88th Congress
2d Session

COMMITTEE PRINT

BLUE CROSS AND PRIVATE HEALTH INSURANCE COVERAGE OF OLDER AMERICANS

A REPORT

BY THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

TO THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

TOGETHER WITH

MINORITY AND INDIVIDUAL VIEWS

JULY 1964

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LETTER OF TRANSMITTAL

U.S. SENATE,
July 21, 1964.

Hon. GEORGE A. SMATHERS,
Chairman, Special Committee on Aging,
U.S. Senate.

DEAR MR. CHAIRMAN: I have the honor to transmit herewith a report evaluating Blue Cross and other private health insurance programs for older Americans. The report expresses the unanimous views of the majority members of the Subcommittee on Health of the Elderly. Minority views are also included.

Private health insurance is an important and valuable means of financing part of the medical care costs for part of our older population. The current report represents a major effort by the subcommittee to determine the present and potential ability of the private health insurance industry to meet the health care financing needs of our elderly citizens.

This report should be of assistance to the Members of the Congress in their consideration of legislative approaches designed to help older people meet the heavy expenses of health care.

With all good wishes.

Sincerely,

PAT MCNAMARA,
Chairman. Subcommittee on Health of the Elderly.

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INTRODUCTION

Opponents of congressional action to establish a program of hospital insurance for the elderly maintain that such action is not needed because of the existence of the Kerr-Mills program of medical assistance for the aged and the growth in private health insurance coverage of older people.

This subcommittee has described the strengths and weaknesses of the Kerr-Mills program in previous reports.[1] The analysis contained in the pages which follow is concerned with the ability of private health insurance to meet the needs of the elderly.

The principal areas of concern in appraising private health insurance are:

1. The number of older people covered by insurance.
2. The adequacy of the insurance held.
3. The premium cost of insurance—price as it affects the ability to acquire and retain insurance protection.

This report is, in large part, based upon new and extensive data heretofore unavailable. We believe this information contributes to the making of an authoritative and meaningful document which should prove helpful to the Congress.

Much of the information contained herein was developed during the months of preparation for the hearings held by the Subcommittee on Health of the Elderly in April 1964 on the subjects of "Blue Cross and Other Private Health Insurance for the Elderly." [2] Comprehensive questionnaires were submitted to and completed by the three largest commercial insurers of the aged; the Blue Cross Association, the four principal "State 65" insurance plans; the Health Insurance Association of America; and others concerned with the provision of health insurance to the aged.

Significant material for this report was also forthcoming from the testimony at the April hearings of representatives of the commercial health insurance industry, Blue Cross, government, and consumer groups.

Thus, the Subcommittee on Health of the Elderly has had the opportunity to evaluate private health insurance coverage for the aged on the basis of a vast body of information, much of which was previously unavailable. At this point, we feel it appropriate to express our appreciation to those insurance companies which invested a very substantial amount of time and effort to compile data on their programs for the aged.

The conclusions of the subcommittee, based upon analysis of all available information, are outlined in the summary which follows.

[1] "Medical Assistance for the Aged—The Kerr-Mills Program, 1960-63," October 1963; "Performance of the States, 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program," June 15, 1962; "State Action To Implement Medical Programs for the Aged," June 8, 1961.

[2] "Blue Cross and Other Private Health Insurance for the Elderly," pts. I-III, 1964.

SUMMARY

Private health insurance is unable to provide the large majority of our 18 million older Americans with adequate hospital protection at reasonable premium cost.

The Subcommittee on Health of the Elderly of the Special Committee on Aging has arrived at that conclusion following many months of intensive study of the health insurance needs and problems of the elderly.

The investigation by the subcommittee developed a substantial body of information heretofore not compiled or available. In large part, these new data (included in the body and appendix of this report) lead to the following findings concerning the inability of private health insurance to meet the needs of the aged:

1. Only 9 million of the Nation's elderly—one-half of the total—held hospital insurance policies at the end of 1962. The other half—predominately the very old, those in poor health, the unemployed, and those with the lowest incomes—were without hospital insurance coverage of any kind. They are the most difficult to insure—even in terms of acquiring the cheapest and most inadequate of policies, and, additionally, are the very ones who need the protection the most.

2. The health insurance industry has reported a substantially greater number as insured—10.3 million. The subcommittee is convinced that this is an inflated figure, concocted to create an illusion of great strides by private health insurance in extending coverage to the aged. In reality, however, the "stride" was no more than a "limp." Based on our hearings and investigation we are convinced that facts were distorted and manipulated in an effort to create an impression that Congress need consider no further action to meet the hospital insurance needs of the elderly.

For example, the Health Insurance Association of America told the Ways and Means Committee of the House of Representatives in November 1963 that "more than 2 million" aged were covered by individual company mass enrollment programs. The source they cited was their own publication which upon inspection was revealed to state "well over 1 million"—not the same as "more than 2 million." But reports to this subcommittee from the companies concerned show that at most not more than 750,000 people are covered under the individual company mass enrollment programs.

The inaccurate data furnished by the health insurance industry was used to support the "Minority Views" included in our subcommittee report of October 1963 on the Kerr-Mills program which contained the following statement:

> * * * there has been an intensive development and sale of new health insurance plans for older people. *These have included mass enrollment plans requiring no physical examination. Several companies have sold over 1 million each of such plans.* [Emphasis supplied.]

Again, reports to the subcommittee from the companies involved, indicate that all of the individual company mass enrollment plans put together insure not "several million" but less than 750,000 different people.

3. Only one in four older people holds adequate hospital insurance under the definition of adequacy established by the American Hospital Association. Well over one-half of all commercial hospital insurance policies pay only $10 or less a day toward hospital room and board charges which now cost an average of $20. Commercial insurance coverage of hospital "extras"—drugs, laboratory fees, X-rays, etc.—is equally poor. This is significant because these services cost about as much as the room and board bill.

4. For many years Blue Cross has come closest to providing adequate hospital insurance for the aged. But now Blue Cross, under competitive and cost pressures, is employing a variety of devices—deductibles, coinsurance, and dollar limits on benefits—which reduce the extent of protection. Those aged who have been adequately covered in the past will find their hospital insurance covering smaller and smaller proportions of their bills in the future.

5. The older Blue Cross subscriber is being subjected to double barreled pressure. Not only are his benefits being cut, but his premium charges are being increased with painful regularity. The cost problem is further aggravated by another development to the point where the older Blue Cross member is virtually being priced out of the market. Blue Cross plans have or are seeking to abandon the concept of "community rating" in favor of "experience rating." "Experience rating" bases premium charges on the extent of use of insurance benefits. The aged, who use far more hospital services than other subscribers, will be particularly affected. As an example of the impact of "experience rating," the chairman of the New York State Joint Legislative Committee on Health Insurance Plans told the subcommittee that premium charges to the elderly might rise as much as 100 percent within 3 years under the "experience rating" system proposed by the New York City Blue Cross Plan—the largest in the country.

6. The best of the commercial health insurance plans—the so-called "blue ribbon" policies—are so expensive that they are beyond the economic reach of most elderly persons. Although they offer only partial protection, such policies now cost an elderly couple from $500 to $600 a year, with the strong probability that further premium increases will be forthcoming.

Since the median income of aged couples in 1962 was only $2,875, it is obvious that the vast majority of them cannot afford this kind of protection.

7. The so-called "State 65" programs, where several insurance companies combine to operate a pooled-risk plan, have made virtually no progress in meeting the needs of the aged. They are costly now and will cost even more in the future. They have built-in factors—such as lack of growth in numbers covered and the increasing age of participants—which raise serious questions concerning their long-term stability.

In summary, the extensive data and testimony presented to the subcommittee led us to the firm conclusion that private health insurance—with respect to the aged—is losing ground, not making progress.

The elderly who now hold private health insurance are having great difficulty keeping even an inadequate level of protection. They find themselves squeezed between higher premiums and shrinking benefits, as hospital and medical costs continue to climb.

As a result, increasing numbers of our older people are confronted with financial catastrophe brought on by illness.

It is quite clear that the Congress has the responsibility and the obligation to act, and act quickly.

It is equally apparent that enactment of a program of hospital insurance financed through social security is the logical course for us to follow.

CHAPTER I

THE NUMBER OF OLDER PEOPLE COVERED BY HEALTH INSURANCE

Slightly more than 9 million of the 18 million older Americans hold hospital insurance policies.

The health insurance industry has claimed at least 1 million more aged are insured than is indicated by the total we have cited above. The Health Insurance Association of America says that "10,300,000 aged were insured at the end of 1962—60 percent of the noninstitutional aged population."

The dispute over this 1 million difference goes to the core of the controversy over the most suitable methods of financing hospital insurance for the elderly. Conceivably, the disparity could be the result of honest differences of methodology. But, extensive data developed by this subcommittee leads to the firm conclusion that the inflated coverage figures of the health insurance industry were concocted to create the impression that commercial health insurance coverage is expanding so rapidly that Congress need consider no further action on the problem. To create an illusion of tremendous strides by private health insurance in covering the aged would undoubtedly have an effect upon congressional consideration of health care measures such as the King-Anderson proposal. In reality, however, the "stride" was no more than a "limp."

This "numbers game" has most serious implications for the well-being of our older people. It is one thing to present a point of view in the most favorable light possible. It is quite another thing to substitute fancy for fact.

A clear-cut example of our concern over the accuracy of the claims of the Health Insurance Association of America occurred last November. On November 22, 1963, the association (a registered lobbyist) appeared before the Ways and Means Committee of the House of Representatives to testify in opposition to H.R. 3920, the King-Anderson bill. During the course of their testimony, spokesmen for the Health Insurance Association said:

> Today the aged have available coverage through (1) individual company mass enrollment programs, first introduced about 5 years ago and affording coverage irrespective of condition of health, which *have already enrolled over 2 million senior citizens.* [Emphasis supplied.]

A footnote to that statement cited as the source of the claim a publication of the Health Insurance Association of America, "An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of December 31, 1962, Health Insurance Association of America, July 1963." This subcommittee examined the source document which says:

> Through a development of the last 4 years, a mass enrollment approach whereby all persons 65 years of age and older

> in a given State can be insured regardless of present or past condition of health, *well over 1 million aged persons have become insured.* [Emphasis supplied.]

The statement "well over 1 million" is not quite the same thing as "more than 2 million." But, there is more to this story.

In November of 1963, only three insurance companies wrote the mass enrollment policies referred to by the Health Insurance Association of America. The programs involved were the "Golden 65" plan of the Continental Casualty Co., the "Senior Security" plan of Mutual of Omaha, and the "Fund 65" policy offered by the Fireman's Fund Insurance Co.

The three companies concerned reported their enrollment to this Subcommittee. The most generous interpretation of the data supplied (see appendix A) yields a total of *less than 750,000 different senior citizens covered* by the mass enrollment programs at the end of 1963—about one-third of the 2 million originally claimed by the HIAA.

The extent to which the health insurance industry misinformation has been relied upon is evident even within our own subcommittee. In the "Minority Views" incorporated in our October 1963 report on the Kerr-Mills program, the following statement was made about the "mass enrollment" programs offered by individual health insurance companies:

> According to a report made by J. F. Follmann, Jr., director of information and research, Health Insurance Association of America, at the end of 1961, 55 percent of the people past 65 had voluntary health insurance coverage.
>
> It should be noted that this report is almost 2 years old. Since then there has been an intensive development and sale of new health insurance plans for older people. *These have included mass enrollment plans requiring no physical examination. Several companies have sold over 1 million each of such plans.* [Emphasis supplied.]

As we have noted, the three companies offering mass enrollment plans which do not include the right on the part of the company to refuse to issue policies because of the older person's medical history, *in total, have less than 750,000 different people covered.*[1]

This example of figure padding is rather clear cut. Later sections of this report describe more subtle variations of the "numbers game."

Other data made available to the Subcommittee on Health of the Elderly in response to its questionnaires also indicate that Blue Cross and other private health insurers—such as the Continental Casualty Co.—have substantially overstated the numbers of different aged people to whom they provide hospital insurance.

SURVEYS TO DETERMINE THE NUMBER OF AGED INSURED

During the past year, three reports have been made public relative to the number of older people holding health insurance. The earliest of the three, that of the Health Insurance Association of America,

[1] (*a*) Continental Casualty Co.: 256,000 different people covered under "Golden 65."
(*b*) Fireman's Fund: 42,000 different people enrolled in "Fund 65."
(*c*) Mutual of Omaha: 450,000 policies of all types issued under its "Senior Security" program (including 83,500 policies which the company could have refused to issue on the basis of medical history, and 145,000 "weekly indemnity" policies which only provide a supplemental hospital benefit of $7.14 daily).

claimed 10,300,000 different persons covered by some form of health insurance, "60 percent of the noninstitutionalized aged," at the end of December 1962. The HIAA claim was based upon reports from 123 of its member insurance companies and projected to include the association's estimate of the number of elderly insured by nonmember companies. HIAA then added to its total the enrollment of Blue Cross and other noncommercial insurers.

The second report was made by the National Health Survey of the U.S. Public Health Service based upon household interviews conducted during the period July 1, 1962, through June 1963. That report indicated 9,100,000 different older people insured—"approximately 54 percent of the civilian, noninstitutional population." (An estimated 750,000–800,000 of the elderly are institutionalized.)

The third report was that made by the Social Security Administration predicated upon interviews of the elderly in households and institutions by the Bureau of the Census. That survey revealed that 9 million of the total population (including those in institutions)—some 51 percent of our elderly—held hospital insurance at the end of December 1962.

The social security "Survey of the Aged" noted that relatively few of the elderly in institutions have hospital insurance policies. But, assuming that as many as 10 percent of the institutionalized aged held hospital insurance policies, this would add about 80,000 people to the National Health Survey's 9,100,000. The difference in the totals reported by the National Health Survey and the Social Security Administration is relatively slight and may, in part, be accounted for by the fact that the report of the National Health Survey spanned a different period of time. The addition of the approximately 80,000 institutionalized aged with insurance to the National Health Survey's total of 9,100,000 for the noninstitutionalized elderly would result in a finding that 52 percent of the total older population hold some form of hospital insurance.

The survey conducted for the Social Security Administration by the Bureau of the Census yielded, in our opinion, the most accurate estimate of the number of aged covered by hospital insurance. The National Health Survey included the aged within a survey of all ages, while the social security study concentrated exclusively on older people. Nonetheless, as we have noted, the difference between the two surveys is very slight. The findings of the Health Insurance Association of America, however, are subject to serious question.

CRITICISM OF HEALTH INSURANCE ASSOCIATION'S METHODOLOGY

Our first disagreement with HIAA stems from that organization's conclusion that its reports from member-insurers and projections for nonmembers, indicate that "60 percent of the noninstitutionalized aged" are protected by "some form of health insurance." The key words, at this point, are "noninstitutionalized aged." For, unless specifically omitted (and the member companies were not asked to do so), the insurance company reports would include in their totals the elderly in institutions who held policies. Thus, the percent of older people with hospital insurance should have been calculated on the basis of the total aged population—including those hundreds of thousands in institutions.

How is "hospital insurance" defined? Basically, a hospital insurance policy is one which includes benefits for specified services—for example, a separate benefit for hospital room and board charges, and a separate benefit for hospital "extras." Hospital "extras" include items such as laboratory and X-ray services, drugs, use of the operating room, etc.

Both the National Health Survey and the Social Security Administration define "hospital insurance" as we have outlined. The Health Insurance Association of America similarly defined "hospital insurance" in its July 1961 report on the number of aged insured. In his testimony before this subcommittee on April 28, 1964, the research director of HIAA, Mr. Joseph F. Follmann, Jr., referred to hospital insurance in terms of specific allowances for hospital room and board charges and specific allowances for hospital "extras."

We stress the definition of hospital insurance coverage because of an important fact: The Health Insurance Association of America in its last published survey of the aged which stated that "10,300,000 elderly held health insurance on December 31, 1962," altered the definition (without mentioning the alteration) from that used in its previous survey of July 1, 1961. The effect of changing the definition of hospital insurance was to present an inaccurate and misleading picture of the growth of private health insurance coverage for the aged between July 1, 1961, and December 31, 1962.

The Health Insurance Association of America told the Ways and Means Committee on November 22, 1963:

> In July 1961, insurance companies covered 4¾ million persons aged 65 and over. Eighteen months later, in December 1962, the number of aged covered by insurance companies had increased by 28 percent to more than 6 million. In addition, Blue Cross reported that, as of the end of 1962, 5.3 million aged were covered under their plans.
>
> Allowing for those persons covered under more than one policy, the number of aged with voluntary health insurance in December 1962 was 10.3 million or 60 percent of the non-institutionalized aged population.

The technique employed by HIAA in December 31, 1962, to inflate the number of aged policyholders of commercial insurance was simply to debase the generally accepted definition of "hospital insurance" to include the so-called weekly or monthly indemnity policies. They no longer required that a hospital insurance policy provide a benefit toward room and board charges and a benefit toward the cost of hospital extras. This altered definition allowed them to count hundreds of thousands of policies which pay a minimal flat dollar allowance—completely unrelated to hospital charges or services—for each day that the older person is hospitalized.

These weekly indemnity policies are nothing more than a supplemental type of coverage to be added by someone already holding hospital insurance. In this regard, it resembles surgical and medical insurance. One such policy offered by Mutual of Omaha provides the older person with the handsome sum of $1.67 a day—or $50 per month. Other Mutual of Omaha policies pay $3.33 or $7 a day.

Acknowledgment of the supplemental nature of such policies came from the Bankers Life & Casualty Co., in their statement to this Subcommittee, when they referred to "supplementary coverage such as

weekly indemnity during hospitalization." The function of the weekly indemnity policy is to provide the older individual with some additional cash in order to help him meet expenses arising out of his illness which are not covered or only partially covered by his hospital insurance policy. It is a distortion of the facts to count weekly indemnity policies as bona fide hospital insurance coverage.

There are several additional factors which make the findings of the Health Insurance Association of America subject to question. First, the reports of their member companies on aged people covered often include dependents under age 65. For example, a group certificate holder of age 70 may have a wife who is only 60 but they would be counted as two older policyholders in the HIAA survey. (Parenthetically, it is interesting to note that the Bureau of the Census found that among all aged couples—defined as "one or both spouses age 65 or over"—40 percent included one spouse under age 65.) A careful reading of HIAA's methodology (see app. C–1) indicates that no reduction was made in their totals to adjust for spouses under 65.

The second flaw in the Health Insurance Association of America's methodology concerns their estimates of older people insured by nonmembers of the association. They assumed that the proportion of aged enrollment to the total is roughly the same as the proportion of accident and health insurance premiums written to total premiums. This is in error. For example in December 1962, the 123 member companies reported a total of 4.8 million aged policyholders (not necessarily different people as many hundreds of thousands of aged hold more than one policy). The HIAA projected, with some modifications, the number of aged policyholders insured by nonmembers by a rather imprecise method. HIAA said:

> Since the health insurance premium volume of these companies (the 123 members) is about 70 percent of the total health insurance premium volume written by insurance companies in the United States, it is estimated that, among all insurance companies in the United States, there were slightly over 6 million senior citizens covered as of the end of 1962.

The fallacy of this method is very simply demonstrated. The Prudential and Metropolitan Life Insurance Companies, for example, were among the 123 reporting members. Those two companies accounted for 15 percent of the total accident and health insurance premiums written in 1962, yet their aged enrollment represents less than 9 percent of HIAA's 6.1 million total.

NUMBER OF AGED COVERED BY BLUE CROSS

The HIAA's claim of 10,300,000 aged covered is further upset by the fact that they attributed a total of 5,300,000 aged subscribers to Blue Cross as of December 31, 1962. Actually, this figure overstates Blue Cross coverage by 355,000.

The Blue Cross Association reported to the subcommittee a total of 5,219,000 elderly covered as of January 1, 1963 (see app. D–1), including 275,000 aged persons on public assistance, whose premium costs are paid by State welfare departments. Obviously, these 275,000 people on relief are not Blue Cross subscribers in the normal sense of the term. Most of them have special policies providing substan-

tially less coverage than that available to regular Blue Cross subscribers. It is clearly apparent that these 275,000 people on public assistance cannot be used to inflate a total to indicate that private health insurance is "doing the job" and that Government action is not needed when government already is paying the full cost of their insurance.

The fact that Blue Cross had 80,000 subscribers less than the total used by HIAA, plus the fact that an additional 275,000 elderly included in the Blue Cross figure are there only because of being on relief rolls, requires a downward adjustment of 355,000.

THREE LARGEST COMPANIES INSURING OLDER PEOPLE

One of the most confusing aspects of seeking to determine the numbers of aged persons covered by private health insurance was the fact that most companies don't know how many different older people they insure. Claims are made in terms of so many policyholders insured. But, as we found out, there is a substantial difference between a total of policyholders and the number of different people covered. In this context, it should be understood that most people would interpret a claim of "1,450,000 policyholders over age 65" as meaning 1,450,000 different aged persons covered. But this is not the case. Many hold more than one policy with the same company. A person with three policies for example, would be counted as three policyholders.

To illustrate, Continental Casualty gave widespread publicity to the claim that the company had "1,450,000 aged policyholders." In fact, however, the company, under questioning by the subcommittee, admitted that it has no more than 900,000 different people 65 and over insured. The 900,000 total may also be high for it includes in part, dependents under age 65 and enrollment in special group plans where persons under age 65 may participate. Furthermore, not all of the 900,000 different people are covered for hospital insurance.

Continental Casualty's "Golden 65" program has three separate component plans. An older person may apply to participate in one or all three plans. A separate policy is issued for each plan in which he is enrolled. Thus, as of December 31, 1963, the "Golden 65" program had 396,000 policies issued to 256,000 different people.

The subcommittee appreciates the fact that the Continental Casualty Co. cooperated by investing a substantial amount of effort in developing the information required. In developing information for the subcommittee Continental Casualty officials also discovered that they had overstated the total hospital policies on aged persons in their report to the Health Insurance Association of America, by some 370,000 policies.

The Bankers Life & Casualty Co. (a nonmember of the Health Insurance Association of America) also cooperated fully with the subcommittee. Bankers Life had not, prior to our inquiry, surveyed the number of aged to whom it provided hospital insurance.

The initial response of Bankers Life did not reveal the number of different persons insured but only the number of policies issued. Bankers Life advised the subcommittee that they had 665,000 hospital insurance policies issued to people 65 and over plus an additional 98,000 supplemental "weekly indemnity" policies outstanding.

As Bankers Life & Casualty has written a substantial number of policies offering relatively limited protection, the subcommittee assumed that a large percentage of the company's policyholders hold more than one policy with Bankers Life. Confirmation of this assumption came subsequent to the close of the hearings.

The best policy offered to the elderly by Bankers Life is its "P–27" contract. The company has more than 143,000 of the "P–27" policies issued to the aged. At the request of the chairman of this subcommittee, Senator McNamara, Bankers Life undertook to determine just how many of its "P–27" policyholders held other hospital insurance policies with Bankers Life. As the following letter indicates, a statistically valid sample revealed that 37 percent held more than one hospital insurance policy (not including weekly indemnity policies) with Bankers Life.

Based upon this finding by the company, it is reasonable to assume that Bankers Life has approximately 500,000 different aged persons covered under 665,000 hospital insurance policies. Of course, many of the 500,000 undoubtedly hold hospital insurance policies with other insurance companies as well, so a further decrease in the total would be necessary to allow for duplication when those covered by Bankers Life are added to the overall total of all aged with hospital insurance.

BANKERS LIFE & CASUALTY CO.,
Chicago, Ill., June 8, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: In accordance with your request we made a special study to determine the number of our policyholders 65 and over who have other hospital policies with us.

To determine this we took a sample of 6 percent of our total in force for our senior citizens hospital-surgical policy (P–27) and checked each policy for other hospital policies in force. We found that 36.95 percent of the P–27 policyholders had another hospital policy with us.

We hope this information will be helpful.

Yours very truly,

EDWARD J. KELLY, *First Vice President.*

Mutual of Omaha reported a total of 1,281,000 policies of all types held by people age 65 and over. A substantial percentage of these would be surgical-medical, accident, and other nonhospital insurance policies. (In this connection note Bankers Life & Casualty's 337,000 surgical-medical only policies.) The company says it does not know how many *different older people* it insures.

Some 220,000 of the 839,000 policies reported by Mutual of Omaha as issued to people at age 65 or over—or more than 25 percent—are of the "weekly indemnity" variety—not hospital insurance as generally defined. Another 17,000 of their policies offered coverage for "dread diseases" only—again, not hospital insurance as generally defined. Subtraction of the nonhospital insurance policies leaves a total of 600,000 policies offering hospital coverage.

On the basis of the data supplied by companies writing health insurance comparable to that offered by Mutual of Omaha—such as Bankers Life & Casualty and Continental Casualty—as well as information supplied by the company itself, we believe that (1) Mutual of

Omaha has approximately 500,000 different older people covered under hospital insurance policies; and (2) of these 500,000 different people, not more than 300,000 are covered for hospital insurance under the company's "Senior Security" program.

The findings detailed in the preceding paragraph are particularly interesting in view of a claim made by Mutual of Omaha in its 1963 "Annual Report and Financial Statement." Referring to a 111-year-old policyholder, the company said: "He is symbolic of the more than 1,300,000 persons age 65 and over who rely on Mutual of Omaha and its famous Senior Security policy."

DUPLICATION OF POLICIES

As we have indicated, a substantial percentage of the elderly with hospital insurance hold more than one policy.[2] This multiple policy holding takes two forms: (1) more than one policy with the same company and (2) one policy with one company and additional policies with other companies. For these reasons it is necessary to subtract from the total of all policies held by older people, a specified percentage in order to arrive at the number of different people covered. This percentage adjusts for multiple policy holding by the older person within the same company and between companies.

The Health Insurance Association has taken the total of all commercial, Blue Cross and independent plan health insurance and reduced them by 13 percent to arrive at their estimate of the number of different aged people insured. Based upon the data presented in the preceding pages on the high percentage of multiple policy holding just within the same company, alone, (for example Continental Casualty and Bankers Life) the HIAA 13-percent factor appears much too low. It is readily conceivable that the overall percentage reduction should be as much as 20 percent.

The U.S. Public Health Service, in its study of the aged noted that 13½ percent of the aged surveyed indicated that they held other hospital insurance policies. HIAA has used this fact to justify its own low 13-percent factor. But, during the course of questioning on this point by Senator McNamara, Dr. Forrest E. Linder, Director of the Public Health Service's National Center for Health Statistics stated: "We feel that the under-reporting of this item is very substantial." The National Health Survey, of course, at the time its report was prepared, did not have the benefit of the information on multiple policy holding developed for this subcommittee.

The data on multiple policy holding provided to this subcommittee by Continental Casualty and Bankers Life are based upon samples far more extensive than those used by the Health Insurance Association of America to justify its 13-percent factor. Indeed, the HIAA sample is far less reliable because it was based upon a sample of policyholders of all ages, rather than on a specific survey of older policyholders.

[2] Continental Casualty, for example, reported that some 43 percent of 100,000 applications for individual health insurance received from older people during 1961-63 noted that the applicant held other health insurance policies. All of these, of course, were not hospital policies, but the high percentage indicating other coverage does provide an indication of the extent of multiple policy holding. (See app. A-2.)

TERMINATION OF HEALTH INSURANCE

An important consideration in evaluating health insurance for the elderly is an understanding of the extent to which older people, for one reason or another, drop their policies or have them canceled or terminated. In response to a question at our hearings the Health Insurance Association of America stated that it had no information on this vital question.

However, through the cooperation of the Continental Casualty Co. and Bankers Life & Casualty Co., the subcommittee does have the benefit of meaningful data (see app. A) shedding light on the degree to which the elderly, voluntarily or involuntarily, lose the protection of health insurance.

The data in appendix A indicate that, even allowing for attrition by reason of death, the turnover among older policyholders is extremely high. In Continental Casualty's "Golden 65" program, for example, 80,000 policies (not necessarily that many people, for some may have held more than 1 policy) were dropped during 1963 alone. Bankers Life & Casualty reported that of 76,764 policies issued during 1961 for its special plan for the elderly, only 41,130 were still in force at the end of 1963—a loss of 46 percent. Of 77,631 similar policies issued during 1962, only 48,446 were still in effect at the end of 1963—a drop of 38 percent. Many of these terminations are attributable to the death of the policyholder. But, based upon the hundreds of letters received by the subcommittee, many more undoubtedly dropped their protection because of an inability to continue premium payments.

None of these policyholders who dropped their coverage was forced to do so because of cancellation or termination. The policies for which data were shown are guaranteed renewable. However, both companies also issue other types of policies where they can and do exercise their option to cancel or terminate coverage. Continental Casualty advised the subcommittee that during the years 1961 through 1963 more than 9,000 people ages 65 and over had their health insurance policies either canceled or not renewed by the company. Thousands of other older persons who had filed claims were either required to agree to waive future benefits for certain illnesses or accept substandard coverage as preconditions to the continuation of their policies.

Detailed data similar to that furnished by Continental Casualty were not provided to the subcommittee by either Bankers Life & Casualty or Mutual of Omaha. However, careful study of the "Post-Claims Underwriting Manual" of Bankers Life indicates that the practices of that company with regard to cancellation, termination, etc., of individual health insurance would be comparable to those of Continental Casualty. Indeed, all three companies offer essentially the same types of individual health policies to the elderly. It can be assumed that because of competitive circumstances, their underwriting procedures are similar.

But the older person may not only be required to take reduced benefits and/or pay higher premiums after he has been issued a policy. He may very well have had to accept such conditions before being initially issued a health insurance policy. Continental Casualty, in its response to the questionnaire of the subcommittee reported that

37 percent, or more than one-third, of the 98,431 applications for individual health insurance, received during the period 1961 through 1963 from people 65 and over, were waivered and/or rated by the company. That is, the applicants had to agree to accept lower benefits and/or higher premiums than those standard to the policy applied for. In contrast to this, Continental Casualty waivered or rated only 14 percent of the applications for individual coverage received from persons under age 65 during the same period, demonstrating the extra load carried by older people.

No doubt the companies had sound business or actuarial reasons for canceling, terminating, or increasing the cost of insurance protection to people over age 65. But justification of these practices in terms of the aged being poor insurance risks does not solve the problems of those people who find themselves forced to take limited coverage or, even, as we have indicated, suffer complete loss of their health insurance at a time when their health insurance needs are greatest.

CHAPTER II

ADEQUACY OF HOSPITAL INSURANCE FOR THE ELDERLY

The subcommittee has found that only one in four of our 18 million older Americans hold hospital insurance which can be considered as reasonably adequate under acceptable standards of quality. But even those people who are now reasonably well protected will soon find their hospital insurance covering smaller and smaller proportions of their bills due to the steadily rising costs of hospital care. The results of this will be either a reduction in benefits, an increase in premiums, or both.

SIGNIFICANCE OF HOSPITAL INSURANCE

Within the spectrum of medical expense, the costs of hospital care have the greatest impact upon the elderly. The older person requiring hospitalization incurs total annual medical costs which are 5 to 10 times as great as those of the individual who has not been in a hospital. One-half of the total annual medical expenses of the person who needs hospital care are directly attributable to his hospital bills.

As we have noted, the Bureau of the Census recently undertook an extensive survey of the aged for the Social Security Administration. The survey revealed that where one or both spouses had been hospitalized during the year 1962, aged couples had total medical expenses averaging $1,200—of which $600 was accounted for by hospital bills. Comparable figures for the nonmarried elderly were $1,040 and $540.

Thus, some one-half of the total medical expenses of an older person who requires hospitalization are for items outside of the hospital. Nonhospital medical expenses—doctors' fees, prescribed drugs, dental fees, private nursing, and so forth—which comprise such a substantial portion of total medical costs, are precisely those areas which are only partially covered or not covered at all by health insurance. Obviously, then, unless most, or all, of his hospital bill is covered by insurance, the older person cannot possibly cope with his out-of-hospital medical costs without seriously depleting or exhausting his already limited financial resources. Given such a situation, it is readily apparent why one-third of the older people applying for public relief programs cite problems of health as the principal reason for application.

Table I indicates the extent to which the need for hospitalization affects the total medical costs of an older person in comparison with the dramatically lower medical costs of the aged who do not require hospital care during the year. Table II offers data concerning the costs of short-term hospital care to older people who were hospitalized during 1962. Both of these tables vividly demonstrate that the older person's fear of hospitalization as a threat to his economic independence is well founded.

TABLE I.—*Medical costs incurred and hospitalization status of persons 65 and over: Percentage distribution of aged by amount of costs, hospitalization status, marital status, and sex, 1962*

Medical costs incurred [1]	Married couples		Nonmarried men		Nonmarried women	
	In hospital [2]	Not in hospital [3]	In hospital [2]	Not in hospital [3]	In hospital [2]	Not in hospital [3]
Total: Number (thousands)	1,291	4,100	362	1,813	878	5,035
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Reporting costs [4]	76.0	91.4	52.8	88.9	62.9	89.5
Not reporting costs	24.0	8.6	47.2	11.1	37.1	10.4
Care without charge [5]	17.3	6.1	38.1	9.7	28.1	8.8
Cost unknown	6.7	2.5	9.4	1.4	8.9	1.6
Reporting costs [4]	100.0	100.0	100.0	100.0	100.0	100.0
None incurred	----	3.4	----	18.3	----	10.0
$1 to $99	----	30.6	2.1	51.2	1.3	44.7
$100 to $199	3.4	21.7	5.2	15.1	3.6	24.0
$200 to $299	2.3	16.9	8.9	6.0	9.1	9.8
$300 to $399	5.6	11.2	11.0	4.1	8.9	4.6
$400 to $499	8.3	5.2	5.8	2.4	8.5	2.5
$500 to $749	19.0	6.7	11.0	1.8	22.8	3.2
$750 to $999	15.1	2.4	19.9	.5	10.0	.3
$1,000 to $1,499	19.7	1.3	18.3	.6	17.2	.5
$1,500 to $1,999	10.6	.2	4.7	----	8.9	.2
$2,000 to $2,450	7.6	.1	3.1	----	4.3	.2
$2,500 or more	8.5	.1	9.9	----	5.3	.1
Median cost	$938	$173	$820	$61	$703	$89
Mean cost	$1,220	$233	$1,084	$102	$1,022	$142

[1] Includes costs met by health insurance but excludes the premium of the insurance.
[2] In general and short-stay special hospitals. In the case of couples, 1 or both members were hospitalized.
[3] Excludes persons in nursing homes and long-stay hospitals.
[4] Units reporting total medical costs of known amounts without any care provided by Government or private voluntary agencies; units assuming responsibility for payment out of their own resources, including health insurance, or with the help of relatives.
[5] Units receiving some or all care provided through Government or private voluntary agencies, or supplied by a doctor or hospital with no bill rendered.

Source: "Medical Care Costs for the Aged," an article based upon 1963 Survey of the Aged which will appear in July 1964 issue of the Social Security Bulletin.

TABLE II.—*Short-stay hospital costs incurred by persons 65 and over. Percentage distribution of aged by amount of costs, marital status, and sex, 1962.*

Hospital costs incurred [1]	Married couples [2]	Nonmarried men	Nonmarried women
Total number (thousands)	1,291	362	878
Percent	100.0	100.0	100.0
Reporting costs [3]	79.9	54.4	65.1
Not reporting costs [4]	20.1	45.6	34.9
Care without charge	14.9	37.6	26.3
Cost unknown	5.3	8.3	8.5
Reporting costs [3]	100.0	100.0	100.0
$1 to $99	8.7	14.2	7.3
$100 to $199	17.7	16.8	18.5
$200 to $299	14.5	14.7	19.9
$300 to $399	10.9	6.1	9.4
$400 to $499	7.0	5.6	8.0
$500 to $749	17.2	19.8	18.4
$750 to $999	7.8	8.6	6.8
$1,000 to $1,499	7.9	8.1	6.1
$1,500 to $1,999	3.5	4.6	2.3
$2,000 to $2,499	2.7	1.0	1.6
$2,500 or more	2.2	1.0	1.6
Median cost	$383	$366	$344
Mean cost	$588	$525	$541

[1] In general and short-stay special hospitals; includes costs met by insurance, excludes premium costs.
[2] With one or both members hospitalized.
[3] Units reporting total medical costs of known amounts without any care provided by government or private voluntary agencies; units assuming responsibility for payment out of their own resources, including health insurance or with the help of relatives.
[4] Units receiving some or all care provided through government or private voluntary agencies, or supplied by a doctor or hospital with no bill rendered.

Source: "Medical Care Costs for the Aged," an article based upon 1963 Survey of the Aged which will appear in July 1964 issue of the Social Security Bulletin.

STANDARD OF ADEQUACY OF HOSPITAL INSURANCE

Perhaps the best yardstick for measuring the adequacy of hospital insurance is that applied by the American Hospital Association in its "approval" program for Blue Cross plans. In order to receive recognition as an "approved" Blue Cross plan, the plan's insurance contracts must cover "not less than 75 percent of the total amount billed for usual and customary hospital services rendered on an inpatient basis in multiple-bed accommodations."

A leader of an important segment of the commercial health insurance industry also supported use of the "75 percent or more" yardstick. In his testimony before this subcommittee on April 28, 1964, Mr. Morton Miller, president of the "New York 65" health insurance program (and vice president of the Equitable Life Assurance Society), stated that the "New York 65" plan was designed and intended to cover "about 75 percent of the hospital costs within the limits of the benefits provided."

Other representatives of the commercial health insurance companies and their industry association were unwilling to define concretely an adequate hospital insurance policy. They pointed instead to the types of policies available. On this point, Senator Muskie commented: "I am not talking about what is available; I am talking about what they have."

The director of the social security department of the AFL–CIO, Mr. Nelson Cruikshank, also remarked during our hearings on the "availability of private health insurance." Mr. Cruikshank said:

> * * * it is interesting to us that as we were here to see the picture that was suggested by representatives of the insurance industry that people have a great smorgasbord of policies before them and apparently operating with complete freedom to determine what kind and extent of insurance is tailored to their individual needs, and then buy that which is available.
>
> One representative kept inserting a note that insurance was available to everyone in the country; everyone over 65 had a policy available to him. Well, this I suppose is true exactly in the sense that every person in the United States has a Cadillac available to him, if he could meet the conditions of the Cadillac agency in his community * * *.

It is important to know the kinds of hospital insurance policies available to the aged. But this information is virtually meaningless unless related to the kinds of policies older people actually have been able to afford, and the extent to which those policies actually meet hospital expenses.

The average costs per patient-day in short-term general hospitals now approximate $40. Of that amount, some $20 is for the cost of room and board, with the balance going for miscellaneous hospital charges such as X-rays, laboratory fees, medications, etc.

In view of the facts we have cited, we agree with the American Hospital Association that hospital insurance covering less than 75 percent of the hospital bill is manifestly inadequate. A good case can be made that any policy covering less than 100 percent of the hospital bill is inadequate in terms of the medical and financial situation of the elderly.

PROPORTION OF THE ELDERLY WITH "ADEQUATE" HOSPITAL INSURANCE

Half of the Nation's older people hold hospital insurance policies. But only slightly more than half of those who hold policies are "adequately" protected under the definition of the American Hospital Association.

According to the 1963 Bureau of the Census "Survey of the Aged" only 55 percent of those who were hospitalized during 1962 and who held hospital insurance had 75 percent or more of their bills covered.

An unpublished study undertaken by the Health Insurance Association of America [1] reported that in July 1961 more than half of the elderly holding commercial hospital insurance policies were eligible for daily room-and-board benefits of only $10 or less. Table III, extracted from the HIAA study, notes that 53 percent of the policies covered $10 or less of the daily room and board charge.

[1] "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of July 1961."

TABLE III

(A.) Extent of health insurance among persons 65 years of age and older by 90 insurance companies [1] by type of coverage, July 1961

Type of coverage	Total	Group	Individual and family
Hospital expense	3,615,140	1,715,169	1,899,971
Surgical expense	3,185,937	1,711,249	1,474,688
Regular medical expense	1,098,878	951,646	147,232
Major medical expense	730,140	594,529	135,328

[1] These companies write ⅔ of the U.S. health insurance premium.

(B.) Extent of hospital expense insurance among persons 65 years of age and older by 90 insurance companies [1] by quality of coverage, July 1961

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Daily hospital room and board benefit:						
$15 and over	1,049,478	29	696,489	41	352,989	19
$11 to $14	657,440	18	502,149	29	155,291	8
$10 or less	1,908,222	53	516,531	30	1,391,691	73
Maximum duration of stay:						
71 days and over	1,489,758	41	576,340	34	913,418	48
32 to 70 days	901,557	25	568,500	33	333,057	18
31 days or less	1,223,825	34	570,329	33	653,496	34
Ancillary hospital expense benefit:						
$500 and over	985,950	27	562,176	33	423,774	23
$200 to $499	749,077	21	520,108	30	228,969	12
Less than $200	1,880,113	52	632,885	37	1,247,228	65

[1] These companies write ⅔ of the U.S. health insurance premium.

All indications are that the percentage of aged with commercial hospital insurance policies paying $10 or less for daily room and board charges is substantially greater today than the 53-percent figure for July 1961.

The main reasons for this are that the principal mass enrollment programs offered to the aged by commercial insurers since July 1961 have been the "Senior Security" plan of Mutual of Omaha, and the "Golden 65" program of the Continental Casualty Co., both of which have a basic $10 a day allowance toward hospital daily room and board charges. Further, HIAA's data on room and board allowances do not include the large number of Bankers Life & Casualty policies most of which, according to the company, "would probably be around $10 a day."

Thus, the large majority of older people who have commercial hospital insurance hold policies paying $10 or less at a time when daily room and board charges average $20.

The inadequacy of commercial hospital insurance allowances toward room and board charges is compounded by equally meager coverage of hospital "extras." As we have noted, the daily cost of hospital extras—X-rays, drugs, operating room charges, laboratory fees, etc.—averages about the same as the cost of room and board. Thus, to the $20 average daily hospital charge for room and board, must be added an additional $20 for hospital "extras"—a total of $40 per day.

The maximum benefit for hospital "extras" under most commercial hospital insurance policies is calculated on the basis of 10 times the daily room and board allowance. Thus, a policy with a $10 daily room benefit would cover up to a maximum of $100 during the period of hospitalization.

As table III (above) indicates, 52 percent of commercial hospital insurance policies allowed less than $200 for ancillary hospital expenses—or hospital extras. However this figure is misleading because the majority of older people with commercial hospital insurance are covered for $10 a day or less for room and board—and have therefore in most instances, a maximum of $100 toward ancillary hospital expense.

The Health Insurance Association of America, and its information arm, the Health Insurance Institute have in numerous press releases hailed the growth in the number of aged covered by private health insurance. They have, however, demonstrated a pronounced reticence in coming forward with information on the quality of commercial health insurance. For example, the information contained in parts A and B of table III were collected at the same time. The data in part A on the number of aged holding insurance were released in 1961. The information in part B—indicating definite failings in the quality of commercial insurance—was not made public, however, until late 1963.

"ADEQUACY" OF BLUE CROSS COVERAGE

As we have noted, only one-half of the aged with hospital insurance policies can be considered as adequately covered under the definition of the American Hospital Association. Most of those who are adequately covered are insured by Blue Cross.

We have noted the ineffectiveness of most commercial hospital insurance policies which pay only up to specified dollar limits for necessary care regardless of the actual charges for the hospital services required. Many Blue Cross plans have, at least heretofore, offered subscribers protection on the basis of the care provided—that is, service benefits. Service benefits are offered on the basis of coverage of so many days of hospital room, board, and extras. Covered services are generally provided in full without dollar limits. Thus, a Blue Cross subscriber requiring care costing $40 could have that completely covered as might another subscriber whose care cost $100 a day.

The American Hospital Association states in its "General Principles for Approval of Nonprofit Hospital Service Plans," that: "Plans should arrange for service benefits to members rather than provide cash allowances for the purchase of hospital care."

While a number of Blue Cross plans have offered policies paying specified dollar amounts only—for example, $12 or $15 daily toward room and board charges—the larger plans have traditionally made service benefits available to their subscribers. Service benefits obviously cover all or most of the hospital bills, and this unique method of coverage is the reason why Blue Cross accounts for most of the adequate coverage available to the elderly.

But, both Blue Cross and its elderly subscribers are in trouble. Blue Cross plans are to a greater and greater extent (see app. D–2) abandoning the commitment to service benefits and offering contracts which provide dollar allowances for specified services, and include

deductible, copay and coinsurance provisions.[2] These limiting and restrictive provisions are particularly prevalent in the so-called new and expanded senior citizens contracts offered by Blue Cross plans during the last several years. Thirty-four of the sixty-seven Blue Cross plans offering special senior citizen contracts cover less than the full cost of hospital room and board charges (see app. D–2).

An extreme example of an inadequate Blue Cross program for the aged is found in Texas. The Blue Cross plan in Texas provides a special contract of hospital benefits for 230,000 recipients of old-age assistance relief. The contract pays $10 a day plus the cost of extras for 15 days; it then pays $6 daily toward room and board charges and 50 percent of the cost of hospital extras. Premiums for the coverage are paid by the Texas Department of Welfare. Blue Cross has, in the past, included these 230,000 aged in its total of policyholders. The benefits provided to the aged on relief are, however, substantially lower than those afforded regular subscribers.

A highly revealing indication of the quality—or rather lack of quality—of the Texas Blue Cross policy for people on relief was contained in a copy of a letter submitted to this subcommittee by the Texas "65" Health Insurance Association (see app. B–4).

The letter referred to was dated July 25, 1963, and addressed to Mr. H. Lewis Rietz, executive vice president of the Great Southern Life Insurance Co. It was written by Mr. Harvey Galloway, Jr., an insurance company actuary heading the group engaged in developing premium rates for the Texas "65" insurance plan. In his letter to Mr. Rietz (who, is also president of the Health Insurance Association of America), Mr. Galloway indicated that the actuaries had examined the Texas Blue Cross OAA program to see what Blue Cross experience could contribute to the Texas "65" ratemaking process. Following are some of the actuaries' comments on the Blue Cross program covering 230,000 older persons:

> The old-age assistance plan is *constructed to discourage normal lengths of hospital confinement.* The benefits are cut in half at the end of 15 days and at the end of each 15-day period, the doctor must give written certification that the continued confinement is necessary for the health and well-being of the patient. We collected data on about 6,400 claims which had been settled in November 1962 concerning the length of hospital confinement. This data indicated that the above-mentioned *biases* were *operating to a very great extent to reduce the average length of confinement* * * *. [Emphasis supplied.]

The progressive abandonment by Blue Cross plans of the commitment to offer service benefits—particularly pronounced in the case of their programs for the elderly—means quite simply that Blue Cross coverage is becoming less adequate. Coupled with the obvious weaknesses of commercial hospital insurance, the fact that Blue Cross now covers an increasingly smaller proportion of the hospital bill confronts the older American with the frightening prospect of having to pay more and more for less and less protection.

[2] A deductible is the amount that the individual must pay out of pocket before he is eligible for any insurance benefits. A copay provision requires that the person pay a specified dollar amount—say $5 a day—for each day that he is hospitalized. Coinsurance, which is usually found in combination with deductibles, requires that the insured pay a specified percentage of charges—usually 20 percent or 25 percent.

CHAPTER III

COST OF HOSPITAL INSURANCE TO THE ELDERLY

No end is in sight to the spiralling premium cost of hospital insurance for older people. In fact, based upon information developed at our hearings, not only are these periodic increases expected to continue, but, in the case of Blue Cross they may well be substantially greater than past increases.

The effect of these sharp increases in the premium cost of hospital insurance is to further seriously impair the capacity of older Americans to secure and retain adequate policies. Good coverage is expensive, and more and more is being pushed beyond the limited means of the aged.

COST OF COMMERCIAL HEALTH INSURANCE POLICIES

Perhaps the most dramatic recent increase in the cost of commercial health insurance was that effected by the Continental Casualty Co. in its "Golden 65" program. Premium charges were raised from 23 to 36 percent on three of the four components of the Golden 65 package. The only segment which was not increased—the $5,000 medical plan—does not provide a hospital benefit.

It would appear that the increases were necessary in terms of the claims experience of the "Golden 65" program (see app. A–2). Nonetheless, the very substantial cost rise—coming only 6 short months after the company had mounted a multimillion-dollar national advertising campaign which resulted in the enrollment of 105,000 people age 65 and over—came as an acute shock to the 250,000 older people insured under the program.

This subcommittee received a substantial number of bitter protests from older people relative to the action of the Continental Casualty Co. Many advised that they would no longer be able to retain their policies. Indeed, the company estimates that approximately 17,000 Golden 65 policies, held by some 11,000 different people, were dropped as a direct result of the rate rise (see app. A–2). It is possible that many more Golden 65 policyholders will find the program too heavy a financial burden over the months to come and be forced to terminate their policies.

The two other mass enrollment programs sponsored by individual health insurance companies are the "Fund 65 Plan—Plus $10,000 Plan" of the Fireman's Fund Insurance Co. and the "Senior Security" plan of Mutual of Omaha.

The "Plus $10,000" segment of the "Fund 65" program was sharply increased in premium cost in August 1963—from $11 monthly to $15.75, a rise of 43 percent.

Mutual of Omaha, despite steadily increasing claims, in response to a question by Senator McNamara advised that "We are not considering a rate increase * * * " on the "Senior Security" plan.

The premium costs of the several mass enrollment plans are substantial. Monthly charges for the "Golden 65" plan range from $8 for the "65-plus" hospital plan to a total of $25.50 for the full package. An older couple purchasing the complete "Golden 65" program pays $612 per year for insurance which provides only partial protection against their total medical costs. Mutual of Omaha's "Senior Security" plan costs an older couple a total of $204 annually (with less benefits of course, that the "Golden 65" package). The "Fund 65—Plus $10,000" program requires the older couple to pay a total of $534 a year—again, for partial protection only.

These premium costs for incomplete coverage must be weighed against the hard fact that older people have limited incomes. Half of the aged couples have annual incomes of $2,875 or less. Half of the nonmarried elderly (widowed, divorced, separated, never married) have annual income of $1,130 or less. This certainly doesn't indicate a vast reservoir of purchasing power for health insurance.

The premium cost situation under the several State "65" programs is not appreciably better than that just described for the Continental Casualty, Mutual of Omaha, and Firemen's Fund plans—in fact, it may be worse over the long run.

STATE "65" HEALTH INSURANCE PLANS

Over the past several years, groups of insurance companies have banded together to offer statewide mass enrollment programs. The principal programs for which meaningful data are now available are Connecticut "65," Massachusetts "65," and New York "65."

Each of the programs varies in the benefits provided and premiums charged. Their common elements include (1) establishment of a separate insurance organization representing all of the various participating insurance companies; (2) offering of policies periodically on a mass-enrollment basis without requirement of physical examination; and (3) unusually low commissions to agents selling and servicing the policies.

Despite the most stringent economies and costcutting, premium charges for the three State "65" programs are high relative to the ability of the aged to pay for health insurance. Costs are kept down to a limited extent, by means of use of the donated services of executives of participating member insurance companies as well as by the fact that agents are paid nominal commissions only. Despite these unique economies, the annual premium charges to an older couple for the privilege of securing limited basic and major medical protection are $420 in Massachusetts, and $456 in Connecticut and New York. Again, these heavy premium charges must be evaluated in terms of the median annual incomes of the elderly—$2,875 for couples and $1,130 for the nonmarried aged.

Data supplied to the subcommittee by the three "65" plans (see app. B), make it quite likely that each of the three programs will require premium increases sometime within the next 12 months.

While the Texas "65" plan's claims experience was not significant due to the newness of the program, the actuarial subcommittee for

"Texas 65" had this to say about future premium charges (app. B–4): "The actuarial subcommittee does not feel that the proposed rates are inadequate but it does feel they are close enough that *we will have to anticipate a rate increase at least by the end of the second year of plan operation and, presumably, about every second or third year thereafter.* [Emphasis supplied.]

The Connecticut "65" plan was permitted to raise its premium charges (as well as to reduce certain benefits) effective January 1, 1964. The plan received a smaller increase than that requested of the State insurance department and indicated that it would have to ask for an additional increase sometime within the near future.

The Massachusetts "65" plan advised the subcommittee that its premium rates were developed on the basis of a 2-year estimate. The estimate was founded upon anticipated claims expenses of 85 percent over the 2-year period. However, the plan's claims experience was at the 85-percent level after only 1 year of operation. Obviously, an upward adjustment will be required before too long in order to bring the program into reasonable balance.

The New York "65" plan testified that its claims experience was greater than initially anticipated. According to officials administering the program, barring an extremely unusual change in the usage of the plan by its policyholders, premiums will have to be raised.

Thus, we have a pattern of initial high cost coupled with the prospect of further premium increases. But this is by no means the only problem confronting the State "65" plans.

There has been virtually no growth in the number of aged people covered by the "65" plans since their inception. The Massachusetts "65" plan has actually suffered a net loss of 5,000 people since it commenced operations 1½ years ago.

The average age of the "65" plan participant remains much too high to insure any degree of premium stability. The average age today, 74 years, of the "65" participant is approximately the same as the average of the initial enrollees in the programs. In other words, the plans have been unable to secure sufficient numbers of new subscribers from among the younger segment of the older population to reduce the average age of their policyholders. The plans are desperately treading water, for without the compensating effect of younger policyholders they are faced with the prospect of insuring a group of increasingly older people. And, simply stated, the greater the average age of the "65" plan group, the greater the requirement for and use of medical care.

Faced with these facts, it is extremely difficult to place much faith in the long-term stability of the State "65" approach to providing health insurance. Even the insurers have their doubts. Mr. A. M. Wilson, chairman of the executive committee of the Massachusetts "65" was quoted as follows:

> The early enthusiasm for a 65 plan as a means to combat Federal intervention is very rapidly subsiding as companies begin to realize the extent of their financial involvement. We are still a business which cannot function as a private social relief association.[1]

[1] "Interinsurer Arrangements To Provide Over-65 Medical Care Coverage," by Robert D. Eilers, Journal of Insurance, December 1963, p. 485.

GUARANTEED RENEWABLE COVERAGE

The health insurance industry has devoted a great deal of time and money to promoting the guaranteed renewable feature of the mass enrollment programs of the State "65" plans and those of Continental Casualty, Mutual of Omaha, and Fireman's Fund as well as individual policies of other insurers. Guaranteed renewable means that the insurer cannot cancel or terminate a policy unless all such policies are canceled or terminated. Guaranteed renewability is important in an insurance policy, but it is only one part of the picture. The policy is guaranteed renewable all right, *but the premium cost is not guaranteed.* It is extremely difficult to persuade an older policyholder that he possesses a great buy when he is periodically asked to pay higher premiums for the same benefits. And he may even be asked to pay higher premiums for less protection. Where he has previously used some benefits and the guaranteed renewable policy has a lifetime maximum amount payable (such as $5,000 or $10,000 as is true of some of the programs we have mentioned), the maximum for which he is eligible is, of course, reduced by the payments made to him during a prior policy year or years.

The fact that premium charges are not guaranteed to continue unchanged is the hook concealed in the bait of guaranteed renewable health insurance.

BENEFITS IN RELATION TO PREMIUMS

Another important element in considering the costs of health insurance to the elderly is the extent to which premiums paid are returned to the aged in the form of benefits. In other words, "How good a value is commercial health insurance?"

In responding to questions during our hearings, concerning the percentage of premiums returned in the form of benefits, insurance industry spokesmen repeatedly cited the mass enrollment or group health insurance plans as illustrative of high benefits return—with payout of anywhere from 80 percent of premiums upward.

A good example of how the health insurance industry sought to portray the unusual situation as being the usual is contained in the response of the research director of the HIAA, Mr. Joseph F. Follmann, Jr., to a question by Senator McNamara:

> Senator MCNAMARA. Doesn't insurance company overhead account for almost half of the premiums paid on individual policies and would this not be an important factor in the cost of providing insurance?
>
> Mr. FOLLMANN. No, Senator. In the data which we have with respect to coverages for people over 65, for example, in the statewide programs, the expense of operation runs from 5 or 7 percent to 10 to 15 percent. This is made up of essentially three components, two of which are about equal—one being operating costs, and the other being what we call acquisition costs—the cost of putting the business into effect. The third factor is taxation.
>
> Senator MCNAMARA. So you think that it is closer to, shall we say 10 percent? This is slightly exaggerating the figures you gave us, the overhead involved in insurance premiums.

Mr. FOLLMANN. That is right, the cost of operation and taxes.

Senator MCNAMARA. Well, this sounds astonishingly low to me, but this is your evaluation of the situation.

The three "State 65" plans which Mr. Follmann used as illustrative of typical insurance company overhead have only 175,000 people enrolled. Mr. Follmann's reply begged the question for very good reason.

At least one-half of the commercial health insurance policies held by older people *are not* of the mass enrollment or group type. They are the policies issued on an individual basis and subject to individual acceptance or rejection by the company. The payout picture here is considerably different than that for the group or mass enrollment plans. According to data provided by the Health Insurance of America, itself, only 51 percent of all premiums received for individual health insurance policies (for people of all ages) was returned in benefits in 1962. In 1961 the benefits payout was only 53 percent of premiums.

During the course of our hearings (Apr. 28, 1964) Senator Hiram L. Fong, had an illuminating colloquy on the question of benefits paid in relation to premiums charged, with Mr. A. M. Hansen, Vice President of Mutual of Omaha:

Senator FONG. * * * Now, as a mutual company, do I understand that you do not make any profit? That is, *you charge the policyholder what it costs you to really give him the benefit. Is that correct?*

Mr. HANSEN. *That is correct.*

Senator FONG. So, from that standpoint, *if the cost is low, your premium will be low, and if the cost is high, your premium will mount accordingly?*

Mr. HANSEN. *That is correct.* There is no money paid out of our organization to stockholders who may buy stock for the purpose of seeking a profit.

Senator FONG. *But does the premium you charge reflect what it really costs you?*

Mr. HANSEN. *It does.* [Emphasis supplied.]

Mutual of Omaha, subsequent to our hearings, provided the subcommittee with data on premiums received and benefits paid for each of the different types of policies in which people 65 and over are insured (see app. A–4). The following table indicates the percentage of payout on several of the individual health insurance policies issued by Mutual of Omaha to the elderly. Apparently it costs Mutual of Omaha a great deal to provide these policies for the benefits payout ranged from only 31 percent to 43 percent in 1963.

	Mutual of Omaha policy form				
	30HO/FHO	36HO/FHO	40HO/FHO	56HO/FHO	58HO/FHO
1961					
(1) Premiums	$5,323,540	$769,798	$1,044,432	$225,635	$152,808
(2) Benefits	$1,928,247	$199,563	$332,850	$99,129	$41,252
(2) as percent of (1)	36	26	32	44	27
1962					
(1) Premiums	$7,286,058	$1,024,236	$1,329,667	$396,179	$190,601
(2) Benefits	$2,851,453	$366,337	$468,464	$148,717	$53,627
(2) as percent of (1)	39	36	35	38	28
1963					
(1) Premiums	$8,853,617	$1,229,432	$1,463,936	$548,573	$218,394
(2) Benefits	$3,782,321	$489,564	$588,030	$216,038	$68,630
(2) as percent of (1)	43	40	40	39	31

The statement of the Health Insurance Association of America, presented at our hearing on April 28, 1964, by the organization's research director, Mr. Joseph F. Follmann, Jr., included the following: "The cost of health insurance is and must remain a reflection of the costs of and expenditures for hospital and medical care." That comment reflects, however, only a very incomplete image. The "cost of health insurance" also remains a reflection of the very substantial costs of insurance company overhead.

COST OF BLUE CROSS COVERAGE

Blue Cross hospital insurance coverage, on the other hand, has a relatively small percentage of its total premium income allocable to the costs of operation. It is true, of course, that Blue Cross does not have to include in its overhead payment of taxes, commissions to insurance agents, and profit factors. But, Blue Cross has problems of its own.

Blue Cross is in serious trouble. Under cost and competitive pressure, it is rapidly divesting itself of those unique characteristics—"service benefits" and "community rating"—which have heretofore justified its special status. Abandonment of the "service benefits" feature places the older Blue Cross subscriber in a tight box. Loss of the advantage of "community rating" clamps the lid on that box.

In our discussion of the "adequacy" of hospital insurance for the elderly we described how Blue Cross coverage for older people was covering progressively smaller proportions of the hospital bills. This unwholesome consequence is attributable to the increasing usage by more and more Blue Cross plans of deductibles, coinsurance, and indemnity allowances in their "senior citizen" and other nongroup programs. The elderly are given less protection while hospital costs continue to rise.

Simply stated, "community rating" means that an average premium rate is charged all of the subscribers covered under a Blue Cross plan's hospital insurance contract. The high-risk subscriber and the low-risk subscriber pay the same premium—the former a lower rate than would otherwise be necessary and the latter a higher rate than the extent of his use of covered services would ordinarily

justify. "Experience rating" is essentially a method whereby each of the two policyholders described would pay a premium closely related to his actual use of insurance.

The advantage of "community rating" to the older person is obvious. The elderly use 2½ times as much hospital care as do persons under age 65. Unfortunately many of the so-called new and expanded "senior citizen" contracts offered by Blue Cross plans are "experience rated," and the heavy impact of that rating method is reflected in the premium charges detailed in appendix D–4.

Prof. Frank van Dyke, of Columbia University, has spent many years studying and reporting upon the operations of Blue Cross plans. In a statement submitted at the hearings of this subcommittee, Professor van Dyke described the seriousness of the situation confronting the older Blue Cross participant. Pertinent and enlightening comments include these:

> According to New York State Insurance Department figures, a given health insurance contract pure premium cost of $15.90 per year for a 25-year-old man would cost a 55-year-old man $45 and a 65-year-old man $72.90. A community-rated plan averages out these costs I have cited, so that one premium is charged for each of these three men, if all of them have Blue Cross group coverage.
>
> A young man would pay higher than age-specific rates and an elderly man would pay less. This is community rating. It has required social foresight for Blue Cross to, in effect, say to the young "pay more when you are young, so that you will not be priced out of the health insurance market when you are old." *The New York City Blue Cross plan and the other plans which have adopted or are moving in the direction of experience rating are depriving elderly people of an opportunity to pay their own way at premiums they can afford* * * *. [Emphasis supplied.]

The subcommittee had the benefit of the testimony of another witness knowledgeable in the ways of Blue Cross and keenly aware of the desperate situation confronting the older person who loses the protective umbrella of community rating. State Senator George R. Metcalf, chairman of the New York State Senate's Public Health Committee, as well as chairman of the New York State Joint Legislative Committee on Health Insurance Plans, expressed his concern to the subcommittee in these words:

> Until recently, people covered by Blue Cross had relatively little to worry about because of Blue Cross dedication to service benefits, liberal conversion privileges, and community rating. But now Blue Cross plans are having difficulties in continuing to function as the enlightened social mechanisms they were when they first came into existence.
>
> Skyrocketing costs of hospital care are imposing serious drains upon Blue Cross resources. In recent weeks, the Blue Cross plan serving 7,400,000 subscribers in the New York City area applied not only for a substantial premium increase but *announced its intention to abandon community rating.*
>
> Blue Cross needs more money, unquestionably. But I urged the New York State Insurance Department to deny, for

the time being, the request to abandon community rating in favor of experience rating.

Elderly people are worried and desperate about their need for health insurance protection. Many marginal health insurance subscribers in the upper-age levels are just not going to be able to pay the new, increased Blue Cross premiums predicated on experience rating * * *. [Emphasis supplied.]

The Michigan Blue Cross plan has also indicated its intention to drop community rating in favor of a form of experience rating. The Blue Cross Association, reporting to the subcommittee on the situation in Michigan, said that the Michigan Blue Cross plan intends "to change from community to group experience rating, January 1965. If permission denied, may have increase in rates. No benefit changes."

Many smaller Blue Cross plans are already experience rating their subscribers. The significance of the developments in New York and Michigan is that the two Blue Cross plans involved are the largest of the more than 70 plans in the country. They are the pattern setters for the others. From the standpoint, however, of the elderly and other nongroup subscribers, the leadership now being demonstrated in New York and Michigan is in the direction of retreat—not advance. Even with all the rationalizations offered by Blue Cross in justification of experience rating, the behavior of the plans can only be interpreted as strategic withdrawal from the traditional Blue Cross objectives of offering adequate hospital insurance at premium levels acceptable to high-risk population groups such as the elderly.

The older Blue Cross subscriber fortunate enough to have his coverage through a group may very well receive a temporary premium cost advantage through operation of the experience rating mechanism.[2] But, the large majority of the almost 5 million Blue Cross subscribers over age 65, are not covered through groups. They are the nongroup subscribers who will bear the brunt of substantially higher premium charges developed under experience rating. The temporary premium advantage accruing to the employed older Blue Cross subscriber by virtue of coverage in a group at his place of employment will evaporate in large part when he leaves the labor force. Not only will he have to pay much more for Blue Cross protection, but as may be seen in appendix D–2, he may be required to transfer to a contract which often provides substantially less insurance than he previously received.

We believe our concern with these unwholesome trends in Blue Cross is understandable. More than one-half of those older people who now hold any kind of hospital insurance are insured by Blue Cross. Blue Cross protection has, on the whole, represented the best protection available to the older person for the premium charged. Blue Cross policies are not canceled or terminated because a particular subscriber requires extensive hospital care. But all of the advantages of Blue Cross are meaningless if the older subscriber is priced out of the market. And, as app. D–4 notes, the elderly who hold Blue Cross policies have been virtually priced out of the market in most plans even without the final blow of experience rating. The Blue Cross

[2] Another serious problem suggests itself as emerging from the switch from "community" to "experience" rating. Under "community" rating the premium cost to an employer of providing coverage to his older workers is the same as for his younger employees. Under "experience" rating the greater cost of coverage for older employees (and their older spouses) might very well serve as one more barrier to the employment or retention of older workers.

Association reporting to the subcommittee in behalf of the various plans, documented the familiar pattern of increase upon premium increase in the charges for Blue Cross protection (see app. D–4). The Blue Cross Association's response to the questionnaire of the subcommittee also listed a substantial number of plans which intend to increase premium rates even further during the near future.

There are a number of reasons why Blue Cross seeks to abandon community rating in favor of experience rating. While the principal reasons are those relating to increasing the ability of Blue Cross to compete with the commercial health insurers, there is another important consideration which must not be overlooked.

Where a Blue Cross plan operates under the community rating method, its application for a general increase in premium charges is usually subject to a public hearing which affords all parties concerned in a given plan area an opportunity to comment upon, criticize, or endorse the proposed change. This procedure of open hearings conducted by State insurance departments is very definitely in the public interest. Blue Cross plays too significant a role in a community involving too many consumer dollars for it to be permitted to make broad policy changes without the salutary effects of widespread public participation in the decisions. While the publicity often given to Blue Cross requests for rate increases may make some plan officials uncomfortable, we believe it is far better for a quasi-public institution such as Blue Cross to regularly place all of its cards on the table—out in the open. Public hearings would be far less frequent an occurrence if experience rating becomes the standard pattern for Blue Cross ratemaking.

Both Professor van Dyke and Senator Metcalf described the competitive pressures upon Blue Cross. Professor van Dyke stated:

> The reason usually given for the desire of some Blue Cross officials to experience-rate their contracts is competition from the insurance companies. The insurance companies single out the so-called good risks and leave the remainder to Blue Cross. This is undoubtedly so, but it is not the whole story. Many employers and unions do not want to pay the premiums necessary to provide the high level of service benefits available through Blue Cross. They want indemnity coverage because indemnity insurance, by paying only a portion of the hospital bill, can be sold at a lower premium. Blue Cross cannot pick up such accounts unless it abandons service benefits * * *.

When questioned as to why Blue Cross sought to drop community rating in favor of experience rating, Senator Metcalf told the subcommittee:

> Well, I think basically the reason why they are forced into that position is because of the attitude and the practices of the commercial carriers who have stimulated this kind of insurance writing for a number of years. As a matter of fact, one of the main reasons now why they have gone into experience rating is to protect a great many of the contracts that they now have who insist upon some kind of experience rating or they will depart from the Blue Cross fold. So I

think this is primarily a step in the direction of protecting themselves against competition.

As to the effects of abandonment of community rating upon the nongroup subscriber, Senator Metcalf said:

> Now, of course, what happens to those people who are in the direct pay groups and who cannot realize the advantages of experience rating and must, therefore, depend upon a reduced community rating in the areas in which they are, *those people are going to have a higher rate to pay.* As a matter of fact, it was brought out during the testimony in New York City that those *rates could increase by as much as 100 percent within a period of 3 years.*
>
> Now, if anything like that should happen, which I doubt, but it could happen, those people on reduced income would be almost in the position of having their insurance taken from them. [Emphasis supplied.]

The chairman of this subcommittee and other members closely followed the careful and thoughtful analysis of the implications of a Blue Cross change from community to experience rating presented by Senator Metcalf. Later, that same day (April 29, 1964), Senator McNamara, concerned with the possible consequences of a change to experience rating in Michigan, questioned the president of the Blue Cross Association, Mr. Walter J. McNerney:

> Senator MCNAMARA. Then if I were the individual who owned a Blue Cross policy, it will cost me more if I have to pay it all myself. Is that not correct?
>
> Mr. MCNERNEY. It is true that if people who are high risks paid according to their own experience then it would cost a lot of money for them. But the whole philosophy of prepayment is that you spread that risk as broadly as possible which we would continue to do under this new type of class rating.
>
> Senator MCNAMARA. But obviously people over 65 are a higher risk by themselves than if you take it all the way across the board, so therefore, we come out the same as stated in our case.
>
> Mr. MCNERNEY. They are a higher risk by approximately a factor of 2, and therefore must, in some manner, be folded within a group.
>
> Senator MCNAMARA. You say a factor of 2, and I say it costs about twice as much, so we are saying the same thing are we not?
>
> Mr. MCNERNEY. Very good.

It is clear that community rating, coupled with service benefits and the broad availability of Blue Cross to most segments of the community, have placed Blue Cross in a difficult competitive position in relation to commercial insurance companies. As hospital costs rise, the benefits expense of a service benefit plan rise much more rapidly than the cash indemnity type of program typical of most commercial health insurance. For example, the cost of a commercial hospital

insurance daily room and board allowance of $10 remains the same even though the actual cost of that care rises from $15 to $20 a day. Blue Cross, on the other hand, under the service concept of payment must increase its payout by another $5 to meet the rise. Thus, the increasing cost of care plus the fact that Blue Cross enrolls people—such as the elderly—who use above-average quantities of hospital services, means that Blue Cross rates rise more rapidly and sharply than commercial health insurance. These facts undoubtedly scare off many prospective Blue Cross group accounts.

But appreciation of the competitive situation confronting some Blue Cross plans does not solve the problem of providing reasonably priced adequate protection to older people. And, as Professor van Dyke put it, there are important questions as to whether Blue Cross should mold itself into a shape resembling that of the commercial health insurer so that it may compete on similar terms. Professor van Dyke commented:

> I would like to discuss, however, the question of competition from a somewhat different point of view than a series of companies with a series of salesmen taking business away from each other in a saturated market. *Competition to be meaningful to the public, should offer a choice.* It is painful to a Blue Cross board to lose a large account when it is clear that it could be retained through experience rating. But if Blue Cross abandons community rating, the public is deprived of the choice between a community-rated and experience-rated plans. Anyone who wants an experience-rated hospital plan can buy it from an insurance company. Blue Cross is the only plan offering community rating. *Looking at it from the public viewpoint, what advantage is it to the public to establish a tax exempt Blue Cross corporation for the purpose of competing with insurance companies on their own terms? Who gains from such an arrangement?* [Emphasis supplied.]

As we have stated and indicated Blue Cross and its older subscribers are in very serious trouble. Blue Cross is faced with an impossible dilemma under present circumstances. To continue as it has, means frequent rate increases which will make Blue Cross virtually noncompetitive with the commercial health insurers. The route of experience rating and abandonment of service benefits is nothing less than a complete denial of the basic reasons for the existence of Blue Cross. There is, however, an alternative—enactment of a program of hospital insurance benefits for the elderly financed through the social security mechanism.

A social-security-financed hospital insurance program would relieve Blue Cross of the virtually intolerable pressure upon premium rates generated by the millions of its over-65 subscribers who have, heretofore, paid substantially less than the actual cost of their protection. (A Blue Cross spokesman estimated in 1961 that it then cost Blue Cross $375 million a year to provide benefits to older subscribers but that the plans received only $200 million in premiums from the elderly.) Blue Cross would, obviously, then be in a more competitive position.

Without a social-security-financed, hospital insurance program for the elderly, older Blue Cross subscribers will find it progressively more difficult to cope with the rapidly rising premium costs. The elderly will, in effect, be priced out of Blue Cross. Without Blue Cross protection, millions of older Americans may have no recourse other than the public assistance rolls when illness strikes.

MINORITY VIEWS OF SENATOR EVERETT McKINLEY DIRKSEN, SENATOR BARRY GOLDWATER, AND SENATOR FRANK CARLSON

Progress in financing health care for older Americans during the past 10 years, 5 years and, indeed, the past 2 years, has been swift and far reaching.

The dynamic character of the recent record, attested by statistical evidence from all sources, clearly promises continuing growth of effective health protection for older persons in the months ahead.

These advances are products of individual action, private corporate initiative, both profit and nonprofit, and governmental programs at Federal and State levels.

Future progress calls for aggressive extension of voluntary health insurance, which is the method of choice for most Americans, and for more effective use of Federal-State programs for persons in need of help.

Abandonment of the national philosophy through which the current vigorous movement has been created would be regrettable. Appropriate changes in governmental programs within the concepts of established policies, on the other hand, should be considered most carefully.

Any evaluation of progress, past and anticipated, must be based on the record. In health care for older Americans, the facts, including those revealed during the April 27–29, 1964, hearings of the subcommittee, speak for themselves.

Appraisal of progress calls for answers to several key questions.

Have recent increases in health insurance coverage of older persons kept pace with the needs of most in this age group?

Does the evidence show that effective health insurance is available to more and more people?

Does the record show increases in access to and purchase of guaranteed renewable insurance?

Does the variety of insurance policies and plans permit selection of coverages most suited to the varying needs of individuals?

Are benefits being paid through voluntary health insurance to older people commensurate with rising cost of services?

Are Blue Cross, Blue Shield, and the health insurance industry making vigorous efforts to expand and improve coverage for persons past 65?

Is progress of voluntary health insurance sufficient to warrant confidence in its ability to meet the needs of most older persons?

The answer to each of these questions, as clearly revealed in the April 27–29, 1964, hearings by the subcommittee, is a resounding "Yes".

SUBCOMMITTEE HEARINGS, APRIL 27–29, 1964

Approximately 5 million persons past 65 now hold Blue Cross plan membership, including many who have had such coverage throughout

their lives. A comparable number of older persons are protected through private insurance companies and other prepayment plans. These totals approximated 54 to 60 percent of the present population over 65 at the end of 1962.

In these minority views, we are concerned chiefly with the voluntary health insurance record and its relationship to older people. Secondarily, recognition must be given to progress made in Federal-State medical assistance programs. The majority report, however, highlights a diversion which demands special immediate comment.

The majority statement, employing language at once strong and emotionally charged, impugns the integrity of a reputable organization representing a highly important segment of our economy. It is both implied and openly stated that the Health Insurance Association of America, a respected association of insurance companies, has deliberately engaged in falsification of its statistics.

In the development of this thesis, the majority statement contains incorrect statements and false assumptions which will be specified in an appropriate place.

It is recognized by statisticians, including those in Government agencies, that data on any subject can differ. A major reason is difference in methodology. Regardless of methodology, however, errors will occur. The evidence does not show that the data gathering process of the Health Insurance Association of America was other than scientifically conceived and honestly reported.

Dr. Forrest E. Linder, Director, National Center for Health Statistics, Public Health Service, was asked by Senator Dirksen during the April 27–29 subcommittee hearings:

> Would you explain the difference [between National Center for Health Statistics and HIAA estimates of persons over 65 holding health insurance] as a result of difference in methodology?

Dr. Linder, responding to this lone question voiced on this matter during the hearings, said:

> Well, the two figures are collected by entirely different methods and both methods are subject to technical variation and technical error. As a matter of fact, we regard the correspondence between our figure and the insurance figure as very satisfactorily close, with one factor of the difference being this still undetermined knowledge about the extent of multiple coverage.
>
> I think it is pertinent to say that if the insurance figure is 60 percent and if that is based on the multiple-coverage estimate of 13.5, then if the true multiple-coverage figure was as much as 22, the insurance figure would correspond exactly with ours.
>
> So, I think we can say with some degree of confidence * * * that the amount of coverage is someplace between 54 and 60 and on the amount of duplication, multiple coverage is someplace between 13 and 22.

There is a real possibility, however, that the smokescreen raised in the majority report may obscure the private health insurance record of progress developed at the April 27–29 subcommittee hearings.

In testimony presented to the subcommittee, there was much information on availability of private health insurance for persons over 65, the types of coverage, and the trends with respect to (1) growth in the number of persons covered and (2) expansion of benefits under various plans. None of this positive testimony appears in the majority report.

The minority has no intent to impugn the motives of the majority report. We would caution, however, against uncalled for discrediting of private enterprise and initiative which in so many instances, particularly as related to interests of the elderly, have greatly lessened what might become unnecessary burdens on Government.

It is almost inconceivable that a statement purporting to report on the status of private health insurance for older citizens should be void of reference to progress over the past decade. Regardless of which source of data is used, a tremendous growth pattern is revealed. A report which gives no recognition to this fact can only raise questions as to its credibility.

Neither space nor time available to the minority permits complete response to every specific in the majority's unrestrained criticism of voluntary insurance. Its statement appears to be aimed at discrediting and undermining public confidence in Blue Cross and the health insurance industry.

Nor is such response necessary.

The facts are in the published record of the April 27–29 hearings held by the subcommittee.

At the April hearings the principals involved presented their records and responded to interrogation. Judgment of the majority statement can only be valid when it is related to and compared with those direct confrontations.

NEW DEVELOPMENTS, 1957–62

A chronological review of selected events in the 5 years between 1957 and 1962 provides a dramatic picture of recent developments in financing medical care and the manner in which the Nation is responding to special health needs of older persons:

1957—First over-65 mass enrollment health insurance offering by an individual company (Continental Casualty Co.).

1958—First offering of association group health insurance through an organization with membership generally open to all older persons (American Association of Retired Persons).

1958—First over-65 mass enrollment health insurance offering by an individual company on a national basis (Mutual of Omaha).

1960—Enactment of Kerr-Mills Act by Congress and inauguration under it of first State medical assistance for the aged programs (Massachusetts, Michigan, Oklahoma, Washington, West Virginia).

1961—First offering of statewide mass enrollment plans by a voluntary association of health insurance companies (Connecticut 65).

1962—First offering of over-65 major medical coverage through mass enrollment by an individual insurance company (Continental Casualty Co.).

1962—Fiftieth State extended vendor payment medical services (under Kerr-Mills Act and previous Federal authorization) to old-age assistance recipients (Delaware).

The Blue Cross-Blue Shield plans, which have had wide enrollment among older people since their inception, have, of course, conducted mass enrollments since 1957 for persons over 65 who did not choose to enroll at an earlier time in life.

Inclusion of Federal-State programs in this chronology is appropriate because there are portions of the population for which voluntarily purchased private health insurance does not normally provide answers to medical financing needs.

Regarding health insurance, the way in which these new approaches have been and are being extended was developed in detail at the subcommittee's April 27–29 hearings.

It should be noted that this chronology takes no account of growth in longer established types of coverage including regular group health insurance coverage of employed and retired persons and the widely held Blue Cross-Blue Shield plans.

Over the latest 10-year period, 1952–62, on which data has been reported, insurance protection against costs of medical care—as a result of these and other continuing developments—has been extended to approximately 9 or 10 million persons over 65, an increase of from 6 to 7 million over the 3.4 million covered in 1952.

Concurrently medical vendor payment programs under old-age assistance have been improved and expanded to cover more than 2 million persons, an increase in excess of 1 million.

This total of roughly 11 to 12 million covered people is exclusive of persons eligible for the medical assistance for the aged programs created under the 1960 Kerr-Mills Act.

In view of this continuing progress and the fact that nonmedical problems loom large for many older persons, the desire of older people to live independently and with maximum freedom of choice should be respected.

FEDERAL GOVERNMENT'S ROLE

The Federal Government should direct its primary efforts toward encouraging and stimulating:

(1) Improvement in income—for both those now past 65 and those who will attain such age in the future.

(2) Improvement in publicly financed medical care programs for those who are unable to meet the costs without help.

(3) Continued growth in private voluntary health insurance.

(4) Reduction in unfair economic burdens on older people which result from inflation.

The Federal Government should avoid action which (1) would do injury to the Nation's excellent medical care system, or (2) undermine the institution of voluntary health insurance which is contributing so much to that system's growth.

VOLUNTARY INSURANCE RECORD

A comprehensive review of progress in voluntary health insurance for older Americans comparable to that afforded by the proceedings of the subcommittee's April 27–29 hearings is not practical here. Some information relating to important patterns and trends as to the variety of plans available to older people—including those with infirmities and poor health records—on a guaranteed renewable basis, however,

deserves the emphasis which comes with brief repetition and correlation.

Apparently most of the health insurance coverage of persons past 65 is divided about equally between Blue Cross-Blue Shield and health insurance companies. Both make protection available to older persons through group plans, mass enrollments, and individual underwriting.

Walter J. McNerney, president of the Blue Cross Association reporting to the subcommittee that persons past 65 represent 9.1 percent of the total Blue Cross enrollment, commented at the April 27–29 hearings:

> This percentage is practically the same as the percentage of senior citizens in the total national population.

With reference to steps taken by Blue Cross plans on behalf of older persons, Mr. McNerney said:

> Every Blue Cross plan in the United States has enrolled senior citizens through some combination of the following methods. You have already heard of most, if not all, of the methods.
>
> Blue Cross has stimulated management and labor interest in retaining retired workers within groups of those actively employed.
>
> Members leaving a group are encouraged to convert to an individual, direct-pay basis. Open enrollment periods are held during which all persons in the community including the aged are able to enroll. Special programs for the aged have been designed and offered.
>
> We do not as a matter of practice cancel anybody who has become a member of Blue Cross. Our benefits are designed to be as helpful and as economical as possible and we believe that the rates covering these benefits are probably lower for comparable coverages than almost any you can find by any responsible carrier.
>
> Those on group rates, those aged that are part of a group, receive the same rates and benefits as other members of the group. In many instances this care is financed completely or in part by the employer.

Mr. J. F. Follmann, Jr., director of information and research, Health Insurance Association of America, summarized a description of expanding types of coverage available through health insurance companies as follows:

> There are nine principal methods being employed by insurance companies to make health insurance available to both the present aged population as well as those that will become senior citizens in the future.
>
> These methods include both group approaches, mass enrollment techniques, and individual coverages of various types. In addition, there are, of course, coverages available through Blue Cross and Blue Shield plans. It is clear that private health insurance is generally available, regardless of physical condition, for both the present and future aged.

Almost half of the aged insured with insurance companies are covered under group policies. For such persons, it is not infrequent that the employer pays some or all of the premium charge.

Vigorous competition among insurance companies and Blue Cross plans, all under the supervision of State insurance departments, assures the public of a reasonable relationship between benefits and premiums in the instance of both group and individual policies.

Testimony by other witnesses at the April 27–29 subcommittee hearings confirms the opinion that there has been substantial expansion in the scope of benefits provided by voluntary health insurance coverages. The combination of public spirit and intense competition reflected in the record, and in statements by the several representatives of Blue Cross and the insurance industry, has produced further a situation in which the number and percentage of persons past 65 with private health insurance clearly is increasing rapidly.

INCREASES IN HEALTH INSURANCE COVERAGE

According to a Social Security Administration study made in March 1952,[1] 3.4 million persons past 65 held health insurance, or 26 percent of the noninstitutionalized aged.

A September 1956 [2] study, also made by the Social Security Administration, showed an increase in coverage to 36.5 percent of the older population.

A third study,[3] by the Department of Health, Education, and Welfare, made in the fall of 1959, showed still another increase to 46.1 percent. At about the same time a Health Insurance Association of America study (December 1959) showed voluntary health insurance coverage of 49 percent of the persons 65 and over.

The most recent data supporting this growth pattern was reviewed at the April hearings by the subcommittee and was based on three different studies.

The National Center for Health Statistics, Public Health Service, study showed voluntary health insurance coverage as of 1962 to be 54 percent of the noninstitutionalized aged.

The study reported by the Division of Research and Statistics, Social Security Administration, showed 1962 coverage of 51 percent of all persons past 65. When allowance is made to exclude the institutionalized aged, this study corresponds closely to the Public Health Service data. Both studies employed household interviews of older people.

The third set of data for 1962 is that from the Health Insurance Association of America based on a survey of insurance company records and coverages reported from other sources for Blue Cross and other type plans. It concluded that 60 percent of the noninstitutionalized persons past 65 were insured.

[1] I. S. Falk and Agnes W. Brewster, "Hospitalization and Insurance Among Aged Persons, A Study Based on a Census Survey in March 1952," Bureau Rept. No. 18, Division of Research and Statistics, Social Security Administration, Washington, D.C., April 1953.

[2] "Hospitalization Insurance for OASDI Beneficiaries," report submitted to the Committee on Ways and Means by the Secretary of Health, Education, and Welfare, Washington, D.C., Apr. 3, 1959, p. 43.

[3] U.S. National Health Survey, "Interim Report on Health Insurance," Health Statistics, series B–26, U.S. Department of Health, Education, and Welfare. PHS Publication No. 584–B26, Public Health Service, Washington, D.C., December 1960.

Regardless of differences in survey techniques, each of these three studies demonstrates a growth situation the magnitude of which cannot be ignored.

This recent record and new developments commented on earlier indicate continued future expansion of coverage and benefits despite the fact that already well over half the 65-plus population is now insured.

It is understandable that those who advocate replacing the voluntary movement with a compulsory scheme choose to close their eyes to this impressive record. Only by so doing can they persist in claims of a vast unmet need, a need which, in fact, is steadily diminishing. It is declining not alone as a result of newly available voluntary health insurance, but also as a result of expanding Government assistance programs for those in need of help and as a result of improving economic situations among those who have and will attain age 65.

The improvement in basic economic capacity among older people has been vigorously supported by the minority. Our efforts toward this objective will be continued aggressively.

It appears prudent to build on what we have. Federal policies and actions, therefore, should continue to emphasize effective encouragement of voluntary health insurance offering older people a wide variety of choice to be freely exercised by them as individuals.

FEDERAL-STATE SUPPLEMENTARY PROGRAMS

Efforts to evaluate the effectiveness of voluntary health insurance alone, without reference to other resources of older people, inevitably produce an incomplete picture. Disregard of voluntary health insurance in appraising Government programs similarly produces an incomplete and obviously faulty record.

Some advocates of special points of view, in their eagerness to make a case, unfortunately have succumbed to just such temptations. To avoid this error, the minority believes that a brief review of existing Federal-State programs is called for.

The past 10 years have seen substantial expansions in coverages and medical benefits for the 12 to 14 percent of the over-65 population who rely on Federal-State old-age assistance programs.

According to the 1952 Annual Report of the Federal Security Agency, there were, in that year, 13 States participating in the modest Federal-State program of OAA vendor payments for medical care authorized by the Congress in 1950. Medical services under these programs were available to approximately 550,000 old-age assistance recipients. Seven other States, with a total of approximately 425,000 OAA recipients, had medical vendor payment programs without Federal participation.

These State and Federal-State programs together made medical services available to approximately 975,000 persons.

Expansions of the medical vendor payment programs were authorized by the Congress in 1956, 1958, and, most recently, under the Kerr-Mills Act in 1960. All 50 States, as a result, have now undertaken, with greatly expanded benefits, this type of program for older persons presumed to be in greatest need.

As of December 1962, the number of persons thus covered was 2,225,731.[4] This increase of over 1 million is significant in any appraisal of coordinated governmental and voluntary efforts to meet the medical needs of older people.

More recent than the OAA programs, and still developing rapidly, is the medical-assistance-for-the-aged program authorized by Congress in 1960. Its very newness, and current recordkeeping practices under the program, make accurate statistical evaluation difficult, but it constitutes a major step in meeting medical needs of many older persons.

This program, based on Federal grants to the States, is intended to provide help to older persons who are not on old-age assistance rolls, but need aid in meeting medical expenses. The law requires that State programs make available both institutional and noninstitutional care.

Thirty-nine States and the District of Columbia have enacted necessary legislation, including assignment of funds, for implementation of medical-assistance-for-the-aged programs. Two additional States have authorized the program.

It should be noted that, of the nine States which have taken no action to implement MAA under the Kerr-Mills Act, five have, presumably as a result of other provisions of that act, extended the medical vendor payments program to old-age assistance recipients since 1960 for the first time. Three others expanded existing OAA medical programs. That the first steps by these States should be for the benefit of those in greatest need is understandable.

It is a reasonable assumption that, with the experience thus gained, these States, too, will make medical-assistance-for-the-aged programs available. Current legislation now under consideration by several gives support to this assumption.

Action by the States on the medical-assistance-for the-aged program since adoption of the Kerr-Mills Act, has not been confined to passage of original enabling legislation. A number of States have expanded their MAA programs. It may be expected that this process of making eligibility rules and benefits more reasonably match the need of older people will continue.

It is impossible, on the basis of data available, to know how many persons past 65 are, or will be, eligible for help under the 40 fully authorized medical-assistance-for-the-aged programs. Some are not yet in operation; others have been in existence less than a year. Calculation of numbers eligible is further complicated by the fact that the only current records simply show, for specific months, the number of persons who actually receive benefits. Since only a small portion of those eligible require services during a given month, such figures give but little indication of the programs' scope. It is clear, however, that the number eligible for services is substantial and growing.

Vigorous steps, based on careful and positive-minded study, certainly should be undertaken at both Federal and State levels to assure full implementation of the medical assistance for the aged program in accordance with the intent of the Congress.

[4] "Advance Release of Statistics on Public Assistance," Division of Program Statistics and Analysis, U.S. Department of Health, Education, and Welfare, Washington, D.C., December 1962.

INFORMATIONAL GAPS

Oversimplification of problems encountered in paying for medical care can result in a serious disservice to the Nation and its people, young and old.

For example, if we conclude that an estimated total of 12 to 14 million persons over 65 are covered by voluntary health insurance, old-age assistance medical programs, and medical assistance for the aged, to then assume that there remains an unmet need embracing 3 to 6 million people would produce a gross oversimplification.

As indicated by a number of independent studies, such as that by the National Opinion Research Center of the University of Chicago in 1959, numerous other factors must be considered to get an accurate picture.

How many of the noninsured are so by choice because they are eligible for medical care as veterans? How many have the means to purchase insurance, but choose not to do so? How many rely on still other arrangements for needed medical care?

Some information is available to shed light on such questions. Problems of statistical duplication, however, create a cloudy picture.

There were 2.2 million veterans over 65, for example, in December 1962, over 12 percent of the older population. We do not know how many of these choose to rely on the Veterans' Administration for care when needed.

There are others who receive care from local public or private agencies. There are some who receive care as being totally and permanently disabled or as being members of the Armed Forces, seamen, members of religious orders, or as a professional courtesy, and still others who have sufficient income, accumulated assets, or family resources to feel no need for insurance.

Ethel Shanas, in her report on the study conducted by the National Opinion Research Center of the University of Chicago,[5] said:

> All persons who had no health insurance were asked whether they would be interested in obtaining coverage. Half of them said they would be, but that they could not afford it (34 percent of the total) or that "They won't sell me any" (16 percent). One-fourth said flatly, "I don't want it," and the same proportion said, "I've never thought about it."

In her testimony at the subcommittee hearings in April, regarding the study conducted under her direction for the Social Security Administration, Dr. Ida C. Merriam reported on health insurance coverage among married couples, single women, and single men, respectively, according to whether their incomes were in the upper, lower, or middle thirds. In the upper income brackets, 20 percent of the couples, 34 percent of the single women, and 36 percent of the single men, she stated, had no health insurance.

This data for upper income people appears to confirm the conclusion that many older persons simply do not want health insurance.

Unfortunately, for reasons best known to themselves, some prefer to rely on the inaccuracies produced by oversimplification. As a

[5] Ethel Shanas, "The Health of Older People, A Social Survey" (Harvard University Press, 1962), p. 81.

result little has been done to clear away even those statistical clouds capable of dispersion.

Much more intensive study and correlation of available and procurable data appears appropriate. Without it, appraisal of the medical situation of our older people is quite hazy.

References usually made to income statistics and budgetary requirements of older persons constitute another common oversimplification.

To assume that a retired couple with an annual income of $2,000 is in serious financial straits, or is incapable of purchasing health insurance, simply does not jibe with reality. Depending on mode of living, homeownership, geographic location, and other individual circumstances, such income could either produce financial difficulties, or permit reasonably handsome living.

Reference is often made to a national median income for an over-65 couple of $2,875 per year. Immediately, then, the implication is made that half of the over-65 couples cannot provide for themselves.

This is a classical oversimplification which can be misleading. In what part of the country do these couples live? What type of community? What assets do they have? Are most of those with incomes above the median living in high-cost areas? Are most of those with incomes below $2,875 a year living in low-cost areas?

These questions suggest need for a thoroughgoing study, including examination of budgets related to living patterns of people in a variety of individual circumstances. The immense costs borne by taxpayers, young and old, in any governmental program demands such a study. It has not yet been made.

Available information suggests that the wisdom of State rather than Federal administration of any broadened medical assistance would be supported by such a study.

QUESTIONS ON NUMBER OF OLDER PERSONS INSURED

The "core of the controversy over the most suitable methods" of financing medical care for older Americans is not, as stressed in the majority statement, to be found in judgments as to the comparative accuracy of the three studies reported to the subcommittee regarding the number of persons past 65 covered by voluntary health insurance.

The important fact is that each of the three studies showed:

(1) Most older citizens are now covered by voluntary insurance.

(2) Increases in coverage, both numerically and percentage-wise, have been rapid during recent years.

The attack on the Health Insurance Association of America in the majority report is predicated on two claims: (1) an alleged overstatement by the association in 1963 of the numbers of persons past 65 insured by individual companies under mass enrollment plans, and (2) faulty statistical methodology alleged to have been deliberately used by the association (in its December 1962 study) for the purpose of creating a falsely exaggerated picture of insurance coverage among older people.

The objective is to discredit HIAA's estimate that, as of December 31, 1962, voluntary health insurance coverage was held by 10,300,000 persons past 65.

As noted earlier, the only professional opinion requested by the subcommittee on this point was a question by Senator Dirksen of the

minority and was directed to Dr. Forrest E. Linder, Director, National Center for Health Statistics, Public Health Service. His response gave recognition to the validity of Health Insurance Association of America methodology and the normal probability of differences in results between the HIAA study and his own.

It is not the purpose of the minority to defend the Health Insurance Association of America or its data. A judicious attitude and long acceptance of their reliability by numerous Government agencies, both legislative and executive, however, call for a careful review of charges in the majority statement with particular emphasis on what is revealed in the subcommittee record.

Regarding the alleged overstatement of plus-65 coverage under mass enrollment programs conducted by individual companies, the subcommittee record is far from complete.

If this claim had the validity and importance attributed to it in the majority statement, it is difficult to understand why the Health Insurance Association of America witnesses who appeared before the subcommittee were not then directly confronted with it.

It can only be surmised that such full and open exposure of the question might have produced a refutation or reasonable explanation. The evidence in the record, however, does not show deliberate dishonest intent by HIAA.

The more significant majority claim, of course, is that which challenges the Health Insurance Association of America 1962 estimate that 10,300,000 older persons had health insurance as being patently and deliberately in error.

On this question the record does speak. Careful review of the April 27–29 subcommittee hearings and the majority statement, including its appendix, discloses a number of errors which raise serious questions about the majority thesis.

The majority statement's first disagreement with HIAA involves no challenge of the association's conclusion that 10,300,000 persons over 65 were insured, but instead questions the statement that this number relates to the noninstitutionalized elderly population. It suggests that HIAA should have specifically instructed reporting companies to exclude from their data insurance policies held by the institutionalized. Studies which have been made generally agree that the institutionalized population carry little, if any, health insurance. Lacking evidence to the contrary, this suggests that this key point in the majority statement is little more than a statistical quibble.

The majority gives recognition to this when it says:

> The Social Security "Survey of the Aged" noted that relatively few of the elderly in institutions have hospital insurance policies.

The majority statement next, in a discussion of health insurance definitions, accuses the Health Insurance Association of America of altering the definition—"without mentioning the alteration"—between its July 1, 1961, and December 31, 1962, surveys. The record available to this subcommittee fails to support this contention. On the contrary, reading of the questionnaires employed by HIAA in the two surveys, as reproduced in the appendix to the majority report, discloses that the two used identical definitions.

The contention which follows, that policies which pay a specific flat dollar benefit each day a person is hospitalized should be excluded from statistical studies on coverage, is open to serious argument. In any event, as indicated in the preceding paragraph, the record shows no evidence to support the majority claim that HIAA changed its definitions deliberately "to present an inaccurate and misleading picture of the growth of private health insurance coverage for the aged between July 1, 1961, and December 31, 1962."

Part II of the HIAA questionnaire as set forth in the majority statement's appendix is pertinent to the next charge leveled against that organization's study. It contained instructions which specifically requested companies to report only those persons and dependents 65 years of age or older. These instructions were applicable to both group and individual coverage. The majority statement indicating that the study made no adjustment for spouses under 65, therefore, does not appear to be accurate.

The majority statement says:

> The second flaw in the Health Insurance Association of America's methodology concerns their estimates of older people insured by nonmembers of the association. They assume that the proportion of aged enrollment to the total is roughly the same as the proportion of accident and health insurance premiums written to total premiums. This is in error.

It then goes on to say that "HIAA projected with some modifications, the number of aged policyholders by a rather imprecise method" in a manner described as fallacious.

The fallaciousness was "demonstrated" by pointing out that the Prudential and Metropolitan Life Insurance Cos. "accounted for 15 percent of the health and accident insurance premiums written in 1962, yet their aged enrollment represents less than 9 percent" of the total reported by HIAA. This example, conceivably selected because the companies are household words, appears to ignore several questions. How much do different companies tend to emphasize different kinds of insurance in their total business? How preponderant in the "health and accident business" of these two companies is disability income protection? Are the citing of individual instances such as this, without comparable citations with reference to coverage provided through companies like Continental Casualty Co., Mutual of Omaha, and Bankers Life & Casualty Co., valid in challenging a statistical projection?

While these questions remain unanswered, the basic charge by the majority that HIAA employed imprecise statistical methods requires, in all fairness, specific consideration of what the record contains.

In the statement received from the asosciation, and reproduced in the majority report's appendix, entitled "Methodology Employed by the Health Insurance Association of America in Developing Its Estimate With Respect to the Extent of Private Health Insurance Coverage of the Aged," there appears the following which is pertinent to the charge.

> The 123 companies which reported a total of 4.8 million persons at ages 65 and over with some form of insurance company coverage wrote about 70 percent of the U.S. health

insurance premiums in 1962 (including both disability income premiums as well as hospital-surgical-medical expense premiums). The methodology employed in the regular annual survey of the association with respect to persons insured at all ages entails projecting numbers covered by reporting companies to a grand total for all insurance companies, based on the relationship of premiums written by reporting companies to the total U.S. written premiums for health insurance by all companies. Had this methodology been employed for the association survey of aged policyholders, the result would have been an estimated 6.9 million aged persons insured by insurance companies (i.e., 4.8/7).

To avoid the possibility of any overstatement with respect to its estimate as to the extent to which insurance companies covered persons at ages 65 and over, and to eliminate duplication of coverage within the insurance business, the association did not use the foregoing methodology for projecting reported enrollment statistics to a grand total. If the nonreporting companies writing 30 percent of the premium had the same proportion of persons at ages 65 and over as had the reporting companies, they would have covered 2.1 million people. Rather than use this 2.1 million or a figure even higher, it was assumed that it would be conservative to use 1.3 million for nonreporting companies.

From this it would appear that the Health Insurance Association of America made commendable efforts to avoid overstating its estimate.

The majority statement then goes on to say:

> HIAA's claim of 10,300,000 aged covered is further upset by the fact that they attributed a total of 5,300,000 aged subscribers to Blue Cross as of December 31, 1962.

It then refers to the Blue Cross Association report to the subcommittee that 5,219,000 elderly were covered as of January 1, 1963.

While no explanation of this difference appears in the record, the HIAA data source is reported in the majority appendix. The source document, which was also referred to by Dr. Ida Merriam of the Social Security Administration in her testimony before the subcommittee, is "Blue Cross-Blue Shield Nongroup Coverage for Older People," Social Security Administration, Division of Research and Statistics, Research Report No. 4. It reports Blue Cross estimated enrollment of persons past 65, as of December 31, 1962, to be 5,313,771.

Finally, in its list of charges against the Health Insurance Association, the majority statement makes the claim that the HIAA assumption of a 13-percent duplication of policy ownership among older people "appears much too low." The duplication reported by Dr. Forrest E. Linder, Director of the National Center for Health Statistics, Public Health Service, from that agency's study, was 13½ percent.

The majority statement's challenge of both of these studies takes two forms.

First, reference is made to data, provided by two insurance companies on direct request from the subcommittee chairman, and alleged to "provide samples far more extensive than those used by the Health Insurance Association of America," which show a much higher duplication percentage.

It is common knowledge, even to the statistical layman, that the size of a sample is not the sole determinant of its validity.

A number of questions immediately occur, therefore, regarding use of the raw data supplied by these companies—questions which are not answered by the record. They include the following: Were the samples selected by methods recognized as statistically valid? How heavily weighted was the sample with reference to applications for major medical coverages or other types of insurance normally purchased subsequent to other policies? Did the responses reveal other basic hospital coverage only, or were they based on questions which referred to all types of coverage? Is it probable that persons applying for the types of policies reported on would be those most interested in supplementary coverage? Is it known how many of the applications actually resulted in issuance of a policy?

Answers to these and other possibly pertinent questions do not appear in the subcommittee record.

The second way in which the majority statement chose to try and discredit the HIAA 13-percent duplication estimate was through questions directed to Dr. Linder in which he expressed the opinion that underreporting of this item may have been high in the Public Health Service survey made under his supervision.

The danger of underreporting on a question in any household survey of the type conducted under direction of Dr. Linder, and incidentally, that conducted under direction of Dr. Merriam for the Social Security Administration, is commonly acknowledged. Recognition is clearly given to this danger by the Census Bureau in many of its reports and by others working in the statistical study field.

It is a factor which unquestionably must be considered in evaluating all household interview type surveys. Whether a person's age is a factor in the extent to which underreporting produces statistics below actual facts is not clear. There is a distinct possibility, however, that this method may produce figures lower than those arrived at through other survey methods.

That this can sometimes be significant is shown by a 1959 Public Health Service study of "Reporting of Hospitalization in the Health Interview Survey" [6] conducted as part of the U.S. National Health Survey. This showed underreporting of hospital episodes for the survey year which ranged from 8 percent in the 18 to 34 age group to 18 percent in the 65 to 74 age group and 14 percent in the age group 75 and over.

If people will forget they have been in a hospital during the preceding year, it is understandable that they would forget hospital insurance policies.

For this reason credence might well be given to the possibility that the duplication figure produced by Dr. Linder's report may be too low. If there is understatement on this point, however, it is equally probable that there has been understatement with reference to holding of health insurance at all. It is regrettable that this has not been given recognition in the majority statement.

Even more regrettable, as mentioned before, is that statement's failure to recognize the tremendous strides—yes, "strides"—shown by

[6] U.S. National Health Survey, "Reporting of Hospitalization in the Health Interview Survey," Health Statistics, series D-4, Michigan University, Survey Research Center. PHS Publication No. 584-D4, Public Health Service, Washington, D.C., May 1961.

all data in the record that have taken place in voluntary health insurance coverage of older persons.

As pointed out earlier in these minority views, attention of the subcommittee was directed, during the April 27–29 hearings, to three different studies with reference to the number of persons past 65 holding private health insurance. Their estimates as to the increase during the 10 years between 1952 and 1962 range from approximately 170 to 200 percent.

The percentage of noninstitutionalized older persons now covered by voluntary health insurance has more than doubled over the 1952 percentage according to all three of these studies.

Unquestionably more than half of older Americans have such insurance. The number and percentage appears to be growing every month.

HEALTH INSURANCE COSTS

The majority report concludes with a discussion of rising costs of health insurance and advances a program for financing hospital care through the social security system as the alternative.

We are fully conscious of the need of health insurers to adjust the cost of insurance periodically, as they are compelled to do with respect to health insurance coverages for persons at all ages. The reason for this is readily apparent.

Any method of financing health care—whether it be through personal means, voluntary health insurance, philanthorpy, public assistance programs, veterans facilities, or the proposed social security approach—must be directly responsive to costs of providing that care. These costs have been rising, in the main very understandably, as our system of health care continues to improve in quality, and to respond to human needs and ever-advancing scientific techniques.

These improvement have relieved suffering and extended the span of life. They are greatly to be desired. Frequently they are costly to achieve. The American public has clearly displayed a choice in favor of them, and increasingly finances these services through voluntary health insurance.

If the majority intend to imply that these rising costs of care are only reflected in the cost of health insurance, and that the financing of these costs through the OASI system would somehow avoid this process, they are in error.

The cost of health care must be reflected in any financing method. To do otherwise would be to retard rapid progress being made with respect to health care in the United States—or possibly produce an actual setback in our medical care system.

As was brought out by both private and Government witnesses before the House Ways and Means Committee in 1963, currently proposed financing of social security administered hospital care plans is grossly inadequate. In addition, and even if adequately financed, the benefits of the proposed program do not by any means fit the majority's stated concept of coverage adequacy.

According to spokesmen for the Department of Health, Education, and Welfare,[7] older people would still have to pay 70 to 75 percent

[7] Wilbur J. Cohen, Assistant Secretary for Legislation, Department of Health, Education, and Welfare, "Financing Medical Care for the Aged Through Social Security," an address presented to the Junior Branch of the Actuaries Club of New York, Mar. 18, 1964; and
U.S. Congress, House, Committee on Ways and Means, hearings on H.R. 3920, 88th Cong., Nov. 18, 1963, pt. 1, p. 63. Testimony by Robert M. Ball, Commissioner of Social Security Administration, Department of Health, Education, and Welfare.

of their health care costs from their own resources. This situation impresses and concerns minority members of the subcommittee.

Equally disturbing is the threat such a medical program would be to the ability of the social security system to pay higher cash benefits now and in the future.

For these and other valid reasons, we remain convinced that the majority's conclusion is unwarranted.

INDIVIDUAL VIEWS OF SENATOR HIRAM L. FONG

SUMMARY OF FINDINGS

The record developed during 3 days of hearings by the Subcommittee on Health of the Elderly, which I attended, can be briefly summarized as follows:

1. Over the past 10 years, tremendous progress has been made in health insurance benefits and care for the aged and in numbers of persons past 65 having health insurance coverage.

Broader, more comprehensive benefits, guaranteed renewable (nonrevocable) provisions, group insurance, mass enrollments, and other improvements described in the hearings are solid evidence of progress.

Further improvement in aged health insurance is expected.

2. Some 54 to 60 percent of the Nation's approximately 17 million noninstitutionalized people age 65 or older have voluntary health insurance. Another 12 to 14 percent of this aged group have medical coverage through old-age assistance, and an indeterminate additional number are eligible for medical assistance for the aged.

3. Approximately one-half of those with voluntary health insurance are under nonprofit Blue Cross protection; the other half have insurance written by private companies, many of which are nonprofit.

4. A great variety of health insurance plans are presently available from which the elderly may choose policies best matching their needs and willingness and ability to pay.

No accurate judgment is possible as to how many of older persons have "adequate" coverage. What is adequate for one person may not be adequate for another. What is adequate in a low-cost area may not be adequate in a high-cost area. The hearing record did not develop sufficient information on adequacy.

5. Costs of health care are rising and this trend is expected to continue. Whether health care is financed through Government expenditures or individual insurance premiums, such financing must be adjusted from time to time to reflect these rising costs.

MAJORITY REPORT BIASED AND INCONSISTENT

The majority report distorts the record of hearings by failing to cite the obvious progress made in health protection for older Americans. It lacks balance and objectivity by ignoring the substantial public service rendered by nonprofit Blue Cross and private insurance companies in behalf of the aged.

The evident bias of the majority report against voluntary health insurance is very disturbing, for the total impact seems designed to undermine confidence of existing policyholders and prospective policyholders—aged and young alike—in fine organizations like Blue Cross. This is a great disservice to the people of America.

For the majority report to condemn the vast majority of voluntary aged health insurance as inadequate and then to recommend instead the administration's hospital insurance plan, which administration spokesmen admit will cover only 25 to 30 percent of aged health care costs, is inconsistent to say the least.

COMPREHENSIVE INSURANCE NOW AVAILABLE

The hearings showed that there are presently available for older persons policies offering comprehensive hospital, surgical, and other major medical benefits on a guaranteed renewable basis. The premiums naturally reflect the comprehensive benefits.

From the hearings it is clear that those who can afford and who are willing to pay the premiums for such coverage can obtain it.

It is also clear from the hearing record that some—how many no one knows—of those 65 and older cannot afford to pay the premiums for the best policies available.

FINANCING IS HEART OF PROBLEM

The central problem in providing health insurance protection is financing.

Available statistics on the financial status of our aged population are very sketchy, too incomplete to derive an accurate picture. It is reasonable to say, however, that a good many older persons lack the wherewithal to buy comprehensive health insurance.

Old-age assistance takes care of medical care costs of those without resources. This program should be improved through Federal-State cooperation.

Medical assistance for the aged takes care of a growing number of persons who are normally self-sustaining but who cannot pay for needed medical care. The Federal law is so broad that States have great leeway to provide substantial benefits and liberal eligibility requirements. This the States should do.

Persons of means can afford voluntary health insurance.

It is those aged not in the OAA, MAA, or affluent categories that arouse my further concern.

I agree with the minority views that steps must be taken to raise the income of persons past 65 and of those who will attain such age in the future.

I agree that public policy must make war on inflation, to stop the cost-price squeeze on those with fixed incomes as so many older citizens are.

In this connection with regard to costs, I interject to urge all those comprising the health care industry vigorously to explore ways to reduce spiralling costs while maintaining high standards.

But beyond this, I further believe additional Federal legislation is needed to assist older persons to finance comprehensive health protection, with the Federal share paid out of general revenues of the Treasury. This is the equitable way to distribute the cost of such a program.

SOCIAL SECURITY FINANCING UNFAIR TO WORKERS

Social security financing of medical care for the aged is grossly unfair. It would put the burden very heavily on wage earners regardless of their income or ability to pay. The $5,200-a-year clerk would pay as much social security tax as the $50,000 corporation executive.

It would be especially unfair on young people, struggling to feed, clothe, house, and educate their children and protect them currently with medical insurance, to be forced to shoulder at the same time the tax for hospital insurance for the aged.

Through all their working years, America's working men and women would be compelled to pay a social security health insurance tax, yet receive none of the benefits for themselves until they reached age 65. Should they die before age 65, they would receive nothing for all their payments.

Social security taxation for aged health insurance is a very regressive tax, hurting most those in the lowest wage brackets. About 50 percent of America's workers earn wages of $5,000 a year or less.

Under the social security financed insurance plan of the administration, even those of the blind, the handicapped, the domestic workers, and the farmworkers who pay social security taxes would be taxed to pay for health care of the well-to-do.

Meantime, 40 percent of all taxable income in the United States on which no social security tax is levied would escape any responsibility whatsoever to help in this problem, including the income of 9 million American workers not in the soecial security system.

This year administration spokesmen conceded that proper financing of its hospital insurance plan requires an increase of 1 percent in social security tax—one-half of 1 percent on the worker and one-half percent on the employer—and raising the wage base to $5,200.

This is double the tax rate the administration said 2 years ago was needed.

The social security tax on workers and employers is already scheduled to go up to 3.8 percent each in 1965 and the tax will apply to the first $5,400 of wages (now $4,800) under a bill reported by the House Ways and Means Committee to finance a 5-percent increase in benefits for social security recipients.

By 1971, the tax rate would be 4.8 percent on workers and a like rate for employers.

The administration's hospital insurance plan would burden the worker with another half percent tax, and the employer, too.

A worker earning $5,200 today now pays $222 in social security tax at the present $4,800 wage base. Under the administration hospital insurance plan with its $5,200 wage base and a one-half percent increase in tax, he would pay $266.50.

Of this $44.50 increase, $13.82 is for additional OASDI benefits and $30.68 for health insurance.

If instead of paying the administration's proposed maximum hospital insurance tax of $30.68, a worker age 20 deposited $30.68 each year for 45 years to age 65 in an insured savings and loan association at 4¾ percent interest compounded quarterly (a common rate in Hawaii and west coast States), he would have a nest egg of $4,761.62.

If he continues to invest the $4,761.62 at 4¾ percent interest compounded quarterly, he could buy an excellent medical care insurance policy with the $230.23 in interest on his savings each year and get better coverage than the administration's plan would provide.

Most startling of all, after he died, his nest egg of $4,761.62 would go to his family. Should he die before age 65, his family would inherit his accumulated savings plus compound interest amassed by time of death. Under the administration plan, he would build no nest egg.

As one who has cosponsored an excellent voluntary health insurance plan for aged persons not eligible for Kerr-Mills or old-age assistance and as one who voted for the Kerr-Mills Act of 1960, I believe there are better ways than the social security plan of the administration to meet the remaining problem.

As the administration plan is woefully inadequate, Congress should continue to explore better ways to meet the need.

APPENDIXES[1]

APPENDIX A

RESPONSES TO SUBCOMMITTEE QUESTIONNAIRES RECEIVED FROM INDIVIDUAL INSURANCE COMPANIES:

1. BANKERS LIFE & CASUALTY CO.
2. CONTINENTAL CASUALTY CO.
3. FIREMAN'S FUND INSURANCE CO.
4. MUTUAL OF OMAHA.

1. BANKERS LIFE & CASUALTY CO.

BANKERS LIFE & CASUALTY CO.,
Chicago, Ill., April 22, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR MCNAMARA: Enclosed herewith is table 1–A which we request that you kindly add as an addendum to our submission dated April 15, 1964, of material responsive to questions submitted to us by your committee. You will note that the added table segregates the numbers of insured persons having hospital-surgical plans, medical-surgical plans and hospital indemnity plans. The totals add up to the same number of policyholders as appeared on our original submission.

It was our impression that you originally requested figures as to total policyholders of health insurance over age 65 excluding only disability income. This was the basis upon which we suppplied the material as originally submitted. With the addition of table 1–A you will have the benefit of the breakdown as above indicated. It should be noted, however, that with the exception of those insured under the GR–706 and P–12, certain scheduled benefits for X-rays, laboratory, etc., were payable whether such expenses were incurred in or out of a hospital on other listed medical-surgical policies. All of the medical-surgical plans contain a surgical schedule, the benefits of which could be assigned to the hospital.

Yours very truly,

EDWARD J. KELLY, *First Vice President.*

[1] References appear in the several appendixes to certain enclosures and attachments which have been omitted due to limitations of space. These data are on file with the subcommittee and are available for study in the subcommittee offices upon written request.

TABLE 1-A

NUMBER OF PERSONS AGE 65 AND OVER APPEARING ON TABLE I HAVING HOSPITAL-SURGICAL PLANS

Plan	In force as of—		
	Dec. 31, 1961	Dec. 31, 1962	Dec. 31, 1963
GR-702	1,285	1,176	869
GR-708		121	242
GR-709		16,589	43,255
P-5	151,036	148,824	133,354
P-6	72,295	65,993	58,544
P-15	1,596	1,470	1,298
P-27	71,375	119,081	143,444
P-33	1,018	869	831
P-45	190	162	119
P-56	1,284	1,676	1,664
P-62	950	2,985	2,674
P-65	101,634	72,770	65,835
P-72	3,289	2,560	2,260
P-76	7,137	9,736	10,685
P-77	5,649	6,883	6,664
P-85	233,400	210,367	186,323
OBS	9,167	9,333	8,609
NC-701	92	119	186
Subtotal	661,397	670,714	666,856
NUMBER OF PERSONS ELIMINATED FROM TABLE I HAVING MEDICAL-SURGICAL PLANS			
GR-706		12,824	33,079
P-9	25,841	23,345	20,785
P-12	139,442	130,996	113,140
P-19	1,503	1,361	1,213
P-69	2,419	24,040	21,874
P-89	181,490	163,991	147,027
Subtotal	350,695	356,557	337,118
NUMBER OF PERSONS ELIMINATED FROM TABLE I HAVING HOSPITAL INDEMNITY PLANS			
GR-710		7,379	17,702
P-39	15,602	15,719	14,391
P-55	73,167	71,613	64,277
Subtotal	88,769	94,711	96,370
Total per table I	1,100,861	1,121,982	1,100,344

BANKERS LIFE & CASUALTY CO.,
Chicago, Ill., April 15, 1964.

HON. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR MCNAMARA: This company is happy to respond with the best available data to the questions submitted to us by the subcommittee. Our personnel has been most appreciative of the assistance of the subcommittee staff members in clarifying problem areas and providing guidance to assure maximum responsiveness.

The material, related information, sources, and exhibits with respect to persons aged 65 and over for the last 3 calendar years will be treated in the order of your questionnaire.

I. TOTAL POLICYHOLDERS (CLASSIFIED BY GROUP AND INDIVIDUAL)

Figures below refer to individual and family group policies written by this company—not true group insurance. Under true group insurance, not a significant part of this company's business, we insure only about 3,000 persons 65 years of age or over.

Total policyholders covered under individual, hospital-medical, and surgical policies (estimated):

As of Dec. 31, 1961	1,100,861
As of Dec. 31, 1962	1,121,982
As of Dec. 31, 1963	1,100,344

Data providing answers to this question was not readily available from standard company records. We have attempted to use the most accurate techniques applicable to the pertinent information to formulate the above estimates.

Our policy P–27 is written exclusively on an individual basis for people age 65 and over so for this policy we have an exact count. Under policies GR–735, GR–739, P–7, P–7A, P–29, 959, 978, and P–86, we assumed no insureds would have reached 65 because the maximum issue ages combined with the maximum duration as of December 31, 1963, would have resulted in few, if any, insureds being 65 or more.

The total number of FH–42 and FH–75 policies was only 3,522, too small a number to have substantially affected the results, prompting us to assume no over 65 insured among these policyholders.

For policies 706, 709, and 710, we were able to analyze by computer the issues of the first 6 months of 1963 and from the data obtained by such analysis estimate the total number of persons insured under these plans at ages 65 and over.

Our estimate for all remaining policies was based on a computer analysis of the age of the applicant for 15 selected plans plus studies of various samples of in-force business made in the past.

A. Available data concerning other health insurance coverage held by policyholders

This company has no data regarding other health insurance coverage of our policyholders.

II. BENEFITS AND PREMIUMS

A. Policy forms, benefits, changes

B. Monthly premium charge, changes

The enclosed binder, "The Modern Answer," contains detailed information on benefits, premiums, and changes on each policy, plus sample policies, for each plan available to persons over 65 during 1961, 1962, 1963. Rate cards indicate rates applicable to those years. Also included are rates which are applicable on policies written since January 1, 1964. Policies issued prior to that date continue at previous rates.

C. Number of policyholders for each policy described

Attached hereto as table I is our estimate of policyholders for each policy form. Included are those covered by policy forms in exhibit noted above (II–B). Other policies appearing in table I were available to persons over 65 prior to the years requested in this survey.

III. EXPERIENCE

A. Premiums earned by policy form

B. Claims incurred by policy form

Present company recordkeeping does not facilitate gathering data on either premiums earned or claims incurred by policy form with respect to insureds over 65. Again, our experience with the policy form issued solely to persons over that age (P–27) does provide total premium and benefit figures as reported to the State insurance department each June 30. (This experience is attached as table II.)

IV. EXCLUSIONS AND LIMITATIONS

Detailed information contained in the exhibit referred to in question II ("The Modern Answer") specifically covers exclusions, limitations, and waiting periods for all policy forms.

V. ADVERTISING

Radio and printed advertising material directed specifically at persons over 65 has been bound separately as an enclosed exhibit for convenience.

VI. UNDERWRITING

A. Initial issuance, impaired risks

We do not have and cannot accurately estimate any relative figures on persons rated as impaired risks over 65 in comparison with younger applicants.

B. Administrative directives

You will note that there are no special instructions pertaining to overage applicants in the field office bulletins included with the exhibit material titled, "The Modern Answer."

C. Reunderwriting

1. Riders or waivers

All riders or restrictive riders are included in the exhibit "The Modern Answer" previously referred to.

2. Riders or waivers issued

3. Cancellation and termination

Again, the company's recordkeeping procedure provides no basis for making figures available and no base for a valid estimate, particularly since rewriting is not done on the basis of age.

4. Administrative directive to claims personnel

Enclosed as a separately bound exhibit is the company's entire catalog of directives and instructions for reunderwriting, entitled "Postclaim Underwriting."

VII. ATTRITION

A. Number of policyholders signed up during 1961, 1962, 1963

B. Those no longer insured for reasons other than death

C. Those no longer insured who received benefit

D. Reinstatement

Company recordkeeping again makes impractical any valid estimates of over 65 policyholders in the categories questioned. The same statistical method used to accurately estimate an answer to question I could be applied to question IV, A only, but would not be applicable for the other parts of the question.

However, the company's experience with its policy form written solely for over-65 persons (P–27), used previously for illustrative purposes, might again be useful.

IN FORCE

Year	Issued	Dec. 31, 1961	Dec. 31, 1962	Dec. 31, 1963
1961	76,764	66,654	49,804	41,130
1962	77,631		64,834	48,446
1963	62,280			50,364

These figures are raw and do not take into account the accepted level of persistency seen in all policies, or mortality. Application of the 1958 CSO mortality tables for the age group in question to the above would account for attrition by death of approximately 14,317 insureds. Normal persistency rate for those over 65 is believed to run higher than the average for all insured though, again, no firm estimates can be made.

Nonetheless, even among this identifiable example group of former over-65 policyholders it is impossible to determine how many had received benefits.

While no statistical correlation can be made with the above figures, it is worth noting that they have been drawn from the same policy form experience (P–27) instanced in answer to question III, B, with table II revealing a 1963 loss ratio of 76 percent for 1961 policies.

VIII. RISKS, CAPABILITY OF PRIVATE HEALTH INSURANCE: PREMIUM PROJECTION

Since this company entered the health insurance field it has purposefully designed coverage and premium patterns to provide health protection to large numbers of people, at all ages, at a price within reach.

We were the first private company to offer the convenience and budgeting ease of monthly premium payments. This practice continues. As a result, our policies have had appeal to middle and lower income groups.

Over a relatively few years we have been part of the growth of a new service industry which arose in answer to need and demand with, initially, very little available data for projecting claim-premium ratios.

Blue Cross organizations, originally specializing in group coverage, left millions unprotected while at the same time creating a growing awareness of and demand for protection among those not eligible for group protection. Against this background, early policies in the field were limited in protection and were cancelable, following generally accepted underwriting principles correlating premium cost to the insured risk.

Accumulated experience led us to move from cancelable policies to those renewable at the option of the company. This advance in policy form enabled many thousands to maintain their health insurance, without change in benefit or cost, through a predetermined renewal date.

More recently, still more extensive experience has evolved the guaranteed renewable policy form, with the reserved right to adjust premiums on a class basis. First, many such policies were renewable only to certain ages—usually 50 to 65—but now many are renewable for life, again with the reserved right to adjust premiums.

This company issues such policies and is currently developing new basic, major medical and hospital disability policies. A recent policy provides paid-up coverage at age 65.

Parallel with the pattern of developing ever-increasing coverage to an ever-broadening segment of the population and to an ever-higher age level, has been our effort to keep in mind the appeal to those of limited means by standardizing the risks at the outset.

The result—no increase in premium rate for our policies until 1963. At that time, an across the board percentage increase was made, regardless of age, on policies issued prior to 1955.

This pattern of evolution has been a business philosophy, as well as a policy. As was said by an official of the company in an address at a recent accident and health industry meeting: "Our general objective in underwriting at all ages has been to obtain a body of insured lives in each premium class whose individual prospects of suffering an insured loss do not differ widely from the norm for that class. To achieve this we must consider antiselection by declining to insure or by offering special treatment to the individual who presents a risk appreciably greater than that which the standard premium was designed to cover."

This history and the company philosophy which underlies it must color our answer. We can be realistic and practical despite the relatively short span of our experience with over-65 insurance.

There simply does not exist sufficient information to document a definite conclusion regarding comprehensive insurance of persons over 65 for the indefinite future. But we do have sufficient experience to come to some tentative conclusions.

We know health costs are rising. We know insurance administrative costs are rising. We know enormous strides have been taken in private insurance in the last few years. We know millions of elderly people have been relieved of the nagging worry of their future health needs.

While we also know we have not got the answer for everyone, we believe progress will continue.

And we also know there are realistic limitations, quite apart from what one company or an industry can do, which will affect the individual's opportunity or ability to continue or obtain health insurance coverage when he reaches 65.

We take considerable pride in our role in the evolution of this business. Since 1945, we have made a constantly widening variety of protective policies available to an increasing percentage of persons to age 80 and above with the valuable advantage of monthly budgeted premiums.

We have also developed a plan of mass marketing, predicated on direct mail and media advertising, carefully planned to bring interested applicants to State licensed local resident agents.

Basic renewable coverage to impaired risks, with limited coverage for particular conditions, has permitted us to afford valuable protection to elderly persons who would normally otherwise be totally uninsurable. Supplementary coverage, such as weekly indemnity during hospitalization, guaranteed renewable medical coverage now under study and other projected refinements—made scientifically and not for pure competitive reasons—will, in our view, continue to make private health insurance more attractive to the elderly.

In the health insurance area, and with particular regard to the elderly, we confidently believe we can continually offer health coverage, providing the greatest good to the greatest number, within their economic reach, consistent with the welfare of the company and justice to other policyholders.

Beyond that, we cannot go in good conscience and on the basis of experience thus far accumulated.

Respectfully submitted.

EDWARD J. KELLY, *First Vice President.*

TABLE 1.—*Number of persons age 65 and over, by plan*

Plan	In force as of—		
	Dec. 31, 1961 [1]	Dec. 31, 1962 [1]	Dec. 31, 1963 [1]
GR-702	1,285	1,176	869
GR-706		12,824	33,079
GR-708		121	242
GR-709		16,589	43,255
GR-710		7,379	17,702
P-5	151,036	148,824	133,354
P-6	72,295	65,993	58,544
P-9	25,841	23,345	20,785
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P-15	1,596	1,470	1,298
P-19	1,503	1,361	1,213
P-27	71,375	119,081	143,444
P-33	1,018	869	831
P-39	15,602	15,719	14,391
P-45	190	162	119
P-55	73,167	71,613	64,277
P-56	1,284	1,676	1,664
P-62	950	2,985	2,674
P-65	101,634	72,770	65,835
P-69	2,419	24,040	21,874
P-72	3,289	2,560	2,260
P-76	7,137	9,736	10,685
P-77	5,649	6,883	6,664
P-85	233,400	210,367	186,323
P-89	181,490	163,991	147,027
OBS	9,167	9,333	8,609
NC-701	92	119	186
Total	1,100,861	1,121,982	1,100,344

[1] Dec. 31, 1961, in-force was based on manual records, and Dec. 31, 1962, and Dec. 31, 1963, in-force on computer records.

TABLE 2.—*P-27 experience (incurred basis)*

Issue year	Year of experience		
	1961	1962	1963
1960:			
Premiums	$412,687	$319,019	$267,533
Claims	$179,114	$208,041	$202,617
Loss ratio (percent)	43	65	76
1961:			
Premiums	$2,842,359	$4,273,048	$3,403,532
Claims	$889,848	$2,339,090	$2,264,292
Loss ratio (percent)	31	55	67
1962:			
Premiums		$3,116,726	$4,247,586
Claims		$1,275,673	$2,552,003
Loss ratio (percent)		41	60
1963:			
Premiums			$2,512,120
Claims			$978,885
Loss ratio (percent)			39

MARCH 11, 1964.

Mr. JOHN MACARTHUR,
President, Bankers Life & Casualty Co.,
Chicago, Ill.

DEAR MR. MACARTHUR: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, Mr. Constantine, of the subcommittee staff, at my direction, called on you some 2 weeks ago to discuss certain questions on an informal basis. The attached list of questions includes some modifications developed as a result of your meeting with Mr. Constantine.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon it is our intention to ask you to testify on the efforts of your organization to meet the health insurance needs of our older Americans.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA, *U.S. Senate,*
Chairman, Subcommittee on Health of the Elderly.

PLEASE PROVIDE INFORMATION AS OF END OF EACH OF LAST 3 CALENDAR YEARS FOR PERSONS AGE 65 AND OVER (EXCEPT WHERE OTHERWISE INDICATED)

I. Total number of different persons insured against items of medical expense—exclusive of holders of disability insurance policies. (Classified by group and individual.)

A. Available data (of any type) concerning other health insurance coverage held by your policyholders—commercial and/or Blue Cross.

II. Benefits and premiums:

A. Policy forms where initial issuance is available to persons age 65 or over: by principal benefits (hospital daily room and board indemnity; allowances for hospital extras; allowances for physicians' services; surgical schedule) noting changes made during each year.

B. Monthly premium charged for each type of policy form described in A (please note all changes made during each year).

C. Number of policyholders for each policy form described in A.

III. Experience:

A. Premiums earned by policy form (described in II–A).

B. Claims incurred by policy form (described in II–A).

IV. Exclusions and limitations (including waiting periods) on conditions covered (for each form described in II–A).

V. Copies of all advertising and promotional literature principally directed toward older people and all press releases issued pertaining to the mass enrollment programs.

VI. Underwriting:

A. Initial issuance of individual policies to persons age 65 and over (exclusive of mass enrollment policies)—percent rated as impaired risks and comparison with persons under age 65 rated risks.

B. Copies of all administrative directives to agents and/or brokers relating to field underwriting of individual policies for 65-and-over applicants.

C. Underwriting subsequent to policy issuance or filing or payment of claims (information on policy forms described in II–A):

1. Copies of all restrictive riders or waivers employed.

2. Number of riders issued and number of those to whom riders or waivers were issued who received or filed for a benefit.

3. Cancellation and/or number terminated (nonrenewal) by type of policy and indicating how many of these had received a benefit.

4. Copies of administrative directives to claims personnel relative to company policy on cancellation, ridering of policies, nonrenewal and rating-up of policies where age or claims experience is a factor.

VII. Attrition:

A. Number of different persons signed up during calendar years 1960, 1961, and 1962 (with breakdown of totals as outlined in the note to question II–C).

B. Of those who (during the above years) are no longer policyholders, number

who are no longer insured for reasons other than death (specify reasons: lapses, terminations, cancellations, etc.).

C. Of all those no longer insured (including deaths) how many received a benefit?

D. How many were reinstated?

VIII. Other:

A. What are the unique risks involved in underwriting health insurance for the aged and to what extent do you believe these can be met by private health insurance?

B. Do you anticipate that premium increases will be necessary on some or all of your policies for the 65-and-over population during the next 2 years? Please elaborate, indicating, where appropriate, the percentage increase anticipated and the reasons therefor.

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2. CONTINENTAL CASUALTY CO.

CONTINENTAL CASUALTY CO.,
Chicago, Ill., April 23, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
Special Committee on Aging, U.S. Senate,
Washington, D.C.

MY DEAR SENATOR MCNAMARA: As mentioned in my previous letter of April 17, I am forwarding herewith the response to the list of questions specifically directed to the Golden 65 program.

Also enclosed is a revision of the first page of our response to the general questionnaire for Golden 65 previously forwarded you. In II–C some of the figures opposite the policies or combinations were transposed. This occurred on the second, third, and fourth lines.

We are presently preparing the statements for submission to your subcommittee and will submit 60 copies as requested.

Very truly yours,

RAYMOND M. DEFOSSEZ.

Enclosures.

ANSWERS TO SPECIFIC QUESTIONS ON CONTINENTAL CASUALTY CO. GOLDEN 65 PROGRAM

1. The major national campaign of 1963 resulted in the issuance of 143,854 policies to 105,460 persons:

Combinations of policies issued:	*Number insured*
65-Plus only	26,548
10,000 Reserve only	32,003
5,000 Medical Only	17,319
10,000 Reserve and 65-Plus	6,153
10,000 Reserve and 5,000 Medical	9,762
65-Plus and 5,000 Medical	4,871
65-Plus, 10,000 Reserve and 5,000 Medical	8,804
Total	105,460
Policy:	
65-Plus	46,376
10,000 Reserve	56,722
5,000 Medical	40,756

2.

	Earned premiums	Incurred claims evaluated as of January 1964
65-Plus:		
1957	$117,726	$61,049
1958	891,058	577,750
1959	10,595,472	6,569,303
1960	13,447,915	10,675,134
1961	13,410,076	11,269,778
1962	13,571,395	11,799,857
1963	14,563,353	13,158,573
5,000 Reserve:		
1960	2,129,948	1,314,236
1961	6,590,694	6,107,738
1962	5,545,418	5,613,905
1963	2,965,004	3,070,247
10,000 Reserve:		
1962	3,372,483	3,478,070
1963	9,857,582	9,048,105
5,000 Medical:		
1962	1,065,979	133,248
1963	3,155,597	845,570

3. We have had 3,626 claims filed through March 31, 1964 for the period July 1 through December 31, 1963, by persons who enrolled as a result of the June 1963 advertising campaign. Past experience has shown that additional claims chargeable to this period will be reported in subsequent months.

The total dollars of claims incurred for the same 6-month period is estimated to be $1,009,307.

4. The necessity for a rate increase for 65-Plus, 5,000 Reserve and 10,000 Reserve was first acknowledged in late October 1963. Premium increases were not planned when advertising was first placed for the June 1963 campaign.

5. As a consequence of the adjusted estimates of 1962 loss experience as viewed on July 29, 1963, the Actuarial Department first began close scrutiny of 1962 results suspecting that this loss experience might have been inaccurately evaluated in earlier analyses. By October 1963, it was apparent that the July 29 analysis was substantially correct and this, in addition to the rising loss ratios developing for 1963 experience, was responsible for the rate increases which were recommended for the 65-Plus, 5,000 Reserve and 10,000 Reserve programs. These increases were recommended in order to maintain the programs on a self-sustaining basis.

6. On the basis of our previous experience with 65-Plus, we anticipate that the revised rates should prove adequate for about 5 years, as did the former rates. The rates for 10,000 Reserve are more affected by inflation, and may require much earlier review, but they should prove adequate for at least 2 to 3 years.

7. The attached exhibit I depicts the 1962 loss experience for the 65-Plus, 5,000 Reserve and 10,000 Reserve programs as it appeared at successive periods in 1963. Also shown is 1963 loss experience as evaluated in July and October 1963.

8. According to information now available, it is estimated that 4.2 percent of existing in force policies (including 5,000 Medical, 65-Plus, 10,000 Reserve and 5,000 Reserve) terminated because of the rate increase.

No data are available which enable us to determine the number of policyholders which terminated since a lapsed policy may be only one of three held by the policyholder or the only one held by the policyholder. Furthermore, in order to derive the data above, it was necessary to estimate the terminations in excess of the average terminations normally experienced from all other causes. The normal terminations for business inforce for 6 months or more, and the figure used for this estimate, is approximately 1 percent per month.

EXHIBIT I

1962 loss experience

	Evaluated as of—			
	January 1963	April 1963	July 1963	October 1963
65-Plus:				
Earned	$13,571,395	$13,571,395	$13,571,395	$13,571,395
Incurred	$11,734,996	$11,678,254	$11,822,146	$11,802,359
Loss ratio	.865	.861	.871	.870
5,000 Reserve:				
Earned	$5,545,418	$5,545,418	$5,545,418	$5,545,418
Incurred	$5,641,819	$5,589,313	$5,627,095	$5,619,237
Loss ratio	1.017	1.008	1.015	1.013
10,000 Reserve:				
Earned	$3,372,483	$3,372,483	$3,372,483	$3,372,483
Incurred	$2,529,362	$2,782,512	$3,490,000	$3,498,562
Loss ratio	.750	.825	1.035	1.037

1963 loss experience, excluding new business written, June 1963

	Evaluated as of—	
	July 1963 (5 months)	October 1963 (9 months)
65-Plus:		
Earned	$5,651,058	$9,885,066
Incurred	$5,307,000	$9,443,266
Loss ratio	.939	.955
5,000 Reserve:		
Earned	$1,458,765	$2,340,792
Incurred	$1,574,572	$2,599,307
Loss ratio	1.079	1.093
10,000 Reserve:		
Earned	$3,024,869	$5,305,298
Incurred	$3,674,940	$6,248,206
Loss ratio	1.215	1.178

CONTINENTAL ASSURANCE CO.,
Chicago, Ill., April 17, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
Special Committee on Aging, U.S. Senate,
Washington, D.C.

MY DEAR SENATOR MCNAMARA: The four attachments to this letter and the files contained in the carton forwarded herewith are in response to the list of questions submitted with your letter of March 13, 1964, to Mr. Edwin H. Forkel.

Attachment I covers our individual and association franchise lines. Attachment II covers our Golden 65 program. Attachment III covers our group and mass enrollment programs other than Golden 65. Attachment IV answers questions VIII–A and VIII–B for all lines of business.

In each instance where data was available, we have supplied detailed information. In those instances where data was not readily available but reliable estimates could be prepared, they have been furnished. Only where data was not available and reliable estimates could not be supplied was the response negative.

The material in response to the list of questions specifically directed to the Golden 65 program is still in preparation. We should be able to forward it to you during the coming week.

As you can appreciate the compilation of data in reply to both lists of questions has necessitated a considerable amount of time, effort, and expense. If you have any questions concerning the material forwarded thus far, please let me know.

Sincerely yours,

RAYMOND M. DEFOSSEZ.

ATTACHMENT I

INDIVIDUAL AND ASSOCIATION FRANCHISE LINES

I. Total number of different persons insured against items of medical expense. (See exhibit A.)

A. Available data concerning other health insurance coverage of overage policyholders. Data are available for the individual lines only.

Data are only on any other coverage and cannot be broken down to indicate which coverage duplicates that being applied for.

Year	Number indicating other coverage	Percentage indicating other coverage (percent)
1963	13,469	42.4
1962	12,102	42.9
1961	16,426	44.3

II. Benefits and premiums:

A. Policy forms where initial issuance is available to persons age 65 and over. See exhibit B for a summary of major benefits by policy form and enclosed folders containing copies of these forms currently sold to persons 65 and over.

These also contain:

(1) Policy form variations by State.
(2) Circulars, brochures, and advertising pieces.
(3) Underwriting bulletins.
(4) Rates.
(5) Exclusions and limitations (specified in the policy).

B. Monthly (and/or annual) premium. See brochures and/or rate sheets in enclosed folders on policy forms and exhibit C for association franchise.

C. Number of policyholders and dependents on each form who are age 65 and over. See exhibit A.

III. Experience:

Data are not available on insureds age 65 or over for the individual lines. This is because the majority of these forms are available to persons both under and over age 65. Even those forms designated as overage are sold to persons age 60 and over. For association franchise forms experience is available and is given in exhibit C.

IV. Exclusions and limitations: See enclosed folders and policy forms.

V. Advertising and promotional literature: See enclosed folders on policy forms. Not all literature included is directed exclusively to overage persons.

VI. Underwriting:

A. Initial issuance to persons age 65 and over. See exhibit C.

B. Copies of all administrative directives relating to field underwriting. See enclosed folders on policy forms.

C. Underwriting subsequent to policy issuance.

1. Copies of all restrictive riders or waivers employed. See folder entitled "Restrictive Riders or Waivers."

2. Number of riders or waivers issued. See exhibit E.

3. Cancellation and termination. See exhibit E. No data are available by type of policy.

4. Administrative directives to claims personnel. See folder entitled "Postclaim Underwriting—Age Reviews."

VII. Attrition:

A. Number of different persons signed up by calendar year. See exhibit F.

B. Number no longer insured for reasons other than death. See exhibit F.

C. Number no longer insured for any reason who received benefits. See exhibit F.

D. Number reinstated. No data available.

EXHIBIT A

Overage insureds and dependents by policy form

Form	Type	1963	1962	1961
DP-1543	Hospital	3,286	3,464	3,578
IP-7472	do	35,730	37,266	38,410
IP-7473	do	9,477	9,562	9,941
DP-8502	do	10,652	11,145	12,540
DP-8503	do	15,180	17,381	18,925
AP-8701	Catastrophe hospital	4,287	4,791	5,436
AP-8715	do	1,149	1,287	1,427
RP-9372	Hospital		[1]	
RP-9372	do		[1]	
CP-9962	do	12,503	12,691	12,428
SSP-11070	Substandard hospital	9,655	9,197	8,932
AP-11704	Catastrophe hospital	19,099	16,357	16,884
AP-11856	Catastrophe	4,319	4,254	4,183
SSP-15167	Substandard catastrophe hospital	643	591	517
DP-16461	Hospital	454	379	303
AP-16921	Catastrophe hospital	405	312	256
SSP-16950	Substandard hospital (60 and over)	174	213	207
AP-17025	Hospital	767	776	679
AP-17026	Hospital (age 60 and over)	186	181	176
IP-18528	Hospital	9,801	5,606	1,431
DP-18596	do	4,257	2,192	187
DP-20677	Surgical-medical	1,413	239	[2]
DP-21601	Weekly indemnity hospital	1,162	98	[2]
AGP-10503				
AGP-15152				
AGQ-15269	Hospital	656	622	383
AGP-15764				
AGQ-18528				
AGQ-20586				
	Total [3]	145,255	138,604	136,823
	Other [4]	37,839	42,323	40,620
	Total [5]	183,094	180,927	177,443

[1] Not available.
[2] Not sold.
[3] Includes both insureds and dependents.
[4] Includes both insureds and dependents on forms no longer available for issue.
[5] Includes both insureds and dependents. Persons covered for hospital, surgical, or miscellaneous expense on disability income forms are not included.

NOTE.—The data shown in this exhibit are the result of some extrapolation and estimation but are believed to be as accurate as our records allow.

EXHIBIT B

Summary of coverage

Form	Hospital R. & B.	Surgical	Miscellaneous	Medical
DP-1543	Available in policy	Available by rider	Available in policy	Not available.
IP-7472	do	do	do	Available by rider.
IP-7473	do	do	do	Do.
DP-8502	do	do	do	Not available.
DP-8503	do	Not available	do	Do.
AP-8701	do	do	do	Do.
AP-8715	do	do	do	Do.
RP-9372	do	Available by rider	Available by rider	Available by rider.
RP-9373	do	do	do	Do.
CP-9962	do	do	Available in policy	Not available.
AGQ-10503	do	Available in policy	do	Do.
SSP-11070	do	Available by rider	do	Do.
AP-11704	do	Available in policy	do	Available in policy.
AP-11856	do	do	do	Do.
AGP-15152	do	do	do	Not available.
SSP-15167	do	do	do	Do.
AGQ-15269	do	do	do	Do.
AGP-15764	do	do	do	Do.
DP-16461	do	do	do	Available in policy.
AP-16921	do	do	do	Do.
SSP-16950	do	Available by rider	do	Not available.
AP-17025	do	do	do	Do.
AP-17026	do	do	do	Do.
AGQ-18044	do	Available in policy	do	Available by rider.
IP-18528	do	Available by rider	Not available	Do.
DP-18596	do	do	Available in policy	Do.
AGQ-20586	do	Not available	Not available	Not available.
DP-20677	Not available	Available in policy	do	Available in policy.
DP-21601	Available in policy	Not available	do	Not available.

EXHIBIT C

Association franchise rate and experience data

ANNUAL PREMIUMS

Form	Insured	Insured and spouse
AGQ-10503	$60.00	$140.00
AGP-15152	106.00	212.00
AGQ-15269	75.00	150.00
AGP-15764	79.20	158.40
AGQ-18044	110.00	220.00
AGQ-20586	28.00	56.00

EXPERIENCE ON ALL THE ABOVE FORMS

Year	Earned premium	Incurred losses
1963	$66,762	$48,519
1962	53,449	35,649
1961	41,738	28,978

EXHIBIT D

	1963	Percent	1962	Percent	1961	Percent
Total applications written	221,619		215,318		208,893	
Total hospital, surgical, catastrophe applications written	102,794		92,703		109,280	
Overage hospital, surgical, catastrophe	32,268		28,624		37,539	
Waivered, rated	11,577		10,240		14,953	
Percentage to total overage hospital, surgical, catastrophe		35.9		35.8		39.8
Standard	20,691		18,384		22,586	
Percentage to total overage hospital, surgical, catastrophe		64.1		64.2		60.2
Underage hospital, surgical, catastrophe	70,526		64,079		71,741	
Waivered, rated	9,753		8,642		10,520	
Percentage to total underage hospital, surgical, catastrophe		13.8		13.6		14.3
Standard	60,773		554,437		61,221	
Percentage to total underage hospital, surgical, catastrophe		86.2		86.4		85.7

EXHIBIT E

Underwriting subsequent to policy issuance

	1963	1962	1961
A. Due to the filing of claims:			
Total overage hospital, surgical, catastrophe claims received	22,442	22,160	22,246
I. Number offered waivers or substandard	5,610	5,540	5,562
Number of these who had received benefits	(1)	(1)	(1)
II. Number canceled or nonrenewed	898	886	890
Number of these who had received benefits	884	873	877
B. Due to age:			
Total overage hospital-surgical catastrophe applications reviewed	6,377	6,966	8,666
I. Number of these nonrenewed	1,913	2,090	2,600
(All were offered rewrite to overage hospital) Number of these who had received benefit	1,664	1,818	2,262
C. Total:			
Number canceled or nonrenewed	2,811	2,976	3,490
Number of these who received benefits	2,548	2,691	3,139

[1] Not available.

EXHIBIT F

	1962	1961	1960
Total overage hospital, surgical, catastrophe applications	28,624	37,539	41,103
Basic hospital only	16,159	21,133	23,262
Catastrophe only	9,248	12,088	13,144
Combination basic and catastrophe	3,158	4,240	4,590
Miscellaneous (hospital, surgical only)	59	78	107
Number no longer insured for reasons other than death	7,843	15,390	18,579
Lapsed	7,528	14,790	18,373
Nonrenewed	229	450	575
Canceled	86	150	206
Number no longer insured for any reason who received benefits	1,717	4,692	7,522

ATTACHMENT II

REVISION—GOLDEN 65

I. Total number of persons holding active policies at the end of each calendar year:

Plan	1961	1962	1963
65-Plus	174,602	181,052	194,708
5,000 Reserve	90,672	42,062	28,884
10,000 Reserve	(1)	66,311	106,245
5,000 Medical	(1)	39,613	64,669
Total	265,274	329,038	394,506

[1] Not issued.

Numbers of those persons holding one policy only and those persons holding each of the various combinations of policies, are available at the end of 1963 only, and are submitted in reply to II–C.

A. Data concerning other health insurance coverages held by Golden 65 policyholders are not available. Such information has not been requested by the company.

II. Benefits and premiums:

A. See exhibit A.

B. Monthly premium charged for each type of policy form described in II–A:

Plan	1961	1962	1963	1964 [1]
65-Plus	$6.50	$6.50	$6.50	$8.00
5,000 Reserve	7.00	7.00	7.00	9.50
10,000 Reserve	(2)	9.50	9.50	12.50
5,000 Medical	(2)	5.00	5.00	5.00

[1] Policyholders on 3 of our plans were notified in December 1963 of a nationwide rate increase effective in the 1st quarter of 1964.
[2] Not issued.

C. Numbers of those persons holding one policy only and those persons holding each of the various combinations of policies are available as of the end of calendar year 1963 only.

Policies or combinations of policies:	*Number of policyholders at Dec. 31, 1963*
65-Plus only	101,702
10,000 Reserve only	35,045
5,000 Medical only	6,053
5,000 Reserve only	9,246
65-Plus and 10,000 Reserve	27,432
65-Plus and 5,000 Reserve	18,376
65-Plus and 5,000 Medical	13,586
10,000 Reserve and 5,000 Medical	11,276
5,000 Medical and 5,000 Reserve	142
65-Plus, 10,000 Reserve and 5,000 Medical	32,492
65-Plus, 5,000 Reserve and 5,000 Medical	1,120
Total	256,470

Numbers of active policies held at the end of each calendar year are submitted in reply to I.

III. Experience:

Plan	A. Premiums earned	B. Claims incurred
65-Plus:		
1961	13,410,076	11,269,778
1962	13,571,395	11,799,857
1963	14,563,353	13,158,573
5,000 Reserve:		
1961	6,590,964	6,107,738
1962	5,545,418	5,613,905
1963	2,965,004	3,070,247
10,000 Reserve:		
1962	3,372,483	3,478,070
1963	9,857,582	9,048,105
5,000 Medical:		
1962	1,065,979	133,248
1963	3,155,597	845,570

IV. Exclusions and limitations: See exhibit A.

V. Advertising, promotional literature, and press releases: See exhibit B.

VI. Underwriting:

A. There is no initial underwriting on Golden 65.

B. Administrative directives relating to field underwriting are not applicable to Golden 65 plans.

C. Underwriting subsequent to policy issuance or filing or payment of claims is not applicable to golden 65 plans.

1. Restrictive riders or waivers are not employed.
2. Restrictive riders or waivers are not employed.
3. No Golden 65 policy has been canceled or nonrenewed by the company.
4. Administrative directives to claims personnel relative to company policy on cancellation, ridering, nonrenewal, or rating-up of policies are not applicable to Golden 65 plans.

VII. Attrition:

A. Detailed information regarding the number of persons issued a policy or a combination of policies as opposed to the number of policies issued was not kept for years prior to 1963.

Total policies issued

Plan	1960	1961	1962
65-Plus	9,216	31,131	34,704
5,000 Reserve	57,722	61,980	423
10,000 Reserve	(1)	(1)	[2] 37,034
5,000 Medical	(1)	(1)	40,069

[1] Not issued.
[2] Does not include 33,874 conversions from 5,000 Reserve.

Combinations of policies issued:	*1963*
65-Plus only	26,548
10,000 Reserve only	32,003
5,000 Medical only	17,319
10,000 Reserve and 65-Plus	6,153
10,000 Reserve and 5,000 Medical	9,762
65-Plus and 5,000 Medical	4,871
65-Plus, 10,000 Reserve and 5,000 Medical	8,804
Total	105,460

B. Annual counts for total reduction of in-force policies only are available:

Year:	*Total reduction of in-force policies*
1960	38,129
1961	47,911
1962	48,466

Information regarding the cause of lapse is not available. However, during 1961 we maintained counts of those policies no longer active due to reported deaths. These totaled 18,517. Since notification of death is not required, we have no means of knowing how many additional lapses were due to unreported deaths.

C. We have no available data with which to obtain the number of those no longer insured who had received a benefit under Golden 65 policies.

D. Reinstatement information is impossible to supply. It has been the policy of the company to be as lenient as possible regarding reinstatements. Once a reinstatement has been made, the reinstated record is indistinguishable from other in-force records.

VIII. A. and B. Responses to these questions are offered elsewhere in reference to all our 65 and over business.

ATTACHMENT III

COMPOSITE GENERAL GROUP

I. 1961, 300,487; 1962, 353,062; and 1963, 414,597.

I. A. No available data of any type.

II. A. See the enclosures for the respective component categories.

B. See the enclosures for the respective component categories.

C. These data are included in (I) above.

III.[1] A. 1961, $20,817,158; 1962, $27,722,698; and 1963, $33,594,690.

B. 1961, $16,598,407; 1962, $19,898,808; and 1963, $27,935,103.

IV. See the enclosures for the respective component categories.

V. See the enclosures for the respective component categories.

VI. A. There is no rating of impaired risks.

B. There have been no administrative directives issued relating to field underwriting of this coverage for age 65 and over applicants.

C. 1. There have been no restrictive riders or waivers employed.

2. There have been no restrictive riders or waivers employed.

3. There have been no cancellations or nonrenewals.

4. There have been no administrative directives issued to claims personnel relative to company policy on cancellation, ridering of policies, nonrenewal and rating up of policies where age or claim experience is a factor.

VII. A. 1960, 4,682; [2] 1961, 50,568; [3] and 1962, 78,401.[3]

B. 1960, 855; [2] 1961, 19,027; [3] and 1962, 42,478.[3]

C. See the enclosures for the respective component categories.

D. See the enclosures for the respective component categories.

ATTACHMENT IV

ALL OVERAGE PROGRAMS—ANSWERS TO QUESTIONS VIII-A AND VIII-B

VIII-A

Every class of insureds has characteristics peculiar to itself and requires an underwriting approach tailored to these characteristics. The outstanding characteristic of the overage population are the much higher incidence of illness, frequent occurrence of spontaneous and rapid deterioration in health and the preponderance of chronic, disabling or semidisabling illnesses which endure with attendant costs for the balance of the individual's life. In the past, these characteristics have presented problems in the availability, permanence, and cost of health insurance coverage.

The private insurance industry has in recent years evolved two major approaches to deal with these problems. The needs of the present overage population can be served through the mass enrollment approach, which eliminates initial underwriting, provides permanence of coverage, and permits operating economies which hold the cost of providing insurance to a minimum. To meet the need for health insurance in the future, the insurance industry is developing programs of hospital insurance for overage risks which are designed to provide paid-up benefits at age 65 or to provide level premium guaranteed renewable coverage for the life of the

[1] Excludes category "All other general group cases."

[2] Excludes categories "American Association of Retired Persons," "National Retired Teachers Association," "National Association of Retired Civil Employees," and "All other general group cases."

[3] Excludes categories "National Association of Retired Civil Employees" and "All other general group cases."

insured at rates level from the younger issue age. This coverage is available to all persons through individual policies. Similar programs are being tested for group insurance with the tendency being to create special groups of retiring employees with coverage and rates similar to that of the active employees. Such programs also meet the requirements of availability and permanence of insurance, and substantially reduce or eliminate the problem of high premium rates at advanced ages.

VIII–B

Within the past year we have reviewed and revised where necessary, all our major overage rate structures. As a result, we do not anticipate that any additional revisions will be required in the near future.

MARCH 19, 1964.

Mr. EDWIN A. FORKEL,
President, Continental Casualty Co., Chicago, Ill.

DEAR MR. FORKEL: Senator McNamara would appreciate your making the following modifications in the questionnaire attached to his letter of March 13.

All data concerning the number of persons insured, or enrolled during a given period should be accompanied by figures indicating the number of persons under age 65 included in the total. For example, the Golden 65 program permits a spouse who is under age 65 to be insured along with the spouse over age 65. Additionally, one of your large mass enrollment programs—that of the AARP–NRTA—includes many persons under age 65. I am sure that you can appreciate our concern that the figures distinguish between age 65 and over and those below that age.

Thank you again for your cooperation.

Sincerely,

JAY B. CONSTANTINE,
Staff Director,
Subcommittee on Health of the Elderly.

MARCH 13, 1964.

Mr. EDWIN A. FORKEL,
President, Continental Casualty Co.,
Chicago, Ill.

DEAR MR. FORKEL: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, Mr. Constantine of the subcommittee staff, at my direction, called on officials of your company some 2 weeks ago to discuss certain questions on an informal basis. The attached list of questions includes some modifications developed as a result of that meeting and subsequent correspondence.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon it is our intention to ask you to testify on the efforts of your company to meet the health insurance needs of our older Americans.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

CONTINENTAL CASUALTY CO. GOLDEN 65 PROGRAM

1. How many different persons were issued policies as a result of the major national advertising effort of last summer to promote Golden 65? (Please breakdown total as per note in preceding question II–C.)

2. Would you indicate separately, the earned premiums and incurred claims for each of the options of the Golden 65 program, by calendar year since initial offering of each option.

3. During the period July 1 through December 31, 1963, how many different persons of those enrolled in your 65-Plus option, as a result of your advertising campaign, received a benefit? What was the total dollar amount of incurred claims during that 6-month period from those new policyholders?

4. When was a premium increase on one or more options of the Golden 65 first discussed and considered? Were you aware when the advertising was placed for the campaign of the summer of 1963 that a premium increase was planned or probable on segments of the Golden 65 program?

5. When did your underwriting and/or actuarial department first note and first indicate the necessity for or recommend a premium increase on one or more of the golden 65 options?

6. Are your new premiums based upon present costs of medical care or projected costs of care? If projected cost basis, how far projected?

7. Please attach significant correspondence or documents pertinent to the above questions.

8. How many policyholders have failed to pay their premiums, since the increase was announced?

PLEASE PROVIDE INFORMATION AS OF END OF EACH OF LAST 3 CALENDAR YEARS FOR PERSONS AGE 65 AND OVER (EXCEPT WHERE OTHERWISE INDICATED)

I. Total number of different persons insured against items of medical expense—exclusive of holders of disability insurance policies. (Classified by group and individual.)

A. Available data (of any type) concerning other health insurance coverage held by your policyholders—commercial and/or Blue Cross.

II. Benefits and premiums:

A. Policy forms where initial issuance is available to persons age 65 or over: by principal benefits (hospital daily room and board indemnity; allowances for hospital extras; allowances for physicians' services; surgical schedule) noting changes made during each year.

B. Monthly premium charged for each type of policy form described in A (please note all changes made during each year).

C. Number of policyholders for each policy form described in A.

NOTE.—With regard to your mass enrollment policies please provide breakdowns indicating persons covered for basic only, major medical only, and basic and major medical. For example, on "Golden 65" indicate number holding "65-Plus" only, number holding "5,000 Reserve" only, number holding "10,000 Reserve" only, and separate totals of persons for each of the various combinations of options held by policyholders.

III. Experience:

A. Premiums earned by policy form (described in II–A.)

B. Claims incurred by policy form (described in II–A).

IV. Exclusions and limitations (including waiting periods) on conditions covered (for each form described in II–A).

V. Copies of all advertising and promotional literature principally directed toward older people and all press releases issued pertaining to the mass enrollment programs.

VI. Underwriting:

A. Initial issuance of individual policies to persons age 65 and over (exclusive of mass enrollment policies)—percent rated as impaired risks and comparison with persons under age 65 rated risks.

B. Copies of all administrative directives to agents and/or brokers relating to field underwriting of individual policies for 65-and-over applicants.

C. Underwriting subsequent to policy issuance or filing or payment of claims (information on policy forms described in II–A):

1. Copies of all restrictive riders or waivers employed.

2. Number of riders issued and number of those to whom riders or waivers were issued who received or filed for a benefit.

3. Cancellation and/or number terminated (nonrenewal) by type of policy and indicating how many of these had received a benefit.

4. Copies of administrative directives to claims personnel relative to company policy on cancellation, ridering of policies, nonrenewal and rating-up of policies where age or claims experience is a factor.

VII. Attrition:

A. Number of different persons signed up during calendar years 1960, 1961, and 1962 (with breakdown of totals as outlined in the note to question II–C).

B. Of those who (during the above years) are no longer policyholders, number who are no longer insured for reasons other than death (specify reasons: lapses, terminations, cancellations, etc.).

C. Of all those no longer insured (including deaths) how many received a benefit?

D. How many were reinstated?

VIII. Other:

A. What are the unique risks involved in underwriting health insurance for the aged and to what extent do you believe these can be met by private health insurance?

B. Do you anticipate that premium increases will be necessary on some or all of your policies for the 65-and-over population during the next 2 years? Please elaborate, indicating, where appropriate, the percentage increase anticipated and the reasons therefor.

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3. FIREMAN'S FUND INSURANCE CO.

FIREMAN'S FUND INSURANCE CO.,
San Francisco, Calif., May 6, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: With reference to my letter of April 17 acknowledging yours of March 31 concerning Fund 65 Plan—Plus $10,000 Plan, the following responses are submitted to your seven listed questions and request for material.

1. Attached are the following items:

Item A. Initial enrollment newspaper announcement (February 1, 1959).

Item B. Initial enrollment question and answer booklet (February 1, 1959).

Item C. Second enrollment newspaper announcement (July 1, 1959).

Item D. Payment card enrollment book mailer.

Item E. Third enrollment newspaper announcement (February 1, 1960).

Item F. Fourth enrollment general letter and newspaper mat (September 1, 1960).

Item G. Fifth enrollment staff letter and newspaper mat (February 1, 1961).

Item H. Sixth and seventh enrollment newspaper mat (October 1, 1961 and April 1, 1962).

Item I. Seventh enrollment staff letter and newspaper mat (April 1, 1962).

Item J. Tenth enrollment staff letter, question and answer booklet, newspaper mat (October 1, 1963).

Item K. Twelfth enrollment newspaper mat (April 1, 1964).

2. Fund 65 and Plus $10,000 are two separate coverages not optional plans. In order to buy the Plus $10,000 coverage, the insured must either already have the Fund 65 coverage or apply for both at the same time. Figures in the following answers are for fund 65 only since this gives number of insureds. In all instances, the figures reflect the number of people over age 65 since our plans do not allow the writing of applicants under that age

Item A. Total number of persons enrolled from inception (February 1, 1959 to March 1, 1964)? 78,351.

Item B. Total number of persons accepted for coverage during initial "open" period (February 1, 1959)? 24,465.

Item C. Total number insured immediately prior to and following each of the subsequent "open" periods?

Date:	*Number of new insureds*	Date:	*Number of new insureds*
July 1959	5,007	April 1962	6,835
February 1960	6,681	November 1962	4,385
September 1960	6,271	March 1963	5,315
February 1961	5,373	October 1963	4,500
October 1961	6,979	February 1964	2,540

Item D. Total number of persons insured as of March 1, 1964? 41,882.

3. Of the persons accepted for coverage during our initial open enrollment period, 10,325 were still insured under the program as of March 1, 1964.

4. The average age of the "fund 65" policyholder as of February 1, 1959 was 73.016 years; and as of March 1, 1964 was 75.746 years.

5. Please see attached exhibit I.

6. Please see attached exhibit II.

7. Our current premium which became effective August 1, 1963, anticipated that such premium structure would pay for benefits of the policy as of that date for the foreseeable future.

Very truly yours,

KENNETH T. KING, *Vice President.*

EXHIBIT I

	Premium earned	Losses incurred	Number of claims
1959:			
Basic	1,622,736	998,014	
Plus $10,000			
Total	1,622,736	998,014	4,200
1960:			
Basic	2,297,043	1,457,191	
Plus $10,000			
Total	2,297,043	1,457,191	7,183
1961:			
Basic	2,716,172	1,960,154	
Plus $10,000	191,435	193,148	
Total	2,907,607	2,153,302	9,138
1962:			
Basic	3,172,729	2,256,197	
Plus $10,000	1,089,816	1,262,754	
Total	4,262,545	3,518,951	12,374
1963:			
Basic	3,467,789	2,557,276	
Plus $10,000	1,921,690	2,832,934	
Total	5,389,479	5,390,210	15,286

EXHIBIT II

FUND 65 PLAN PLUS $10,000 PLAN

DEAR POLICYHOLDER: On February 1, 1959, the Fireman's Fund introduced its Fund 65 Plan to help defray the cost of illness and accident to our senior citizens. Later, recognizing the need for greater amounts of protection, we added the Plus $10,000 Plan. Policyholders have received more than $9 million in benefits under these plans in the 4½-year period that coverage has been available. We are justifiably proud of having been one of the first insurance companies to recognize these needs and to provide this protection.

However, during the past several years, costs of medical and hospital care have gradually and substantially increased and at a much higher rate than most other costs of living. The result has been a substantial increase in benefit payments.

These, together with other factors of increasing cost, create the necessity for raising the premium on the Plus $10,000 Plan effective August 12, 1963. Believing there is a real need and desire for this protection, we had no difficulty in concluding that this action was preferable to the alternative of curtailing existing coverage or eliminating the Plus $10,000 Plan from the program.

If you wish to keep your present Fund 65-Plus $10,000 policy, your new monthly premium, effective August 12, 1963, will be $15.75. If this is your desire, you should use one of the payment cards in the enclosed book to make your August 1963 payment and subsequent payments. Any advance payments you have made beyond August 12, 1963, which were received by us prior to June 15, 1963, have been credited in your new Fund 65-Plus $10,000 payment book at the rate of $15.75 per month. The first payment card indicates the amount and the due date of your next premium payment, provided that you have paid the July premium.

If you wish, you may participate in the Fund 65 Plan only at a cost (unchanged) of $6.50 per month. The coverage provided is that described under parts II and III in your present policy. If this is your desire, you should make your August

1963 payment by sending $6.50, together with the enclosed Fund 65 only election card. We will then send you a new policy and a new payment book which wil reflect any advance payments you have made.

Your current supply of return envelopes can be used to make this payment and subsequent payments. If you do not have return envelopes, please address your response to the post office box number shown on the payment coupons and the election card.

The effective date of coverage indicated in your present policy will not change regardless of whether you choose to keep your present Fund 65-Plus $10,000 policy or participate only in the Fund 65 Plan. This means the 6-month waiting period in your policy for preexisting conditions will not apply.

It is important that you make your decision without delay. If you do not pay either $15.75 to continue the Fund 65-Plus $10,000 program or $6.50 for the Fund 65 only Plan (unless you have advance premiums as outlined in the above paragraphs), you should understand that your coverage will expire under the terms of the policy on August 12, 1963, for nonpayment of premium.

Even with the increase in monthly premium, we believe thoughtful evaluation will indicate to you that the Fund 65-Plus $10,000 protection still represents the most outstanding value in the field of insurance for senior citizens.

Sincerely,

KENNETH T. KING, *Vice President.*

MARCH 31, 1964.

MR. KENNETH T. KING,
Vice President, Fireman's Fund,
San Francisco, Calif.

DEAR MR. KING: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff, to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

"FUND 65 PLAN—PLUS $10,000 PLAN"

1. All literature describing benefits and premiums, including scripts and "tearsheets" used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open enrollment" period; total number of persons insured immediately prior to and following each of any subsequent "open" periods; and total number of persons insured as of March 1, 1964. (Please break down these data to show subtotals indicating number of different persons in each of your various coverage options.)

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those persons under age 65.

3. How many of those persons accepted for coverage during your initial "open enrollment" period were still insured under the program as of March 1, 1964?

4. What was the average age of the "Fund 65" policyholder as of the end of your initial enrollment period? What was the average age as of March 1, 1964?

5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

6. Please provide the details of any premiums and/or benefit changes which have been made in your program since its inception.

7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

4. MUTUAL OF OMAHA INSURANCE CO.

MUTUAL OF OMAHA INSURANCE CO.,
Washington, D.C., April 24, 1964.

Mr. JAY B. CONSTANTINE,
Staff Director, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR MR. CONSTANTINE: Attached is our response to the questionnaire which has been prepared by our staff in Omaha.

Reference is made in the questionnaire to policy bulletins and certain other printed matter. As of this writing (5:05 p.m., Friday) I have not received the carton shipped to me from Omaha which is now being traced by the Air Express officials.

As explained to you previously by other officials of our company, we regret our inability to be more prompt in our reply to your questionnaire. As you have been previously informed, the officials of our company have been committed to sales meetings in various parts of the country and have been able to work on this survey only on week ends and the 1 or 2 days their busy schedule has allowed them to return to the general offices. Also, we had a very difficult time programing some of this information into our electronic system since it was already committed to regular business runs.

As soon as the answers to the remainder of the questions are made available to me, I will see that you receive them without delay.

Sincerely,

JAMES E. BARRETT,
Vice President.

I. Total policyholders (classified by group and individual) on persons age 65 and over as of year ending—

	Individual	Group [1]	Total
1961	1,022,423	[2]	[2]
1962	1,204,033	[2]	[2]
1963	1,279,351	1,689	1,281,040
TOTAL INDIVIDUALS COVERED BY ABOVE POLICIES			
1961	1,061,358	[2]	
1962	1,241,315	[2]	
1963	1,341,838	1,689	1,343,527

[1] See memorandum of Apr. 14, 1964, marked as exhibit No. 1.
[2] Not available.

I-A. Information and data concerning other insurance is requested and obtained only at the time of issuance of the policy contract from the application. No continuing record is maintained.

II. Benefits and premiums:

A. Policy forms issued.[1]

B. Monthly premium charged.[1]

C. Number of policyholders in force for each form described in "A" as of December 31, 1963. See exhibit No. 3.

III. Experience:

(Not yet available.)

IV. Exclusions and limitations on conditions covered.

See exhibit No. 2, included in reply to questions II-A, policy forms issued.

V. Copies of advertising:

(Not yet available.)

VI. Underwriting:

A. Policies issued during an open enrollment on nonselective forms are issued as applied for. None are rated or ridered. Those issued on a selective basis are considered upon the answers to the questions as asked in application. No record of comparison is available or kept on those rated or issued as impaired risks on either over or under age 65.

[1] See exhibit No. 2 listing policy forms and documented for information requested by separate presentation of bulletins giving rules, regulations, rates, etc., as requested.

B. See policy bulletins supplied in answer to question II, parts A and B.
C. Underwriting subsequent to policy issuance:
1. Copies attached: 1793–M, 2326–M.
2. No record is maintained.
3. No record is kept. The major portion of the business is issued with a renewal safeguard with no right to cancel on an individual policy.
4. The usual investigation is made in regard to payment of the claim in accordance with the terms of the policy contract.

VI. Attrition:

A. See exhibit No. 7. This covers years 1961, 1962, 1963. This covers policies issued on both the open enrollment (nonselective) and other policies available throughout the year on a selective basis.

B. No records are kept of the reason for terminations. All terminations are recorded just as a termination, regardless of reason.

C. No records kept.

D. No record of those that reinstate after the grace period has expired is maintained. A normal procedure, as on our regular business, is followed. That is, an offer to reinstate without penalty of a lapsed period is made at the end of 45 days from due date, and again at 65 days. No record of payments during this period is maintained as we do not record on our records a lapse until such efforts have been put forth to reinstate the coverage.

VII. Other:

A. There are unique risks involved in underwriting health insurance for the aged created primarily by the increased morbidity. The needs of these people have been obvious to the private insurance industry for a number of years. Continuous forward steps have been taken to solve them until today a wide selection of insurance coverages is available, from many sources, to each individual so that he can determine his particular need and adequately protect himself from financial loss.

Many other advances have occurred such as:

1. The entry of many insurance carriers into the field of providing hospital and medical care benefits for those 65 and over.
2. The provisions in regular policies that are sold for continuance during the entire lifetime of the insured.
3. Continuance of group insurance programs for life following retirement.
4. The mass marketing approaches now being used.
5. Programs of paid up at age 65 health insurance.

These, and many other innovations, are rapidly eliminating any problem of health insurance for the aged.

B. Mutual of Omaha is by its charter a mutual organization owned by its policyowners and dedicated to their service. When our board of directors authorized the senior age program, they directed that it be a break-even program.

We anticipate no different problems in the rates applicable to the over 65 age group of business than to the under 65 age group. All ages will be affected in the future by the same factors.

EXHIBIT NO. 1

Re group survey of the aged.

Attached is the report sent to the Health Insurance Association of America as of December 31, 1963.

The completion of this report on an accurate basis for the group operation would be quite costly and time consuming as we do not maintain records on the majority of the certificateholders covered under our group policies. Where records are maintained, they are on a per-case basis and used daily for the administration under the policies. To remove them for this overall purpose would be detrimental to our workflow and policyholder service.

The figures contained in this report were determined by writing to the majority of our larger policyholders and requesting the information. The replies were tabulated and the count on groups of less than 500 lives were included in the State where the master policy was located. On cases with more than 500 lives the count was distributed in accordance with the 500 life rule.

As we did not do any sampling for ratios to apply against the total certificates in force there is a definite understatement made.

EXHIBIT No. 2

POLICY FORMS

76DV	54HO/FHO	3HSO
80DV	56HO/FHO	7HSO
84DV	57HO/FHO	11HSO
86DV	58HSO/FHSO	4HSO
37DO	65HO/FHO	8HSO
37DVO	68HO/FHO	12HSO
4DLO	70HO/FHO	3HO-3FHO-3DV
55-110	74HO/FHO	24HO/FHO
WSDO	2CLO/FCLO	26HO/FHO
22DV	2HRO	31HO/FHO-31DV-33DV-31DRO
41DV	16HO/FHO	55HO/FHO
64DO	16HSO/FHSO	6HMLO
59DRO	6HSO	8HMLO
59DV	10HSO	9HMLO
25HO/FHO	66HO	11CH
30HO/FHO	9HO-9FHO	15CH
36HO/FHO	27HO/FHO	50HO
38HV/FHV	29HSO	58HO/FHO
40HO/FHO	BOH	
52HO/FHO	8HO	

NOTE.—The above list does not contain several policy forms which are sold to people of all ages and on which no tabulation is made as to whether the policyowner is over 65 or under 65.

EXHIBIT 3

Number of policyholders in force as of Dec. 31, 1963

Form	*Policies in force*	*Form*	*Policies in force*
76DV	8,483	6HSO	4,563
80DV	1,649	10HSO	1,499
84DV	16	66HO	1,409
86DV	213	9HO-9FHO	396
37DO	229	27HO-FHO	925
37DVO	85	29HSO	38,593
4DLO	18	BOH	7,545
55-110	23,879	8HO	671
WSDO	11,839	3HSO	82,079
22DV	11	7HSO	1,167
41DV	1,333	11HSO	281
64DO	44	4HSO	205,961
59DRO	21	8HSO	6,324
59DV	193	12HSO	1,326
25HO/FHO	2,740	3HO-3FHO	88,763
30HO/FHO	87,673	3DV	22,405
36HO/FHO	11,279	24HO/FHO	168
38HV/FHV	1,667	26HO/FHO	249
40HO/FHO	14,788	31HO/FHO	4,057
52HO/FHO	53	31DV	6,459
54HO/FHO	935	33DV	5,363
56HO/FHO	12,585	31DRO	740
57HO/FHO	63	55HO/FHO	174
58HSO/FHSO	65	6HMLO	16,191
65HO/FHO	146	8HMLO	107
68HO/FHO	1,094	9HMLO	644
70HO/FHO	174	11CH	4,691
74HO/FHO	14	15CH	7,818
2CLO/FCLO	42	50HO	145,276
2HRO	36	58HO/FHO	2,179
16HO/FHO	43		
16HSO/FHSO	298	Total	839,731

NOTE.—The above listing of policies in force by form does not contain the policyholders on several forms where no tabulation is made as to age. Records are not maintained by distribution of age within policy form on this type of coverage.

EXHIBIT 4

Premiums earned per year

Form	1961	1962	1963
76DV	$37,020.87	$406,337.28	$742,692.87
80DV		42,237.38	146,902.17
84DV	35.71	821.84	1,397.40
86DV		8,067.32	19,754.73
37DO	17,754.70	20,800.39	12,442.42
37DVO	8,514.77	10,177.41	10,454.21
4DLO	992.10	1,231.65	1,463.83
55-110	2,601,435.77	2,208,567.67	1,842,661.49
WSDO	1,747,757.37	1,488,215.41	1,248,952.59
22DV	1,131.78	977.91	667.64
41DV	202,647.27	224,893.48	175,556.01
64DO	4,005.30	14,250.09	9,135.39
59DRO	1,316.80	1,471.28	1,951.29
59DV	28,493.76	30,898.86	24,093.86
25HO/FHO	196,366.81	240,232.84	252,593.21
30HO/FHO	5,323,540.26	7,286,058.66	8,853,617.69
36HO/FHO	769,798.57	1,024,236.19	1,229,432.51
38HV/FHV	83,539.45	115,896.91	145,678.04
40HO/FHO	1,044,432.54	1,329,667.04	1,463,936.89
52HO/FHO	2,039.31	2,603.66	2,923.37
54HO/FHO	58,114.52	77,645.72	95,815.34
56HO/FHO	225,635.65	396,179.48	548,573.17
57HO/FHO	1,270.87	1,779.00	2,590.43
58HSO/FHSO	2,201.16	6,332.57	5,753.93
65HO/FHO	2,265.41	5,103.82	7,004.24
68HO/FHO	11,154.47	36,512.97	55,181.41
70HO/FHO			−697.24
74HO/FHO			192.56
2CLO/FCLO	1,944.86	2,240.22	2,086.09
2HRO	3,549.14	4,484.14	4,079.59
16HO/FHO	4,032.17	4,117.50	4,155.94
16HSO/FHSO	41,918.87	40,828.66	37,279.35
6HSO	338,265.70	322,080.13	315,678.76
10HSO	43,935.21	45,783.91	47,274.83
66HO	39,088.73	57,895.84	71,832.35
9HO-9FHO	15,568.49	18,793.94	19,322.25
27HO-FHO	15,113.28	38,054.51	61,446.57
29HSO	1,443,445.46	2,368,940.91	3,047,837.17
BOH	737,941.42	630,459.61	550,498.19
8HO	46,440.40	44,700.76	47,070.18
3HSO	4,649,180.30	6,521,660.52	7,754,867.68
7HSO	61,250.16	82,510.98	102,050.29
11HSO	14,121.45	23,434.96	29,779.72
4HSO	16,792,620.62	19,129,308.57	20,838,704.13
8HSO	440,025.88	528,827.13	614,197.24
12HSO	114,193.12	131,787.68	147,125.74
3HO-3FHO	7,283,339.98	7,252,428.12	7,589,147.42
3DV	2,687,345.39	2,602,895.18	2,470,744.83
24HO/FHO	11,797.89	11,163.25	11,982.72
26HO/FHO	24,205.31	22,572.72	19,709.18
31HO/FHO	443,659.98	384,435.61	332,739.09
31DV	1,055,424.53	919,645.60	735,331.27
33DV	244,717.65	303,203.95	332,524.61
31DRO	52,210.14	63,341.69	64,662.88
55HO/FHO	10,160.04	12,762.34	14,349.44
6HMLO	1,404.00	82,123.37	223,966.55
8HMLO		401.50	1,306.30
9HMLO		−1.50	4,930.87
11CH	40,604.74	370,038.00	383,400.89
15CH		105,312.62	445,074.75
50HO	4,167,954.81	5,574,301.18	6,874,749.82
58HO/FHO	152,808.61	190,601.41	218,390.62

EXHIBIT 5

Claims incurred by year

Form	1961	1962	1963
76DV	$22,791.99	$179,164.86	$315,741.82
80DV		21,131.66	73,363.28
84DV	380.03	363.68	−363.73
86DV		2,961.79	14,113.26
37DO	4,969.96	8,324.60	5,003.96
37DVO	1,782.75	2,536.19	2,050.40
4DLO	−509.69	388.32	296.65
55-110	2,112,466.63	2,049,210.21	1,583,793.47
WSDO	1,337,335.07	1,215,000.24	1,020,940.55
22DV	−505.36	1,197.21	126.67
41DV	78,765.48	120,307.44	111,339.36
64DO	−85.47	1,885.99	3,464.24
59DRO	934.51	2,216.55	781.05
59DV	7,428.54	14,109.35	13,437.10
25HO/FHO	102,082.50	107,707.54	154,413.49
30HO/FHO	1,928,247.68	2,851,453.13	3,782,321.06
36HO/FHO	199,563.72	366,337.27	489,564.47
38HV/FHV	32,425.25	33,766.13	57,602.97
40HO/FHO	332,850.18	468,364.17	588,030.18
52HO/FHO	403.58	1,513.73	433.71
54HO/FHO	27,212.61	39,876.10	53,453.32
56HO/FHO	99,129.10	148,717.63	216,038.36
57HO/FHO	700.88	444.66	1,820.61
58HSO/FHSO	613.56	3,532.36	3,539.68
65HO/FHO		900.16	2,833.29
68HO/FHO	6,686.15	10,793.49	16,436.63
70HO/FHO			
74HO/FHO			722.89
2CLO/FCLO	274.88	1,619.63	292.64
2HRO	1,608.54	2,332.98	2,499.94
16HO/FHO	2,289.15	3,169.36	3,512.04
16HSO/FHSO	15,136.61	17,957.75	19,575.18
6HSO	188,517.48	223,880.57	216,814.57
10HSO	23,437.07	26,867.89	26,910.15
66HO	17,503.43	24,277.38	32,446.86
9HO-9FHO	6,675.01	9,066.12	12,717.71
27HO-FHO	4,976.59	12,263.17	32,227.38
29HSO	707,793.81	1,320,535.72	1,868,679.74
BOH	454,271.71	396,800.21	359,824.56
8HO	11,731.06	15,855.23	19,547.71
3HSO	2,315,799.90	3,356,445.89	4,265,217.77
7HSO	36,127.58	42,412.63	51,944.58
11HSO	6,103.76	12,083.72	13,917.09
4HSO	13,150,708.23	15,292,585.83	17,748,412.39
8HSO	349,930.78	407,783.30	462,136.23
12HSO	82,100.35	101,210.45	123,671.13
3HO-3FHO	4,884,141.67	5,117,894.85	5,321,065.79
3DV	1,707,977.26	1,801,963.80	1,784,061.79
24HO/FHO	5,116.28	3,793.71	6,833.01
26HO/FHO	14,224.77	18,292.61	14,022.05
31HO/FHO	178,001.42	182,151.18	182,242.16
31DV	435,455.79	438,627.17	436,646.46
33DV	96,954.77	112,206.36	170,812.68
31DRO	31,174.82	22,729.40	46,733.41
55HO/FHO	6,691.85	6,883.37	5,239.68
6HMLO	4,010.20	49,764.32	90,322.16
8HMLO		2,131.45	−456.46
9HMLO			6,344.64
11CH	12,650.00	135,407.46	295,679.80
15CH		21,947.22	171,748.36
50HO	3,460,044.49	3,635,918.83	5,751,164.15
58HO/FHO	41,252.42	53,627.95	68,634.90

EXHIBIT No. 6

ELIMINATION RIDER

This rider is attached to and made a part of Policy No. _____ and is subject to all provisions of the policy which are not in conflict with the provisions of this rider.

The effective date of this rider is _____.

In consideration of the company's continuing the policy in force after the effective date of this rider and not exercising its then known rights to rescind the policy, it is understood and agreed that none of the benefits provided in the policy shall accrue for any loss sustained by _____ resulting from _____

_____

_____

_____

Signature of the Insured

MUTUAL OF OMAHA INSURANCE CO.,
V. J. SKUTT, *President.*

RIDER FORM 2326M, ELIMINATION RIDER; RIDER FORM 2327M, DEPENDENT ELIMINATION RIDER

BRIEF DESCRIPTION

1. These are new riders to be used with any applicable policy or certificate in lieu of rescission.
2. Rider form 2326M eliminates coverage for a specific condition for the insured or other covered person.
3. Rider form 2327M removes a dependent and may be used, subject to benefits department instructions, even though the insured's coverage cannot be rescinded.
4. Copies of the riders appear on the reverse side of this bulletin.

UNDERWRITING RULES

1. Rules governing the use of these riders are stated in detail in benefits department bulletins. Note that special instructions apply when the riders are used on forms other than regular individual policies, such as association group certificates.
2. The effective date of the rider is the date it is signed.
3. The riders are to be signed in duplicate, the original for the application file and the duplicate for the insured.

HOME OFFICE PROCEDURE

1. Approval notifications to be given separately.
2. Rider code: 2326M—Elimination. 2327M—Elimination.
3. Keypunch code: 2326M—C26. 2327M—C27.

G. A. LEBENS.

ELIMINATION RIDER

This rider is attached to and made a part of Policy/Certificate No. _____ and is subject to all provisions of the policy/certificate which are not in conflict with the provisions of this rider.

The effective date of this rider is _____.

In consideration of the company's continuing the policy/certificate in force after the effective date of this rider and not exercising its then known rights of rescission it is understood and agreed that none of the benefits provided in the policy/certificate shall accrue for any loss sustained by _____ resulting from _____
_____
_____

_____
Signature of the insured

MUTUAL OF OMAHA INSURANCE CO.,
V. J. SKUTT, *President.*

DEPENDENT ELIMINATION RIDER

This rider is attached to and made a part of Policy/Certificate No. _____ and is subject to the conditions, exceptions and limitations of the policy/certificate not amended herein and to any further conditions, exceptions and limitations stated in this rider.

The date of this rider is _____.

In consideration of the company's continuing the policy/certificate in force and waiving its then known rights of rescission on account of the insured's material misrepresentation in the application, relating to _____, a copy of which application is attached to and made a part of the policy/certificate, it is understood and agreed that in lieu of such rescission, such dependent is hereby removed from the policy/certificate effective the date of the policy/certificate. All premiums paid for such dependent (less any benefits paid under the policy/certificate for such dependent) are hereby returned to the insured.

This rider shall be null and void unless it is signed by the insured.

_____
Signature of the insured

MUTUAL OF OMAHA INSURANCE CO.,
V. J. SKUTT, *President.*

EXHIBIT 7

Number of policies issued by year

Forms	Year		
	1961	1962	1963
76DV	2,243	5,558	4,731
80DV		1,052	1,186
84DV	6	16	11
86DV		164	148
37DO	90	59	40
37DVO	32	13	11
4DLO	12	5	7
55-110	351	350	276
WSDO	365	356	317
22DV	2	1	7
41DV	1,154	165	1
64DO	46		
59DRO	17	7	4
59DV	208	7	
25HO/FHO	846	724	525
30HO/FHO	27,885	32,749	26,984
36HO/FHO	3,681	4,584	3,737
38HV/FHV	577	566	597
40HO/FHO	5,505	4,860	3,529
52HO/FHO	21	17	16
54HO/FHO	422	345	351
56HO/FHO	5,154	5,423	5,423
57HO/FHO	19	26	21
58HSO/FHSO	79	40	19
65HO/FHO	77	59	78
68HO/FHO	546	536	570
70HO/FHO			174
74HO/FHO			14
2CLO/FCLO	28	11	5
2HRO	39	16	20
16HO/FHO	10	19	3
16HSO/FHSO	109	60	7
6HSO	641	618	564
10HSO	372	255	262
66HO	691	581	525
9HO-9FHO	129	80	29
27HO-FHO	414	435	447
29HSO	17,638	17,711	13,965
BOH	1,082	897	1,241
8HO	99	196	184
3HSO	32,685	30,973	27,833
7HSO	399	359	417
11HSO	116	98	125
4HSO	41,547	91,286	41,961
8HSO	1,130	2,487	1,592
12HSO	231	531	210
3HO-3FHO	1,741	2,093	1,466
3DV	367	313	203
24HO/FHO	42	24	45
26HO/FHO	20	8	2
31HO/FHO	361	69	19
31DV	3,540	42	4
33DV	2,388	2,115	1,795
31DRO	401	329	227
55HO/FHO	85	80	61
6HMLO	1,050	8,385	8,981
8HMLO		40	79
9HMLO		2	663
11CH	3,092	3,310	847
15CH		4,086	6,174
50HO	33,244	78,339	38,911
58HO/FHO	765	937	506
Total	193,794	304,467	198,150

NOTE.—The above listing of policies issued by form does not contain the policyholders on several forms where no tabulation is made as to age. Records are not maintained by distribution of age within policy form on this type of coverage.

MUTUAL OF OMAHA INSURANCE CO.,
Omaha, Nebr., May 22, 1964.

Hon. PAT MCNAMARA,
U.S. Senator, U.S. Senate Building,
Washington, D.C.

DEAR SENATOR MCNAMARA: Attached you will find the information which we indicated was not yet available in the answers to the questionnaire which you furnished us.

In answer to question No. 5, we have attached representative copies of our advertising.

Cordially yours,

A. M. HANSEN,
Vice President.

OMAHA, NEBR., *March 19, 1964.*

Mr. V. J. SKUTT,
President, Mutual of Omaha,
Benefit Health & Accident Association.

DEAR MR. SKUTT: Senator McNamara has asked me to write to you in connection with his letter of March 11.

Would you be kind enough to modify the questionnaire to reflect the following changes:

Question I, "total policyholders (classified by group and individual)" should read, "total number of different persons insured against items of medical expense—exclusive of holders of disability insurance policies (classified by group and individual)."

In question No. VI, where reference is made to policyholders, it should be understood that the intent of the question is to determine persons. That is, if the individual has two or more policies he should not be counted as two policyholders but rather as one person.

As a general rule it would be appreciated if you would subtract from all totals those persons who are under age 65 and who are enrolled in one of your "senior security" contracts by virtue of having a spouse age 65 or over.

Thank you for your cooperation.

Sincerely,

JAY B. CONSTANTINE,
Staff Director, Subcommittee on Health of the Elderly.

MARCH 11, 1964.

Mr. V. J. SKUTT,
President, Mutual of Omaha, Benefit Health & Accident Association,
Omaha, Nebr.

DEAR MR. SKUTT: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings Mr. Constantine, of the subcommittee staff, at my direction, has been in touch with your Mr. Chamberlain to discuss certain questions on an informal basis.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon, it is our intention to ask you to testify on the efforts of your organization to meet the health insurance needs of our older population.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

PLEASE PROVIDE INFORMATION AS OF END OF EACH OF LAST 3 CALENDAR YEARS FOR PERSONS AGE 65 AND OVER (EXCEPT WHERE OTHERWISE INDICATED)

I. Total policyholders (classified by group and individual).

A. Available data (of any type) concerning other health insurance coverage held by your policyholders—commercial and/or Blue Cross.

II. Benefits and premiums:

A. Policy forms issued, by principal benefits (hospital daily room and board indemnity; allowances for hospital extras; allowances for physicians' services; surgical schedule) noting changes made during each year.

B. Monthly premium charged for each type of policy form described in A (please note all changes made during each year).

C. Number of policyholders for each policy form described in A.

III. Experience:

A. Premiums earned by policy form.

B. Claims incurred by policy form.

IV. Exclusions and limitations (including waiting periods) on conditions covered for each of the policies currently available.

V. Copies of all advertising and promotional literature directed toward older people.

VI. Underwriting:

A. Initial issuance of individual policies—percent rated as impaired risks and comparison with persons under age 65 rated risks.

B. Copies of all administrative directives to agents and/or brokers relating to field underwriting of individual policies for 65 and over applicants.

C. Underwriting subsequent to policy issuance or filing or payment of claims.

1. Copies of all restrictive riders or waivers employed.

2. Number of riders issued and number of those to whom riders or waivers were issued who received or filed for a benefit.

3. Cancellation and/or number terminated (nonrenewal) by type of policy and indicating how many of these had received a benefit.

4. Copies of administrative directives to claims personnel relative to company policy on cancellation, ridering of policies, non-renewal and rating-up of policies.

VI. Attrition:

A. Number of policyholders signed up during calendar years 1960, 1961, and 1962.

B. Of those who (during the above years) are no longer policyholders, number who are no longer insured for reasons other than death (specify reasons: lapses; terminations; cancellations; etc.)

C. Of all those no longer insured (including deaths) how many received a benefit?

D. How many were reinstated?

VIII. Other:

A. What are the unique risks involved in underwriting health insurance for the aged and to what extent do you believe these can be met by private health insurance?

B. Do you anticipate that premium increases will be necessary on some or all of your policies for the 65 and over population during the next 2 years? Please elaborate, indicating, where appropriate, the percentage increase anticipated and the reasons therefor.

APPENDIX B

RESPONSES TO SUBCOMMITTEE QUESTIONNAIRES RECEIVED FROM "STATE 65" INSURERS:

1. CONNECTICUT "65"
2. MASSACHUSETTS "65"
3. NEW YORK "65"
4. TEXAS "65"

1. CONNECTICUT "65"

ASSOCIATED CONNECTICUT HEALTH INSURANCE COS.
Hartford, Conn., April 15, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SIR: In accordance with the request in your letter of March 10 addressed to the Associated Connecticut Health Insurance Cos. which I acknowledged under date of March 20, I am pleased to enclose herewith a memorandum covering the seven questions forwarded with your letter of March 10, together with the material requested. To the extent that it has been possible and practical to do so, the answers given are full and complete.

Sincerely yours,

WILLIAM N. SEERY,
Chairman, Executive Committee.

ANSWERS TO QUESTIONS RECEIVED WITH LETTER OF MARCH 10, 1964, FROM HON. PAT MCNAMARA, U.S. SENATOR, CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE ELDERLY

Question 1. All literature describing benefits and premiums, including scripts and "tearsheets" used in promotion.

Answer 1. Herewith are the following items:

A. Question and answer leaflet used in connection with open enrollment period.
B. Sales folder used in connection with second open enrollment period.
C. Sales folder used in connection with third open enrollment period.
D. Sales folder currently in use.
E. Enrollment booklet provided for each person insured.
F. Enrollment booklet amendment effective November 1, 1962.
G. Enrollment booklet amendment effective January 1, 1964 (form 651–2).
H. Current enrollment booklet for each person becoming insured.
I. Copies of newspaper advertisements.
J. Copies of scripts for radio and television.

Question 2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open" period, total number insured immediately prior to and following each of the two subsequent "open" periods; and total number of persons insured as of March 1, 1964 (please break down these data to show subtotals indicating numbers of persons in each of your various coverage options).

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those under age 65.

Answer 2. A. The total number of individuals enrolled at any time, up to March 1, 1964, is 35,166.

B. The total number of individuals accepted for insurance during the initial open enrollment period was 21,849, broken down as follows:

Option 1: (648 under 65)	13,770	Option 3: (42 under 65)	2,225
Option 2: (208 under 65)	4,891	Option 4: (33 under 65)	964

C. The total number insured as of April 1, 1962, preceding the second open enrollment period was 19,848, broken down by option as follows:

Option 1	13,222	Option 3	1,988
Option 2	3,824	Option 4	814

D. The total number insured as of May 1, 1962, after the second open enrollment period was 25,577, broken down by option as follows:

Option 1	17,153	Option 3	2,893
Option 2	4,488	Option 4	1,043

E. The total number insured as of October 1, 1962, before the third open enrollment period was 24,581, broken down by option as follows:

Option 1	16,552	Option 3	2,801
Option 2	4,216	Option 4	1,012

F. The total number insured as of November 1, 1962, after the third open enrollment period was 27,017, broken down by option as follows:

Option 1	18,456	Option 3	3,009
Option 2	4,476	Option 4	1,076

G. The total number insured on March 1, 1964, was 25,479, broken down by option as follows:

Option 1 (642)	18,076	Option 3 (38)	2,720
Option 2 (141)	3,787	Option 4 (22)	896

NOTE.—The number of those under 65 as indicated in B and G above is not significant. A count on those under 65 is not available with respect to C, D, E, and F without undue time and expense being involved.

Question 3. How many of those persons accepted for coverage during your initial open period were still insured under the program as of March 1, 1964?

Answer 3. Of the 21,849 original insured members, there are 15,619 who remain insured, broken down by option as follows:

Option 1	10,191	Option 3	1,510
Option 2	3,338	Option 4	580

Question 4. What was the average age of the "Connecticut 65" policyholders as of end of your initial enrollment period? What was the average age as of March 1, 1964?

Answer 4. The average age of those insured as of October 1, 1961, was 74.6 years. The average age of those insured as of March 1, 1964, was 74.1 years.

Question 5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

Answer 5. A. The following is the earned premium by option and the incurred claims from October 1, 1961, to March 1, 1964:

	Earned premium	Incurred claims
Option 1	$4,843,986	$4,709,037
Option 2	902,986	666,135
Option 3	1,293,791	1,358,256
Option 4	399,332	351,567
Total	7,440,095	7,084,995

B. In the period from October 1, 1961, to March 1, 1964, claim payments have been made to 8,670 different individuals.

C. The following is a count of 1963 claims broken down by option:

Option 1	3,694	Option 3	801
Option 2	722	Option 4	263

Question 6. Please provide the details of any and all premium and/or benefit changes made to date in your program.

Answer 6. Amendment effective January 1, 1964 (form 651-2 included as item G with answer 1) covers all premium and/or benefit changes made to date. These include a limitation of $1,000 per calendar year for the "covered" expense of registered graduate nurses under the $10,000 maximum major medical expense benefits and a similar limitation to $750 per calendar year with respect to the $5,000 maximum major medical expense benefits. Premium rates were increased from $10 to $11 for option 1, from $17 to $19 for option 3, and from $14.50 to $15.50 for option 4. For future enrollees a modification was made with respect to benefits in certain instances where medical or surgical care, treatment, diagnosis, or consultation was provided in connection with an injury or sickness during the 90 consecutive days immediately preceding the effective date of coverage.

Question 7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

Answer 7. Herewith is a copy of a statement by Mr. W. N. Seery, vice president of the Travelers Insurance Co., to the Insurance Committee of the Connecticut General Assembly on March 7, 1961. This statement describes the purposes and aims of the program.

Also enclosed is a statement by Mr. Seery as chairman of the Executive Committee of Connecticut 65 at a public hearing called by Commissioner Alfred N. Premo of the Connecticut State Insurance Department on October 23, 1963. This statement and the exhibits with it describe the progress and situation of Connecticut 65 at that time. Following the hearing the modest changes in premium rates and benefits indicated in answer 6 above were made effective.

Additional information with respect to the number of people insured is included in answers 2 and 3 above. The claim and premium figures in answer 5 above include claims and premiums to March 1, 1964, as requested.

A new insurance program requires analysis and study of a continual nature and adjustments are to be anticipated as the need arises. It will be noted from the statement on October 23, 1963, that claim rates have somewhat exceeded our anticipations. Steadily increasing medical and hospital rates are also having their effect and are expected to continue in the future. However, at this point the Executive Committee of Connecticut 65 has made no decisions as to any further premium or benefit adjustments.

CONNECTICUT 65,
ASSOCIATED CONNECTICUT HEALTH INSURANCE COS.,
Hartford, Conn., March 20, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly, U.S. Senate, Washington, D.C.

DEAR SIR: We have for acknowledgment your letter of March 10 addressed to the Associated Connecticut Health Insurance Cos., and requesting certain information relative to Connecticut 65. We are reviewing our records and the full reply will be sent to you later.

Sincerely yours,

WILLIAM N. SEERY,
Chairman, Executive Committee.

MARCH 10, 1964.

PRESIDENT, ASSOCIATED CONNECTICUT HEALTH INSURANCE CO.,
Hartford, Conn.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff, to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

"CONNECTICUT 65"

1. All literature describing benefits and premiums, including scripts and "tearsheets" used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open" period; total number insured immediately prior to and following each of the two subsequent "open" periods; and total number of persons insured as of March 1, 1964. (Please break down these data to show subtotals indicating numbers of persons in each of your various coverage options.)

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those under age 65.

3. How many of those persons accepted for coverage during your initial "open" period were still insured under the program as of March 1, 1964?

4. What was the average age of the "Connecticut 65" policyholders as of the end of your initial enrollment period? What was the average age as of March 1, 1964?

5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

6. Please provide the details of any and all premium and/or benefit changes made to date in your program.

7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

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2. MASSACHUSETTS "65"

MASSACHUSETTS 65,
HEALTH INSURANCE ASSOCIATION,
Boston, Mass., April 22, 1964.

Senator PAT MCNAMARA,
U.S. Senate, Special Committee on Aging,
Subcommittee on Health of the Elderly,
Washington, D.C.

DEAR SENATOR MCNAMARA: Enclosed are the answers to the questions contained in your letter of March 10, 1964:

1. Exhibit I lists the attached items of literature requested.

2. The total number of persons enrolled in the program from inception to March 1964 is shown on the attached exhibit II.

3. The number of persons continuously insured since the original enrollment is not readily available. This information can be secured, if necessary, by a special run of our records.

4. The average age of the Mass 65 policyholder as of the initial enrollment period was 73.5 years. Exhibit III shows our most recent statistics available of the breakdown by ages.

5. Annual statement highlights, exhibit IV. Exhibit V shows the close correlation between the geographical distribution of the aged population and the Mass 65 enrollment.

6. There have been no rate changes since the inception of the program. Several benefit changes, all of which have been liberalizations, have been incorporated in the attached certificates of insurance.

7(*a*). No changes in the benefits provided by our plan are currently anticipated.

7(*b*). The initial premium rates assumed that, during the first 2 years, incurred claims would be equal to 85 percent of the premium. At the end of the first policy year the actual experience was, in fact, at this level. After a thorough review of the experience statistics, the executive committee authorized continuance of the initial premium rate for the policy year through December 31, 1964, at which time there will be a further review of accumulated claim experience.

The favorable claim experience to date has been achieved through the wholehearted cooperation of the 46 sponsoring companies and the entire medical profession.

Sincerely yours,

HERBERT S. WOODS, *General Manager.*

EXHIBIT I

(*a*) Sales folder used in connection with first "open" enrollment period.
(*b*) Sales folder used in connection with second and the current "open" enrollment periods.
(*c*) Letter for occupant mailing, influence group, inquiries, and letter to participants.
(*d*) Copies of newspaper advertisements.
(*e*) Agent-broker sales kit.
(*f*) Newsletters to members, agents-brokers, doctors, and hospitals.
(*g*) Copies of radio scripts.
(*h*) Certificates of insurance, plans 1 and 2.
(*i*) Benefit summary chart, plans 1 and 2.
(*j*) Hospital manual.

EXHIBIT II

(a) The total response during initial enrollment period was 49,893. This represented 8.7 percent of the aged population in Massachusetts and a much larger percentage of the effective market. After eliminating returns permitted under the 10-day free-look provision, duplicate applications, etc., the initial enrollment figure proved to be 43,383. This figure which exceeds by a considerable margin the original expectations is divided between the two plans, as follows:

Plan I	32,728
Plan II	10,655
Total	43,383

(b) At the time of the April 1963 and March 1964 enrollments there were the following numbers insured:

April 1963 (including 941 new enrollees during open enrollment period):	
Plan I	31,269.
Plan II	11,401
Total	42,670
March 1964 (including 1,305 new enrollees during March enrollment period):	
Plan I	26,969
Plan II	11,138
Total	38,107

(c) The enrollment activity can be summarized as follows:

Number of enrollees Dec. 31, 1962		43,383
April 1963 and March 1964 enrollees	2,246	
Other enrollees	3,609	
		5,855
Total		49,238
Less deaths	4,247	
Other terminations	6,884	
		11,131
Present number of enrollees		38,107
Less 3.2 percent under age 65		−1,219
Total		36,888

EXHIBIT III

Mass 65 distribution by ages

Age	Males	Females	Total	Age	Males	Females	Total
50 [1]		5	5	77	621	1,109	1,730
51 [1]	1	12	13	78	573	1,068	1,641
52 [1]		17	17	79	512	954	1,466
53 [1]		22	22	80	465	937	1,402
54 [1]		21	21	81	366	738	1,104
55 [1]	1	34	35	82	340	792	1,132
56 [1]	1	49	50	83	325	609	934
57 [1]	2	60	62	84	270	606	876
58 [1]	3	75	78	85	239	452	691
59 [1]	3	90	93	86	188	383	571
60 [1]	3	91	94	87	196	351	547
61 [1]	7	120	127	88	127	240	367
62 [1]	10	205	215	89	90	175	265
63 [1]	17	242	259	90	85	184	269
64 [1]	35	302	337	91	48	96	144
65	1,036	1,455	2,491	92	48	92	140
66	1,153	1,600	2,753	93	18	56	74
67	1,001	1,611	2,612	94	19	30	49
68	987	1,486	2,473	95	11	19	30
69	972	1,507	2,479	96	9	17	26
70	903	1,569	2,472	97	6	16	22
71	913	1,387	2,300	98	2	5	7
72	859	1,503	2,362	99	5	9	14
73	821	1,429	2,250	100 and over	22	17	39
74	825	1,480	2,305	Unknown	9	4	13
75	712	1,316	2,028				
76	675	1,202	1,877	Total	15,534	27,849	43,383

[1] Dependent spouse of enrollee age 65 or over.

EXHIBIT IV

Massachusetts 65 Health Insurance Association 1st policy year highlights

		Percent of premium
Premiums paid by Massachusetts 65 subscribers	$6,442,137	100
Claims incurred by 11,358 claimants	5,475,532	85
Net cost of operating Massachusetts 65	449,379	7
State premium taxes (estimated)	129,000	2
Developmental, promotional, and acquisition costs charged to the 1st policy year	388,226	6

EXHIBIT V

Geographical distribution by County

[Percent]

County	1960 census, population 65 and over	Mass 65 enrollees	County	1960 census, population 65 and over	Mass 65 enrollees
Barnstable	1.6	2.7	Middlesex	21.8	23.9
Berkshire	2.8	2.3	Nantucket	.1	1.9
Bristol	8.0	3.8	Norfolk	8.8	14.3
Dukes	.2	.2	Plymouth	4.9	4.7
Essex	12.1	11.0	Suffolk	16.8	14.0
Franklin	1.3	.9	Worcester	11.8	9.4
Hampden	7.9	9.0			
Hampshire	1.9	1.9	All counties	100.0	100.0

MASSACHUSETTS 65 HEALTH INSURANCE ASSOCIATION,
Boston, Mass.

YOU MUST ACT PROMPTLY TO TAKE ADVANTAGE OF THIS REMARKABLE NEW MAJOR MEDICAL PLAN

There are only 10 days left for you to get in on Mass 65, the wonderful new health insurance plan for Massachusetts residents 65 and over. Applications can be accepted only through October 31.

If you are 65 or over, or if you are financially responsible for somebody who is, you still have time to apply for this protection if you haven't already done so.

As you will recall from the descriptive folder recently mailed to you, Mass 65 pays up to a lifetime maximum of $10,000 for major medical health insurance coverage. It's practically like having a special emergency fund from which you can draw up to $5,000 in any one year to pay the big medical bills that usually result from a major accident or serious illness.

Mass 65 begins paying benefits when most basic hospital and surgical plans leave off. It helps pay big bills from your doctor, the hospital, or a convalescent nursing home. And it's easy to take advantage of this plan designed exclusively for Massachusetts residents 65 and over. There's no medical exam required * * * no health questions asked.

When you have the protection Mass 65 gives you, you can enjoy new peace of mind * * * lessen your worries about the impact of a serious or prolonged illness or crippling injury. Even if your expenses run into thousands of dollars, and this is not at all unusual, you will be helped substantially in meeting the really staggering bills that can be incurred.

Mass 65 major medical protection is the type of coverage that people 65 and over have always needed most, yet have often found extremely difficult to obtain. And now it's available, at low cost, for everybody in Massachusetts 65 and over.

But you must not delay. The initial enrollment period for Mass 65 ends October 31, no applications can be accepted after that date. So please call or see your agent or broker today * * * before time runs out. He'll gladly answer any questions you might have about the plan, and will help you enroll.

Sincerely yours,

A. M. WILSON,
Chairman, Executive Committee.

MASSACHUSETTS 65 HEALTH INSURANCE ASSOCIATION,
Boston, Mass., October 1962.

DEAR SIRS: May we ask your cooperation in supporting the new Massachusetts 65 plan?

Will you help us spread the good news about Massachusetts 65—the new major medical health insurance plan for Massachusetts residents 65 and over? The support of prominent people like yourself will help us substantially in making this first enrollment period in October successful.

You've probably already heard and read a great deal about Massachusetts 65 and the voluntary association of leading insurance companies behind it. The plan has received widespread and enthusiastic coverage and commentary in the press, radio, and TV.

This is not surprising, for Massachusetts 65 presents a dramatic answer to the critical need of older people in Massachusetts for low-cost major medical health protection, at a time they can most benefit—when a serious accident or prolonged illness incurs medical and hospital bills that can run into thousands of dollars.

As the enclosed folder about Massachusetts 65 points out, expenses of this extent go far beyond the coverage normally provided by basic hospital-surgical insurance. Yet major medical protection is the type of health insurance people 65 and over have often needed most, yet have usually found most difficult to secure without having to take a medical exam.

Massachusetts 65 offers benefits that extend up to $10,000 over a person's lifetime * * * for medical and surgical bills, for care in a hospital or convalescent home or even in the individual's own home. The plan was designed exclusively for Massachusetts residents 65 and over, and was actually made possible only through passage of a special State law.

If you'd like to cooperate in getting across the important story of Massachusetts 65, you can do so by making copies of the enclosed folder available to those in your community who might benefit from the plan. We'll gladly send you as many folders as you wish—just fill in and return the slip accompanying this letter in the postage-paid envelope provided.

And thanks for your help.

Sincerely yours,

A. M. WILSON,
Chairman, Executive Committee.

MARCH 10, 1964.

PRESIDENT, MASSACHUSETTS 65,
Boston, Mass.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
U.S. Senate,
Chairman, Subcommittee on Health of the Elderly.

1. All literature describing benefits and premiums, including scripts and tearsheets used in promotion.
2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open enrollment" period, total number of persons insured immediately prior to and following each of any subsequent "open" periods; and total number of persons insured as of March 1, 1964. (Please breakdown these data to show subtotals indicating number of different persons in each of your various coverage options.)

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those persons under age 65.

3. How many of those persons accepted for coverage during your initial "open enrollment" period were still insured under the program as of March 1, 1964?
4. What was the average age of the policyholder as of the end of your initial enrollment period? What was the average age as of March 1, 1964?
5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.
6. Please provide the details of any premiums and/or benefit changes which have been made in your program since its inception.
7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

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3. NEW YORK "65"

NEW YORK 65 HEALTH INSURANCE ASSOCIATION,
New York, N.Y., April 15, 1964.

HON. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging.
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: The attached information is submitted in response to your letter of March 10 and that of Mr. Constantine dated March 17.

Sincerely yours,

MORTON D. MILLER, *President.*

Answers to questions outlined in letters of March 10 and 17, 1964, from Subcommittee on Health of the Elderly under the chairmanship of the Honorable Pat McNamara:

Question 1. All literature describing benefits and rates, including scripts and tearsheets used in promotion.

Answer 1. The following material is enclosed:

Initial open enrollment—October 15 to November 15, 1962—Exhibits

1. New York 65 filmstrip and record.
2. Proofs of four newspaper ads.
3. Sales aids kit (agents-brokers).
4. Talk for community groups.
5. Kit for hospital administrators.
6. Insureds enrollment packet.

Second open enrollment—June 1–15, 1963

7. Proof of newspaper ad.
8. Sales aids kit (agents-brokers).
9. Two TV scripts.
10. Inquiry letter.

Special enrollment opportunities

11. Agent-broker kit, February 1963.
12. Agent-broker kit, October 1963.

This material constitutes the major portion of the promotional material prepared by New York 65 and directed to the general public or the agents and brokers of New York State.

Question 2. (*a*) Total number of different persons enrolled in program from inception to March 1, 1964; (*b*) total aged persons insured as of March 1, 1964; (*c*) total number of persons accepted for coverage during initial enrollment period and total number of persons insured immediately prior to commencement of second "open" enrollment period. (Please provide subtotals indicating persons covered for basic only, major medical only, and basic and major medical).

Answer 2. (*a*) The total number of persons who submitted applications for coverage from inception to March 1, 1964 were:

Initial "open" enrollment (Oct. 15–Nov. 15, 1962)	107,404
Interim enrollments (see folder entitled "Special Enrollment Opportunities in New York 65" for eligibility requirements)	1,734
2d "open" enrollment (June 1–15, 1963)	[1] 33,552
Total applications	142,690

[1] In addition, 702 persons who already had some coverage with New York 65 took this opportunity to add additional coverage, as follows:

Basic added	281
Major medical added	421
Total	702

The distribution by plan is as follows:

	Initial open enrollment	Interim enrollments	2d open enrollment
Basic	39,739	523	13,421
Major medical	41,888	844	12,079
Combination	25,777	367	8,052
Total	107,404	1,734	33,552

Of the 142,690 applications received by New York 65 from the inception of the program until March 1, 1964, 3,031 applications (2,237 in the initial "open" enrollment and 794 in the second "open" enrollment) could not be processed because the individual was not eligible due to age or nonresidence, or was confined to a hospital or nursing home, or no premium payments were received or the application was incomplete in other respects.

Deducting the 3,031 leaves 139,659 applicants to whom certificate booklets were issued of whom 4,980 (3,723 in initial open enrollment and 1, 257 in the second open enrollment) took advantage of the "free look" provision under which an

individual has 10 days after receiving his certificate booklet to decide whether he is satisfied with New York 65. When he is not, the certificate booklet may be returned and the premium paid is refunded in full. In such cases, the insurance is considered as never having been issued.

Therefore, the total number of different persons who became insured under New York 65 was:

Basic	50,658
Major medical	51,749
Combination	32,272
All plans	134,679

Answer 2. (*b*) Total aged persons insured as of March 1, 1964:

Basic	41,741
Major medical	41,882
Combination	26,512
All plans	110,135

Answer 2. (*c*) Total number of persons who became insured during the initial enrollment period and total number of persons insured immediately prior to commencement of second "open" enrollment period.

	Initial "open" enrollment	Prior to 2d "open" enrollment
Basic	37,534	33,214
Major medical	39,564	34,763
Combination	24,346	21,054
All plans	101,444	89,031

Our terminations during the 4 months, December 1963 through March 1964, have been less than 1 percent per month and our best estimate indicates that more than one-half are due to death. This is only to be expected, based on our average age of about 74 years.

Question 3. How many of those persons accepted for insurance during your initial "open" enrollment period were still insured under the program as of March 1, 1964?

Answer 3. Of the 101,444 persons insured during the initial "open" enrollment period, 81,822 were still insured as of March 1, 1964. We have no breakdown of this last figure by plan.

Question 4. What was the average age of New York 65 policyholders as of the end of your initial "open" enrollment period? What was the average age of your policyholders as of March 1, 1964?

Answer 4. The average age of policyholders at the end of the initial "open" enrollment was 73.5 years.

Plan	Male	Female	Total
Basic	74.6	74.0	74.2
Major medical	71.8	71.3	71.5
Combination	75.9	75.7	75.8
All plans	73.7	73.4	73.5

NOTE.—The average age of persons who enrolled during our 2d "open" enrollment period was 73.3 years.

Plan	Male	Female	Total
Basic	74.2	73.7	74.0
Major medical	71.8	71.2	71.4
Combination	75.7	75.2	75.4
All plans	73.6	73.2	73.3

NOTE.—We believe that the average age of those insured as of Mar. 1, 1964, is substantially the same.

Question 5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various segments of the New York "65" program (provide separate data for the "regular basic" and "major medical" portions).

Answer 5.

	Basic	Major medical	Total
Premiums earned	$8,880,894	$8,119,186	$17,000,080
Total claims incurred	8,204,283	6,461,166	14,665,449
Number of beneficiaries			23,069
Number of claim payments			47,989

NOTE.—These figures relate to the period from Oct. 15, 1962, through Dec. 31, 1963.

Question 6. Based upon all available information, advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years.

Answer 6. It is difficult at this time to answer this question. New York 65 has been operating for slightly more than 17 months. Our original projections on which our current premium rates are based were made for 2 years. So far we have been running somewhat ahead of our estimates as far as payments of benefits are concerned.

We are presently conducting our third "open" enrollment during the month of April. Since this enrollment is being undertaken without widespread public advertising, we do not at this time know what the final results will be in terms of numbers of new enrollees and in terms of additional premium income.

Our original projections indicated that if medical and hospital costs continue to increase at the same rates as they had for the previous 2 years, it seemed likely that some upward adjustment in the premium rates would have to be made at the end of the second year or reasonably soon thereafter. So far, medical and hospital rates have continued to increase at rates similar to those of the 2 previous years.

With the unknown of additional premium income due to new enrollments, which exclude benefit payments for preexisting conditions for 6 months, it is difficult for us to come to definite conclusions concerning future premium rates at this time.

All other indicators, however, point to the need for a modest increase within the next 2 years unless our current claims demands change from their present pattern.

We do not now anticipate any change in benefits.

Question 7. NOTE.—To extent possible, provide all data for persons age 65 and over, excluding spouses who are under age 65.

Answer 7. We do not maintain such records. However, our best estimates would indicate about 3 percent of our insureds are spouses under the age of 65.

Question 8. *Supplemental request of March 17.*—Results of your mail survey of "several thousand recent terminations" designed to determine the principal reasons for such termination and their relative frequency.

Answer 8. A questionnaire (copy attached) was mailed in November 1963 to 1,748 individuals and replies were received from 703, or about 41 percent.

The replies to the questionnaire were as follows:

Unsatisfactory experience with a claim	22
Bought other health insurance protection	114
Benefits too limited	40
Moved out of New York State	1
Did not receive offer to reinstate the insurance	14

Combination of two of the above reasons:

Benefits too limited and bought other health insurance protection	52
Unsatisfactory experience with a claim and benefits too limited	19
Unsatisfactory experience with a claim and bought other health insurance protection	5

Other:
Deceased ---- 139
Cost ---- 46
Confined to home for the aged ---- 42
Duplicate coverage ---- 7
Requested reinstatement ---- 45
Questioned premium status ---- 145
Miscellaneous ---- 12

The 139 replies stating that the insured had died are significant in that we had eliminated the deaths which had been reported to us before mailing out the questionnaires.

NEW YORK 65,
HEALTH INSURANCE ASSOCIATION,
New York, N.Y.

DEAR ———: We were sorry to note that the premium payments on the above certificate have stopped. Since you did not take advantage of the offer to reinstate the insurance, as outlined in our last letter, it has now lapsed.

Could you please let us know why you dropped this valuable insurance? This will involve only a few minutes of your time and your answers will help us to provide better service for more people. Your reply will be treated as confidential and your name will not be used in any way.

Please check one or more of the reasons listed below:

[ ] Unsatisfactory experience with a claim.
[ ] Bought other health insurance protection.
[ ] Benefits too limited.
[ ] Moved out of New York State (insurance could have been continued).
[ ] Did not receive offer to reinstate the insurance.
[ ] Other (please explain)----------

Please add any other comments you may care to make on the back of this letter.

A postage-paid, self-addressed envelope is enclosed for your convenience in replying.

Thanks in advance for your help.

Sincerely,

FRED MALLEY,
Executive Director.

Enclosure.

MARCH 17, 1964.

Mr. MORTON D. MILLER,
President, New York 65 Health Insurance Association,
New York, N.Y.

DEAR MR. MILLER: This is by way of supplement to Senator McNamara's request for information on the New York 65 program. It would be appreciated if you would also provide the Subcommittee on Health with the results of your mail survey of "several thousand recent terminations" designed to determine the principal reasons for such termination and their relative frequency.

Thank you for your cooperation.

Sincerely,

JAY B. CONSTANTINE,
Staff Director, Subcommittee on Health of the Elderly.

MARCH 10, 1964.

PRESIDENT,
New York 65 Health Insurance Association,
New York, N.Y.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and

requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

NEW YORK "65" PROGRAM

1. All literature describing benefits and rates, including scripts and "tear-sheets" used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total aged persons insured as of March 1, 1964; total number of persons accepted for coverage during initial enrollment period and total number of persons insured immediately prior to commencement of second "open" enrollment period. (Please provide subtotals indicating persons covered for basic only, major medical only, and basic and major medical.)

3. How many of those persons accepted for insurance during your initial "open" enrollment period (November 1963) were still insured under the program as of March 1, 1964?

4. What was the average age of the New York "65" policyholders as of the end of your initial "open" enrollment period? What was the average age of your policyholders as of March 1, 1964?

5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc. for each of the various segments of the New York "65" program (provide separate data for the "regular basic" and "major medical" portions).

6. Based upon all available information, advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

NOTE.—To extent possible, provide all data for persons age 65 and over, excluding spouses who are under age 65.

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4. TEXAS "65"

TEXAS 65 HEALTH INSURANCE ASSOCIATION,
Dallas, Tex., April 17, 1964.

Hon. PAT MCNAMARA,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: In compliance with your request, we are sending you under separate cover copies of our health insurance certificates, master policy, and all literature describing the benefits and premiums, including both radio and TV scripts and "tear-sheets" used in the promotion of our initial enrollment last October by the Texas 65 Health Insurance Association. This is in line with question 1 of your questionnaire.

In question 2 you asked for the total number of persons enrolled during the initial "open enrollment." Also, total number of different persons insured as of March 1, 1964. For this and subsequent questions, you asked that we provide you data distinguishing between persons age 65 and over and those persons under age 65. I explained to Mr. Jay Constantine that we did not carry a breakdown between persons age 65 and over and those persons under age 65; consequently, we were unable to provide this data for the initial enrollment. The number of certificates issued during the initial enrollment broken down by plan is as follows:

Plan I	12,031
Plan II	26,425
Plan III	7,710
Total	46,166

We are in a position to give you the two age groups, that is, persons age 65 and over and those persons under age 65 insured as of March 1, 1964, by plan which is as follows:

	Plan I		Plan II		Plan III		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under age 65	519	4	594	3.2	263	3.1	1,376	3.5
Over age 65	12,396	96	17,726	96.8	8,158	96.9	38,280	96.5
Total	12,915	------	18,320	------	8,421	------	39,656	------

You will observe a large decrease in the number of persons covered under plan 2 with a slight increase under both plan 1 and plan 3. This is due to the fact that on February 14, 1964, we wrote all of the persons insured under plan 2, which is our major medical plan, giving them the opportunity to change to plan 1, our basic hospital plan, or change to plan 3, the combination basic hospital and major medical plan, providing they had no other basic coverage and the request for change was received in our office on or before March 2, 1964. This change was made effective March 1, 1964. We took this action in order that these people fully understood the type of health insurance protection they had with the opportunity to make this change if it better fitted their needs.

In answer to your third question, we wish to advise that the initial enrollment was from October 1–31, 1963, with the coverage going into effect on November 1, 1963. The number of persons still insured as of March 1, 1964, is as follows:

	Plan I		Plan II		Plan III		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under age 65	499	4	573	3.2	253	3	1,325	3.4
Over age 65	12,127	96	17,387	96.8	7,934	97	37,448	96.6
Total	12,626	------	17,960	------	8,187	------	38,773	------

In answer to question 4, the average age of the Texas 65 certificate holder as of the end of our initial enrollment period was 73.

In establishing the premium rates for Texas 65, we anticipated costs in our calculations from a period of 2 years from the initial enrollment. We are enclosing copy of letter from Mr. Harvey Galloway, Jr., of our actuarial subcommittee, to Mr. H. Lewis Rietz, president of the Texas 65 Health Insurance Association, to substantiate our rate calculation that is self-explanatory.

In question 6 you have asked whether or not any premium and/or benefit changes are anticipated or will be required within the next 2 years. You can readily appreciate the fact that the Texas 65 Health Insurance Association has been in existence less than 6 months. Our experience is too young at the present time, but it is not unfavorable. We do not, however, anticipate making any changes during the next 2 years.

Sincerely,

CHARLES M. BARRY, *Administrator.*

EXHIBIT X

SOUTHLAND LIFE INSURANCE CO.,
Dallas, Tex., July 25, 1963.

Subject: Rate Basis Consideration for Texas 65.

Mr. H. LEWIS RIETZ,
Executive Vice President,
Great Southern Life Insurance Co.,
Houston, Tex.

The purpose of this report is not to give an exact basis for the rate computations for the Texas 65 plans but in general terms to indicate some of the considerations and data used.

BACKGROUND

From the offset it was apparent that our task would not be a particularly easy one due to the small amount of data compiled on senior citizens, particularly in the major medical area. It then became apparent that some of the information available for base type benefits was not particularly applicable due to the time and locality of exposure. Fortunately three other States had met this situation and at least one of them had provided some experience results prior to our arriving at our final rates. Although the Connecticut results were not conclusive, it was somewhat informative to discuss the Connecticut experience situation with some of the responsible people in Connecticut and to determine how the experience had deviated from the underlying experience which was used for the rate computation. Mr. Pettengill of the Aetna advised that the basic data used in the Connecticut plan was from the retired Federal employees group plan and that the Connecticut experience was considerably higher than that derived under the retired Federal employees plan. In fact, at one time he indicated that the cost was 50 percent higher than would be anticipated from reviewing the retired Federal employees group experience. Apparently the Connecticut people must have anticipated some additional losses because the final Connecticut results did not appear this far out of line. The State which offered the most information concerning rates was New York. Fortunately we had access to a very complete written report to the New York insurance department regarding the rate mechanism for the New York 65 Plan. This memo served as a starting point for our deliberations.

One of our earlier problems was generated when we started to compare the utilization differences by area since most of the experience available was on exposure in the Northeast or in the Nation as a whole. The annual reports for the Transaction of the Society of Actuaries indicated a higher claim cost in Texas than for the Nation as a whole in both hospital and surgical benefits. The latest group major medical paper written by Pettengill & Burton indicates this higher claim cost extends into the major medical area as well as base type benefits. Mr. Pettengill offered to have some of his people make a special study comparing Texas with Connecticut under the retired Federal employees plan. There were some obvious biases and the size of the data indicated that the results could not be too meaningful for rate purposes. However, the relationships derived in the study indicated that the higher claim utilization for Texas under normal group operations also carried over into the senior citizen area.

Mr. John Winters of the Texas Department of Public Welfare gave us quite a bit of data which had been derived from the old-age assistance program in Texas during the year 1962. Since this program covered approximately 225,000 people 65 and over in Texas, the results should have been meaningful. However, we tended to distrust the results for several reasons:

(1) The old-age assistance benefits were payable to low-income people in Texas who were receiving State money for subsistence. It could be argued that the health needs of these people would not be the same as the health needs for people who would buy our product.

(2) The old-age assistance plan is constructed to discourage normal lengths of hospital confinement. The benefits are cut in half at the end of 15 days and at the end of each 15-day period, the doctor must give written certification that the continued confinement is necessary for the health and well-being of the patient. We collected data on about 6,400 claims which had been settled in November 1962 concerning the length of hospital confinement. This data indicated that the above-mentioned biases were operating to a very great extent to reduce the average length of confinement. The average length of confinement generated under the old-age assistance plan was about 60 percent of the average length of confinement shown for age 74 in a report on the problem of

continuation of medical care benefits for the aged in New York State, voluntary health insurance and the senior citizen. The annual rate of hospitalization under the old-age assistance plan was almost double the rate indicated in the New York report. Age 74 for the New York study data was used for comparative purposes as the average age for the old-age assistance plan is approximately 74.

METHOD AND ANTICIPATED RESULTS

Using our best estimate of the area variations and all the data mentioned above, the latest articles on the group hospitalization from the Transaction of the Society of Actuaries, plus the anticipated selection against the plans, the actuarial subcommittee derived rates which we anticipated would produce an 83 percent loss ratio. However, subsequent changes have modified this position to the point where a first-year loss ratio in the neighborhood of 85 percent is expected. This loss ratio is somewhat lower than we feel we need for a going plan, however, we feel that some margin for fluctuation is necessary as well as some allowance for the amortization of acquisition expenses. We also need some allowance for the increase in claim cost due to the force of inflation which should be at an annual rate of 3 to 5 percent.

The actuarial subcommittee does not feel that the proposed rates are inadequate but it does feel they are close enough that we will have to anticipate a rate increase at least by the end of the second year of plan operation and presumably about every second or third year thereafter.

Due to the nebulous nature of the data in this experimental area, it should be obvious that the actuarial subcommittee cannot make any guarantee as to the adequacy of the proposed rates. We can simply say that this is our best estimate of the rate situation.

PROPOSED MONTHLY RATES

Texas 65 basic plan	$9
Texas 65 major medical plan	10

Sincerely,

HARVEY GALLOWAY, Jr.

MARCH 10, 1964.

PRESIDENT,
Texas 65, Dallas, Tex.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would foward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff, to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

"TEXAS 65"

1. Copies of policies, and all literature describing benefits and premiums, including scripts and "tear-sheets" used in promotion.

2. Total number of different persons enrolled during initial "open enrollment" period. Total number of different persons insured as of March 1, 1964. (Please breakdown these data to show subtotals indicating number of different persons in each of your various coverage options.)

Note.—For this and subsequent questions, provide data distinguishing between persons age 65 and over and those persons under age 65.

3. How many of those persons accepted for coverage during your initial "open enrollment" period were still insured as of March 1, 1964?

4. What was the average age of the "Texas 65" policyholder as of the end of your initial enrollment period?

5. In establishing premiums for "Texas 65" were anticipated costs rather than then-current costs used in your calculations? If so, how far ahead were costs projected and anticipated?

6. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

APPENDIX C

SUPPLEMENTAL MATERIALS SUPPLIED TO SUBCOMMITTEE BY HEALTH INSURANCE ASSOCIATION OF AMERICA:

1. EXPLANATION OF METHODOLOGY. (Provided to Subcommittee in May 1964.)
2. ESTIMATE OF EXTENT OF PRIVATE HEALTH INSURANCE COVERAGE OF THE AGED AS OF DECEMBER 31, 1962.
3. THE EXTENT OF INSURANCE COMPANY COVERAGE FOR THE MEDICAL EXPENSES OF THE SENIOR CITIZEN AS OF JULY 1961.

1. METHODOLOGY EMPLOYED BY THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN DEVELOPING ITS ESTIMATE WITH RESPECT TO THE EXTENT OF PRIVATE HEALTH INSURANCE COVERAGE OF THE AGED

By means of a questionnaire survey with regard to aged persons covered at the end of 1962, member companies of the association were asked to report on the extent to which they insured persons at ages 65 and over for hospital expenses, surgical expenses, regular medical expenses and major medical expenses. Of the 312 member companies in the association at the time of the survey, 123 were able to provide statistics with respect to the extent of health insurance coverage of persons at ages 65 and over.

The 123 companies which reported data indicated that they insured 4.8 million persons at ages 65 and over for either basic hospital expense coverage or comprehensive major medical expense coverage. It is to be noted that these companies reported additional persons with surgical expense coverage, regular medical expense coverage, and supplementary major medical coverage. Such additional persons were not counted by the association in its total of 4.8 million, since it was assumed that these people had already been included as having basic hospital expense coverage with either some other insurance company or other type of insurer. It was also assumed that persons with supplementary major medical expense coverage were already included among the 4.8 million with basic hospita expense coverage.

The 123 companies which reported a total of 4.8 million persons at ages 65 and over with some form of insurance company coverage wrote about 70 percent of the U.S. health insurance premiums in 1962 (including both disability income premiums as well as hospital-surgical-medical expense premiums). The methodology employed in the regular annual survey of the association with respect to persons insured at all ages entails projecting numbers covered by reporting companies to a grand total for all insurance companies, based on the relationship of premiums written by reporting companies to the total U.S. written premiums for health insurance by all companies. Had this methodology been employed for the association survey of aged policyholders, the result would have been an estimated 6.9 million aged persons insured by insurance companies (i.e., 4.8/7).

To avoid the possibility of any overstatement with respect to its estimate as to the extent to which insurance companies covered persons at ages 65 and over, and to eliminate duplication of coverage within the insurance business, the association did not use the foregoing methodology for projecting reported enrollment statistics to a grand total. If the nonreporting companies writing 30 percent of the premium had the same proportion of persons at ages 65 and over as had the reporting companies, they would have covered 2.1 million people. Rather than use this 2.1 million or a figure even higher, it was assumed that it would be conservative to use 1.3 million for nonreporting companies. As it turned out, this figure was too conservative, for one of the nonreporting companies later reported that it alone insured 1.1 million aged persons.

The 1.3 million, when added to the total insured by reporting companies of 4.8 million, yields a net total for insurance companies of 6.1 million persons with some form of health insurance coverage at ages 65 and over.

The foregoing statistics, prepared in April 1963, are contained in the survey report entitled "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of December 31, 1962." Subsequent to the preparation of this survey memorandum, specifically in early April 1964, the association was informed by the Continental Casualty Insurance Co. that it had found an error in the statistics which it had submitted to the association in past surveys concerning the insured aged population. This company informed the association that in the process of preparing data for a more current survey of the aged as of the end of 1963, it had found some duplication among the statistics previously furnished to the association. The revised figures furnished to the association by this company results in a reduction of 370,000 persons from the

reported insurance company total of 4.8 million cited in the foregoing paragraphs of this memorandum. At about the same time, in April 1964, the association received data from the Bankers Life & Casualty Co. concerning the extent to which that company insured persons at ages 65 and over. That company, not being a member of the association, had not been requested to furnish data for the various association surveys. The company reported that it insured approximately 1.1 million persons at ages 65 and over. Upon inquiry to this company by the association, it was determined that 763,000 of the 1.1 million persons which they reported as insured, had coverage which met the definition of the association count of persons with some form of health insurance coverage with insurance companies.

The net effect of the reduction in persons insured by the Continental Casualty Co. together with the now available information of persons insured by the Bankers Life & Casualty Co. was to increase the reported enrollment by insurance companies from 4.8 to 5.2 million persons insured as of December 31, 1962. In other words, rather than reported statistics from 123 companies which wrote about 70 percent of the premiums in the United States, the association now had "reported data" from 124 companies which wrote 73 percent of the U.S. premiums in 1962.

Again, rather than assume that the reported statistic of 5.2 million should be projected to a total on the basis of all of the remaining 27 percent of the U.S. premium, the association chose to be conservative. If the nonreporting companies writing 27 percent of the premium had the same proportion of persons at age 65 and over as had the reporting companies they would have covered 1.9 million persons. Rather than use the 1.9 million figure, it was assumed that it would be conservative to use about half, or 0.9 million. This figure, when added to the 5.2 million cited above, yields 6.1 million found to be appropriate at the time of the association's survey in April 1963.

Documentation of the sources of enrollment statistics of the aged, for other insurers, are contained in the association's document "An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of December 31, 1962" dated July 1963. As indicated in reference 3 of that memorandum, the Blue Cross enrollment data concerning the extent to which that organization insures persons at ages 65 and over were reported by a Blue Cross executive at an annual meeting of the American Optometric Association in Chicago, Ill., on July 2, 1963. Subsequently, this statistic on Blue Cross enrollment; namely, 5.3 million persons insured as of the end of 1962, appeared in "Blue Cross-Blue Shield Nongroup Coverage for Older People," Research Report No. 4, Social Security Administration, U.S. Department of Health, Education, and Welfare. Reference 4 and 5 of the July 1963 association memorandum contains documentation for the sources of the estimate as to the extent to which other insurers provide coverage to the aged. As indicated, it was estimated that such organizations insured 400,000 persons at ages 65 and over as of the end of 1962.

Unlike its regular annual survey with respect to the total population, the survey concerning coverage of the aged population did not measure the extent of duplicate coverage as between insurance companies and/or insurance companies and other insurers. The usual methodology employed in eliminating such duplicate coverage is outlined on pages 12 through 16 of the memorandum entitled "The Extent of Voluntary Health Insurance Coverage in the United States as of December 31, 1962" (sources of data and methods of compilation). As indicated on these pages, various factors are utilized to eliminate duplication of coverage within the insurance business and between the insurance business data and those having coverage provided by other insurers. The net effect of the application of all these factors is to reduce the grand total by approximately 13 percent.

To eliminate the duplicate coverage in the association's estimated count of persons covered at the upper ages, the association assumed that the same extent of duplicate coverage existed among the aged as for the total population. It subtracted an additional one and a half million persons (13 percent) from its estimated enrollment total for insurance companies (6.1 million), for Blue Cross (5.3 million), and for other insurers (0.4 million). The net total thus obtained was 10.3 million persons at ages 65 and over or approximately 60 percent of the noninstitutional aged population.

In connection with the association's use of 13 percent as a factor for eliminating duplication of coverage, it is interesting to note that Dr. Forest Linder, Director of the U.S. National Center for Health Statistics, reported during the course of his appearance before the Senate Subcommittee on Health of the Elderly on April 27, 1964, that the U.S. National Health Survey found duplication of coverage among the aged at this same level. It is also of interest to note that, upon questioning, Dr. Linder stated that it was his opinion that the proportion of 60

percent estimated by the association was not inconsistent with the 54 percent insured among the aged as estimated by the U.S. National Health Survey, and that such a difference could result entirely from differences in survey techniques.

The survey which the association conducted with respect to the aged population insured by insurance companies as of December 31, 1962, did not request information with respect to the size of the room and board benefit held in policies covering aged persons. Such information had been obtained in a July 1961 survey and it was felt to be too expensive to re-request at this time. This being the case, there was no way of determining the extent to which aged persons held policies of $30 a day, $20 a day, $10 a day, $5 a day, etc. Should the association have wanted to do so, therefore, it could not have eliminated aged persons with policies paying $5 a day or less from its estimated count, since it did not have such information available.

With respect to the total population, however, the association obtains, in its survey of individual policy enrollment, a measurement as to the extent to which persons at all ages have policies which provide room and board benefits for $5 a day or less. During 1962, among persons at all ages, of the 345 companies which reported in the survey, only 23 indicated some coverage in force with room and board benefits of $5 a day or less. Of these 23, 17 indicated that policies of $5 a day or less represented less than 1 percent of their total individual business in force. Of the other six companies, only one reported to the association in its survey of coverage on the aged. This company reported that it insured slightly over 14,000 persons at ages 65 and over at the end of 1962. As indicated heretofore, it is not known as to the extent to which any or all of the aged persons insured by this one company have policies which pay $5 a day room and board benefits or less. It will be noted, however, that even in the unlikely event that all 14,000 had policy benefits at such a level, the exclusion of this amount would have little effect upon the association's estimate of 6.1 million persons insured with insurance companies at the end of 1962.

2. An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of December 31, 1962

Health Insurance Association of America, Chicago, New York, and Washington

EXTENT OF PRIVATE HEALTH INSURANCE COVERAGE OF THE AGED, DECEMBER 31, 1962

As of the end of 1962, the Health Insurance Association of America estimates that 60 percent of the noninstitutionalized aged population had some form of private health insurance coverage.

This estimate is based upon an analysis of the following: (1) recent surveys of the extent of aged policyholders, conducted by private insurers; (2) the trend in the proportion of the aged population covered by private health insurance as evidenced in household interview surveys; and (3) other relevant statistics developed within the private health insurance business.

Recent surveys of aged policyholders

A survey of the Health Insurance Association of America [1] indicated that slightly over 6 million persons 65 years of age and older held some form of health insurance coverage with insurance companies as of December 31, 1962. This total represented about 1¼ million more persons than the 4¾ million covered by insurance companies as of July 1961. It was 2½ times the 2.3 million aged persons with insurance company coverage at the end of 1958.

A study conducted by the Blue Cross Association [2] indicated that 5.1 million aged persons were enrolled in Blue Cross plans as of November 1961. More recently, a Blue Cross spokesman has stated that 5.3 million aged persons are "currently" enrolled under Blue Cross programs.[3]

Other studies [4 5] have shown that the so-called independent plans, that is plans not affiliated with either the Blue Cross, or underwritten by an insurance company, covered about one-half million aged persons in 1961.

[1] "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of December 31, 1962," Health Insurance Association of America, April 1963.

[2] "Financing Health Care of the Aged," pt. I, p. 127, Blue Cross Association and American Hospital Association, January 1962.

[3] H. Pierce, vice president, Blue Cross Association, presented at annual meeting of American Optometric Association, Chicago, Ill., July 2, 1963.

[4] Testimony with respect to H.R. 4222 by H. Lewis Rietz before House Ways and Means Committee, July 1961 (vol. 2, pp. 852 and 853).

[5] "Health Statistics from the U.S. National Health Survey, Interim Report on Health Insurance, Series B-26," Department of Health, Education, and Welfare, 1960.

If the extent of duplicate coverage among the aged is assumed to be similar to that which exists for the total civilian population,[6] then an estimated 10.3 million persons 65 years of age and older were covered by some form of private health insurance at the end of 1962. This represents 60 percent of the total noninstitutionalized aged population.

Trend in the proportion of the aged covered

Presented in the following table is an indication of the recent trend in the proportion of the aged covered by private health insurance.

Percent of the noninstitutionalized population at ages 65 and over with private health insurance

Date of survey:	Percent insured
March 1952 [1]	26.3
July 1953 [2]	31.0
September 1956 [3]	36.5
Spring 1957 [4]	38.6
Spring 1958 [5]	43.0
Fall 1959 [6]	46.1
July 1961 [7]	53.0
December 1961 [7]	55.0

[1] I. S. Falk and A. W. Brewster, "Hospitalization and Insurance Among Aged Persons," Bureau Rept. No. 18, Social Security Administration, April 1953.
[2] O. W. Anderson and J. J. Feldman, "Family Medical Costs and Voluntary Health Insurance," McGraw-Hill Book Co., 1956, p. 107.
[3] Research and Statistics Note No. 13, Social Security Administration, May 21, 1958.
[4] Progress in Health Services, vol. 8 (January 1959), Health Information Foundation.
[5] Progress in Health Services, vol. 8 (May 1959), Health Information Foundation.
[6] Interim Report on Health Insurance, series B-26, HEW, 1960.
[7] Ibid.

It will be observed that during a 9-year period from 1952 to 1961 the proportion of the aged with health insurance has more than doubled. It is of further interest to note the relatively greater increases during the more recent period covered by the table.

The table also illustrates the relatively more rapid rate of growth of health insurance among the aged population as compared with the total civilian population. At the beginning of the period depicted, 1952, 59 percent of the total civilian population was insured and this increased by 17 percent to an estimated 76 percent by the end of 1962. For the total noninstitutionalized aged population, the proportion insured more than doubled during this period, increasing from 26 percent to about 60 percent. It should be noted further that the 26 percent insured in 1952 represented 3.4 million of the then 13 million aged persons. The 60 percent insured today consists of 10.3 million people or more than three times the number of aged insured in 1952.

Recent relevant statistics within the business

During the last 5 years, there have been a number of significant developments within the private health insurance business which portend a further rapid extension of insurance coverage among senior citizens. Evaluations of these developments have to be considered, separately, for (1) those persons presently at ages 65 years or older and (2) for those persons who will reach this age group in the future.

For persons currently 65 years of age and older, the following statistics are relevant:

(1) Through a development of the last 4 years, a mass enrollment approach whereby all persons 65 years of age and older in a given State can be insured regardless of present or past condition of health, well over 1 million aged persons have become insured.

(2) In 1961 and 1962 residents of Connecticut, Massachusetts, and New York became eligible for enrollment in State 65 plans written by insurance companies through voluntary associations. These plans provide both basic and major medical insurance to residents of a State, and are open for enrollment regardless of past or present health status. To date, in excess of 200,000 aged people have been enrolled. There are indications that similar approaches will soon be introduced in other States.

[6] "The Extent of Voluntary Health Insurance Coverage in the United States," Health Insurance Council, annual.

(3) Groups of retired people, such as the American Association of Retired Persons, can acquire health insurance protection, and thus have the advantages of the group insurance approach.

(4) In 1961, retired civil service employees of the Federal Government were offered health insurance protection. This could eventually add 400,000 aged persons to the rolls of health insurance. In addition, State governments, such as New York, have made similar health insurance protection available to their retired civil service employees in the past few years.

(5) In 1961, 4.1 million aged persons and their dependents received money income from employment.[7] For those of these 4 million aged who are employed in industries where there is group insurance, these persons currently have health insurance protection with all or a larger portion of the premium paid for by the employer. Although it cannot be definitely established as to the exact number of these who are so protected, it is known that in excess of three-quarters of the total working population and their dependents are insured through the group insurance mechanism.[8]

(6) In addition to the mass enrollment approaches discussed under (1) and (2) above, the current aged population has access to the new issuance of individual policies. There are currently at least 170 insurance companies that will issue new health insurance policies to persons 65 years of age and older. Of these, at least 38 companies offer policies to the aged which are guaranteed renewable.

With respect to those persons presently under 65 years of age, who will over the next several years become senior citizens, there have been an equally significant number of developments relative to health insurance coverage as follows:

1. There is a growing practice within the private health insurance business for group plans to provide for a continuance of the health insurance protection offered to active employees after they retire. In most of such plans that are presently being written, the employer pays for or prefunds the premium cost for continuing the coverage on his pensioners or retirees. The following statistics are relevant to this trend:

(*a*) A survey conducted by the New York State Insurance Department [9] indicated that among all insurance companies licensed to do business in New York State all group plans providing for continuation of coverage after retirement had the provision included in the policy during or subsequent to 1954.

(*b*) A study conducted by the Health Insurance Association [10] indicated that in 1952, only 24 percent of group plans surveyed had provision for continuation of the coverage after retirement whereas by 1956, 48 percent of these plans had had this provision added to the policy.

(*c*) A survey conducted by the U.S. Bureau of Labor Statistics in 1958 [11] indicated that 68 percent of the group insurance plans surveyed provided benefits for retired workers as compared with 54 percent in late 1954. This study indicated further that in all but 3 of the 92 group plans surveyed the employer pays all or a very large portion of the premium.

(*d*) Insurance company witnesses [12] before the Senate Subcommittee on the Aged and Aging indicated that under group insurance plans insured through their companies, anywhere from 45 to 60 percent will have the coverage continued after retirement and that for about 70 percent of those so protected the coverage will be provided without any contribution on their part.

(*e*) A study [13] conducted among a sample of group insurance policies issued in 1960 indicated that 68 percent of the employees covered under such policies will have the right to retain their benefits upon retirement.

2. Another recent development which will afford protection to the future retirees concerns the availability of the right to convert group coverage to an individual policy at time of retirement. Most insurers which write group insurance today make this benefit available and its growth has been rapid

3. At least 61 insurance companies offer individual policies which are guaranteed renewable for life. This means that an individual can purchase health insurance at a relatively young age, when the premiums are relatively smaller, and continue to pay this relatively small premium into advanced ages. At least six insurance

[7] Research and Statistics Note No. 7, 1961, Social Security Administration.
[8] Ibid.
[9] "Voluntary Health Insurance and the Senior Citizen," New York State Insurance Department, 1958
[10] Trend in Medical Care Benefits Provided to Active Employees and at Retirement Through Group Insurance Plans.
[11] Monthly Labor Review, vol. 81, No. 11, pp. 1243-1249, November 1958.
[12] Testimony of Morton D. Miller of the Equitable Life Assurance Society and Richard R. Shinn of the Metropolitan Life Insurance Co. before the Senate Subcommittee on the Problems of the Aged and Aging, Apr. 13, 1960.
[13] Health Insurance Institute, May 1961.

companies issue such guaranteed renewable coverage which becomes paid up at age 65, thus enabling the policyholder to prepay his protection.

4. Apart from the specific development of new techniques for insuring the future aged, it might also be observed that those persons reaching senior citizen status in future years emerge from a cohort of the population which has been subjected, during the last 10 years, to a considerable growth of health insurance coverage. Specifically, at the beginning of 1947, only 30 percent of the total population had some form of health insurance protection whereas currently this proportion has reached 76 percent. This is further illustrated in the following two analyses:

(1) A 1952 survey by the Social Security Administration [14] indicated that 26 percent of persons 65 years of age and older were insured. For those 65 to 69 the percentage was 36 percent; for those 70 to 74 it was 25 percent; and it was 15 percent for those 75 years of age and older. In 1947, when the above cited 65 to 69 cohort was 60 to 64, only 30 percent of the entire population was insured. It is unlikely that the people in the age group 60 to 64 were covered to the same extent. Yet 5 years later, these same people were 36 percent covered. Similarly, the people who were 70 to 74 years of age in 1952, were 60 to 64 in 1942. At the beginning of 1942 only 12 percent of the population had acquired voluntary health insurance. Thus, the percentage of this age group insured in 1952, about 25 percent, represents a substantial increase over the average extent of coverage at the time when these same people were in the 60 to 64 age bracket. Finally, those who were aged 75 and over in 1952 were 60 and over in 1937, at which time health insurance coverage in this country was almost negligible, covering fewer than 5 percent of the total population. The 15 percent of this age group covered in 1952 must, therefore, represent protection almost entirely acquired after age 65.

(2) In the fall of 1959, the Department of Health, Education, and Welfare estimated that 46.1 percent of the aged had health insurance.[15] Of those 65 to 74 years of age, the percent insured was 53.2 percent, and it was 32.5 percent for those 75 years of age and older. In 1949, when the above cited 65 to 74 cohort was 55 to 64, only 45 percent of the total population had health insurance. Even if people in this age group were insured to the same extent, within 10 years their coverage had increased to 53 percent. Similarly, when those 75 and over in 1959 were 60 and over in 1944, only 23 percent of the total population were insured. Thus, more than a third of the coverage among this group in 1959 (32 percent) must represent insurance acquired after age 65.

The examination of the increasing trend in the proportion of the aged protected by health insurance during 1952 to 1961, together with consideration of the other recent developments noted in the foregoing section of this memorandum, indicates that the current HIAA estimate to the effect that 60 percent of the noninstitutionalized aged were insured at the end of 1962, is statistically reliable.

According to the Social Security Administration,[16] 14 percent of the aged population are currently receiving old-age assistance benefits and are, therefore, eligible to obtain governmental help in meeting medical care costs. To this proportion should be added the aged who are receiving medical care assistance under the Kerr-Mills law. Since few, if any, of the aged in these categories have health insurance, the aforecited 60 percent of the total noninstitutionalized aged with private insurance coverage when added to the at least 14 percent eligible for medical care under OAA and MAA, means that about three-fourths of the aged presently have a means for meeting medical care costs either through private health insurance or present governmental programs.

Exhibit 7

Instructions for Part I, Individual and Family Policies

1. Information reported is to be based on an actual analysis of individual policies in force in the United States on December 31, 1962, and which provide hospital, surgical, regular medical, or major medical expense coverage. Where an actual analysis is not possible, representative samples or other appropriately qualified estimates will be acceptable. Where samples are used, however, data should be expressed in terms of totals based on the samples utilized.

2. Exclude special-risk, limited accident, polio, and other such policies not providing medical expense benefits for both accidents and illness. Franchise and

[14] Social Security Bulletin, November 1952.
[15] Ibid.
[16] Social Security Bulletin, June 1961.

blanket policies should be included in part I unless reported in part II. Kindly indicate by footnote the part in which you have included your franchise and blanket coverages. Coverage under mass enrollment plans and conversions from group policies should also be shown in part I.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident.

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident.

(*c*) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i.e., exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home and office visits. Distribute this total in line 3, however, as between categories shown in lines (*a*) and (*b*).

(*d*) *Major medical expense, supplementary.*—Include only the major medical expense or catastrophic coverage policies which may be superimposed on basic hospital, surgical, and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(*e*) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (*d*) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. Include only policies written on a direct basis. Reinsurance assumed from other companies should be excluded, while reinsurance ceded to other companies should not be deducted. Do not include participation in State 65 association plans. Such data will be obtained direct from the association.

5. In the event that individuals are covered for hospital-surgical-medical expenses by rider to a loss of income policy, such persons should be included for purposes of this questionnaire.

6. Please note that persons with a policy providing hospital, surgical, and regular medical expense benefits should be entered in each of the appropriate lines of part I.

PART I

Number of people 65 years of age and older covered under individual and family health insurance policies, as of Dec. 31, 1962

Type of coverage	*Total*
1. Hospital expenses, total	
2. Surgical expenses, total	
3. Regular medical expenses, total	
(*a*) In hospital only	
(*b*) Home, office, and hospital	
4. Major medical expenses, supplementary	
5. Major medical expenses, comprehensive	

INSTRUCTIONS FOR PART II. GROUP POLICIES

1. Information reported is to be based on actual analysis of group policies in force in the United States on December 31, 1962, and which provide hospital, surgical, medical, or major medical expense coverage. An actual analysis should be made and reported for all policies covering 500 or more employees. For smaller groups, analyze and report on all policies or use a sample by taking from either a numerical or alphabetical file (*a*) at least every 10th policy covering between 50 and 499 employees, and (*b*) at least every 20th policy (with a minimum sample of 100 policies) covering less than 50 employees. When a sample is used, the results entered in the tables should be the totals for your entire business as estimated from the sample. Other appropriate estimating procedures, where necessary, will be acceptable.

Exclude special-risk blanket coverages (e.g., polio, limited accident, volunteer firemen, schoolchildren). Other franchise and blanket coverages should be excluded if reported in part I.

2. Include only coverages written on a direct basis—reinsurance accepted from other organizations should be excluded, while reinsurance ceded to other organizations should be included. For coverages jointly underwritten by your organization and one or more other organizations on a coinsurance basis, the figures included should be a fractional part of the individuals so underwritten, the fraction used being the proportion of the total coverage under such cases which is underwritten by your organization. Do not include participation in State 65 Association plans. Such data will be obtained direct from the association.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident. Do not include, however, the extra hospitalization coverage provided in addition to weekly indemnity in policies issued under the California UCD law, if the benefit is only the minimum required by law ($12 for 20 days).

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident.

(*c*) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i.e., exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home, and office visits.

(*d*) *Major medical expense (supplementary to basic plans).*—Include only the major medical expense or catastrophic coverage policies which are superimposed on basic hospital, surgical and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical, or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(*e*) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (*d*) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. The following instructions apply with respect to the basis for reporting individuals: Include under each benefit classification the total number of individuals for whom such coverage is provided. Individuals with several kinds of coverage should be counted under each of the appropriate classifications.

5. It is recognized that some of the data for tables 1 and 2 may, in some instances, have to be obtained from your policyholders. The importance of this survey is such as to warrant such a procedure wherever possible. If such proves not to be practicable, qualified estimates will be acceptable.

PART II

TABLE 1.—*Number of actively employed individuals and dependents 65 years of age and older insured under group health insurance policies, as of Dec. 31, 1962*

Type of coverage	*Total*
1. Hospital expenses, total	
2. Surgical expenses, total	
3. Regular medical expenses, total	
(*a*) In-hospital only	
(*b*) Home, office, and hospital	
4. Major medical expenses, supplementary	
5. Major medical expenses, comprehensive	

TABLE 2.—*Number of retirees and retirees' dependents 65 years of age and older insured under group health insurance policies, as of Dec. 31, 1962*

Type of coverage	*Total*
1. Hospital expenses, total	
2. Surgical expenses, total	
3. Regular medical expenses, total	
(*a*) In-hospital only	
(*b*) Home, office, and hospital	
4. Major medical expenses, supplementary	
5. Major medical expenses, comprehensive	

3. THE EXTENT OF INSURANCE COMPANY COVERAGE FOR THE MEDICAL EXPENSES OF THE SENIOR CITIZEN AS OF JULY 1961

A Survey of Member Companies of the Health Insurance Association of America

TABLE OF CONTENTS

I. HIGHLIGHTS OF SURVEY

(1) As of July 1961, there were at least 220 member companies of the Health Insurance Association of America which offered health insurance coverage against the costs of medical care to the senior citizen (persons age 65 and older). This survey was conducted to determine the extent and quality of these coverages written by these companies. Of the 220 companies, 90 responded to the survey. The remainder were unable to provide data of the type requested.

(2) The 90 companies reported a total in-force of 3.6 million persons 65 years of age or older with some form of medical expense insurance in mid-1961. Since the health insurance premium volume of these companies is about two-thirds of the total health insurance premium volume in the United States, it is estimated that, among all insurance companies in the United States, there were about 4¾ million senior citizens covered as of mid-1961.

(3) A previous survey by the association indicated about 2.3 million aged with insurance company coverage at the end of 1958. Thus, in the last two and a half years, the number of aged persons covered by insurance companies is estimated to have more than doubled.

(4) Of the aged covered, 47 percent were insured under group policies and 53 percent under individual and family policies.

(5) Of the senior citizens with hospital expense coverage, 88 percent also had surgical expense insurance and 30 percent had coverage for regular medical expenses. Almost three-fourths of a million, 730,000 aged persons, were covered by major medical expenses insurance policies as of July 1961. Major medical policies provide coverage for all usual, customary, and necessary medical expenses in and out of the hospital including surgery, physicians services, prescribed drugs, nursing care, and appliances, subject to stated deductible, coinsurance, and maximum amounts.

(6) Of the aged with hospital expense insurance almost one-third had policies with daily hospital room and board benefits of $15 a day or more. About a fifth (18 percent) had benefits of from $11 to $14 per day and the remainder (53 percent) were covered for $10 a day or less.

(7) The nationwide average daily room and board charge in hospitals in 1960 was $17. Based on this average, almost one-third of the insureds would have the room and board portion of their hospital bill met in full or practically in full; 18 percent would have between 65 percent to 82 percent of the bill covered; and 53 percent would be covered for about half the room and board charge.

(8) Twenty-seven percent of the aged with hospital expense coverage had ancillary hospital expense benefits of $500 or more and an additional 21 percent had benefits of between $200 and $499. The remaining 52 percent were covered for ancillary hospital expenses up to $200. This coverage provides benefits for such hospital expenses as the operating room, anesthesia, and drugs.

(9) According to data developed by the Society of Actuaries, a $200 ancillary hospital expense benefit will provide full reimbursement of all hospital ancillary expenses in at least 80 percent of all confinements.

(10) More than two-fifths of the insured aged had hospital expense benefits of over 70 days per year. About a quarter had coverage for from 32 to 70 days per year. The remaining third had policies providing for 31 days, and in a few instances, for less than 31 days per year.

(11) According to U.S. National Health Survey data, two-fifths of the aged are discharged from hospital after a week or less; 70 percent after 2 weeks or less; and 91 percent after 30 days or less. Less than 10 percent of the aged spend 31 days or more in hospital. Based on these averages, all but a small proportion of the insureds would have sufficient benefit days to provide coverage for their entire hospital stay.

(12) More than half of the aged with surgical expense insurance (53 percent) have maximum surgical benefits of over $200. The remainder have such benefits for $200 or less (most usually $200).

(13) About a third of the aged with regular medical expense insurance have coverage for physicians visits in home, office, and hospital. The remaining two-thirds have coverage for nonsurgical physicians visits while hospitalized.

(14) As of mid-1961, several insurance companies were making available coverages which specifically include the cost of skilled nursing home care. Although the survey did not obtain data with respect to the total number of aged covered for such care, it is known that the predominant coverage is $7.50 a day for 31 days and $5 a day for the next 90 days in nursing homes.

(15) Four-fifths of the 730,000 aged persons with major medical insurance are covered by group policies. The remainder have individual and family coverage. Of those insured under group policies, 70 percent have the supplementary and 30 percent the comprehensive type of major medical coverage. These policies are written with maximum amounts up to $15,000, subject to deductibles and coinsurance.

(16) More than four-fifths of the aged covered under individual and family policies for hospital and surgical expenses have policies which are either guaranteed renewable or under which the company has voluntarily relinquished its right to nonrenew the policy because of any change in the physical condition of the insured.

(17) Upon retirement, more than one out of every two aged currently employed and insured under a group insurance policy have the right either to convert to an individual policy or to continue their coverage as a member of the group.

(18) Since July 1961, there have been such developments as the Connecticut 65 plan, the Federal Government retiree plan, and others, which portend a further extension of the coverages held and available to the aged.

II. BACKGROUND AND PURPOSE

In December 1957, the board of directors of the Health Insurance Association of America appointed a special committee on continuance of coverage.

In October 1958, that committee recommended a special meeting of the association to be held in New York City in December 1958. At that meeting, the following recommendations of the committee were adopted by the member companies of the Health Insurance Association of America:

1. Insurers offering individual and family coverage of the cost of health care under contracts which are renewable at the option of the insurer should continue to accelerate their progress in minimizing the refusal of renewal solely because of deterioration of health after issuance.

2. Every insurer offering health care coverages should, among the types of insurance contracts it offers, promptly make available to insurable adults policies which are guaranteed renewable for life.

3. Every insurer should develop sales programs designed to encourage the sale of permanent health care insurance where the need for this type of coverage exists.

4. Every insurer offering individual and family hospital, surgical, and medical care coverages should promptly take steps if it is not presently doing so to offer insurance coverage of persons now over age 65.

5. It is essential that adequate voluntary health insurance be available to broad classes of physically impaired people. Initial insurance underwriting standards essential to fulfilling the first two of these recommendations increase the need for insurance for the physically impaired. Otherwise, in the future, these people may be deprived of insurance coverage. It is recommended that each company carefully consider how to contribute to the achievement of this objective.

6. Every insurer writing coverage on a group basis should develop and aggressively promote soundly financed coverages that will continue after retirement.

7. Every insurer offering coverage on a group basis should encourage the inclusion in the group contract of the right to convert to an individual contract on termination of employment.

It is the purpose of this survey to determine the extent and quality of coverages against the costs of medical care presently covering senior citizens and to measure the accomplishments of member companies as respects such coverages since the adoption of the aforecited recommendations. Specifically, the survey develops data on the extent and quality of insurance company coverage for the medical care expenditures of persons 65 years of age or older with measurement taken as of July 1, 1961. Along with this current measurement, there is presented an indication of the recent trend with respect to such data.

III. SCOPE AND METHODOLOGY OF STUDY

The survey was conducted by mail among the 282 member companies of the Health Insurance Association of America by means of a questionnaire (see appendix B). Survey forms were distributed in June with responses requested by the end of September 1961. Of the 282 members, at least 220 made medical expense coverage available to persons 65 years of age and older. As of the date of this analysis (December 1961), 152 member companies had responded.

Among the 152 respondents, 43 were necessarily excluded from participation in the survey for one of the following reasons: the company did not write medical expense insurance for persons 65 or over (32 companies); the company wrote reinsurance only (4 companies); or the company did not write insurance in the United States (7 companies). There were, therefore, 109 member companies which reported writing medical expense insurance for the senior citizen on a direct basis in the United States. Of these 109, however, 19 could not supply data in sufficient detail to be usable for purposes of the study.

The results of the study are based, therefore, upon statistics provided by 90 member companies of the Health Insurance Association of America. Since certain of these companies write group insurance only, or individual insurance only, the total respondents for various sections of the survey (see questionnaire in appendix B) differ. The adequacy of the response rate for the several sections may be adjudged from the data presented below.

Responses to survey

	Number of companies	Percent of total U.S. premium
Total	90	66.0
Pt. I, individual	70	42.7
Pt. II, group:		
Table 1	63	59.7
Table 2	55	62.8

It will be noted that respondents to the survey write approximately two-thirds of the health insurance premiums in the United States. The sample, is therefore, deemed to be statistically valid and representative of the total U.S. business.

IV. ANALYSIS OF RESULTS, JULY 1961

(*A*) *Extent and type of coverage*

As of July 1, 1961, the 90 respondents to the survey reported 3.6 million persons 65 years of age or older with some form of medical expense insurance coverage. Since the health insurance premium volume of these companies is approximately two-thirds of the total health insurance premium volume in the United States, the complete extent of medical expense coverage by insurance companies, among

senior citizens in the United States, is estimated to have numbered about 4¾ million persons as of mid-1961.[1] [2]

It is of interest to compare the total of 4¾ million aged persons covered as of July 1961 with data obtained in a previous survey by the association. Although the statistics are not entirely comparable, since there were several different companies responding in each survey, the trend depicted is noteworthy. In the prior survey, data indicated 2.3 million aged covered at the end of 1958.[3] In a space of 2½ years, therefore, the number of aged persons covered by insurance company respondents to the association's survey is estimated to have more than doubled.

Among the aged persons insured as of July 1961, 47 percent were covered by group insurance and 53 percent by individual and family policies (see table 1, app. A).

Of those with hospital expense protection, 88 percent also had surgical expense protection and 30 percent had additional protection for regular medical expenses. A fifth of the aged with insurance company coverage, 730,000, had major medical expense policies.

Among the 730,000 persons with major medical expense coverage, 81 percent are protected under group policies and 19 percent have individual and family policies. Of those with group major medical expense coverage, 70 percent have such coverage superimposed upon a basic hospital-surgical policy and 30 percent have comprehensive plans which usually have deductibles of $25 or $50. The pertinent numbers are presented below.

Number of aged persons with major medical insurance, July 1961

Total	730,140
Individual	135,328
Group	594,812
Supplementary	409,529
Comprehensive	185,283

The above noted aged persons with major medical expense policies have coverage in amounts up to $15,000 subject to deductibles and coinsurance. Benefits are paid for all the usual, customary, and necessary medical care expenditures both in and out of hospital, subject to deductible, coinsurance, and maximum amounts.. Benefits include the costs of surgery, physicians services, prescribed drugs, nursing care, and appliances.

It is of interest to compare the proportions of the aged with hospital expense protection who also have surgical and regular medical with comparable data for the total population at all ages. Of persons covered by insurance companies for hospital expenses as of January 1961 (79 million), 75 million or 95 percent had protection for surgical expenses—a proportion only slightly higher than that among the aged. Although the proportion who also have regular medical expense coverage among the total population (52 percent) is considerably higher than the 30 percent among the aged, the latter proportion is significantly high in view of the fairly recent development of health insurance coverage for the aged. Ten years ago only 23 percent of the total population covered by insurance companies for hospital expenses also had coverage for regular medical expenses.

Additional data with respect to the extent and type of coverage of aged persons, as between group and individual insurance, may be found in table 1.

(B) Quality of coverage

(1) Hospital expenses

As indicated in table 2 (app. A), about one-third (29 percent) of the aged persons with hospital expense insurance had policies which provide daily hospital room and board benefits of $15 a day or more. About a fifth (18 percent) had benefits of $11 to $14 per day. The remainder, slightly over half (53 percent), were covered for $10 a day or less.

[1] In testimony before the Committee on Ways and Means, House of Representatives, in July 1961, the association estimated that 9 million aged were covered—4 to 4¼ million by insurance companies, 4¼ million by the Blue Cross, and one-half to three-fourths million by other plans. In light of the current study, these estimates were probably understated.

[2] Data with respect to the extent of duplicate coverage among the aged were not obtained in this survey. The factors used to eliminate such duplicate coverage, therefore, were similar to those for the total population. These are shown in the regular annual survey of the Health Insurance Council, "The Extent of Voluntary Health Insurance Coverage in the United States."

[3] These data are based on reported statistics projected to a total. This was accomplished in a similar manner as the data for mid-1961, i.e., reported premium against total U.S. premium.

Two points are worthy of note with respect to these findings:

(1) The average daily room and board charge in non-Federal short-term hospitals in the United States in 1960 was $17.[4] In terms of this nationwide average, 29 percent of the aged insureds would have their daily room and board charges covered in full or practically in full; 18 percent would have between 65 to 82 percent of the bill covered; and the remainder would have, on the average, slightly over half the bill covered.

(2) The nationwide average hospital room and board charge varies significantly by geographical area in the United States. Thus, in States like Mississippi and Arkansas, as examples, where the average daily bed charges are $10[4] and $11[4] respectively, a daily hospital room and board insurance benefit of $10 a day would about cover the entire cost.

In addition to the daily room and board benefit, the aged insureds had benefits for ancillary hospital expenses in amounts up to $500 or more. Of the total, 27 percent had benefits for $500 or more; 21 percent had benefits of between $200 and $499; and 52 percent were covered for amounts up to $200. (See table 2.)

With respect to the foregoing, it is of interest to note that a $200 ancillary expense benefit will provide full reimbursement of all hospital extras in at least 80 percent of hospital confinement.[5]

More than two-fifths of the insureds (41 percent) had hospital expense coverage for more than 70 days per year. An additional 25 percent had benefits providing coverage for 32 to 70 days per year. The remaining third (34 percent) had policies which provided benefits for 31 days, and in a few instances, for less than 31 days.

An evaluation of the relative effectiveness of these findings may be obtained from a review of U.S. National Health Survey data.[6] According to this material, 41 percent of persons 65 and over are discharged from hospitals after stays of a week or less. An additional 31 percent are discharged after 1 to 2 weeks and about 19 percent spend from 15 to 30 days in hospital. Less than 10 percent of the aged stay in hospital for more than 31 days. Based on these data, all but small proportion of the aged insured would have sufficient benefit days to provide coverage for their entire hospital stay.

(2) Surgical expenses

A distribution of the aged persons with surgical expense insurance, by level of the coverage, is presented in table 3, appendix A.

Of the total, 10 percent had maximum surgical benefits of $300 or more and 43 percent had benefits of between $201 and $300. The remaining 47 percent had benefit maximums of $200.

(3) Regular medical expenses

As indicated in table 4 (app. A), two-thirds of the insured aged with coverage for regular medical expenses had such coverage in hospital only. The remaining third had coverage for physicians visits in home, office, and hospital.

The foregoing distribution is not too dissimilar from that which exists for the total insured population. Thus, a recent analysis by the Health Insurance Institute[7] among a sample group insured cases indicated that of those with regular medical expense coverage, 77 percent had coverage for in-hospital physicians visits and 23 percent for visits in home, office, and hospital.

(4) Nursing home expenses

The current survey did not measure the extent of insurance company coverage with respect to nursing home care. It is known, however, that as of mid-1961, several large insurance companies were making available coverages which specifically include the cost of skilled nursing home care. The predominant of such coverages is for $7.50 per day for the first 31 days in a nursing home and $5 per day for the next 90 days.

Additional data on the level of coverage among aged persons by type of coverage, as between group and individual insurance, may be found in tables 2–4.

[4] "Daily Service Charges in Hospital, 1960," American Hospital Association.
[5] "A Reinvestigation of Group Hospital Expense Insurance," Transactions of the Society of Actuaries, vol. XII, 1960.
[6] "Hospitalization, Patients Discharged from Short Stay Hospitals, United States, July 1957–June 1958," series B–7, Department of Health, Education, and Welfare.
[7] "Source Book of Health Insurance Data, 1961," Health Insurance Institute.

(C) Continuance of coverage

(1) Individual and family policies

As indicated in table 5 (app. A), over a fourth of the aged covered under individual and family policies for hospital and surgical expenses (27 and 28 percent respectively) had policies which are guaranteed renewable. An additional 54 percent of the aged covered for these two categories of expense had policies subject to nonrenewal under which the companies have voluntarily relinquished their right to nonrenew the policy because of any change in the physical condition of the insured. In less than a fifth of the individual policies for hospital and surgical expense (19 and 18 percent respectively) had there been no such voluntary action.

Of the aged insured under individual policies for regular medical expenses, 8 percent had guaranteed renewable policies and 92 percent had policies subject to nonrenewal. For a third of the latter, however, companies have voluntarily relinquished their right to nonrenew the policy because of any change in the physical condition of the insured.

Practically all aged persons covered for individual and family major medical insurance were covered by policies under which the company might refuse renewal. For more than three-quarters of these (77 percent), however, companies have voluntarily relinquished their right to nonrenew because of any change in the physical condition of the insured.

(2) Group policies

Table 6 (app. A) provides a distribution of the actively employed aged currently insured under group policies with an indication of the extent to which such coverage would continue after retirement. More than one out of every two had the right to continued coverage either as part of the group or by means of individual conversion.

V. CERTAIN DEVELOPMENTS SINCE JULY 1961

There have been several significant developments during the past few months which should further affect both the extent and quality of coverage among the aged. Two are particularly worthy of note.

In July 1961, retired employees of the Federal Government who retired prior to July 1, 1960, became eligible for health insurance coverage on a group basis written by insurance companies. Under the uniform Government program the benefits may be basic hospital and surgical expense coverage, major medical expense coverage (including hospital, surgeon, physicians, nursing home, drugs and nursing care) up to $5,000, or both. During the first month of this program, about 237,000 of an estimated 400,000 retirees acquired protection under this program.[8]

Federal employees who retired after July 1, 1960, are eligible for more liberal benefits under the Federal Employee Health Benefits Act of 1959.

In October 1961, residents of Connecticut aged 65 and over (and spouse, if 55 or older) became eligible for enrollment in the Connecticut 65 extended health insurance program. This plan, which is available without physical examination, provides lifetime benefits to $10,000 after a $100 deductible. It covers all medical expenses in and out of hospital. By the end of the first month enrollment period under this program, about 22,000 senior citizens were enrolled. Of these, 14,000 chose the $10,000 major medical plan only; 5,000 selected the $5,000 major medical plan only; about 2,000 selected a combination of the $10,000 major medical with additional basic plan benefits; and about 1,000 selected the $5,000 plan plus basic coverage. Of additional interest is the fact that 30 percent of the newly covered senior citizens were enrolled by someone other than themselves, usually their son or daughter. Similar programs are under consideration in other States.

In addition to the foregoing, companies continue to experiment with new forms of coverage for the aged. For example, in July 1961, a large insurance company introduced a new program of health insurance policies designed specifically for aged persons. Under these policies, major medical benefits are available up to $10,000 subject to a $50 deductible. These policies can be purchased by a relative of the senior citizen.

[8] U.S. Civil Service Commission.

APPENDIX A

STATISTICAL TABLES

TABLE 1.—*Extent of health insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by type of coverage, July 1961*

Type of coverage	Total	Group	Individual and family
Hospital expense	3,615,140	1,715,169	1,899,971
Surgical expense	3,185,937	1,711,249	1,474,688
Regular medical expense	1,098,878	951,646	147,232
Major medical expense	730,140	594,529	135,328

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 2.—*Extent of hospital expense insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by quality of coverage, July 1961*

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Daily hospital room and board benefit:						
$15 and over	1,049,478	29	696,489	41	352,989	19
$11 to $14	657,440	18	502,149	29	155,291	8
$10 or less	1,908,222	53	516,531	30	1,391,691	73
Maximum duration of stay:						
71 days and over	1,489,758	41	576,340	34	913,418	48
32 to 70 days	901,557	25	568,500	33	333,057	18
31 days or less	1,223,825	34	570,329	33	653,496	34
Ancillary hospital expense benefit:						
$500 and over	985,950	27	562,176	33	423,774	23
$200 to $499	749,077	21	520,108	30	228,969	12
Less than $200	1,880,113	52	632,885	37	1,247,228	65

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 3.—*Extent of surgical expense insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by quality of coverage, July 1961*

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Maximum surgical benefit:						
More than $300	319,116	10	268,671	16	50,445	4
$201 to $300	1,366,071	43	744,366	43	621,705	42
$200 or less	1,500,750	47	698,212	41	802,538	54

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 4.—*Extent of regular medical expense insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by quality of coverage, July 1961*

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Physicians visits:						
Hospital, home, and office	366,047	33	347,249	36	18,798	13
In-hospital only	732,831	67	640,397	64	128,434	87

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 5.—*Extent of health insurance under individual policies among persons 65 years of age and older by 70 insurance companies,*[1] *by type of coverage and renewability provision, July 1961*

Type of coverage	Guaranteed renewable		Subject to cancellation and nonrenewal			
			With voluntary restriction on right to cancel		With no voluntary restriction on right to cancel	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Hospital expense	512,729	27	1,021,461	54	365,781	19
Surgical expense	408,986	28	789,773	54	275,929	18
Regular medical expense	11,708	8	46,826	32	88,698	60
Major medical expense	344	1	104,617	77	30,367	22

[1] These 70 companies write 43 percent of individual health insurance premiums.

TABLE 6.—*Extent of health insurance under group policies among actively employed persons and dependents 65 years of age and older by 63 insurance companies,*[1] *by type of coverage and continuance provision, July 1961*

Type of coverage	Total	With right to convert on retirement		With right to continue under group on retirement		Percent with 1 right or the other
		Number	Percent of total	Number	Percent of total	
Hospital expense	922,645	332,692	36.1	292,914	31.7	54.2
Surgical expense	921,868	328,792	35.7	306,102	33.2	56.4
Regular medical expense	574,856	140,111	24.3	195,439	33.9	49.7
Major medical expense	391,365	74,686	19.2	136,498	35.0	47.5

[1] These 63 companies write 60 percent of the group health insurance premiums.

APPENDIX B

QUESTIONNAIRE

EXHIBIT 6

INSTRUCTIONS FOR PART I. INDIVIDUAL AND FAMILY POLICIES

1. Information reported is to be based on an actual analysis of individual policies in force in the United States on June 30, 1961, and which provide hospital, surgical, regular medical, or major medical expense coverage. Where an actual analysis is not possible, representative samples or other appropriately qualified estimates will be acceptable. Where samples are used, however, data should be expressed in terms of totals based on the samples utilized.

2. Exclude special-risk, limited accident, polio and other such policies not providing medical expense benefits for both accidents and illness. Franchise and blanket policies should be included in part I unless reported in part II. Kindly indicate by footnote the part in which you have included your franchise and blanket coverages. Coverage under mass enrollment plans and conversions from group policies should also be shown in part I.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident. Indicate total number of persons 65 and over covered for hospital expenses opposite line 1. Please show distribution of this total, by amount of daily hospital room and board benefit, in appropriate lines a, b, and c. For example, if you insure 100 aged persons for hospital expenses, of whom 75 have policies which pay $10 a day or less in hospital, 20 pay $12 a day, and 5 pay $20 a day, insert 100 in line 1, 75 in line a, 20 in line b, and 5 in line c.

Similarly, distribute total in line 1 by maximum duration of hospital benefits in lines d, e, and f and by maximum ancillary hospital expenses in g, h, and i.

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident. Please show distribution of total number covered for surgical expenses in line 2, by maximum surgical benefit provided, in appropriate lines j, k, and l.

(*c*) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i.e., exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home, and office visits. Distribute this total in line 3, however, as between categories shown in lines m and n.

(*d*) *Major medical expense, supplementary.*—Include only the major medical expense or catastrophic coverage policies which may be superimposed on basic hospital, surgical, and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical, or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(*e*) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (*d*) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. For each type of coverage; e.g., hospital expenses, the total shown in column (A) should be distributed by type of renewability provision in columns (B), (C), and (D).

5. Include only policies written on a direct basis. Reinsurance assumed from other companies should be excluded, while reinsurance ceded to other companies should not be deducted.

6. In the event that individuals are covered for hospital-surgical-medical expenses by rider to a loss of income policy, such persons should be included for purposes of this questionnaire.

7. Please note that persons with a policy providing hospital, surgical, and regular medical expense benefits should be entered in each of the appropriate columns of part I.

PART I

Number of people 65 years of age and older covered under individual and family health insurance policies, as of June 30, 1961

Type of coverage	Total	Type of renewability provision		
		Guaranteed renewable	Subject to cancellation or nonrenewal	
			With voluntary restriction on right to cancel or nonrenewable	Other
	(A)	(B)	(C)	(D)
1. Hospital expenses, total				
(a) $10 a day or less				
(b) $11 to $14 a day				
(c) $15 a day or more				
(d) 31 days a year or less				
(e) 32 to 70 days a year				
(f) Over 70 days a year				
(g) Less than $200 ancillary expenses				
(h) $200 to $499				
(i) $500 and over				
2. Surgical expenses, total				
(j) $200 or less				
(k) $201 to $300				
(l) More than $300				
3. Regular medical expenses, total				
(m) Inhospital only				
(n) Home, office, and hospital				
4. Major medical expenses, supplementary				
5. Major medical expenses, comprehensive				

INSTRUCTIONS FOR PART II—GROUP POLICIES

1. Information reported is to be based on actual analysis of group policies in force in the United States on June 30, 1961, and which provide hospital, surgical, medical, or major medical expense coverage. An actual analysis should be made and reported for all policies covering 500 or more employees. For smaller groups, analyze and report on all policies or use a sample by taking from either a numerical or alphabetical file (*a*) at least every 10th policy covering between 50 and 499 employees, and (*b*) at least every 20th policy (with a minimum sample of 100 policies) covering less than 50 employees. When a sample is used, the results entered in the tables should be the totals for your entire business as estimated from the sample. Other appropriate estimating procedures, where necessary, will be acceptable.

Exclude special-risk blanket coverages (e.g. polio, limited accident, volunteer firemen, schoolchildren). Other franchise and blanket coverages should be excluded if reported in part I.

2. Include only coverages written on a direct basis—reinsurance accepted from other organizations should be excluded, while reinsurance ceded to other organizations should be included. For coverages jointly underwritten by your organization and one or more other organizations on a coinsurance basis, the figures included should be a fractional part of the individuals so underwritten, the fraction used being the proportion of the total coverage under such cases which is underwritten by your organization.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident. Do not include, however, the extra hospitalization coverage provided in addition to weekly indemnity in policies issued under the California U.C.D. law, if the benefit is only the minimum required by law ($12 for 20 days). See instructions to part I for distributions by scope of benefit.

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident. See instructions to part I for distributions by scope of benefit.

(c) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i. e. exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home and office visits. See instructions to part I for distributions by scope of benefit.

(d) *Major medical expense (supplementary to basic plans).*—Include only the major medical expense or catastrophic coverage policies which are superimposed on basic hospital, surgical, and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical, or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(e) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (d) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. The following instructions apply with respect to the basis for reporting individuals:

Include under each benefit classification the total number of individuals for whom such coverage is provided. Individuals with several kinds of coverage should be counted under each of the appropriate classifications.

5. It is recognized that some of the data for tables 1 and 2 may, in some instances, have to be obtained from your policyholders. The importance of this survey is such as to warrant such a procedure wherever possible. If such proves not to be practicable, qualified estimates will be acceptable.

PART II

TABLE 1.—*Number of actively employed individuals and dependents 65 years of age and older insured under group health insurance policies, as of June 30, 1961*

Type of coverage	Total	With right to convert on retirement	With right to continue under group on retirement
1. Hospital expense, total			
(a) $10 a day or less			
(b) $11 to $14 a day			
(c) $15 a day or more			
(d) 31 days a year or less			
(e) 32 to 70 days a year			
(f) Over 70 days a year			
(g) Less than $200 ancillary expenses			
(h) $200 to $499			
(i) $500 and over			
2. Surgical expense, total:			
(j) $200 or less			
(k) $201 to $300			
(l) More than $300			
3. Regular medical expense, total			
(m) In-hospital only			
(n) Home, office and hospital			
4. Major medical expense, supplemental			
5. Major medical expense, comprehensive			

TABLE 2.—*Number of retirees and retirees' dependents insured under group health insurance policies, as of June 30, 1961*

Type of benefit	*Number of individuals*
1. Hospital expense, total	
(*a*) $10 a day or less	
(*b*) $11 to $14 a day	
(*c*) $15 a day or more	
(*d*) 31 days a year or less	
(*e*) 32 to 70 days a year	
(*f*) Over 70 days a year	
(*g*) Less than $200 ancillary expenses	
(*h*) $200 to $499	
(i) $500 and over	
2. Surgical expense, total	
(*j*) $200 to less	
(*k*) $201 to $300	
(*l*) More than $300	
3. Regular medical expense, total	
(*m*) In-hospital only	
(*n*) Home, office, and hospital	
4. Major medical expense, supplementary	
5. Major medical expense, comprehensive	

APPENDIX D

DATA PROVIDED BY BLUE CROSS ASSOCIATION IN RESPONSE TO SUBCOMMITTEE QUESTIONNNAIRE:

1. ENROLLMENT OF PERSONS AGED 65 AND OVER.
2. BENEFIT SUMMARY OF BLUE CROSS CONTRACTS.
3. SUMMARY OF EXCLUSIONS AND RESTRICTIONS IN BLUE CROSS CONTRACTS.
4. SUMMARY OF RATE CHANGES AND CLAIMS EXPERIENCE.

1. TABLE I.—*Blue Cross enrollment of persons aged 65 and over, by Blue Cross plan and type of contract, Jan. 1, 1963.*

Plan	Total aged enrollment	Aged group enrollment	Aged nongroup enrollment	Senior citizens plan enrollment
Alabama	65,641	12,900	50,000	2,741
Arizona	15,303	3,689	10,043	1,571
Arkansas	19,339	4,903	8,240	6,196
California:				
Los Angeles	81,494	18,664	55,980	6,850
Oakland	55,986	16,738	36,352	2,896
Colorado	102,792	[1] 69,453	28,096	5,243
Connecticut	153,226	55,931	97,295	None
Delaware	[2] 22,515	[3]	[3]	[3]
District of Columbia	43,312	16,735	26,577	[3]
Florida	92,657	13,500	76,500	2,657
Georgia:				
Atlanta	10,762	4,978	5,784	[4]
Columbus	10,931	5,071	4,675	1,185
Savannah	2,322	1,219	1,103	[5]
Idaho	4,056	1,709	2,270	77
Illinois	[6] 226,075			
Indiana	155,328	44,698	110,630	[5]
Iowa:				
Des Moines	62,807	15,278	42,010	5,519
Sioux City	15,467	6,392	7,519	1,556
Kansas	50,982	11,400	36,376	3,206
Kentucky	82,980	11,450	67,924	3,606
Louisiana:				
Baton Rouge	10,945	3,815	7,130	[5]
New Orleans	14,752	9,538	5,140	74
Maine	33,470	9,035	24,435	None
Maryland	74,614	25,105	49,229	280
Massachusetts	295,665	128,494	167,171	[5]
Michigan	254,553	127,854	108,424	18,275
Minnesota	82,971	29,210	53,761	[4]
Mississippi	41,683	[7] 11,026	30,657	[5]

See footnotes at end of table, p. 102.

1. TABLE I.—*Blue Cross enrollment of persons aged 65 and over, by Blue Cross plan and type of contract, Jan. 1, 1963.*—Continued

Plan	Total aged enrollment	Aged group enrollment	Aged nongroup enrollment	Senior citizens plan enrollment
Missouri:				
Kansas City	44,972	14,016	26,871	4,085
St. Louis	88,453	30,490	54,833	3,130
Montana	[2] 2,329	1,547	728	54
Nebraska	33,407	7,236	25,386	785
New Hampshire-Vermont	61,237	18,152	43,085	[5]
New Jersey	180,321	93,430	81,746	5,145
New Mexico	3,680	1,042	2,377	261
New York:				
Albany	44,608	16,527	20,126	7,955
Buffalo	81,773	41,626	36,421	3,726
Jamestown	4,720	1,150	3,570	None
New York City	583,371	277,545	294,856	10,970
Rochester	53,989	30,890	20,592	2,507
Syracuse	45,546	29,082	12,848	3,616
Utica	20,981	9,620	10,164	1,197
Watertown	3,253	997	2,016	240
North Carolina				
Chapel Hill	36,267	11,745	19,648	4,874
Durham	27,877	9,499	13,060	5,318
North Dakota	12,396	4,053	7,122	1,221
Ohio:				
Canton	26,807	8,496	17,504	807
Cincinnati	127,157	55,277	71,880	[5]
Cleveland	162,000	63,504	98,496	[5]
Columbus	58,191	17,543	38,778	1,870
Lima	18,941	3,527	15,075	339
Toledo	42,710	16,393	25,295	1,022
Youngstown	26,905	9,568	16,506	831
Oklahoma	44,831	9,868	28,462	6,501
Oregon	20,484	8,395	10,940	1,149
Pennsylvania:				
Allentown	46,357	29,762	15,113	1,482
Harrisburg	67,879	28,626	35,524	3,729
Philadelphia	206,587	71,101	118,120	17,366
Pittsburgh	181,333	59,674	90,660	30,999
Wilkes-Barre	39,972	26,017	10,714	3,241
Rhode Island	69,776	28,073	41,703	None
South Carolina	16,119	5,419	8,452	2,248
Tennessee:				
Chattanooga	48,452	22,611	23,015	2,826
Memphis	8,295	3,778	4,517	[5]
Texas	307,802	37,751	43,918	[10] 226,133
Utah	11,525	7,296	4,229	[5]
Virginia:				
Lynchburg	1,282	360	786	136
Richmond	37,794	14,024	22,774	996
Roanoke	14,603	4,284	9,473	846
Washington-Alaska	18,177	4,825	12,892	460
West Virginia:				
Bluefield	1,913	358	1,555	[5]
Charleston	8,208	3,417	4,791	[5]
Parkersburg	3,031	769	2,153	109
Wheeling	7,746	3,174	4,484	88
Wisconsin	98,844	37,569	59,979	1,296
Wyoming	3,968	790	2,532	646

[1] Includes 49,117 persons who are enrolled through public assistance under the OAA program.
[2] Enrollment as of Sept. 1, 1963, was 19,362.
[3] Not available.
[4] The senior citizen plan was first offered after Apr. 1, 1963.
[5] Senior citizen plan enrollment is included in nongroup enrollment.
[6] Enrollment as of Apr. 1, 1964, was 274,308 total: 141,962 group; 39,108 nongroup; and 93,240 senior citizen.
[7] Does not include OAA and AB recipients.
[8] Includes 803 persons who are enrolled through public assistance under the OAA program.
[9] Senior citizen plan was first offered Aug. 1, 1963. The enrollment in this plan as of Mar. 31, 1964, was 8,316.
[10] Includes 223,232 persons who are enrolled through public assistance under the OAA program.

NOTE.—An additional 76,000 aged are enrolled under the program for Federal employees and another 3,000 are insured by a Blue Cross subsidiary, Health Insurance, Inc.

Source: Blue Cross Association.

2. TABLE II.—*Benefit summary of Blue Cross contracts held by aged persons, by plan and type of contract*

Plan	Hospital days	Room and board	Operating room	Drugs and medicine	Anesthesia supplies	Diagnostic X-ray	Laboratory	Oxygen	Visiting nurse service	Nursing home
Alabama: G, NG, and SC	70	SP	F	F	F	F	F	F	(—)	(—).
Arizona:										
G	120	SP	F	F	F	P(R)	F	F	(—)	(—).
NG	30	$20	F	F	F	F	F	F	(—)	(—).
SC No. 1	30	$16	F	F	F	F	F	F	(—)	(—).
SC No. 2	70	SP	F	F	F	F	F	F	$4 per day.	$8.
Arkansas:										
G and NG	120	$8 to $15	F	F	F	F	F	F	(—)	(—).
SC No. 1	30	$10	F	P	P	P	P	F	(—)	(—).
SC No. 2	70	$10	F	P	P	P	P	F	F	P.
California:										
Los Angeles:										
G	100	W	F	F	F	F	F	F	(—)	(—).
NG	30 [1]	W	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	(2)	F	F	F	F	F	F	P	P.
SC No. 2	30	W	F	F	F	F	F	F	(—)	(—).
Oakland:										
G	70	F	F	F	F	F	(—)	F	(—)	(—).
NG	21 [3]	F	F	F	F	P	(—)	F	(—)	(—).
SC No. 1	31	W+80 percent charges.	P	P	P	(—)	P	P	(—)	(—).
SC No. 2	70	do	P	P	P	(—)	P	P	$3 per day, 140 days.	$8.
Colorado:										
G	120	F	F	F	F	F	F	F	(—)	(—).
NG	120	$14	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	$14	F	F	F	F	F	F	P	P.
SC No. 2	70	$10	F	F	F	F	F	F	P	P.
Connecticut (no SC):										
G	120 [4]	$15	F	F	F	F	F	F	(—)	(—).
NG	30	$15	F	F	F	F	F	F	(—)	(—).
Delaware:										
G and NG	70F+295P	SP	F	F	BS	P	F (routine)	F	(—)	$10.
SC No. 1	30F+30P	$18	F	F	BS	P	P	F	Covered	$8.
SC No. 2	70	$18	F	F	BS	P	P	F	do	Covered.
District of Columbia: [5]										
G	180	SP	F	F	F	BS	BS	F	(—)	(—).
NG	31F+100P	SP	F	F	F	BS	BS	F	(—)	(—).
SC	90	SP	F	F	F	BS	BS	F	(6)	P.

See footnotes at end of table, p. 131.

2. TABLE II.—*Benefit summary of Blue Cross contracts held by aged persons, by plan and type of contract*—Continued

Plan	Hospital days	Room and board	Operating room	Drugs and medicine	Anesthesia supplies	Diagnostic X-ray	Laboratory	Oxygen	Visiting nurse service	Nursing home
Florida:										
G	31(R)	$12	F	F	F	F	F	F	(—)	
NG	31	$12	F	P	F	P	F	F	(—)	
SC No. 1	70	$12	F	F	F	F	F	F	138 visits	138 days.
SC No. 2	31	$12	F	P	F	P	F	F	(—)	(—).
Georgia:										
Atlanta:										
G and NG	30	SP	F	F	F	F	F	F	(—)	(—).
SC	30	$15	F	F	F	F	F	F	(—)	(—).
Columbus:										
G and NG	30	$8 to $20	F	F	F	P	F	F	(—)	(—).
SC	30(R)	$10	F	F	F	P	F	F	(—)	(—).
Savannah:										
G, NG, and SC	30	SP	F	P	F	(—)	F	F	(—)	(—).
Idaho:										
G	35–120	W to $18	F	F	F	F	F	F	(—)	(—).
NG	35	W to $14	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	W to $18	F	F	F	F	F	F	$3 per day	$8.
SC No. 2	35	W to $14	F	F	F	F	F	F	(—)	(—).
Illinois:										
G	120	SP	F	F	F	F	F	F	(—)	(—).
NG	120	SP	F	F	F	(—)	F	F	(—)	(—).
SC	30	SP	F	F	F	(—)	F	F	(?)	(?).
Indiana:										
G	120	SP	F	F	F	F	F	F	(—)	(—).
NG	30F+30P	$12	F	F	F	F	F	F	P	(—).
SC	70	$12	F	F	F	F	F	F	F	P.
Iowa:										
Des Moines:										
G and NG	70	SP	F	F	F	BS	BS	F	(—)	(—).
SC No. 1	30	SP	F	F	F	BS	BS	F	(—)	(—).
SC No. 2	70	SP	F	F	F	BS	BS	F	P	F.
Sioux City:										
G and NG	70	SP	F	F	F	F	F	F	(—)	(—).
SC No. 1	30	SP	F	F	F	F	F	F	(—)	(—).
SC No. 2	70	SP	F	F	F	F	F	F	F	80 percent.
Kansas:										
G and NG	120	SP	F	F	F	BS	F	F	(—)	(—).
SC	70	SP	F	F	F	BS	F	F	F	F.
Kentucky:										
G and NG	70	$10	F	F	(—)	(—)	F	F	(—)	(—).
SC	70	$12	F	F	F	F	F	F	$3 per visit	F.

Louisiana:											
Baton Rouge:											
G, NG, and SC No. 2	120	$8	F	F	F	F	F	F	(1)	(1).
SC No. 1	30	$8	F	P	F	P	P	F	(1)	(1).
New Orleans:											
G	125	$10	F	F	(1)	F	F	F	(1)	(1).
NG	75	$12	F	P	(1)	P	P	F	(1)	(1).
SC	70	$12	F	F	(1)	F	F	F	(1)	(1).
Maine:											
G and NG (no SC)	21+100P	$12 to $24	F	P	F	P	P	P	(8)	(8).
Maryland:											
G and NG	30	SP	F	F	F	F	F	F	(1)	(1).
SC No. 1	70	SP	F	F	F	F	F	F	F (contracting).	P.
SC No. 2	30	SP	F	F	F	F	F	F	(1)	(1).
Massachusetts:											
G [9]	120	SP	F	F	F	F	F	F	(1)	(1).
(No SC); NG [10]	40	$18	F	F	F	F	F	F	(1)	(1).
Michigan:											
G and NG	120 (R)	F	F	F	F	BS	F	F	(1)	(1).
SC	30	F	F	F	F	BS	F	F	(1)	(1).
Minnesota:											
G and NG	70(R)	SP	F	F	F	F	F	F	(1)	(1).
SC No. 1	30	$10	F	F	F	F	F	F	(1)	(1).
SC No. 2	70	SP	F	F	F	F	F	F	(1)	P.
Mississippi:											
G	100	$10	F	F	F	F	F	F	(1)	(1).
NG	70	$12	F	F	F	F	F	F	(1)	(1).
SC No. 1	30	$8	F	F	F	F	F	F	(1)	(1).
SC No. 2	30	$12	F	F	F	F	F	F	(1)	(1).
Missouri:											
Kansas City:											
G	70	SP	F	F	F	BS	P	F	(1)	(1).
NG	70	$12 [11]	F	F	F	BS	P	F	(1)	(1).
SC	70	SP	F	F	F	BS	P	F	P	P.
St. Louis:											
G	70F+180P	SP	F	F	F	BS	F (routine)	F	(1)	(1).
NG	70F+180P	$10	F	F	F	P(R)	P(R)	F	(1)	(1).
SC No. 1	70F+180P	$14	F	F	F	P(R)	P(R)	F	P	P.
SC No. 2	70F+180P	$7	F	F	F	P(R)	P(R)	F	P	P.
Montana:											
G	120	$12	F	F	F	BS	F	F	(1)	(1).
NG	60F+30P	F	F	F	F	BS	F	F	(1)	(1).
SC No. 1	30F+40P	SP	F	F	F	BS	F	F	(1)	(1).
SC No. 2	30	$10	P	P	P	BS	P	P	(1)	(1).
Nebraska:											
G	150	$11	F	F	F	BS	BS	F	(1)	(1).
NG	120	$8	F	P	P	BS	BS	P	(1)	(1).
SC	70	$12	F	P	P	BS	BS	P	P	P.

See footnotes at end of table, p. 131.

2. TABLE II.—*Benefit summary of Blue Cross contracts held by aged persons, by plan and type of contract*—Continued

Plan	Hospital days	Room and board	Operating room	Drugs and medicine	Anesthesia supplies	Diagnostic X-ray	Laboratory	Oxygen	Visiting nurse service	Nursing home
New Hampshire: (No. SC); G and NG	60F+60P	$15	F	F	F	P	F	F	(—)	(—).
New Jersey:										
G and NG	(12)	SP	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	SP	F	F	F	F	F	F	(13)	(14).
SC No. 2	30	SP	F	F	F	F	F	F	(—)	(—).
New Mexico:										
G	365	SP	F	F	F	F	F	F	(—)	(—).
NG	365	$15	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	$15	F	F	F	F	F	F	P(R)	P(R).
SC No. 2	30	$15	F	F	F	F	F	F	P(R)	P(R).
New York:										
Albany:										
G and NG	70	SP	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	75 percent SP	F	F	F	F	F	F	F	P.
SC No. 2	30	do	F	F	F	F	F	F	(—)	(—).
Buffalo:										
G and NG	120	SF	F	F	F	BS	BS	F	(—)	(—).
SC No. 1	70	SP	F	F	F	BS	BS	F	Covered	Covered.
SC No. 2	30	SP	F	F	F	BS	BS	F	(—)	(—).
Jamestown:										
G	21P+90P	SP	F	50 percent	F	$15/yr	F	F	(—)	(—).
(No. SC); NG	30	SP	F	F	F	F	F	F	(—)	(—).
New York:										
G and NG	21F+180P	SP	F	F	F	F	F	F	(—)	(—).
SC	21F+180P	SP	F	F	F	F	F	F	(—)	(—).
Rochester:										
G and NG	70F+50 at $10	SP	F	F	F	(—)(R)	F	F	(15)	(—).
SC	30F+60 at $10	SP	F	F	F	(—)(R)	F	F	F	(—).
Syracuse: G, NG, and SC	70	SP	F	F	F	(—)	F	F	(—)	(—).
Utica: G, NG, and SC	70F+80 at $5	SP	F	F	F	(—)	F	$20	(—)	(—).
Watertown:										
G	120	SP	F	F	F	(—)	F	F	(—)	(—).
NG and SC	30F+90 at $10	SP	F	F	F	(—)	F	F	(—)	(—).
North Carolina:										
Chapel Hill:										
G and NG	70	$10(R)	F	F	F	F	F	F	(—)	(—).
SC No. 1	31	$10	F	P	F	P	P	F	(—)	(—).
SC No. 2	70	$12	F	P	F	P	P	F	Covered	Covered.
SC No. 3	30	$9	F	P	F	P	P	F	(—)	(—).
Durham:										
G	70	$10(R)	F	F	F	F	F	F	(—)	(—).
NG	70	$8	F	F	F	F	F	F	(—)	(—).
SC No. 1	31	$8 or $10	F	F	F	F	F	F	(—)	(—).
SC No. 2	70	$12	F	F	F	F	F	F	F	F.

SC No. 3	30	$9	F	F	F	F	F	F	(—)	(—).
Ohio:										
Canton:										
G and SC	70	SP	F	F	F	F	F	F	(—)	(—).
NG	30	SP	F	F	F	F	F	F	(—)	(—).
Cincinnati:										
G	120	SP	F	F	F	F	F	F	(—)	(—).
(No SC); NG	70	W	F	F	F	F	F	F	(—)	(—).
Cleveland:										
G and NG	120	SP	F	F	F	F	F	F	(—)	(—).
SC	70	SP	F	F	F	F	F	F	(—)	(—).
Columbus:										
G	70 or 120	SP	F	F	F	F	F	F	(—)	(—).
NG and SC	30	80 percent	P	P	(—)	$15	P	P	(—)	(—).
Lima:										
G, NG and SC No. 1	30	do	P	P	P	P	P	P	(—)	(—).
SC No. 2	70	do	P	P	P	P	P	P	(—)	(—).
Toledo:										
G	70	SP	F	F	(—)	F	F	F	(—)	(—).
NG and SC	70	SP	P	P	(—)	P	P	P	(—)	(—).
Youngstown:										
G and NG	120	SP	F	F	F	F	F	F	(—)	(—).
SC	70	SP	F	F	F	F	F	F	(—)	(—).
Oklahoma:										
G and NG	90	SP	F	F	F	BS	F	F	(—)	(—).
SC	30	SP	F	F	F	BS	F	F	(—)	(—).
Oregon:										
G	70	W to $18	F	F	F	F	F	F	(—)	(—).
NG	30 F and 30 P [16]	W to $24	F	F	F	F	F	F	(—)	(—).
SD No. 1	70	W to $18	F	F	F	F X	F	F	P [17]	P [17].
SC No. 2	30	W to $15	F	F	F	F	F	F		
Pennsylvania:										
Allentown:										
G	30 to 70	SP	F	F	F	F	F	F	[18]	[18].
NG	21 to 36	SP	F	F	F	F	F	F	[18]	[18].
SC No. 1	21 to 30	SP	F	F	F	F	F	F	[18]	[18].
SC No. 2	70	SP	F	F	F	F	F	F	[18]	[18].
Harrisburg:										
G	120	SP	F	F	F	P	P	F	[18]	[18].
NG	70	SP	F	F	F	P	P	F	[18]	[18].
SC No. 1	30	SP	F	F	F	BS	P	F	[18]	[18].
SC No. 2	70	SP	F	F	F	BS	P	F	[18]	Covered.
Philadelphia:										
G	30 to 70 [19]	SP	F	F	F	F	F	F	[18]	[18].
NG and SC No. 1	21 to 30 [20]	SP	F	F	F	F	F	F	[18]	[18].
SC No. 2	70	SP	F	F	F	F	F	F	[18]	[21].
Pittsburgh:										
G	30 to 70	SP	F	F	F	F	F	F	Covered	(—).
NG	21 to 33	SP	F	F	F	F	F	F	do	(—).
SC No. 1	70	SP	F	F	F	F	F	F	do	Covered.
SC No. 2	21 to 30	SP	F	F	F	F	F	F	do	(—).

See footnotes at end of table, p. 131.

2. TABLE II.—*Benefit summary of Blue Cross contracts held by aged persons, by plan and type of contract*—Continued

Plan	Hospital days	Room and board	Operating room	Drugs and medicine	Anesthesia supplies	Diagnostic X-ray	Laboratory	Oxygen	Visiting nurse service	Nursing home
Pennsylvania—Continued										
Wilkes-Barre:										
G	120	SP	F	F	F	BS	F	F	(15)	
NG	30	SP	F	F	F	BS	F	F	(15)	
SC No. 1	70	SP	F	F	F	BS	F	F	(22)	(18).
SC No. 2	30	SP	F	F	F	(—)	F	F	(15)	(—).
Rhode Island:										
G	120	$20	F	F	(—)	(—)	F	F	(—)	(—).
(No SC) NG	120	$14	F	F	(—)	(—)	F	F	(—)	(—).
South Carolina:										
G	70A	W	F	F	F	P 23	P 23	F	(—)	(—).
NG	70Y	$10	F	F	F	P 23	P 23	F	(—)	(—).
SC No. 1	70A	SP	F	F	F	P 23	P 23	F	(—)	(—).
SC No. 2	70Y	$10	F	F	F	P 23	P 23	F	(21)	(21).
Tennessee:										
Chattanooga:										
G and NG	70	$8	F	F	(—)	F	F	F	(—)	(—).
SC	30	$10	F	F	(—)	F	F	F	(—)	(—).
Memphis:										
G	30	$8 to SP	F	F	F	F	F	F	(—)	(—).
NG	30	$12	F	P	(—)	P	F	$300	(—)	(—).
SC	30	$10	F	F	F	F	F	F	(—)	(—).
Texas:										
G	70	$10	F	F	F	P	F	F	(—)	(—).
NG	70	$7.50	F	F	F	P	F	F	(—)	(—).
"Senior Texan"	70	$12	F	F	F	F	F	F	(—)	$5.
OAA	15 at $10; unlimited at $6.	$10	(24)	(24)	(24)	(24)	(24)	(24)	(—)	(—).
Utah:										
G	70	W	F	F	F	F	F	F	(—)	(—).
NG and SC No. 2	30	W	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	W	F	F	F	F	F	F	F	P.
Virginia:										
Lynchburg:										
G	30	SP	F	F	F	BS	F	F	(—)	(—).
NG and SC	70	SP	F	F	F	BS	F	F	(—)	(—).
Richmond:										
G and NG	60(R)	$12(R)	F	F	F	(—)	F	F	(—)	(—).
SC	60(R)	SP	F	F	F	(—)	F	F	(—)	(—).
Roanoke: G, NG, and SC	70	SP	F	F	F	P	F	F	(—)	(—).
Washington-Alaska:										
G	70	W to $20	F	F	F	F	F	F	(—)	(—).
NG	35	W to $18	F	P	F	F	P	F	(—)	(—).

SC No. 1	35	W to $15	F	P	F	F	F	F	(—)	(—).
SC No. 2	70	W to $22	F	F	F	F	F	F	Covered	Covered.
West Virginia:										
Bluefield:										
G, NG, and SC	30	W	F	F	F	F	F	F	(—)	(—).
Charleston:										
G	70	$12	F	F	F	F	F	F	(—)	(—).
(No SC) NG	70	$8	F	F	F	F	F	F	(—)	(—).
Parkersburg:										
G and NG	70	$10	F	F	F	F	F	F	(—)	(—).
SC No. 1	70	80 percent SP	80 percent	80 percent	80 percent	80 percent	80 percent	80 percent	(—)	(—).
SC No. 2	30	do	do	do	do	do	do	do	(—)	(—).
Wheeling:										
G and NG	70	$8 to $16	F	F	F	F	F	F	(—)	(—).
SC	70	$16	F	F	F	F	F	F	(—)	(—).
Wisconsin:										
G	120	SP	F	F	F	F	F	F	(—)	(—).
NG and SC No.1	31	SP	F	F	F	F	F	F	(—)	(—).
SC No. 2	70	SP	F	F	F	F	F	F	F	P.
Wyoming:										
G	120	$12	F	F	F	F	F	F	(—)	(—).
NG	120	$10	F	F	F	F	F	F	(—)	(—).
SC No. 1	30	$10	F	F	BS	BS	BS	F	(—)	P.
SC No. 2	70	$10	F	F	BS	BS	BS	F	F	P.

Legend:
G = Group plan.
NG = Nongroup plan.
SC = Senior citizen plan (No. 1 and No. 2 where given in data).
R = Rider available to extend coverage.
SP = Payment for semiprivate accommodations.
W = Payment for ward accommodations.
F = Full payment for covered items (no details on items covered beyond those in table).
P = Partial payment for covered items.
BS = Covered under Blue Shield or other surgical-medical plan.
(—) = Not covered under plan.
A = Per admission.
Y = Per year.

[1] 30 days for persons 65-plus; 50 days for persons under 65.
[2] 100 percent if ward charges are $18 or less; 80 percent, but not less than $18, if ward is over $18.
[3] 21 days for persons 65-plus; 55 days for those under 65.
[4] 120 days for persons 65-plus; 485 days for those under 65.
[5] Federal employees plan is most widely held, but is not available to general public.
[6] Full for participating, partial for nonparticipating nurses.
[7] 2 days or visits for each unused hospital day.
[8] Excluded, but covered under an extended benefit endorsement.
[9] 63 percent have extended benefit coverage, including visiting nurse services and unlimited days in general hospital, nursing home, and chronic disease hospital, subject to $5,000 (for 31 percent of enrollees) or $15,000 (32 percent of enrollees) maxima.
[10] 41 percent have extended benefits providing additional 90 days at $12 per day in general hospital, 120 days in nursing home, and visiting nurse services, to $5,000 maximum.
[11] $14 for persons under age 65.
[12] Persons under 65, 120 full days, 245 days at $5; persons 65 to 69, 60 full days; 70 and over, 30 full days.
[13] Contracting nurses, full; noncontracting, $3 per visit.
[14] Contracting, full; noncontracting, 60 percent of charges or $8 per day.
[15] Visiting nurses covered only through organized home care. If eligible for home care, visiting nurse service required in judgment of home care organization is covered in full.
[16] 30 full plus 180 partial if person is under 65.
[17] 6-month waiting period.
[18] For persons 65 and over, full for unused days.
[19] Ranges from 30 days in 1st year of enrollment to 70 days in 5th year.
[20] Ranges from 21 days in 1st year to 30 days in 4th year.
[21] Full in contracting hospital, partial in noncontracting.
[22] Full for 40 unused days.
[23] In contracting hospitals.

NOTE.—Deductibles and copay features are not considered when "full" payment is described. See table III.

3. TABLE III.—*Summary of exclusions and restrictions in Blue Cross contracts held by aged persons, by plan and type of contract*

	Deductible copay or coinsurance	Mental, nervous, and tuberculosis	Waiting period or coverage status for preexisting conditions	Health statement	Maximum age for new enrollment	Benefit reductions due to age	Rate increase due to age	Transfer required due to age	Conversion privileges different for aged from other subscribers	Post-underwriting through riders
Alabama:										
G	$25	MN 30 days TB till diagnosed.	9 months	No	65	No	No	19	No	No.
NG	$50	do	do	Yes	65	do	do	19	(—)	Do.
SC	$50 deductible; $5 copay.	do	do	do [1]	No	do	do	No	(—)	Do.
Arizona:										
G	None	Excluded	Covered	No	do	do	do	19	No	Do.
NG	20 percent 1st $500	do	do	do	60 [2]	do	do	19	(—)	Do.
SC No. 1	20 percent ancillaries	do	Excluded	Yes	No	do	do	19	(—)	Do.
SC No. 2	None	30 days after 3-day deductible.	3 months	No	do	do	do	19	(—)	Do.
Arkansas:										
G	$25	30 days	1 year	do	do	do	do	19	No	Do.
NG	$25	do	do	Yes	60	do	60	19	(—)	Do.
SC No. 1	None	14 days	Excluded	do	No	do	No	19	(—)	Do.
SC No. 2	do	30 days	6 months	No	do	do	do	19	(—)	Do.
California:										
Los Angeles:										
G	do	Covered	Covered	do [3]	do	do	do	19	No	Do.
NG	20 percent	Excluded	6 months	do	do	do	65 [4]	19	(—)	Do.
SC No. 1	do	30 days (Y)	do	do	No	do	do	19	(—)	Do.
SC No. 2	$50 and 20 percent	Excluded	11 months	Yes	do	do	do	19	(—)	Do.
Oakland:										
G	None	do	None	No	do	do	do	19	No	Do.
NG	do	do	11 months	do	65	65 [5]	do	19	(—)	Do.
SC No. 1	20 percent	do	6 months	do	No	No	do	19	(—)	Do.
SC No. 2	do	30 days	do	do	do	do	do	19	(—)	Do.
Colorado:										
G	None	do	11 months [6]	do	65 [7]	do	do	19	No	Do.
NG	do	do	do	Yes	65	do	do	19	(—)	Do.
SC Nos. 1 and 2	do	do	do	do	No	do	do	No	(—)	Do.
Connecticut (no SC):										
G	do	Full	Covered	No	do	65 [8]	do	19	No	Do.
NG	do	do	do	do	do	No	do	19	(—)	Do.
Delaware:										
G	do	MN 60 days; TB excluded.	1 year	do	65	do	do	19	No	Do.
NG	do	do	Excluded for other than conversion.	Yes [9]	65	do	do	(10)	(—)	Do.

SC No. 1	do	do	1 year	do	No	do	do	19	(1)	Do.
SC No. 2	do	60 days	6 months	No	do	do	do	19	(1)	Do.
District of Columbia:										
G	do	30 days	10 months	do	do	do	do	19	No	Do.
NG	do	10 days	do	Yes	do	do	do	19	(1)	Do.
SC	do	30 days	6 months	No	do	do	do	19	(1)	Do.
Florida:										
G	do	31 days	Covered	do	do	do	do	19	No	Do.
NG	do	do	9 months	Yes	65	do	do	19	(1)	Do.
SC Nos. 1 and 2	do	do	6 months	No	No	do	do	19	(1)	Do.
Georgia:										
Atlanta:										
G	do	Excluded	None	do	do	do	do	19	No	Do.
NG	$5 per day	do	do	do	do	do	do	19	(1)	Do.
SC	do	MN 30 days; TB—F in general hospital.	6 months	do	do	do	do	19	(1)	Do.
Columbus:										
G	None	30 days (R)	12 months	do	do	do	do	No	No	Do.
NG	do	do	24 months	do	60	do	do	do	(1)	Do.
SC	do	do	12 months	Yes	No	do	do	do	(1)	Do.
Savannah:										
G	do	Excluded	do	do	65	do	do	19	No	Do.
NG	do	do	do	do	65	do	do	19	(1)	Do.
SC	do	do	do	do	No	do	do	19	(1)	Do.
Idaho:										
G	do	20 days (Y)	11 months	No	do	do	do	No	No	Do.
NG	80-percent ancillaries	Excluded	do	Yes	65	do	do	do	(1)	Do.
SC No. 1	do	30 days (Y)	6 months	No	No	do	do	do	(1)	Do.
SC No. 2	do	Excluded	11 months	do	do	do	do	do	(1)	Do.
Illinois:										
G	None	120 days	270 days [11]	do	do	do	do	19	Yes	Do.
NG	$25 and 25 percent	do	None [12]	do	64	(13)	(13)	(13)	(1)	Do.
SC	$3 or $5 per day [14]	30 days	180 days [12]	do	No	No	No	No	(1)	Do.
Indiana:										
G	None	do	9 months	do	do	do	do	do	No	Do.
NG	do	do	365 days	do	do	do	do	do	(1)	Do.
SC	do	do	180 days	do	do	do	do	do		Do.
Iowa:										
Des Moines:										
G	do	do	11 months	do	do	do	do	19	No	Do.
NG	do	do	do	Yes	65	do	do	19	(1)	Do.
SC No. 1	$25 1st day; $3 per day thereafter.	do	6 months	No	No	do	do	19	(1)	Do.
SC No. 2	1st $25 to $125, then 20 percent.	do	do	do	do	do	do	19	(1)	Do.
Sioux City:										
G	$25	do	11 months	do	do	do	do	No	No	Do.
NG	$25	do	do	Yes	65	do	do	do	(1)	Do.
SC No. 1	$50	do	do	do	No	do	do	do	(1)	Do.
SC No. 2	$25 or 20 percent	Excluded	6 months	No	do	do	do	do	(1)	Do.

See footnotes at end of table, p. 141.

3. TABLE III.—*Summary of exclusions and restrictions in Blue Cross contracts held by aged persons, by plan and type of contract*—Con.

	Deductible copay or coinsurance	Mental, nervous, and tuberculosis	Waiting period or coverage status for preexisting conditions	Health statement	Maximum age for new enrollment	Benefit reductions due to age	Rate increase due to age	Transfer required due to age	Conversion privileges different for aged from other subscribers	Post-underwriting through riders
Kansas:										
G	$10	MN 30 days	Covered [13]	No	No	65	No	21	No	No.
NG	$10	do	240 days for specified conditions.	Yes	60	65 [14]	do	21	(—)	Do.
SC	25 percent	do	6 months	No	No	No	do	21	(—)	Do.
Kentucky:										
G	None	M 31 days during life; TB excluded.	12 months	do	do	do	do	19	No	Do.
NG	do	do	do	Yes	64	do	do	19	(—)	Do.
SC	do	30 days	6 months	No	No	do	do	No	(—)	Do.
Louisiana:										
Baton Rouge:										
G	Initially $25	do	1 year	do	do	do	do	19 or 24	No	Do.
NG	do	Excluded	do	Yes	65	do	do	do	(—)	Do.
SC No. 1	None	do	Excluded	do	No	do	do	do	(—)	Do.
SC No. 2	Initially $25	do	1 year	do	do	do	do	do	(—)	Do.
New Orleans:										
G	$25	30 days	Covered	No	do	do	do	No	No	Do.
NG	None	45 days	12 months	Yes	65	do	do	do	(—)	Do.
SC	25 percent	30 days	do	do	No	do	do	do	(—)	Do.
Maine:										
G	None	21 days	Covered if enrollment requirements are met.	No	do	do	do	19	No	Do.
NG	do	do	Not covered	Yes	65	do	do	19	(—)	Do.
Maryland:										
G	None	M and N 30 days (Y); TB excluded.	9 months	No	No	do	do	19	No	Do.
NG	do	do	do	Yes	65	do	do	19	(—)	Do.
SC Nos. 1 and 2	$15 1st day, $5 2d to 13th to $75.	do	6 months	No	No	do	do	19	(—)	Do.
Massachusetts:										
G	None	M and N 10 days; TB full.[16]	8 months	do	do	do	do	No	No	Do.
NG	do	do [17]	do	Yes	do	do	do	do	(—)	Do.
Michigan:										
G	do	30 days (A)	Covered	No	do	do	do	19	No	Do.
NG	do	do	do	do	do	do	do	19	(—)	Do.
SC	$25 or first 20 percent	30 days in life of certificate.	180 days	do	do	do	do	19	(—)	Do.

Minnesota:										
G	None	70 days	Covered	do [18]	Dependent on group.	do	do	19	No	Do.
NG	20 percent	do	do	do [18]	No	do	do	19	(—)	Do.
SC No. 1	$25	30 days	9 months	Yes	do	do	do	No	(—)	Do.
SC No. 2	25 percent	70 days	do	do	do	do	do	do	(—)	Do.
Mississippi:										
G	None	M and N 30 days; TB excluded.	Excluded	No	do	do	do	19	No	Do.
NG	$25	do	do	Yes	65	do	do	19	(—)	Do.
SC	$25	do	do	do	No	do	do	19	(—)	Do.
Missouri:										
Kansas City:										
G	None	30 days	Covered in groups over 10.	No	do	do	do	19	No	Do. [1]
NG	do	do	Excluded	Yes	do	$14 day under 65, $12 day 65+	do	19	(—)	Do. [19]
SC	do	do	6 months	No	do	No	do	19	(—)	Do. [19]
St. Louis:										
G	do	14 days or $140	Excluded	do	do	do	do	19	No	Do.
NG	do	do	do	do	do	do	do	19	(—)	Do.
SC	do	30 days or $300	6 months	do	do	do	do	19	(—)	Do.
Montana:										
G	do	30 days (Y)	12 months	do	65	do	do	19	No	Do.
NG	$25	do	do	do	60	do	65	19	do	Do.
SC No. 1	$25	do	6 months	do	No	do	No	19	do	Do.
SC No. 2	None	do	do	do	do	do	do	19	do	Do.
Nebraska:										
G	do	30 days	12 months	do	do	do	do	19	do	Do.
NG	do	do	do	Yes	60	do	do	19	(—)	Do.
SC No. 1	do	10 days	do	do	No	do	do	19	(—)	Do.
SC No. 2	do	30 days	([20])	([20])	do	do	do	19	(—)	Do.
SC No. 3	do	10 days	6 months	No	do	do	do	19	(—)	Do.
New Hampshire: G and NG	do	Full, GEN, hospital	9 months	do	do	do	do	19	No	Do.
New Jersey:										
G	do	20 days (Y)	Covered	do	do	65 and 70 [21]	do	19	do	Do. [22]
NG	do	do	12 months	Yes	do	do [21]	do	19	(—)	Do. [22]
SC No. 1	do	30 days (A)	6 months	No	do	No	do	19	(—)	Do. [22]
SC No. 2	Copay	20 days (A)	do	do	do	do	do	19	(—)	Do.
New Mexico:										
G	None	30 days (AY)	180 to 270 days	do	do	do	do	23	No	Do.
NG	do	30 days	do	Yes	65	do	do	23	(—)	Do.
SC Nos. 1 and 2	do	30 days (Y)	6 months	No	No	do	do	23	(—)	Do.

See footnotes at end of table, p. 141.

3. TABLE III.—*Summary of exclusions and restrictions in Blue Cross contracts held by aged persons, by plan and type of contract*—Con

	Deductible copay or coinsurance	Mental, nervous, and tuberculosis	Waiting period or coverage status for preexisting conditions	Health statement	Maximum age for new enrollment	Benefit reductions due to age	Rate increase due to age	Transfer required due to age	Conversion privileges different for aged from other subscribers	Post-underwriting through riders
New York:										
Albany:										
G	None	M and N 30 days (Y); TB excluded.	Covered	No	65 [23]	No	No	19	No	No.
NG	do	do	11 months	do	65	do	do	19	(—)	Do.
SC Nos. 1 and 2	25 percent	do	do	do	No	do	do	19	(—)	Do.
Buffalo:										
G	None	Excluded (R)	11 months [24]	do	do	do	do	19	No	Do.
NG	do	Excluded	Excluded	Yes	65	do	do	19	(—)	Do.
SC No. 1	do	30 days (Y)	6 months	No	No	do	do	19	(—)	Do.
SC No. 2	do	Excluded	do	do	do	do	do	19	(—)	Do.
Jamestown:										
G	do	do	Not covered	Yes [25]	65	do	do	19	No	Do.
NG	do	30 days	11 months	do	65	do	do	19	(—)	Do.
New York:										
G	do	21 days + 9 days at 50 percent M and N.	do	No	65	do	do	19	No	Do.
NG	do	do	do	Yes	65	do	do	19	(—)	Do.
SC	do	do	do	do	No	do	do	No	(—)	Do.
Rochester:										
G	do	30 days M and N; TB full.	12 months	No	65	do	do	19 [26]	No	Do.
NG	do	do	do	Yes	65	do	do	19 [26]	(—)	Do.
SC	do	do	do	No	No	do	do	No	(—)	Do.
Syracuse:										
G	do	30 days (Y) M and N; TB excluded.	11 months	do	65	do	do	19 [27]	No	Do.
NG	do	do	do	Yes	65	do	do	19 [27]	(—)	Do.
SC	$50	do	do	do	No	do	do	19 [27]	(—)	Do.
Utica:										
G	None	30 days M and N; TB excluded.	do	No	65 [23]	do	do	19	No	Do.
NG	do	do	do	[29]	65	do	do	19	do	(—).
SC	do	do	do	No	No	do	do	19	do	(—).
Watertown:										
G	$50	Covered (general hospital).	12 months	do	65 [23]	do	do	19	do	No.
NG	$50	do	do	Yes	60	do	do	19	(—)	Do.
SC No. 1	$50	do	do	do	No	do	do	No	(—)	Do.
SC No. 2	$50	do	do	do	do	do	do	do	(—)	Do.

North Carolina:										
Chapel Hill:										
G	None	30 days M and N; TB excluded.	24 months	No	65	do	do	19	No	Do.
NG	do	do	do	Yes	65	do	do	19	(—)	Do.
SC No. 1	do	21 days M and N; TB excluded.	do	do	No	do	do	No	(—)	Do.
SC No. 2	do	30 days	6 months	No	do	do	do	19	(—)	Do.
SC No. 3	do	10 days	do	do	do	do	do	19	(—)	Do.
Durham:										
G	do	30 days (A)	24 months	do	64	do	do	19	No	Do.
NG	$50 of first $100 of ancillaries.	30 days	do	Yes	64	do	do	19	(—)	Do.
SC No. 1	50 percent of ancillaries.	do	Covered	do	No	do	do	No	(—)	Do.
SC No. 2	$50 ancillaries deductible.	do	No benefit for illness 1st 6 months.	No	do	do	do	do	(—)	Do.
SC No. 3	$100 ancillaries	10 days	do	do	do	do	do	do	(—)	Do.
North Dakota:										
G	$25	70 days (A)	9 months (some conditions).	do	65	do	do	19	No	Do.
NG	$25	do	do	Yes	60	do	do	19	(—)	Do.
SC No. 1	$25	30 days (A)	6 months	No	No	do	do	19	(—)	Do.
SC No. 2	$25 and 20 percent	do	do	do	do	do	do	19	(—)	Do.
Ohio:										
Canton:										
G	None	Full	Full	do	do	do	do	19-23 (R)	No	Do.
NG	$25	do	do	do	do	do	do	19	(—)	Do.
SC	None	do	do	do	do	do	do	19	(—)	Do.
Cincinnati: G and NG	do	Full in general hospitals; limited in others.	Covered	do	do	do	do	19	No	Do.
Cleveland:										
G and NG	do	Full	Full	do	do	do	do	19	do	Do.
SC	do	do	do	do	do	do	do	No	(—)	Do.
Columbus:										
G	do	Excluded	do	do	do	do	do	19	No	Do.
NG	20 percent	do	9 months for some conditions.	do	65	do	do	19	(—)	Do.
SC	do	do	270 days for some conditions.	Yes	No	do	do	No	(—)	Do.
Lima:										
G	do	80/20 [30]	12 months	No	do	do	do	19	No	Do.
NG	do	80/20 [30]	do	do	65	do	do	19	(—)	Do.
SC No. 1	do	6-month waiting period.	6 months	Yes	No	do	do	19	(—)	Do.
SC No. 2	do	do	do	do	do	do	do	19	(—)	Do.
Toledo:										
G	None	M and N 31 days (A); TB 31 days (Y).	Covered	No	do	do	do	19	No	Do.
NG	20 percent	do	12 months	Yes	65	do	do	19	do	Do.
SC	do	do	do	do	No	do	do	No	do	Do.

See footnotes at end of table, p. 141.

3. TABLE III.—*Summary of exclusions and restrictions in Blue Cross contracts held by aged persons, by plan and type of contract*—Con.

	Deductible copay or coinsurance	Mental, nervous, and tuberculosis	Waiting period or coverage status for preexisting conditions	Health statement	Maximum age for new enrollment	Benefit reductions due to age	Rate increase due to age	Transfer required due to age	Conversion privileges different for aged from other subscribers	Post-underwriting through riders
Ohio—Continued										
Youngstown:										
G	None	N and M rider 30 days (Y); TB excluded.	Covered	No	No	No	No	19	No	No.
NG	do	do	do	do	64½	do	do	19	(—)	Do.
SC	do	Full	do	do	No	do	do	19	(—)	Do.
Oklahoma:										
G	do	M and N pulmonary TB excluded.	do	do	do	do	do	19	No	Do.
NG	$25	do	Excluded	Yes	60	do	do	19	(—)	(31).
SC	$25	do	do	do	No	do	do	19	(—)	(31).
Oregon:										
G	None	M and N 21 days; TB full.	6 months	No	do	do	do	19	No	No.
NG	do	M and N 30 days; TB full.	12 months [32]	For new group only.	65	65 [4]	do	19	(—)	Do.
SC No. 1	20 percent	do	6 months	No	No	No	do	19	(—)	Do.
SC No. 2	do	Full	6 months open; 12 months, continuous.	None open, yes, continuous.	do	do	do	19	(—)	Do.
Pennsylvania:										
Allentown:										
G	None	30 days	Covered	No	do	do	do	19 [33]	No	Do.
NG	do	do	6 months	Yes	65	do	do	19 [33]	do	Do.
SC No. 1	$5 per day	do	do	do	No	do	do	19 [33]	do	Do.
SC No. 2	do	do	do	No	do	do	do	19 [33]	do	Do.
Harrisburg:										
G	None	30 days, lifetime	Covered	do	do	do	do	19	do	Do.
NG	do	do	12 months	Yes	65	do	do	19	(—)	Do.
SC No. 1	$2.50 per day for 20 days.	do	6 months	do	No	do	do	19	(—)	Do.
SC No. 2	$5 per day 1st 15 days (Y).	M and N 30 days (Y), TB 30 (life).	do	No	do	do	do	19	(—)	Do.
Philadelphia:										
G	$15 per day 1st 15 days; $5 per day next 10 days.	20 days (Y)	12 months	do	do	do	do	19	No	Do.

NG	do	do	do	Yes	65	do	do	19	(—)	Do.
SC No. 1	do	do	6 months	do	No	do	do	19	(—)	Do.
SC No. 2	None	M and N 30 days (Y), TB, full.	do	No	do	do	do	19	(—)	Do.
Pittsburgh:										
G	do	30 days (Y)	Covered [34]	do	do	do	do	19	No	Do.
NG	do	do	do [34]	Yes	65	do	do	19	(—)	Do.
SC	do	do	6 months	No	No	do	do	19	(—)	Do.
Wilkes-Barre:										
G	$5 per day, 15 days (per 12 months).	30 days [35]	Excluded	do	do	do	do	19	No	Do.
NG	do	do [35]	do	Yes	do	do	do	19	(—)	Do.
SC No. 1	do	do [35]	6 months	No	do	do	do	19	(—)	Do.
SC No. 2	None	Full [35]	Excluded	do	do	do	do	19	(—)	Do.
Rhode Island:										
G	do	do	Full	do	do	do	do	No	No	Do.
NG	do	do	Excluded	do	do	do	do	do	(—)	Do.
South Carolina:										
G	$20 deductible	15 days (Y)	12 months	do	do	do	do	19 [36]	No	Yes.
NG	$50 deductible	15 days	do	Yes	65	do	do	19 [36]	(—)	Do.
SC Nos. 1 and 2	do	30 days (Y)	do	do	No	do	do	19 [36]	(—)	Do.
Tennessee:										
Chattanooga:										
G	None	Excluded (R)	1 year	No	do	do	do	19	No	No.
NG	do	Excluded	2 years	Yes	60	do	do	19	(—)	Do.
SC	$25 deductible	do	6 months	No	No	do	do	19	(—)	Do.
Memphis:										
G	20 percent	M and TB 30 days; N—Full.	6 months (T and A12)	do	do	do	do	19	No	Do.
NG	None	Excluded	2 years [37]	Yes	60	do	do	19	(—)	Do.
SC	25 percent	30 days	do [37]	do	No	do	do	19	(—)	Do.
Texas:										
Dallas:										
G	None	Full	12 months	No	do	do	do	No	No	Do
NG	do	do	do	Yes	do	do	do	do	(—)	Do.
SC No. 1	do	do	6 months	do	do	do	do	do	(—)	Do.
SC No. 2	do	Excluded	Covered	No	do	do	do	do	(—)	Do.
Utah:										
G	do	(39)	do	do	No [39]	do	do	19	No	Do.
NG	20 percent	Excluded	11 months less time in group.	do	64	do	do	19	(—)	Do.
SC Nos. 1 and 2	(40)	do	6 months	do	No	do	do	19	(—)	Do.
Virginia:										
Lynchburg:										
G	None	do	12 months	do	do	do	do	19	No	Do.
NG	$50	do	do	Yes	64	do	do	19	(—)	Do.
SC	50	do	do	do	No	do	do	No	(—)	Do.
Richmond:										
G	None	Full	do	No	do	do	do	do	No	Do.
NG	$50	do	do	Yes	65	do	do	65	(—)	Do.
SC	1st $50 or $4 per day	do	do	do	No	do	do	No	(—)	Do.

See footnotes at end of table, p. 141.

3. TABLE III.—*Summary of exclusions and restrictions in Blue Cross contracts held by aged persons, by plan and type of contract*—Continued

	Deductible copay or coinsurance	Mental, nervous, and tuberculosis	Waiting period or coverage status for preexisting conditions	Health statement	Maximum age for new enrollment	Benefit reductions due to age	Rate increase due to age	Transfer required due to age	Conversion privileges different for aged from other subscribers	Post-underwriting through riders
Virginia—Continud										
Roanoke:										
G	None	$5 per day	12 months	No	No	No	No	19	No	No.
NG	do	do	do	Yes	64	do	do	19	(—)	Do.
SC	do	Full, General hospital, limited institution.	do	do	No	do	do	No	(—)	Do.
Washington:										
G	do	M and N 7 days; TB 14 days.	6 months	No	do	Yes	do	19	No	Do.
NG	do	Excluded	12 months	do	do	No	do	19	(—)	Do.
SC No. 1	do	do	Excluded	Yes	do	do	do	No	(—)	Do.
SC No. 2	do	30 days	6 months	No	do	do	do	19	(—)	Do.
West Virginia:										
Bluefield:										
G	do	Full	270 days	do	60	do	do	19	No	Do.
NG	do	do	do	Yes	60	do	do	19	(—)	Do.
SC	do	30 days	do	do	No	do	do	19	(—)	Do.
Charleston:										
G	do	do	do.[41]	No	65	do	do	19	No	Do.
NG	do	do	do.[41]	Yes	65	do	do	19	(—)	Do.
Parkersburg:										
G	do	do	180 days	do	No	do	do	No	No	Do.
NG	do	do	6 months	do	65	do	do	do	(—)	Do.
SC Nos. 1 and 2	20 percent or $10 per day.[4]	do	180 days	No	No	do	do	do	(—)	Do.
Wheeling:										
G	None	Excluded (R)	270 days	do	do	do	do	19	No	Do.
NG	do	Excluded	Excluded	Yes	59	do	do	19	(—)	Do.
SC	do	do	Covered	do	No	do	do	19	(—)	Do.
Wisconsin:										
G	do	MN 120 days; TB excluded.	9 months	No	do	do	do	19	No	Do.
NG	$25 and 20 percent	MN 31 days; TB excluded.	do	do	do	do	do	19	(—)	Do.
SC No. 1	$50 and 20 percent	MN 31 days; TB excluded after diagnosis.	6 months	Yes	do	do	do	19	(—)	Do.
SC No. 2	20 percent	do	do	do	do	do	do	19	(—)	Do.

Wyoming:										
G	None	30 days	T and A, 11 months	No	(42)	---do	---do	19	No	Do.
NG	---do	---do	11 months	Yes	55	---do	---do	19	(—)	Do.
SC No. 1	---do	30 days lifetime	---do	---do	No	---do	---do	19	(—)	Do.
SC No. 2	---do	30 days	6 months	---do	---do	---do	---do	19	(—)	Do.

Legend:
G=group plan.
NG=nongroup plan.
SC=senior citizen plan.
(Y)=per year.
(A)=per admission.
M=mental condition.
N=nervous condition.
TB=tuberculosis.
(—)=not applicable.

1 If enrolled during a specified enrollment period, health statement is not required.
2 For new business, not for persons converting or transferring within the plan.
3 Health statement if applying after original eligibility.
4 Benefits reduced to 30 hospital days.
5 Benefits reduced from 55 days to 21 days.
6 Waived for groups of 50 or more with 75 percent participation.
7 No maximum age for groups of 10 or more.
8 Days reduced to 120.
9 For other than conversion.
10 If enrolled after age 60 must convert to senior citizen plan (65 limited) at age 65.
11 Applies only to groups of less than 25 contracts.
12 Credit is given for prior Blue Cross coverage in satisfying waiting period.
13 Transfer to senior citizen plan (series 65) at age 65.
14 Amount of daily co-pay depends on county of hospital location.
15 Waiting period if employee does not join when first eligible.
16 32 percent of enrollees have unlimited mental coverage; 31 percent have 60 days' mental coverage.
17 41 percent of enrollees have a contract providing 30 days' mental coverage.
18 Health statement required from additions to existing groups subsequent to period of original eligibility.
19 Will consider postunderwriting as a future cost control mechanism in lieu of future rate increase.
20 Initial open enrollment period: 6-month waiting period and no health statement.
21 Persons under 65, 120 full days, 245 days at $5; persons 65 to 69, 60 full days; 70 and over, 30 full days.
22 Only if a preexisting condition not disclosed on application but which would have been ridered if existence had been known.
23 Employees over 64 years of age may enroll in groups of 25 or more employees, where at least 75 percent of eligible employees are enrolled.
24 May be waived, depending on size of group and percent excluded.
25 If less than 25 members.
26 Disabled or retarded children are covered as member of family after 19th birthday, if disability is incurred before 19th birthday.
27 Transfer required due to age—children sponsored dependents 65.
28 Waived for certain accounts such as with employer contributions.
29 Require only name of physician.
30 Care of TB, N and M disorders in specialized hospitals limited to 30 days per life of certificate and $5 per day after 12-month waiting period.
31 Riders or exclusions issued after the effective date are limited to situations constituting obvious medical abuse and then only after consultation with the physician. These are extremely rare.
32 If certificate issued to replace prior certificate, clause of prior certificate re preexisting conditions applies.
33 Exception: Unmarried children incapable of self-support and who are dependent on subscriber for over half their support, coverage may be extended to age 25.
34 12 months for associated group subscribers—groups not meeting underwriting requirements.
35 In noncontracting hospitals up to $10 per day for 30 days per certificate year. Care limited to 10 days in contracting hospitals of other BC plans; $60 in noncontracting hospitals.
36 Extended to age 23 if child is a dependent and is enrolled in an accredited school or is incapacitated.
37 1 year by administrative practice.
38 21 days per confinement in contracting hospital; $12.50 per week in institutions for these conditions.
39 For small groups there is a 65 maximum.
40 20 percent if charges exceed $125; if charges under $125, $25 deductible.
41 May be removed by rider for groups.
42 Groups under 10—age 65. Groups 10 and over—none. Sponsored dependents—aged 65 when enrolled.

Source: Blue Cross Association.

4. TABLE IV.—*Summary of current rates, rate and benefit changes,*

Plan	Monthly family rates				Anticipated rate or benefit changes
	Method	1964	1963	1960	
Alabama:					
G	C	$9.30	$9.30	$6.50	
NG	C	9.50	9.50	6.15	
SC	C	[1] 9.50	[1] 9.50	None	
Arizona:					
G	E	13.04	13.04	9.14	
NG	C	15.26	14.57	10.37	
SC No. 1	C	15.00	11.35	11.35	
SC No. 2	C	25.05	25.05	None	
Arkansas:					
G	C	5.75	5.75	5.10	As of May 1, 1964, nongroup 30 percent; group conversion, 40 percent; senior, 47 percent.
NG	C	7.40	7.40	7.40	do
SC No. 1	C	10.30	10.30	7.85	do
SC No. 2	C	17.90	17.90	None	do
California:					
Los Angeles:					
G	E	12.67	12.67	10.02	
NG	C	13.65	13.65	11.17	
SC No. 1	C	[1] 31.60	[1] 31.60	None	
SC No. 2	C	[3] 8.75	8.75	None	
Oakland:					
G	E	10.75	10.75	9.00	
NG	C	12.09	12.09	9.39	
SC No. 1	C	[1] 23.00	[1] 23.00	None	
SC No. 2	C	[1] 31.60	[1] 31.60	None	
Colorado:					
G	E	[4] 13.20	[4] 13.20	[5] 11.30	
NG	C	15.00	15.00	11.90	
SC No. 1	C	[3] 9.50	[3] 9.50	None	Probably during 1964
SC No. 2	C	[3] 8.05	[3] 8.05	None	do
Connecticut:					
G	C	8.70	8.70	7.80	
NG	C	9.22	9.22	9.22	
Delaware:					
G	C	7.96	7.96	None	Rate increase of about 20 percent, early 1965.
NG	C	10.31	10.31	None	do
SC No. 1	C	11.04	11.04	None	do
SC No. 2	C	18.55	18.55	None	do
District of Columbia:					
G	[6]	[7] 9.80	[7] 9.20	6.72	All contracts experience rated on annual review basis.
NG	[6]	10.20	10.20	7.00	
SC	[6]	24.00	24.00	None	
Florida:					
G	[6]	[8] 9.90	[8] 9.90	[3] [8] 6.55	Experience rating
NG	[6]	5.50	5.50	8.15	
SC No. 1	[6]	24.00	24.00	None	Experience rating
SC No. 2	[6]	17.00	17.00	None	do
Georgia:					
Atlanta:					
G	E	[11] 9.82	[11] 7.25	[11] 6.67	
NG	C	10.94	8.75	None	
SC	C	18.90	18.90	None	
Columbus:					
G	E	[12] $5.25–8.05	$5.25–8.05	$5.25–8.05	
NG	C	6.90–17.05	6.90–17.05	6.05–10.20	
SC	C	14.70	14.70	14.70	
Savannah:					
G	C	9.50	9.50	5.70	
NG	C	11.20	11.20	6.40	
SC	C	10.20	10.20	None	
Idaho:					
G	C	10.80	10.80	None	
NG	C	12.50	12.50	None	
SC No. 1	C	22.90	22.90	None	
SC No. 2	C	15.20	15.20	None	
Illinois:					
G	E	[16] 16.92	[16] 16.92	[16] 13.58	
NG	C	17.84	17.84	None	
SC	C	[3] 9.65	[3] 9.65	[3] 9.65	
Indiana:					
G	E	[17] 13.00	[17] 11.92	[17] 9.48	Rates reviewed annually
NG	E	11.56	11.56	None	do
SC	E	15.75	15.75	None	do

See footnotes at end of table, pp. 152–53.

and claims experience on Blue Cross contracts held by aged persons

Benefit changes, 1960–64	Premiums (earned policy described), 1963	Claims incurred (policy described), 1963	Premiums earned (policy described), 1962	Claims incurred (policy described), 1962	Premiums earned (all plans), 1963	Claims incurred (all plans) 1963
	NA	NA	NA	NA	NA	NA
	$3,152,547	$3,177,941	NA	NA	$6,313,719	$6,612,2
	311,173	202,312	NA	NA	311,173	202,368
Increased outpatient; added EKG, 1962.	4,492,216	4,247,616	$3,823,147	$3,910,625	5,543,742	5,241,868
Added EKG, 1962	1,601,643	1,432,892	1,237,684	1,605,885	2,683,651	2,469,188
	138,016	135,800	90,157	88,338	138,016	135,800
			[2] 2,761,680	[2] 2,842,613	[2] 3,687,651	[2] 3,763,50
			[2] 4,056,606	[2] 4,327,101	[2] 6,138,480	[2] 6,380,734
$7 room to $10, 1961			[2] 663,370	[2] 688,409	[2] 663,370	[2] 688,409
	51,838	31,275	None	None	51,838	31,275
	5,177,168	4,993,814	4,621,476	4,490,287	5,177,168	4,993,814
	12,026,661	10,711,068	11,948,839	10,032,667	12,026,661	10,711,068
	569,587	405,760	None	None	864,587	568,925
	295,000	163,165	161,648	35,419		
	None	None	[2] 47,387,453	[2] 42,925,464	[2] 56,839,797	[2] 51,236,402
	None	None	[2] 23,116,259	[2] 21,367,853	[2] 28,031,178	[2] 25,556,250
	None	None	[2] 672,345	[2] 540,633	[2] 672,345	[2] 540,633
Outpatient full (formerly $50 limit) 1962.	15,686,740	15,801,228	14,063,541	13,721,600	17,904,961	17,870,889
do	4,010,745	3,634,937	5,174,404	4,965,644	5,329,470	4,716,193
	545,373	526,015	328,594	363,130	545,373	526,015
	22,555,767	20,580,782	19,995,598	17,727,674	29,023,467	27,136,343
	7,419,131	6,785,923	9,880,463	9,762,860	14,871,233	15,189,115
	5,675,677	4,914,955	5,091,218	4,562,221	5,908,606	5,117,488
	1,758,399	1,863,544	1,606,494	1,804,855	1,865,432	1,986,676
	108,363	132,152	84,621	84,135	141,200	166,582
	32,837	34,430				
Several benefit increases, 1962	33,228,807	32,035,952	28,971,701	28,917,328	3,328,807	32,035,952
Outpatient time limit lengthened, 1961.	[10] 35,434,280	[10] 33,709,400	[10] 31,736,157	[10] 50,879,810	[10] 35,434,280	[10] 33,709,400
	343,771	269,288	None	None	435,613	327,667
	91,841	58,379	None	None		
Added outpatient minor surgery.	2,821,106	2,905,740	2,718,175	2,375,841	3,933,330	4,050,300
do	1,326,473	1,197,530	1,017,925	993,826	1,933,741	1,697,740
	10,460	4,189	None	None	10,460	4,189
	[13] 1,641,929	[13] 1,377,140	[13] 1,546,009	[13] 1,255,629	1,641,929	1,377,140
	[14] 720,065	[14] 719,815	[14] 661,966	[14] 601,562	720,065	719,815
	98,357	88,017	64,162	42,013	98,357	88,017
	None	None	[15] 142,003	[15] 158,573	142,003	158,573
	None	None	[15] 179,200	[15] 182,285	179,200	182,285
	None	None	[15] 3,933	[13] 3,020	3,933	3,020
All new contracts, 1962	1,151,138	[13] 968,444	[13] 867,172	702,824	1,359,202	1,127,208
do	429,109	314,915	433,021	341,864	429,109	314,915
do	5,850	2,108	None	None	8,502	2,776
do	2,652	668	None	None		
	45,147,780	41,662,091	39,097,947	35,879,529	72,339,909	67,753,363
	25,178,630	24,460,725	23,604,838	23,470,099	33,847,937	32,397,741
	2,512,233	2,429,625	1,882,390	1,641,087	2,512,233	2,429,625
	[18] 8,207,814	[18] 7,817,535	[18] 6,902,729	[18] 6,345,122	8,207,814	7,817,535
	[14] 16,843,492	[4] 16,294,752	[14] 16,341,903	[14] 14,381,967	16,843,492	16,294,752
	(19)	(19)	(19)	(19)	(19)	(19)

4. TABLE IV.—*Summary of current rates, rate and benefit changes, and*

Plan	Monthly family rates				Anticipated rate or benefit changes
	Method	1964	1963	1960	
Iowa:					
Des Moines:					
G	G	$9.65	$9.65	$7.15	
NG	C	10.40	10.40	6.00	
SC No. 1	C	[5] 5.70	[5] 5.70	[5] 3.30	
SC No. 2	C	15.85	None	None	
Sioux City:					
G	E	[20] 5.75	[20] 5.75	[20] 4.25	June 1, 1964, direct pay $25 deductible.
NG	C	[21] 10.10	[21] 10.10	[21] 8.60	Plan changed to 80/20 with $25 minimum copay; no rate change.
SC No. 1	C	[21] 5.05	[22] 5.05	[22] 4.30	
SC No. 2	C	[21] 15.85	[21] 15.85	None	
Kansas:					
G	C and E	9.90	9.90	7.40	Community-rated experience, about 10 percent.
NG	C	14.00	12.60	None	do
SC	C	17.50	17.50	None	
Kentucky:					
G	C	6.00	6.00	6.00	Rate increase requested for direct and nongroup, average 37 percent. Should hold 2½ years.
NG	C	6.68	6.68	6.68	do
SC	C	15.50	15.50	None	
Louisiana:					
Baton Rouge:					
G	E	7.15	7.15	7.00	
NG	C	12.17	10.67	10.67	
SC No. 1	C	11.58	11.58	11.58	
SC No. 2	C	12.17	10.67	None	
New Orleans:					
G	C	8.25	8.25	6.75	
NG	C	10.00	10.00	7.50	
SC	C	20.00	20.00	None	
Maine:					
G	C	7.85–12.85	7.85–12.85	6.60	
NG	C	8.15–13.95	8.15–13.95	6.90	
Maryland:					
G	C	10.10	10.10	7.20	Rate increase effective, July 1 1964.
NG	C	10.70	10.70	7.80	do
SC No. 1	C	[3] 10.90	[3] 10.90	None	
SC No. 2	C	[3] 7.90	[3] 7.90	None	
Massachusetts:					
G	E	[25] 9.92–11.36	[25] 9.92–11.36	[25] 9.92–11.36	
NG	C	9.20	9.20	9.20	
Michigan:					
G	C	16.91	16.91	11.48	To change from community to group experience rating, January 1965. If permission denied, possible rate increase.
NG	C	19.45	19.45	None	
SC	C	[3] 6.45	[3] 6.45	[3] 5.23	
Minnesota:					
FG	E	21.15	21.15	15.15	
NG	C	19.80	16.20	13.95	
SC No. 1	C	[3] 8.00	8.00	None	
SC No. 2	C	[3] 12.50	12.50	None	
Mississippi:					
G	E. (Mod.)	9.21/ 9.86	9.21/ 9.86	8.57/ 9.21	
NG	E. (Mod.)	10.90	10.90	8.10	Approximately 10 percent increase.
SC No. 1	E. (Mod.)	10.00	10.00	10.00	do
SC No. 2	E. (Mod.	12.20	12.20	None	do

See footnotes at end of table, pp. 152–53.

claims experience on Blue Cross contracts held by aged persons—Continued

Benefit changes, 1960–64	Premiums earned (policy described), 1963	Claims incurred (policy described), 1963	Premiums earned (policy described), 1962	Claims incurred (policy described), 1962	Premiums earned (all plans), 1963	Claims incurred (all plans), 1963
	$7,125,055	$6,284,107	$6,671,641	$6,038,812	$7,673,477	$6,788,681
	4,274,710	3,963,786	3,961,706	3,471,006	5,744,334	5,324,137
	365,533	283,693	174,940	224,375	440,967	351,181
	75,434	67,488	NA	NA		
			[2] 5,024,000	[2] 4,191,000	[2] 6,630,000	[2] 5,505,000
			[2] 3,280,000	[2] 3,126,000	[2] 3,483,000	[2] 3,356,000
Made available room allowance, $6 to $12.			[2] 91,000	[2] 90,000	[2] 91,000	[2] 90,000
	7,092,497	6,383,921	6,697,488	5,923,704	8,222,629	7,461,650
	7,033,984	6,497,762	6,741,405	6,227,929	[23] 7,558,403	[23] 6,785,029
	[23] 162,852	[23] 92,228	None	None	[23] 762,852	[23] 92,228
	2,948,660	2,744,392	3,282,128	2,989,792	5,932,712	5,632,051
	2,998,945	2,975,326	2,940,172	2,884,737	4,251,940	4,275,794
	131,271	134,029	None	None	131,271	134,029
Benefits added, 1963	[13] 1,196,078	[13] 2,042,845	NA	NA	1,961,078	2,042,845
Benefits added, 1964	[14] 1,930,453	[14] 1,588,014	[14] 1,532,743	[14] 1,127,262	1,930,453	1,588,014
Benefits added, 1964	202,949	108,756	123,000	73,809	202,949	108,756
	NA	NA	2,486,387	2,648,806	[24] 2,765,429	[24] 2,925,676
Days increased 60 to 75; room allowance, $10 to $12, 1961.	NA	NA	1,037,795	793,588	[24] 1,037,795	[24] 793,588
	11,461	9,287	None	None	11,461	9,287
Added $24 room, 1963	1,348,193	1,293,818	1,627,094	1,542,269	6,240,663	6,606,890
do	3,674,261	3,732,673	3,347,285	3,209,142	4,548,564	4,546,519
	14,758,524	13,914,463	13,986,155	14,224,674	18,692,524	17,782,262
	[14] 12,803,405	[14] 13,742,718	[14] 11,261,554	[14] 12,363,927	[14] 12,803,405	[14] 13,742,718
	None	None	None	None	None	None
	None	None	None	None	None	None
Waiting period reduced to 8 months.	73,875,168	77,555,554	70,522,393	[13] 69,719,127	73,875,168	77,555,554
Day limitation for TB removed; NG days increased 30 to 40, 1961.	24,000,269	27,475,516	21,324,232	[14] 24,662,572	24,000,269	27,475,516
	149,219,467	142,816,953	131,335,377	[13] 130,990,572	149,219,467	142,816,953
	17,190,971	20,861,925	15,834,983	19,618,715	24,772,975	27,853,751
	1,402,899	1,774,726	1,187,029	1,812,416	1,402,899	1,774,726
	6,285,306	5,547,968	6,858,846	6,181,053	8,168,761	7,132,788
	4,363,787	4,166,363	3,648,540	3,388,479	7,160,148	6,858,553
	18,896	5,311	None	None	42,897	15,897
	24,001	10,586	None	None		
			5,610,345	[26] 5,874,123	[2] 5,610,345	[2] 5,874,123
			5,551,053	[20] 4,676,640	[2] 5,551,053	[2] 4,676,640
			817,718	[26] 794,702	[2] 817,718	[2] 794,702

4. TABLE IV.—*Summary of current rates, rate and benefit changes, and*

Plan	Monthly family rates				Anticipated rate or benefit changes
	Method	1964	1963	1960	
Missouri:					
Kansas City:					
G	C	$12.05	$10.00	$7.30	New rates, June 1, 1964; percent not given. Further increase anticipated June 1, 1965; 13 percent G, 10 percent NG.
NG	C	11.05	9.90	9.00	do
SC	C	18.55	17.40	None	do
St. Louis:					
G	C	8.50	8.50	6.90	20.9 percent rate increase Apr. 20, 1964.
NG	C	8.35	8.35	None	do
SC	C	19.70	19.70	None	
Montana:					
G	C	13.51	11.60	11.60	
NG	C	[27] 15.64	[28] 14.80	[28] 14.80	
SC No. 1	C	29.60	29.60	None	
SC No. 2	C	19.40	19.40	None	
Nebraska:					
G	C	7.45	7.45	7.45	
NG	C	6.05	6.05	6.05	
SC No. 1	C	[3] 4.70	[3] 4.70	[3] 4.70	
SC No. 2	C	[3] 7.90	[3] 7.90	None	
SC No. 3	C	[3] 6.40	[3] 6.40	None	
New Hampshire:					
G	C	8.75	8.75	8.20	
NG	C	11.65	11.65	9.50	
New Jersey:					
G	C	10.29	10.29	8.61	Approved for Aug. 1, 1964, $12.30 rate.
NG	C	11.22	11.22	9.49	Approved for Aug. 1, 1964, $12.93 rate.
SC No. 1	C	19.00	19.00	None	
SC No. 2	C	14.48	14.48	None	
New Mexico:					
G	C	14.95	14.95	8.85	Probable rate adjustment within 2 years.
NG	C	15.05	14.54	12.05	do
SC No. 1	C	22.50	22.50	None	do
SC. No. 2	C	21.80	21.80	None	do
New York:					
Albany:					
G	C	15.40	15.40	10.12	January 1965 estimate 20 percent rate increase.
NG	C	19.60	19.60	11.31	do
SC No. 1	C	[3] 9.66	[3] 9.66		do
SC No. 2	C	[3] 8.00	[3] 8.00		do
Buffalo:					
G	C	10.15	10.15	8.40	Probable rate change early 1965.
NG	C	12.10	12.10	10.15	do
SC No. 1	C	20.85	20.85		do
SC No. 2	C	18.40	18.40		do
Jamestown:					
G	E	7.98	7.98	4.45	Merit rating
NG	C	11.64	8.45	8.45	Just converted to merit rating
New York:					
G	C	8.72	8.72	6.60	Changes anticipated
NG	C	10.35	10.35	7.77	do
SC	C	[3] 10.80	[3] 10.80	None	do
Rochester:					
G	C	10.48	10.48	6.96	
NG	C	13.50	13.50	8.60	
SC	C	[3] 11.00	[3] 11.00	[3] 7.70	

See footnotes at end of table, pp. 152-53.

claims experience on Blue Cross contracts held by aged persons—Continued

Benefit changes, 1960–64	Premiums earned (policy described), 1963	Claims incurred (policy described), 1963	Premiums earned (policy described), 1962	Claims incurred (policy described), 1962	Premiums earned (all plans), 1963	Claims incurred (all plans), 1963
	$5,938,218	$5,767,749	$5,838,307	$5,513,879	$8,413,083	$8,067,011
	2,443,566	2,506,363	2,091,108	2,184,414	3,745,507	3,517,241
	518,212	678,568	None	None	518,212	678,568
			[2] 20,387,662	[2] 18,304,757	[2] 27,248,654	[2] 24,427,813
			NA	NA	NA	NA
			[2] 348,240	[2] 296,187	[2] 348,240	[2] 296,187
Days increased 90 to 120, 1960. Full loan EKG, 1964. TB, M. and N. covered 30 days (Y), formerly excluded, 1960.	NA	NA	NA	NA	NA	NA
do	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA
	1,286,698	1,152,219	1,321,889	1,220,209	2,173,696	2,046,498
	423,916	391,345	455,240	430,881	1,130,742	1,054,575
	110,466	93,887	94,489	116,336	183,168	160,642
	67,986	62,072	11,004	57		
	4,716	4,683	844	None	None	None
	2,850,382	2,277,898	2,856,306	2,511,947	6,049,679	4,747,438
	1,167,505	1,101,893	1,115,028	1,214,977	2,178,369	2,200,365
	65,983,000	66,801,000	60,120,000	61,622,000	70,074,000	70,491,000
	20,088,000	19,636,000	16,721,000	14,666,000	21,691,000	21,433,000
	497,000	577,000	None	None	497,000	577,000
SP room allowance (was $15), plasma and OP preliminary tests included, 1961. $50 deductible, 1964, plasma and OP tests included, 1961.	NA	NA	NA	NA	NA	NA
do	NA	NA	NA	NA	NA	NA
	17,606	11,566	2,590	1,943	17,606	11,556
Full OP (formerly, $15); 30 days.	7,223,846	6,455,584	6,564,218	6,448,193	8,928,967	7,936,897
M and N (formerly excluded)	4,160,551	4,004,575	4,528,269	4,718,458	5,899,201	5,665,695
do	76,038	38,686	None	None	86,348	49,682
	10,310	10,996	None	None		
	18,484,831	17,368,680	18,004,410	16,157,337	18,484,831	17,368,680
	9,761,868	9,875,808	10,063,561	9,830,091	9,761,868	9,875,808
	504,901	415,544	None	None	504,901	415,544
Room increased to SP, 1961	[13] 832,439	[13] 705,348	[13] 803,654	[13] 663,400	832,439	705,348
	[14] 646,991	[14] 631,997	[14] 639,106	[14] 687,728	646,991	631,997
Increased private room allowance, noncontracting hospital benefits, M and N benefits.	119,487,400	115,096,863	122,428,359	107,360,619	143,713,890	140,612,674
do	48,225,714	55,720,174	52,609,266	53,458,181	61,305,060	72,870,280
	1,520,039	1,201,040	1,139,366	691,655	1,520,039	1,201,040
Increased OP benefits, added home care, 1963.	NA	NA	14,422,692	13,517,691	[24] 15,267,974	[24] 14,305,359
do	NA	NA	3,845,924	3,984,308	[24] 3,923,115	[24] 4,039,260
	NA	NA	180,457	186,549	[24] 180,457	[24] 186,549

4. TABLE IV.—*Summary of current rates, rate and benefit changes, and*

Plan	Monthly family rates				Anticipated rate or benefit changes
	Method	1964	1963	1960	
New York—Continued					
Syracuse:					
G	C	$10.90	$10.90	$6.95	Probable benefit increase in next 2 years.
NG	C	11.80	11.80	7.80	do
SC	C	[2] 6.60	[3] 6.60	[3] 5.60	do
Utica:					
G	C	8.20	8.20	6.70	Some change anticipated
NG	C	9.60	9.60	7.80	do
SC	C	[29] 10.66	[29] 10.66	[29] 10.66	do
Watertown:					
G	C	11.60	9.19	5.85	
NG	C	12.50	9.47	6.20	
SC No. 1	C	[3] 9.60	[3] 8.00	None	
SC No. 2	C	[3] 8.60	[3] 7.23	None	
North Carolina:					
Chapel Hill:					
G	E	6.60	6.60	6.60	
NG	C	9.55	9.55	9.55	Approximately 10 to 20 percent in fall, 1964.
SC No. 1	C	[3] 6.50	[3] 6.50	[3] 6.50	
SC No. 2	C	15.80	15.80	None	
SC No. 3	C	10.90	10.90	None	
Durham:					
G	([20])	8.58	8.58	8.58	Group experience rating.
NG	C	6.50	6.50	6.50	Rate increase, early 1965
SC No. 1	C	[29] 6.50	[29] 6.50	[29] 6.50	Effective Nov. 15, 1965
SC No. 2	C	15.80	15.80	None	do
SC No. 3	C	10.90	10.90	None	do
North Dakota:					
G	E	13.20	13.20	9.95	Possible rate increase, 1965
NG	C	16.15	16.15	10.35	do
SC No. 1	C	21.20	21.20	None	do
SC No. 2	C	15.60	15.60	None	do
Ohio:					
Canton:					
G	C	12.20	10.30	9.25	
NG	C	11.90	10.30	9.00	
SC	C	[3] 11.50	[3] 11.50	None	
Cincinnati:					
G	C	11.10	11.10	9.60	Rate adjustment of approximately 22½ percent effective Oct. 1, 1964.
NG	C	10.90	10.90	9.00	do
Cleveland:					
G	By area	11.90–14.90	11.90–14.90	10.60	
NG	do	16.10–20.10	16.10–20.10	13.80	
SC	C	[3] 7.95–9.95	[3] 7.95–9.95	None	
Columbus:					
G	C	8.10– 8.20	8.10– 8.20	7.55– 7.85	Effective Apr. 1, 1964, $12.30 to $12.40 rate.
NG	C	7.25	7.25	5.95	
SC	C	[3] 5.00	[3] 5.00	None	
Lima:					
G	C	6.50	6.50	5.60	Anticipate 20-percent increase in next few months.
NG	C	7.50	7.50	6.40	do
SC No. 1	C	[3] 5.50	[3] 5.50	None	do
SC No. 2	C	14.00	14.00	None	do
Toledo:					
G	C	11.40	11.40	9.10	Anticipate 16- to 18-percent increase shortly. Also improvements in OP and M and N benefits.
NG	C	10.30	10.30	8.50	do
SC	C	[3] 7.00	[3] 7.00	[3] 7.00	do
Youngstown:					
G	C	13.55	13.55	12.00	
NG	C	20.75	20.75	16.75	Direct pay but not senior preferred rate, will probably be increased June 1, 1964.
SC	C	20.00	20.00	None	do
Oklahoma:					
G	County rating	7.80	7.80	7.80	
NG	do	5.20	5.20	5.20	
SC	do	6.80	6.80	6.80	
Oregon:					
G	C	7.75	7.75	7.75	Currently making benefit change and 6 percent rate increase.

See footnotes at end of table, pp. 152-53.

claims experience on Blue Cross contracts held by aged persons—Continued

Benefit changes, 1960–64	Premiums earned (policy described), 1963	Claims incurred (policy described), 1963	Premiums earned (policy described), 1962	Claims incurred (policy described), 1962	Premiums earned (all plans), 1963	Claims incurred (all plans), 1963
70 days (was 30+90), 30 days M and N (was excluded), 1960.	$8,382,019	$7,289,704	$7,959,936	$5,993,229	$10,099,241	$8,645,007
do	2,952,814	2,922,427	2,668,966	2,522,256	2,991,572	2,955,165
	250,997	269,605	168,616	133,932	250,997	269,605
	1,296,032	1,232,136	1,606,847	1,360,895	2,400,510	2,224,236
	1,775,252	1,817,691	1,854,239	1,754,038	2,029,684	2,072,298
	106,886	121,104	69,917	76,464	106,886	121,104
	113,408	103,091	149,540	127,732	163,828	148,924
	139,877	150,987	125,729	111,554	156,638	169,079
	21,984	18,025	NA	NA	21,984	18,025
			NA	NA		
	4,293,574	4,057,795	3,796,454	3,534,642	6,700,396	6,176,677
	None	None	890,669	849,972	[24] 1,560,261	[24] 1,466,591
	80,338	56,302	81,567	36,041	252,981	168,674
	172,643	112,372	None	None		
	11,567,161	10,578,564	10,147,857	8,868,078	11,567,161	10,578,564
	3,923,930	3,589,256	3,507,296	3,054,336	3,923,930	3,589,256
	319,026	219,955	122,029	59,576	319,026	219,955
	3,007,719	2,584,016	2,966,610	2,464,287	3,202,457	2,731,246
	2,437,181	2,244,996	2,282,140	2,186,655	2,472,450	2,267,008
	79,714	67,817	5,131	1,401	83,398	68,373
	3,684	556	66	None		
	2,684,762	2,712,186	3,199,423	5,286,866	4,782,664	4,862,501
	[14] 1,502,424	[14] 617,772	[14] 1,456,784	[14] 1,543,458	1,502,424	1,617,772
	885,657	121,169	None	None	85,657	121,169
Various in- and out-patient benefit increases, 1960.	16,601,871	15,308,310	14,977,251	13,907,268	26,469,123	25,085,871
do	[14] 16,208,143	[14] 15,739,008	[14] 14,492,160	[14] 14,452,827	16,208,143	15,739,008
	49,174,085	44,791,970	47,108,793	45,957,520	57,523,367	52,700,978
	20,876,094	23,173,974	20,061,076	23,339,685	20,876,094	23,173,974
	None	None	None	None	None	None
	6,710,159	6,693,350	4,934,790	4,813,421	12,108,594	12,358,899
	2,326,088	2,660,154	2,456,331	2,557,039	2,974,379	3,286,142
	123,820	129,622	86,142	65,762	123,820	129,622
	1,234,401	1,266,937	None	None		
	1,534,260	1,594,957	None	None	1,582,130	1,594,124
	73,843	62,630	None	None	1,534,260	1,594,957
					73,843	62,630
	6,319,455	7,084,994	6,951,963	6,314,032	9,519,103	9,831,964
	NA	NA	NA	NA	NA	NA
	363,389	348,967	270,022	220,236	363,389	348,967
	4,409,848	4,315,851	4,325,716	4,279,387	7,265,013	7,045,603
	2,295,196	2,466,471	1,913,856	2,191,474	3,061,647	3,265,489
	[21] 107,317	[21] 135,273	None	None	107,317	135,273
	[13] 7,532,618	[13] 6,561,555	[13] 960,951	[13] 5,837,759	7,532,618	6,561,553
	[14] 8,300,615	[14] 7,695,118	[14] 8,280,091	[14] 7,658,521	8,300,615	7,695,118
	(22)	(22)	(22)	(22)		
	1,043,069	867,561	908,689	759,392	2,150,676	1,960,528

4. TABLE IV.—*Summary of current rates, rate and benefit changes, and*

Plan	Monthly family rates				Anticipated rate or benefit changes
	Method	1964	1963	1960	
Oregon—Continued					
NG	C	$13.90	$9.50	$9.50	Currently making benefit change and 17 percent rate increase.
SC No. 1	C	22.90	22.90	None	
SC No. 2	C	15.70	15.70	None	
Pennsylvania:					
Allentown:					
G	M	9.45	8.85	6.10	Based on merit rate changes.
NG	M	9.95	9.10	6.60	do.
SC No. 1	M	11.14	11.14	None	do.
SC No. 2	M	17.54	17.54	None	do.
Harrisburg:					
G	M	[33] 9.80	[33] 9.70	[33] 8.70	do.
NG	M	11.10	10.50	8.70	Estimated annual increase of 7 to 8 percent.
SC No. 1	M	[3] 7.00	[3] 7.00	[3] 6.00	do.
SC No. 2	M	21.50	21.50	None	do.
Philadelphia:					
G	M	13.35	13.35	7.92	Based on merit rate changes.
NG	M	12.50	12.50	8.08	do.
SC No. 1	M	13.34	13.34	None	do.
SC No. 2	M	20.84	20.84	None	do.
Pittsburgh:					
G	C	[34] 12.15	12.15	10.10	Probably within 12 to 24 months, 15 to 20 percent increase and some benefit improvement.
NG	C	12.95	12.95	10.60	do.
SC No. 1	Class	24.80	22.94	None	
SC No. 2	do	16.70	14.90	None	
Wilkes-Barre:					
G	M	[34] 9.50	[34] 9.50	6.00	
NG	C	12.60	12.60	8.15	
SC No. 1	C	19.20	19.20	None	
SC No. 2	C	10.70	10.70	None	
Rhode Island:					
G	E	[35] 8.30	[35] 8.30	7.95	Rate increase and increase in mental coverage in specialty hospitals, July 1, 1964.
NG	E	7.15	7.15	7.75	do.
South Carolina:					
G	E	7.85	7.85	7.85	
NG	C	10.00	8.30	5.20	
SC No. 1	C	22.10	22.10	None	
SC No. 2	C	17.10	17.10	None	
Tennessee:					
Chattanooga:					
G	Self-adjusting	7.20	7.20	5.60	Probable increase in next 2 years.
NG	Rating formula	10.00	9.00	7.20	do.
SC	do	[1] 25.00	[1] 25.00	None	do.
Memphis:					
G	E	[1] 10.10	[1] 10.10	[1] 10.10	
NG	C	13.05	13.05	13.05	
SC	C	25.00	25.00	None	
Texas:					
G	E	7.70	7.70	7.70	Changes September 1964.
NG	C	9.43	9.45	7.45	do.
SC No. 1	C	[3] 8.75	[3] 8.75	None	
SC No. 2	E	(37)	(37)	None	
Utah:					
G	C	11.95	9.56	8.40	A 10- to 14-percent increase, 1965.
NG	C	10.22	8.94	7.66	do.
SC No. 1	C	19.80	19.80	None	do.
SC No. 2	C	14.30	14.30	None	do.
Virginia:					
Lynchburg:					
G	C	7.10	7.10	7.10	Undetermined rate increase in 1964.
NG	C	6.85	6.85	6.85	do.
SC	C	[3] 6.50	[3] 6.50	None	do.
Richmond:					
G	C	9.40	9.40	9.40	
NG	C	7.50	7.50	7.50	Yes.
SC	C	[29] 8.44	[29] 8.44	None	

See footnotes at end of table, pp. 152–53.

claims experience on Blue Cross contracts held by aged persons—Continued

Benefit changes, 1960–64	Premiums earned (policy described), 1963	Claims incurred (policy described), 1963	Premiums earned (policy described), 1962	Claims incurred (policy described), 1962	Premiums earned (all plans), 1963	Claims incurred, (all plans) 1963
	$1,364,890	$1,213,841	$1,313,301	$1,171,137	$1,364,890	$1,213,841
	87,489	52,783	None	None	132,108	75,796
	44,619	23,013	None	None		
Waiting periods reduced, 1962; OP benefits included, 1963.	3,918,917	3,657,996	3,900,416	3,565,765	7,538,478	6,833,453
do	2,199,941	2,277,408	2,061,411	2,053,097	2,199,941	2,277,408
	76,557	51,610	62,417	34,774	104,656	75,450
	28,099	23,840	None	None		
	4,282,386	3,927,258	4,242,029	3,995,912	6,442,002	5,920,081
	3,658,082	3,765,835	3,065,109	3,283,055	5,329,493	5,574,086
	190,944	154,629	128,070	120,346	278,108	218,673
	87,164	64,044	None	None		
	27,225,585	25,069,582	23,627,025	22,613,845	51,170,480	46,303,048
	14,146,689	15,084,937	13,298,812	14,210,421	21,895,609	21,882,994
	1,113,518	1,114,579	432,540	326,253	1,113,518	1,114,579
MN service included 65+, 1962.	14,106,050	12,836,809	12,673,365	12,713,540	46,148,751	41,042,809
	10,801,055	11,625,153	9,031,224	10,253,495	16,941,548	17,626,353
	2,117,802	1,943,235	1,320,886	1,213,295	2,117,802	1,943,235
Number of days increased, 1963.	4,979,549	4,449,042	4,411,077	4,104,054	6,829,722	6,083,740
do	3,057,606	3,370,796	2,823,303	3,102,534	4,224,612	4,508,599
	60,872	50,583	None	None	104,627	79,067
	43,755	28,484	None	None		
Number of days increased, 1963.	6,864,714	6,829,027	6,760,717	6,194,111	9,952,796	9,827,643
do	2,034,990	2,092,067	2,074,840	2,012,316	4,695,647	4,915,518
	2,097,673	1,942,527	1,856,611	933,176	3,896,526	3,518,109
Room allowance increased $8 to $10, 1962.	250,153	232,586	209,891	203,573	474,285	399,411
	44,229	25,812	None	None	57,790	37,324
	13,561	11,512	None	None		
	[13] 18,760,147	[13] 18,243,272	[13] 16,801,149	[13] 15,901,929	18,760,147	18,243,272
	[14] 5,902,132	[14] 6,478,150	[14] 5,730,505	[14] 5,847,408	5,902,132	6,478,150
	138,901	[35] 125,000	None	None	138,901	[35] 125,000
	474,683	460,557	467,512	402,595	976,824	914,546
	756,767	780,628	782,069	787,420	756,767	780,028
	3,644	1,728	None	None	3,644	1,728
	3,500,376	3,253,281	3,171,079	2,977,104	6,555,909	6,085,184
	2,755,893	2,640,748	2,836,055	1,967,228	5,402,447	5,647,403
	382,576	355,787	128,371	69,150	18,315,417	17,741,632
Increased, 1963	17,932,841	17,385,845	15,751,893	15,215,953		
Increased noncontracting hospital benefits, 1963.	1,533,251	1,607,611	2,199,407	2,227,417	2,506,080	2,713,250
do	408,286	476,828	549,005	600,317	484,399	542,445
	36,415	35,407	43,925	47,618	36,415	35,407
	[13] 350,760	[13] 251,649	[13] 346,151	[13] 213,140	350,760	251,649
	[14] 60,006	[14] 125,536	[14] 59,200	[14] 111,234	60,006	125,536
	4,394	4,118	None	None	4,394	4,118
	5,186,962	4,904,146	4,535,768	3,961,253	7,357,076	6,875,709
	3,072,395	2,977,823	3,084,362	2,675,814	3,634,574	3,556,781
	69,059	39,119	23,878	16,008	69,059	39,119

4. TABLE IV.—*Summary of current rates, rate and benefit changes, and*

Plan	Monthly family rates				Anticipated rate or benefit changes
	Method	1964	1963	1960	
Virginia—Continued					
Roanoke:					
G	C	$8.30	$8.30	$6.60	Rate changes anticipated within 1 year; amount of increase not established. No benefit changes.
NG	C	9.05	9.05	7.10	ditto
SC	C	[3] 10.50	[3] 10.50	None	ditto
Washington:					
G	C	[38] 8.75	8.75	8.75	Plan to introduce new contract.
NG	C	9.50	9.50	9.50	ditto
SC No. 1	C	[29] 8.50	[29] 8.50	[29] 8.50	
SC No. 2	C	[39] 27.50	[39] 27.50	None	
West Virginia:					
Bluefield:					
G	C	9.20	9.20	6.85	
NG	C	10.00	10.00	7.55	
SC	C	[1] 23.60	[1] 23.60	None	
Charleston:					
G	C	9.10	9.10	9.10	Approximate 25 percent rate increase Aug. 1, 1964.
NG	C	8.40	8.40	8.40	ditto
Parkersburg:					
G	C	8.30	8.30	7.75	
NG	C	10.35	10.35	9.05	
SC No. 1	C	21.20	21.20	None	
SC No. 2	C	19.70	19.70	None	
Wheeling:					
G	C	10.80	10.80	10.80	Possibly early 1965.
NG	C	12.85	12.85	12.85	ditto
SC	C	23.30	23.30	None	ditto
Wisconsin:					
G	E	[42] 14.55	[42] 14.55	[42] 13.30	Anticipate rate increase, Sept. 11, 1964, for NG and SC. Undecided on community group. No benefit change.
NG	C	15.00	15.00	12.50	ditto
SC No. 1	C	[1] 24.00	[1] 24.00	None	ditto
SC No. 2	C	[1] 30.00	[1] 30.00	None	ditto
Wyoming:					
G	C	4.85	4.85	4.85	Rate increase anticipated next 12 months.
NG	C	10.90	10.90	10.90	ditto
SC No. 1	C	[1] 7.50	[1] 7.50	[1] 7.50	ditto
SC No. 2	C	16.50	16.50	None	ditto

Legend:
G=group.
NG=nongroup.
SC=senior citizen plan (No. 1, No. 2, etc, where more than — plan offered).
C=community rating.
E=experience or group experience rating.
E (mod.)=modified experience rating.
M=merit rating by group or class.
Class=rated as separate class.
NA=not available.
OP=outpatient benefits.

[1] Hospital-medical-surgical (usually Blue Cross-Blue Shield) combined.
[2] 1962–63 combined data.
[3] Single, rather than family, rates.
[4] New groups.
[5] Still in effect in "low use", groups.
[6] Community rating through August 31, 1962; experience rating thereafter.
[7] Rate for groups under 50.
[8] Experience by group and classification after 1962.
[9] Groups of 35 to 99.
[10] Total for plan. (Plan does usually tabulate experience for each type of contract. Senior data given is included in totals.)
[11] New group base rates.
[12] Partial group experience rating.
[13] Total group experience.
[14] Total nongroup experience.
[15] 1962 and 1963 combined for each type of plan; premiums calculated.
[16] Groups of less than 100.

claims experience on Blue Cross contracts held by aged persons—Continued

Benefit changes, 1960–64	Premiums earned (policy described), 1963	Claims incurred (policy described), 1963	Premiums earned (policy described), 1962	Claims incurred (policy described), 1962	Premiums earned (all plans), 1963	Claims incurred (all plans), 1963
	[18] $4,867,175	[18] $4,281,146	[18] $4,547,410	[18] $3,845,151	$4,867,175	$4,281,146
	2,084,491	2,689,818	2,046,609	2,491,382	2,084,491	2,689,818
	38,950	23,520	None	None	38,950	23,520
Raised Alaska benefits $4 per day; no rate increase.	[40] 1,819,412	[40] 1,631,341	[40] 1,733,944	[40] 1,466,440	[40] 1,819,412	[40] 1,631,341
do	[40] 3,241,220	[40] 2,796,380	[40] 3,058,754	[40] 2,632,927	[40] 3,241,220	[40] 2,796,380
	[40] 66,443	[40] 36,436	[40] 22,155	[40] 11,197	[40] 66,443	[40] 36,436
Increased outpatient benefit and allowance to better accommodation.	NA	NA	NA	NA	NA	NA
do	NA	NA	NA	NA	NA	NA
	NA	NA	NA	NA	NA	NA
	568,667	616,688	483,312	475,646	796,600	878,734
	402,002	475,834	419,582	440,903	728,618	811,394
Lengthened outpatient time limit. Added M.N. and TB coverage.	333,764	335,869	326,967	309,709	395,640	398,144
do	389,271	363,075	375,895	381,958	389,271	363,075
	7,953	6,530	None	None	7,953	6,530
	1,585,757	1,472,524	1,511,921	1,478,222	1,585,757	1,472,524
	510,726	[41] 545,975	[41] 477,131	[41] 535,306	[41] 1,044,072	[41] 1,016,585
	533,346	[41] 470,610	[41] 517,878	[41] 511,914		
	7,303,923	6,711,647	6,360,259	5,587,552	12,862,766	11,659,370
	2,787,915	2,323,414	1,064,055	999,355	3,336,547	2,703,467
	156,022	109,978	None	None	156,022	109,978
	668,247	641,561	637,935	581,428	834,494	787,563
	277,765	274,149	301,749	301,721	565,863	571,126
	36,570	24,779	27,277	13,811	42,237	27,862
	5,667	3,083	None	None		

[17] First quarter rates, groups of 50 and over.
[18] Total group. Several large groups having a common benefit pattern and average rates used to develop group experience.
[19] Included in nongroup.
[20] Low utilization rates in Iowa.
[21] Iowa rates (different in South Dakota).
[22] Single rate, Iowa.
[23] Not a full year's experience.
[24] 1962 data only.
[25] Rate differential is due to area—low cost and high cost.
[26] Total 1962–63 experience for type of plan.
[27] $13.59 if under age 65.
[28] $12.85 if under age 65.
[29] Hospital-surgical-medical, single (rather than family) rate.
[30] Self-adjusting rate formula.
[31] Feb. 1, 1963, to Feb. 28, 1964, experience.
[32] Included in nongroup, since both categories pay same dues and are rated together.
[33] Initial rate for groups of 175 or more.
[34] Groups of 41 to 75 employees.
[35] Rates for less than 50 in group.
[36] SC coverage has not been in force long enough to estimate incurred claims to a high degree of accuracy.
[37] $8.68 combined Blue Cross-Blue Shield per recipient, of which plans retain $0.26 for administrative costs.
[38] 1963–64 Alaska rate, $7.85.
[39] Hospital-medical-surgical, 1964 Alaska rate, $31.50.
[40] Hospital-medical-surgical, total premium for type of plan (G, NG, SC).
[41] NC includes conversion plans only; SC includes direct pay and senior plan.
[42] Groups of 25–49.

Source: Blue Cross Association.