	440	1,290	250	360	8,898	6.2
1948	10,573	4,600	3,737	1,927	1,810	3,538	2,435	530	1,250	330	325	12,895	8.8
1949	14,082	6,400	5,086	2,736	2,350	4,827	2,855	703	1,217	643	292	16,862	11.3
1950	20,721	9,400	8,301	5,587	2,714	8,001	3,320	930	1,660	460	270	21,589	14.3
1951	28,741	13,200	12,176	7,946	4,230	11,711	3,830	1,000	2,110	470	250	27,723	18.1
1952	34,970	16,200	15,122	10,157	4,965	14,220	4,550	1,270	2,570	480	230	35,670	22.9
1953	44,208	20,600	19,611	13,787	5,824	18,361	5,247	1,531	3,018	488	210	42,684	27.0
1954	50,661	24,600	22,291	15,778	6,513	20,721	5,340	1,700	2,990	450	200	47,248	29.3
1955	58,971	28,500	26,942	20,678	6,264	25,031	5,440	1,870	2,960	420	190	55,506	33.7
1956	67,040	31,700	31,966	25,177	6,789	29,756	5,584	2,062	2,941	395	186	64,891	38.7
1957	73,585	34,700	35,688	28,317	7,371	33,240	5,645	2,185	2,890	380	190	71,813	42.0
1958	77,272	36,400	37,737	29,868	7,869	35,142	5,730	2,310	2,850	370	200	75,395	43.4
1959	83,234	39,200	41,051	32,469	8,582	38,227	5,807	2,432	2,801	360	214	82,615	46.7
1960	89,928	41,700	44,704	35,802	8,902	41,312	6,916	2,680	3,670	346	220	87,541	48.7
1961	96,129	43,700	48,120	38,003	10,117	44,399	8,030	2,924	4,523	346	237	94,209	51.6
1962	100,799	46,000	50,986	40,012	10,974	47,010	7,789	2,897	4,297	346	249	98,204	53.0
1963	106,001	48,200	53,950	42,066	11,884	49,708	8,093	3,093	4,398	346	256	102,177	54.3
1964	112,934	49,800	57,764	47,446	12,318	55,174	7,960	3,300	4,400	10	250	108,717	57.0

[1] Estimated.

[2] Less deduction for duplication.

CHART 3.—Enrollment for hospital benefits under group and individual policies of insurance companies, 1940–64



organizations consistently run about 10 percent higher than the findings of the various household interview surveys that asked if the person did or did not have health insurance coverage. This difference may be the result of underreporting in the household surveys, gross understimation of the extent of duplicatory coverage among the three types of organizations, or overestimation of the net enrollment of insurance companies.[17]

[17] The Public Health Service household surveys of the extent of health insurance coverage in 1959 and 1962–63 provide data on the proportion of persons with hospital and with surgical coverage who had coverage through both "Blue plans" and "other plans." Use of these data in conjunction with the enrollment figures in tables 1, 2, and 3 yields estimates of net enrollment for hospital and surgical coverage for 1959 and 1962 that are not significantly different from the HIAA estimates for the same years.

Finances

The financial data on the operations of health insurance organizations, shown in table 5, relate to the United States, excluding Puerto Rico. The data for Blue Cross and Blue Shield plans are based on individual income statements for all plans, made available to the Social Security Administration by the Blue Cross and Blue Shield associations. The data have been adjusted to exclude duplication arising from the fact that seven plans are joint Blue Cross-Blue Shield plans and to include operating results of Health Services, Inc., and Medical Indemnity of America—two insurance companies owned by the Blue Cross and the Blue Shield associations, respectively.

The HIAA estimates for the insurance companies are based on data from the annual survey, conducted jointly by the HIAA and the Life Insurance Institute of America, of all group business in the United States; the Spectator Aggregates on group and individual accident and health business; and the HIAA's annual survey of accident and health benefits paid by type of coverage. The operating expense ratios for all group and individual accident and health insurance in 1964, as published in the Spectator Aggregates, were used as the bases for the operating expense ratios under group and under individual policies.

The data for the independent plans are preliminary. They are based on returns in 1965 from approximately 30 of the larger independent plans,

TABLE 5.—Financial experience of private health insurance organizations, 1964

[Amounts in millions]

Type of organization	Total income	Subscription or premium income	Claims expense		Operating expense		Net gain from underwriting		Net income	
			Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of total income
Total	(1)	$8,958.1	$7,807.4	87.2	$1,302.8	14.5	−$152.1	−1.7	(1)	(1)
Blue Cross-Blue Shield plans	$3,836.3	3,785.1	3,574.4	94.4	223.2	5.9	−12.5	−.3	$38.7	1.0
Blue Cross	2,732.8	2,697.6	2,592.8	96.1	122.9	4.6	−18.1	−.7	17.1	.6
Blue Shield	1,103.5	1,087.5	981.6	90.3	100.3	9.2	5.6	.5	21.6	2.0
Insurance companies	(1)	4,652.0	3,763.0	80.9	1,040.0	22.4	−151.0	−3.2	(1)	(1)
Group	(1)	3,297.0	3,024.0	91.7	425.0	12.9	−152.0	−4.6	(1)	(1)
Individual	(1)	1,355.0	739.0	54.5	615.0	45.4	1.0	.1	(1)	(1)
Independent plans	[2] 521.0	[2] 521.0	470.0	90.2	39.6	7.6	11.4	2.2	11.4	2.2
Community	197.0	197.0	178.3	90.5	16.5	8.4	2.2	1.1	2.2	1.1
Employer-employee-union	298.9	298.9	268.8	89.9	20.8	7.0	9.3	3.1	9.3	3.1
Medical society	.7	.7	.6	85.7	.1	14.3				
Dental society	11.0	11.0	11.0	100.0	.8	7.3	−.8	−7.3	−.8	−7.3
Private group clinic	13.4	13.4	11.3	84.3	1.4	10.4	.7	5.2	.7	5.2

[1] Not available.
[2] Represents total income; data on subscription income by itself not available. Total income includes income from charges for services paid directly by covered persons and a small amount of investment income.

TABLE 6.—Percentage distribution of total subscription or premium income, claims expense, and operating expense of private health insurance organizations, 1964

Type of organization	Premium income	Claims expense	Operating expense
Total percent	100.0	100.0	100.0
Blue Cross-Blue Shield plans	42.3	45.8	17.1
Blue Cross	30.1	33.2	9.4
Blue Shield	12.1	12.6	7.7
Insurance companies	51.9	48.2	79.8
Group	36.8	38.7	32.6
Individual	15.1	9.5	47.2
Independent plans	5.8	6.0	3.0
Community	2.2	2.3	1.3
Employer-employee-union	3.3	3.4	1.6
Medical society	(1)	(1)	(1)
Dental society	.1	.1	.1
Private group clinic	.1	.1	.1

[1] Less than 0.05 percent.

in conjunction with the Social Security Administration's survey of all independent plans. The results of the Administration's survey are not yet available. The operating expenses of these plans must be regarded as approximations for two reasons. First, the plans that directly provide health services through their own facilities and salaried personnel find it difficult to separate the administrative expenses of prepayment from the administrative expenses of furnishing medical care. Secondly, some employer plans do not keep full account of all administrative expense, and welfare funds that provide various types of benefits (life insurance, disability and medical care) do not break down their administrative expenses. Allocation of administrative expense on the basis of the expenditures for the various types of benefits yields only an approximate picture.

The distribution of premium income, claims or benefit expense, and operating expense among the different types of organizations is shown in table 6. Data on subscription or premium income, benefit expense, and retentions are distributed between hospital care and physicians' services and other types of care in table 7. (Retention is the difference between premium income and benefit expense; it is made up of operating expense and net underwriting gain.)

In making this allocation for Blue Cross-Blue Shield, all premium income and benefit expenditures of Blue Cross plans writing only hospital benefits were allocated to hospital care. (Actually a small part of these benefit expenditures—and of premium income as well—is for services other than hospital care.) For Blue Cross plans writing both hospital and surgical-medical benefits, income was allocated on the basis of claims expense. For Blue Shield plans writing only surgical-medical benefits, all income and benefit expenditures were allocated to physicians' services and other types of care. Plans writing both physicians' services and hospital care had their income allocated on the basis of benefit expenditures.

The data for insurance companies shown in table 7 are estimates made by the HIAA. Income and benefit expenditures under major medical

TABLE 7.—Subscription or premium income, benefit expense, and retentions [1] of private health insurance organizations, by type of care, 1964

[Amounts in millions]

Type of organization	Income			Benefit expenditures			Retentions		
	Total	Hospital	Physicians' services and other types of care	Total	Hospital	Physicians' services and other types of care	Total	Hospital	Physicians' services and other types of care
Total	$8,958.1	$5,865.2	$3,092.9	$7,807.4	$5,205.1	$2,602.3	$1,150.7	$660.2	$490.5
Blue Cross-Blue Shield plans	3,785.1	2,701.5	1,083.6	3,574.4	2,594.3	980.1	210.7	107.2	103.5
Blue Cross	2,697.6	2,635.8	61.8	2,592.8	2,535.9	56.9	104.8	99.9	4.9
Blue Shield	1,087.5	65.7	1,021.8	981.6	58.4	923.2	105.9	7.3	98.6
Insurance companies	4,652.0	2,932.0	1,720.0	3,763.0	2,402.0	1,361.0	889.0	530.0	359.0
Group policies	3,297.0	1,966.0	1,331.0	3,024.0	1,877.0	1,147.0	273.0	89.0	184.0
Individual policies	1,355.0	966.0	389.0	739.0	525.0	214.0	616.0	441.0	175.0
Independent plans	521.0	231.7	289.3	470.0	208.0	261.2	51.0	23.0	28.0
Community	197.0	77.8	119.2	178.3	70.5	107.8	18.7	7.4	11.3
Employer-employee-union	298.9	151.2	147.7	268.8	136.0	132.8	30.1	15.2	14.9
Medical society	.7	.2	.5	.6	.2	.4	.1	(2)	.1
Dental society	11.0	----------	11.0	11.0	----------	11.0	(2)	----------	(2)
Private group clinic	13.4	2.5	10.9	11.3	2.1	9.2	2.1	.4	1.7

[1] Amounts retained by the organizations for operating expenses, additions to reserves, and profits.

[2] Less than $100,000.

policies were allocated between hospital care and physicians' services and other types of care. The allocation among the independent plans is based on data on benefit expenditures by type of service; income is allocated in the same proportion as benefit expenditures. For all health insurance organizations together, approximately two-thirds of benefit expenditures are for hospital care and one-third is for physicians' services and other types of care. The low proportion spent by the independent plans for hospital care results from the fact that two of the largest community type independent plans cover only physicians' services.

The historical data on total premium income and benefit expenditures of all private health insurance organizations show plainly the tremendous increase from 1948 to 1964 in private health insurance in this country (table 8). During the 17 years covered by the series, the premium income of all health insurance organizations has increased more than tenfold, and benefit expenditures in 1964 were almost 11 times the 1948 figure. Both premium income and benefit expense rose 11 percent in 1964.

Through 1957 the share of the Blue Cross-Blue Shield plans in the total income of all health insurance organizations declined slightly and has since increased somewhat (table 9). The share of insurance companies in the total showed a small increase through 1957 and since then has declined slightly or held constant (with the volume of group business increasing and individual policy business decreasing). The share of the independent plans in the total declined slightly for the entire period. In the past 6 or 7 years there has been little change in the relative positions of the three groups of organizations.

Benefit expenditures as a percentage of income

TABLE 8.—Subscription or premium income and benefit expenditures of private health insurance organizations, 1948–64

[In millions]

Year	Total	Blue Cross-Blue Shield plans			Insurance companies			Independent plans
		Total	Blue Cross	Blue Shield	Total	Group policies	Individual policies	
	Income							
1948	$862.0	$365.0	$315.0	$50.0	$421.0	$212.0	$209.0	$76.0
1949	1,015.5	455.3	362.2	93.1	461.0	241.0	220.0	99.2
1950	1,291.5	574.0	436.7	137.3	605.0	333.0	272.0	112.5
1951	1,660.3	684.9	505.5	179.4	797.6	468.6	329.0	177.8
1952	1,993.4	851.3	616.2	235.1	957.6	569.0	388.6	184.5
1953	2,405.3	988.6	708.4	280.2	1,181.4	722.6	458.8	235.3
1954	2,756.3	1,133.7	803.7	330.0	1,389.6	867.3	522.3	233.0
1955	3,149.6	1,292.4	910.7	381.7	1,626.9	1,022.5	604.4	230.3
1956	3,623.7	1,493.2	1,046.3	446.9	1,839.1	1,216.3	622.8	291.4
1957	4,143.9	1,667.8	1,162.9	504.9	2,175.0	1,476.0	699.0	301.1
1958	4,497.8	1,867.0	1,305.9	561.1	2,314.0	1,606.0	708.0	316.8
1959	5,139.2	2,157.4	1,522.5	634.9	2,639.0	1,853.0	786.0	342.8
1960	5,841.0	2,482.1	1,773.0	709.1	3,027.0	2,104.0	923.0	331.9
1961	6,673.3	2,805.1	2,004.4	800.7	3,427.0	2,414.0	1,013.0	441.2
1962	7,411.1	3,118.6	2,212.8	905.8	3,810.0	2,708.0	1,102.0	482.5
1963	8,053.6	3,399.4	2,438.7	960.7	4,136.0	2,913.0	1,223.0	518.2
1964	8,958.1	3,785.1	2,697.6	1,087.5	4,652.0	3,297.0	1,355.0	521.0
	Benefit expenditures							
1948	$606.0	$308.0	$269.0	$39.0	$228.0	$148.0	$80.0	$70.0
1949	766.8	382.8	308.6	74.2	295.0	180.0	115.0	89.0
1950	991.9	490.6	382.9	107.7	400.0	257.0	143.0	101.3
1951	1,352.6	605.0	454.0	151.0	587.5	415.5	172.0	160.1
1952	1,603.9	736.5	550.1	186.4	698.7	498.1	200.6	168.7
1953	1,919.2	851.5	626.8	224.7	854.7	625.8	228.9	213.0
1954	2,178.9	984.6	718.1	266.5	983.0	716.6	266.4	211.3
1955	2,535.7	1,146.7	832.2	314.5	1,179.0	858.0	321.0	210.0
1956	3,014.7	1,353.7	968.1	385.6	1,410.6	1,082.5	328.1	250.4
1957	3,474.0	1,547.0	1,106.0	441.0	1,655.0	1,318.0	337.0	272.0
1958	3,877.3	1,768.0	1,268.8	499.2	1,809.0	1,464.0	345.0	300.3
1959	4,398.8	1,994.8	1,424.3	570.5	2,080.0	1,680.0	400.0	324.0
1960	4,996.3	2,287.1	1,646.2	640.9	2,389.0	1,901.0	488.0	320.2
1961	5,695.4	2,585.4	1,867.1	718.3	2,706.0	2,170.0	536.0	404.0
1962	6,343.8	2,893.6	2,064.5	829.1	3,012.0	2,453.0	559.0	438.2
1963	6,979.3	3,179.5	2,317.3	862.2	3,332.0	2,671.0	661.0	467.8
1964	7,807.4	3,574.4	2,592.8	981.6	3,763.0	3,024.0	739.0	470.0

TABLE 9.—Percentage distribution of subscription or premium income and benefit expenditures of private health insurance organizations, 1948–64[1]

Year	Total	Blue Cross-Blue Shield plans			Insurance companies			Independent plans
		Total	Blue Cross	Blue Shield	Total	Group policies	Individual policies	
	Income							
1948	100.0	42.3	36.5	5.8	48.8	24.6	24.2	8.8
1949	100.0	44.8	35.7	9.2	45.4	23.7	21.7	9.8
1950	100.0	44.4	33.8	10.6	46.8	25.8	21.1	8.7
1951	100.0	41.3	30.4	10.8	48.0	28.2	19.8	10.7
1952	100.0	42.7	30.9	11.8	48.0	28.5	19.5	9.3
1953	100.0	41.1	29.5	11.6	49.1	30.0	19.1	9.8
1954	100.0	41.1	29.2	12.0	50.4	31.5	18.9	8.5
1955	100.0	41.0	28.9	12.1	51.7	32.5	19.2	7.3
1956	100.0	41.2	28.9	12.3	50.8	33.6	17.2	8.0
1957	100.0	40.2	28.1	12.2	52.5	35.6	16.9	7.3
1958	100.0	41.5	29.0	12.5	51.4	35.7	15.7	7.0
1959	100.0	42.0	29.6	12.4	51.4	36.1	15.3	6.7
1960	100.0	42.5	30.4	12.1	51.8	36.0	15.8	5.7
1961	100.0	42.0	30.0	12.0	51.4	36.2	15.2	6.6
1962	100.0	42.1	29.9	12.2	51.4	36.5	14.9	6.5
1963	100.0	42.2	30.3	11.9	51.4	36.2	15.2	6.4
1964	100.0	42.3	30.1	12.1	51.9	36.8	15.1	5.8
	Benefit expenditures							
1948	100.0	50.8	44.4	6.4	37.6	24.4	13.2	11.6
1949	100.0	49.9	40.2	9.7	38.5	23.5	15.0	11.6
1950	100.0	49.5	38.6	10.9	40.3	25.9	14.4	10.2
1951	100.0	44.7	33.6	11.2	43.4	30.7	12.7	11.8
1952	100.0	45.9	34.3	11.6	43.6	31.1	12.5	10.5
1953	100.0	44.4	32.7	11.7	44.5	32.6	11.9	11.1
1954	100.0	45.2	33.0	12.2	45.1	32.9	12.2	9.7
1955	100.0	45.2	32.8	12.4	46.5	33.8	12.7	8.3
1956	100.0	44.9	32.1	12.8	46.8	35.9	10.9	8.3
1957	100.0	44.5	31.8	12.7	47.6	37.9	9.7	7.8
1958	100.0	45.6	32.7	12.9	46.7	37.8	8.9	7.7
1959	100.0	45.3	32.4	13.0	47.3	38.2	9.1	7.4
1960	100.0	45.8	32.9	12.8	47.8	38.0	9.8	6.4
1961	100.0	45.4	32.8	12.6	47.5	38.1	9.4	7.1
1962	100.0	45.6	32.5	13.1	47.5	38.7	8.8	6.9
1963	100.0	45.6	33.2	12.4	47.7	38.3	9.5	6.7
1964	100.0	45.8	33.2	12.6	48.2	38.7	9.5	6.0

[1] Derived from table 8.

TABLE 10.—Retentions[1] of private health insurance organizations as a percent of subscription or premium income, 1948–64[2]

Year	All organizations	Blue Cross-Blue Shield plans			Insurance companies			Independent plans
		Total	Blue Cross	Blue Shield	Total	Group policies	Individual policies	
1948	29.7	15.6	14.6	22.0	45.8	30.2	61.7	7.9
1949	24.5	15.9	14.8	20.3	36.0	25.3	47.7	10.3
1950	23.2	14.5	12.3	21.6	33.9	22.8	47.4	10.0
1951	18.5	11.7	10.2	15.8	26.3	11.3	47.7	10.0
1952	19.5	13.5	10.7	20.7	27.0	12.5	48.4	8.6
1953	20.2	13.9	11.5	19.8	27.7	13.4	50.1	9.5
1954	20.9	13.2	10.7	19.2	29.3	17.4	49.0	9.3
1955	19.5	11.3	8.6	17.6	27.5	16.1	46.9	8.8
1956	16.8	9.3	7.5	13.7	22.9	11.0	47.3	14.1
1957	16.2	7.2	4.9	12.7	23.9	10.7	51.8	9.7
1958	13.8	5.3	2.8	11.0	21.8	8.8	51.3	5.2
1959	14.4	7.5	6.4	10.1	21.2	9.3	49.1	5.5
1960	14.5	7.9	7.2	9.6	21.1	9.6	47.1	3.5
1961	14.7	7.8	6.8	10.3	21.0	10.1	47.1	8.4
1962	14.4	7.2	5.7	11.0	20.9	9.4	49.3	9.2
1963	13.3	6.5	5.0	10.3	19.4	8.3	46.0	9.7
1964	12.8	5.6	3.9	9.7	19.1	8.3	45.5	9.8

[1] Amounts retained by the organizations for operating expenses, additions to reserves, and profits.
[2] Derived from table 8.

have more or less steadily increased in the years 1948–64, and retentions have more or less steadily declined (table 10). The independent plans are an exception to this trend. In 1964, retentions of Blue Cross-Blue Shield and insurance companies declined to the lowest levels in the series.

The share of the Blue Cross-Blue Shield plans in total income and benefit expenditures is relatively greater for hospital care than for physicians' and other types of care (table 11). The shares of the insurance companies and the independent plans are relatively greater for physicians' services and other types of care than for hospital care. This situation is undoubtedly caused by the large volume of major medical expense coverage written by insurance companies, and the emphasis placed by the independent plans on comprehensive coverage of physicians' services and their development of coverage of dental care, drugs, etc.

TABLE 11.—Percentage distribution of subscription or premium income and benefit expenditures of private health insurance organizations, by type of care, 1964

Type of organization	Income			Benefit expenditures		
	Total	Hospital care	Physicians' services and other types of care	Total	Hospital care	Physicians' services and other types of care
Total amount (in millions)	$8,958.1	$5,865.2	$3,092.9	$7,807.4	$5,205.1	$2,602.3
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Blue Cross-Blue Shield plans	42.3	46.1	35.0	45.8	49.8	37.7
Blue Cross	30.1	44.9	2.0	33.2	48.7	2.2
Blue Shield	12.1	1.1	33.0	12.6	1.1	35.5
Insurance companies	51.9	50.0	55.6	48.2	46.1	52.3
Group policies	36.8	33.5	43.0	38.7	36.1	44.1
Individual policies	15.1	16.5	12.6	9.5	10.1	8.2
Independent plans	5.8	4.0	9.4	6.0	4.0	10.0

TABLE 12.—Subscription or premium and benefit expense per enrollee in private health insurance organizations, by type of care, 1964

Type of organization	Hospital care[1]		Physicians' services and other types of care[2]	
	Premiums	Benefits	Premiums	Benefits
Blue Cross-Blue Shield	$43.28	$41.55	$19.90	$17.99
Insurance companies:				
Group policies	30.48	29.10	20.50	17.66
Individual policies	24.32	13.22	11.19	6.15
Independent plans	33.33	30.03	34.16	30.85

[1] Total premiums and benefits for hospital care divided by number of persons enrolled for hospital care.
[2] Total premiums and benefits for physicians' services and other types of care divided by number of persons enrolled for surgical service.

It is of interest to compare the relative shares of the different types of organizations in terms both of enrollment and premium volume. Of the gross number of enrollments for hospital care (almost 163 million), Blue Cross-Blue Shield plans had 38.4 percent, insurance companies (net) 57.3 percent, and independent plans 4.3 percent. Of the total premium volume for hospital coverage the Blue Cross-Blue Shield plans had 46 percent, insurance companies 50 percent, and independent plans 4 percent.

Premium income and benefit expenditures per enrollee of the various types of organizations are shown in table 12 for hospital care and physicians' and other types of care. Blue Cross-Blue Shield premium income per enrollee for hospital care is about 40 percent higher than such income under the group policies of insurance companies and almost double that under the individual policies of insurance companies. In terms of benefit expenditures per enrollee the differences are still greater.

Premium income and benefit expenditures per enrollee for physicians' services and other types of care under the Blue Cross-Blue Shield plans and the group policies of insurance companies are about the same magnitude. They are highest

(Continued on page 48)

TABLE 15.—Public assistance: Number of recipients and monthly amount of assistance payments (total and average), by month, August 1964–August 1965 [1]

[Except for general assistance, includes vendor payments for medical care and cases receiving only such payments]

Year and month	Total [2]	Old-age assistance [3]	Medical assistance for the aged [3]	Aid to the blind [3]	Aid to the permanently and totally disabled [3]	Aid to families with dependent children			General assistance [5]	
						Families	Total recipients [4]	Children	Cases	Recipients
	Number of recipients									
1964										
August		2,167,588	205,711	97,066	511,595	1,005,821	4,175,979	3,132,370	323,000	713,000
September		2,162,386	206,440	96,853	514,938	1,003,466	4,164,828	3,126,988	321,000	702,000
October		2,160,925	218,790	96,587	519,065	1,005,871	4,174,687	3,138,005	319,000	691,000
November		2,161,452	215,230	96,417	521,787	1,010,020	4,195,145	3,152,501	322,000	702,000
December		2,159,015	224,594	96,438	527,499	1,029,948	4,292,323	3,220,591	346,000	779,000
1965										
January		2,154,586	227,606	96,155	534,602	1,046,971	4,371,936	3,274,859	352,000	806,000
February		2,150,290	228,078	95,834	534,276	1,056,145	4,424,029	3,311,726	352,000	801,000
March		2,151,542	244,534	96,194	540,394	1,073,033	4,491,840	3,360,553	359,000	809,000
April		2,152,244	254,632	95,525	545,285	1,076,061	4,505,880	3,374,923	345,000	759,000
May		2,150,592	257,506	95,504	549,893	1,069,668	4,469,527	3,352,227	327,000	693,000
June		2,149,220	267,030	95,350	555,594	1,062,802	4,429,038	3,325,987	317,000	663,000
July		2,144,951	264,516	95,170	559,287	1,052,529	4,377,147	3,291,558	306,000	642,000
August		2,144,534	264,687	95,135	563,113	1,053,899	4,388,290	3,296,637	313,000	662,000
	Amount of assistance									
1964										
August	$422,234,000	$168,196,378	$39,228,163	$8,198,173	$39,874,356		$136,270,529		$20,941,000	
September	423,655,000	168,527,705	38,263,807	8,179,619	40,478,606		137,613,993		21,263,000	
October	434,086,000	170,460,986	43,738,448	8,237,591	41,283,451		139,491,306		21,687,000	
November	428,300,000	168,958,898	39,967,657	8,194,102	41,294,048		139,298,640		21,320,000	
December	444,770,000	170,316,837	44,141,314	8,271,899	42,514,587		145,182,490		23,743,000	
1965										
January	442,181,000	169,149,172	43,848,997	8,275,409	42,486,266		145,748,741		23,191,000	
February	446,512,000	170,189,513	42,535,323	8,267,896	43,302,081		148,891,335		23,444,000	
March	460,828,000	172,509,810	45,585,652	8,372,511	45,391,949		154,259,544		24,306,000	
April	466,251,000	173,958,755	49,842,346	8,315,346	45,629,421		154,713,550		23,252,000	
May	457,982,000	171,419,500	49,325,801	8,262,655	45,913,531		152,032,610		21,389,000	
June	459,856,000	172,862,075	50,867,075	8,392,761	47,063,386		149,814,741		20,784,000	
July	454,690,000	171,604,790	49,313,639	8,283,762	46,671,695		148,816,277		20,185,000	
August	459,067,000	171,839,667	50,326,713	8,282,225	48,162,941		150,496,032		20,228,000	
	Average payments									
1964										
August		$77.60	$190.70	$84.46	$77.94	$128.58	$32.63		$64.78	$29.38
September		77.94	185.35	84.45	78.61	137.14	33.04		66.14	30.25
October		78.88	199.91	85.29	79.53	138.68	33.41		68.02	31.38
November		78.17	185.70	84.99	79.14	137.21	33.20		66.18	30.37
December		78.89	196.54	85.77	80.60	140.96	33.82		68.60	30.48
1965										
January		78.51	192.65	86.06	79.47	139.21	33.34		65.94	28.77
February		79.15	186.49	86.27	81.05	140.98	33.66		66.53	29.27
March		80.18	186.42	87.04	84.00	143.76	34.34		67.70	30.06
April		80.83	195.74	87.05	83.68	143.78	34.34		67.32	30.63
May		79.71	191.55	86.52	83.50	142.13	34.02		65.48	30.88
June		80.43	190.41	88.02	84.71	140.96	33.83		65.54	31.33
July		80.00	186.43	87.04	83.45	141.39	34.00		65.96	31.42
August		80.13	190.14	87.06	85.53	142.80	34.29		64.62	30.58

[1] All data subject to revision.

[2] Total amount exceeds sum of columns because of inclusion of vendor payments for medical care from general assistance funds and from special medical funds; data for such expenditures partly estimated for some States.

[3] Represents data for payments to recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged.

[4] Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.

[5] Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available.

PRIVATE HEALTH INSURANCE

(Continued from page 21)

for the independent plans. For the individual policies of insurance companies they are small enough to indicate that such policies provide a very limited coverage.

One indication of the importance of private health insurance is the proportion of the population with some coverage. Another is the proportion of all consumer medical care expenditures met by health insurance—33 percent in 1964, as will be shown in the article on national health expenditures in the January issue of the BULLETIN.