Private Health Insurance: Coverage and Financial Experience, 1940-66

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PRIVATE HEALTH INSURANCE in 1966 continued its expansion in the number of persons and services covered and in premiums and benefit expenditures. About four-fifths of the population under age 65 have private health insurance coverage of one type or another. Health insurance meets more than 70 percent of all consumer expenditures for hospital care but less than a third of consumer expenditures for all types of personal medical care. In 1966 private health insurance organizations entered on a new role—as fiscal intermediaries under the Federal Government's program of health insurance for the aged (Medicare).

COVERAGE

Up to the present, estimates of the number and proportion of the population having health insurance have typically run in terms of persons with some health insurance coverage of hospital care, surgery, and in-hospital physician visits. Private health insurance has now outgrown these conceptions. Today the extent of health insurance can be discussed adequately only in terms of the number and proportion of the population with some coverage of all the main types of personal health care, including at a minimum: hospital care; physician services for surgery, in-hospital medical visits, out-of-hospital X-ray and laboratory examinations, and office and home visits; dental care; out-of-hospital prescribed drugs; visiting-nurse service; private-duty nursing; and care in extended-care facilities and/or nursing homes.

For a complete picture, of course, other items of care should be added—for example, hospital outpatient care for accidents and emergency illness; prosthetic appliances (artificial limbs, braces, etc.); home health services other than nursing; eye refraction examinations and the provision of eyeglasses; ambulance service; and medical rehabilitation to the extent that this service is not fully included in any of the foregoing. In other words a discussion of health insurance coverage should deal with all types of personal health care required for the prevention and cure of disease and the maintenance or restoration of health. To keep the discussion within manageable limits, this article will deal only with items of care listed in the preceding paragraph.

Only as short a time ago as, say, 10 years, many of the above-mentioned services or items of care were considered "uninsurable"—that is, it was thought that insurance against them could not be written with profit to the carrier or with advantage to the insured. One reason for this viewpoint was the presumed danger of adverse selection since the use of these services was considered to be so largely within the control of the individual. Another was that there was no real need of spreading the risk for such services since the costs could be foreseen or tended to occur in small amounts. Still another reason may have been the lack of knowledge of the extent to which the services would be demanded or their cost. Today all these services or items of care are being covered by health insurance organizations.

It has become necessary, then, to break out of former confining shells and to deal with health insurance for all of the main items of health care. This will be done henceforth in this series of annual articles on private health insurance.

This year's article makes a new departure in another respect. Because of Medicare, which began operations July 1, 1966, it is no longer fully meaningful to discuss health insurance in terms of the number of people of all ages with private health insurance protection. Formerly, to all intents and purposes, private health insurance was the only instrumentality through which the public could purchase health care on a prepayment basis or obtain insurance protection against its costs. Now virtually all persons aged 65 and over have substantial entitlement to hospital care, care in extended-care facilities, and certain home health services under the hospital insurance provisions

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of Medicare, and approximately 93 percent of all aged people have some coverage of physicians' services (whether in the hospital, office or home), of certain home health services, and of appliances (artificial limbs, braces, etc.) under the medical insurance provisions. The private health insurance that most of the aged have is complementary to their Medicare coverage. Some of the aged (perhaps 20 or 25 percent) who formerly had private health insurance coverage have dropped it. Because of this new factor in the situation, meaningful discussion of the extent of private health insurance should henceforth be in terms of the numbers in the population under and over age 65, as well as the total for all ages.

Estimates of the number and percent of the population having some coverage of each main item of care as of the end of 1966 are summarized below and are set forth in detail in tables 1, 2, and 3.

Type of service	All ages		Under age 65		Aged 65 and over	
	Number (in thousands)	Percent of population [1]	Number (in thousands)	Percent of population [1]	Number (in thousands)	Percent of population [1]
Hospital care	158,022	81.2	148,589	84.5	9,433	50.5
Surgery	144,715	74.4	137,448	78.1	7,267	38.9
In-hospital visits	116,462	59.9	110,754	63.0	5,708	30.6
X-ray and laboratory examinations [2]	93,459	48.0	89,750	51.0	3,709	19.9
Physicians' office and home visits	73,706	37.9	70,993	40.4	2,713	14.5
Dental care	4,227	2.2	4,143	2.4	84	.4
Prescribed drugs [2]	65,544	33.7	63,845	36.3	1,699	9.1
Private-duty nursing	68,722	35.3	66,632	37.9	2,090	11.2
Visiting-nurse service	79,004	40.6	76,453	43.5	2,551	13.7
Nursing-home care	17,814	9.2	14,999	8.5	2,815	15.1

[1] Civilian population. [2] Out-of-hospital.

It should be emphasized at the outset that these figures are estimates. They are approximations, since precise accuracy is not yet possible in this field. Second, the figures are based on the enrollment reported by or for the various types of health insurance organizations. Over the years such estimates have run consistently higher than the findings of household surveys by the Public Health Service and other organizations on the number of people with health insurance coverage. The margin of difference is now about 6 percentage points for hospital care and 4 percentage points for surgical service. It was formerly higher but was narrowed this year by a downward revision in the Health Insurance Association of America (HIAA) estimate of persons covered under the individual policies of insurance companies. Third, the data indicate only the number with some protection, and for certain services the degree of protection in terms of the proportion of expense covered by the insurance is quite slight.

According to these estimates 85 percent of all persons under age 65 have some health insurance protection against hospital care and 78 percent have some insurance against surgical expense. The proportion with protection ranges downward for the other types of care to about 2 percent for dental care. Although substantial proportions—40 percent and 36 percent—are shown as having some insurance against doctors' office and home visits and out-of-hospital prescribed drugs, the great majority of these are covered under "major medical" provisions that allow benefits only after the insured has paid a certain amount (a deductible) out of pocket. In any one year only a small proportion of covered persons would have any part of their expenses for these items covered.

Among persons aged 65 and over, 51 percent have private health insurance coverage of hospital care and 39 percent are covered for surgical expense. Before Medicare, approximately 60 percent of the aged (according to estimates based on enrollment reported by carriers) were estimated to have some hospital insurance coverage. It is plain that most of the aged who formerly had private coverage have continued it, though for benefits that complement those under Medicare. The figures reflect the fear of heavy medical expenses that many of the aged have and their strong desire for as good protection as they can obtain.

The extent of insurance protection is greatest for hospital care, surgery and in-hospital physician visits—that is, for services received by hospital bedpatients. A much lower proportion has protection against services or care outside of the hospital. The proportion with coverage against the cost of care in extended-care facilities or nursing homes and for visiting-nurse service or home health services—services that can reduce the need for hospital care—is low. Since the major medical policies or contracts, which provide almost all of the coverage of doctors' office and home visits, uniformly exclude coverage of physician services for physical examinations and health check-ups,

TABLE 1.—Private health insurance enrollment as of December 31, 1966: Number of persons of all ages with some coverage of specified services or expense

[In thousands]

Type of plan	Hospital care	Physician services				Dental care	Prescribed drugs (out-of-hospital) [3]	Private-duty nursing	Visiting-nurse service [4]	Nursing-home care
		Surgical services	In-hospital visits	X-ray and laboratory examinations [1]	Office and home visits [2]					
Blue Cross-Blue Shield plans	65,638	57,916	54,441	28,800	14,753	16	10,800	13,150	21,900	10,900
Blue Cross	63,408	3,417	3,212	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Blue Shield	2,230	54,499	51,229	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Insurance companies:										
Group policies	69,570	70,268	54,050	53,000	52,000	2,000	51,700	51,000	51,000	6,000
Individual policies	38,641	29,301	11,473	9,800	5,100		4,400	5,100	5,100	
Unadjusted total	108,211	99,569	65,523	62,800	57,100	2,000	56,100	56,100	56,100	6,000
Less duplication [6]	10,807	9,275	4,683	3,085	2,800		2,750	2,750	2,750	177
Net total	97,404	90,294	60,840	59,715	54,300	2,000	53,350	53,350	53,350	5,823
Independent plans	6,633	8,325	7,526	7,835	[7] 6,933	2,211	2,732	3,624	5,366	1,271
Community-consumer	1,964	3,526	3,514	3,547	3,358	170	312	1,615	3,565	71
Employer-employee-union	4,618	4,601	3,777	4,100	3,351	389	2,400	2,000	1,800	12,00
Private group clinic	51	198	235	188	224	622	20	9	1	
Dental society plans						1,030				
Gross total, all plans	169,675	156,535	122,807	96,350	75,986	4,227	66,882	70,124	80,616	17,994
Less duplication [8]				2,891	2,280		1,338	1,402	1,612	180
Net number of different persons	[9] 58,022	[9] 144,715	[9] 116,462	93,459	73,706	4,227	65,544	68,722	79,004	17,814
Percent of U.S. civilian population [10]	[9] 81.2	[9] 74.4	[9] 59.9	48.0	37.9	2.2	33.7	35.3	40.6	9.2

[1] In physicians' offices, clinics or health centers. Excludes those covered only in hospital outpatient departments or those covered only in accident or fracture cases or when services are followed by surgery.
[2] Number covered for all conditions. Excludes those eligible for care only after hospitalization.
[3] Excludes those covered for drugs only after hospitalization.
[4] Assumes that all persons covered for private-duty nursing are also covered for visiting-nurse service.
[5] Not estimated separately, in many cases coverage is jointly written.
[6] Calculated by HIAA for hospital care, surgery, and in-hospital visits; for other services, derived from tables 2 and 3.
[7] About 15 percent of this number not covered for home calls.
[8] Calculated at 3 percent for X-ray and laboratory examinations and for office and home visits, zero for dental care, 2 percent for drugs, private-duty nursing, and visiting-nurse service and 1 percent for nursing-home care.
[9] HIAA estimates.
[10] Based on Census estimate of 194,550,000 as of Jan. 1, 1967.

it follows that almost all of this health insurance is for the care of illness and very little gives any coverage of services for the prevention of illness.

Sources of the Data

These estimates are built up from data provided by or gathered for each of the three groups of health insurance organizations—the Blue Cross and Blue Shield plans, insurance companies, and the so-called independent plans (all organizations providing prepayment or health insurance coverage other than Blue Cross-Blue Shield plans or insurance companies).

The data on hospital and surgical coverage of the Blue Cross and Blue Shield plans have been furnished to the Office of Research and Statistics by the Blue Cross Association and the National Association of Blue Shield Plans. The data represent enrollment reported by the plans to the national organizations.[1]

The Office of Research and Statistics has been responsible for the combination of Blue Cross and Blue Shield data. The figures for all other services are Office of Research and Statistics estimates, based upon data supplied by the two national organizations.

Both national organizations reported separately the enrollment for aged persons under coverage complementary to Medicare. Data from a previous study had shown the benefits provided by individual plans under complementary contracts.[2] By considering the enrollment of each plan, it was possible to approximate the number of aged persons covered for each service and by subtraction to obtain the number of persons under age 65 so covered.

The data for insurance companies have been provided by the Health Insurance Association of America, an association of insurance companies writing health insurance. This organization annually makes surveys of all insurance companies writing group and individual accident and health insurance policies. In the survey for 1966, re-

[1] For enrollment of individual plans and data by state, see Louis S. Reed and Willine Carr, *Blue Cross-Blue Shield Enrollment and Finances, 1966*, Research and Statistics Note No. 19, 1967.

[2] See Louis S. Reed and Kathleen Myers, "Private Health Insurance Coverage Complementary to Medicare," *Social Security Bulletin*, August 1967. This article summarizes a more detailed report now in preparation.

TABLE 2.—Private health insurance enrollment as of December 31, 1966: Number of persons under age 65 with some coverage of specified services or expense

[In thousands]

Type of plan	Hospital care	Physician services				Dental care	Prescribed drugs (out-of-hospital) [3]	Private-duty nursing	Visiting-nurse service [4]	Nursing-home care
		Surgical services	In-hospital visits	X-ray and laboratory examinations [1]	Office and home visits [2]					
Blue Cross-Blue Shield plans	60,707	53,805	50,563	26,665	13,564	16	10,400	12,400	20,750	8,300
Blue Cross	58,635	3,161	2,971	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Blue Shield	2,072	50,644	47,592	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Insurance companies										
Group policies	67,546	68,574	52,901	52,000	51,000	1,960	50,700	50,000	50,000	5,900
Individual policies	35,729	27,479	10,857	9,700	5,000		4,300	5,000	5,000	
Unadjusted total	103,275	96,053	63,758	61,700	56,000	1,960	55,000	55,000	55,000	5,900
Less duplication [6]	10,484	9,060	4,599	3,085	2,800		2,750	2,750	2,750	177
Net total	92,791	86,993	59,159	58,615	53,200	1,960	52,250	52,250	52,250	5,723
Independent plans	6,196	7,838	7,047	7,324	[7] 6,482	2,167	2,516	3,363	5,039	1,128
Community-consumer	1,862	3,389	3,377	3,388	3,199	167	297	1,539	3,408	68
Employer-employee-union	4,295	4,263	3,447	3,760	3,071	381	2,200	1,815	1,630	1,060
Private group clinic	39	186	223	176	212	610	19	9	1	
Dental society						1,009				
Gross total	159,694	148,636	116,769	92,604	73,246	4,143	65,166	68,013	78,039	15,151
Less duplication [8]				2,854	2,253		1,321	1,381	1,586	152
Net number of different persons	[9] 148,589	[9] 137,448	[9] 110,754	89,750	70,993	4,143	63,845	66,632	76,453	14,999
Percent of population under age 65 [10]	[9] 84.5	[9] 78.1	[9] 63.0	51.0	40.4	2.4	36.3	37.9	43.5	8.5

[1] In physicians' offices, clinics or health centers. Excludes those covered only in hospital outpatient departments or those covered only in accident or fracture cases or when services are followed by surgery.

[2] Number covered for all conditions. Excludes those eligible for care only after hospitalization.

[3] Excludes those covered for drugs only after hospitalization.

[4] Assumes that all persons covered for private-duty nursing are also covered for visiting-nurse service.

[5] Not estimated separately; in many cases coverage is jointly written.

[6] As estimated by HIAA for first three services; calculated at 5 percent for X-ray and laboratory examinations, office and home visits, prescribed drugs, private-duty nursing and visiting-nurse service, at 3 percent for nursing-home care and zero for dental care.

[7] About 15 percent of this number not covered for home calls.

[8] Duplication as shown in table 1, less estimated duplication among aged as given in table 3.

[9] HIAA estimates.

[10] Based on Census estimate of 175,880,000 as of Jan. 1, 1967.

plies were received from companies writing 99 percent of all group business and 83 percent of all individual business.

The Association estimates the number of persons covered by nonresponding companies on the basis of their premium volume as reported to the State insurance commissions. From the gross total number of persons covered under group and individual policies a deduction is made for persons covered under more than one group policy or holding more than one individual policy or with coverage under both group and individual policies. The remainder represents the HIAA estimate of the net number of different persons with some coverage by insurance companies. The HIAA estimates have generally been confined to three services—hospital care, surgery, and what it calls "regular medical" (all persons so covered are deemed to be covered for physicians' in-hospital visits). Insurance company coverage of the other services has been estimated by the Office of Research and Statistics from HIAA data.

The HIAA asked responding companies to provide data on the number of persons of all ages and the number of persons under age 65 covered for eight different items of care or types of coverage, with a breakdown of "regular medical" coverage into five subdivisions. From these data it estimated coverage for the three chief services, by age.[3]

There are now four types of "independent" plans: (1) plans operated by community or consumer groups; (2) plans operated by union welfare funds, employers, employee benefit associations, and unions; (3) plans operated by private medical and/or dental group clinics; and (4) dental care prepayment plans sponsored by dental societies.[4]

The Office of Research and Statistics is the sole source of national information regarding the number of persons covered by the first three types of plans. Its information is based upon surveys every 3 or 4 years of all known plans of these types, combined with data from surveys in the intervening years of approximately 30 of the larger plans that have a substantial share of the total enrollment. The last full survey of all

[3] See *High Points of Voluntary Health Insurance in the United States, as of December 31, 1966*, Health Insurance Council, 1967.

[4] A fifth type—medical prepayment plans sponsored by medical societies (other than Blue Shield), has become insignificant or nonexistent as such plans have affiliated with Blue Shield and thus ceased to be "independent."

TABLE 3.—Private health insurance enrollment as of December 31, 1966: Number of persons aged 65 and over with some coverage of specified services or expense

[In thousands]

Type of plan	Hospital care	Physician services				Dental care	Prescribed drugs (out-of-hospital)[3]	Private-duty nursing	Visiting-nurse service[4]	Nursing-home care
		Surgical services	In hospital visits	X-ray and laboratory examinations[1]	Office and home visits[2]					
Blue Cross-Blue Shield plans	4,931	4,111	3,878	2,135	1,189	----------	400	750	1,150	2,600
Blue Cross	4,773	256	241	(5)	(5)	----------	(5)	(5)	(5)	(5)
Blue Shield	158	3,855	3,637	(5)	(5)	----------	(5)	(5)	(5)	(5)
Insurance companies:										
Group policies	2,024	1,694	1,149	1,000	1,000	40	1,000	1,000	1,000	100
Individual policies	2,912	1,822	616	100	100	----------	100	100	100	----------
Unadjusted total	4,936	3,516	1,765	1,100	1,100	40	1,100	1,100	1,100	100
Less duplication[6]	323	215	84	----------	----------	----------	----------	----------	----------	----------
Net total	4,613	3,301	1,681	1,100	1,100	40	1,100	1,100	1,100	100
Independent plans	437	487	479	511	[7] 451	44	216	261	327	143
Community-consumer	102	137	137	159	159	3	15	76	157	3
Employer-employee-union	323	328	330	340	280	8	200	185	170	140
Private group clinic	12	12	12	12	12	12	1	----------	----------	----------
Dental society	----------	----------	----------	----------	----------	21	----------	----------	----------	----------
Gross total	9,981	7,899	6,038	3,746	2,740	84	1,716	2,111	2,577	2,843
Less duplication[8]	----------	----------	----------	37	27	----------	17	21	26	28
Net number of different persons covered	[9] 9,433	[9] 7,267	[9] 5,708	3,709	2,713	84	1,699	2,090	2,551	2,815
Percent of population aged 65 and over[10]	[9] 50.5	[9] 38.9	[9] 30.6	19.9	14.5	.4	9.1	11.2	13.7	15.1

[1] In physicians' offices, clinics, or health centers. Excludes those covered only in hospital outpatient departments or those covered only in accidents or fracture cases or when services are followed by surgery.
[2] Number covered for all conditions. Excludes those eligible for care only after hospitalization.
[3] Excludes those covered for drugs only after hospitalization.
[4] Assumes that all persons covered for private-duty nursing are also covered for visiting-nurse service.
[5] Not estimated separately; in many cases coverage is jointly written.
[6] As estimated by HIAA for first three services; considered insignificant for the other services and hence shown as zero.
[7] About 15 percent of this number not covered for home calls.
[8] Calculated at 1 percent for all services other than dental care for which duplication is estimated at zero percent.
[9] HIAA estimates.
[10] Based on Census estimate of 18,670,000 as of Jan. 1, 1967.

known plans was made in 1965 and obtained data for 1964. The estimates for 1966 here provided are based upon the findings of that survey, adjusted for changes in the enrollment of the larger plans since then. Each of the surveys obtains enrollment data for all the services listed in table 1. The surveys made in 1966 and 1967 asked for separate data on enrollment of persons aged 65 and over.[5]

The data on persons covered by the dental society plans have been provided by the Division of Dental Health of the Public Health Service.

Extent of Duplication

There are appreciable numbers of persons who have coverage for specific services through more than one type of carrier—that is, they have Blue Cross and Blue Shield coverage and also have insurance company coverage, or they have coverage by an independent plan and also by an insurance company, or some other combination. The extent of such multiple coverage has not been firmly established.

One basis for estimating the amount of multiple or duplicatory coverage is the findings of the Public Health Service in its 1962–63 survey of the extent of health insurance coverage. This survey found that 7.1 percent of those who had hospital insurance (who knew their type of plan) had such insurance with both a Blue Cross or Blue Shield plan and another plan (insurance company or independent plan).[6] Of those who had surgical insurance, 5.4 percent had both Blue Cross-Blue Shield and another plan coverage. From these data it can be calculated that the extent of duplicatory coverage in terms of gross enrollment in all plans—Blue Cross-Blue Shield plans, insurance company policies (net enrollment), and independent plans—is 6.6 percent for hospital coverage and 5.1 percent for surgical coverage. Before applying these figures to gross

[5] For more details, see Louis S. Reed, Arne H. Anderson, and Ruth S. Hanft, *Independent Health Insurance Plans in the United States, 1965 Survey* (Research Report No. 17) and Louis S. Reed and Willine Carr, *Independent Health Insurance Plans, 1966*, Research and Statistics Note No. 15, September 1967.

[6] Public Health Service, National Center for Vital Statistics, *Health Insurance Coverage, United States, July 1962–June 1963*, Series 10—No. 11, August 1964, and *Health Insurance—Type of Insuring Organization and Multiple Coverage*, Series 10—No. 16, April 1965.

enrollment, however, it is necessary to make a deduction for duplication between insurance companies and independent plans.

Use of the procedure outlined above yields estimates of net enrollment for hospital and surgical coverage of about the same level of magnitude as the HIAA estimates of net enrollment for these services.[7] Because the basis for an independent estimate of the extent of duplicatory coverage is not fully firm and the figures of net enrollment thus developed are not materially different from those the HIAA publishes, the HIAA estimates of net enrollment for hospital, surgical, and in-hospital medical coverage are used here, as shown in tables 1, 2, and 3.

For the other services, no studies of the extent of duplication, either within the insurance industry or among the different groups of carriers, have been made. (There is every reason to believe that the extent of duplicatory coverage in these services is less than that in hospital, surgical, and in-hospital coverage and varies with the gross enrollment. Factors of duplicatory coverage have therefore been assumed that seem reasonable in relation to those estimated for the three primary services.)

As previously mentioned, all estimates of coverage based upon enrollment reported by health insurance organizations run higher than estimates of coverage based on household surveys. The findings of the Public Health Service 1962–63 survey on the number of persons with hospital and surgical coverage at the end of 1962, increased by the percentage rise in gross enrollment between 1962 and 1966 shown by the Office of Research and Statistics data, yields an estimate of 146.4 million persons covered at the end of 1966 for hospital care (75.2 percent of the civilian population) and 136.8 million covered for surgery (70.3 percent of the civilian population).

The most nearly precise statement that can now be made on the extent of private health insurance coverage at the end of 1966 is that it is probably within the range of 75–81 percent of the population for hospital coverage and 70–74 percent of the population for surgical coverage.

[7] For a brief description of the HIAA methods of estimating duplicatory coverage, both within the insurance industry and among the three types of carriers, see Louis S. Reed, *The Extent of Health Insurance Coverage in the United States* (Research Report No. 10), 1965.

Interpretation of the Data

Some notes on the extent of coverage shown for certain services are required. The figures for X-ray and laboratory examinations include only persons covered for these services in doctors' offices or clinics and for all types of cases. They do not include persons covered for these services only in hospital outpatient departments or only in accident or fracture cases or when the examination is later followed by surgery. Substantial numbers of Blue Cross and Blue Shield members have the latter type of restricted coverages.

The figures on persons covered for physicians' office and home visits likewise include only persons entitled to such services for all conditions and do not include substantial numbers of Blue Cross-Blue Shield members covered for office and home visits only for continued care after hospitalization. Similarly, with respect to out-of-hospital prescribed drugs, persons covered for drugs only for continued care after hospitalization are excluded.

The figures on dental coverage relate only to persons with coverage of at least dental diagnosis, fillings, and extractions—in other words, a fairly broad coverage—and exclude persons covered only for dental care required as a result of an accident or when dental surgery must be performed in a hospital. Virtually all persons with major medical coverage have the first type of restricted coverage, and most Blue Shield plans cover dental surgery in a hospital.

The coverage shown for private-duty nursing relates to services of a registered nurse in the hospital or home, though some policies will also cover services of a practical nurse in the hospital. The large number of people shown as covered for visiting-nurse service may seem surprising. Major medical policies agree to reimburse for the cost of services of a registered nurse. Visiting nurses are registered nurses, and the policies do not specify that service must be for at least 8 hours a day. Such policies would therefore reimburse for charges for visiting-nurse service. It has been assumed that all persons covered for private-duty nursing are also covered for visiting-nurse service, although the use of visiting nurse service by those covered for private-duty nursing is actually infrequent. The difference between the number of persons with private-duty nursing coverage and

the number with visiting-nurse coverage represents the fairly substantial numbers of persons covered for visiting-nurse service but not private-duty nursing by Blue Cross and certain independent plans. Persons covered for visiting-nurse service only after hospitalization are included—since it was deemed that for this service the restriction is of minor importance.

The figures on persons covered for nursing-home care or care in extended-care facilities do include those entitled to such care only after hospitalization—a rather common provision in Blue Cross coverage and one that also exists under Medicare. The figures for nursing home coverage by Blue Cross-Blue Shield plans and by independent plans can be considered as reliable. Those for persons covered by insurance companies represent only an informed guess.

Major Medical and Extended-Benefit Coverage

Most of the coverage shown for physicians' office and home visits, prescribed drugs, private-duty nursing, visiting-nurse service and a large share of that for nursing-home care is under insurance company major medical policies or supplementary major medical provisions of Blue Cross-Blue Shield—that is, under provisions where the insurance pays 80 or 75 percent of the cost over and above a deductible. By contrast the coverage of these services by the independent plans is mainly of the so-called basic or first-dollar type.

The HIAA reports the following number of persons covered under major medical policies of insurance companies at the end of 1966:

[In thousands]

Type of policy	Total number	Number with—	
		Supplementary to basic coverage	Comprehensive (no basic coverage)
Group	52,002	39,685	12,317
Individual	4,740	[1] 4,740	

[1] The HIAA does not classify these policies as supplementary or comprehensive but does treat them as providing a supplementary coverage.

The virtually universal pattern is for all these policies to cover X-ray and laboratory examinations, physicians' office and home visits, prescribed drugs, and private-duty nursing (and visiting-nurse service also) and a small proportion also covers nursing-home care. Persons covered under these policies account for all or the vast majority of the number shown as covered for the above-mentioned services by insurance companies.

The number shown as covered by insurance companies for X-ray and laboratory examinations and for physicians' office and home visits is believed to be understated by a considerable margin. It is estimated from HIAA data that 34.2 million persons under age 65 have basic (first-dollar) coverage of X-ray and laboratory examinations and another 12.1 million are covered for these services under comprehensive major medical policies. But 38.8 million persons under age 65 are also covered for these services under supplementary major medical policies, bringing the total—after some allowance for persons with both basic and supplementary major medical coverage—to perhaps 77 million. Similarly, HIAA data show about 8.2 million persons with basic coverage of physicians' office and home visits. This number, together with the 12.1 million covered under comprehensive major medical policies and the 38.8 million covered under supplementary major medical policies would bring the total to about 55 million (again with allowance for duplication). To have used these figures instead of the estimates shown in table 2 would have thrown the coverage for such services out of line with the coverage shown by the HIAA for physician in-hospital visits, which is certainly larger than for either of the other two services.[8]

[8] Basically the discrepancies arise from the fact that the HIAA, in making its estimates of persons covered for hospital care, surgery, and what it calls "regular medical" coverage counts only those with basic coverage and comprehensive major medical coverage and excludes those with supplementary major medical coverage on the grounds that they are already included in the count of persons with basic coverage. This is probably true for hospital care and surgery but not true for in-hospital visits, since appreciable numbers of persons have the latter coverage only through supplementary major medical policies. The HIAA figure for in-hospital medical visits is therefore almost certainly too low.

The HIAA at the request of the Office of Research and Statistics has asked five of the larger companies to study a small sample of their larger supplementary major medical policies to determine what services these policies cover and what are the basic coverages they supplement (and whether through insurance companies or Blue Cross-Blue Shield plans). The results will be available too late to be taken into account here, but they should aid in more accurate reporting next year.

TABLE 4.—Percentage distribution of gross enrollment among carriers, 1966

Age and type of plan	Hospital care	Physician services				Dental care	Prescription drugs	Private-duty nursing	Visiting-nurse services	Nursing-home care
		Surgical services	In-hospital visits	X-ray and laboratory	Office and home visits					
Total, all ages	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Blue Cross-Blue Shield	38.7	37.0	44.3	29.9	19.4	.4	16.1	18.8	27.2	60.6
Insurance companies	57.4	57.7	49.5	62.0	71.5	47.3	79.8	76.1	66.2	32.4
Independent plans	3.9	5.3	6.1	8.1	9.1	52.3	4.1	5.2	6.7	7.1
Under age 65, total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Blue Cross-Blue Shield	38.0	36.2	43.3	28.8	18.5	.4	16.0	18.2	26.6	54.8
Insurance companies	58.1	58.5	50.7	63.3	72.6	47.3	80.2	76.8	67.0	37.8
Independent plans	3.9	5.3	6.0	7.9	8.8	52.3	3.9	4.9	6 5	7.4
Aged 65 and over, total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Blue Cross-Blue Shield	49.4	52.0	64.2	57.0	43.4	----------	23.3	35.5	44.6	91.5
Insurance companies	46.2	41.8	27.8	29.4	40.1	47.6	64.1	52.1	42.7	3.5
Independent plans	4.4	6.2	7.9	13.6	16.5	52.4	12.6	12.4	12.7	5.0

The Blue Cross Association and the National Association of Blue Shield Plans report that the unduplicated number of Blue Cross-Blue Shield members with supplementary major medical coverage is 10,409,000 with an additional 3,943,000 covered under extended benefit provisions.[9] Both counts exclude aged persons with complementary coverage. The supplementary coverage in virtually all cases covers X-ray and laboratory examinations, physicians' office and home visits, drugs, private-duty nursing, and visiting-nurse service. The extended-benefit contracts frequently cover physicians' office and home visits, prescribed drugs, and visiting-nurse service but generally only after hospitalization. Most of the Blue Cross-Blue Shield coverage of physicians' office and home visits is under supplemental major medical provisions, including the supplemental major medical provisions of complementary contracts. Blue Shield plans report only 3.2 million persons with basic coverage of office and home visits—6 percent of the total membership.

Shares of the Carriers in Enrollment

The shares of the three groups of health insurance organizations in the total gross enrollment for each type of service are indicated in table 4. It is evident that, among the population of all ages and among those under age 65, insurance companies have considerably more enrollment for most services than Blue Cross-Blue Shield plans, and that the insurance companies have made considerably further progress in providing the newer services (those other than for hospital care, surgery, and in-hospital medical services). In general, this growth has resulted from the wide sale of major medical policies by insurance companies.

The independent plans cut only a small figure in the total enrollment for the older types of coverage but show strength in the coverage of X-ray and laboratory examinations and physicians' office and home calls—a reflection, of course, of the emphasis given by these plans to comprehensive coverage of physician services. The independent plans also play a major role in dental coverage.

The picture is different with respect to the aged. Blue Cross and Blue Shield plans have been relatively more successful than insurance companies in the sale of complementary coverage to older people.

In considering these figures, it should be borne in mind that Blue Cross-Blue Shield coverage of hospital care and physician services is generally somewhat deeper or more extensive than that of the insurance companies—especially in comparison with individual insurance company policies. The data on benefit expenditures per covered person, presented later in this article, make this point clear. For premiums or benefit expenditures, the Blue Cross-Blue Shield plans' share in the total is slightly larger and the shares of the insurance companies slightly smaller than their respective shares in total enrollment.

[9] An additional 3,683,000 persons are covered under dread-disease or prolonged-illness coverage, but because the coverage is restricted to certain diseases they are not considered here.

Quality of Coverage

It is important, of course, to know the number of persons who have some protection against the various types of medical care costs. To appraise the contribution of voluntary health insurance to the health and welfare of the American people, however, much more knowledge is required. It is essential to know how good and how extensive the coverage is and to what degree it affords security against burdensome medical costs and removes financial barriers to the receipt of care.

The Blue Cross plans have made considerable efforts to present meaningful data on the extent of service available to covered persons. One survey shows that, at the end of 1965, approximately 8 percent of the members were covered for 21–69 days of care, 18 percent for 70–119 days, 47 percent for 120 or more days, and 8 percent for 21–365 days; in addition, 18 percent were covered for some combination of full and partial benefits that adds to 120 days or more and 1 percent for some combination of full and partial benefits that adds to less than 120 days.[10]

Of the members in plans reporting these data, 67 percent were covered for the full room cost in semiprivate accommodations, 5 percent for a percentage of the cost in semiprivate accommodations, 2½ percent for the full room cost in ward accommodations, 16 percent for a dollar allowance against the room cost, and 9 percent for other benefits.

Of plans with a total membership of about 56 million that cover laboratory examinations, approximately nine-tenths of the members were covered for all laboratory examinations and one-tenth had only partial coverage. In some places, Blue Shield provides this service. Of plans with 45 million members that cover X-ray examinations, again almost nine-tenths were covered for all X-ray examinations and about one-tenth had partial coverage. Some 53 million Blue Cross members at the end of 1965 had full coverage of anesthesia supplies, and 2.5 million had partial coverage.

Virtually all Blue Cross members are covered in full for use of the operating room, according to a survey for 1964. The same survey found that 98.5 percent of Blue Cross members were covered in full for drugs during their period of benefit coverage.[11]

Reasonably complete data on the number of Blue Shield members covered for different services are available. At the end of 1966, 89 percent of those enrolled in the United States were covered under basic contracts for anesthesia service, 72 percent for office X-ray examinations (with about 60 percent of this group covered in all types of cases), 59 percent for office laboratory examinations (with about 60 percent covered in all types of cases), 6 percent for office and home visits, and 94 percent for in-hospital medical visits. What is not known is how many of these persons are entitled to full coverage of doctors' charges for these services—that is, to full service benefits.

Most persons covered under community–consumer independent plans have a hospital coverage as good or better than that of the average Blue Cross member, and they are entitled to all necessary services of physicians in the office, home, and hospital. Coverage under the employer-employee-union plans varies widely.

The greatest gap in knowledge of the quality of health insurance coverage is the lack of adequate data on insurance company coverage. The annual surveys of the Health Insurance Institute, *New Group Policies Issued*, though useful do not give a reliable picture of the extent and depth of coverage possessed by the insured population at any given time. Data are almost totally lacking on the depth of coverage given under individual policies.

Trends in Enrollment, 1940–66

Data on enrollment for hospital care, surgical service, and in-hospital physician visits are available for each year since 1940. Figures on the extent of coverage for the other services were first compiled only a few years ago.

Hospital, surgical, and in-hospital medical protection.—The figures in tables 5, 6, and 7 for Blue Cross and Blue Shield have been compiled by the Office of Research and Statistics from data supplied by the Blue Cross Association and the National Association of Blue Shield Plans. The data for insurance companies are estimates com-

[10] Blue Cross Association, *Statistical Bulletin No. 8*, October 13, 1966.

[11] Blue Cross Association, *Statistical Bulletin No. 6*, December 30, 1965.

TABLE 5.—Enrollment for hospital benefits, 1940–66

[In thousands]

End of year	Gross total	Blue Cross-Blue Shield			Insurance companies					Independent plans					HIAA estimate	
		Total	Blue Cross	Blue Shield	Group policies	Individual policies	Gross total	Less duplication	Net total	Total	Community-consumer	Employer-employee-union	Medical society	Private group clinics	Net enrollment	Percent of population
1940	12,022	6,072	6,012	60	2,500	1,200	3,700	.....	3,700	2,250	140	1,560	110	440	12,312	9.3
1941	16,089	8,469	8,399	70	3,850	1,500	5,350	.....	5,350	2,270	140	1,560	130	440	16,349	12.4
1942	19,456	10,295	10,215	80	5,080	1,800	6,880	.....	6,880	2,290	140	1,560	150	440	19,695	15.2
1943	23,915	12,696	12,600	96	6,800	2,100	8,900	.....	8,900	2,319	144	1,560	170	445	24,160	18.9
1944	29,123	15,828	15,748	80	8,400	2,400	10,800	.....	10,800	2,495	280	1,619	185	420	29,232	22.9
1945	32,135	18,961	18,881	80	7,804	2,700	10,504	.....	10,504	2,670	420	1,660	200	390	32,068	24.0
1946	41,477	24,342	24,250	92	11,315	3,000	14,315	.....	14,315	2,820	560	1,700	200	360	42,112	29.9
1947	51,813	27,646	27,489	157	14,190	7,584	21,774	647	21,127	3,040	700	1,760	250	330	52,584	36.4
1948	60,685	30,619	30,448	171	16,741	11,286	28,027	1,241	26,786	3,280	840	1,810	330	300	60,995	41.5
1949	67,415	33,576	33,381	195	17,697	14,729	32,426	2,210	30,216	3,623	977	1,870	508	268	66,044	44.2
1950	79,045	37,645	37,435	210	22,305	17,296	39,601	2,646	36,955	4,445	1,445	2,280	500	220	76,639	50.7
1951	88,990	39,412	38,424	988	26,663	20,802	47,465	3,177	44,288	5,290	1,910	2,700	500	180	85,348	55.9
1952	94,315	41,353	40,495	858	29,455	21,412	50,867	4,025	46,842	6,120	2,380	3,120	490	130	90,965	58.5
1953	101,380	43,684	42,857	827	33,575	21,860	55,435	4,712	50,723	6,973	2,851	3,541	493	88	96,206	60.8
1954	104,430	45,355	44,243	1,112	35,090	22,172	57,262	4,867	52,395	6,680	2,890	3,380	340	70	98,771	61.2
1955	112,755	48,924	47,719	1,205	39,029	24,131	63,160	5,874	57,286	6,515	2,920	3,220	360	45	105,452	64.1
1956	122,026	51,455	50,108	1,347	45,211	25,570	70,781	6,640	64,141	6,430	2,956	3,066	388	20	114,044	68.0
1957	127,876	53,282	51,869	1,413	48,439	26,337	74,776	6,593	68,183	6,411	2,920	3,090	371	30	119,610	70.0
1958	129,584	53,623	52,258	1,365	49,508	26,784	76,292	6,720	69,572	6,389	2,880	3,120	354	35	121,018	69.6
1959	134,529	55,054	53,673	1,381	51,255	28,971	80,226	7,131	73,095	6,380	2,846	3,153	337	44	125,753	71.1
1960	140,117	57,464	55,938	1,526	55,218	30,187	85,405	8,746	76,659	5,994	1,604	4,000	340	50	130,007	72.3
1961	144,034	57,960	56,489	1,471	57,013	30,951	87,964	8,992	78,972	7,102	1,851	4,850	344	57	134,417	73.7
1962	149,154	59,618	58,133	1,485	59,153	32,921	92,074	9,475	82,599	6,937	1,830	4,703	344	60	138,890	74.9
1963	155,170	60,698	59,141	1,557	62,817	34,462	97,279	9,972	87,307	7,165	1,947	4,814	344	60	144,575	76.8
1964	159,307	62,429	60,478	1,951	64,506	35,857	100,363	10,325	90,038	6,840	1,859	4,785	8	188	148,338	77.8
1965	164,369	63,662	61,651	2,012	67,104	37,372	104,476	10,753	93,723	6,984	1,954	4,971	8	51	153,133	79.4
1966	169,675	65,638	63,408	2,230	69,570	38,641	108,211	10,807	97,404	6,633	1,964	4,618	.....	51	158,022	81.1

TABLE 6.—Enrollment for surgical benefits, 1940–66

[In thousands]

End of year	Gross total	Blue Cross-Blue Shield			Insurance companies					Independent plans					HIAA estimate	
		Total	Blue Cross	Blue Shield	Group policies	Individual policies	Gross total	Less duplication	Net total	Total	Community consumer	Employer-employee-union	Medical society	Private group clinics	Net enrollment	Percent of population
1940	4,790	260	.....	260	1,430	850	2,280	.....	2,280	2,250	200	1,480	110	460	5,350	4.0
1941	6,215	645	.....	645	2,300	1,000	3,300	.....	3,300	2,270	200	1,480	130	460	6,775	5.1
1942	7,580	815	.....	815	3,275	1,200	4,475	.....	4,475	2,290	200	1,480	150	460	8,140	6.3
1943	9,488	1,065	11	1,054	4,700	1,400	6,100	.....	6,100	2,323	205	1,481	170	467	10,069	7.9
1944	11,183	1,583	65	1,518	5,625	1,600	7,225	.....	7,225	2,375	280	1,470	185	440	11,713	9.2
1945	12,092	2,335	127	2,208	5,537	1,800	7,337	.....	7,337	2,420	350	1,460	200	410	12,890	9.7
1946	17,357	4,236	332	3,904	8,661	2,000	10,661	.....	10,661	2,460	430	1,450	200	380	18,609	13.2
1947	24,295	6,187	455	5,732	11,103	4,875	15,978	420	15,558	2,550	500	1,450	250	350	26,247	18.2
1948	33,565	10,516	631	9,885	14,199	6,944	21,143	764	20,379	2,670	580	1,440	330	320	34,060	23.2
1949	39,749	12,842	907	11,935	15,590	9,315	24,905	1,024	23,881	3,026	653	1,438	643	292	41,143	27.5
1950	54,441	17,253	1,151	16,102	21,219	13,718	34,937	1,509	33,428	3,760	940	1,950	600	270	54,156	35.8
1951	66,842	22,052	1,806	20,246	26,376	15,623	41,999	1,719	40,280	4,510	1,230	2,470	570	240	64,892	42.5
1952	75,952	25,775	2,190	23,585	29,621	18,354	47,975	3,056	44,919	5,258	1,520	2,990	538	210	72,459	46.6
1953	83,037	29,527	2,625	26,902	34,039	17,039	51,078	3,575	47,503	6,007	1,803	3,516	502	186	78,321	49.5
1954	87,605	33,081	2,923	30,158	35,723	16,825	52,548	3,994	48,554	5,970	1,970	3,350	470	180	81,900	50.8
1955	96,613	37,395	3,194	34,201	39,725	18,769	58,494	5,206	53,288	5,930	2,130	3,200	430	170	88,856	54.0
1956	105,442	40,542	3,502	37,040	45,906	18,831	64,737	5,736	59,001	5,899	2,298	3,040	401	160	97,713	58.2
1957	112,813	43,305	3,801	39,504	48,955	20,349	69,304	5,786	63,518	5,990	2,360	3,070	390	170	105,359	61.7
1958	115,227	44,331	3,927	40,404	49,917	20,808	70,725	5,909	64,816	6,080	2,430	3,100	370	180	107,527	61.9
1959	120,315	46,386	4,129	42,257	51,756	22,198	73,954	6,213	67,741	6,188	2,496	3,138	360	194	112,842	63.8
1960	126,646	48,266	3,773	44,493	55,504	23,012	78,516	7,472	71,044	7,336	2,760	4,020	346	210	117,304	65.2
1961	132,186	49,374	3,048	46,326	57,373	24,862	82,235	7,917	74,318	8,494	3,026	4,801	346	231	122,951	67.4
1962	136,266	50,876	2,814	48,062	59,787	25,491	85,278	8,175	77,103	8,287	3,003	4,695	346	243	126,900	68.4
1963	142,587	52,371	2,740	49,631	63,288	26,973	90,261	8,653	81,608	8,608	3,206	4,806	346	250	131,954	70.1
1964	146,368	54,473	3,222	51,251	64,939	27,506	92,445	8,847	83,598	8,297	3,111	4,968	10	208	135,433	71.0
1965	152,494	56,330	3,660	52,669	67,557	29,239	96,796	9,316	87,480	8,684	3,400	5,068	10	206	140,462	72.8
1966	156,535	57,916	3,417	54,499	70,268	29,301	99,569	9,275	90,294	8,325	3,526	4,601	.....	198	144,715	74.3

piled by the Health Insurance Association of America based on its annual surveys and its estimates of duplicatory coverage within the insurance industry. The data for the independent plans are based on the surveys of such plans over the years by the Office of Research and Statistics.

TABLE 7.—Enrollment for in-hospital medical benefits, 1940–66

[In thousands]

End of year	Gross total	Blue Cross-Blue Shield, total [1]	Insurance companies					Independent plans					HIAA estimate	
			Group policies	Individual policies	Gross total	Less duplication	Net total	Total	Community-consumer	Employer-employee-union	Medical society	Private group clinics	Net enrollment	Percent of 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	100	100	200	----------	200	2,300	265	1,390	185	460	3,840	3.0
1945	3,620	750	335	200	535	----------	535	2,335	350	1,360	200	425	4,713	3.5
1946	4,607	1,450	567	300	867	----------	867	2,290	370	1,330	200	390	6,421	4.6
1947	6,856	2,400	1,098	1,111	2,209	93	2,116	2,340	440	1,290	250	360	8,898	6.2
1948	10,673	4,700	1,927	1,810	3,737	199	3,538	2,435	530	1,250	330	325	12,895	8.8
1949	14,082	6,400	2,736	2,350	5,086	259	4,827	2,855	703	1,217	643	292	16,862	11.3
1950	20,771	9,450	5,587	2,714	8,301	300	8,001	3,320	930	1,660	460	270	21,589	14.3
1951	28,741	13,200	7,946	4,230	12,176	465	11,711	3,830	1,000	2,110	470	250	27,723	18.1
1952	35,020	16,250	10,157	4,965	15,122	902	14,220	4,550	1,270	2,570	480	230	35,670	22.9
1953	43,598	20,650	13,787	5,124	18,911	1,210	17,701	5,247	1,531	3,018	488	210	42,118	26.6
1954	49,740	24,650	15,778	5,459	21,237	1,487	19,750	5,340	1,700	2,990	450	200	46,366	28.7
1955	58,454	28,600	20,678	5,602	26,280	1,866	24,414	5,440	1,870	2,960	420	190	54,935	33.4
1956	66,282	31,800	25,177	6,193	31,370	2,472	28,898	5,584	2,062	2,941	395	186	64,118	38.2
1957	73,222	34,900	28,317	6,716	35,033	2,366	32,677	5,645	2,185	2,890	380	190	71,303	41.7
1958	76,784	36,600	29,868	7,069	36,937	2,483	34,454	5,730	2,310	2,850	370	200	74,771	43.0
1959	82,446	39,200	32,469	7,667	40,136	2,697	37,439	5,807	2,432	2,801	360	214	81,901	46.3
1960	89,286	41,800	35,802	7,997	43,799	3,229	40,570	6,916	2,680	3,670	346	220	86,889	48.3
1961	95,282	43,700	38,003	9,084	47,087	3,535	43,552	8,030	2,924	4,523	346	237	93,466	51.2
1962	99,989	46,100	40,012	9,865	49,877	3,777	46,100	7,789	2,897	4,297	346	249	97,404	52.5
1963	105,520	47,600	43,343	10,550	53,893	4,066	49,827	8,093	3,093	4,398	346	256	102,302	54.4
1964	111,225	49,800	47,446	10,886	58,332	4,332	54,000	7,425	3,100	4,069	10	264	107,686	56.4
1965	117,909	52,950	50,632	11,013	61,645	4,514	57,131	7,828	3,388	4,187	10	243	111,696	57.9
1966	122,807	54,441	54,050	11,473	65,523	4,683	60,840	7,526	3,514	3,777	----------	235	116,462	59.8

[1] Estimated.

The estimates of net enrollment are those of the HIAA.

The figures for insurance companies for the years 1953–65 differ from those previously reported by the HIAA. The estimates of coverage under individual policies were revised downward because of drastically reduced figures for one large company. (This company, which had not responded to the HIAA questionnaires for 1958–65, submitted figures for 1966 much lower than its reported enrollment in 1953–57.)

The estimates for hospital and surgical coverage for 1962 and 1959 are a little higher (about 5 and 4 percentage points respectively for the two services for 1962 and 4 and 2 percentage points for 1959) than the estimates of the Public Health Service for these years based on its household surveys of the extent of health insurance coverage. The difference between the two sets of figures could be the result of overreporting of enrollment by some health insurance organizations, underestimation of the extent of duplicatory coverage, or underreporting in the household surveys of the Public Health Service. The figures are more closely in agreement than in the past because of the above-mentioned downward revision of the HIAA figures for insurance companies. In any case, it should be understood that the figures in tables 5 to 7 are estimates and that they may possibly overstate the extent of health insurance enrollment by a few percentage points.

It is evident that during the forties and early fifties there was an exceedingly rapid growth of private health insurance and that since about 1957 hospital coverage has grown at a slower pace, with surgical and in-hospital medical coverage gradually approaching the enrollment level for hospital coverage.

Over the years, as shown in table 8, the share of Blue Cross-Blue Shield plans in the total gross enrollment of all organizations has declined and the share of insurance companies has grown, although changes have been quite minor since about 1961. The share of independent plans in total enrollment has consistently declined.

Enrollment for other coverages.—Table 9 presents estimates of the number and proportion of the population covered for services other than hospital care, surgery, and in-hospital medical visits in 1962, 1965, and 1966. The rapid growth of coverage of these services is evident.

Enrollment under major medical policies of in-

TABLE 8.—Percentage distribution of total gross enrollment of private health insurance organizations, by type of benefit, 1940–66

End of year	Hospital care			Surgical services			Physician in-hospital visits		
	Blue Cross-Blue Shield	Insurance companies (net)	Independent plans	Blue Cross-Blue Shield	Insurance companies (net)	Independent plans	Blue Cross-Blue Shield	Insurance companies (net)	Independent plans
1940	50.5	30.8	18.7	5.4	47.6	47.0	2.9	----	97.1
1945	59.0	32.7	8.3	19.3	60.7	20.0	20.7	14.8	64.5
1950	47.6	46.8	5.6	31.7	61.4	6.9	45.5	38.5	16.0
1955	43.4	50.8	5.8	38.7	55.2	6.1	48.9	44.8	9.3
1960	41.0	54.7	4.3	38.1	56.1	5.8	46.8	45.4	7.7
1961	40.2	54.8	4.9	37.4	56.2	6.4	45.9	45.7	8.4
1962	40.0	55.4	4.7	37.3	56.6	6.1	46.1	46.1	7.8
1963	39.1	56.3	4.6	36.7	57.2	6.0	45.1	47.2	7.7
1964	39.2	56.5	4.3	37.2	57.1	5.7	44.8	48.6	6.7
1965	38.7	57.0	4.2	36.9	57.4	5.7	44.9	48.5	6.6
1966	38.7	57.4	3.9	37.0	57.7	5.3	44.3	49.5	6.1

TABLE 9.—Number and percent of population covered for services other than hospital care, surgery and in-hospital medical visits, 1962–66

End of year	X-ray and laboratory examinations	Physician office and home visits	Dental care	Prescribed drugs	Private-duty nursing	Visiting-nurse service	Nursing-home care
	Net number of different persons (in thousands)						
1962	65,671	56,986	1,006	47,907	46,143	43,203	4,975
1965	79,500	63,400	3,100	53,200	56,000	60,100	9,900
1966	93,459	73,706	4,227	65,544	68,722	79,004	17,814
	Percent of civilian population						
1962	35.0	31.0	.5	26.0	25.0	23.0	3.0
1965	41.2	32.9	1.6	27.6	29.0	31.2	5.1
1966	48.0	37.9	2.2	33.7	35.3	40.6	9.2

Source: Data for 1962 from Louis S. Reed, *The Extent of Health Insurance Coverage in the United States*, Research Report No. 10, Office of Research and Statistics, 1965, p. 41; 1965 data from Louis S. Reed, "Private Health Insurance: Coverage and Financial Experience, 1965," *Social Security Bulletin*, November 1966.

TABLE 10.—Number of persons covered under major medical policies of insurance companies and under supplementary major medical and comprehensive extended-benefit contracts of Blue Cross-Blue Shield plans, 1951–66

[In thousands]

End of year	Insurance companies					Blue Cross-Blue Shield plans [1]		
	Total	Group policies			Individual and family policies	Total	Supplementary major medical	Comprehensive extended benefit
		Total	Supplementary	Comprehensive				
1951	108	96	96	----	12	----	----	----
1952	689	533	533	----	156	----	----	----
1953	1,220	1,044	1,044	----	176	----	----	----
1954	2,198	1,892	1,841	51	306	----	----	----
1955	5,241	4,759	3,928	831	482	----	----	----
1956	8,876	8,294	6,881	1,413	582	----	----	----
1957	13,262	12,428	9,290	3,138	834	----	----	----
1958	17,375	16,229	11,072	5,157	1,146	----	----	----
1959	21,850	20,353	13,900	6,453	1,497	[2]	[2]	[2]
1960	27,448	25,608	17,285	8,323	1,840	3,713	3,020	693
1961	34,138	31,517	22,281	9,236	2,621	5,059	4,015	1,044
1962	38,250	35,053	25,301	9,752	3,197	7,501	5,068	1,735
1963	42,441	38,699	28,248	10,451	3,742	[2]	[2]	[2]
1964	47,001	42,579	31,772	10,807	4,422	[2]	[2]	[2]
1965	51,946	47,269	35,988	11,281	4,677	[3] 14,600	[2]	[2]
1966	56,742	52,002	39,685	12,317	4,740	[4] 14,352	[4] 10,409	[4] 3,943

[1] Comparable data not available for earlier years; data shown are for Blue Cross plans only, except for 1965 and 1966. Data exclude persons covered under polio and dread-disease and prolonged-illness contracts offering coverage only for diseases specified.

[2] Not available.

[3] Data for Blue Cross plans plus an estimated 1,600,000 in Blue Shield plans not affiliated with Blue Cross.

[4] Data jointly developed by Blue Cross Association and National Association of Blue Shield plans on unduplicated number of persons covered.

Source: Data for insurance companies from *Source Book of Health Insurance, 1966* and HIAA; data for Blue Cross and Blue Shield plans from the Blue Cross Association and the National Association of Blue Shield plans.

surance companies and under major medical and extended benefit contracts of Blue Cross-Blue Shield plans has grown rapidly (table 10).

Group-Practice Plans

Special interest attaches to the enrollment of plans that provide service through group-practice units of physicians and/or dentists. The 1965 survey of all independent plans found that in 1964 there were 196 plans providing service through group practice. Twenty-eight of these plans were operated by community-consumer groups, 147 by employer-employee-union units, and 21 by private group clinics of physicians and/or dentists. Total enrollment for hospital care was 2.7 million, for surgical service it was 3.5 million, and for office, clinic, or health center visits 3.8 million.

Returns from 17 of the larger group-practice plans included in the 1967 survey of independent plans provide a good basis for estimating 1966 enrollment of all group-practice plans. The estimates for four principal services are tabulated below, by type of plan.

Type of plan	Hospital care	Surgery	In-hospital medical visits	Office, clinic, or health center visits
All plans	2,771	3,763	3,430	4,158
Community	1,670	2,415	2,415	2,434
Employer-employee-union	1,050	1,150	780	1,500
Private group clinic	51	198	235	224

Between 1964 and 1966, total enrollment of group-practice plans is estimated to have increased by 3 percent for hospital care and 8 percent for surgical service. Community plans increased their enrollment for surgical service (or for physician services generally) by 13 percent; employer-employee-union plans had little change in enrollment.[12]

Health Insurance Organizations As Intermediaries

A new chapter in the history of private health insurance in the United States opened with the inauguration of Medicare in July 1966. At that time all the Blue Cross plans in the United States and a few insurance companies became intermediary fiscal agents (for the paying of hospitals) under the hospital insurance provisions of the program and slightly more than half of all Blue Shield plans and 14 insurance companies became fiscal intermediaries under the medical insurance provisions.

It is not possible to state specifically how many aged persons are in effect served by the various types of intermediaries under Medicare since, with one exception,[13] intermediaries are not responsible for a designated population but handle claims for certain providers of service (hospitals) or for services provided in given areas.

Of the 6,680 hospitals in the country participating in Medicare, approximately 90 percent have named a Blue Cross plan as their intermediary for obtaining reimbursement of the cost of hospital care provided to aged beneficiaries. It may therefore be roughly estimated that Blue Cross plans are serving as intermediaries for approximately 90 percent of the 18.8 million aged population entitled to hospital insurance benefits.

Some 17.6 million aged persons were enrolled for medical insurance benefits as of July 1, 1966. It may be roughly estimated that of these, Blue Shield plans are serving approximately 9.6 million persons, insurance companies 7.6 million, and independent plans about 0.4 million.[14]

Under the State programs of medical assistance (title XIX of the Social Security Act) or other State assistance programs a considerable number of States have asked Blue Cross or Blue Shield plans or in a few cases insurance companies to serve as agents for payment of hospitals and/or physicians. The Blue Cross Association estimates that approximately 4 million persons were being served under such arrangements at the end of 1966. (Many of these are also included

[12] Louis S. Reed and Willine Carr, *Independent Health Insurance Plans, 1966*, op. cit.

[13] The exception is the Travelers Insurance Company, which handles medical insurance claims for all railroad workers (and their dependents)—about 761,000 persons—who are eligible for old-age benefits under the railroad retirement program.

[14] Only one independent plan is serving as a fiscal intermediary for an area—Group Health Insurance, Inc., for Queens County, New York. Approximately 23 "independent" group-practice prepayment plans provide physician services under Medicare and are reimbursed directly by the Social Security Administration on a cost per annum basis for covered services per enrolled beneficiary.

in the count of persons served under Medicare.) Blue Cross plans estimate that they serve another 770,000 military dependents and retired personnel under the Defense Department's civilian health and medical program for the uniformed services.

The National Association of Blue Shield Plans reports that at the end of 1966, Blue Shield plans served 11,190,000 persons under fiscal arrangements. This total includes persons served under the medical insurance provisions of Medicare, under State medical assistance and other State public assistance programs, and the program for military dependents.

In addition to insurance company operations under Medicare and a few State public assistance programs, one company is serving about one-third of the military dependents for hospital care under the uniformed services' civilian medical program and other insurance companies are acting as fiscal intermediaries for payment of physicians in various States under that program.

It is difficult to make an unduplicated count of persons served by private health insurance organizations under fiscal intermediary arrangements, but it is obvious that the total is large and adds a new dimension to the role of private health insurance.

FINANCIAL EXPERIENCE

In 1966 all private health insurance organizations in the United States had a total subscription or premium income of $10.6 billion. They paid out 86.5 percent in providing benefits, used 14.4 percent for operating expenses, and had a net underwriting loss of 0.9 percent. It is probable that most or all of this underwriting loss was offset by investment income (income from investment of reserves), but data on such income are not available for all carriers. These data relate only to the regular or private operations of the organizations—that is, they exclude receipts and expenditures as fiscal intermediaries or providers of care under health insurance for the aged (Medicare) or other Government programs. The financial experience of each type of organization is presented in table 11.

Blue Cross and Blue Shield Plans

The data for the Blue Cross and Blue Shield plans were compiled from individual financial statements for all plans submitted to the Office of Research and Statistics by the Blue Cross Association and the National Association of Blue Shield Plans. Duplication resulting from the fact that seven plans are both Blue Cross and Blue Shield plans and submit identical data to both national organizations has been eliminated. The figures for Blue Cross plans include data for Health Services, Inc., an insurance company wholly owned by the Blue Cross Association, and the figures for Blue Shield include those for Medical Indemnity of America, an insurance company wholly owned by the National Association of Blue Shield Plans.

Together the Blue Cross and Blue Shield plans had a total income of $4.4 billion and subscription

TABLE 11.—Financial experience of private health insurance organizations, 1966

[Amounts in millions]

Type of plan	Total income	Subscription or premium income	Claims expense		Operating expense		Net underwriting gain		Net income	
			Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of premium income	Amount	Percent of total income
Total	(1)	$10,564.1	$9,141.8	86.5	$1,517.2	14.4	−$94.9	−0.9	(1)	(1)
Blue Cross-Blue Shield	4,394.4	4,327.8	3,975.4	91.9	272.8	6.3	79.6	1.8	$146.2	3.3
Blue Cross	3,132.6	3,085.9	2,882.2	93.4	152.3	4.9	52.3	1.7	99.0	3.2
Blue Shield	1,261.8	1,241.9	1,093.2	88.0	120.5	9.7	27.3	2.2	47.2	3.7
Insurance companies	(1)	5,595.0	4,585.0	81.9	1,205.0	21.5	−195.0	−3.5	(1)	(1)
Group	(1)	3,987.0	3,711.0	93.1	510.0	12.8	−234.0	−5.9	(1)	(1)
Individual	(1)	1,608.0	874.0	54.4	695.0	43.2	39.0	2.4	(1)	(1)
Independent plans	641.3	641.3	581.4	90.7	39.4	6.1	20.5	3.2	20.5	3.2
Community	237.0	237.0	218.0	92.0	17.0	7.2	2.0	.8	2.0	.8
Employer-employee-union	370.7	370.7	332.7	89.8	20.0	5.4	18.0	4.8	18.0	4.8
Private group clinics	13.6	13.6	12.0	88.5	1.2	8.6	.4	2.9	.4	2.9
Dental society	20.0	20.0	18.7	93.5	1.2	6.0	.1	.5	.1	.5

[1] Data not available.

income of $4.3 billion; the difference between the two figures represents mainly interest or other investment income on reserves. Aggregate reserves at the end of 1966 amounted to $1.05 billion. Blue Cross paid out 93.4 percent of subscription income in benefits (payments to hospitals and other providers of services), used 4.9 percent for operating expenses, and had a net underwriting gain of 1.7 percent of subscription income and a net income of 3.2 percent of total income. (Net income becomes an addition to reserves.)

The Blue Shield plans paid out 88 percent of subscription income in the provision of benefits, used 9.7 percent for operating expense, and had a net underwriting gain of 2.2 percent of subscription income and a net income of 3.7 percent of total income. The higher operating expense ratio for Blue Shield than for Blue Cross reflects the fact that medical claims are more numerous than hospital claims, that their handling is more complex and that premium income per covered person is considerably less.

Both the Blue Cross and the Blue Shield plans had a lower claims expense ratio and a higher operating expense ratio in 1966 than in 1965. Both changes reflect the impact of the Medicare program. The claim expense ratio is lower because (1) beginning in July 1966 the plans were freed of the losses formerly incurred on aged subscribers (before Medicare aged subscribers did not pay their way and were heavily subsidized by younger subscribers) and (2) the new complementary coverages were priced so that the experience would be favorable. The higher operating expense ratio (in earlier years the trend had been consistently downward) probably reflects the expense of offering new coverages to aged subscribers and of serving as fiscal intermediaries under Medicare. The plans are reimbursed for all costs incurred for services rendered under Medicare, but the new load on personnel and facilities probably caused at least a temporary increase in the cost of carrying on their regular business.

Insurance Companies

The data for insurance companies are estimates and are based largely upon figures supplied by the Health Insurance Association of America for estimated premium income and losses incurred under the health insurance business of insurance companies as distinguished from their disability or wage replacement business. Unfortunately the reports that insurance companies make to the State Insurance Commissions on group and individual "accident and health insurance," as this general type of insurance is called, do not provide a breakdown between health and disability coverages. The HIAA annually provides such a breakdown to the Office of Research and Statistics that is based on the HIAA annual surveys of insurance companies, its surveys of benefits paid by type of coverage, and the Spectator aggregates for all accident and health insurance. The operating expense ratios under both group and individual policies are calculated by the Office of Research and Statistics and are taken from or derived from the aggregates compiled by the Spectator Company for virtually all companies writing accident and health insurance.[15]

The data show that in 1966 insurance companies under group health insurance policies had a premium income of $4.0 billion, paid out $3.7 billion in claims (93.1 percent), had operating expenses that amounted to 12.8 percent of premium income, and incurred a net underwriting loss of $234 million, equal to 5.9 percent of premium income. Probably all or a major portion of this underwriting loss is offset by investment income from reserves. No precise data on such income are available. The substantial underwriting loss on group health insurance business in this and previous years (it was −5.5 percent in 1965 and −4.6 percent in 1964) tends to suggest that the companies are subsidizing their health insurance business from their disability and life insurance business.[16]

Premium income under individual health insurance policies was $1.6 billion; 54.4 percent was paid out in claims, 43.2 percent used for operating expense, and the net underwriting gain was 2.4 percent.

The HIAA estimates that premium taxes, licenses, and fees paid by insurance companies

[15] *1967 Health Insurance Index*, The Spectator, Philadelphia.

[16] Similarly compiled data on group disability insurance show a net underwriting gain of 16.3 percent of premium income.

amounted to 2.4 percent of premium income on group business and 3.4 percent on individual business. (In comparing operating expenses of insurance companies and the Blue Cross and Blue Shield plans it should be borne in mind that with minor exceptions the plans do not pay such premium taxes and other fees.)

The high operating expense ratio under the individual policy business of insurance companies is characteristic—the ratio was 44 percent in 1965 and 45.4 percent in 1964—and it largely reflects the high cost of selling these policies.

INDEPENDENT PLANS

The data for independent plans are estimates, based upon the 1965 survey of all known independent plans made by the Office of Research and Statistics and the 1966 and 1967 surveys of a small number of the larger plans.[17] The figures shown for subscription income and total income are identical, though they are not, of course, actually the same. The difference that exists represents in large part the direct charges to subscribers for service. Such income must be included since total expenses of the plan represent all expense in providing services whether paid through subscription charges or direct charges.

The data for dental society plans are very rough estimates. They are based upon data for a few of the larger plans and were supplied by the Division of Dental Health and Resources of the Public Health Service.

The employer-employee-union plans received 58 percent of the total income of independent plans, the community plans 37 percent, dental society plans 3 percent, and private group clinic plans 2 percent. Expenditures for the provision of benefits and for operating expense amounted to 91 percent and 6 percent of total income, respectively, leaving 3 percent of total income for additions to reserves, expansion of facilities, etc.

Shares of the Carriers

Of the total subscription or premium income of all health insurance organizations, Blue Cross-Blue Shield received 41 percent, insurance companies 53 percent, and independent plans 6 percent (table 12). The Blue Cross-Blue Shield share of the private health insurance market is larger in terms of these figures than in terms of enrollment, which was 39 percent for hospital care and 37 percent for surgical coverage.

TABLE 12.—Percentage distribution of subscription or premium income, claims expense, and operating expense, for private health insurance organizations, 1966

Type of plan	Subscription income	Claims expense	Operating expense
Total	100.0	100.0	100.0
Blue Cross-Blue Shield	41.0	43.5	18.0
Blue Cross	29.2	31.5	10.0
Blue Shield	11.8	12.0	7.9
Insurance companies	53.0	50.2	79.4
Group	37.7	40.6	33.6
Individual	15.2	9.6	45.8
Independent plans	6.1	6.4	2.6
Community	2.2	2.4	1.1
Employer-employee-unions	3.5	3.6	1.3
Private group clinic	.1	.1	.1
Dental society	.2	.2	.1

Distribution of Benefit Expenditures

Table 13 shows a breakdown of benefit expense by type of service. It is estimated that for all carriers 65.6 percent of total expenditures went for hospital care, 31.0 percent for physician service, and 3.4 percent for other types of care—dental care, drugs, nursing service, etc.

Despite some broadening of their benefit structure in recent years the Blue Cross and Blue Shield plans are still concerned almost totally with hospital care and physician service, and only 1.4 percent of their benefit payments go for other types of services. Of the benefit payments of insurance companies, 4.6 percent are estimated to be for reimbursement of charges for services other than hospital care and physician service. Many independent plans have been innovators in the coverage of dental care, drugs, vision care, and visiting nurse service, and 9 percent of the benefit expense of all independent plans go for services other than hospital care and physician services.

The proportion of total benefit expenditure of all health insurance organizations going for services other than hospital care and physician service is rising. In 1965 it was 3.0 percent. Health insurance coverage of these other services is grow-

[17] See Louis S. Reed and Willine Carr, *Independent Health Insurance Plans, 1966*, op. cit.

TABLE 13.—Benefit expenditures of private health insurance organizations, by type of service, 1966

[Amounts in millions]

Type of plan	Total benefit expense		Hospital care		Physician service		Other types of care	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$9,141.8	100.0	$5,993.1	65.6	$2,831.1	31.0	$317.6	3.4
Blue Cross-Blue Shield	3,975.4	100.0	2,844.0	71.5	1,076.4	27.1	55.0	1.4
Blue Cross	2,882.2	100.0	2,778.4	96.4	66.3	2.3	37.5	1.3
Blue Shield	1,093.2	100.0	65.6	6.0	1,010.1	92.4	17.5	1.6
Insurance companies	4,585.0	100.0	2,911.0	63.5	1,462.0	31.9	212.0	4.6
Group	3,711.0	100.0	2,288.0	61.7	1,245.0	33.5	178.0	4.8
Individual	874.0	100.0	623.0	71.3	217.0	24.8	34.0	3.9
Independent plans	581.4	100.0	238.1	41.0	292.7	50.3	50.6	8.7
Community	218.0	100.0	61.0	28.0	154.0	70.6	3.0	1.4
Employer-employee-union	332.7	100.0	175.7	52.8	129.0	38.8	28.0	8.4
Private group clinic	12.0	100.0	1.4	11.7	9.7	80.8	.9	7.5
Dental society	18.7	100.0					18.7	100.0

ing but in financial terms it is not yet of great importance.

Benefit Expenditure Per Covered Person

Table 14, for the various groups of carriers, shows the benefit expenditures in 1966 per person enrolled. These figures in a rough way reflect the relative depth or extensiveness of the coverage provided by the different types of organizations.

It will be seen that Blue Cross-Blue Shield benefit expenditures for hospital care per person covered for this type of care (as shown in table 1) are higher by almost a third than the analogous benefit expenditures under group policies of insurance companies and considerably more than double the benefit expenditures under individual policies. Since utilization rates per covered person are probably somewhat similar, the figures indicate that in general Blue Cross-Blue Shield contracts provide more days of coverage and more comprehensive coverage of hospital costs than the group policies of insurance companies. By the same token, individual policies, on the average, are found to provide a rather meager coverage.

TABLE 14.—Benefit expenditures of private health insurance organizations, per person enrolled for specified benefits, 1966

Type of plan	Hospital care	Physician service
Blue Cross-Blue Shield	$43.35	$18.59
Insurance companies:		
Group policies	32.87	17.71
Individual policies	16.14	7.41
Independent plans	36.08	35.27

Among independent plans the data on benefit expenditures per person covered for hospital care suggest that the coverage of these plans is, on the average, less comprehensive than that of Blue Cross-Blue Shield but somewhat more comprehensive than that under group policies of insurance companies. However, one must take into account the fact that hospital utilization rates under the community group-practice plans are considerably lower than under Blue Cross-Blue Shield plans. In many of these group-practice plans the hospital coverage may be as extensive as that under the Blue Cross and Blue Shield plans, but lower rates of hospital utilization result in lower benefit expenditures for hospital care per covered person.

Benefit expenditures per person covered for physician service (that is, for surgical service) indicate a slightly more comprehensive coverage, overall, by Blue Cross-Blue Shield plans than under the group policies of insurance companies, and much more extensive coverage, on the average, than under the individual policies of insurance companies. The much higher benefit expenditures of independent plans reflect the fact that many of these plans provide comprehensive coverage of physician service—all needed service in the office, home, and hospital.

Trends 1950 to 1966

Data on the financial experience of the various types of health insurance organizations from 1948 or 1950 to 1966 are presented in the tables that

TABLE 15.—Financial experience of Blue Cross plans 1950–66

[Amounts in thousands]

Year	Reserves	Earned subscription income	Total earned income	Claims expense	Operating expense	Total net income or loss	As percent of subscription income			Net income as percent of total income
							Claims expense	Operating expense	Underwriting gain or loss	
1950	$116,531	$433,770	$436,984	$383,331	$36,281	$17,371	88.4	8.4	3.3	4.0
1951	122,959	506,439	510,180	454,786	40,872	14,522	89.8	8.1	2.1	2.8
1952	146,115	603,309	607,506	538,704	45,103	23,699	89.3	7.5	3.2	3.9
1953	186,449	713,212	717,605	630,407	49,953	37,245	88.4	7.0	4.6	5.2
1954	224,135	808,377	815,022	721,141	55,287	38,595	89.2	6.8	4.0	4.7
1955	254,407	916,690	925,197	836,546	58,368	30,283	91.3	6.4	2.4	3.3
1956	279,248	1,053,416	1,063,503	973,452	64,983	25,068	92.4	6.2	1.4	2.4
1957	278,254	1,191,552	1,202,189	1,131,618	72,154	−1,583	95.0	6.1	−1.0	−.1
1958	251,864	1,315,471	1,329,924	1,276,232	78,691	−24,999	97.0	6.0	−3.0	−1.9
1959	287,360	1,539,776	1,554,606	1,438,368	83,998	32,240	93.4	5.5	1.1	2.1
1960	363,253	1,783,172	1,802,789	1,654,951	90,821	57,017	92.8	5.1	2.1	3.2
1961	410,658	2,011,062	2,035,740	1,872,939	99,269	63,531	93.1	4.9	1.9	3.1
1962	454,626	2,230,747	2,257,523	2,103,084	107,204	47,235	94.3	4.8	.9	2.1
1963	492,872	2,467,195	2,497,377	2,343,231	115,228	38,918	95.0	4.7	.4	1.6
1964 [1]	511,112	2,731,380	2,766,829	2,624,302	124,909	17,558	96.1	4.6	−.7	.6
1965 [1]	561,906	3,031,470	3,074,551	2,887,187	134,559	52,805	95.2	4.5	.3	1.7
1966	649,633	3,121,111	3,168,187	2,912,733	154,132	101,322	93.3	4.9	1.7	3.2

[1] Includes Puerto Rico.

Source: Data for 1950–1965 from *The Blue Cross and Blue Shield Fact Book, 1966*. Data in all years exclude Health Services, Inc., and are not adjusted for duplication between Blue Cross and Blue Shield.

TABLE 16.—Financial experience of Blue Shield plans, 1950–66

[Amounts in thousands]

Year	Reserves	Earned subscription income	Total earned income	Claims expense	Operating expense	Total net income or loss	As percent of subscription income			Net income as percent of total income
							Claims expense	Operating expense	Underwriting gain or loss	
1950	$34,954	$140,817	$141,594	$111,039	$18,653	$11,902	78.8	13.2	7.9	8.4
1951	52,622	195,663	196,730	155,973	24,687	16,070	79.7	12.6	7.7	8.2
1952	75,123	246,362	247,998	195,646	29,985	22,367	79.4	12.2	8.4	9.0
1953	103,255	295,001	297,449	237,157	34,015	26,277	80.4	11.5	8.1	8.8
1954	134,050	344,653	347,963	279,387	39,342	29,234	81.1	11.4	7.5	8.4
1955	164,705	399,781	404,294	331,068	43,610	29,616	82.8	10.9	6.3	7.3
1956	185,413	470,583	476,009	407,350	50,702	17,957	86.6	10.8	2.7	3.8
1957	202,017	540,700	547,394	473,490	57,202	16,702	87.6	10.6	1.9	3.1
1958	212,632	592,272	600,447	528,589	61,362	10,496	89.2	10.4	.4	1.7
1959	221,239	678,333	687,730	610,342	69,035	8,353	90.0	10.2	−.2	1.2
1960	228,634	741,164	751,529	670,776	76,245	4,508	90.5	10.3	−.8	.6
1961	236,101	837,773	848,992	752,695	82,741	13,556	89.8	9.9	.3	1.6
1962 [1]	266,536	974,086	985,373	868,816	91,136	25,421	89.2	9.4	1.5	2.6
1963 [1]	289,440	1,086,356	1,101,745	977,147	99,662	24,936	89.9	9.2	.9	2.3
1964 [2]	317,528	1,209,394	1,227,557	1,095,713	108,691	23,153	90.6	9.0	.4	1.9
1965 [2]	347,266	1,318,915	1,338,907	1,190,486	115,940	32,481	90.3	8.8	.9	2.4
1966	398,374	1,390,890	1,413,185	1,226,383	129,864	56,938	88.2	9.3	2.5	4.0

[1] Includes Jamaica.

[2] Includes Puerto Rico but does not include Jamaica.

Source: Data for 1950–1965 from *The Blue Cross and Blue Shield Fact Book, 1966*. Data in all years exclude Medical Indemnity of America and are not adjusted for duplication between Blue Cross and Blue Shield.

follow. The figures for Blue Cross plans show that over the years the plans have tended to pay out a larger share of subscription income for benefits, have gradually whittled down the operating expense ratio, and have had a lower underwriting gain (table 15). The 1966 data are contrary to the trend for reasons already discussed. The Blue Shield data likewise show an increasing claims expense ratio, a declining operating expense ratio, and a declining ratio of underwriting gain to subscription income (table 16).

The data for group policies of insurance companies likewise show an increasing proportion of premium income paid out for claims, a decline in the operating expense ratio,[18] and increasingly unfavorable financial results—net underwriting losses in all years since 1956 (table 17).

For individual policies, relatively little change is shown for the entire period, when 1948 data, which are atypical, are omitted (table 18).

Full data on the financial experience of inde-

[18] These ratios are those for all group accident and health insurance as shown in the annual Spectator publications.

TABLE 17.—Financial experience under group health insurance policies of insurance companies, 1948–66

[Amounts in millions]

Year	Premium income	Claims expense	Operating expense	Net underwriting gain or loss	Percent of premium income		
					Claims expense	Operating expense	Net gain or loss
1948	$212	$148	$35	$29	69.8	16.5	13.7
1949	241	180	39	22	74.7	16.1	9.2
1950	333	257	52	24	77.2	15.7	7.1
1951	469	416	68	−15	88.7	14.6	−3.3
1952	569	498	77	−7	87.5	13.6	−1.1
1953	723	626	95	2	86.6	13.1	.3
1954	867	717	127	23	82.6	14.7	2.7
1955	1,023	858	143	21	83.9	14.0	2.1
1956	1,216	1,083	163	−29	89.0	13.4	−2.4
1957	1,476	1,318	(1)	(1)	89.3	(1)	(1)
1958	1,606	1,464	217	−75	91.2	13.5	−4.7
1959	1,853	1,680	248	−75	90.7	13.4	−4.1
1960	2,104	1,901	276	−73	90.4	13.1	−3.5
1961	2,414	2,170	323	−80	89.9	13.4	−3.3
1962	2,708	2,453	352	−97	90.6	13.0	−3.6
1963	2,913	2,671	382	−140	91.7	13.1	−4.8
1964	3,297	3,024	425	−152	91.7	12.9	−4.6
1965	3,665	3,413	454	−203	93.1	12.4	−5.5
1966	3,987	3,711	510	−234	93.1	12.8	−5.9

[1] Data not available.

TABLE 18.—Financial experience under individual health insurance policies of insurance companies, 1948–66

[Amounts in millions]

Year	Premium income	Claims expense	Operating expense	Net underwriting gain or loss	Ratio to premium income		
					Claims expense	Operating expense	Net gain or loss
1948	$209	$80	$97	$32	38.3	46.3	15.4
1949	220	115	98	8	52.3	44.6	3.4
1950	272	143	120	9	52.6	44.0	3.4
1951	329	172	147	10	52.3	44.8	2.9
1952	389	201	175	13	51.6	45.1	3.3
1953	459	229	207	23	49.9	45.1	5.0
1954	552	266	243	13	51.0	46.6	2.4
1955	604	321	277	7	53.1	45.8	1.1
1956	623	328	283	12	52.7	45.4	1.9
1957	699	337	(1)	(1)	48.2	(1)	(1)
1958	708	345	331	32	48.7	46.8	4.5
1959	786	400	371	15	50.9	47.2	1.9
1960	923	488	427	8	52.9	46.3	.8
1961	1,013	536	471	6	52.9	46.5	.6
1962	1,102	559	508	35	50.7	46.1	3.2
1963	1,223	661	559	3	54.0	45.7	.3
1964	1,355	739	615	1	54.5	45.4	.1
1965	1,559	852	686	21	54.7	44.0	1.3
1966	1,608	874	695	39	54.4	43.2	2.4

[1] Data on operating expense separate from underwriting profit not available.

TABLE 19.—Subscription or premium income and benefit expenditures of private health insurance organizations, 1948–66

[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	8,983.6	2,785.1	2,697.6	1,087.5	4,652.0	3,297.0	1,355.0	546.5
1965	10,001.3	4,169.0	2,993.7	1,175.3	5,224.0	3,665.0	1,559.0	608.3
1966	10,564.1	4,327.8	3,085.9	1,241.9	5,595.0	3,987.0	1,608.0	641.3
	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	5,965.4	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	7,832.1	3,574.4	2,592.8	981.6	3,763.0	3,024.0	739.0	494.7
1965	8,728.9	3,912.9	2,853.4	1,059.5	4,265.0	3,413.0	852.0	551.0
1966	9,141.8	3,975.4	2,882.2	1,093.2	4,585.0	3,711.0	874.0	581.4

TABLE 20.—Percentage distribution of subscription or premium income and benefit expenditures of private health insurance organizations, 1948–66

[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	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	42.1	30.0	12.1	51.8	36.7	15.1	6.1
1965	100.0	41.7	29.9	11.8	52.2	36.6	15.6	6.1
1966	100.0	41.0	29.2	11.8	53.0	37.7	15.2	6.1
	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	49.5	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	45.6	33.1	12.5	48.0	38.6	9.4	6.3
1965	100.0	44.8	32.7	12.1	48.9	39.1	9.8	6.3
1966	100.0	43.5	31.5	12.0	50.2	40.6	9.6	6.4

pendent plans are available only for 1964 and subsequent years. The ratios shown for 1966 are not significantly different from those for 1964.

Aggregate premium income and benefit expenditures of all types of health insurance organizations are given in table 19. The data for Blue Cross and Blue Shield include the operations of Health Services, Inc., and Medical Indemnity of America and are unduplicated.

The shares of the different types of organizations in total premium income or benefit expenditures have shown only minor change in the past 10 years (table 20). Premium income of Blue Cross-Blue Shield plans as a proportion of the total has stayed about the same, 40–42 percent. The share of insurance companies has increased slightly—with group policies showing a small gain and individual policies declining. The share of the independent plans has dropped slightly.

Total benefit expenditures of all private health insurance organizations, by type of care, from 1950 to 1966 have been as follows:

[In millions]

Year	Total	Hospital care	Physician service	"Other"
1950	$992	$680	$312	(1)
1955	2,536	1,679	857	(1)
1960	4,996	3,304	1,593	$99
1961	5,695	3,766	1,796	133
1962	6,344	4,197	1,992	155
1963	6,980	4,642	2,153	185
1964	7,832	5,187	2,427	218
1965	8,729	5,790	2,680	259
1966	9,142	5,993	2,831	318

[1] Included in physician service.

Proportion of Consumer Expenditures Met by Insurance

A major test of the significance of private health insurance is the extent to which it covers health care costs. In 1965 benefit expenditures under private health insurance amounted to 32.6 percent of total private consumer expenditures for health care (not including the net cost of obtaining health insurance). Insurance met 71.2 percent of consumer expenditures for hospital care, 31.8 percent of consumer expenditures for physician services, and 2.5 percent of consumer expenditures for all other types of health care.

The tabulation that follows shows the proportions of consumer expenditures met or paid for through health insurance in selected years from 1950 to 1965 (1966 data not yet available).[19]

Year	Total	Hospital care	Physicians' services	Other types of care
1950	12.1	34.6	12.0	(1)
1955	21.5	51.8	25.0	(1)
1960	27.7	62.6	30.0	1.3
1961	30.0	65.6	32.8	1.7
1962	30.8	67.4	33.0	1.9
1963	31.7	67.0	33.6	2.1
1964	31.6	68.1	32.1	2.3
1965	32.6	71.2	31.8	2.5

[1] Included in physician services.

It is evident that the extent to which health insurance covers consumer health costs is increasing, on the whole, but only slowly.

[19] Based on data in Ruth S. Hanft, "National Health Expenditures, 1950–65," *Social Security Bulletin*, February 1967.