# ACHIEVEMENTS OF VOLUNTARY HEALTH INSURANCE*

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VOLUNTARY insurance was not exactly a babe in arms when my introduction to its achievements and potentials took place in 1950. It might, however, have been described as barely of school age—it had the lusty appetite and the lack of book learning, sophistication, and direction characteristic of a first grader.

Fifteen years later we might ask ourselves whether health insurance is now in its teens or has reached its majority. Has it matured so rapidly that it is approaching middle age? It certainly does not show signs of the waning vigor of the senior citizen.

Why then has this war baby become the whipping boy of the press, of Congressional committee reports, of state insurance commissions and legislative hearings, and a popular subject for criticism in medical-care circles? Obviously, its rising premium costs, its uneven distribution, and its uncertainties for the individual as well as its inflationary effects on hospital use make more exciting copy than its successes and solid achievements. In 1950 few students of the subject—I among them—believed the day would come when at least 70 per cent of the civilian population would have insurance for spreading the costs of medical care. There is probably not a person here today who cannot cite an example of a family that has had major financial assistance from its health insurance. Eric Hodgins' best-selling *Episode*[1] is merely a more dramatic and better-written report of the kinds of situations each of us knows, affirming the value of this development.

## A SEVEN-BILLION-DOLLAR INDUSTRY

Between 1948 and 1964 nearly $61 billion had been extracted relatively painlessly from the public for voluntary health insurance. Nearly

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TABLE I—INCOME AND BENEFIT EXPENDITURES OF VOLUNTARY HEALTH INSURANCE ORGANIZATIONS, 1948-63
(In millions)

| Year | Premium income | Benefit expenditures Amount | Benefit expenditures Percentage of total | Retentions* Amount | Retentions* Percentage of total |
|---|---|---|---|---|---|
| Total, 1948-63 | $60,500.9 | $50,720.9 | 83.8 | $9,780.0 | 16.2 |
| 1948 | 862.0 | 606.0 | 70.3 | 256.0 | 29.7 |
| 1949 | 1,015.5 | 766.8 | 75.5 | 248.7 | 24.5 |
| 1950 | 1,291.5 | 991.9 | 76.8 | 299.6 | 23.2 |
| 1951 | 1,660.3 | 1,352.6 | 81.5 | 307.7 | 18.5 |
| 1952 | 1,993.4 | 1,603.9 | 80.5 | 389.5 | 19.5 |
| 1953 | 2,405.3 | 1,919.2 | 79.8 | 486.1 | 20.2 |
| 1954 | 2,756.3 | 2,178.9 | 79.1 | 577.4 | 20.9 |
| 1955 | 3,149.6 | 2,535.7 | 80.5 | 613.9 | 19.5 |
| 1956 | 3,623.7 | 3,014.7 | 83.2 | 609.0 | 16.8 |
| 1957 | 4,143.9 | 3,474.0 | 83.8 | 669.9 | 16.2 |
| 1958 | 4,497.8 | 3,877.3 | 86.2 | 620.5 | 13.8 |
| 1959 | 5,139.2 | 4,398.8 | 85.6 | 740.4 | 14.4 |
| 1960 | 5,841.0 | 4,996.3 | 85.5 | 844.7 | 14.5 |
| 1961 | 6,673.3 | 5,695.4 | 85.3 | 977.9 | 14.7 |
| 1962 | 7,411.1 | 6,343.8 | 85.6 | 1,067.3 | 14.4 |
| 1963 | 8,037.0 | 6,965.6 | 86.7 | 1,071.4 | 13.3 |

*Difference between subscription or premium income and benefit expenditures; the amount retained by the organization for operating expenses, additions to reserves, and profits. Private consumer expenditures for medical care and voluntary health insurance, 1948-63, *Soc. Sec. Bull.*, Dec. 1964.

$51 billion represented benefit payments channeled into medical and hospital and other services. The remainder, about $10 billion, supported jobs in the insurance industry, provided states with tax revenue, was invested in the economy, and contributed financially to communications media through its advertising (Table I). All this voluntary effort has benefited people and stabilized hospital operations, raised doctors' incomes, and generally increased access to medical care and improved health.

Voluntary health insurance has exhibited a marked reduction since 1948 in retentions as a percentage of income (Table I) so that 17 per cent more of the premium dollar now goes to pay medical claims. While expanding enrollment and broadening protection, to have progressively reduced the combined retention of all forms of insurance from 30 per cent in 1948 to 13 per cent in 1963 is laudable. Part of the reduction comes from more efficient operations made possible by large volume and mechanization. Part is concomitant with redistribution

of the market, which has reduced the share provided through individual insurance with its high retentions; group insurance has expanded both absolutely and relatively and at the same time reduced its over-all retention ratio drastically.

Another factor accounting for some part of the reduced retention ratio is the simple arithmetic result of inflation of the prices of units of medical care; it costs little more to process today's $1,000 hospital bill than it cost to process one of $500 a few years back. Medical costs have risen faster than ordinary business expense.

Consider for a moment this thought.

Had taxation, rather than voluntary health insurance, been the mechanism that supported the same volume of health services in the United States in these 17 years, who can say with certainty that government would have simultaneously found the means to support medical research and hospital facility construction as generously as it has? Can you name a single government elsewhere in the world that has invested capital in health facility construction and health research on the scale of the United States government, while at the same time providing the operating funds to furnish adequate services? What the alternative might have been is indicated by the failure of government to provide adequate support for research into causes of dependency while channeling billions into welfare, or to underwrite research related to federal income maintenance programs, particularly the Federal Old-Age Survivors, and Disability Insurance.[2] We are far ahead of other nations in the health field, thanks to this phenomenon unique to the United States.

## The Two Avenues for Financing Medical Services

In the United States the funds financing medical care are employed in two distinct ways. Under one system the funds are used both to organize and to deliver the services. Examples are largely but not entirely drawn from government and prepaid group practice and include the Veterans Administration, the military, the Indian Health Service, state mental hospitals and, in the private sector, HIP, Kaiser, and other group-practice plans. Under the other approach—the prevailing one—the individual seeks out services, guided or not by his individualistically oriented doctor, and then pays for them himself or indicates the source from which payment will come. It may be insurance or public welfare.

TABLE II—INSURANCE COVERAGE OF THE CIVILIAN, NONINSTITUTIONAL POPULATION, BY AGE AND TYPE OF INSURANCE, FISCAL YEAR 1963

| | | *Hospital insurance* | | *Surgical insurance* | |
|---|---|---|---|---|---|
| *Age* | *Total population** | *Number insured* | *Percentage of total* | *Number insured* | *Percentage of total* |
| Total | 183,146 | 128,703 | 70.3 | 119,413 | 65.2 |
| Under 15 | 58,241 | 40,030 | 68.7 | 37,744 | 64.8 |
| 15-24 | 25,700 | 16,979 | 66.1 | 15,564 | 60.6 |
| 25-34 | 21,441 | 16,027 | 74.7 | 15,132 | 70.6 |
| 35-44 | 23,912 | 18,574 | 77.7 | 17,452 | 73.0 |
| 45-54 | 20,992 | 16,277 | 77.5 | 15,152 | 72.2 |
| 55-64 | 15,994 | 11,708 | 73.2 | 10,662 | 66.7 |
| 65-74 | 11,060 | 6,723 | 60.8 | 5,787 | 52.3 |
| 75 and over | 5,806 | 2,384 | 41.1 | 1,920 | 33.1 |

*Includes persons of unknown insurance status. Source: U.S. Department of Health, Education, and Welfare, Health Insurance Coverage, United States, July 1962-June 1963, in: *Public Health Service Publication,* No. 1000, Ser. 10, No. 11.

## SIGNIFICANT FACTORS IN EXPANSION OF VOLUNTARY HEALTH INSURANCE

What were the major factors influencing the development and evolution of voluntary health insurance, determining its course in the postwar years? Foremost has been the tie-in with industry and labor, the source of groups relatively easy to enroll, especially where a co-operative employer was involved[3] or where a strong union was able to bargain health benefits for its members. Health benefits are now widely accepted as a supplement to wages. The pressures of the employment market have made most employers provide this fringe benefit. Two milestones of union-management participation that caused excitement in the early 1950's come to mind. One was the decision of the United Mine Workers to self-insure medical benefits and provide capital for facilities as a way of bringing quality care into the bleak picture of medicine in coal mining regions.

The other was the development by Blue Cross, the steel industry, and the United Steelworkers of America of the first nationwide uniform Blue Cross contract.[4] Without the exercise in coordinating the activities of the 78 Blue Cross plans and providing nationwide uniform benefits, Blue Cross would not be under consideration for a role in the program of hospitalization for the aged now before Congress. The solutions of complex problems in negotiating the steel contract gave

Blue Cross the background for participation in the Federal Employees' program and led to underwriting the Communications' Workers of America's contract, the second largest "case" ever written.

Employer contributions and payroll deductions for the employees' share of premium costs account for the high degree of labor-force participation in health insurance.[5] As a consequence, relatively more of the young and most vigorous elements of society—the best risks—are enrolled (Table II). Enrollment of groups of workers has brought in its wake the problem of dual coverage in many instances; the working wife may be entitled in her own right to family coverage as well as having coverage through her husband's employment. She is loath to forego her own fringe benefit by not participating.

Efforts to broaden coverage to presently uncovered types of services continue to arise from union activities. The most notable recent one is the Autoworkers' negotiation of benefits for mental illness, to begin in September 1966.

Federal and state governments have been second in influential importance. Perhaps some would quibble that the uniformed services' Medicare—benefits in nongovernmental facilities for the dependents of service personnel—is not voluntary health insurance. This first government program involving private insurance has its effect, however, in introducing millions to the nonprofit plans and the ways of commercial insurance. It also has implied approval by the federal government of the carriers. Then came coverage of civil servants—with New York the first sizeable state. Innovations for New York State employees included retaining retirees in the coverage group and the first choice program, including more than two alternatives, offered to state employees living in the city of New York. Next, the Federal Employees' Health Benefits Program, enacted in 1959, now covers more than 6 million people.[6] Congress broadened the multiple choice concept but was reluctant to include any but future annuitants in the groups. Later, those already retired were covered under a separate contract.

California designed its coverage of state civil servants on the federal pattern and devised a pooled fund approach to solve the problem of those already retired. Other states followed, but they usually adopted the more traditional approach of private employers, with a single carrier and a variety of schemes for including annuitants. While endorsing and spreading the idea of employer contributions, no consistent pattern

resulted from the government-sponsored programs—no clear-cut definition of the proper degree of government concern as an employer with the employees' own health insurance has emerged, and it is even less clear with regard to dependents.[7] This uneven treatment is true also in private industry.

A third significant element in the spread of voluntary insurance has stemmed from its success. People in the United States discovered for themselves when they used their insurance or through word of mouth that budgeting health-care expense is a good idea. The grapevine seems to me to have been a more potent educational force than the advertising of the plans. Our rising standard of living has also been a contributing force.[8]

However, consumer interest in participating in a good thing has created new sets of problems that the insurance industry has not yet solved in a satisfactory manner.[9] One of these is the penchant for purchasing several policies for the same contingency. Some consumers, anxious to prepay fully their hospital and surgical expenses and aware, at least to some degree, of hospital room rates and surgeons' "normal" fees, have augmented both their group and their individual coverage by buying one, two, three, or more additional policies. As their sophistication increases, extra coverage is purchased to help pay noncovered expenses, particularly out-of-hospital costs.

When given the opportunity, employees elect as broad a coverage under a single policy as is possible—witness the overwhelming preference for the high-option choice under the Federal Employees' Health Benefits Program. The differential in cost must be paid by the employee. It is the preference of the lower-income worker. The low option apparently appeals mainly to the higher income federal worker who can afford to self-insure health costs.

## The Status Quo or New Horizons?

With consumers "apparently" satisfied and willing to devote funds to purchasing adequate coverage, preferably through one policy, why is there so much criticism of voluntary health insurance? Part of our United States heritage seems to be a natural dissatisfaction with the *status quo*. We are prone to dream of an even better way of life. We justify our dreams by accentuating the negative on the current scene, whether it be in the field of foreign affairs, politics, or health insurance.

Psychiatrists call this escapism; none of us can be certain that what lies at the end of the rainbow will in fact be better. While dreaming of a better world, we often fail to appreciate what we already have.

Actually only a part of the vast army of insured people grumble about their coverage. Disenchantments arise only when there are claims to file. Not everyone files every year, and many who receive benefits are grateful for them. But the squeaking wheels are heard by union leaders who, in turn, may speak out. They are joined by the champions of those not under the umbrella of insurance. The "have-nots" and the individually insured, such as the aged, have almost no way of being heard outside of writing Congress or the newspapers.

## Teen-Age Immaturity?

From a ship in outer space (since Mount Olympus no longer symbolizes detachment from the world below) it looks as if voluntary health insurance entrepreneurs and subscribers both suffer from teen-age immaturity or, possibly, schizophrenia. The observer from on high sees us torn between admiration on the one hand for private enterprise, with its laissez-faire approach, and a belief in the effectiveness of some, if not all, social actions for changing matters for the better on the other. The one ideology can complacently view the phenomenon of health insurance as a purely fiscal mechanism whose purpose is paying medical bills. The other ideology sees it as a vehicle for improvement in services and is disturbed by the distortions that are created by some of the forms health insurance is taking. To the laissez-faire group, profit making, experience rating, and making it easy to overinsure are part of the play of the market. To the social-action group, overemphasis on hospitalized illness is viewed as retarding improvements in the organization and delivery of the full range of services the public needs. The likelihood of inflation of medical prices that accompanies some insurance approaches is viewed with alarm by the latter because it affects the pocketbooks of the noninsured; experience rating is deemed unacceptable because it tends to eliminate the poor risks from the accepted way of spreading medical-care costs over time.

Providers of services are equally schizophrenic about voluntary health insurance. For the most part, physicians appear to gravitate toward the private enterprise camp. Hospitals tend to be in the other camp. They have surmounted the problem of organizing the facilities

and the staff. Insured patients are often the main source of hospital income. But their support of the more socially oriented Blue Cross form of insurance is waning in a direct correlation to the abandonment of community-rating among the local Blue Cross plans. Nursing homes, largely proprietary, have allied themselves with the laissez-faire group. Patients pay generously toward amortizing the facility, but insurance has not been a source of much support. The dentists, new to the prepayment field, seem to be headed in the direction of the individual entrepreneur.

Consumers, including union members, once they have achieved insured status, appear to be little concerned with those who have not. They show evidence of teen-age conflicts when their desire to have even broader coverage conflicts with their desire to spend as little as possible. They wear blinders vis-à-vis overutilization, and union leadership gives less than lip service to efforts to improve the organization and delivery of the full range of services that they would like to have their insurance cover.

Employers have only recently begun to evince any interest in the employee health benefits whose costs they are more and more generously financing; concern is still far from universal. This new consciousness of the implications of the billions of dollars industry is channeling into these particular fringe benefits expresses itself in a new concern over wise use of insurance dollars vis-à-vis existing health problems of workers and their families. It is surprising that certain similarities between the employer's role in health insurance and workmen's compensation have not struck them more forcefully. The homework is surprisingly alike. The newly negotiated psychiatric benefits in the auto industry reportedly appealed to the manufacturers because they recognized that productivity might be improved if workers and their dependents had help with emotional problems. The three *A's* of absenteeism, alcoholism, aggressiveness can be disrupting to an assembly-line operation. Businessmen serving on hospital planning councils learn of the impact of hospital-oriented insurance benefits on the calls on them to support drives to finance hospital construction.

In all the turmoil created by conflicting philosophies and objectives, some strange contradictions have occurred. The objective of keeping government out has led to a belated effort to enroll the aged in voluntary plans. The results have demonstrated that competitive private

enterprise cannot accommodate to providing a social good of this magnitude—witness the small enrollment achieved and the premium increases now being requested under the various "State-65" plans.[10] This effort appears to have convinced Congress that a federal program is essential—just the opposite result from that intended by the plans. There is a strong inference in this chapter in the history of voluntary insurance that it has not reached college age—the lessons of college courses in economics and logic had not been absorbed.

## Major Medical: A Split Personality

One of the virtues attributed to voluntary health insurance has been its capacity to experiment. In the scientific sense an experiment includes measurement of results. Insurance has flunked the course in research design. There has been little reported that allows the results of all the experimenting to be assessed; experimenting has become tinkering, euphemistically called "tailoring." For instance, the chief tenet of major medical's design, that of a deductible and coinsurance control price and utilization, has really never been tested.

In the 1950's it began to look as if separate forms of insurance were going to be marketed for every kind of illness, even every part of the body—not only dental, but polio, dread disease, vision care, drugs, blood and, lately, mental illness were marketed—proliferating retention costs. Major medical expense insurance has applied brakes to this separatist movement. In turn, it has imposed restrictions on the kinds of care it would cover, since it excludes or limits dental care, vision care, nursing home care, and psychiatric care—some of these obviously of major and some of minor impact. It has included others, minor in themselves but, like the excluded items, with a cumulative effect that could have a major impact on family finances. Less desirably, it also reversed the trend toward fixed-fee schedules that assured payment in full, substituting "reasonable and customary charges," which are difficult to define.

Deductibles were borrowed from automobile liability insurance where their purpose was to keep premium costs down by shifting known and bearable amounts of risk of loss to the insured. Automobile insurance, however, is sold individually, so the purchaser can select the level of self-insurance he can afford.

As applied to major medical insurance, deductibles, coupled with

coinsurance, leave the insured's liability unpredictable. Under group insurance, the individual has no voice even in establishing his level of self-insurance. The amount of his coinsurance liability depends on the size of his medical bill, which is a pure gamble.

For psychiatric services, still another argument has been advanced for coinsurance. One body of psychiatrists, with more apparent sincerity than logic, believes that the patient will not benefit from psychiatric services unless he is "hurting in the pocketbook."[11] This belief loses some of its credibility as far as very wealthy patients or children are concerned. Are there no instances of successful treatment among these two groups because no pinch of the purse could possibly be inflicted on them?

We used to hear of teen-age growing pains. Major medical expense insurance has not outgrown them. Major medical expense insurance of the comprehensive type was designed to compete with basic insurance by requiring only a small deductible. It thus runs contrary to the philosophy that led to the design of supplementary major medical expense, that of providing for the truly major catastrophe. This newer form involves a great deal of paper work both by the insured and the insurance company for claims processing, belying the long-held posture of insurance companies that payment of small claims was so uneconomic that doctor's office visits and other minor charges should be excluded from coverage.[12] Insurance companies write both forms of major medical, even while insurance journals continually deplore some of the long-range consequences of each. The interest the company can earn on the large reserves required for major medical expense produces a short-range "plus" factor that seems to intrigue the company more than some nebulous impact on consumer medical care prices, so the sale of policies continues apace.

## Maternity Benefits

The lack of clear-cut intent and the nearly complete absence of social philosophy in the voluntary health insurance movement is perhaps best illustrated by its approach to covering maternity and newborn care. Many countries of the world have accepted as a social, and hence, public responsibility such provisions to ensure healthy mothers and children. Voluntary insurance in the United States has never, apparently, made up its mind whether it should provide the one benefit

that its youngest and healthiest enrollees will find useful or whether it wishes—as is often proclaimed—to foster individual responsibility by paying little or nothing toward such expenses. Character building has not been heralded yet as a benefit. However, we do have such a phenomenon as nearly 78 different endless variations in provisions for maternity and infant care coverage in the Blue Cross-Blue Shield plans and a host of others among commercial policies—this for a nearly uniform health condition requiring quite standardized services.[13]

As costs of all forms of care have risen, it is my impression that insured maternity benefits have been held at earlier levels, lowering their relative value. One predictable result called to my attention recently was that hospital "accounts receivable" are higher for obstetrical patients than for any other patients, including the aged.

## Conformity or New Behavior Patterns

A further comment on willingness to experiment. Physicians show tendencies toward conformity similar to the junior high school set. Whereas they endorse experimentation by insurance companies, experiments in the organization and delivery of services—as in prepaid group practice—are resisted by organized medicine. New York is almost the only city where hospitals as well as consumer groups have felt free to experiment in using their outpatient departments to afford nonwelfare groups a prepaid ambulatory care service.[14-16]

When the Hill-Burton program was first launched, provisions that would have financed ambulatory care facilities were suggested but not included, largely because of the resistance of the American Medical Association. Our present crying need for community health facilities results from this myopia. The recent addition of support for such facilities to the grant program requires that they be hospital-based.

Current efforts to conserve scarce health manpower and to effect improvements in the organization of services, such as providing home-health services to reduce hospital stays bog down because the implementing funds aren't generated by the prevailing fee-for-each-service system that keeps providers and purchasers in distinct compartments. To their credit, some health insurance carriers have been willing to experiment with nontraditional services, but in general the absence of an identifiable and clear-cut demand emerging from myriads of members of diverse insured groups has effectively deterred experiments

with extensions of prepaid care such as preventive services and home health services. The dynamic social link between the desired or desirable community service and the third party paying cash on behalf of patients[17] is missing. The Public Health Service program of Community Health Project Grants is helping to fill a small part of the gap.[18]

A separation that places the control of the funds equidistant from the vendor and the patient and makes the third party merely a fiscal transfer agent, frequently with a profit motive, has still another consequence that is coupled with the philosophy of leaving the individual completely free to choose the services he receives. Minimal or no sanctions are ordinarily placed on the qualifications of the providers of services by plans that merely act as fiscal agents. The leverage of mass purchasing is seldom used to upgrade the quality of care. Willingness to pay for surgery by doctors not properly qualified to perform it, paying for care in substandard hospitals, paying for faith healers, all may be dangerous for the unsophisticated patient and may perpetuate poor medicine as well as waste the collective funds. The consumer is further confused by the Madison Avenue approach that sells nostrums as aggressively as accepted kinds of care.

Under public pressure, several Blue Cross plans are assuming a positive role in assuring that the hospitals supported in such large measure by member premiums are accredited. Unfortunately, such plan actions are far from universal. Blue Shield rewards the specially trained and the poorly qualified physician equally. Relative Value Scales provide an instrument to differentiate the physician who places a higher value on his longer training from a less well-trained man, but this fact reintroduces uncertainty into the contractual arrangements, either when extra charges are billed to the patient or, under major medical, by producing an unpredictable volume of claims.

## Group Practice Plans

Many of the shortcomings of voluntary insurance that occasion criticism are absent from comprehensive prepaid group-practice plans. Benefits are available and quite complete both in and out of the hospital, so there is no need for purchasing a second policy to backstop the first. Quality controls can be built in, in the selection and organization of the medical staff and by using only accredited hospitals. Extra charges are kept small and publicized in advance. Preventive measures

and early diagnosis are included in the covered services. They are particularly attractive to households with youngsters because the service of pediatricians can be prepaid.[19] Services are available 24 hours a day. The plans are locally run, providing jobs for local people. Even with comparatively small enrollments, such plans serve a useful function wherever they exist by providing competition and demonstrating that broad coverage and preventive services, pediatric care, etc., can be purchased.

Yet there has been no burgeoning of this form of prepayment in the country as a whole. California is the only state where prepaid group practice numerically competes with the Blues and commercial insurance.

Why is this so? The chief reason is the difficulty of organizing facilities, staff, and purchasers of service simultaneously. Capital for construction and developmental money are needed well in advance of the date when premiums first become available for services, and yet services must be available when the first insured patient presents himself.[20]

Much has been made of the deterrent to consumer-sponsored group practice plans through legal barriers. But this deterrent is more and more a straw man.

With its activities necessarily at the local level and geared to the wishes of its local members, prepaid group practice keeps all of its members' dollars in the immediate community. This fact should give it an appeal to local businessmen in contrast to coverage bought from an insurance company located in a distant state, where the headquarters state, not the home state of the employer, benefits from a portion of the premium dollar.

For standby, 24-hour service, the emergency room of a hospital is increasingly providing care in many communities. It is a makeshift substitute for properly organized medical services provided by a team of doctors that hospitals, like reluctant dragons, have been backed into providing. Possibly the public would have been more interested in the potentials of group practice for providing ambulatory services were it not for the availability of the hospital emergency room. Blue Cross pays for such emergency visits, and charges for such services are covered in most insurance company policies. The public can get services of a sort without the necessity of creating and organizing a separate

facility or committing themselves to receiving services from a single group of doctors. The physicians in the community welcome the emergency room approach but resist extensions of organized outpatient services to nonindigent patients. Yet the volume of patients continues to grow on the regular outpatient services.

Prepaid group practice seems to be approaching the threshold of a major expansion. Two major unions are actively promoting dual choice for their members wherever there is a group-practice alternate.[21]

## Evidence of Approaching Maturity

When the Social Security Administration first began to develop proposals for hospitalization for social security beneficiaries, there were literally no current utilization data for persons aged 65 and over available from any of the insurance carriers. This situation illustrated the general lack of concern with market analysis that is typical when a product is easy to sell. It was an every-company-for-itself situation.

The formation in 1958 of the Blue Cross Association (BCA), with adequate funds from the plans for operations, is evidence of growing maturity among Blue Cross plans. The BCA services the plans in many useful ways, including national accounts, training programs for plan personnel, special studies, and surveys. It is able to speak with a single voice for the plans; collective effectiveness has been greatly increased.[22]

Blue Shield has made some progress in the last 15 years but has not succeeded in overcoming the handicaps of variations in income ceilings among plans[23] nor has it changed plans using the pure cash indemnity approach over to the one possibly unique feature of Blue Shield—the service-benefit concept as applied to physicians' services. The service benefit in the sense of a fee schedule as full payment only if the subscriber's income is below a given ceiling not only has an unwelcome element of a means test or charity, but it is also becoming more and more of a myth as family incomes rise and the ceilings do not. One small U.S. Blue Shield plan has always provided service benefits for all members; the Canadian Blue Shield plans also early achieved "full service benefits." The patchwork of existing Blue Shield variations in the United States is well illustrated by the Federal Employees' Health Benefits Contract; employees with identical salaries may be charged additional sums for the same operation in one part of the country and not charged in another. It would be unkind to label some of the plans "juvenile delinquents."

The commercial insurance organizations seem to me to have advanced their outlook very little. Few studies in depth emanate from the central organizations. One sign of cooperative endeavor has appeared after six years of study: namely, the introduction of antiduplication clauses in some policies; but there has been great reluctance to apply these to individually purchased policies, which continue to advertise that "we pay regardless of other insurance." Until this situation is faced forthrightly, health insurance will continue to provide incentives for the overuse of services, particularly in hospitals.

Group Health Association of America, the voice of the prepaid group practice movement, has become increasingly effective working with union and other consumer groups interested in establishing community service organizations.

## Measuring Achievements

As long ago as 1950, the Social Security Administration (SSA) recognized that it was impossible to measure the achievements of voluntary health insurance in terms of kinds of care covered, or number of people enrolled, because the disparate provisions of the policies meant counting not only apples and oranges, but lemons, cherries, and some exotic fruits as well. SSA, therefore, devised dollar yardsticks, weighing insurance benefits against private expenditures. The SSA has been following trends for 16 years. Protection afforded against consumer expenditures for medical care has risen from 8 per cent to 31 per cent since 1948, a nearly fourfold expansion achieved in the face of population growth and rising costs and complexity of services. But the rate of expansion has hovered around one per cent annually for the last 10 years (Table III).

If the segments are examined separately, it is obvious that great strides have been made in insuring the privately financed hospital bill. If the amounts consumers spend on hospital care are confined to care in general hospitals with the sums expended adjusted to exclude care purchased for civilians by government, including welfare agencies, and by philanthropy, the ratio of hospital insurance benefits to private payments for hospital care is increased from 67 to 69 per cent. Were we able to remove expenditures made for luxury accommodations, it can be shown that voluntary hospital insurance is in fact within arms' length of providing the means of financing short-term hospital care.

TABLE III—AMOUNT AND PERCENT OF CONSUMER EXPENDITURES FOR MEDICAL CARE* MET BY VOLUNTARY HEALTH INSURANCE, 1948-63

(Amounts in millions)

| | *All medical care* | | | *Hospital care* | | | *Physicians' Services* | | |
|---|---|---|---|---|---|---|---|---|---|
| | | *Met by health insurance* | | | *Met by health insurance*** | | | *Met by health insurance*** | |
| *Year* | *Total** | *Amount* | *Per cent* | *Total** | *Amount* | *Per cent* | *Total** | *Amount* | *Per cent* |
| 1948 | $ 7,407 | $ 606 | 8.2 | $1,689 | $ 455 | 26.9 | $2,490 | $ 151 | 6.1 |
| 1949 | 7,682 | 767 | 10.0 | 1,802 | 539 | 29.9 | 2,501 | 228 | 9.1 |
| 1950 | 8,369 | 992 | 11.9 | 2,126 | 680 | 32.0 | 2,597 | 312 | 12.0 |
| 1951 | 9,072 | 1,353 | 14.9 | 2,334 | 897 | 38.4 | 2,697 | 456 | 16.9 |
| 1952 | 9,745 | 1,604 | 16.5 | 2,602 | 1,074 | 41.3 | 2,851 | 530 | 18.6 |
| 1953 | 10,547 | 1,919 | 18.2 | 2,909 | 1,287 | 44.2 | 3,063 | 632 | 20.6 |
| 1954 | 11,318 | 2,179 | 19.3 | 3,167 | 1,442 | 45.5 | 3,336 | 737 | 22.1 |
| 1955 | 12,292 | 2,536 | 20.6 | 3,512 | 1,679 | 47.8 | 3,433 | 857 | 25.0 |
| 1956 | 13,670 | 3,015 | 22.1 | 3,827 | 2,022 | 52.8 | 3,787 | 993 | 26.2 |
| 1957 | 14,848 | 3,474 | 23.4 | 4,137 | 2,304 | 55.7 | 4,101 | 1,170 | 28.5 |
| 1958 | 16,032 | 3,877 | 24.2 | 4,432 | 2,591 | 58.5 | 4,553 | 1,286 | 28.2 |
| 1959 | 17,503 | 4,399 | 25.1 | 4,746 | 2,945 | 62.1 | 5,101 | 1,454 | 28.5 |
| 1960 | 18,623 | 4,996 | 26.8 | 5,281 | 3,357 | 63.6 | 5,302 | 1,639 | 30.9 |
| 1961 | 19,536 | 5,695 | 29.2 | 5,737 | 3,840 | 66.9 | 5,474 | 1,856 | 33.9 |
| 1962 | 21,011 | 6,344 | 30.2 | 6,220 | 4,288 | 68.9 | 6,039 | 2,056 | 34.0 |
| 1963 | 22,618 | 6,966 | 30.8 | 6,973 | 4,648 | 66.7 | 6,385 | 2,318 | 36.3 |

*Excludes net cost of obtaining health insurance.

**In recent years includes small amount of insurance benefits for nursing services, drugs, appliances, and nursing home care. Source: Reed, L. S., Private consumer expenditures for medical care and voluntary health insurance, 1948-63, *Social Sec. Bull.*, December 1964.

As soon as we say short-term care, the question of long-term care confronts us. Some long-term care is already financed by voluntary insurance, but most of it is not, even in private hospitals and nursing homes. What goals are feasible here? Many of the same elements that gave rise to expansion of hospital and surgical insurance are present—catastrophic costs, low incidence, a relatively limited number of providers with which to make payment arrangements, potentially predictable utilization and costs. But another significant element is lacking. Long-term illness implies an end to earning capacity and discontinuation of a connection with employment. Hence resources for paying premiums are likely to be absent.

From a bare beginning in the immediate postwar years, coverage of private expenditures for hospital and physician care has expanded nearly sixfold in 17 years. But insurance for the remaining parts of the medical bill, over $9 billion annually, is in its infancy. Dental prepayment reaches 1.5 million persons but that leaves 178 million without it. There is great interest in prepaying prescription drugs; it seems likely that automation may eventually resolve the problem of aggregating claims from the multitudes of small drug items.

A federal insurance program for the aged is about to become law. Its impact will be widely felt, suggesting that this is a time for all concerned to reorient their approach to providing protection for those under 65. Will insurance companies that have now had some experience working together in the State Senior 65-coverage translate this experience into developing coverage for other substandard risks and providing more uniformity in their benefit provisions? Will Blue Cross and Blue Shield exert influence toward expanding utilization review activities? Will unions and management exhibit more concern for the whole community's access to medical care and abandon expediency for better long-range goals? How will all the pieces in this elaborate jigsaw puzzle react to the large step ahead in governmental involvement in the insurance field that will come with enactment of H.R. 6675?

The opportunity for voluntary insurance to come of voting age seems to be at hand. Hopefully, this long period of schooling will have been worthwhile. Now is the time to leave teen-age fears and insecurity behind and face adulthood with an integrated and not a split personality.

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## *NOTES AND REFERENCES*


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