center for
health
administration
studies
university
of chicago

the federal employees health benefits program, 1961–1968; a model for national health insurance?

odin w. anderson, ph.d.
professor and
associate director

j. joel may, m.b.a.
assistant director

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perspectives

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I. PREMISE

IN THE CURRENT discussion and debate regarding some form of universal health insurance, no country has had the experience with a variety of delivery and financing methods prior to the enactment of such legislation as has the United States. So far, a country has simply attached a financing mechanism, i.e., the government through obligatory payroll deductions and general tax revenue to a delivery system which is uniform all over the country. If a country is homogeneous, a uniform system may well be appropriate. In a country with the heterogeneity of the United States, a single delivery and payment system would hardly be appropriate. It is then mandatory that significant experiences with a variety of delivery and financing methods be examined as to their possible roles in a universal health insurance program. The Federal Employees Health Benefits Program is such a national program and has been in operation for Federal Civil Service employees since 1960, and now covers eight million employees and dependents. This Program could serve as a viable model for the implementation of universal health insurance in this country, accommodating the aspirations of the providers of services and the recipients of services within politically tolerable cost limits.

Even if universal health insurance is not enacted for some time, the Federal Employees Health Benefits Program can be a model for other big buyers of services, such as large employers and labor unions. The concept of choice among delivery and financing methods is well established in this country. Such precedents facilitate smooth transitions to other sources of funding. The model provides a useful reference point as a viable middle ground between the extremes of a uniform system over the entire country and a simple

income transfer as exemplified by the negative income tax approach directed exclusively at the low income groups.

The cost, use, and enrollment data, assembled annually by the Civil Service Commission, the government administrative agency for the federal employees, will be analyzed since the inception of the program. A statistical analysis of cost, use, and enrollment in itself cannot be used to support the concept of a diversified and competing delivery system and financing mechanism. Any health insurance arrangements which are national in scope, regardless of sponsorship, have to come to terms with American political and economic realities, and it is rather self-evident that the Federal Employees Health Benefits Program does that. With this premise, we turn to a brief legislative history of the Program; presentation of cost, use, and enrollment data; and finally some observations and conclusions that bear on public policy implications.

II. BRIEF HISTORY OF LEGISLATIVE DEVELOPMENTS

By 1950 it was considered a normal part of the operation of private industry for the employer to pay all or some of the health insurance premiums of employees. Health insurance benefits became a regular part of the fringe benefit package along with disability and retirement pensions. Private industry and organized labor through payroll deductions became the backbone of the financing of health insurance in this country. Although it is the largest single employer in the country, the federal government came late in participating in paying for health insurance premiums for its employees.

Since the federal government was such a large employer, voluntary health insurance agencies were anxious that the government embark on some type of employer-employee financed health insurance scheme. Indeed, by 1957 it was reported that 78 percent[1] of the federal employees on their own initiative and as individuals had already enrolled in some type of health insurance coverage. Many, such as the postal workers, had formed their own employee groups. The costs of premiums were borne entirely by the employees. Federal participation and payroll deductions would undoubtedly add many more employees, assure financial stability, and universal enrollment.

As early as 1951, President Truman's Commission on the Health Needs of the Nation recommended that the federal government as an enlightened employer follow the then common practice of private industry in assuring health insurance coverage for its employees.[2]

[1] U.S. Congress Senate Hearings before Subcommittee in Insurance of the Committee on Post Office and Civil Service on S.94. (86th Congress, 1st session) April 15, 1959.

[2] *Ibid,* Vol. I, 1952, pp. 47–48.

In 1954, President Eisenhower endorsed a contributory system of voluntary health insurance for federal employees. Legislation was introduced to this effect later in the year (S.3803) and hearings were held. In 1955 this proposal was rejected, and the Civil Service Commission sent a second proposal to Congress in the form of S.2425. Both these items of proposed legislation would have established a pattern of benefits which included both basic benefits (the prevailing benefit pattern up to that time) and major medical benefits for so-called medical catastrophies. The concept of major medical coverage, i.e., protection against the risk of high losses, was then relatively new.

The Blue Cross and Blue Shield plans promoted the slogan: "What is needed is service not cash" since they contracted for services with the hospitals and doctors whereas the private insurance companies did not then nor now do so. Still as costly episodes of illness became more common and increased in magnitude as well, the limitations on hospital days and exclusion of out-of-hospital services encouraged the introduction of an umbrella type of insurance like major medical to cover, up to a relatively high maximum, a wide range of services both in and out of the hospital after a certain "first-cost" was borne by the insured.

In 1956 President Eisenhower again recommended contributory health insurance for federal employees, this time including a proposal to include the prepaid group health insurance plans as well. The Civil Service Commission proposed major medical benefits only. In 1958 the process was repeated and the Civil Service Commission recommended a combined basic benefits and major medical benefits, but in neither case was there a bill. In 1959 there appeared to be enough support for some type of federal contributory scheme so that extensive hearings were held on two bills: S.94 and S.2162. Finally Public Law 86-382 was approved September 28, 1959, to become effective July 1, 1960. Extensive hearings had been held by the Senate Committee in April and the House Committee in July and August. Representatives of all health insurance agencies, as well as of many groups within the Federal Civil Service and the Civil Service Commission submitted testimony.

There is no need to describe the content of the hearings in detail, but clearly the concept practically taken for granted was that

of assuring payment for high cost episodes. Members of Congress present at the hearings were personally acquainted with, or had actually experienced costly medical care episodes and the emphasis was on covering those episodes and de-emphasizing so-called first dollar coverage if it could be had only at the expense of insurance for high costs. The late Senator Neuberger, Democrat, Oregon, was Chairman of the Committee. There was an amusing interchange during Neuberger's questioning of the President of the National Association of Letter Carriers, William C. Doherty:

> SENATOR NEUBERGER: I have read that many plans are inadequate for genuine catastrophic illnesses, because they lack the deductibility at the beginning. Do you want to apply some deductibility at the start and thereby have greater generosity for the comparatively small numbers who have a major medical illness, whom we know have major medical illnesses? What is your view on this whole situation?
>
> MR. DOHERTY: Our opinion is that we want the generosity on both ends.[3]

Yes, indeed. "Generosity on both ends" is the ideal of those who desire a truly comprehensive health service or insurance system, but what the federal government—and the employees—was facing was the problem of overall cost of premiums. Did they want a health service or insurance? As it turned out the end product contained some of both.

The major medical concept was then quite new to the Blues, and Douglas Colman, then Vice-President of the Blue Cross Association, Chicago, testified that the feeling of the Blues was that basic and major medical should not be split but covered by the same carrier.[4] Robin C. Beurki, M.D., then Chairman, Council on Government Relations, American Hospital Association, advised that the administration proposal (S.94) would compel most government employees to accept the partial indemnity approach, and to reject the service benefit or even the full indemnity approach.[5] "We believe strongly" he testified, "that the Government should provide a choice between service plans and indemnity plans sufficient to meet the

[3] *Ibid*, p. 88.

[4] *Ibid*, p. 110.

[5] *Ibid*, p. 151.

III. SCOPE AND MAGNITUDES

IN THE FINAL negotiations between the Civil Service Commission and the carriers, five types of approved plans emerged within each of which there were "low" and "high" options. The Commission engaged in: 1) a nationwide service contract with Blue Cross and Blue Shield for basic coverage plus a major medical plan for high cost episodes with a deductible and ceilings; 2) a nationwide indemnity contract with Aetna, a private insurance company, for basic and major medical insurance with deductibles, coinsurance, and ceilings; 3) contracts with 13 separate employee organization plans for coverage analogous to the indemnity contract and hence of the same type; 4) contracts with eight separate individual practice plans which differ from Blue Cross/Blue Shield only in that they cover all physicians' services in- and out-of-hospital with very modest charges at times of service as well as hospital services; 5) contracts with 13 separate group-practice prepayment plans with salaried doctors and comprehensive physicians' services regardless of site of service plus hospital service. Types 4 and 5 are regarded as comprehensive plans, i.e., covering hospital services, physician services, and some drugs, but normally excluding other services in the health service spectrum such as dental care, appliances, and nursing home care.

All plans pay for a very high proportion of hospital service, but vary in their extent of payment for physicians' services, drugs, and exclude the other services mentioned. Still, we cannot be too arbitrary in our description because the service and indemnity plans normally pay for a portion of non-hospital services when the major medical contract applies in high cost episodes. It is impossible and perhaps unnecessary in this report to be completely precise in the

description of the benefit structures. We believe it is sufficient to describe the extent to which each type of plan pays for the total range of personal health services and goods and the total range of non-hospital personal health services and goods. In our analysis we have separated hospital service expenditures and all other expenditures as will be explained and shown in due course.

After enrollment of the federal employees was completed, almost 5.5 million employees and their dependents were enrolled with 1.8 million contracts. This was the largest single subscriber group in the country, exceeding the population of a European country like Denmark. It is important to point out that 78 percent of the employees selected the "high option" although it meant a greater contribution from their pay checks, the government contributing approximately a third of the total premium rather than one-half as it does in the "low option." Since that time, the proportion selecting the "high option" has increased to 84 percent indicating continuing overwhelming preference for the "high option" contract. Within the two choices offered, people are interested in the more extensive coverage and have obviously been willing to pay for it.[1]

With the increase in the number of federal employees, the enrollment in 1969 was almost eight million with 2.5 million contracts. The federal employees and their dependents are an appropriate population to use as a reference point in discussing national health insurance options regardless of sources of funding. They represent a stable labor force with an income distribution a little better than the average in the United States, and with fewer low and high income extremes.[2] We feel that the expenditure and use patterns of the federal employees and their dependents would be a little above the national average for the foregoing reasons. It should also be recalled that federal employees are by no means made up solely of the white collar stereotype. A high proportion is also in manual labor and the skilled trades. We assume, further, that the federal employees are likely to reside in areas where personal health ser-

[1] Inez Conley, *Federal Employees Health Benefits Program; Highlights of First Decade of Operation, July 1960–June 1970*, U.S. Civil Service Commission, Bureau of Retirement Insurance, and Occupational Health, Office of the Actuary, December, 1970 (mimeo).

[2] U.S. Civil Service Commission (BRI), November, 1960, Table 6, and U.S. Statistical Abstract, 1962, Table 444, p. 330.

vices are comparatively accessible. We urge, therefore, that in a national health insurance program the problem of supply would be considered seriously, so as to assure access comparable to that of the federal employees.

The distribution among types of plans (Table 1 and 2) shows the same rank order in 1969 as in 1961 with rather modest changes in proportions. The service benefit plan, already the predominant choice, gained members and the indemnity and employee organization plans lost. Since the independent practice and group practice plans are mainly regional—Washington, D.C., and the states of Washington, Oregon, California, and Hawaii—enrollment in these types of plans in these areas would be larger because of greater

TABLE 1

NUMBER OF ENROLLEES BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1969

Carrier	1961	1969
Total (thousands)	5,480	7,934
Service Benefit Plan (Blue Cross/Blue Shield)	55.6%	58.9%
Indemnity Benefit Plan (Aetna)	24.5 } 38.6	19.5 } 34.7
Employee Organization Plans	14.1 }	15.2 }
Individual Practice Plans	1.7 } 5.7	1.9 } 6.5
Group Practice Plans	4.0 }	4.6 }
	100%	100%

Source: Appendix Table 1.

TABLE 2

NUMBER OF CONTRACTS BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1969

Carrier	1961	1969
Total (thousands)	1,821	2,567
Service Benefit Plan (Blue Cross/Blue Shield)	54.8%	58.4%
Indemnity Benefit Plan (Aetna)	26.5 } 39.5	21.1 } 35.2
Employee Organization Plans	13.0 }	14.1 }
Individual Practice Plans	1.5 } 5.7	1.6 } 6.4
Group Practice Plans	4.2 }	4.8 }
	100%	100%

Source: Appendix Table 2.

TABLE 3

SUBSCRIPTION INCOME BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968

Carrier	1961	1968
Total (thousands)	$393,551	$632,646
Service Benefit Plan (Blue Cross/ Blue Shield)	230,325	386,223
Indemnity Benefit Plan (Aetna)	102,283	133,720
Employee Organization Plans	53,312	100,137
Individual Practice Plans	7,632	11,313
Group Practice Plans	18,653	35,113

Source: Appendix Table 4.

availability of options. In California, 21 percent of the federal employees selected either the individual practice or group practice plans; in Washington State the rate was 22 percent, and in Oregon 31 percent. This was during the initial enrollment.[3] There has been a slight expansion since.

With an enrollment approaching eight million people, the absolute expenditures for the Federal Health Benefits Program are large. In 1968 the total subscription income was close to $632 million (Table 3). This total is divided among the types of plans more or less in accordance with each type's proportion of the total enrollment. It is estimated that the federal government contributes about one-third of this subscription income and employees the other two-thirds.[4] The combined contributions account for about one-third of the total expenditures for personal health services on the part of federal employees and their dependents. In a national health insurance program the relative contributions from citizens and the government could be similar or negotiable.

[3] U.S. Social Security Administration Division of Program Research, Research and Statistics Note No. 18, 1960, p. 3.

[4] Effective January 1, 1971, under P.L.91-418, the federal government will pay an amount equal to 40 percent of the average (unweighted) premium charged for the high-option coverage offered by the six largest insurance plans participating in the FEBHP program. The government's contribution, however, cannot exceed 50 percent of the actual premium of any plan or option. Before the amendment, rate increases were largely borne by the enrollee. The new law, with its percentage premiums, ensures an automatic adjustment in the government contribution whenever premiums change for the high-option plan. U.S. Social Security Administration, Office of Research and Statistics, Note No. 20, 1970.

IV. BENEFITS

THESE TREMENDOUS magnitudes of expenditures can be more easily grasped by reducing them to dollar benefits per enrollee by carrier. All data will be presented combining both options. Since the low option is such a small proportion of all options little additional insight is gained by a separate analysis. In 1961 (Table 4) it can be seen that the dollar benefits per enrollee in the entire federal program was $51 and in 1968 it had increased to $87. There are, of course, obvious reasons for this increase—increased price probably being the chief one—but there was also some increase in scope of benefits, i.e., the insurance package was larger. Of the four major types of plans (indemnity benefit and employee organization plan being regarded as similar) the dollar benefit per enrollee increased least for the two comprehensive plans. The service and indemnity plans expanded their original benefit packages but the comprehensive plans were initially much broader in their coverage and had less opportunity (or need) for expansion.

TABLE 4

DOLLAR BENEFITS PER ENROLLEE BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968

Carrier	1961	1968
Total	$51	$87
Service Benefit Plan (Blue Cross/ Blue Shield)	51	89
Indemnity Benefit Plan (Aetna)	46	88
Employee Organization Plans	48	79
Individual Practice Plans	64	73
Group Practice Plans	76	98

Source: Appendix Table 5.

TABLE 5

AVERAGE DOLLAR BENEFITS PAID PER CLAIM BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968

Carrier	1961	1968
Total	$220	$259
Service Benefit Plan (Blue Cross/ Blue Shield)	274	273
Indemnity Benefit Plan (Aetna)	244	350
Employee Organization Plans	210	263
Individual Practice Plans	80	96
Group Practice Plans	89	121

Source: Appendix Table 6.

In Table 5 the great difference between carriers in dollar benefits per claim is due to the fact that the service, indemnity, and employee organization plans are more likely to have fewer small claims than the comprehensive plans because the latter covers house and office calls. Average claims for maternity services (Table 6) reveal great variations between plans. What the plans have in common is a great increase in the average payment per claim from 1961 to 1968. Maternity benefits are popular among subscribers and cannot be ignored politically in a national health insurance program.

The primary criterion, in our view, for the performance of health insurance benefits is the extent to which they cushion the expenditures for high cost medical episodes. There are, of course, other important criteria, the presence of which should be taken for granted in a generously proportioned national health insurance

TABLE 6

AVERAGE DOLLAR BENEFIT, PAID PER MATERNITY CLAIM BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968

Carrier	1961	1968
Total	$180	$383
Service Benefit Plan (Blue Cross/ Blue Shield)	190	366
Indemnity Benefit Plan (Aetna)	145	417
Employee Organization Plans	180	374
Individual Practice Plans	171	269
Group Practice Plans	272	516

Source: Appendix Table 9.

program. They are: the assurance of supply to facilitate ease of access and convenience, and the general quality of the service, and, at a price people and their employers are willing to pay. We believe, however, that the adequacy of payment for high cost episodes is the primary issue rather than the absolute cost of premiums. There is no information from the Federal Employees Program on the distribution of expenditures by magnitudes or on the portion of each magnitude covered by insurance except among a few carriers. Such information requires a household survey to obtain data on services paid for by the insured in addition to those paid by insurance or a suitable reporting procedure on the part of the Civil Service Commission. Since the federal program is nationwide, we felt it would be appropriate to use the national per capita expenditures for all personal health services as the average for enrollees in each of the types of plans and calculate the dollar benefits per enrollee by type of plan as a percentage of the national per capita average. The ideal would be to have the actual expenditures for each enrollee by plan for all services and show the portion of the total expenditure per enrollee which each plan paid.[1] Lacking the ideal, we will deal with national averages. These are hardly abstractions; they do represent actual expenditures. All types of plans will thus use the same reference point on the assumption that annual expenditures per enrollee by plan will not vary greatly above or below the national average.[2]

[1] This was done, e.g., in a survey in 1957 of selected groups enrolled in Health Insurance Plan of Greater New York and Group Health Insurance of New York, the former a group practice plan and the latter an individual practice plan. The portion of total expenditure for health since, per enrollee in each plan was reasonably similar, 35 percent HIP and 34 percent EHI. Odin W. Anderson and Paul B. Sheatsley, *Comprehensive Medical Insurance: A Study of Costs, Use, and Attitudes Under Two Plans*, New York, Health Information Foundation, 1959. Health Information Foundation Research Series No. 9, p. 31.

[2] It can be assumed that the employees of the federal government live in areas that have higher living and health services costs than the general population. Hence, using the national average per capita expenditures for non-hospital services as the reference point yields a somewhat higher percent coverage of such services than if it were possible to determine the actual average expenditures specific to the areas of the country where the federal employees live. Further, it may be that group practice plans exist primarily in relatively high cost areas, i.e., New York City, California, and Washington, D.C. In using the national average for these plans, the proportion of non-hospital services they cover may well be overstated.

TABLE 7

PER CAPITA EXPENDITURES FOR PERSONAL HEALTH SERVICE, UNITED STATES, AND PER CAPITA DOLLAR BENEFITS AS PERCENT OF TOTAL NATIONAL EXPENDITURES, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961–1968

Year	Per capita expenditures, United States	Per capita dollar benefits, enrollees	Benefits as percent of per capita expenditures
1961	$143	$51	36
1962	148	51	34
1963	156	55	36
1964	171	60	35
1965	182	77	42
1966	200	69	34
1967	224	76	34
1968	256	87	34

Source: Appendix Tables 5, 10, 12.

Table 7 shows the per capita expenditures in the United States for all personal health services and the portion paid by the Federal Employees Health Benefits Program for all employees: $256 and $87 respectively in 1968. The federal employees and their dependents are assumed to have the same total expenditures for all personal health services per enrollee as the national per capita. It is then seen that, in 1961, the federal program paid out in benefits, on average, 36 percent of the per capita expenditures in the United States. The variation from this figure has been slight during the years. In essence, this table reveals that by this measure the federal enrollees pay about two-thirds of total expenses out of pocket for uncovered services. As we said earlier, if we could have a measure of proportion of expenditures paid for by insurance ranked according to magnitudes of expenditures we would have a better measure of the extent to which "catastrophic" expnditures are covered. We prefer not to make anything of differences among plans at this point, although they can be examined in the Appendix, because the comprehensive plans reveal much lower use of hospital days than the other plans. Hence, they would be compared with a per capita national expenditure which includes an average of almost twice the per capita hospital use than is actually experienced in the comprehensive plans.

We believe, however, it is reasonable to exclude the hospital expenditure portion of both the national per capita and per enrollee expenditure and determine the extent to which the non-hospital portion of the benefits covers the non-hospital average expenditures experienced by the enrollees. Evidence from national household surveys and reports from the Social Security Administration do reveal that for the insured population hospital insurance is paying 80 percent or more of hospital charges nationally. There is no reason to believe that there is much difference in this regard between the types of plans for the federal employees. Hence, we feel that we can assume a high average hospital insurance coverage for all plans and concentrate on the non-hospital portion.

Accordingly, we calculate an estimated value of hospital benefits by assuming that the enrollees in all plans experienced the same national average *per diem* hospital costs for short-term hospitals, as reported annually in the *Guide Issue* of the American Hospital Association. The estimates of net dollar non-hospital benefits per enrollee are presented in Table 8. It will be seen that on average they increased for all enrollees from $20 to $36 or 80 percent. As might be expected, the comprehensive plans increased their net benefits for non-hospital expenditures relatively little because they started from a relatively high base compared to the other plans.

The crucial information is contained in Table 9. We have selected three years in this table because 1965 represented a peak for

TABLE 8

NET DOLLAR NON-HOSPITAL BENEFITS PER ENROLLEE, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968 (NET OF ESTIMATED VALUE OF HOSPITAL BENEFITS)

Carrier	1961	1968
Total	$20	$36
Service Benefit Plan (Blue Crocs/ Blue Shield)	20	35
Indemnity Benefit Plan (Aetna)	15	33
Employee Organization Plans	15	31
Individual Practice Plans	40	44
Group Practice Plans	57	72

Source: Appendix Table 11.

TABLE 9

PERCENT OF AVERAGE NON-HOSPITAL PER CAPITA EXPENDITURES FOR PERSONAL HEALTH SERVICES COVERED BY FEDERAL EMPLOYEES HEALTH PROGRAM BENEFITS, 1961, 1965 AND 1968

Carrier	1961	1965	1968
Total	23%	29%	24%
Service Benefit Plan (Blue Cross/Blue Shield)	23	26	23
Indemnity Benefit Plan (Aetna)	17	28	22
Employee Organization Plans	17	29	21
Individual Practice Plans*	45	38	29
Group Practice Plans	64	56	48

* 39 percent in 1963.

Source: Appendix Table 13.

all plans in the proportion of non-hospital expenditures covered by insurance. (In the comprehensive plans, even though there appears to be a straight line decrease, the percentage for 1965 was higher than for any other year other than 1961 and after 1965 dropped again. See Appendix 13.) What Table 9 reveals is that the service, indemnity, and employee plans held their ground in covering the non-hospital portion of personal health service expenditures per enrollee and that the individual practice and group practice plans actually lost considerable ground in this respect.

There is also the important question as to what extent enrollees in the group practice plan sought physician services elsewhere. We would assume that since enrollees in individual practice plans have free choice of virtually all physicians in the areas served by these plans there would be little or no use of service outside of the plan.

There is evidence that enrollees in group practice plans seek some of their services elsewhere. In the HIP-GHI study by Anderson and Sheatsley referred to previously, it was shown that 20 percent of the physician expenditures by HIP enrollees was attributed to physicians' services outside of HIP.[3] Another study by Williams, *et al.* showed that in the Kaiser Foundation Health Plan serving the San Francisco Bay area, 13 percent of physicians expenditures were for physicians' services outside of the Kaiser Plan.[4] On the assumption that the same pattern obtains in the group practice plans reveiewed in this report the percentage of 48 in 1968 for these plans would then be reduced to near 40 percent, still an appreciable difference from other plans.

In any case, the non-covered portion of personal health services expenditures is appreciable in all plans if it is assumed that 80 percent or so of the cost of all services should be covered. These are the only measures of performance of health insurance benefits available, but they still provide some reference points when contemplating truly comprehensive coverage. Since comprehensive coverage is the long-range trend, it needs to be taken into account when contemplating a national health insurance program.

[3] Anderson and Sheatsley, *op. cit.*, Table 12, p. 31.

[4] Josephine J. Williams, Ray E. Trussell, and Jack Elinson, "Family Medical Care Under Three Types of Health Insurance," New York: Foundation on Employee Health, Medical Care and Welfare, Inc., 1962, Table IX-4, p. 113. Herbert Klarman has a detailed discussion of this in his "Approaches to Moderating the Increases in Medical Care Costs," *Medical Care*, 7:175–190, May–June, 1969, in which he mutes the current prevailing assumption that group practice plans are as different from other plans in cost savings as is believed.

V. USE OF SERVICES

THE DATA on use assembled by the Civil Service Commission is limited to hospital admissions, length of stay, and proportion of enrollees receiving benefits in a year. We would naturally like to have more data on use, such as physician visits so as to compare the volume of services supplied by each plan irrespective of its costs. Still, if we had such information, we would be dealing with the issue of what is "proper" use rather than the issue of "what proportion of expenditures do the benefits cover?" We feel that the primary issue is the extent to which the various plans pay for prescribed services in each context. Obviously, the volume of services affects the total costs that insurance needs to cover and the cost of premiums. Nevertheless, the current generally accepted criterion of performance is the extent to which health insurance plans pay for services.

Still, there is great fascination with the fact that group practice plans use fewer hospital days than other plans. Among the various types of plans in which the federal employees are enrolled there is a truly staggering range of use which so far cannot be explained without research going beyond studies carried out so far. What has been established to date is the simple fact of variations in hospital use between different types of delivery methods. The range of variation is from nearly 900 days per 1,000 enrollees in the service benefit and indemnity plans to near 400 days in group practice plans (Table 10). What has not been pointed out so far in the analysis of hospital use among federal employees is that experience in individual practice plans is quite close to that of the group practice plans. It will be recalled that both types are quite similar in their

TABLE 10

HOSPITAL DAYS PER 1,000 ENROLLEES (NON-MATERNITY) FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM, 1968, AND AVERAGE FOR 1961–1968

Carrier	1968	1961–1968
Total	835	846
Service Benefit Plan (Blue Cross/ Blue Shield)	879	897
Indemnity Benefit Plan (Aetna)	885	867
Employee Organization Plans	775	783
Individual Practice Plans	472	542
Group Practice Plans	419	448

Source: Appendix Table 14.

comprehensiveness and in their benefits for hospital and physician services, but the individual practice plans operate with fee-for-service and free choice principles in the entire community, whereas group practice plans operate on predetermined remuneration and formally organized group principles. It used to be an easy conclusion that the lower hospital use in group practice was the result of the method of organizing physicians' services in that particular manner. In our data it becomes apparent that a relatively low level hospital use—compared to service and indemnity plans—can be attained within the prevailing structure of private practice given certain systematic review mechanisms the individual practice plans are reported to apply.[1] This also bears some systematic research if we are to consider options on any rational basis.

The use of general hospitals appears to be the most volatile of all personal health service components because the range between areas and countries with similar social and economic conditions is so great and for no easily discernible reason. Even the Kaiser Foundation plans, which presumably have a similar organizational pattern wherever they operate, reveal a range of 287 days per 1,000

[1] See, e.g., Richard Sasuly and Carl E. Hopkins, "A Medical Society-Sponsored Comprehensive Medical Care Plan; The Foundation for Medical Care of San Joaquin County, California," *Medical Care*, 5:234–248, July–August, 1967, and George A. Shipman, Robert J. Lampman, and S. Frank Miyamoto, *Medical Service Corporations in the State of Washington; A Study of the Administration of Physician-Sponsored Prepaid Medical Care*, Cambridge: Harvard University Press, 1962.

TABLE 11

HOSPITAL ADMISSIONS PER 1,000 ENROLLEES (NON-MATERNITY) BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961, 1968, AND AVERAGE 1961–1968

Carrier	1961	1968	1961–1968
Total	109	89	96
Service Benefit Plan (Blue Cross/ Blue Shield)	105	95	102
Indemnity Benefit Plan (Aetna)	103	84	88
Employee Organization Plans	107	86	94
Individual Practice Plans	134	64	89
Group Practice Plans	71	48	54

Source: Appendix Table 15.

enrollees in Oregon to 424 in southern California.[2] Since hospital care is a relatively expensive component of personal health services, there is a desire to reduce this type of service in favor of less expensive services. Indeed, group practice proponents are pushing such practices in large part because of the saving in hospital costs that appear to be possible. This is a primary reason among others that emerging national health insurance legislation is trying to affect the organization of services.

In Table 11 we present the non-maternity hospital admission rates by plan which, of course, again reveal great differences across

[2] George S. Perrott, "The Federal Employees Health Benefits Program: Sixth Term Coverage and Utilization," *Group Health and Welfare News: Special Supplement*, October, 1968, Table V, p. 6.

TABLE 12

AVERAGE LENGTH OF STAY FOR HOSPITALIZED ENROLLEES (NON-MATERNITY) BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968

Carrier	1961	1968
Total	8.5	9.4
Service Benefit Plan (Blue Cross/ Blue Shield)	8.5	9.2
Indemnity Benefit Plan (Aetna)	8.5	10.5
Employee Organization Plans	8.9	9.1
Individual	5.0	7.3
Group Practice Plans	7.7	8.7

Source: Appendix Table 16.

types of plans. On average, for the eight years, the range is from 102 to 54. Interestingly, however, the rates have been decreasing in all plans, the greatest shift taking place among individual practice plans. In Table 12 it is seen that the average length of stay has increased quite appreciably from 8.5 days to 9.4. There has been an increase among all plans likely due to an increase in the older ages among enrollees, particularly the retired.

The length of stay per maternity admission (Table 13) is quite uniform among the plans with the inexplicable exception of the individual practice plans in 1962.

A measure of use as measure of exposure to the plan is the extent to which the enrollees receive any benefits. In Table 14 it is seen that enrollees in comprehensive plans have far more contact

TABLE 13

AVERAGE LENGTH OF STAY FOR HOSPITALIZED ENROLLEES (MATERNITY) BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1962 AND 1968

Carrier	1962	1968
Total	4.3	3.8
Service Benefit Plan (Blue Cross/ Blue Shield)	4.5	3.7
Indemnity Benefit Plan (Aetna)	4.3	3.9
Employee Organization Plans	4.1	4.1
Individual Practice Plans	3.7	4.8
Group Practice Plans	4.4	3.9

Source: Appendix Table 17.

TABLE 14

PERCENT OF ENROLLEES RECEIVING BENEFITS BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1961 AND 1968

Carrier	1961	1968
Total	23%	34%
Service Benefit Plan (Blue Cross/ Blue Shield)	19	33
Indemnity Benefit Plan (Aetna)	19	25
Employee Organization Plans	23	30
Individual Practice Plans	80	76
Group Practice Plans	85	81

Source: Appendix Table 18.

than in other plans becuse of the coverage of all physicians' services. It may be that enrollees in the other plans have the same amount of contact, but this cannot be measured by the proportion receiving benefits since payment for out-of-hospital physicians' services is comparatively limited. It is clear, however, that a larger proportion of enrollees in the service, indemnity, and employee plans are receiving benefits than previously.

The comprehensive plans have much less leeway here than the other plans because of the initial comprehensiveness of services. Were the comprehensive plans to expand benefits to all drugs, appliances, and dental care the percent of non-maternity claims involving hospital care would then decrease appreciably.

VI. ADMINISTRATION

WE APPROACH this chapter on administration with the feeling that we do not have adequate information on or knowledge of the complicated operational problems involved primarily because of lack of comparability in the way the data are reported by various carriers. These data should then be approached by others with the same caution. We still believe, however, it is of value to publish what data we have since they are rather standard and accepted indicators of administrative costs. We do not wish to infer that they are measures of efficiency of administration. They do reveal the relationships of subscription income to benefits and what is entailed in the costs of administration of the kinds of plans described in this report.

Table 15 reports the proportion of administrative expense as a percent of subscription income by plan. These might be regarded as

TABLE 15

ADMINISTRATIVE EXPENSES AS A PERCENT OF SUBSCRIPTION INCOME BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, 1968

Carrier	Administrative expenses as a percent of subscription income
Service Benefit Plan (Blue Cross/Blue Shield)	4.1%
Indemnity Benefit Plan (Aetna)	2.8
Employee Organization Plans	4.4
Individual Practice Plans	8.2
Group Practice Plans	6.6

Source: Appendix Table 22.

the visible cost of administration in relation to subscription income as reported by the plans. The high proportions of administrative expense attributed to the comprehensive plans may be due to the fact that these plans are directly engaged in the production of physicians' and/or hospital services. The question can be posed regarding the extent to which purely payment agencies such as the service and indemnity plans have lower administrative expenses as a percentage of subscription income because the producers of service—hospitals and physicians—absorb administrative expenses which may be present in the comprehensive plans.

Table 16 shows the benefit value of the average premium dollar paid to each plan. These were computed by dividing weighted annual total premium costs by benefits paid out per contract. In the service benefit plan, for example, the enrollee received 92 cents in benefits for each premium dollar paid by the government and the employee. In the individual practice plans the enrollee received 85 cents on every premium dollar and so on. Again, the comprehensive plans return less on the premium dollar than the other plans for presumably the same reasons given in relation to Table 15.

From the standpoint of the enrollee, however, this is not an important consideration. Unless administrative costs are much higher than those revealed in these tables, for example, equal to the acquisition costs for individual health insurance policies, they can be deemed reasonable and defensible in either a voluntary or a national health insurance context.

TABLE 16

EXPECTED BENEFIT VALUE PER AVERAGE PREMIUM DOLLAR PAID BY CARRIER, FEDERAL EMPLOYEES HEALTH BENEFITS PLAN, AVERAGE 1961–1968

Carrier	Average benefit value
Service Benefit Plan (Blue Cross/Blue Shield)	.92
Indemnity Benefit Plan (Aetna)	.92
Employee Organization Plans	.96
Individual Practice Plans	.85
Group Practice Plans	.90

Source: Appendix Table 23.

VII. OBSERVATIONS AND CONCLUSIONS

IF THE COUNTRY is given a mandate in the near future to inaugurate some type of universal and compulsory health insurance, possibly the wisest thing it can do politically and practically is to negotiate within the options presented in this report and in the same manner. In fact, since the government owns or controls very little of the personal health services resources it has hardly any other choice. Wholesale expropriation of facilities and the co-opting of physicians into a salaried service are simply not politically feasible even if they were logically wise. The political process is not logical in an abstract sense, but in this country it seems uncannily wise in the art of the possible. The concept of the art of the possible is frequently under attack as harboring cynicism. This is a matter of definition. The height of cynicism is to promise more than can be delivered or in a form most of the people and providers of service do not want.

This is why we believe that the final legislation worked out in the Federal Employees Health Benefits Program was ingenious: the employees wanted it; the providers wanted it; the government agreed to it; the insurance agencies wanted it; and the existing methods of delivery wanted it. Since we feel no single method of delivery and paying for services so far devised has been sufficiently acceptable to all groups at interest, the offering of a variety of options and the opportunity to change from one option to another at specified times will be a safety valve for dissatisfactions which inherently tend to be quite high in a service which touches both the pocketbook and the fears of the people. Further, the federal program reviewed here does provide a concept of basic services to be paid for in part by the employer, or possibly by taxation,

above which the citizen can add what he wishes within the rather wide range of alternatives available from first dollar coverage to catastrophic. The low-income and poor segment of the population can be subsidized by the government so that they can exercise choice, too. This is the surest way to prevent a two class system of medical care.

We are wary of the federal government using its financing power directly to influence the particular form a delivery method should take. We are also wary of the federal government exercising direct financial controls on the methods of reimbursing providers of services, and on the volume of services. We would prefer to see the federal government exercise cost controls through premium negotiations within which each of the various carriers could work out its benefit package and price. There will be benchmarks for cost comparisons between plans over time. Benefit structures, accessibility, and use of services are related to one another. All three are related to premiums and together they influence enrollment and solvency of the insurance operation. We believe that this set of relationships constitutes a viable (or, perhaps more accurately, a potentially viable) control mechanism which is both more sensitive to changes in the system and at the same time more acceptable to the various concerned groups than a more direct and necessarily more arbitrary form of financial control. We would, therefore, prefer to see the government facilitate competition between delivery methods by putting the purchasing power in the hands of the buyers to decide their choice of a variety of options as described in this report. Employers as contributors can do likewise together with their employees.

We are not impressed with the differences in costs between the five options in this report as measured by dollar benefits per enrollee and proportion of total expenditures covered by the benefits. We feel that probably the price differences between the plans is not an issue; the issues are the exceedingly complicated and practically nonmeasurable factors of quality, influences of preventive services, and convenience. We would prefer to see these issues hammered out in a context of open choice permitting both the consumer and the provider options, with only a portion paid by compulsory payroll deductions or taxation. Simultaneously, the government and private resources should assure an ample supply of facilities and personnel without playing a numbers game of specious precision as to what is really "needed." Within the framework of "structured pluralism" let the consumers decide.

We predict that if the Congress and the government decided to legislate a tight system with many direct controls on direction of development and expansion, a large minority of this country would opt out of the system in order to have access to the range and convenience of services they want and, as a result, create a parallel large and plush private sector. The result could be a two-class system, one for the poor and low-income and one for the well-off. A generous supply situation, coupled with options within the system is much more likely to appeal to persons throughout the income range.

Although we are impressed with the fact of a lower hospital use in individual practice and group practice plans, we are much less impressed with what it means in terms of whatever may be regarded as "proper" use of hospitals. We prefer to regard the volume of hospital use as an expression of an equilibrium of choices physicians and patients make in different contexts. The selection of the hospital as the villain in terms of costs is both uncharitable and unwise unless, perhaps, we wish to use the hospital as it was used say, in the 1920's: only for those who are awfully sick. The substitution of out-of-hospital services remains to be tested—as it, of course, should be—and a range of options would permit this. The home and doctor's office were probably overrated as a place to treat sick people before modern scientific medicine and are likewise overrated now, but substitutions must be tested.

As a counter value-judgment we prefer to believe that there is an obsession with rising costs. In a service which has to absorb the proliferating technology, more people, and more illness the only way is up. We can debate the pace of increase and the allocation of resources in relation to other resources. But to fear that health services will "price themselves out of the market" as frequently asserted is an economic fallacy. Once we spread the costs over the entire population via insurance and subsidize the poor adequately, internal adjustments in the system made in response to changing patterns of use and actuarial determinations on the part of insurors

reflecting themselves in benefit and premium structures will provide for checks and balances in the system. In order to maintain the capability of any enterprise, the economy must buy at the price required to maintain that enterprise or go without. We believe that there is an unreasoning reluctance to face these realities of choice with respect to the health services system even in this tremendous consumer economy of ours.

We then end this report in obvious support of the Federal Employees Health Benefits Program concept as a model for national health insurance with the conditions set forth. If, as the President of the National Association of Letter Carriers, William C. Doherty said to Senator Neuberger:

Our opinion is that we want the generosity on both ends, such generosity is possible for those who opt and pay for it among the choices reviewed in this report.

APPENDIX TABLES

NOTE TO APPENDIX TABLES:

NEARLY ALL the data in the Appendix Tables have been drawn from the Annual Reports of the United States Civil Service Commission, Bureau of Retirement and Insurance, for the years 1961 through 1969.

To enable interested parties to expand or extend any particular aspect of the tabulation, the following list is presented. It relates the data presented to the particular year's report, to the table involved therein, and to the calendar period involved which occasionally differs from year to year.

I. ENROLLMENT DATA

Year Reported in Appendix Tables	Actual Calendar Period Involved	Source Table and Date of Annual Report
1961	as of 6/30/61	O-1 (1961)
1962	as of 6/30/62	O-6 (1962)
1963	as of 6/30/63	O-6 (1963)
1964	as of 6/30/64	C-6 (1964)
1965	as of 6/30/65	C-6 (1965)
1966	as of 6/30/66	C-6 (1966)
1967	as of 6/30/67	C-6 (1967)
1968	as of 6/30/68	C-6 (1968)
1969	as of 6/30/69	C-6 (1969)

II. CLAIMS AND BENEFITS DATA

1961	7/1/60–10/31/61	O-3 (1962)
1962	11/1/61–10/31/62	O-3 (1963)
1963	11/1/62–10/31/63	C-3 (1964)
1964	11/1/63–10/31/64	C-3 (1965)
1965	11/1/64–12/31/65	C-3 (1966)
1966	1/1/66–12/31/66	C-3 (1967)
1967	1/1/67–12/31/67	C-3 (1968)
1968	1/1/68–12/31/68	C-3 (1969)

III. FINANCIAL DATA

1961	7/1/60–10/31/61	O-1, O-2 (1962)
1962	11/1/61–10/31/62	O-1, O-2 (1963)
1963	11/1/62–10/31/63	C-1, C-2 (1964)
1964	11/1/63–10/31/64	C-1, C-2 (1965)
1965	11/1/64–12/31/65	C-1, C-2 (1966)
1966	1/1/66–12/31/66	C-1, C-2 (1967)
1967	1/1/67–12/31/67	C-1, C-2 (1968)
1968	1/1/68–12/31/68	C-1, C-2 (1969)

TABLE 1

ENROLLMENT (in thousands)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	5480.1	3047.3 55.6	1345.3 24.5	771.8 14.1	94.1 1.7	221.6 4.0
1962....	5853.1	3234.2 55.3	1356.5 23.2	912.4 15.6	106.6 1.8	243.5 4.2
1963....	6134.8	3404.5 55.5	1416.8 23.1	954.5 15.6	109.9 1.8	249.1 4.1
1964....	6684.8	3781.1 56.6	1441.2 21.6	1070.1 16.0	120.7 1.8	271.7 4.1
1965....	6866.6	3883.0 56.5	1432.1 20.9	1138.7 16.6	128.6 1.9	284.2 4.1
1966....	7149.3	4068.0 56.9	1464.9 20.5	1186.0 16.6	132.8 1.9	297.7 4.2
1967....	7648.3	4417.2 57.8	1531.2 20.0	1214.6 15.9	137.9 1.8	347.3 4.5
1968....	7817.0	4548.5 58.1	1553.8 19.9	1211.2 15.5	144.3 1.8	359.1 4.6
1969....	7934.3	4672.0 58.9	1546.8 19.5	1205.2 15.2	147.0 1.9	363.2 4.6

Source: Tables O-1 (1961), O-6 (1962–63), C-6 (1964–69), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

Remarks: Numbers in upper left—in thousands. Numbers in lower right—percent of total.

TABLE 2

NUMBER OF CONTRACTS (in thousands)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	1820.8	998.2 54.8	482.0 26.5	237.1 13.0	27.0 1.5	76.5 4.2
1962....	1958.1	1074.5 54.9	487.9 24.9	280.5 14.3	31.4 1.6	83.7 4.3
1963....	2042.4	1132.7 55.5	504.0 24.7	288.1 14.1	32.2 1.6	85.4 4.2
1964....	2145.8	1206.5 56.2	500.1 23.3	315.6 14.7	33.8 1.6	89.8 4.2
1965....	2194.7	1234.4 56.2	495.6 22.6	335.9 15.3	35.9 1.6	92.9 4.2
1966....	2300.3	1301.6 56.6	509.0 22.1	353.2 15.4	37.5 1.6	99.1 4.3
1967....	2460.9	1410.8 57.3	532.1 21.6	362.9 14.7	39.5 1.6	115.6 4.7
1968....	2526.5	1459.4 57.8	541.4 21.4	363.0 14.4	41.8 1.7	120.8 4.8
1969....	2567.4	1500.1 58.4	540.5 21.1	362.5 14.1	42.3 1.6	122.0 4.8

Source: Tables O-1 (1961), O-6 (1962–63), C-6 (1964–69), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

Remarks: Numbers in upper left—in thousands. Numbers in lower right—percent of total.

TABLE 3

NUMBER OF ENROLLEES/CONTRACT
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	3.01	3.05	2.79	3.26	3.49	2.90
1962....	2.99	3.01	2.78	3.25	3.39	2.91
1963....	3.00	3.01	2.81	3.31	3.41	2.92
1964....	3.12	3.13	2.88	3.39	3.57	3.03
1965....	3.13	3.15	2.89	3.39	3.58	3.06
1966....	3.11	3.13	2.88	3.36	3.54	3.00
1967....	3.11	3.13	2.88	3.35	3.49	3.00
1968....	3.09	3.12	2.87	3.34	3.45	2.97
1969....	3.09	3.31	2.86	3.32	3.48	2.98

Source: Computed from Appendix Tables 1 and 2.

TABLE 4

SUBSCRIPTION INCOME (in thousands of dollars)
BOTH OPTIONS

Year	Total*	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961...	393,550.8	230,325.0	102,283.0	53,311.7	7,631.6	18,652.6
1962...	327,038.5	191,914.5	77,688.2	49,798.9	7,636.9	16,123.2
1963...	349,961.8	202,811.2	80,749.8	51,431.9	7,968.8	17,097.0
1964...	370,911.5	216,033.4	85,343.0	60,592.7	8,942.3	19,511.6
1965...	537,243.3	316,860.2	122,742.3	86,331.6	11,309.3	24,999.1
1966...	522,055.1	302,690.2	121,310.8	89,815.9	11,238.3	23,283.5
1967...	616,862.8	378,007.5	124,163.4	101,767.2	11,554.7	33,239.0
1968...	632,646.0	386,223.0	133,720.0	100,137.3	11,312.8	36,366.2

Source: Tables O-3 (1961), O-1 and O-2 (1962), C-1 and C-2 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

Remarks: * does not include "community-rated" plans. Numbers in thousands.

TABLE 5

DOLLAR VALUE OF BENEFITS PER ENROLLEE

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	50.78	51.30	45.93	48.40	63.85	75.69
1962....	50.64	51.31	48.71	47.42	55.25	62.71
1963....	55.39	56.31	54.03	51.54	57.21	64.42
1964....	59.76	59.85	61.49	54.96	57.33	69.45
1965....	76.83	77.82	80.55	67.45	71.42	85.27
1966....	68.87	68.13	71.69	66.70	62.04	76.82
1967....	75.86	76.24	77.56	70.43	63.38	87.48
1968....	87.23	89.05	87.56	78.56	73.23	97.74

Source: Computed from Tables O-3 and C-3, Annual Reports, U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 6

AVERAGE AMOUNT OF BENEFITS PAID PER CLAIM (Total)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	$219.80	$273.95	$243.95	$210.34	$79.80	$ 88.70
1962....	220.15	278.68	264.02	197.23	69.11	78.38
1963....	228.39	282.60	270.41	205.11	71.47	80.54
1964....	225.29	271.63	284.37	199.09	71.45	80.94
1965....	249.30	296.92	303.98	216.41	81.58	96.43
1966....	230.93	259.09	306.25	220.32	76.12	90.61
1967....	251.07	279.61	326.29	245.48	80.45	106.49
1968....	258.76	272.86	349.91	262.60	96.13	121.15

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 7

AVERAGE AMOUNT OF BENEFITS PER CONTRACT
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	$152.82	$156.62	$128.20	$157.55	$222.54	$219.26
1962....	150.80	152.92	135.50	156.03	187.74	181.76
1963....	167.20	170.75	151.68	170.86	196.88	188.05
1964....	184.53	185.81	175.59	184.96	204.20	208.20
1965....	241.16	244.79	232.77	233.16	270.70	260.96
1966....	214.05	212.95	206.31	223.94	219.22	230.86
1967....	235.77	238.70	223.21	235.74	221.60	266.69
1968....	269.90	277.53	251.28	262.09	252.98	290.63

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 8

AVERAGE AMOUNT OF BENEFITS PAID PER CLAIM (NON-MATERNITY)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	$218.58	$277.25	$253.51	$210.34	$74.04	$81.96
1962....	216.89	279.63	271.44	191.05	64.59	71.97
1963....	225.09	282.66	277.16	198.77	67.74	72.78
1964....	220.93	270.74	282.49	191.71	68.35	74.48
1965....	243.65	294.95	299.30	209.71	78.43	89.29
1966....	223.11	251.87	301.15	214.00	73.52	84.08
1967....	242.10	270.88	319.43	236.41	77.81	99.08
1968....	249.15	262.80	342.92	255.48	93.37	111.11

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 9

AVERAGE AMOUNT OF BENEFITS PAID PER CLAIM (MATERNITY)

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	$179.81	$189.74	$144.57	$180.41	$170.71	$271.90
1962....	211.67	222.48	150.77	231.79	187.09	302.72
1963....	218.40	230.90	147.72	249.51	178.80	330.59
1964....	253.38	242.84	254.30	263.71	196.00	363.23
1965....	289.62	281.91	305.93	285.78	194.79	375.45
1966....	300.17	293.17	326.00	279.09	227.08	394.67
1967....	345.36	334.53	374.07	339.84	226.77	423.81
1968....	382.65	365.69	417.09	374.03	269.17	515.95

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 10

PER CAPITA EXPENDITURES FOR PERSONAL HEALTH SERVICES

Year	Total Personal Health Expenditures (in millions)	Civilian Population Estimate (in millions)	(1)÷(2)	Per Capita Hospital Expenditures	Net Non-Hosp. Per Capita
1961.....	$25,821	181,207	142.49	53.70	88.79
1962.....	27,131	183,796	147.61	56.77	90.84
1963.....	29,088	186,667	155.82	61.45	94.37
1964.....	32,408	189,372	171.13	65.68	105.45
1965.....	34,942	191,894	182.09	68.47	113.62
1966.....	38,742	193,767	199.94	77.13	122.81
1967.....	43,879	195,666	224.25	88.79	135.46
1968.....	50,508*	197,560	255.65	105.00	150.65

Source: Column (1): Stat. Abs. U.S., 1969, Table 83, p. 64. Column (2): Stat. Abs. U.S., 1969, Table 2, p. 4. Column (4): Stat. Abs. U.S., 1966, Table 89, p. 70 (1961–63); 1969, Table 81, p. 63 (1964–68).
Remarks: * Estimated.

TABLE 11

NET DOLLAR NON-HOSPITAL BENEFITS/ENROLLEE
BOTH OPTIONS
(Net of Estimated Value of Hospital Benefits)

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	19.96	19.95	15.31	15.15	40.29	56.72
1962....	22.55	20.89	22.64	20.57	34.46	45.98
1963....	24.18	22.63	24.16	22.16	36.99	47.66
1964....	25.19	23.23	24.55	24.92	34.88	50.69
1965....	32.37	29.85	31.52	32.94	43.42	63.71
1966....	28.42	25.93	29.15	27.76	38.02	57.18
1967....	31.75	29.13	32.35	29.94	38.12	66.26
1968....	35.97	35.11	33.27	30.98	44.24	72.04

Source: Computed as per text from Tables O-3 and C-3, Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance, *AHA Guide Issue*, 1969, and Appendix Table 10.
Remarks: Compare with Table 5, Dollar Value of Benefits per Enrollee.

TABLE 12

PERCENT OF AVERAGE PER CAPITA EXPENDITURES FOR PERSONAL HEALTH SERVICES COVERED BY FEHB BENEFITS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	35.6	36.0	32.2	34.0	44.8	53.2
1962....	34.3	34.8	33.0	32.1	37.4	42.5
1963....	35.5	36.1	34.7	33.1	36.7	41.3
1964....	34.9	35.0	35.9	32.1	33.5	40.6
1965....	42.2	42.7	44.2	37.0	39.2	46.8
1966....	34.4	34.1	35.9	33.4	31.0	38.4
1967....	33.8	34.0	34.6	31.4	28.3	39.0
1968....	34.1	34.8	34.2	30.7	28.6	38.2

Source: Computed from Appendix Tables 5 and 10.

TABLE 13

PERCENT OF AVERAGE *Non-Hospital* PER CAPITA EXPENDITURES FOR PERSONAL HEALTH CARE COVERED BY FEHB BENEFITS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	22.5	22.5	17.2	17.1	45.4	63.9
1962....	24.8	23.0	24.9	22.6	37.9	50.6
1963....	25.6	24.0	25.6	23.5	39.2	50.5
1964....	23.9	22.0	23.3	23.6	33.1	48.1
1965....	28.5	26.3	27.7	29.0	38.2	56.1
1966....	23.1	21.1	23.7	22.6	31.0	46.6
1967....	23.4	21.5	23.9	22.1	28.1	48.9
1968....	23.9	23.3	22.1	20.6	29.4	47.8

Source: Computed from Appendix Tables 10 and 11.

TABLE 14

HOSPITAL DAYS/1000 ENROLLEES (NON-MATERNITY)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	880.8	896.4	875.4	950.6	673.8	542.4
1962....	762.5	826.2	707.9	729.0	538.0	454.2
1963....	802.0	865.4	767.4	754.7	519.9	430.8
1964....	831.5	880.5	880.5	722.4	539.9	451.3
1965....	999.5	1078.4	1102.3	775.8	629.6	484.7
1966....	840.2	876.5	883.6	808.6	498.9	408.0
1967....	815.6	871.0	836.0	748.8	467.1	392.5
1968....	835.1	878.6	884.5	775.1	472.3	418.7
Average All Years..	845.9	896.6	867.2	783.1	542.4	447.8

Source: Computed from Tables O-3 and C-3, Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 15

HOSPITAL ADMISSION RATES/1000 ENROLLEES (NON-MATERNITY)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	108.9	105.0	103.2	106.8	133.9	70.8
1962....	92.1	98.8	77.8	98.3	97.5	57.3
1963....	94.0	99.5	85.4	97.2	92.1	55.4
1964....	94.9	101.9	83.8	95.5	91.4	54.2
1965....	106.7	117.2	99.5	94.0	92.6	58.7
1966....	91.6	97.8	84.7	92.7	70.9	46.0
1967....	88.9	96.5	81.6	85.5	69.5	44.3
1968....	88.9	95.4	84.4	85.5	64.4	48.2
Average All Years..	95.8	101.5	87.6	94.4	89.0	54.4

Source: Tables O-3 and C-3, Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 16

AVERAGE L.O.S. FOR HOSPITALIZED BENEFICIARIES (NON-MATERNITY)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	8.47	8.54	8.48	8.90	5.03	7.66
1962....	8.28	8.36	9.10	7.42	5.52	7.93
1963....	8.53	8.69	8.98	7.76	5.65	7.78
1964....	8.76	8.64	10.50	7.57	5.91	8.32
1965....	9.36	9.20	11.08	8.26	6.80	8.25
1966....	9.17	8.97	10.43	8.73	7.03	8.87
1967....	9.18	9.03	10.25	8.76	6.72	8.85
1968....	9.39	9.21	10.48	9.06	7.33	8.69

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 17

AVERAGE L.O.S. FOR HOSPITALIZED BENEFICIARIES (MATERNITY)
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	NA	NA	NA	NA	NA	NA
1962....	4.32	4.51	4.32	4.08	3.73	4.37
1963....	4.41	4.60	4.21	4.26	3.55	3.86
1964....	4.25	4.60	3.80	3.81	3.75	4.00
1965....	4.16	4.14	4.26	4.20	3.79	4.04
1966....	3.95	3.92	4.03	3.92	4.46	4.05
1967....	3.93	3.86	3.94	4.28	4.62	3.60
1968....	3.79	3.68	3.90	4.07	4.83	3.93

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 18

PERCENT OF ENROLLEES RECEIVING BENEFITS
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	23.1	18.7	18.8	23.0	80.0	85.3
1962....	23.0	18.4	18.4	24.0	79.9	80.0
1963....	24.5	19.9	20.0	25.1	80.1	80.0
1964....	26.5	22.0	21.8	27.6	80.2	85.8
1965....	30.8	26.2	26.5	31.2	87.5	88.4
1966....	29.8	26.3	23.4	30.3	81.5	84.8
1967....	30.2	27.3	23.8	28.7	78.8	82.1
1968....	33.7	32.6	25.0	29.9	76.2	80.7

Source: Tables O-3 (1961–62), C-3 (1963–68) computed from Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 19

PERCENT OF ENROLLEES RECEIVING NON-MATERNITY BENEFITS
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	21.1	16.8	16.7	20.5	79.4	85.0
1962....	21.5	16.8	16.9	22.5	79.6	79.7
1963....	22.9	18.4	18.6	23.8	79.7	79.6
1964....	25.1	20.7	20.2	26.3	80.1	84.7
1965....	29.4	24.6	25.2	29.9	87.4	88.3
1966....	28.9	25.3	22.5	29.3	81.4	84.6
1967....	29.3	26.3	22.8	28.1	78.7	81.9
1968....	32.9	31.8	24.1	29.2	76.0	80.6

Source: Tables O-3 (1961–62), C-3 (1963–68) computed from Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 20

PERCENT OF NON-MATERNITY CLAIMS INVOLVING HOSPITALIZATION
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	49.2	62.6	61.9	52.1	16.9	8.3
1962....	42.8	58.8	46.0	43.7	12.2	7.2
1963....	41.1	54.0	46.0	40.8	11.6	7.0
1964....	37.7	49.3	41.6	36.3	11.4	6.4
1965....	36.3	47.6	39.5	31.4	10.6	6.7
1966....	31.7	38.6	37.7	31.6	8.7	5.4
1967....	30.3	36.7	35.7	30.4	8.8	5.4
1968....	27.0	30.0	35.0	29.3	8.5	6.0

Source: Computed from Tables O-3 (1961–62), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 21

PERCENT OF BENEFICIARIES RECEIVING NON-MATERNITY BENEFITS
WHOSE CLAIMS DID NOT INVOLVE HOSPITALIZATION
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	NA	NA	NA	NA	NA	NA
1962....	46.2	16.6	44.4	49.8	82.3	92.6
1963....	43.1	19.2	44.3	50.7	80.7	92.6
1964....	56.0	26.6	45.9	55.9	84.9	93.3
1965....	59.5	29.4	47.2	62.6	82.0	91.7
1966....	54.8	41.7	48.7	62.0	83.9	93.5
1967....	55.8	43.5	50.1	63.0	83.7	93.5
1968....	54.7	43.9	50.1	63.6	83.3	93.0

Source: Computed from Tables O-3 (1962), C-3 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

TABLE 22

ADMINISTRATIVE EXPENSES AS A PERCENT OF SUBSCRIPTION INCOME
BOTH OPTIONS

Year	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961.....	4.1	4.0	5.5	9.3	5.4
1962.....	3.1	3.1	5.5	8.2	5.6
1963.....	3.8	3.4	5.6	8.5	5.5
1964.....	4.0	3.7	5.2	7.9	5.3
1965.....	3.5	3.0	4.9	7.7	5.3
1966.....	3.4	2.6	4.4	7.7	5.0
1967.....	3.3	2.9	4.1	7.6	5.1*
1968.....	4.1	2.8	4.4	8.2	6.6*

Source: Table O-3 (1961), O-1 and O-2 (1962), C-1 and C-2 (1963–68), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

Remarks: * for those reporting as "experience-rated" plans.

TABLE 23

EXPECTED BENEFIT VALUE PER AVERAGE PREMIUM DOLLAR PAID
BOTH OPTIONS

Year	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961	.8525	.7742	.9282	.9793	1.0115
1962	.8214	.8136	.8948	.8143	.8339
1963	.9101	.9038	.9742	.8440	.8237
1964	.9753	.9877	.9849	.8038	.8434
1965	1.0559	1.0839	1.0860	1.0301	1.0162
1966	.9232	.8824	.9310	.7675	.8736
1967	.8748	.9695	.9088	.7347	.8947
1968	.9765	.9843	.9804	.8129	.9034
Average All Years	.9237	.9249	.9610	.8483	.9001

Source: Computed as described in text and from Appendix Table 7.

TABLE 24

NUMBER OF ANNUITANT CONTRACTS
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961						
1962						
1963	116.3	62.7 53.9	33.0 28.4	14.9 12.8	1.3 1.1	4.4 3.8
1964	160.9	86.8 53.9	45.2 28.1	20.7 12.9	1.9 1.2	6.3 3.9
1965	206.3	113.0 54.8	57.1 27.7	25.9 12.6	2.4 1.2	8.0 3.9
1966	272.9	151.1 55.4	73.7 27.0	34.5 12.6	3.3 1.2	10.3 3.8
1967	310.6	172.6 55.6	83.9 27.0	38.8 12.5	3.7 1.2	11.6 3.7
1968	353.3	196.3 55.6	95.8 27.1	44.0 12.5	4.3 1.2	12.9 3.6
1969	393.6	218.7 55.6	105.6 26.8	50.1 12.7	4.7 1.2	14.5 3.7

Source: Table O-1 (1961), O-6 (1962–63), C-6 (1964–69), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

Remarks: Number in upper left—in thousands. Number in lower right—percent of total.

SUPPLEMENTARY TABLES

TABLE 25

PERCENT OF TOTAL CONTRACTS HELD BY ANNUITANTS
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	.....	.....	.....	.....	.....	.....
1962....	.....	.....	.....	.....	.....	.....
1963....	5.7	5.5	6.5	5.2	4.0	5.2
1964....	7.5	7.2	9.0	6.6	5.6	7.0
1965....	9.4	9.1	11.5	7.7	6.7	8.6
1966....	11.9	11.6	14.5	9.8	8.8	10.4
1967....	12.6	12.2	15.8	10.7	9.4	10.0
1968....	14.0	13.5	17.7	12.1	10.3	10.7
1969....	15.3	14.6	19.5	13.8	11.1	11.9

Source: Computed from Appendix Tables 2 and 24.

TABLE 26

NUMBER OF SELF-ONLY CONTRACTS
BOTH OPTIONS

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	474.4	267.6 56.4	137.3 28.9	39.0 8.2	7.1 1.5	23.4 5.0
1962....	498.5	283.9 57.0	137.7 27.6	44.1 8.8	7.7 1.5	25.1 5.0
1963....	512.3	296.1 57.8	138.4 27.0	44.4 8.7	7.8 1.5	25.6 5.0
1964....	525.6	306.9 58.4	136.1 25.9	48.4 9.2	8.0 1.5	26.2 5.0
1965....	529.4	309.3 58.4	133.7 25.3	52.0 9.8	8.3 1.6	26.1 4.9
1966....	572.7	336.0 58.7	139.8 24.4	58.1 10.1	9.3 1.6	29.5 5.2
1967....	626.6	373.7 59.6	146.7 23.4	61.4 9.8	10.2 1.6	34.6 5.5
1968....	656.0	393.6 60.0	151.0 23.0	63.0 9.6	11.0 1.7	37.4 5.7
1969....	672.4	405.6 60.3	152.7 22.7	64.5 9.6	11.1 1.7	38.5 5.7

Source: Tables O-1 (1961), O-6 (1962–63), C-6 (1964–69), Annual Reports of U.S. Civil Service Commission, Bureau of Retirement and Insurance.

Remarks: Numbers in upper left—in thousands. Numbers in lower right—percent of total.

TABLE 27

PERCENT OF TOTAL CONTRACTS WHICH ARE SELF ONLY

Year	Total	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961....	26.1	26.8	28.5	16.4	26.3	30.7
1962....	25.5	26.4	28.2	15.7	24.5	30.0
1963....	25.1	26.1	27.5	15.4	24.2	30.0
1964....	24.5	25.4	27.2	15.3	23.7	29.2
1965....	24.7	25.1	27.0	15.5	23.1	28.1
1966....	24.9	25.8	27.5	16.4	24.8	29.8
1967....	25.5	26.5	27.6	16.9	25.8	29.9
1968....	26.0	27.0	27.9	17.4	26.3	31.0
1969....	26.2	27.0	28.3	17.8	26.2	31.6

Source: Computed from Appendix Tables 2 and 26.

TABLE 28

AVERAGE MONTHLY/ANNUAL PREMIUM WEIGHTED BY PERCENTAGE OF CONTRACTS OF EACH TYPE

	Service Benefit Plan	Indemnity Benefit Plan	Employee Organization Plans	Individual Practice Plans	Group Practice Plans
1961.....	$15.309 $183.71	$13.800 $165.60	$14.144 $169.73	$18.937 $227.24	$18.063 $216.76
1962.....	15.515 186.18	13.878 166.54	14.531 174.37	19.213 230.56	18.163 217.96
1963.....	15.635 187.62	13.986 167.83	14.616 175.39	19.440 233.28	19.026 228.31
1964.....	15.876 190.51	14.815 177.78	15.649 187.79	21.171 254.05	20.571 246.85
1965.....	19.318 231.82	17.986 214.75	17.891 214.69	21.899 262.79	21.401 256.81
1966.....	19.222 230.66	19.483 233.80	20.045 240.54	23.802 285.62	22.022 264.26
1967.....	22.739 272.87	19.187 230.24	21.616 259.39	25.133 301.60	24.840 298.08
1968.....	23.685 284.22	21.273 255.28	22.278 267.34	25.935 311.22	26.809 321.71

Source: Computed from annual publications (Series BRI-41) describing premiums and benefits for all plans, Bureau of Retirement and Insurance, U.S. Civil Service Commission, various years.