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AUTHOR	Farley, Pamela J.
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ABSTRACT

This report presents estimates on private health insurance for 1977, based on the National Medical Care Expenditure Survey (NMCES). The NMCES obtained information on private insurance policies in force in 1977 from the employers and insurance companies of a nationally representative sample of the civilian noninstitutionalized population. A brief discussion of the financing of health care through private health insurance and the importance of employer-sponsored plans is included. A detailed description of insurance benefits of the population under age 65 in the United States is provided. Their insurance is characterized in terms of the inclusion of specific health services, the provisions of basic and major medical insurance, and the benefits applicable to expenses for a variety of health services. The distribution of insurance characteristics is described in general and in relation to group enrollment, employment, and the characteristics of insured persons. The description of private health insurance in the United States incorporates more recent data from other sources to complement the more detailed and comprehensive estimates from NMCES. Eleven summary tables, 75 tables, and 13 figures are included in the text. (Author/NB)

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NCHSR National Health Care Expenditures Study

Private Health Insurance in the United States

Data Preview 23

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Abstract

The estimates in this report are for 1977 and are based on the National Medical Care Expenditure Survey (NMCES). Information on private insurance policies in force in 1977 was obtained from the employers and insurance companies of a nationally representative sample of the civilian noninstitutionalized population. A brief discussion of the financing of health care through private health insurance and the importance of employer sponsored plans introduces a detailed description of insurance benefits of the population under age 65 in the United States. Their insurance is characterized in terms of the inclusion of specific health services, the provisions of basic and major medical insurance, and the benefits applicable to expenses for a variety of health services. The distribution of insurance characteristics is described in general and in relation to group enrollment, employment, and the characteristics of insured persons. The description of private health insurance in the United States incorporates more recent data from other sources to complement the more detailed and comprehensive estimates from NMCES.

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Private Health Insurance in the United States

Data Preview 23

Data from the Health Insurance/Employer Survey of the 1977 National Medical Care Expenditure Survey

Pamela J. Farley

September 1986

DHHS Publication No. (PHS) 86-3406

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
National Center for Health Services Research
and Health Care Technology Assessment

September 1986

Background of the study

Pamela J. Farley, Ph.D., is an economist with the National Health Care Expenditures Study, Division of Intramural Research, National Center for Health Services Research and Health Care Technology Assessment.

Although Pamela J. Farley made the most important contribution to the preparation of this report, the organization and analysis of the data, as well as the initial draft of the estimates, reflect the collective effort of the following National Health Care Expenditures Study staff members, without whose efforts publication would not have been possible: **Amy Bernstein**, M.H.S.A., Service Fellow; **Gail Lee Cafferata**, Ph.D., sociologist; **Michael M. Hagan**, Cand. Ph.D., economist; **Alan C. Monheit**, Ph.D., senior economist; and **Claudia L. Schur**, Ph.D., Service Fellow.

Information on the National Health Care Expenditures Study is available from: Daniel C. Walden, Ph.D., Senior Research Manager, National Center for Health Services Research and Health Care Technology Assessment, 3-50 Park Building, Rockville, MD 20857; 301/443-4836.

Data in this and other National Health Care Expenditures Study reports on health insurance coverage, benefits, and costs were obtained from the Health Insurance Employer Survey (HIES) and the Employer/Health Insurance Cost Survey (EHICS) of the National Medical Care Expenditure Survey (NMCES). Detailed information on the sample design and weighting procedures, including the data collection instruments, is in *Estimation and Sampling Procedures in the NMCES Insurance Surveys*, NHCES Instruments and Procedures 3 (Cohen and Farley, 1984).

The following public use tapes and related documentation are currently available from the National Technical Information Service, Springfield, VA 22161: National Medical Care Expenditure Survey Household Data, Person Records SAS File (PB83-198077) and Person Records EBCDIC File (PB83-199539); Hospital, Physician, Nonphysician, and Dental Event Records SAS Files (PB85-246619) and EBCDIC Files (PB85-246635); Prescribed Medicines, Vision Aids, and Medical Equipment and Supplies Event Records SAS Files (PB85-246627) and EBCDIC Files (PB85-246643); NMCES Health Insurance/Employer Survey Data, Private Health Insurance Coverage Status, Premiums, and Sources of Payment, and Private Insurance Benefits of the Population Age 65 and Older, SAS Files (PB86-194669) and EBCDIC Files (PB86-194685). Benefit data from the NMCES Health Insurance/Employer Survey for persons under age 65 will be available in 1986-1987.

Examining how Americans use health care services and determining national patterns of health expenditures and insurance coverage are the goals of a landmark study by the National Center for Health Services Research and Health Care Technology Assessment. The National Health Care Expenditures Study (NHCES) is a major component of the Center's Intramural Research Program. NHCES provides information on a number of critical issues of national health policy. Topics of particular interest to government agencies, legislative bodies, health professionals, and others concerned with health care policies and expenditures include:

- The cost, utilization, and budgetary implications of changes in federal financing programs for health care and of alternatives to the present structure of private health insurance
- The breadth and depth of health insurance coverage
- The proportion of health care costs paid by various insurance mechanisms
- The influence of Medicare and Medicaid programs on the use and costs of medical care
- How and why Medicaid participation changes over time
- Patterns of use and expenditures as well as sources of payment for major components of care
- The cost and effectiveness of federal, state, and local programs aimed at improving access to care
- The loss of revenue resulting from current tax treatment of medical and health insurance expenses, particularly with regard to the benefits currently accruing to different categories of individuals and employers, and the potential effects on the federal budget of proposed changes to tax laws
- How costs of care vary according to diagnostic categories and treatment settings.

The data for these studies were obtained in the National Medical Care Expenditure Survey (NMCES), which has provided the most comprehensive statistical picture to date of how health services are used and paid for in the United States. The survey was completed in September 1979.

Data were obtained in three separate, complementary stages. About 14,000 randomly selected households in the civilian, noninstitutionalized population were interviewed 6 times over an 18-month period during 1977 and 1978. This survey was complemented by additional surveys of physicians and health care facilities providing care to household members during 1977 and of employers and insurance companies responsible for their insurance coverage.

Funding for NMCES was provided by the Center, which cosponsored the survey with the National Center for Health Statistics. Data collection for the survey was done by Research Triangle Institute, NC, and its subcontractors, National Opinion Research Center of the University of Chicago, and Abt Associates, Inc., Cambridge, MA, under contract HRA 230-76-0268. Data processing support was provided by Social and Scientific Systems, Inc., Bethesda, MD, under contracts 233-79-3022 and 233-80-3012.

This report is one of a Data Preview series presenting estimates of several key measures of health insurance. The series also has provided estimates of the use of and expenditures for ambulatory services provided by physicians and other health care professionals, inpatient hospital services, dental services, and prescribed medicines.

Even though NMCES was designed to meet specific research goals, NCHSR is making the information collected in these surveys available to researchers and other interested persons through public use tapes.

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NHCES reports are available from the NCHSR Publications and Information Branch, 1-46 Park Building, Rockville, MD 20857; 301/443-4100.

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Private Health Insurance in the United States

Pamela J. Farley

1. Introduction

Private insurance plays a central role in the financing of health care in the United States. Roughly four out of five Americans have some form of private coverage, and about 3 percent of the Gross National Product is spent on health insurance premiums (Gibson et *al*., 1984). Benefits paid under private insurance account for a larger share of health care expenditures than direct payments by patients or the combined spending under Medicare and Medicaid. Given this predominance, private insurance figures significantly in most issues related to the financing of health care, whether they arise from concern about costs, the inability of some population groups to afford care, or protection of medical providers against bad debt and the financial burden of providing free care to patients unable to pay for it. Furthermore, since most private insurance is obtained as a fringe benefit of employment, it is a major expense to employers and an important factor in the compensation of employees.

The following discussion of the financing of health care through private health insurance, and the importance of employer sponsored plans, is intended as a brief introduction to a detailed description of insurance benefits in the United States and their distribution both in general and among particular population groups in 1977.

Financing health care through private insurance

Enrollment in private health insurance and the benefit provisions of private plans affect both the magnitude and the distribution of personal health care expenditures in the United States. By redistributing the burden of payment, insurance not only makes possible but even encourages the use of services and thus greater national expenditures for health care. No less important, differences in the extent of private insurance are one of the major reasons for the uneven distribution of expenditures, especially out-of-pocket expenditures, across different population groups. For example, a disproportionate number of the working poor are neither enrolled in Medicaid nor hold private insurance; they not only receive less health care than their insured counterparts, but also pay more out of pocket despite lower rates of use (Berk and Wilensky, 1984).

More than two-thirds of all insured persons in the United States rely exclusively on private insurance, since most of the civilian population is not eligible for Medicare, Medicaid, or other public programs that finance health care. Even as many as two-thirds of the elderly, who with few exceptions are covered by Medicare, purchase private coverage to supplement their Medicare benefits rather than pay program deductibles and coinsurance directly (Cafferata, 1984a). Only about a tenth of the U.S. population remains uninsured over the course of a year instead of obtaining private insurance, although a roughly equal percentage are uninsured for at least part of the year (Walden, Wilensky, and Kasper, 1985).

A second factor shaping the financing of health care through private insurance is the nature of the benefits in terms of the types of services covered and the structure of coverage. Traditionally, insurers have tended to offer the most comprehensive benefits for hospital and related inpatient services, while coverage for other types of care, such as ambulatory physician visits, has been much less extensive. Only about 10 percent of hospital expenses of the population under 65 are paid out of pocket (Taylor, 1983) compared to about 45 percent of ambulatory physician expenses (Wilensky and Bernstein, 1983). On average, even privately insured Medicare beneficiaries pay 25 percent of their health expenses out of pocket (Cafferata and Wilson, forthcoming), because their private insurance is typically limited to the same services as those covered by Medicare and may adopt other Medicare restrictions such as the program limit on allowable charges for reimbursement (Cafferata, 1984a).

The provisions of private insurance thus affect not only the distribution of payment between the insurer and insured but also influence the nature and growth of health expenditures. Private insurance can encourage or discourage the use of certain types of care, depending, for example, on whether or not insurers pay for certain kinds of providers, or on the relative comprehensiveness of benefits for alternative methods of treatment. Patients insulated by insurance from all or part of the cost of their care are known to incur more expenses (Newhouse et *al*., 1981; Newhouse, 1978). These effects figure importantly in attempts to control the level and mix of health expenditures. Concern over health care costs has meant greater

scrutiny of deductibles, coinsurance requirements, and other cost-sharing provisions and has encouraged a search for alternatives to the traditional methods of financing health insurance and organizing health care.

Although the private health insurance industry is still dominated by the two types of insurers that have traditionally sold most of the health insurance in the United States, that is, the nonprofit Blue Cross and Blue Shield (BC-BS) plans and commercial insurance companies, attempts to reorganize financing arrangements along other than traditional insurance lines continue. They include the promotion of Health Maintenance Organizations (HMOs) and, more recently, Preferred Provider Organizations (PPOs). HMOs provide to their enrollees, on a prepaid basis, a comprehensive range of services, including routine physical examinations and other preventive services commonly excluded by traditional insurance plans. Under Preferred Provider Organization schemes, groups of physicians or hospitals offer discounts to a third-party insurer who, in return, directs patients to the PPO through financial incentives such as reduced cost sharing (Rice et *al.*, 1985).

Employment as a major source of coverage

Because employers play as important a role in the provision of private insurance as private insurance plays in the financing of care, the concerns about the effects of financing health care through private insurance, as well as competition for the health care dollar among insurers, tend to focus on employment-related plans. In 1977, nine out of 10 of the civilian noninstitutionalized privately insured under 65 were covered by group plans (nearly all of them employment-related); and slightly more than a third of those on Medicare who had private insurance were covered through groups sponsored by their current or former employer (Farley, 1985a; Cafferata, 1984a,b). Although employee health benefits are a relatively small proportion of national payroll expenses (about 3.5 percent by 1982), employer premium contributions as a percentage of total labor compensation have increased at a 5 percent annual rate from 1970 to 1982 (Chollet, 1984). By 1977, about two-thirds of all private health insurance premiums were paid by employers on behalf of their employees (Cafferata, 1984b). The majority of medium and large employers pay the entire cost of coverage for their employees, and a substantial number pay for dependents as well (Bureau of Labor Statistics, 1984).

In the year of the survey, about 80 percent of employees in the United States worked for firms where they were eligible for health insurance (Taylor and Lawson, 1981). Firms that do not offer any health benefits at all tend to be small and not unionized, to hire seasonal workers, and to employ relatively large numbers of low-wage employees (Taylor and Lawson, 1981; Battelle, 1980; Rossiter and Taylor, 1982; Monheit et *al.*, 1985). Part-time and low-wage workers are least likely to be eligible for an insurance plan offered by their employer to other employees (Monheit et *al.*, 1985). Also, there is often little opportunity for individual choice in the selection of insurance plans. Most employees are offered only one plan by their employer; in 1977, the reference year of this report, more than 80 percent had only one plan option (Farley and Wilensky, 1983).

The system of employment-related group insurance conveys a number of advantages for enrollees. First, administrative and marketing economies make group plans less costly than purchasing insurance directly from an insurer. Second, enrollment is based primarily on employment and only indirectly on the individual employee's need for health insurance. For this reason, and because it is possible to base the group's premium on actuarial experience, insurers charge less for their risk. Finally, and in contrast to the cost of a nongroup policy purchased from an insurance company out of an employee's take-home pay, the premiums paid by employers on behalf of their employees are not subject to income or payroll taxes. The estimated savings to employees amounted to $33 billion in 1983 (Taylor and Wilensky, 1983), a loss in tax revenue nearly equal to the cost of Medicaid for the noninstitutionalized population (see also Wilensky, 1982).

An unfortunate effect of employment-based health insurance is that persons who are least able to pay for health care have the least insurance, because lack of employment (or full-time employment) not only means less income but also a lack of group health insurance. The only alternatives are to purchase a nongroup plan, a usually less generous and more expensive option in terms of out-of-pocket premiums, or to accept the risk of

doing without any insurance at all. Thus, largely because employment varies widely among sociodemographic groups, so does enrollment in private insurance and benefit provisions.

The content and structure of this report

The estimates in this report are for 1977 and are based on the National Medical Care Expenditure Survey (NMCES), a survey of the health insurance and health expenditures of a nationally representative sample of the civilian noninstitutionalized population. Information on private insurance policies in force in 1977 and a description of the amount and financing of premiums were obtained from employers and insurance companies in the Health Insurance/Employer Survey (HIES) of NMCES.

Unlike much of the available information on private health insurance, which is obtained in the aggregate from employers and insurance companies, this report refers to the insurance of individual persons. In addition, all benefits available to persons with more than one plan are taken into account, whether the plans were held as a dependent of another or as the primary insured. (See the section on data sources and methods of estimation for a description of insurance industry procedures for coordinating the benefits of multiple plans, and the treatment of persons with multiple plans in this report.) By the same token, all insured persons—and not just the employees and policy holders known to employers and insurers contacted in most other insurance surveys—are included in the estimates. Because the health insurance data collected in NMCES are population based and apply to a representative national sample of persons, the characteristics of these persons can be related to the characteristics of their insurance, permitting a description of the variation in private insurance associated with economic and sociodemographic characteristics.

It should be noted that persons 65 and older are excluded from this description of the private health insurance of the population, although as many as two-thirds of the elderly purchase private insurance to supplement their Medicare coverage and employers pay as much as a third of their premiums (Cafferata, 1984a). However, since many of the elderly do not work and many employers do not offer insurance to their retirees, employment-related group insurance plays a far less important role in their insurance. Also, the elderly have different benefit requirements because of their almost universal Medicare coverage. Their insurance is often specifically tailored to the gaps in Medicare and offers, for example, much less major medical insurance than is characteristic of most other health insurance.

Other reports on the National Health Care Expenditures Study contain information from the HIES on the private insurance of the elderly Medicare population in 1977 (Cafferata 1984a), estimates of the availability and financing of employment-related insurance (Taylor and Lawson, 1981), expenditures and sources of payment for private insurance in the United States (Cafferata, 1984b), the coverage of health services offered by both private and public sources (Farley, 1985a), and changes in the health insurance status of persons over time (Walden, Wilensky, and Kasper, 1985). The distribution and payment of health care expenses by private insurance as reported in the NMCES household survey is described in a series of NHCES publications (1981-1986) on expenditures and sources of payment for a variety of health services.

This report completes the series of national estimates of private health insurance in the United States provided by the NMCES. In part 2, summary Tables A-K and appended Tables 1-43 provide a detailed description of the characteristics of the private insurance held by persons under 65 in terms of the inclusion of specific health services, the provisions of their basic and major medical insurance, and the benefits applicable to expenses for a variety of health services. Part 3 and appended Tables 44-75 compare the coverage of different population groups, defined by employment status and related characteristics as well as by more conventional sociodemographic categories. Part 4 summarizes and comments on some of the changes in private insurance since the time of the more detailed estimates available from NMCES. Separate sections provide specific information on the derivation of the data and the construction of variables, and on sampling information and standard error estimates that must be considered in assessing the confidence levels of the estimates presented. A glossary of selected insurance terms is provided for ease of reference.

2. The extent and structure of private health insurance benefits

Private health insurance coverage varies widely in the range of services for which benefits are provided, the extent of reimbursement for each covered service, and various exclusionary provisions such as those limiting benefits to specific providers or time periods. In practice, the comprehensiveness of insurance with regard to each of these aspects, often referred to as the breadth and depth of coverage, is determined by the presence and mix of basic and major medical coverage, the two major types of plans marketed by Blue Cross-Blue Shield (BC-BS) and commercial insurers.

Basic insurance plans usually cover inpatient hospital and physician services as well as outpatient diagnostic and laboratory procedures. They typically exclude many ambulatory services, such as prescribed medicines, and specify separate deductibles, payment rates, and benefit limits for each covered service. Common limits may apply to a group of related services such as those provided during the course of a hospitalization. While designed primarily to provide limited protection for the most expensive services, it is common for basic plans to fully cover as many as 120 to 365 days of hospital care.

Major medical insurance, by contrast, usually involves a single set of benefits that apply in common to a wide range of services. Under this type of plan, benefits extend not only to inpatient care but also to such services as physician office visits, medicines prescribed out of hospital, and outpatient care for mental health conditions. The insurer typically pays a specified share (generally 80 percent) of the total expense for all covered services in excess of a deductible (usually $100 per year), up to a fairly high maximum.

The insured is required to pay the deductible and the share of expenses not covered by the plan as coinsurance. Total coinsurance payments by the insured often are limited to a specified amount, however, by a provision known as an "out-of-pocket limit" or a "stop-loss provision," and the insurer pays all remaining covered expenses in full. Many major medical plans limit deductibles for family members to a specified amount (typically $300 per family) or waive the deductible for the rest of the family once two or three members have met their deductibles. Most plans include a "carryover" provision, allowing unreimbursed expenses near the end of the year to be counted against the next year's deductible. Thus, major medical plans are designed to offer protection both in the event of large medical bills, as well as for a large part of expenses associated with more ordinary types of care.

Generally, major medical insurance is designed to supplement basic coverage, and in fact, about two thirds of the privately insured in 1977 had a basic plan in combination with major medical insurance; only 16.9 percent held basic coverage alone (Table 1). In plans of this type, the major medical deductible and other benefit provisions apply to expenses unreimbursable under the basic plan (the difference between the surgeon's charge and the basic benefit schedule, for example), as well as to services covered only by the major medical plan. By offering coverage in addition to and beyond the coverage extended by basic plans, major medical insurance thus constitutes a second tier of benefits: it provides protection by means of ceilings on out-of-pocket expenditures and often quite high maximum benefits and extends coverage beyond the limited range of services typical of conventional basic plans.

In contrast to these supplementary plans, there are comprehensive major medical plans designed to stand alone. Here, the deductible and other provisions apply to all expenses for all covered services, not only to unreimbursed expenses under a basic plan. Modified comprehensive major medical insurance, yet another type of major medical plan, generally provides full coverage without deductibles or coinsurance for inpatient care, resembling a basic plan combined with supplementary major medical coverage. About 15.7 percent of the privately insured had only major medical insurance in 1977.

While the bulk of private health insurance thus consists of basic and major medical plans standing alone or, more often, in conjunction, two other types of coverage reflected in the following estimates should be mentioned. They are hospital indemnity plans and Health Maintenance Organizations (HMO) and similar prepaid plans. Hospital indemnity plans offer specified cash payments for each day of hospitalization regardless of the expenses actually incurred, although payment is typically not generous in relation to actual hospital expenses. This type of coverage was held by only 1.8 percent of the privately insured.

Health Maintenance Organizations and other prepaid plans, in addition to offering coverage against the risk of large health care expenses, provide fairly comprehensive coverage (*i.e.* both primary and hospital care) in return for a prepaid fee, usually without deductibles and coinsurance for most services. Despite the differences between conventional insurance plans and HMOs in the structure of benefits and provider service arrangements, they are not described separately in this report. Instead, the coverage of their enrollees (4 percent of the privately insured population in 1977 under age 65) is characterized in terms of traditional insurance benefits, which from this perspective generally resemble a very comprehensive basic plan. Some HMOs impose copayments with a limit on the total out-of-pocket expense and in this respect may resemble major medical insurance. Others may offer supplementary major medical plans to cover the expense of services not provided directly by the prepaid plan.

With few exceptions, therefore, the level and type of benefits available to insured persons overall and for specific services can be described in terms of their respective basic and major medical coverage, the latter providing an especially good indication of the adequacy of coverage for costly or serious illness. (Tables 1 and 2 offer a detailed breakdown of service coverage and of specific major medical provisions.) In fact, 82.3 percent of the privately insured under age 65 were covered by major medical insurance in 1977, and of these, four out of five held supplementary major medical coverage and the rest had comprehensive major medical plans.

Major medical insurance

The most typical major medical benefits, applicable to 50.6 percent of persons with major medical insurance, provided for a deductible of $100 (usually on an annual basis) and 20 percent coinsurance (Table A). Only 7.1 percent of persons with major medical insurance faced a deductible higher than $100; 33.2 percent had a deductible below $100 (including 19.4 percent with a $50 deductible).

The other fairly standard feature of major medical insurance, a 20 percent coinsurance rate, applied to the benefits of three-quarters of those with major medical insurance. Of those with coverage requiring less than 20 percent coinsurance, many were covered by more than one major medical plan and had virtually complete coverage as a consequence. Only 1.3 percent were faced with paying more than 20 percent of the expense for most covered services.

Table A. Summary of major medical coverage for persons under 65 (United States, 1977).

	Thousands	Percent
Major medical coverage	**126,098**	**100.0**
Deductible less than $100		**33.2**
Coinsurance less than 20 percent		14.6
Coinsurance 20 percent		18.3
Coinsurance more than 20 percent		0.3
Deductible $100		**59.7**
Coinsurance less than 20 percent		8.7
Coinsurance 20 percent		50.6
Coinsurance more than 20 percent		0.4
Deductible more than $100		**7.1**
Out-of-pocket limit less than $750		**35.5**
Maximum total benefit $250,000 or less		19.0
Maximum total benefit more than $250,000		16.5
Out-of-pocket limit $750 or more		**23.3**
Maximum total benefit $250,000 or less		13.4
Maximum total benefit more than $250,000		9.9
No out-of-pocket limit		**41.2**
Maximum total benefit $250,000 or less		37.7
Maximum total benefit more than $250,000		3.5

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Maximum insurer liability for benefits was most commonly $100,000 or $250,000, and typically was specified on a lifetime basis. About 30 percent of those insured had more than $250,000 in coverage. While the maximum benefits payable by insurers were generally quite large, they must be considered in conjunction with another provision of major medical coverage, out-of-pocket limits, to determine the extent of protection. Without such a limit, and at a 20 percent coinsurance rate, beneficiaries whose medical bills actually reached the $250,000 ceiling would stand to pay more than $60,000. In fact, as many as 41.2 percent with major medical coverage had no limit on their out-of-pocket expense, and only 35.5 percent were protected from out-of-pocket expenses of $750 or more.

Coverage of services

A description of the comprehensiveness of private insurance benefits requires an assessment of both basic and major medical coverage, particularly with respect to specific types of health expenses. Attention to specific services and the interrelationships between basic and major medical coverage are important for several reasons. First, the coverage offered by basic plans varies considerably in comprehensiveness and usually involves separate benefit provisions for different types of expense. Second, major medical insurance plans differ in the services they cover and do not always specify identical benefits for all covered services. For the two thirds of the privately insured who held major medical insurance in combination with a basic plan in 1977, basic plan benefits thus played an important role in determining total benefits for many types of expenses, particularly as major medical deductibles and coinsurance rates were quite standardized. Conversely, the coverage of the 16.9 percent of privately insured with only basic benefits reflects the lack of the more generous overall coverage typical of major medical plans.

The following therefore describes in considerable detail the coverage of the privately insured for specific services or types of care; the benefits of those with basic, major medical, or both types of coverage for a particular service; and maximum levels of basic and major medical benefits, considered in conjunction where applicable. In addition, the coordination of related benefits (e.g. for hospital inpatient and skilled nursing facility stays) is shown, as are special provisions governing eligibility or exclusions, such as for maternity care or mental health conditions. For ease of reference, major aspects of coverage and benefits are summarized in Tables B-K; detailed coverage and benefit estimates are presented in Tables 3-43, at the end of part 2.

Benefits for inpatient and related services

Coverage for most inpatient services, including room and board, miscellaneous hospital, and physician charges, was generally high, reflecting the traditional and continuing emphasis on insurance for hospital care (Tables 3-13). Although typically an extension of hospital care, skilled nursing facility stays were insured only half as often as most other inpatient services. (Inpatient coverage for mental health conditions is discussed separately because it often involves special exclusions and limitations.)

Hospital room and board. Nearly everyone with private health insurance (97.7 percent) was covered for hospital room and board, the majority (60.5 percent) under both basic and supplementary major medical coverage. For 74.3 percent with these benefits, they amounted either to the full cost of a semiprivate room or a scheduled daily benefit equal to at least the average semiprivate room charge in 1977 (Table B). Full semiprivate daily benefits defined in this fashion and without a deductible were available to 68.9 percent. Reflecting the modification in some plans of standard major medical provisions so as to insure hospital benefits fully, more than half of those with only major medical insurance were fully insured for the daily semiprivate room charge.

Table B. Summary of inpatient benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Hospital room and board	**150,742**	**100.0**
Full semiprivate charge or $90 or more per day		**74.3**
High maximum[a] with deductible		3.5
High maximum without deductible		49.7
Other maximum with deductible		1.9
Other maximum without deductible		19.2
Less than full semiprivate charge		**25.1**
Hospital indemnity only		**0.6**
Room and board, miscellaneous charges[b]	**150,265**	**100.0**
Full semiprivate charge or $90 or more per day		**74.7**
Full miscellaneous benefits		72.7
Partial miscellaneous benefits		2.0
Less than full semiprivate charge		**25.3**
Full miscellaneous benefits		14.1
Partial miscellaneous benefits		11.2

[a] 365 days of coverage or $50,000 of basic benefits; 90 days or $10,000 of basic benefits with major medical benefits of at least $100,000; or only major medical benefits and a maximum of $250,000 or more. [b] Excluding hospital indemnity.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Maximum coverage limits for room and board also offered high levels of protection to many of the insured. Basic plans covered 365 days of hospital care for nearly half of those with any basic coverage, and for 55.8 percent of those without supplementary major medical insurance. More than three-quarters of persons with supplementary coverage had more than 90 days of basic benefits, and about two-thirds of those without basic benefits (*i.e.* with comprehensive major medical coverage) had an applicable maximum of $250,000 or more. In all, 49.7 percent of those with room and board benefits were protected by maximum benefits of this magnitude, as well as by full semiprivate benefits and no obligation to pay a deductible.

While most of the 25.7 percent with less than full semiprivate coverage had major medical benefits to supplement their basic benefits or held comprehensive major medical coverage, there was a small group of the privately insured with quite limited benefits for even this most expensive of health services. Of those with any hospital room and board benefits, 1.9 percent had only basic or only major medical benefits of $60 or less, another 1.3 percent were partially insured without supplementary major medical coverage, and 0.6 percent relied entirely on hospital indemnity plans, most paying $50 or less per day in 1977.

Miscellaneous hospital charges. Coverage for miscellaneous hospital charges was at levels at least comparable to room and board coverage. These charges apply to commonly incurred inpatient services such as diagnostic procedures, drugs, supplies, and operating room fees, and on average are as high as room and board charges, particularly during the first days of a hospital stay. Ignoring deductibles or the level of maximum benefits, the percent with full coverage for these expenses exceeded the percent fully covered for room and board (86.8 percent compared to 74.7 percent, excluding persons with only hospital indemnity plans; see Table B). Even among the 25.3 percent with only partial room and board benefits, 14.1 percent were fully covered for miscellaneous charges.

Skilled nursing facilities. In contrast to the almost universal and generally comprehensive coverage of hospital inpatient stays, benefits for care in skilled nursing facilities (SNF) were available to only 48.7 percent of the privately insured. The daily charge was less likely to be covered at 100 percent. Only 54.6 percent of those with SNF benefits were covered fully for the daily room charge or at least $50 per day (Table C).

Table C. Summary of skilled nursing facility benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Skilled nursing facility	**74,733**	**100.0**
Maximum shared with hospital[a]		**62.0**
Full semiprivate charge		38.5
Less than full semiprivate charge		23.5
Basic maximum not shared with hospital		**38.0**
High maximum,[b] full semiprivate charge		8.3
High maximum, less than full semiprivate charge		2.9
Other maximum, full semiprivate charge		7.8
Other maximum, less than full semiprivate charge		19.0

[a]Includes persons with major medical only and with dollar maximum. [b]365 days of coverage or $25,000.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Unlike hospital care, SNF stays were rarely covered under a combination of basic and major medical benefits (13.1 percent of those with coverage), while roughly 40 percent were covered under either basic or major medical plans. Here, the basic plans more frequently provided full daily coverage. This type of benefit was typically coordinated with or treated like a hospital benefit, allowing the substitution of SNF for hospital care without insuring nursing home care more generally. Almost two-thirds of those with SNF benefits were covered by plans that did not distinguish between a day of SNF care or a day in a hospital, covering both under the same maximum benefit. This figure not only includes persons with a maximum dollar benefit under major medical insurance, where common benefits for all services are typical, but also 37 percent having a common maximum on basic benefits for SNF and hospital care. Some plans made no distinction between hospital and SNF care at all, and a significant number of major medical plans specified a limit on days of SNF care that did not apply to hospital days. Prior hospitalization permitting only a specified number of days between hospital discharge and SNF admission was often a prerequisite for coverage of SNF care.

Surgery and inpatient physician care. Inpatient physician services, including surgery and anesthesiology, were almost always included in the benefits of the privately insured, and about 60 percent with benefits held combined basic and major med-

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Table D. Summary of inpatient surgery and other inpatient physician benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Surgery (percent of UCR charge)	**148,764**	**100.0**
100 percent		**48.5**
80-99 percent		**20.4**
Less than 80 percent		**31.1**
Basic and major medical		23.1
Basic or major medical only		8.0
Other inpatient physician services	**146,655**	**100.0**
Service benefits		**12.1**
UCR charge		**54.8**
100 percent		32.2
Less than 100 percent		22.6
Fee schedule		**33.2**
Basic, but with major medical		26.1
Basic or major medical		7.1

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

ical coverage. Of those with surgery benefits, half were fully insured for the usual, customary, and reasonable (UCR) surgeon's fee or an equivalent fee schedule (Table D). Of the remainder, a fifth were insured for 80 to 99 percent of the UCR charge and another fifth by less generous basic fee schedules coupled with supplementary major medical insurance. Only 8 percent, almost entirely persons with only basic benefits, were covered for less than 80 percent of the UCR charge and had no other coverage. Anesthesia benefits were less likely to involve a basic fee schedule and were generally insured at 100 percent of the UCR charge. Slightly less than half of those with surgery benefits also were insured for an assistant surgeon's fee. In 1977, less than 5 percent were explicitly insured for the cost of a second surgical opinion and these were mandatory in even fewer cases.

Coverage and benefit levels were similar for inpatient medical care. Of those with benefits (95.7 percent of the privately insured), 44.3 percent were insured for 100 percent of the UCR charge or had a service benefit guaranteeing that the physician would accept the plan's reimbursement as payment in full. A similar percentage had either partial coverage of the UCR charge, mostly under major medical plans alone, or basic fee schedules supplemented by major medical insurance. Only 7.1 percent were limited to benefits under a fee schedule without other coverage.

Outpatient services

Variations in the comprehensiveness of coverage for different types of outpatient care were wide (Tables 14-27). For some services, especially those offering alternatives to inpatient care like outpatient surgery or laboratory and diagnostic testing, coverage was both widespread and comprehensive; about half of those insured for these services held both major medical and basic plans. By contrast, benefits for such services as physician office visits and prescribed medicines were predominantly restricted to major medical coverage and were subject to deductibles and other cost-sharing provisions. But preventive care, such as routine physical examinations, was rarely included in either major medical or basic benefits (see part 3), and coverage was similarly rare for home health care provided by nonphysicians.

Outpatient hospital benefits. Coverage for hospital facility charges associated with outpatient surgery and outpatient treatment of accidents was frequent and comprehensive (Table E). Roughly 95 percent of the privately insured had benefits for these services, usually without a deductible or other cost sharing, but with a requirement for treatment of accidents within three days or less. Even persons with only major medical insurance (roughly a sixth of persons covered for these services) were likely to be fully covered for these expenses.

Insurance for outpatient facility emergency treatment was slightly less common. This benefit was held by 80.9 percent of the privately insured

Table E. Summary of outpatient facility benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Outpatient surgery facility	**144,708**	**100.0**
No deductible, full charge		84.9
Other		15.1
Outpatient facility accident benefits	**145,434**	**100.0**
No deductible, full charge		87.1
Other		12.9
Outpatient facility emergency benefits	**124,070**	**100.0**
No deductible, full charge		53.3
Other		46.7
Supplemental accident expense	**35,599**	**100.0**
$300		53.5
Other		46.5

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

and typically was included under traditional major medical provisions involving a deductible and coinsurance. About half of those with benefits, closely corresponding to the proportion with basic benefits either alone or in conjunction with major medical coverage, had full coverage without a deductible or coinsurance. The other half, generally persons with only major medical coverage, were not fully covered and typically faced a $100 deductible and coinsurance.

In addition to benefits specifically for outpatient hospital care, about a quarter of the privately insured were covered by special provisions for treatment of accidents. Most often, this benefit was a lump sum (usually $300) for expenses not covered elsewhere, but almost a tenth with a supplemental accident benefit were fully insured for all expenses, with no limit specified.

Outpatient diagnostic and laboratory tests. While most of the privately insured (93 percent) had coverage for outpatient diagnostic and laboratory tests, whether in a hospital clinic, physician's office, or in an independent laboratory, the level of benefits varied widely (Table F). This was mainly attributable to differences in basic benefits, which were held by three-quarters of those insured for this service. Generally, they provided full coverage of at least initial expenses, although limits of $200 or less per year (sometimes per disability) were not uncommon. Four out of five with only major medical benefits were subject to copayments. Overall, two fifths of all persons with outpatient diagnostic benefits were insured for more than $200 of UCR charges, a quarter had $200 or less (but most of these had supplementary major medical insurance), and a third were only partially covered for even initial diagnostic expenditures.

Table F. Summary of ambulatory benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Diagnostic (laboratory, X-ray)	**142,583**	**100.0**
100 percent of UCR charge		**68.0**
Basic limit more than $200 or no limit		42.6
Basic limit $200 or less,		
with major medical supplement		21.9
without major medical supplement		3.5
Less than 100 percent of UCR charge, fee schedule, or copayment		**32.0**
Physician office visits	**127,669**	**100.0**
Service benefit, 100 percent of UCR charge, or $20 or more per visit		**20.5**
With deductible		13.1
Without deductible		7.4
80-99 percent of UCR charge, copayment $4 or less, or $16-19 per visit		**70.9**
Other		**8.6**
Prescribed medicines	**125,421**	**100.0**
No deductible, 100 percent		1.1
Major medical only, 20 percent coinsurance and $100 deductible		47.2
Copayment		6.9
Other		44.8

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Physician office visits. Cost-sharing requirements were predominant for physician office visits. Reflecting the fact that 82.1 percent of the privately insured with this type of benefit were covered solely under a major medical plan, benefits were equivalent to 80 to 99 percent of the UCR charge for four-fifths of those covered (see Table F). These benefits, while mostly specified as 80 percent of the UCR charge under a major medical plan, also included fee schedules ($16-19 per visit, compared to an average visit charge of $20 without tests in 1977) or copayments (less than $4). About 9 percent of persons with benefits for office visits were insured for less than 80 percent of the UCR charge or its equivalent. Only 20.5 percent of persons had service benefits, full UCR coverage, or a scheduled benefit of at least $20, and two-thirds of these were subject to a deductible, typically $50 or more.

Prescribed medicines and medical supplies. Closely following the structure of physician office benefits, coverage for prescribed medicines and for durable equipment and supplies was held by roughly four-fifths of the privately insured, usually under a major medical plan only. Just 1.1 percent were insured at 100 percent of the charge for prescribed medicines without deductibles (see Table F). Coinsurance at the 20-percent level and a $100 deductible were the most common provisions, applying to nearly half of those with coverage for prescribed medicines and roughly two-thirds in the case of medical supplies. Copayments, typically a dollar or two per prescription, were common for plans other than major medical insurance (basic plans or separate prescription plans). As a rule, benefits only covered medications requiring a prescription; over-the-counter items, even if prescribed by a physician, were typically excluded.

Home health care. Home health care by nurses and other nonphysician providers ranked low as a

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service covered by private insurance. Only a quarter of the privately insured had any benefits, 70.6 percent of these under a basic plan only. Basic benefits offered full coverage to 67.7 percent of all persons with benefits, but 30.1 percent were subject to a visit maximum, often 90 visits or less (see Table G). While the frequency of visits within this maximum was rarely restricted, prior hospitalization was specified as a prerequisite for over a third of those covered.

Benefits for mental health conditions

Insurance for mental health conditions was typically more restrictive than for general medical conditions. Not only were mental health conditions sometimes specifically excluded, but even where coverage was provided, it often stipulated lower benefits than for general medical care (Tables 28-35). This distinction was most noticeable for, but not restricted to, outpatient services. Group therapy and care by a social worker was specifically excluded from the benefits of half of those with outpatient coverage, and for 40 percent this exclusion applied as well to treatment by an independent psychologist, regardless of the site of care.

Even for inpatient care of mental health conditions, coverage was held by only 82.4 percent of the privately insured, compared to nearly universal coverage of other inpatient hospital care. The difference was substantial as well for physician care: 78.6 percent were covered for inpatient physician services for mental conditions, compared to 95.7 percent for medical conditions; 71.4 percent compared to 83.3 percent were covered for outpatient physician services. Treatment for alcoholism, drug addiction, or self-inflicted injury was sometimes specifically excluded. (It should be noted that the fact of coverage for mental health conditions was often unclear from the policies and brochures on which these estimates are based, and that coverage was not assumed if not specified.)

Inpatient mental health benefits. One indication of the special treatment of mental health conditions was the higher proportion of persons with only major medical benefits for inpatient treatment. More than 40 percent of those with inpatient hospital benefits were covered by major medical plans alone, as were 54.7 percent of those with inpatient physician benefits. Persons with hospital coverage for mental health conditions less often had full semiprivate or at least $90-a-day coverage (66.1 percent compared to 74.3 percent for general hospital care; Table H; see also Table B). Also, the most typical inpatient physician benefit, applying to 48.5 percent of persons with benefits, was partial coverage of usual, customary, and reasonable charges rather than full UCR charge coverage or a service benefit.

Maximum inpatient benefits for mental health conditions, particularly under basic coverage, were much lower. For two-thirds of persons with only basic benefits, limits for mental health conditions were specified, including 27.6 percent with 30 days of benefits or less and 18.6 percent with 31-90 days, usually on an annual basis. Even among those with supplementary major medical insurance, more than half were covered for 90

Table G. Summary of home health care benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Home health care	**37,119**	**100.0**
100 percent basic benefit		**67.7**
90 visits or fewer, or dollar maximum		30.1
More than 90 visits		37.6
Basic benefit less than 100 percent or fee schedule		**8.1**
Major medical only		**24.2**

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table H. Summary of inpatient mental health benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Hospital benefits	**126,371**	**100.0**
Full semiprivate charge or $90 or more per day		**66.1**
High maximum[a] without deductible		17.9
High maximum with deductible		7.8
Other maximum		40.4
Less than full semiprivate charge		**33.8**
High maximum[a]		16.8
Other maximum		17.0
Inpatient physician benefits	**120,499**	**100.0**
Service benefit		**12.6**
UCR charge		**74.3**
100 percent		25.8
Less than 100 percent		48.5
Fee schedule		**13.2**
Basic, with major medical		5.6
Basic or major medical only		7.6

[a] 365 days of coverage or $50,000 of basic benefits; 90 days or $10,000 of basic benefits with major medical benefits of at least $100,000; or only major medical benefits and a maximum of $250,000 or more.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table I. Summary of outpatient mental health benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Outpatient physician benefits	**109,478**	**100.0**
No visit maximum and $1,000 or more		**52.4**
Full coverage of UCR charge		7.4
80-99 percent of UCR charge[a]		19.9
Less than 80 percent of UCR charge[b]		25.1
Visit maximum or less than $1,000		**47.7**
Full coverage of UCR charge		8.8
80-99 percent of UCR charge		11.0
Less than 80 percent of UCR charge		27.9

[a] Includes fee schedule of $20 or more and $5 copayment or less. [b] Includes fee schedule less than $20 and copayments greater than $5.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

days or less under their basic plan. Although such limits were less typical of major medical insurance, 27.8 percent of persons with major medical inpatient mental health benefits were insured for $50,000 or less, and another 4.8 percent were insured for only a limited number of days.

Outpatient mental health benefits. Insurance for outpatient physician services for mental health conditions was comparable to other physician coverage in terms of the predominance of major medical plans (basic coverage only was held by 9.4 percent of all with coverage) but provided far less comprehensive benefits. More than half with benefits were insured for less than 80 percent of the UCR charge or its equivalent (25.1 percent with unlimited visits and benefits of $1,000 or more and 27.9 percent with a limited number of visits or a maximum benefit less than $1,000, usually on an annual basis; Table I). This reflects the lower rate of reimbursement for outpatient mental health care, often 50 percent, under many major medical plans. Also, a substantial number of persons with major medical insurance were covered by fee schedules for mental health care, often for only $10 to $15 per visit. Only 7.6 percent of persons with major medical coverage had no separate limit on outpatient mental health benefits; 17.5 percent had a limit of $500 or less and 18.2 percent between $501 and $1,000, while 6.5 percent were restricted to a limited number of visits (most often 50 visits). Thus, in contrast to coverage for other services, a maximum benefit for outpatient mental health care was, if anything, more common under major medical insurance than under basic plans.

Maternity care

The 1978 Federal Pregnancy Discrimination Act, enacted in the year following the survey on which the present estimates are based, requires all employers offering health insurance plans to provide the same benefits for maternity services as for other health conditions. Because most persons with private insurance are covered by employer plans, benefits for maternity care now correspond closely to benefits for hospital and physician services. In 1977, benefits for maternity care still were sometimes excluded from private insurance or, more often, specified separately with restricted benefit provisions (Tables 36 to 38).

Although close to 90 percent of the privately insured in general and women age 15-44 in particular were entitled to some benefits for maternity care, only about four out of five were insured for care beyond medical complications of pregnancy. Only half of women of child-bearing age with hospital benefits for a normal delivery were fully covered for a semiprivate room without limit on days of care (Table J). Slightly more than 60 percent of women with benefits for the physician's delivery fee were insured for 100 percent of the UCR charge, while 11.8 percent had partial

Table J. Summary of maternity benefits for privately insured women aged 15-44 (United States, 1977).

	Thousands	Percent
Hospital charges for normal delivery	**30,207**	**100.0**
Full coverage, no limit		**54.3**
Without deductible		51.4
With deductible		2.9
Partial coverage		**45.7**
Less than $500 or fewer than 4 days		6.8
Other		38.9
Physician's delivery fee	**29,420**	**100.0**
UCR charge		**73.0**
100 percent		61.2
Less than 100 percent		11.8
Fee schedule		**27.1**
Eligibility requirements[a]	**31,076**	
Waiting period after enrollment		31.7
Must be insured at time of conception		49.3
Coverage ends with termination of employment		5.9
Must be eligible at time of delivery		25.3
Dependents other than spouse ineligible		38.7
Must elect dependent coverage		14.1

[a] For total with any coverage for normal pregnancies. Multiple restrictions may apply.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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coverage of UCR and 27.1 were covered under a fee schedule (18.9 percent allowing less than $500).

More importantly, eligibility for maternity benefits was restricted. Nearly 32 percent of insured women age 15-44 had plans requiring a waiting period for maternity coverage after enrollment. Nearly half were required to be enrolled at the time of conception. Some policy holders, even women wanting coverage for themselves, were required to purchase dependent coverage in order to obtain maternity benefits. Dependents other than the spouse of the policy holder were often excluded.

Dental care

Like home care, dental care was infrequently insured in 1977, with only a quarter of the privately insured covered for at least some dental services. Unlike other types of insurance, however, dental benefits included preventive as often as other services, and benefits for routine and other preventive dental care were the most comprehensive (Table K). Nearly 40 percent of persons insured for routine examinations (including 35.8 percent without a deductible) had full coverage, and benefits for prophylactic treatment were at similar levels. Generally, although there were annual limits on these services, at least two visits per year were allowed. One person in ten had an incentive plan encouraging preventive care, offering higher rates of reimbursement for other dental expenses on the condition of regular visits to a dentist.

Full coverage of other common dental care—fillings, simple extractions, root canal work, and subgingival curettage, a periodontic procedure—was less common. Only about a tenth with coverage were insured for 100 percent of the UCR charge, and 80-99 percent of the UCR charge or a fee schedule was the most common benefit level.

Benefits for elective and more extensive procedures such as crowns, bridges, dentures, and especially orthodontia were substantially lower. For example, 49.9 percent of those with benefits for bridgework were insured for no more than half the expense or had a scheduled benefit of less than $100. Of the small number insured for orthodontia (half of those with any dental benefits, or 13 percent of the privately insured), two-thirds were insured for 50 percent of the expense or less or limited to $500 in total benefits. While most dental expenses were subject to a common annual maximum (the median amount was $750), the maximum benefit for orthodontia was $750 or less for 70.4 percent of those covered; usually there was a special limit on orthodontic services, often specified on a lifetime basis. Waiting periods of a year or more were required for 5 to 10 percent of persons covered for prosthodontia, orthodontia, or crowns. Prior authorization of service was required for more than half of those with dental coverage, especially for expensive types of care.

Table K. Summary of dental benefits for privately insured persons under 65 (United States, 1977).

	Thousands	Percent
Covered for dental services	**39,008**	
Prophylaxis		92.5
Examination		89.2
X-ray		90.2
Amalgam filling		91.7
Synthetic filling		88.6
Periodontia		78.2
Root canal		89.9
Simple extraction		93.5
Crowns		86.0
Bridge work		77.1
Full dentures		87.8
Orthodontia		51.0
Benefits, examinations	**34,781**	**100.0**
Full coverage, no deductible		35.8
75 percent, $10, or less		31.5
Other		32.7
Benefits, bridge work	**30,070**	**100.0**
At least 80 percent or more than $300		28.5
Not more than 50 percent or less than $100		49.9
Other		21.7
Benefits, orthodontia	**19,880**	**100.0**
At least 80 percent, up to $751 or more		18.8
Not more than 50 percent, up to $500, or less		66.2
Other		15.0

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Summary

The preceding estimates (see also the appended Tables 1 to 43) indicate varying levels of comprehensiveness of insurance coverage, both in terms of the range of services covered and the levels of individual benefits. Reflecting the traditional emphasis on hospital coverage, 90 percent or more of persons under age 65 and privately insured were covered for expenses related to an inpatient hospital admission (room and board charges, miscellaneous hospital expenses, surgery, anesthesia, and inpatient medical services). Coverage was at similar levels for outpatient tests and diagnostic procedures and for use of outpatient hospital facilities for surgery and accidents; the use of outpatient facilities and procedures has been emphasized by some insurance plans as a substitute for inpatient care. Private insurance was likely to cover maternity care, ambulance trips, medical supplies and equipment, physician office visits, hospital expenses for mental health conditions, and prescribed medicines. Inpatient and outpatient physician services for mental health conditions were covered less frequently and with specific exclusions, and care in a skilled nursing facility, available to just under half of the privately insured, was limited by special provisions, such as a prior hospital admission. Dental care, home health care, supplemental accident benefits, vision care, and hearing care were rarely covered.

Coverage under both a basic and a major major medical plan was common for the most frequently insured services. Thus, roughly 60 percent of persons with any hospital inpatient benefits had both basic and major medical insurance, a combination providing two separate but complementary tiers of benefits: coverage of initial room and board and most inpatient expenditures were governed by the deductible and reimbursement provisions of the basic plan, with coverage for high levels of expense governed by the limits on out-of-pocket expenditures and maximum benefits of the major medical plan. Persons without this combination of basic and major medical benefits were about evenly divided between those with only basic or only major medical benefits, a pattern which extended not only to coverage of inpatient hospital and physician services but also to the use of hospital facilities for accidents and surgery and outpatient diagnostic testing.

By contrast, physician office visits, prescribed medicines, medical supplies and durable equipment, and outpatient treatment of mental health conditions were generally insured only under major medical plans. The benefit provisions applicable to these services consequently tended to be characteristic of major medical insurance, with deductibles and maximum benefits common to other covered services. Dental insurance, where available, as well involved substantial cost sharing. It limited benefits for expensive restorative or corrective services (bridges, orthodontia) and, although preventive and routine services were as widely included as other services, generally did not provide full coverage.

In part 3, these aggregated estimates for the entire population under age 65 (see Tables 1 to 43) are shown separately for particular population subgroups by relating their private insurance coverage first to characteristics of the primary insured and then to general demographic characteristics. Much of the variation in both service coverage and depth of benefits described in part 2 can be shown to reflect differences between group and nongroup insurance. In turn, the availability of group insurance is closely tied to participation in the labor force, so that population differences in type and comprehensiveness of health insurance coverage reflect corresponding differences in the fact and characteristics of employment.

Table 1. Basic and major medical coverage of the U.S. population: Number and percent distribution of privately insured persons under 65, by most commonly covered services (United States, 1977).

Type of service	Population covered	Percent covered	Basic benefits only	Basic and major medical benefits	Major medical benefits only
	Thousands		Percent distribution		
Any service[a]	153,315	100.0	16.9	66.6	15.7
Hospital, room and board	149,846	97.7	21.7	60.5	17.8
Hospital, miscellaneous	149,729	97.7	21.6	60.7	17.8
Surgeon	148,764	97.0	22.0	60.3	17.8
Physician, inpatient medical	146,655	95.7	19.2	56.7	24.1
Anesthesiologist	144,594	94.3	23.5	54.2	22.4
Outpatient hospital facility					
Accident	145,434	94.9	31.7	51.7	16.7
Surgery	144,708	94.4	28.9	53.9	17.2
Emergency	124,070	80.9	23.3	30.3	46.4
Outpatient diagnostic	142,583	93.0	19.8	54.9	25.4
Maternity	133,983	87.4	29.2	47.3	23.5
Ambulance	131,280	85.6	11.8	33.4	54.9
Durable equipment and supplies	128,261	83.6	9.8	4 3	85.9
Physician office visits	127,669	83.3	8.0	9.9	82.1
Mental health care, hospital	126,371	82.4	31.9	26.5	41.6
Prescribed medicines	125,421	81.8	10.7	1.6	87.6
Mental health care, inpatient physician	120,499	78.6	23.6	21.8	54.7
Mental health care, outpatient physician	109,478	71.4	9.4	6.6	83.9
Skilled nursing facility	74,733	48.7	44.3	13.1	42.6
Dental	39,008	25.4	—	—	—
Home health care	37,119	24.2	70.6	5.3	24.2
Supplemental accident expense	35,599	23.2	75.2	1.4	23.4
Vision	12,593	8.2	—	—	—
Hearing	5,436	3.5	—	—	—
Hospital indemnity	2,709	1.8	—	—	—

[a]About 1 percent of the privately insured had neither basic nor major medical, but only dental, drug, or hospital indemnity plans —: Not applicable.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 2. Major medical insurance: Percent distribution of privately insured persons under 65 with major medical coverage, by selected major medical provisions (United States, 1977).

Major medical benefits		Supplementary[a]	Comprehensive only	All
	Thousands	Percent distribution		
Persons with benefits	126,098	79.8	20.2	100.0
Deductible				
None		3.9	3.6	7.4
Less than $50		3.1	1.0	4.1
$50		15.3	4.1	19.4
$51-99		0.8	1.5	2.3
$100		52.2	7.5	59.8
More than $100		4.7	2.4	7.1
Coinsurance rate				
Less than 20 percent		17.0	7.2	24.2
20 percent		61.8	12.6	74.5
More than 20 percent		0.9	0.4	1.3
Limit on out-of-pocket expense				
Zero		1.2	1.2	2.4
$1-300		12.7	2.1	14.8
$301-500		6.8	2.0	8.8
$501-750		6.6	2.9	9.5
$751-1,000		4.0	1.9	5.9
$1,001-2,000		8.1	4.0	12.1
$2,001-5,000		2.2	0.7	2.9
$5,001-10,000		2.0	*0.2	2.1
More than $10,000		*0.2	*0.1	0.3
No limit		36.0	5.4	41.3
Maximum benefit				
$1-10,000		3.4	0.8	4.2
$10,001-30,000		11.1	1.6	12.6
$30,001-50,000		9.8	1.4	11.2
$50,001-100,000		8.2	2.2	10.5
$100,001-250,000		23.9	7.7	31.6
$250,001-500,000		10.0	1.2	11.1
$500,001-1,000,000		4.6	2.2	6.7
$1,000,000		1.3	*0.2	1.5
No maximum		7.7	2.8	10.6

[a]Includes those with supplementary and comprehensive major medical coverage (3.7 percent of the privately insured with major medical coverage). *Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 3. Hospital room and board benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Room and board benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	149,846	21.7	60.5	17.8	100.0
Daily benefit					
Percent of semiprivate daily charge					
100 percent		16.2	47.2	9.5	72.9
Less than 100 percent[b]		1.3	1.9	6.2	9.4
Daily benefit					
More than $60		0.9	5.0	1.0	6.9
$60 or less		2.9	6.8	1.0	10.7
Deductible[c]					
None		20.5	57.7	9.3	87.5
$1-99		0.6	3.2	3.1	7.0
$100		0.0	0.0	4.0	4.1
More than $100		*0.2	*0.1	1.1	1.4

[a]Persons with basic and major medical benefits are categorized by their basic benefits. [b]Includes persons with copayments or benefits limited to ward accommodations. [c]Deductible applies to miscellaneous expenses as well as room and board for a small percent of persons. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 4. Miscellaneous hospital and ambulance benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Type of benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Miscellaneous hospital expense benefit					
Persons with benefits	149,729	21.6	60.7	17.8	100.0
Full coverage (day limits)					
30 days or less		0.4	0.6	0.0	0.9
31-90 days		1.1	4.5	0.0	5.5
91-364 days		4.5	13.6	0.0	18.1
365 days or more[b]		10.7	27.7	9.2	47.6
Full coverage (dollar limits)					
Less than $1000[c]		0.9	6.1	—	7.0
$1,000-$5,000[c]		0.9	5.8	—	6.7
More than $5,000[c]		0.5	0.5	—	1.1
Partial coverage					
Less than 365 days		0.8	1.0	0.1	1.9
365 days or more[b]		0.5	0.7	8.5	9.8
Dollar limit[c]		0.8	0.6	—	1.4
Ambulance benefit					
Persons with benefit	131,280	11.8	33.4	54.9	100.0
Percent of charge					
100 percent		9.6	28.1	10.2	47.9
Less than 100 percent		0.5	0.4	44.2	45.1
Allowance per trip					
$25 or less		0.5	3.2	*0.1	3.9
$26-50		0.4	1.3	0.4	2.1
More than $50		0.5	*0.2	0.4	1.1

[a]Persons with basic and major medical benefits are categorized by their basic benefits. [b]Includes unlimited benefit. [c]Persons with both dollar and day limits are categorized by their dollar maximum. * Relative standard error equal to or greater than 30 percent. —: Not applicable.
0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 5. Maximum basic hospital room and board benefits: Percent distribution of privately insured persons under 65 with basic room and board benefits only, by days or dollars of coverage (United States, 1977).

Maximum basic benefit	Persons with basic room and board benefits only	
	Thousands	Percent
	32,441	100.0
Days of coverage[a]		
30 days or less		2.8
31-90 days		8.9
91-120 days		21.5
121-364 days		7.5
365 days or more[b]		55.8
Amount of coverage		
Less than $5,000		1.4
$5,000-49,999		1.4
$50,000 or more		*0.9

[a]Persons with day and dollar limits are categorized by maximum days of coverage. [b]Includes unlimited benefit. *Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 6. Maximum basic hospital room and board benefits and major medical coverage: Percent distribution of privately insured persons under 65 with major medical benefits, by type of basic hospital benefit (United States, 1977).

Type of basic hospital benefit		Maximum major medical benefit[a]						
		Less than $50,000	$50,000-$99,999	$100,000-$249,999	$250,000	More than $250,000	Unlimited	All
	Thousands	Percent						
Persons with major medical benefits	117,405	19.5	11.6	10.8	26.3	11.2	20.6	100.0
Without basic benefits		2.8	1.9	2.7	6.9	1.3	7.4	22.9
Maximum basic benefit (day limits)[b]								
30 days or less		0.3	*0.1	0.0	0.4	*0.1	*0.2	1.1
31-90 days		4.3	2.1	1.8	4.3	0.8	2.3	15.6
91-120 days		3.6	1.9	1.4	4.8	1.0	3.6	16.4
121-364 days		1.3	0.7	1.1	1.1	1.1	1.3	6.5
365 days or more[c]		6.8	4.5	3.5	8.5	6.7	5.3	35.3
Maximum basic benefit (dollar limits)								
Less than $5,000		0.3	0.4	*0.2	*0.2	*0.1	0.3	1.5
$5,000 or more		*0.1	*0.1	*0.1	*0.1	0.0	*0.2	0.7

[a]Typically applies to other services covered under major medical plans in addition to hospital room and board. [b]Persons with day and dollar limits are categorized by maximum days of coverage. [c]Includes unlimited benefit. *Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 7. Hospital indemnity benefits: Percent distribution of privately insured persons under 65 with hospital indemnity coverage, by amount and period of benefits (United States, 1977).

Indemnity benefit	Thousands	Percent
Persons with benefits	2,709	100.0
Daily benefit		
$1-15		21.9
$16-25		12.5
$26-50		33.7
$51 or more		16.0
Not specified		16.0
Maximum benefit period		
90 days or less		10.4
91-180 days		8.9
181-270 days		*7.7
271-365 days		27.8
1-5 years		*7.1
Unlimited		23.7
Not specified		14.5

*Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 8. Skilled nursing facility benefits: Percent distribution of privately insured persons under 65 with coverage by days or dollars of basic and major medical benefits (United States, 1977).

Skilled nursing facility benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	74,733	44.3	13.1	42.6	100.0
Percent of daily charge					
100 percent		35.4	7.1	9.3	51.8
75-99 percent		1.2	0.0	16.4	17.6
Less than 75 percent		2.3	2.1	6.1	10.5
Daily benefit					
More than $50		1.4	*0.3	*0.3	2.0
$50 or less		4.4	3.8	9.9	18.1

[a]Persons with both basic and major medical benefits are categorized by their basic benefits. *Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 9. Maximum basic benefits for skilled nursing facility services: Percent distribution of persons under 65 with basic SNF benefits only, by day and dollar limits and coordination with hospital benefits (United States, 1977).

Type of basic benefit	Persons with basic SNF benefits	
	Thousands	Percent
	28,325	100.0
Benefits shared with hospital maximum	17,930	63.3
Benefits separate from hospital benefits[a]	10,395	36.7
Maximum days of coverage		
Less than 31 days		*1.6
31-90 days		6.1
91-120 days		9.8
121-364 days		3.5
365 days or more[b]		13.5
Maximum amount of coverage[a]		
Less than $50,000		*1.6
$50,000 or more		*0.5

[a]Persons with both day and dollar limits are categorized by their dollar maximum. [b]Includes unlimited benefit. *Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 10. Maximum basic skilled nursing facility benefits and major medical coverage: Percent distribution of privately insured persons under 65 with major medical benefits, by type of basic benefit (United States, 1977).

Type of basic SNF benefit		Maximum major medical benefit[a]					
		Less than $50,000	$50,000-249,999	$250,000	Less than 365 days	More than $250,000 or 365 days or more	All
	Thousands	Percent					
Persons with major medical benefits	46,407	9.4	7.1	30.7	32.1	20.6	100.0
Without basic benefits		7.3	5.0	23.8	29.0	12.6	77.7
Benefits shared with hospital maximum[b]		1.3	1.0	5.5	2.3	5.0	15.0
Basic and major medical SNF benefits separate from hospital benefits							
90 days or less		*0.7	*0.9	*0.3	*0.6	*1.0	3.5
91-364 days		*0.2	0.0	*0.1	0.0	1.2	1.4
365 days or more[b]		0.0	*0.2	*1.0	*0.2	0.0	1.4
Less than $50,000[c]		0.0	0.0	0.0	0.0	*0.9	*1.0

[a]Typically applies to other services in addition to SNF services. [b]Includes unlimited basic benefit. [c]Persons with both day and dollar limits are categorized by their dollar maximum. 0.0 indicates less than 0.05 percent. *Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 11. Coordination of hospital and skilled nursing facility benefits under basic and major medical coverage: Percent of privately insured persons under 65 with coverage (United States, 1977).

Type of benefit	Any basic SNF benefits[a]	Major medical benefits	All with SNF benefits
	Percent		
Separate from hospital benefits			
Yes	38.9	32.6	71.5
No	18.5	10.1	28.5
Included in hospital maximum			
Yes	18.5	*0.4	18.9
No	19.1	29.7	48.8
Not specified	1.2	2.5	3.8
Not separate	18.5	10.1	28.5
Prior hospitalization required			
Yes	31.7	31.4	63.1
No	9.5	6.7	16.2
Not specified	16.2	4.6	20.8
Limited days from hospital discharge to SNF admission			
Yes	23.0	27.7	50.7
No	18.5	9.6	28.2
Not specified	15.9	5.3	21.2

[a]Persons with basic and major medical benefits are categorized by their basic benefits. *Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 12. Inpatient physician benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Inpatient physician benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Surgeon					
Persons with benefits	148,764	22.0	60.3	17.8	100.0
Percent of UCR charge					
100 percent		12.8	27.7	3.9	44.4
Less than 100 percent		0.9	2.6	12.1	15.7
Fee schedule as percent of UCR charge					
100 percent		0.6	3.3	0.2	4.1
80-99 percent		0.6	4.2	0.4	5.2
Less than 80 percent		6.6	22.9	1.1	30.6
Anesthesiologist					
Persons with benefits	144,594	23.5	54.2	22.4	100.0
Percent of UCR charge					
100 percent		16.2	37.4	5.6	59.2
Less than 100 percent		1.3	2.9	16.3	20.5
Fee schedule		5.4	14.2	0.6	20.3
Other inpatient physician					
Persons with benefits	146,655	19.2	56.7	24.1	100.0
Service benefit		4.8	7.2	—	12.1
Percent of UCR charge					
100 percent		6.8	21.2	4.2	32.2
Less than 100 percent		0.8	2.6	19.2	22.6
Fee schedule[b]					
Less than $10		4.6	18.2	0.6	23.3
$10		0.6	4.4	*0.1	5.1
$11-14		0.5	2.0	*0.1	2.5
$15 or more		0.6	1.5	0.0	2.1

[a]Persons with basic and major medical benefits are categorized by their basic benefits. [b]Follow-up visit. *Relative standard error equal to or greater than 30 percent. —: Not applicable.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 13. Coverage for assistant surgeon fees and second surgical opinions: Percent distribution of privately insured persons under 65, by type of benefit (United States, 1977).

Type of benefit	Persons with surgery benefits	
	Thousands	Percent
	148,764	100.0
Assistant surgeon fee		
Covered		44.6
Not covered		55.4
Second surgical opinion		
Not explicitly covered		95.2
Covered but not mandatory		
Pays 100 percent		2.8
Pays less than 100 percent		*0.1
Fee schedule		1.7
Covered and mandatory		*0.2

*Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 14. Outpatient surgery facility benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Outpatient surgery facility benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	144,708	28.9	53.9	17.2	100.0
Deductible					
None		28.4	54.0	4.3	86.8
$1 to $99		0.0	*0.2	5.9	6.1
$100		*0.1	0.0	6.4	6.5
$101 or more		0.0	0.0	0.7	0.7
Type of reimbursement					
100 percent					
No dollar limits		26.1	47.3	6.5	79.9
Dollar limits		2.0	6.8	—	8.8
Less than 100 percent		*0.3	*0.2	10.8	11.3

[a]Persons with basic and major medical benefits are categorized by their basic benefits. *Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent. — Not applicable.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 15. Outpatient facility accident benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Outpatient facility accident benefit	Thousands	Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	145,434	31.7	51.7	16.7	100.0
Deductible					
None		31.3	51.9	6.0	89.3
$1 to $99		0.0	*0.1	3.9	4.0
$100		0.0	0.0	5.9	5.9
$101 or more		0.0	0.0	0.8	0.8
Type of reimbursement					
100 percent					
No dollar limits		26.0	45.9	8.7	80.7
Dollar limits		4.7	5.8	—	10.5
Less than 100 percent		0.6	*0.2	8.0	8.9
Time limit					
Within 1 day		3.3	9.7	0.9	13.9
Within 2 days		3.3	9.1	1.6	14.0
Within 3 days		13.0	23.3	1.0	37.3
Within 5 days		0.0	0.5	0.0	0.6
None specified		12.1	9.3	12.8	34.2

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent. —: Not applicable.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 16. Outpatient facility emergency benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Outpatient facility emergency benefit	Thousands	Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	124,070	23.3	30.3	46.4	100.0
Deductible					
None		23.6	29.3	2.7	55.6
$1 to $99		0.0	*0.2	14.6	14.8
$100		0.0	0.0	26.4	26.4
$101 or more		0.0	0.0	3.2	3.2
Type of reimbursement					
100 percent					
No dollar limits		22.1	25.9	6.7	54.7
Dollar limits		1.1	3.0	—	4.1
Less than 100 percent		0.5	0.5	40.2	41.2
Time limit					
Within 1 day		6.5	3.1	0.6	10.3
Within 2 days		0.8	1.7	*0.1	2.6
Within 3 days		3.2	13.7	*0.4	17.3
None specified		12.6	11.9	45.4	69.9

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent. —: Not applicable.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 17. Supplemental accident benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Supplemental accident benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	35,599	75.2	*1.4	23.4	100.0
Type of reimbursement					
Amount of coverage					
Less than $300		17.9	*0.6	*1.4	19.9
$300 or more		51.4	*0.5	18.8	70.6
Percent of UCR charge					
100 percent		6.0	*0.4	2.7	9.0
Less than 100 percent		*0.1	0.0	*0.3	*0.5
Limit on time to treatment					
None		6.5	*0.1	3.6	10.2
7 days or less		6.5	0.0	*1.2	7.7
8-90 days		51.5	*0.8	16.8	69.1
More than 90 days		8.0	*0.2	*0.3	8.4
Unknown		2.8	*0.4	*1.4	4.6

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 18. Benefits for outpatient X-ray and laboratory services: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Outpatient X-ray and laboratory benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	142,583	19.8	54.9	25.4	100.0
Deductible					
None		18.4	54.2	2.9	75.5
$1-99		1.2	0.8	6.7	8.7
$100		0.0	0.0	13.3	13.3
$101 or more		0.0	0.0	2.4	2.5
Type of Reimbursement					
100 percent of UCR charge					
No dollar limit		12.7	20.4	4.6	37.6
Dollar limit $1-200		3.5	21.9	—	25.4
Dollar limit $201 or more		0.6	4.3	—	4.9
Less than 100 percent of UCR charge					
No dollar limit		0.7	2.7	20.5	23.9
Dollar limit		*0.2	0.5	—	0.7
Fee schedule					
No dollar limit		1.5	1.9	*0.2	3.7
Dollar limit		0.4	3.4	—	3.8

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. —: Not applicable. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 19. Physician office visit benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Physician office visit benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	127,669	8.0	9.9	82.1	100.0
Deductible					
None		6.4	7.1	3.6	17.1
$1 to 49		1.1	2.4	3.0	6.5
$50		0.0	0.0	17.3	17.3
$51 to 99		*0.1	*0.2	2.2	2.6
$100		*0.2	0.0	50.3	50.5
$101 or more		*0.1	0.3	6.0	6.1
Type of Reimbursement					
Service benefits		3.0	1.3	—	4.3
Percent of UCR charge					
100 percent		1.9	2.7	11.5	16.0
Less than 100 percent		0.5	0.5	69.8	70.8
Fee schedule					
Less than $10		1.3	3.7	0.6	5.6
$10 or more		0.4	1.1	0.5	2.0
Copayment		0.9	0.4	*0.1	1.3

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent. — : Not applicable.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 20. Maximum basic physician office visit benefits: Percent distribution of privately insured persons under 65 with basic physician office visit benefits only, by maximum visits or dollars of coverage (United States, 1977).

Maximum basic benefit	Persons with basic office visit benefits only	
	Thousands	Percent
	10,217	100.0
No maximum		81.9
Dollar maximum		
Less than $400		6.8
$400 or more		4.2
Visit maximum[a]		
Less than 22 visits		5.6
22 visits or more		*1.5

[a]Persons with both visit and dollar limits are characterized by their visit maximum. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 21. Maximum major medical benefits for physician office visits and basic coverage: Percent distribution of privately insured persons under 65 with major medical coverage, by type of basic benefit (United States, 1977).

Type of office visit benefit		Maximum major medical benefit[a]				
		Less than $50,000	$50,000-$249,999	$250,000-$999,999	$1,000,000 or more	All
	Thousands	Percent				
Persons with major medical benefits	117,452	18.9	23 1	40.6	17.3	100.0
No basic benefit		16.7	20.9	36.8	16.3	90.6
Any basic benefit		2.2	2.2	3.9	1.1	9.4

[a]Typically applies to other services covered under major medical plans in addition to physician office visits.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 22. Basic and major medical benefits for outpatient prescribed medicines: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Prescribed medicine benefit	Thousands	Percent
Basic benefits		
Persons with benefits	15,502	100.0
Deductible		9.3
Allowance per prescription		4.7
Percent of charge		30.2
100 percent		22.9
Less than 100 percent		7.3
Copayment		55.8
$1		23.3
$2		22.6
$2 or more		9.9
Major medical benefits[a]		
Persons with benefits	111,963	100.0
Pays 80 percent		83.0
Less than $100 deductible		21.1
$100 deductible		54.5
More than $100 deductible		5.8
No deductible		1.6
Pays 100 percent		10.0
Deductible		9.2
No deductible		0.8
Other		7.0
Deductible		6.6
No deductible		0.4

[a]The major medical deductible typically applies to charges other than prescribed medicines.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 23. Type of reimbursement and restrictions on basic and major medical coverage for outpatient prescribed medicines: Percent distribution of privately insured persons under 65 with coverage (United States, 1977).

Prescribed medicine benefit		Basic benefits only	Any major medical benefits[a]	All
	Thousands	Percent		
Persons with benefits	125,421	10.7	89.3	100.0
Type of reimbursement				
UCR charge		5.3	71.0	76.3
Wholesale cost		0.4	0.5	0.9
Fee schedule		0.0	*0.2	*0.2
Other/not specified		5.0	17.7	22.6
Restrictions on coverage				
None specified		*0.2	8.6	8.7
Any medication prescribed by a physician		3.7	2.3	6.0
Medications obtainable by prescription and some over-the-counter items		1.3	1.6	2.9
Only medications obtainable by prescription		8.6	73.7	82.3

[a]Persons with both basic and major medical coverage are categorized by their major medical benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 24. Benefits for medical supplies and durable equipment: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Benefit for supplies/equipment		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only[b]	All
	Thousands	Percent			
Persons with benefits	128,261	9.8	4.3	85.9	100.0
Full coverage					
Dollar maximum		*0.2	2.5	12.0	14.7
Unlimited		9.1	1.5	1.0	11.6
Partial coverage					
Dollar maximum		*0.1	*0.1	62.9	63.1
Unlimited		0.5	*0.2	9.9	10.6

[a]Persons with basic and major medical benefits are categorized by their basic benefits. [b]Major medical maximums typically apply to other covered services in addition to supplies and durable equipment. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 25. Home health benefits: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Home health benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	37,119	70.5	5.3	24.2	100.0
Percent of UCR charge					
100 percent		64.4	4.7	4.1	73.2
Less than 100 percent		3.9	*0.4	19.1	23.4
Fee schedule		2.7	*0.1	*0.6	3.5

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 26. Maximum basic home health benefits: Percent distribution of privately insured persons under 65 with basic home health benefits only, by maximum visits or dollars of coverage (United States, 1977).

Type of basic benefit	Persons with basic home health benefits only	
	Thousands	Percent
	26,206	100.0
Visit maximum[a]		
Up to 60 visits		28.0
61-90 visits		16.7
91-120 visits		13.5
121-364 visits		4.8
365 or more visits[b]		34.9
Dollar maximum		
$5,000 or less		2.0
More than $5,000		*0.1

[a]Persons with visit and dollar limits are categorized by maximum visits covered. [b]Includes unlimited benefit. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 27. Coordination of hospital and home health benefits and restrictions on services: Percent of persons under 65 with coverage, by type of restriction (United States, 1977).

	Persons with basic home health benefits only	Persons with any major medical home health benefits	All with home health benefits
	Percent		
Prior hospitalization required			
Yes	30.5	7.4	37.9
No	30.8	12.9	43.7
Not specified	12.8	5.6	18.4
Limited visits per week or month			
Yes	*0.8	0.0	*0.8
No	70.0	23.4	93.4
Not specified	3.3	2.5	5.8

* Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 28. Coverage for mental health conditions: Percent of privately insured persons under 65, by coverage for specific services (United States, 1977).

Type of mental health benefit	All privately insured (percent distribution) Covered	Excluded	Not specified
Any mental health condition	89.7	4.0	6.4
Hospital care	82.4	4.4	13.2
Short-term general facility	80.0	3.6	16.4
Psychiatric facility	20.9	9.1	70.0
Inpatient professional services			
Physician	78.6	5.2	16.2
Independent psychologist	21.7	37.3	41.0
Supervised psychologist	3.4	13.0	83.7
Outpatient professional services			
Physician visits	71.4	13.2	15.4
Group therapy	11.7	50.6	37.7
Independent psychologist	26.2	40.9	32.9
Supervised psychologist	5.2	15.8	79.0
Social worker	4.5	55.6	39.9
Alcoholism			
Hospital care	35.8	6.5	57.7
Inpatient professional services	28.1	7.5	64.3
Outpatient professional services	17.5	17.5	65.0
Drug addiction			
Hospital care	30.4	8.1	61.5
Inpatient professional services	25.6	8.8	65.6
Outpatient professional services	15.2	18.7	66.1
Self-inflicted injury			
Hospital care	1.5	14.4	84.1
Inpatient professional services	*0.1	15.5	84.4
Outpatient professional services	0.0	24.1	75.9

*Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 29. Differences in coverage for medical and mental health conditions for specific services: Percent of persons under 65 privately insured for mental health conditions, by service (United States, 1977).

Type of service	Persons with mental health benefits	Coverage distinguishes benefits for medical from mental health conditions
	Thousands	Percent
Hospital	126,371	59.7
Inpatient physician	120,499	56.7
Outpatient physician		
Diagnosis/Evaluation	109,478	92.3
Therapy	106,902	79.1

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 30. Inpatient hospital and physician benefits for mental health conditions: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Inpatient mental health benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefits	126,371	31.9	26.5	41.6	100.0
Daily room and board benefit					
Percent of semiprivate charge					
100 percent		27.3	23.8	14.1	65.3
Less than 100 percent		1.1	*0.1	24.5	25.7
Daily benefit					
More than $50		2.2	1.6	2.3	6.1
$50 or less		1.0	1.2	0.6	2.9
Deductible					
None		32.2	26.9	6.5	65.6
$1-100		0.4	0.7	31.2	32.3
$101-200		0.0	0.0	1.3	1.3
More than $200		0.0	0.0	0.7	0.7
Miscellaneous hospital expense benefits					
Full coverage					
30 days or less		8.2	6.9	0.0	15.1
31-90 days		5.8	5.5	*0.2	11.5
91-364 days		1.2	1.9	0.0	3.2
365 days or more		14.4	10.2	11.7	36.3
Dollar limit		*0.1	*0.1	2.1	2.4
Partial coverage					
Fewer than 365 days		1.0	0.2	1.3	2.5
365 days or more		0.8	1.8	15.6	18.2
Dollar limit		*0.3	0.0	10.7	11.0
Inpatient physician benefits					
Persons with benefits	120,499	23.6	21.8	54.7	100.0
Service benefit		8.2	4.3	—	12.6
Percent of UCR charge					
100 percent		8.2	10.4	7.1	25.8
Less than 100 percent		0.8	1.4	46.3	48.5
Fee schedule					
Less than $15		4.1	4.7	0.5	9.4
$15 or more		2.3	0.9	0.6	3.8

[a] Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. — : Not applicable. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 31. Maximum basic benefits for inpatient mental health conditions: Percent distribution of persons under 65 with basic benefits only, by maximum days of coverage or benefit levels (United States, 1977).

Maximum basic benefit[a]	Persons with basic mental health inpatient benefits only	
	Thousands	Percent
	40,274	100.0
Days of coverage		
30 or less		27.6
31-90		18.6
91-364		4.6
365 or more		13.4
Limited dollar benefit		*1.3
No separate mental health maximum		34.6

[a]Refers to maximum specifically for treatment of mental health conditions, not to overall benefit. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 32. Maximum basic benefits for inpatient mental health services and major medical coverage: Percent distribution of privately insured persons under 65 with major medical benefits, by type of basic benefit (United States, 1977).

Type of basic mental health benefit		Maximum major medical benefit[a]					
		$10,000 or less	$10,001-$50,000	More than $50,000	Limited days	Unlimited	All
	Thousands	Percent					
Persons with major medical benefits	86,096	12.3	15.5	1.2	4.8	66.3	100.0
No basic benefits		6.6	11.3	0.8	2.3	40.1	61.1
Maximum basic benefit[a]							
30 days or fewer of coverage		2.3	1.6	*0.2	*0.4	5.5	10.0
31-90 days of coverage		2.1	*0.6	0.0	1.3	4.4	8.4
91-364 days of coverage		*0.1	*0.1	*0.1	0.0	2.5	2.8
365 or more days of coverage		*0.1	*0.6	0.0	0.0	1.2	1.8
Limited dollar benefit		0.0	*0.1	0.0	0.0	*0.1	*0.2
No separate mental health maximum		1.1	1.3	*0.1	0.8	12.5	15.7

[a]Refers to maximum specifically for treatment of mental health conditions, not to overall benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 33. Outpatient physician benefits for mental health conditions: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Mental health outpatient physician benefit		Basic benefits only	Basic and major medical benefits[a]	Major medical benefits only	All
	Thousands	Percent			
Persons with benefit	109,478	9.4	6.6	83.9	100.0
Deductible					
None		9.2	5.9	10.9	26.0
$1-49		*0.2	0.3	2.0	2.5
$50-99		0.0	*0.1	18.7	18.8
$100		*0.1	*0.1	48.3	48.4
$101 or more		*0.1	0.0	4.3	4.3
Type of reimbursement					
Percent of UCR charge					
100 percent		5.4	3.7	7.1	16.2
80-99 percent		0.5	1.4	18.8	20.7
Less than 80 percent		0.6	*0.2	30.6	31.3
Fee schedule					
Less than $10		*0.2	0.3	4.1	4.6
$10-15		*0.2	0.3	15.2	15.7
$16-20		*0.1	0.0	6.2	6.4
$21 or more		*0.1	*0.2	3.7	4.0
Copayment		0.8	0.3	0.0	1.1

[a]Persons with basic and major medical benefits are categorized by their basic benefits. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 34. Maximum basic benefits for outpatient mental health physician visits: Percent distribution of persons under 65 with basic benefits only, by visit and dollar limits (United States, 1977).

Maximum basic benefit[a]	Persons with basic outpatient physician benefits only	
	Thousands	Percent
	10,291	100.0
Visit maximum		
Less than 20 visits		10.5
20 visits or more		5.4
Dollar maximum		
$500 or less		25.7
More than $500		23.2
No separate mental health maximum		35.2

[a]Refers specifically to maximum for treatment of mental health conditions, not to overall benefits.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 35. Maximum major medical benefits for outpatient mental health physician visits: Percent distribution of privately insured persons under 65 with major medical coverage, by visit and dollar limits (United States, 1977).

Maximum major medical benefit[a]	Persons with any major medical outpatient physician benefits	
	Thousands	Percent
	99,187	100.0
Limited number of visits		6.5
Dollar maximum		
$500 or less		17.5
$501-1,000		18.2
$1,001-5,000		14.1
$5,001-50,000		17.8
More than $50,000		18.3
No separate mental health maximum		7.6

[a]Refers specifically to maximum for treatment of mental health conditions, not to overall benefits.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 36. Coverage for maternity services: Percent distribution of privately insured persons under 65 and women 15 to 44, by type of coverage and service (United States, 1977).

Type of maternity benefit	Population covered	Percent of privately insured	Covered: Primary insured	Covered: Dependent	Not covered	Coverage not specified
	Thousands		Percent distribution of privately insured			
Persons under 65						
Any benefit[a]	133,983	87.4	36.4	51.0	9.1	3.5
Normal pregnancy						
Any coverage	117,529	76.7	32.7	43.9	18.6	4.8
Hospital inpatient	113,714	74.2	32.4	41.8	20.9	4.9
Physician's delivery fee	113,745	74.2	30.4	43.8	20.8	5.0
Well born infants						
Nursery	66,261	43.2	15.9	27.4	25.5	31.2
Pediatrician	37,112	24.2	8.8	15.4	30.5	45.3
Cesarean delivery						
Hospital charges	114,419	74.6	28.3	46.3	9.3	16.1
Physician charges	92,557	60.4	25.3	35.0	12.3	27.4
Miscarriage						
Physician charges	81,277	53.0	22.2	30.8	13.5	33.5
Women 15 to 44						
Any benefit[a]	34,820	89.2	30.9	58.3	8.1	2.7
Normal pregnancy						
Any coverage	31,076	79.6	27.1	52.5	16.1	4.3
Hospital inpatient	30,206	77.4	26.9	50.5	18.2	4.4
Physician's delivery fee	29,420	75.3	22.1	53.2	19.7	5.0
Well-born infants						
Nursery	16,787	43.0	10.6	32.3	27.7	29.4
Pediatrician	9,407	24.1	5.6	18.5	31.4	44.5
Cesarean delivery						
Hospital charges	29,036	74.3	22.0	52.3	8.8	16.9
Physician charges	24,172	61.9	20.7	41.2	10.7	27.4
Miscarriage						
Physician charges	21,439	54.9	18.2	36.7	11.9	33.1

[a] Includes coverage for "complications only."

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 37. Hospital and inpatient physician benefits for maternity services: Percent distribution of privately insured women 15 to 44 years with coverage, by type of benefit (United States, 1977).

Type of maternity hospital benefit		Any basic benefits[a]	Major medical benefits only	All
	Thousands	Percent		
Hospital maternity room and board				
Persons with benefits	30,207	84.3	15.8	100.0
No limit				
100 percent of UCR charge		48.0	6.6	54.6
Less than 100 percent of UCR charge		6.9	5.7	12.5
Total dollar limit[b]		2.0	*0.3	2.3
Hospital dollar limit		10.1	3.1	13.2
Hospital day limit		17.3	*0.2	17.4
Hospital deductible				
None		81.1	8.3	89.4
$1-99		2.1	2.4	4.4
$100		*0.1	2.6	2.7
More than $100		1.0	2.5	3.5
Physician's delivery fee				
Persons with benefits	29,420	85.6	14.5	100.0
Percent of UCR charge				
100 percent		53.9	7.4	61.2
Less than 100 percent		5.0	6.8	11.8
Fee Schedule				
Less than $500		18.5	*0.4	18.9
Other[c]		8.2	0.0	8.2

[a]Persons with basic and major medical benefits are categorized by their basic benefits. [b]Total maternity benefits, including inpatient and outpatient services. [c] Includes fee not specified. * Relative standard error equal to or greater than 30 percent. 0.0 indicates less than 0.05 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 38. Restrictions on coverage for maternity care: Percent of privately insured persons under 65 and women 15 to 44 years, by type of restriction (United States, 1977).

Restrictions on eligibility	Population covered	Primary insured	Dependent	All
	Thousands	Percent		
Persons with coverage for normal pregnancy	117,529			
Waiting period after enrollment		12.1	20.0	32.1
Must be insured at time of conception		19.2	31.7	50.9
Coverage ends at termination of employment		2.1	3.7	5.9
Must be eligible at time of delivery		10.0	18.1	28.1
Dependents ineligible other than spouse		14.3	24.5	38.7
Must elect dependent coverage		5.1	10.1	15.2
Women 15 to 44 with coverage for normal pregnancy	31,076			
Waiting period after enrollment		9.1	22.5	31.7
Must be insured at time of conception		13.9	35.4	49.3
Coverage ends at termination of employment		*0.8	5.1	5.9
Must be eligible at time of delivery		6.8	18.5	25.3
Dependents ineligible other than spouse		10.4	28.4	38.7
Must elect dependent coverage		2.4	11.7	14.1

* Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 39. Benefits for selected types of routine and preventive dental care: Percent distribution of privately insured persons under 65 with coverage, by type of benefits (United States, 1977).

Type of benefit	Prophylaxis	Examination	X-ray	Amalgam filling	Synthetic filling	Subgingival curettage	Simple extraction
	Thousands						
Persons with benefit	36,068	34,781	35,168	35,764	34,580	30,489	36,468
	Percent						
Percent of UCR charge							
100 percent	38.5	39.2	26.0	13.4	12.7	12.7	13.7
80 to 99 percent	25.8	27.1	38.6	38.5	39.4	39.7	37.9
51 to 79 percent	12.8	13.2	12.1	14.6	14.4	17.2	14.3
50 percent or less	3.2	3.4	5.3	4.3	4.2	5.7	4.5
Fee schedule							
$1 to $10	10.6	14.9	1.8	25.1	11.6	3.0	17.1
$11 to $20	8.9	1.6	11.1	3.8	16.6	9.6	11.9
More than $20	*0.2	*0.5	5.1	*0.3	1.2	12.2	*0.6

* Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 40. Benefits for selected types of orthodontic and restorative dental care: Percent distribution of privately insured persons under 65 with coverage, by type of benefit (United States, 1977).

Type of dental care benefits	Persons with coverage	
	Thousands	Percent
Root canal work		
Persons with benefit	35,067	100.0
Percent of UCR charge		
100 percent		14.6
80 to 99 percent		36.0
51 to 79 percent		14.6
50 percent or less		5.5
Fee schedule		
$50 or less		2.7
$51 to $100		16.5
$101 to $150		9.3
More than $150		1.0
Porcelain jacket crowns		
Persons with benefit	33,552	100.0
Percent of UCR charge		
100 percent		9.2
80 to 99 percent		21.9
51 to 79 percent		9.3
50 percent or less		28.9
Fee schedule		
$50 or less		3.6
$51 to $100		16.5
$101 to $150		9.5
More than $150		1.2
Bridgework		
Persons with benefit	30,070	100.0
Percent of UCR charge		
100 percent		7.6
80 to 99 percent		16.4
51 to 79 percent		8.2
50 percent or less		47.7
Fee schedule		
$100 or less		2.2
$101 to $200		5.1
$201 to $300		8.3
$301 to $400		3.4
More than $400		1.1
Dentures		
Persons with benefit	34,243	100.0
Percent of UCR charge		
100 percent		7.6
80 to 99 percent		15.4
51 to 79 percent		7.3
50 percent or less		39.9
Fee schedule		
$200 or less		3.2
$201 to $300		11.5
$301 to $400		8.5
$401 to $500		5.2
More than $500		1.4
Orthodontia		
Persons with benefit	19,880	100.0
Percent of UCR charge		
100 percent		12.1
80 to 99 percent		5.1
51 to 79 percent		4.9
50 percent or less		37.4
Fee schedule		
$400 or less		2.3
$401 to $500		20.2
$501 to $750		8.9
$751 to $1,000		7.0
More than $1,000		1.9

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 41. Deductibles for dental care: Percent distribution of privately insured persons with coverage under 65, by type of service and amount of deductible (United States, 1977).

Service	Persons with benefits	Deductible[a] None	$25 or less	$26 to $50	$51 to $100	More than $100	Deductible common to all dental services
	Thousands	Percent distribution					Percent
Routine maintenance	36,314	71.1	13.1	12.5	2.5	0.8	23.7
Simple restoration	35,941	56.4	20.6	19.1	3.1	0.8	23.3
Periodontia	30,489	50.9	22.2	22.7	3.3	0.9	24.7
Endodontia	35,067	53.4	21.3	21.0	3.6	0.7	23.3
Prosthodontia	34,712	53.2	19.8	22.0	3.5	1.5	23.8
Crowns	33,552	52.5	20.3	22.4	4.0	0.9	23.5
Oral surgery	36,468	54.6	21.1	20.5	3.1	0.8	22.9
Orthodontia	19,880	60.0	13.0	22.6	3.1	1.4	26.4

[a] Deductibles apply specifically to dental services.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 42. Maximum benefits for dental care: Percent distribution of privately insured persons under 65 with coverage, by type of service (United States, 1977).

Service	Persons with benefits	Maximum benefit[a] $1 to $500	$501 to $750	$751 to $1.000	More than $1,000	No limit	Maximum common to all dental services
	Thousands	Percent distribution					Percent
Routine maintenance	36,314	21.5	20.4	29.2	7.3	21.6	76.7
Simple restoration	35,941	22.0	20.3	31.6	7.9	18.3	77.1
Periodontia	30,489	21.3	20.0	30.9	7.6	20.1	75.4
Endodontia	35,067	20.9	20.2	31.6	7.6	19.6	76.0
Prosthodontia	34,712	21.2	19.9	31.8	8.2	18.9	76.9
Crowns	33,552	22.0	20.8	31.8	7.5	18.0	77.3
Oral surgery	36,468	21.6	19.9	31.0	7.8	19.8	76.2
Orthodontia	19,880	40.3	30.4	20.5	6.6	2.3	12.7

[a] Refers to maximums specifically for dental services.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 43. Reimbursement requirements for dental services: Percent of privately insured persons under 65 with coverage (United States, 1977).

Type of service	Persons with dental benefits	
	Thousands	Percent
Prior authorization of service		
	39,008	100.0
Always required		6.7
Required for certain services only		5.9
Required for benefits exceeding a specified amount		37.9
Required both for certain services and for benefits exceeding a specified amount		4.3
Not required		45.2
Annual limit on preventive services		
Prophylaxis	36,068	100.0
No limit		12.9
One per year		6.5
Two per year[a]		80.6
Examination	34,781	100.0
No limit		20.6
One per year		8.6
Two per year[a]		70.8
Waiting periods		
Prosthodontia	34,712	100.0
None		92.5
One year or less		5.6
More than one year		1.9
Orthodontia	19,880	100.0
None		90.9
One year or less		6.3
More than one year		2.7
Crowns	33,552	100.0
None		94.4
One year or less		4.4
More than one year		1.2
Incentive plan[b]		
	39,008	100.0
Yes		8.5
No		91.5

[a]Includes a small number with a higher limit. [b]Pays higher percentage of dental expenses if insured sees a dentist regularly.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

3. The distribution of insurance benefits

The description in part 2 of private health insurance coverage in 1977 indicates fairly wide differences in types and levels of benefits. To illustrate the national distribution of these benefits among the civilian noninstitutionalized population, a number of population subgroups are described in the following in terms of their health insurance, including group and nongroup coverage. The estimates are based in the main on the characteristics of employment of the primary insured as the person whose work status determines the type of insurance obtained by other family members. Some indication of the distribution of coverage and benefits in terms of the sociodemographic characteristics of each insured person, including self-reported health status, is provided. Finally, geographic differences in private insurance by region and by size and density of population are shown. The estimates relate to three aspects of coverage: (1) the percent of each subgroup enrolled in private insurance, categorized by group and nongroup plans; (2) the percent of enrollees covered for a particular service or by major medical insurance; and, (3) of those covered by major medical insurance or for a specific service, the percent with a particular benefit provision. See the appended Tables 44-75 for details of these estimates.

A number of general observations as to the distribution of benefits are made possible by this approach. First, some differences between population groups are shown to be almost entirely a matter of enrollment: the benefits of privately insured whites were not superior to those of privately insured blacks and Hispanics, but a much higher percentage of whites were enrolled in private insurance. By contrast, groups defined by high and low income had quite different benefits when privately insured, in addition to substantial differences in enrollment.

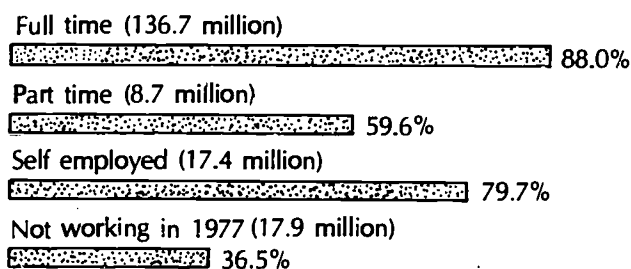
Second, the largest variations in benefits were generally observed for services that were widely covered. For example, more than 95 percent of both nongroup and group enrollees had insurance for hospital room and board charges, but only 38.3 percent of those with nongroup benefits were covered in full, compared to 77.7 percent of those with group benefits. For less commonly insured services, differences in the percentage with coverage were generally larger than differences in the type of benefit.

Third, in population groups where private enrollment or coverage for a particular service was relatively rare, the select few who did have insurance also tended to have unusually generous benefits. Thus, only 36.5 percent of nonworkers and their families were privately insured, and only 51.8 percent were insured for physician office visits. However, those who were covered more often had full benefits (36.4 compared to a national average of 20.5 percent with office benefits).

A related point to be noted in this connection is that of the relative size of some of the groups described. Nonworkers and their families, for example, are a small subgroup of the population in terms of absolute numbers (see Figure 1). Equally important are subsets of major population groups which are small as a percent of the population group but large in absolute numbers, such as full-time employees and their families without private insurance or enrolled in plans offering very limited benefits. For example, the 63.5 percent of nonworkers without private insurance and their families represent only 6.5 million persons, while the 12 percent of full-time workers without private insurance and their families represent 16.4 million.

The cumulative effect of differences in enrollment, services covered, and benefit provisions on the number and percent of each subgroup with a particular type of benefit can be calculated by multiplying the three percentages and applying them to the relevant population base (shown in Tables 44-50 and 59-66, respectively). For example, 39.3 percent of the poor and near poor had private insurance, of whom 74.4 percent had physician office benefits. Of those with physician benefits, 17.2 percent had service benefits or full UCR charge benefits. This latter percentage equals 5.0 percent of the total 25.4 million poor and near poor (Table 59) or about 1.3 million persons.

Figure 1. Percent of the population under 65 with private insurance, by employment status of the household head.



Insurance and characteristics of employment

For the population of working age, enrollment in private insurance and types of benefits are closely related to the fact and characteristics of employment. The majority of workers obtain group health insurance as a work related fringe benefit for themselves and their families. Those who cannot obtain group insurance in this fashion must purchase much less comprehensive nongroup plans directly from an insurance company or go without insurance. This close relationship between health insurance coverage and employment is reflected in patterns and rates of insurance coverage and benefit levels across population groups (Figure 1 and Tables 44-58). Full-time workers are most likely to have private coverage and to be covered by group plans. Self-employed and part-time workers, who are found more frequently in certain industries, are less likely to have group insurance. Size of firm and other factors, such as unionization, that influence fringe benefits and thus the type and levels of insurance, vary by industry as well (Taylor and Lawson, 1981).

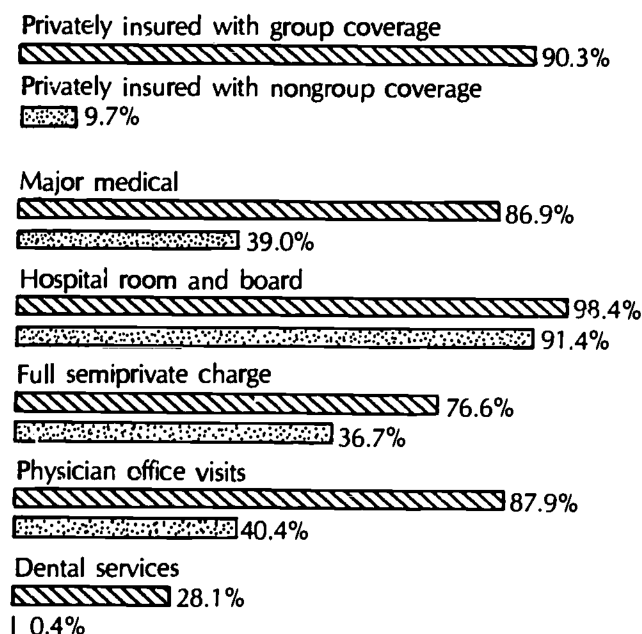
Group and nongroup benefits

Differences between group and nongroup benefits, coupled with employment-related differences in group enrollment, underlie much of the variation in private insurance in the population under 65. Figure 2 illustrates some of these differences. Group enrollees were covered much more frequently by major medical insurance in 1977 than nongroup enrollees (87 percent compared to 39 percent). Group enrollees had benefits for a much wider range of services, especially those covered mainly under major medical plans, such as prescribed medicines and physician office visits. For the commonly insured services, such as hospital room and board, group benefits were more generous, and group coverage was more likely to provide major medical benefits designed to supplement rather than replace a basic plan.

The limitations of nongroup coverage were reflected in the relatively high deductibles and cost sharing provisions of the major medical insurance of nongroup enrollees; 38.4 percent were subject to a major medical deductible of more than $100, compared to 6.2 percent of those with group insurance. Half had no limit on the total amount of cost-sharing required under their plans, compared to two-fifths of group enrollees. Less than a fifth (16.1 percent) were insured for a benefit maximum of $250,000, compared to a quarter of group enrollees.

As noted in part 2, insurance for inpatient hospital expenses (room and board, surgeon, anesthesia, and inpatient medical fees) was common and high among all privately insured, and nongroup coverage f these services was not much below that for group enrollees. Persons covered by a group plan were only somewhat more likely to

Figure 2. Percent of the privately insured population under 65 with selected benefits under group and nongroup coverage.



be covered for stays in a skilled nursing facility than those with nongroup plans, SNF expenses in general being less frequently covered than hospital expenses. Coverage for outpatient hospital facility charges for accidents and surgery was only about 10 percentage points less among nongroup than among group enrollees.

Differences in levels of benefit were much larger. As many as 4.4 percent of nongroup enrollees with hospital insurance were limited to a hospital indemnity plan; fewer than half were fully insured for semiprivate room charges or at least $90 per day (the average semiprivate charge in 1977; Health Insurance Association of America 1977). By contrast, more than three-quarters of persons with group hospital insurance had a full semiprivate benefit, and more than half had a maximum benefit of 365 days or more. Similarly, almost 60 percent of group enrollees, but only 28.8 percent with nongroup insurance providing these benefits, were covered for the full semiprivate SNF charge or at least $50 a day. Fifty percent of group enrollees were fully insured for UCR surgeon fees, while less than a third of those in nongroup plans had these benefits. A significant proportion of nongroup enrollees had benefits limited to less than 80 percent of the UCR charges (mainly by fee schedules) while lacking supplementary major medical coverage.

Even larger differences were observed in the coverage of other services, mainly those insured predominantly under major medical plans. Reflecting the different level of major medical insurance among group and nongroup enrollees, group insurance provided coverage of physician office visits, prescription drugs, and medical equipment to nearly 90 percent of enrollees, while nongroup insurance covered only 40.4 percent of beneficiaries for physician office visits and roughly 30 percent for prescriptions and medical supplies. But even for outpatient diagnostic services, which are generally covered under basic plans, the likelihood of nongroup coverage was well below that for group plans. The narrower range of nongroup coverage was found as well for mental health benefits. Eighty-four percent of group enrollees had inpatient mental health coverage, compared to 65 percent of those in nongroup plans; almost 80 percent of those in group plans were covered for outpatient physician care for mental health conditions, while only about 20 percent of persons with nongroup coverage had such benefits.

The comprehensiveness of coverage for these outpatient services differed, although less than for service coverage. Even under group major medical plans, full coverage of physician office visits (service benefits, full UCR charge benefits, or $20 or more per visit) was relatively rare, the typical benefit being 80 percent of the UCR charge. Nongroup coverage was only slightly less likely to offer comparable physician benefits. Lack of nongroup major medical coverage was also associated with limited benefits for outpatient diagnostic services; copayments, fee schedules, and basic limits unsupplemented by major medical coverage were imposed on more than half of those covered under nongroup plans, compared to a third of group enrollees. Finally, 18 percent of both group and nongroup enrollees covered for inpatient mental health care had relatively complete benefits (no deductible and at least $50,000 or 365 days of basic coverage alone, or at least $100,000 and unlimited days of major medical coverage alone, or at least 90 days of basic coverage in combination with at least $50,000 of major medical coverage). The comprehensiveness of outpatient physician benefits for mental health care again varied only slightly between group and nongroup enrollees.

Group size

The features distinguishing group from nongroup insurance (extensive major medical enrollment, coverage of a broad range of services, and relatively generous benefits) characterized even the smallest health insurance groups. Within this general range, comprehensiveness increased with group size, although some of the differences applied only to the benefits found in very small groups. These small groups (25 members or less) provided less frequent coverage of many services than larger groups. The percent of persons covered for surgery, anesthesia, and inpatient medical care was slightly lower than average in small groups, but substantially lower for ambulance services, physician office visits (including for mental health conditions), and prescribed medicines. These and other excluded services are provided under major medical policies, which were less frequent in the

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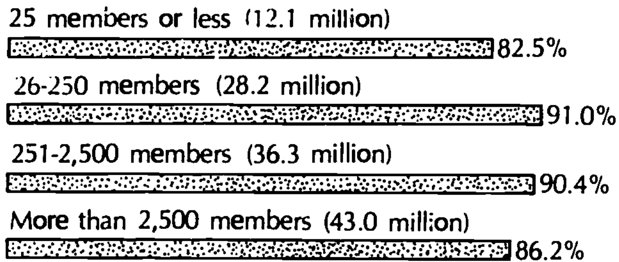
Figure 3. Percent of the privately insured population under 65 with major medical coverage, by size of insurance group.



smallest groups. Although small groups, if anything, were more likely to cover skilled nursing facility care, their insured tended to have less comprehensive benefits.

In other respects the comprehensiveness of benefits increased consistently from the smallest groups to the largest. The larger the group, the more prevalent were benefits for routine physical examinations, outpatient hospital facilities, maternity and dental care. Full semiprivate (or $90 per day) hospital benefits with a high basic or major medical maximum were held by 47.9 percent of those enrolled in small groups, 53.7 percent in groups with from 251 to 2,500 members, and 65.8 percent in groups with more than 2,500 members. The percentage with full coverage for a SNF stay and 100 percent of the UCR charge for surgery also increased with group size.

An exception to this pattern was major medical insurance (Figure 3). Persons in both the largest and the smallest groups were covered slightly less often by major medical insurance, particularly by supplementary plans, than intermediate groups. Large groups offering major medical insurance tended to have lower coinsurance rates, however; for almost a third of persons in groups with more than 2,500 members this rate was less than 20 percent, with a deductible of $100 or less, compared to a fifth in groups of intermediate size. Major medical insurance in the smaller groups was most likely to provide both generous maximum benefits and a limit on the out-of-pocket expenses associated with cost sharing.

Sex of household head or primary insured

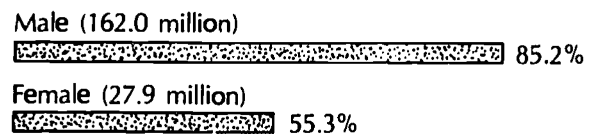
The greatest difference between families headed by men and women, respectively, was the disproportionately lower enrollment in private insurance in households headed by females (about 35 percent; Figure 4; see Farley, 1985a). By contrast, the difference in group and nongroup enrollment by sex of the primary insured was small compared to the differences observed by employment status or industry. Thus, women were only slightly more likely than men to purchase nongroup insurance for themselves and their families, but a large proportion of persons in households headed by females remained uninsured.

Specific benefits nonetheless reflected the somewhat higher nongroup enrollment of female household heads. Their coverage differed little with respect to inpatient hospital and physician use, but was slightly less likely to provide full hospital room and board benefits and slightly more likely to offer only a limited surgical benefit unsupplemented by major medical insurance. Persons insured through policies held by women were covered less frequently by comprehensive major medical insurance and for services such as office visits, prescribed medicines, outpatient mental health care, and dental care.

Employment status

The close connection between employment, especially as a full-time wage-earner, and private health insurance is evident in the fact that 88 percent of full-time employees and their families were

Figure 4. Percent of the population privately insured, by sex of the household head.



Percent of the privately insured population with group coverage, by sex of the primary insured.

covered under private plans in 1977, almost entirely (96.7 percent) through a group. They accounted for nearly three-quarters of the population under 65 and more than four-fifths of the privately insured (see Figure 1). In families where the head did not work at anytime during the year, only 36.5 percent of persons were privately insured. This was the only instance where the majority of the privately insured were covered by nongroup plans.

Compared to full-time wage earners, a somewhat smaller proportion of the self-employed and their families (79.7 percent) had private insurance, but this figure substantially exceeded the 59.6 percent privately insured in families headed by part-time employees. The self-employed who were not covered by group insurance had a much greater tendency than part-time employees to purchase nongroup coverage directly from an insurer. Thus, the relatively few privately insured part-time employees and their families were more likely to have group coverage than the privately insured self-employed.

Generally, differences in private insurance associated with employment status reflected the distribution of group insurance. With few exceptions, the insurance of full-time and, in most cases, part-time employees and their families provided wider coverage of services and more comprehensive benefits compared to the self-employed and nonworkers. This was particularly true with regard to major medical coverage and associated benefits, such as physician office visits (including those for mental health conditions) and prescriptions. For many of these services, the rate of coverage for nonworkers was 10 to 20 percentage points below that for the self-employed and up to 40 percentage points lower than coverage of full-time workers. The percent covered for inpatient hospital and skilled nursing facility care, inpatient and hospital outpatient surgery, and accident treatment did not vary much, although there were some differences between full-time employees and nonworkers.

The greater comprehensiveness of the insurance held by full-time employees and their families was most evident with respect to inpatient hospital and physician services, reflecting the group-nongroup differences noted earlier. For example, 56.3 percent of the families of full-time wage-earners had full semiprivate room and board benefits, with a maximum on the order of 365 days, compared to 46 percent of part-time employees and about a third of the self-employed and nonworkers. For other covered expenses such as SNF stays or surgery, the benefits of part-time employees were more nearly comparable to full-time employees than to the self-employed.

As noted earlier, the majority of persons insured through nonworking policy holders was not covered by group insurance and, in general, their benefits closely followed the pattern for nongroup insurance described earlier. However, among the few with group insurance, some had unusually comprehensive benefits. Thus, only 51.8 percent of all privately insured nonworkers and their families had benefits for physician office visits, compared to a national average of 83.3 percent, but as many as 36.4 percent had first-dollar, full UCR charge, or comparable benefits, or almost twice the national average. More than a third held home health care coverage compared to a quarter of other privately insured, and their coverage for vision and hearing care compared favorably to that of other groups. However, the proportion of nonworkers and their families with the least generous office benefits was more than twice the national average.

Industry

Variation in both private and group enrollment among the major industries of employment was substantial (Figures 5 and 6). Private insurance was most common in families headed by employees in manufacturing and mining, and in transportation, communication and utilities, who comprised almost a third of the privately insured. Along with public employees (including civilian employees of the military), families insured by employees in these industries were the most likely to be enrolled in group plans. Agricultural, construction, and "other service" workers and their families were least likely to be privately insured and to obtain health insurance through a group. Thus, since the category of "other services" includes repairmen, restaurant workers, and domestics, the lowest rates of enrollment were found in the three industries characterized by relatively high rates of part-time or intermittent work and self-employment. Benefits for ambulatory services tended to vary largely in keeping with this distribution of group

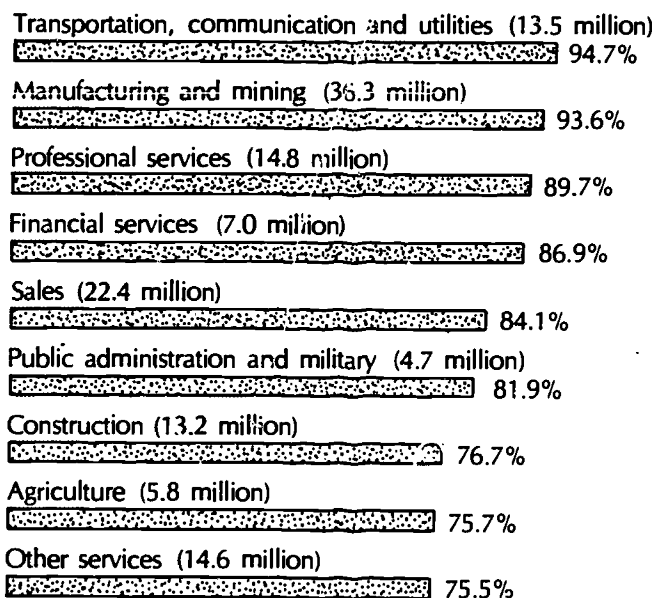


Figure 5. Percent of the population under 65 privately insured, by industry of the household head.

insurance. In general, coverage for physician office visits, diagnostic services, prescribed medicines, and mental health services was most widespread in the three industries with the highest rates of group insurance, and least frequent among agricultural workers, corresponding to the low levels of group insurance in this sector. First-dollar, semiprivate hospital benefits were most prevalent in the three industries with the highest rates of group insurance, as were benefits covering at least 80 percent of UCR charges for surgery.

Several exceptions to this pattern were noted. Major medical insurance was relatively less common in manufacturing and mining, although these industries had among the highest group insurance rates. Construction workers and their families, whose group coverage was less frequent, were covered more often by major medical insurance and for several outpatient services than the national average. Dental insurance was most common in transportation, communication and utilities, followed by the construction industry. Workers in the category of "other services," and their families, despite relatively low group and major medical coverage, were more often covered for outpatient facility services (surgery, accident, and emergency) than the national average.

Despite a shared lack of group insurance, there were some dissimilarities in benefits among workers in agriculture, construction, and "other services." While the proportion of service workers with full semiprivate room and board benefits and a high maximum was 10 percentage points below the national average of 53.2 percent, it was at least 15 percentage points higher than for construction or agricultural workers. And although full benefits for surgical services were also below the national average in these three industries, agricultural workers were most likely to have limited benefits unsupplemented by major medical insurance.

There appeared to be differences across industries in the comprehensiveness of major medical benefits, but most were not statistically significant. Thus, although construction, financial services, and manufacturing and mining had the highest proportions of workers with the most generous coverage for initial expenses (*i.e.* a deductible of $100 or less and a coinsurance rate of less than 20 percent), this was statistically indistinguishable from sales or agriculture.

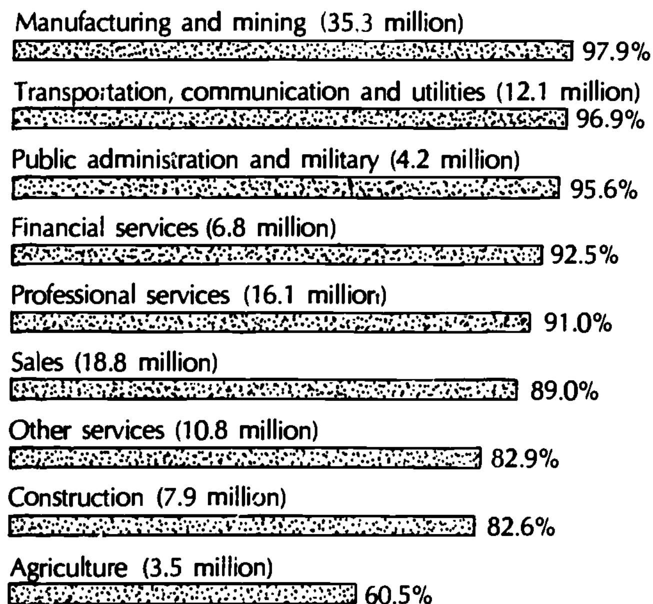


Figure 6. Percent of the privately insured population under 65 with group coverage, by industry of the primary insured.

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Population characteristics

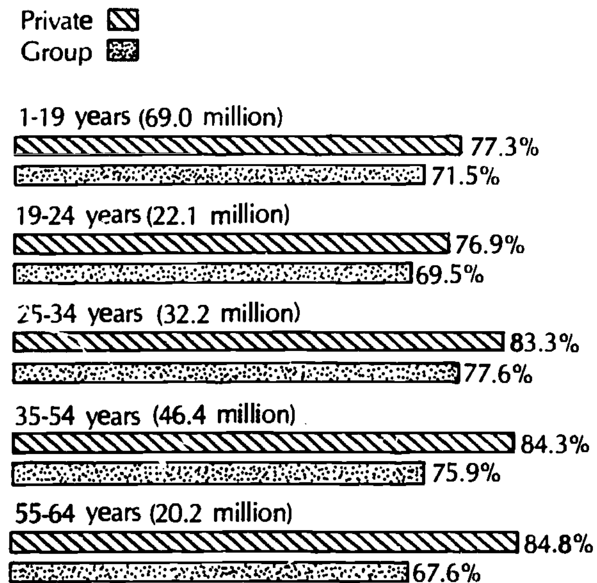
The patterns described relate differences in the private health insurance of the U.S. population under age 65 to the source of their insurance. The following adopts several more conventional approaches to defining population subgroups of interest (Tables 59 to 75). While less obviously related to employment status than the characterisics of the primary insured, the resulting estimates again, and to a large extent, reflect the availability of work-related private insurance benefits in general, and group coverage in particular, to different population groups.

Age and health status, two traditional indicators of the risk of illness, are helpful in evaluating the adequacy of insurance in relation to potential expenditures. For example, older or sicker persons with limited insurance can expect higher out-of-pocket expenditures than young or healthy persons with the same insurance. By the same token, differences by income are important because the ability to pay such out-of-pocket expenses depends on family income. The uneven risk of out-of-pocket expenditures that is implicit in varying patterns of insurance is also examined for inequities related to ethnic and racial background. Two geographic indicators provide some measure of variation in the distribution of insurance benefits by U.S. Census region and place of residence.

Age

The most noticeable point about the age distribution of benefits among the population below age 65 is that the insurance held by adults ages 55 to 64 was quite different from that of the rest of the population beyond age 25. Although just as often privately insured, they were more likely to hold nongroup insurance (Figure 7). This lower rate of group coverage, and the associated lower level of service coverage and benefits, is due partly to declining rates of employment and partly to the relatively large proportion of nonworking women in this age range who, being either widows or spouses of nonworkers, had to purchase nongroup policies of their own. Thus, the privately insured ages 55 to 64 were less likely to have benefits for nearly any type of service or expense. They had lower rates of major medical coverage, relied more often on hospital indemnity plans, and had less mental health coverage. Their benefits for hospital room and board and inpatient mental health

Figure 7. Percent of the population under 65 with private insurance and percent with group insurance, by age.



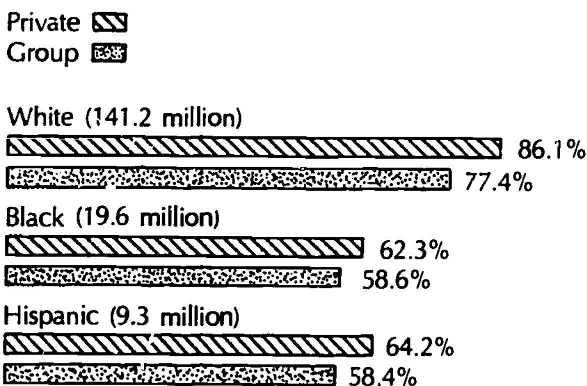
care, SNF care, and surgery were less generous as well.

Children and young adults (under the age of 25) were about 7 percent less likely to be covered by private insurance than adults aged 25 to 64. This situation may in part be attributable to the disproportionate number of children and adolescents living in families that are poor. For young adults, lack of access to employment-related insurance is an additional factor. Many in the 19-24 age group previously covered under a parent's private plan are unable to obtain their own insurance either because they do not work or because they hold jobs that do not provide coverage, such as part-time or low-paid work (Taylor and Lawson, 1981). If covered by private insurance, however, young persons generally followed the averages for the rest of the privately insured population.

Ethnic/racial background

Private insurance was held by only about two-thirds of blacks or Hispanics compared to over four-fifths of whites (Figure 8), due mainly to corresponding differences in employment status. However, differences in types and comprehensiveness of coverage were not consistently large and presented no systematic pattern. Among whites

Figure 8. Percent of the population under 65 with private insurance and percent with group insurance, by ethnic/racial background.



and Hispanics with private insurance, about 10 percent had only nongroup coverage, compared to 6 percent of blacks. Enrollment in both comprehensive and supplementary major medical coverage was nevertheless comparable among all three ethnic/racial groups, as were major medical coinsurance rates and deductibles. Blacks were somewhat more likely to have a major medical limit on out-of-pocket expenses, while a third of Hispanics with major medical coverage were protected both by an out-of-pocket limit and a high maximum total benefit, compared to a fourth of whites and blacks.

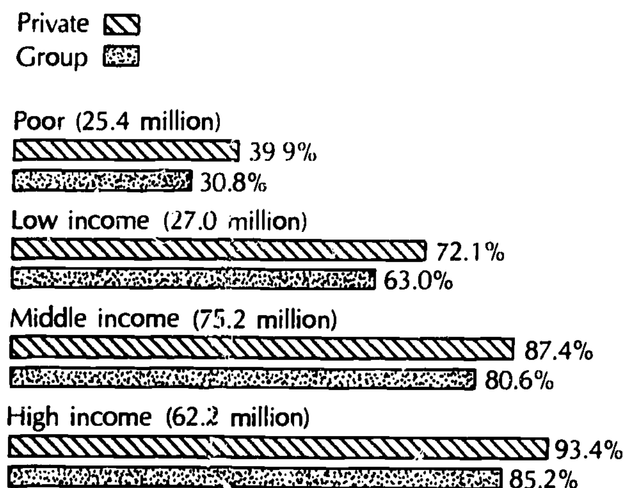
The range of covered services offered few consistent indications of differences among the three groups. For most inpatient services (including mental health and maternity care), coverage rates for whites were only marginally higher; the differences for many outpatient services were even smaller. Of greater interest may be the fact that most of the statistically significant differences involved a contrast between the private insurance of Hispanics on the one hand and that of blacks and whites on the other. For example, Hispanics had relatively high rates of coverage for routine or preventive services (physical examinations, vision care, and dental care) and lower than average rates for expenses related to inpatient and outpatient care for mental health conditions and prescribed medicines. While physician office benefits were comparable in terms of the proportion with cost sharing, Hispanics were less likely than either whites or blacks to have full semiprivate room and board or UCR charge benefits for surgical or outpatient diagnostic services. Some aspects of this different structure of coverage may reflect the fact that almost half (42.2 percent) of privately insured Hispanics lived in the western region of the country, where a similar pattern of insurance benefits was evident.

Income

Differences by income were large and consistent. The benefits of those in the middle and high-income groups were quite similar and generally much more comprehensive than those of persons in poor and low-income families. Not only was there a 50 percentage point gap in private insurance status between poor and near-poor and high-income families (39.3 percent compared to 93.4 percent), but privately insured poor and low-income families were disproportionately likely to have nongroup coverage. Even if enrolled, therefore, the poor and, in many respects, low-income families as well had relatively fewer benefits than middle and high-income families (Figure 9).

The previously mentioned pattern of relatively large benefit differences for widely covered services was observed for poor and low-income persons. They were covered only marginally less often for most inpatient and other hospital-related expenses, but were less likely to have full semiprivate benefits for stays in a hospital or skilled nursing facility. Also, they were more likely than

Figure 9. Percent of the population under 65 with private insurance and percent with group insurance, by family income adjusted for family size.



others to have surgery benefits paying less than 80 percent of UCR charges, and less likely to have major medical insurance; accordingly, fewer had benefits for physician office visits, prescribed medicines, and outpatient mental health care. The comprehensiveness of major medical coverage varied less, although persons in poor households were slightly more likely to face a high deductible or have no out-of-pocket limit than others with major medical insurance.

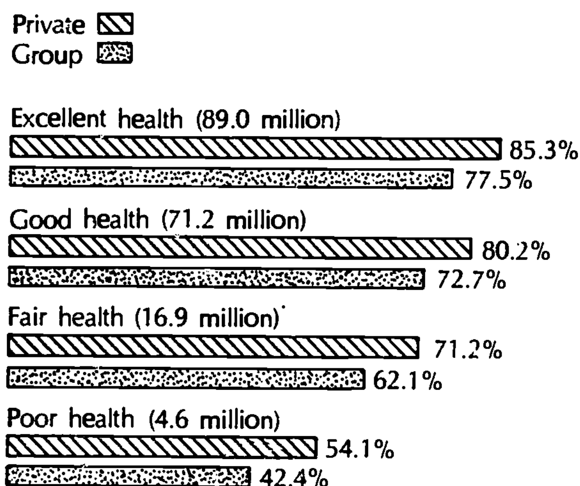
The coverage of low-income families was substantially better than that of the poorest segment in some respects, particularly for outpatient services, but also with regard to the depth of some benefits. Occasionally their insurance more closely resembled that of middle and high-income families. For example, their rates of coverage were only slightly lower than the national average for most outpatient services, including physician office care and prescribed medicines. As many as 60.1 percent insured for skilled nursing facility care held full semiprivate benefits, compared to roughly 50 percent for higher income groups and 29.9 percent for the poor.

In general, the positive relationship between income and comprehensiveness of insurance did not extend to marked differences in the benefits of high and middle income persons. However, relatively more high income persons had the most comprehensive type of hospital room and board benefits (365 days of first-dollar, full semiprivate coverage) or full coverage of physician office visits, and they were covered most often for less commonly insured services like dental and vision care.

Health status

The variation in private insurance by health status was substantial, with progressively lower rates of coverage and less comprehensive benefits with decreasing levels of self-reported health. In part, this is attributable to the circumstantial association of health status with population characteristics that are more directly related to insurance such as income, age, and employment. (The population in poor health, such as those chronically limited in their activity, is disproportionately older and has less income than others; Berk, Cafferata, and Hagan, 1985.) A little over half of persons in poor health were privately insured in 1977, compared to 85 percent of those in excellent health, and the difference in the proportion with group insurance was likewise substantial (Figure 10).

Figure 10. Percent of the population under 65 with private insurance and percent with group insurance, by perceived health status.



Since the privately insured in poor health were also less likely to have major medical insurance than the national average (67.3 compared to 82.2 percent), they had consistently lower rates of coverage for most outpatient services and for items like prescribed medicines and medical equipment. While insurance for inpatient services was more uniform across health status groups, and the depth of benefits varied only slightly for most types of care, persons in poor health were least often covered by full semiprivate room and board benefits.

Geographical patterns

In part, the structure of private health insurance by population density and region of the country reflects geographic differences in employment and other work-related characteristics discussed. However, it also reflects regional differences in the market shares of different insurers in 1977, as well as differences in the types of benefits they emphasized and in the types of benefits that were offered in different insurance markets.

HMOs, for example, emphasize comprehensive and preventive services, as indicated by their relatively high rates of coverage for routine physical examinations and vision or hearing care (Farley,

1985a). They also require little or no cost-sharing for most services. Although HMOs enjoyed a relatively small market share even in the Western U.S. Census region in 1977, their influence on benefit structures may be greater than reflected in their enrollment because of the indirect effect of competitive pressure on other insurers to offer more HMO-like benefits (Frank and Welch, 1985). Commercial insurance most often provided major medical benefits and thus tended to cover such services as prescribed medicines and physician office visits, but emphasized cost sharing of at least 20 percent. The insurance sold by Blue Cross-Blue Shield typically included a basic plan, with or without supplementary major medical insurance. Overall, therefore, persons insured by Blue Cross-Blue Shield had rather complete protection against costs for inpatient services but were less likely to have benefits for physician office visits, prescribed medicines, or dental care.

These insurers are not evenly distributed around the country. Blue Cross or Blue Shield covered over two-thirds of the insured population in the Northeast in 1977, but less than 45 percent in the rest of the country. The proportion covered by commercial insurers varied little about the national average of 62 percent but was highest in the South. In the West, about 16 percent of the insured were enrolled in HMOs, or four times the national average (Figure 11).

Figure 11. Percent of the population under 65 privately insured, by type of insurer and U.S. Census region.

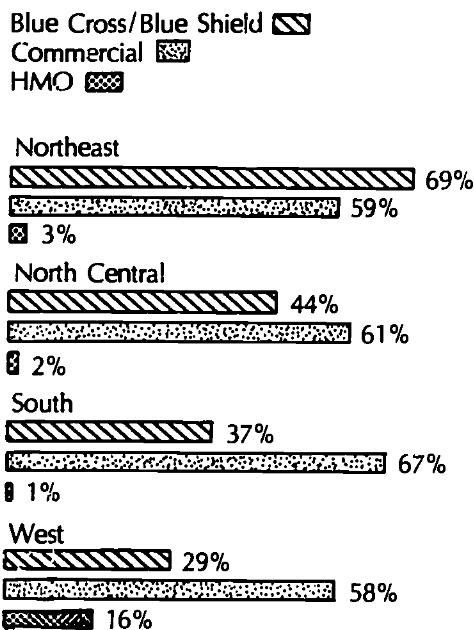
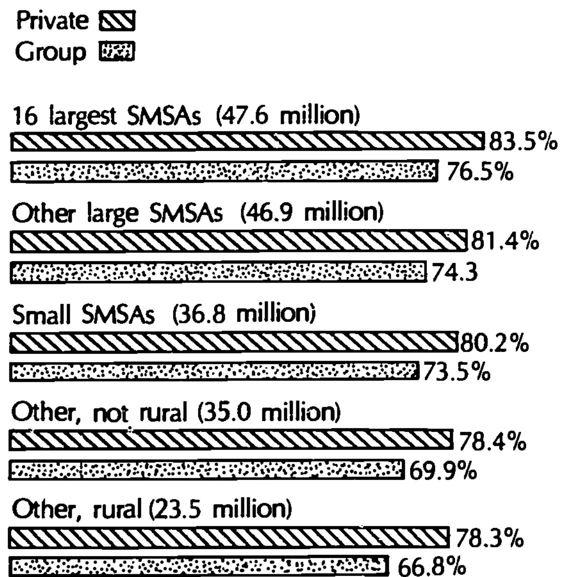


Figure 12. Percent of the population under 65 with private insurance and percent with group insurance, by place of residence.



Place of residence

While the proportion of individuals with private insurance increased with population density, the range of variation was not substantial; 83.5 percent of residents of the 16 largest Standard Metropolitan Statistical Areas (SMSAs) were privately insured in 1977, compared to 78.3 percent in rural areas. Group plans were slightly less prevalent among insured persons outside SMSAs, particularly in rural areas, but the range was small (from 85.3 to 91.6 percent; Figure 12).

Among the privately insured there were consequently few significant or consistent differences associated with populati density. In addition, the distribution of enrol it by type of insurer was relatively similar across areas of different population density, notwithstanding the predominance of Blue Cross-Blue Shield in the densely populated Northeast. The proportion covered by commercial policies was somewhat greater in less densely populated areas.

Small but important differences in major medical coverage were evident; it was slightly less widespread in the most densely populated metropolitan areas and most common in small SMSAs. Like private insurance itself, the frequency of full semiprivate room and board coverage with a high maximum benefit increased with population density. Nearly 48 percent of insured persons in rural areas had hospital benefits of this type, compared to nearly 58 percent in the largest metropolitan areas. In terms of depth of benefits for other services, however, there was little variation.

U.S. Census region

Residents of the Northeast and North Central regions were more often privately insured than in the South and West (Figure 13), while slightly more group insurance was purchased in the West than in the Northeast and the South. The percent of the privately insured with group coverage thus varied little, and the variation in benefits by region is better explained by regional differences in insurance markets than by the small differences in the extent of group coverage.

Coverage was generally broad in the Northeast, where Blue Cross-Blue Shield plans were predominant, although major medical insurance was held less often than in other regions. Characteristically, this meant less coverage of many outpatient services than the national average, for example, physician office visits, prescribed medicines, and medical equipment. More than 90 percent of the major medical insurance was of the supplementary type typical of BC-BS policies, and benefits were more comprehensive than average for inpatient services.

The North Central region was largely typical of the country as a whole, apart from having the highest rates of private and major medical coverage and the second highest group enrollment. Coverage for most inpatient and outpatient services was close to the national average, although benefits tended to be somewhat more comprehensive. Specifically, a larger proportion of persons were covered at semiprivate rates or at 100 percent of UCR charges for hospital room and board, surgery, inpatient mental health care, and hospital maternity care.

The breadth of service coverage in the South also varied little from the national average. Although its proportion with major medical coverage was high, this was not reflected in higher rates of coverage for most outpatient services. Significant features were lower rates of coverage for dental and vision care than in any other region and below average coverage of routine physical examinations. The comprehensiveness of benefits for covered services tended to be less. The South had the lowest proportion with a high maximum for hospital room and board or 100 percent of UCR charges for surgery, office visits, or outpatient diagnostic care, but the highest proportion with hospital indemnity policies.

The most distinctive feature of private insurance in the West, where HMOs had their largest market share, was coverage of routine and preventive services. Coverage for routine physicals was two and a half times the national average, as was that for vision care. Persons in the West were also most often covered for dental care, although with a lower proportion fully covered for routine exams. Rates of coverage were somewhat higher than average for physician office and home visits as well, and persons in the West were more likely to have a service benefit or full UCR charges for these services. In general, coverage for inpatient services was about two percentage points below the national average, with a larger gap for mental health care. General inpatient room and board benefits were slightly less comprehensive.

Figure 13. Percent of the population under 65 with private insurance and percent with group insurance, by U.S. Census region.

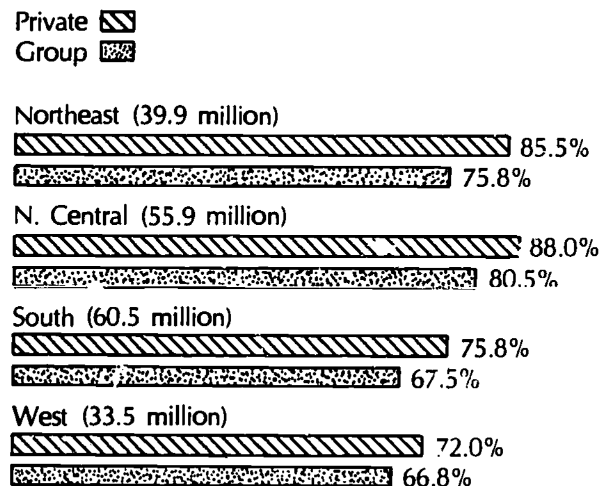


Table 44. Private insurance coverage of the population under 65: Percent covered and percent with group insurance, by sex and employment characteristics of the household head and the primary insured (United States, 1977).

Characteristics of household head		Privately insured
	Thousands	Percent
Population under 65		
All persons[a]	189,837	80.8
Sex		
Male	161,961	85.2
Female	27,877	55.3
Employment status		
Full time	136,686	88.0
Part time	8,653	59.6
Self-employed	17,359	79.7
Did not work in 1977	17,877	36.5
Industry		
Agriculture	5,806	75.7
Manufacturing and mining	36,325	93.6
Construction	13,200	76.7
Transportation, communication and utilities	13,491	94.7
Sales	22,375	84.1
Financial services	7,042	86.9
Professional services	14,805	89.7
Other services	14,566	75.5
Public administration and military	4,687	81.9

Characteristics of primary insured		With group coverage	Without group coverage
	Thousands	Percent distribution	
Privately insured			
All persons[a]	153,315	90.3	9.7
Sex			
Male	113,260	91.8	8.2
Female	40,055	86.3	13.7
Employment status			
Full time	123,967	96.7	3.3
Part time	7,304	80.8	19.2
Self-employed	10,731	60.8	39.2
Did not work in 1977	4,064	38.2	61.8
Industry			
Agriculture	3,508	60.5	39.5
Manufacturing and mining	35,344	97.9	2.1
Construction	7,942	82.6	17.4
Transportation, communication and utilities	12,069	96.9	3.1
Sales	18,767	89.0	11.0
Financial services	6,760	92.5	7.5
Professional services	16,108	91.0	9.0
Other services	10,806	82.9	17.1
Public administration and military	4,201	95.6	*4.4

[a] Includes persons for whom industry and employment status of the household head or the primary insured are unknown. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 45. Comprehensive and supplementary major medical coverage: Percent distribution of the privately insured population under 65 with and without major medical coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Population privately insured	Major medical coverage		
		None	Comprehensive only	Supplementary[a]
	Thousands	Percent distribution		
All persons[b]	153,315	17.8	16.6	65.6
Type of insurance				
Nongroup	14,815	60.9	14.9	24.2
Any group	138,500	13.1	16.8	70.1
25 or fewer members	12,130	17.4	24.3	58.2
26-250 members	28,154	8.9	18.8	72.2
251-2,500 members	36,331	9.6	13.2	77.2
More than 2,500 members	43,020	13.9	17.7	68.5
Sex				
Male	113,260	16.7	17.7	65.6
Female	40,055	20.7	13.7	65.7
Employment status				
Full time	123,967	14.2	16.4	69.4
Part time	7,304	24.3	14.5	61.3
Self-employed	10,731	31.3	24.0	44.6
Did not work in 1977	4,064	61.4	5.9	32.7
Industry				
Agriculture	3,508	25.8	22.8	51.4
Manufacturing and mining	35,344	17.9	14.6	68.1
Construction	7,942	15.6	23.9	60.5
Transportation, communication and utilities	12,069	9.0	17.9	73.1
Sales	18,767	17.4	20.2	62.5
Financial services	6,760	10.7	30.5	58.8
Professional services	16,108	16.3	17.5	66.1
Other services	10,086	20.5	16.7	62.8
Public administration and military	4,201	11.7	11.6	76.7

[a]Includes 3 percent of the privately insured holding both supplementary and comprehensive major medical coverage. [b]Includes persons for whom industry and employment status of the primary insured and group size are unknown.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 46. Coverage for selected inpatient services: Percent of the privately insured population under 65, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Population privately insured	Hospital room and board	Surgery	Anesthesia	Inpatient medical	Ambulance	Skilled nursing facility	Hospital indemnity
	Thousands	Percent covered						
All persons[a]	153,315	97.7	97.0	94.3	95.7	85.6	48.7	1.8
Type of insurance								
Nongroup	14,815	91.4	91.6	85.9	81.8	54.0	43.4	8.4
Any group	138,500	98.4	97.6	95.2	97.1	89.0	49.3	1.1
25 or fewer members	12,130	97.9	95.5	93.1	94.5	82.1	54.6	*1.4
26-250 members	28,154	99.0	97.9	96.2	98.0	89.8	55.0	*0.4
251-2,500 members	36,331	99.2	99.0	96.5	98.0	91.8	50.8	1.3
More than 2,500 members	43,020	98.0	97.7	94.9	97.4	90.3	45.7	1.0
Sex								
Male	113,260	97.8	97.1	94.9	96.1	86.7	47.9	1.4
Female	40,055	97.6	96.9	92.6	94.5	82.5	51.2	2.8
Employment status								
Full time	123,967	98.2	97.6	95.1	96.8	88.2	48.6	1.1
Part time	7,304	96.9	95.7	90.9	93.2	81.8	51.7	*3.1
Self-employed	10,731	96.1	95.5	94.1	92.6	74.4	50.2	2.5
Did not work in 1977	4,064	93.2	90.6	85.2	84.0	58.7	46.9	7.6
Industry								
Agriculture	3,508	95.3	96.7	89.5	92.8	82.5	45.3	*5.5
Manufacturing and mining	35,344	98.9	98.3	96.2	97.7	86.8	51.0	*0.3
Construction	7,942	98.1	97.8	95.0	96.3	87.9	45.3	*1.6
Transportation, communication and utilities	12,069	98.4	96.1	94.6	95.9	90.3	31.7	*1.4
Sales	18,767	97.7	96.9	93.3	95.1	83.8	50.0	1.8
Financial services	6,760	98.5	97.3	97.0	96.3	89.2	54.4	*1.4
Professional services	16,108	98.5	97.5	95.2	96.3	86.3	54.6	2.7
Other services	10,086	95.4	96.0	93.3	93.4	81.6	46.1	*1.9
Public administration and military	4,201	98.3	99.7	97.8	99.6	94.0	45.4	*0.8

[a]Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 47. Coverage for outpatient physician, diagnostic, and outpatient facility services: Percent of the privately insured population under 65, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Population privately insured	Physician office visit	Physician home visit	Routine physical exam	Outpatient diagnostic services[a]	Outpatient facility services: Surgery	Accident	Emergency
	Thousands	Percent covered						
All persons[b]	153,315	83.3	77.7	6.0	93.0	94.4	94.9	80.9
Type of insurance								
Nongroup	14,815	40.4	29.3	3.1	66.0	83.7	88.0	53.2
Any group	138,500	87.9	84.1	6.3	95.9	95.8	95.8	84.6
25 or fewer members	12,130	80.7	82.7	2.9	93.3	88.9	88.9	80.7
26-250 members	28,154	88.8	78.3	4.1	96.1	90.1	89.2	77.4
251-2,500 members	36,331	90.8	91.0	5.9	96.9	96.4	97.4	83.4
More than 2,500 members	43,020	89.5	89.1	9.0	96.0	98.6	98.2	87.6
Sex								
Male	113,260	84.3	79.2	6.0	94.0	94.5	95.1	82.7
Female	40,055	80.2	72.9	6.0	90.2	94.2	94.2	75.6
Employment status								
Full time	123,967	86.8	82.4	6.2	95.0	94.9	95.1	82.5
Part time	7,304	75.5	65.3	6.3	89.3	93.8	96.3	82.4
Self-employed	10,731	69.6	46.6	3.7	84.8	92.9	95.1	67.5
Did not work in 1977	4,064	51.8	39.4	10.5	76.9	92.4	93.3	68.4
Industry								
Agriculture	3,508	66.6	59.0	*0.8	80.0	83.0	83.9	56.6
Manufacturing and mining	35,344	83.5	79.0	5.4	96.0	98.9	98.1	85.9
Construction	7,942	84.4	84.6	11.5	90.7	90.5	88.4	75.5
Transportation, communication and utilities	12,069	90.4	82.9	5.2	96.7	91.0	90.8	83.3
Sales	18,767	80.9	72.6	3.8	92.2	88.5	87.4	77.5
Financial services	6,760	88.4	74.2	3.8	91.7	94.4	94.3	80.3
Professional services	16,108	84.5	76.3	7.5	93.5	91.8	94.3	74.7
Other services	10,086	79.6	74.5	3.6	90.1	99.4	99.4	85.7
Public administration and military	4,201	90.2	86.5	*5.2	95.1	98.9	98.3	82.8

[a]Includes X-ray and laboratory services. [b]Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 48. Coverage for selected outpatient services: Percent of the privately insured population under 65, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Population privately insured	Prescribed medicines	Durable equipment/ supplies	Home health care	Supple-mental accident	Vision care	Hearing care
	Thousands	Percent covered					
All persons[a]	153,315	81.8	83.6	24.2	23.2	8.2	3.5
Type of insurance							
Nongroup	14,815	30.3	33.1	26.4	13.2	2.5	*0.2
Any group	138,500	87.3	90.4	24.0	24.8	8.8	3.9
25 or fewer members	12,130	76.2	83.4	24.9	37.3	2.8	*0.1
26-250 members	28,154	88.4	88.4	22.9	31.5	3.5	*0.4
251-2,500 members	36,331	89.5	91.8	22.1	34.6	9.5	2.3
More than 2,500 members	43,020	90.4	94.3	21.6	17.9	13.2	9.5
Sex							
Male	113,260	83.1	86.2	23.9	23.5	9.1	4.0
Female	40,055	78.1	76.1	25.2	22.4	5.8	2.2
Employment status							
Full time	123,967	86.4	88.5	23.7	24.0	8.7	3.9
Part time	7,304	71.8	71.8	25.6	14.3	9.5	*2.1
Self-employed	10,731	61.1	58.5	24.4	24.8	4.4	*0.7
Did not work in 1977	4,064	40.7	35.6	36.4	5.7	8.6	7.0
Industry							
Agriculture	3,508	63.3	74.8	17.0	40.9	6.2	*0.6
Manufacturing and mining	35,344	86.7	89.7	22.8	17.7	8.3	9.1
Construction	7,942	78.1	85.2	15.3	46.5	19.1	*2.7
Transportation, communication and utilities	12,069	87.4	85.1	15.3	19.8	14.4	*1.2
Sales	18,767	78.0	78.9	21.4	27.7	8.6	*0.9
Financial services	6,760	84.9	94.9	23.2	29.1	4.2	*0.8
Professional services	16,108	83.9	81.7	30.6	25.3	4.8	0.6
Other services	10,086	76.0	79.2	25.2	28.6	5.5	3.5
Public administration and military	4,201	88.4	87.1	32.4	24.1	*3.9	*1.1

[a]Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 49. Coverage for mental health services: Percent of the privately insured population under 65, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Population privately insured	Any mental health coverage	Inpatient hospital	Inpatient physician	Outpatient physician
	Thousands	Percent covered			
All persons[a]	153,315	89.7	82.4	78.6	71.4
Type of insurance					
Nongroup	14,815	66.0	65.0	53.2	20.5
Any group	138,500	92.2	84.3	81.3	76.8
25 or fewer members	12,130	90.0	85.3	81.9	65.9
26-250 members	28,154	95.1	87.2	83.8	78.8
251-2,500 members	36,331	91.1	83.8	81.7	77.8
More than 2,500 members	43,020	92.1	83.2	80.3	81.8
Sex					
Male	113,260	90.6	82.9	79.2	72.9
Female	40,055	87.1	81.1	76.8	67.3
Employment status					
Full time	123,967	91.6	83.8	80.7	76.6
Part time	7,304	82.8	74.0	68.7	60.0
Self-employed	10,731	85.4	82.9	75.7	45.8
Did not work in 1977	4,064	71.3	68.0	61.0	31.2
Industry					
Agriculture	3,508	77.0	69.8	61.1	52.1
Manufacturing and mining	35,344	93.2	83.7	79.4	81.5
Construction	7,942	85.1	80.4	76.6	64.1
Transportation, communication and utilities	12,069	92.2	80.8	78.5	77.3
Sales	18,767	87.1	79.9	74.8	65.6
Financial services	6,760	88.6	82.4	80.5	72.7
Professional services	16,108	91.7	86.6	84.6	69.0
Other services	10,086	87.9	79.5	74.2	66.3
Public administration and military	4,201	93.7	88.2	86.1	75.2

[a]Includes persons for whom industry and employment status of the primary insured and group size are unknown.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 50. Coverage for selected dental services: Percent of the privately insured population under 65, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Population privately insured	Any dental care	Routine maintenance[a]	Orthodontia	Periodontia	Prosthodontia[b]
	Thousands	Percent covered				
All persons[c]	153,315	25.4	23.7	13.0	19.9	22.6
Type of insurance						
Nongroup	14,815	*0.4	*0.2	*0.1	*0.2	*0.2
Any group	138,500	28.1	26.2	14.4	22.0	25.0
25 or fewer members	12,130	11.1	9.3	2.2	7.7	8.9
26-250 members	28,154	17.7	15.4	8.1	13.5	15.1
251-2,500 members	36,331	29.9	28.6	15.6	24.3	27.1
More than 2,500 members	43,020	42.6	40.0	22.4	32.9	38.4
Sex						
Male	113,260	27.0	25.0	14.6	21.0	24.1
Female	40,055	21.0	20.1	8.5	16.8	18.6
Employment status						
Full time	123,967	28.5	26.8	15.0	22.6	25.6
Part time	7,304	21.6	19.2	7.1	15.8	17.9
Self-employed	10,731	9.3	7.2	2.7	5.1	7.7
Did not work in 1977	4,064	7.9	7.0	*2.8	*4.8	7.0
Industry						
Agriculture	3,508	10.8	8.5	*3.2	7.8	8.2
Manufacturing and mining	35,344	30.9	28.8	21.0	25.5	27.8
Construction	7,942	33.6	31.2	17.9	22.8	30.5
Transportation, communication and utilities	12,069	48.8	47.5	24.5	33.8	46.0
Sales	18,767	23.2	21.8	9.6	18.3	20.7
Financial services	6,760	23.8	22.9	8.3	19.4	21.3
Professional services	16,108	17.0	16.3	8.0	14.6	15.0
Other services	10,086	16.3	15.4	7.6	13.8	14.7
Public administration and military	4,201	18.6	15.2	7.3	14.2	16.3

[a]Prophylaxis, examination, or full X-ray. [b]Bridgework or full dentures. [c]Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 51. Major medical benefits: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with major medical coverage	Standard deductible or less[a]		High deductible[d]	Out-of pocket limit and standard maximum or less[e]	Out-of-pocket limit and high maximum[f]	No out-of-pocket limit
		Low coinsurance[b]	Standard or high coinsurance[c]				
	Percent	Percent distribution			Percent distribution		
All persons[g]	82.2	23.3	69.7	7.1	32.4	26.3	41.2
Type of insurance							
Nongroup	39.1	12.3	49.2	38.4	33.0	16.1	50.9
Any group	86.9	23.7	70.5	5.7	32.3	26.9	40.8
25 or fewer members	82.5	21.8	70.1	8.0	35.5	37.1	27.3
26-250 members	91.0	20.5	75.2	4.4	33.0	31.4	35.5
251-2,500 members	[illegible]	21.5	73.5	4.9	31.7	22.4	45.8
More than 2,500 mem[illegible]	[illegible]	31.5	62.3	6.2	32.5	23.0	44.4
Sex							
Male	[illegible]	22.7	70.7	6.7	32.0	25.6	42.4
Female	[illegible]	25.0	66.7	8.2	33.3	28.7	38.1
Employment status							
Full time	85.8	[illegible]	70.7	5.8	32.3	26.3	41.4
Part time	75.8	27.9	65.1	7.0	35.2	21.8	42.9
Self-employed	68.6	18.3	62.2	*9.4	30.9	30.7	38.4
Did not work in 1977	38.5	27.0	63.7	*9.3	20.3	23.7	55.9
Industry							
Agriculture	[illegible]	21.6	63.4	14.9	42.5	18.7	38.8
Manufacturing and mining	82.1	25.5	70.4	4.2	27.9	18.6	53.5
Construction	84.4	29.6	59.9	10.4	34.1	22.4	43.5
Transportation, communication and utilities	91.0	21.4	70.0	8.6	30.9	30.6	38.6
Sales	82.7	24.3	69.1	6.6	32.6	26.1	41.3
Financial services	89.3	25.8	63.6	10.6	37.6	39.0	23.4
Professional services	83.6	20.1	68.7	11.1	38.6	27.3	34.1
Other services	79.5	19.4	74.7	5.9	30.0	31.8	38.1
Public administration and military	88.3	18.2	78.1	*3.7	37.2	28.2	34.7

[a] $100. [b] Less than 20 percent. [c] 20 percent or more. [d] More than $100. [e] Insurer is liable for a maximum of $250,000 per person or less. [f] More than $250,000. [g] Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 52. Benefits for hospital room and board: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with hospital room and board benefits	Full semiprivate charge[a]		Limited daily benefit[c] or hospital indemnity
		High maximum[b]	Other	
	Percent	Percent distribution		
All persons[d]	98.3	53.2	21.1	25.7
Type of insurance				
Nongroup	95.8	11.3	27.0	61.8
Any group	98.6	57.2	20.5	22.2
25 or fewer members	98.0	47.9	18.8	33.4
26-250 members	99.1	50.6	22.5	26.9
251-2,500 members	99.2	53.7	22.4	23.9
More than 2,500 members	98.2	65.8	17.7	16.5
Sex				
Male	98.2	54.1	21.0	25.0
Female	98.6	50.7	21.5	27.9
Employment status				
Full time	98.5	56.3	20.9	22.8
Part time	97.9	46.0	24.9	29.1
Self-employed	97.5	35.0	20.4	44.6
Did not work in 1977	97.2	32.8	26.5	40.7
Industry				
Agriculture	96.0	29.9	19.9	50.2
Manufacturing and mining	98.9	58.3	21.7	20.0
Construction	99.0	27.2	31.3	41.5
Transportation, communication and utilities	98.9	60.1	20.3	19.6
Sales	98.5	42.8	27.1	30.1
Financial services	98.7	49.3	14.7	36.0
Professional services	98.8	55.8	20.0	24.2
Other services	96.4	42.9	23.6	33.4
Public administration and military	98.3	70.7	13.0	16.3

[a] Or at least $90 per day. [b] 365 days of coverage or $50,000 of basic benefits, 90 days or $10,000 of basic benefits with major medical benefits of at least $100,000, or only major medical benefits and a maximum of $250,000 or more. Persons with basic and major medical benefits are categorized by their basic benefits. [c] Less than 100 percent of semiprivate charges, less than $90 per day. [d] Includes persons for whom industry and employment status of primary insured and group size are unknown.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 53. Benefits for skilled nursing facility services: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with skilled nursing facility benefits	Full semiprivate charge[a]	Less than full semiprivate charge
	Percent	Percent distribution	
All persons[b]	48.7	54.6	45.4
Type of insurance			
Nongroup	43.4	28.8	71.3
Any group	49.3	57.7	42.2
25 or fewer members	54.6	23.0	77.1
26-250 members	55.0	44.4	55.6
251-2,500 members	50.8	50.4	49.7
More than 2,500 members	45.7	69.8	30.2
Sex			
Male	47.9	57.2	42.8
Female	51.2	47.3	52.8
Employment status			
Full time employee	48.6	57.9	42.0
Part time employee	51.7	50.4	49.6
Self-employed	50.2	32.7	67.3
Did not work in 1977	46.9	46.6	53.4
Industry			
Agriculture	45.3	*19.1	80.9
Manufacturing and mining	51.0	68.7	31.3
Construction	45.3	32.6	67.5
Transportation, communication and utilities	31.7	43.4	56.6
Sales	50.0	50.2	49.8
Financial services	54.4	28.4	71.7
Professional services	54.6	57.8	42.2
Other services	46.1	30.4	69.7
Public administration and military	45.4	49.0	51.0

[a] Or at least $50 per day. Persons with basic and major medical benefits are categorized by their basic benefits. [b] Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 54. Benefits for inpatient surgery: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with surgery benefits	Percent of UCR charge[a] 100 percent	80-90 percent	Basic less than 80 percent, with major medical	Less than 80 percent, only basic or major medical
	Percent	Percent distribution			
All persons[b]	97.0	48.5	20.4	23.1	8.0
Type of insurance					
Nongroup	91.6	30.4	19.6	10.5	39.5
Any group	97.6	50.2	20.4	24.3	5.0
25 or fewer members	95.5	44.9	23.3	25.2	6.6
26-250 members	97.9	44.8	20.3	29.1	5.7
251-2,500 members	99.0	47.4	17.6	30.0	5.0
More than 2,500 members	97.7	53.8	23.0	20.0	3.2
Sex					
Male	97.1	48.7	21.0	23.1	7.1
Female	96.9	47.9	18.4	23.2	10.4
Employment status					
Full time	97.6	49.3	20.6	24.0	6.2
Part time	95.7	48.4	18.5	23.4	9.8
Self-employed	95.5	39.0	22.7	22.0	16.3
Did not work in 1977	90.6	51.8	9.9	10.1	28.2
Industry					
Agriculture	96.7	31.7	29.4	22.4	16.4
Manufacturing and mining	98.3	54.7	17.3	22.4	5.6
Construction	97.8	36.0	23.8	30.3	9.8
Transportation, communication and utilities	96.1	35.2	35.4	24.6	4.7
Sales	96.9	44.8	21.5	25.3	8.3
Financial services	97.3	36.0	32.1	25.1	6.8
Professional services	97.5	48.2	18.6	24.5	8.7
Other services	96.0	39.4	23.3	26.8	10.4
Public administration and military	99.7	57.6	13.4	23.3	5.7

[a] Persons with basic and major medical benefits are categorized by their basic benefits. [b] Includes persons for whom industry and employment status of the primary insured and group size are unknown.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 55. Benefits for physician office visits and outpatient diagnostic services: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with physician office benefits	Service benefit or full UCR charge[a]	Intermediate visit benefit[b]	Limited visit benefit[c]	Privately insured population with outpatient diagnostic benefits	Full UCR charge or at least $200	Limited UCR charge basic benefit, but major medical	Other[d]
	Percent	Percent distribution			Percent	Percent distribution		
All persons[e]	83.3	20.5	70.9	8.6	93.0	42.6	21.9	35.5
Type of insurance								
Nongroup	40.4	19.8	61.5	18.7	66.0	36.8	10.7	52.6
Any group	87.9	20.5	71.3	8.2	95.9	43.0	22.7	34.4
25 or fewer members	80.7	19.5	74.4	6.0	93.3	39.1	20.8	40.2
26-250 members	88.8	17.1	76.7	6.2	96.1	34.9	28.2	36.9
251-2,500 members	90.8	19.8	71.5	8.7	96.9	41.8	24.3	33.9
More than 2,500 members	89.5	25.0	66.7	8.3	96.0	47.4	20.1	32.5
Sex								
Male	84.3	19.2	72.1	8.7	94.0	42.6	22.2	35.3
Female	80.2	24.3	67.1	8.5	90.2	42.5	21.1	36.4
Employment status								
Full time	86.8	20.2	71.7	8.1	95.0	42.7	22.8	34.6
Part time	75.5	28.3	60.8	10.9	89.3	44.4	19.6	36.0
Self-employed	69.6	18.7	71.0	10.2	84.8	36.8	18.3	44.9
Did not work in 1977	51.8	36.4	44.2	19.4	76.9	49.5	11.9	38.6
Industry								
Agriculture	66.6	13.9	80.3	*5.9	80.0	31.0	23.8	45.3
Manufacturing and mining	83.5	17.6	76.5	5.8	96.0	45.6	22.9	31.5
Construction	84.4	23.5	57.0	19.5	90.7	36.7	30.6	32.8
Transportation, communication and utilities	90.4	16.0	73.1	10.9	96.7	29.5	26.9	43.6
Sales	80.9	20.3	69.7	10.1	92.2	37.4	22.5	40.1
Financial services	88.4	24.0	70.7	5.4	91.7	30.3	25.5	44.2
Professional services	84.5	21.1	72.0	6.9	93.5	42.9	18.8	38.3
Other services	79.6	15.7	73.9	10.4	90.1	37.0	23.3	39.8
Public administration and military	90.2	20.3	74.5	*5.2	95.1	47.7	16.8	35.4

[a] Or $20 or more per visit. Persons with basic and major medical benefits are categorized by their basic benefits. [b] 80 to 99 percent of UCR charge, or copayment of less than $4, or $16-$19 per visit. [c] Less than 80 percent of UCR charge, or copayment in excess of $4, or less than $16 per visit. [d] Includes basic limit of $200 or less without major medical, less than 100 percent UCR charge, fee schedule, or copayment. [e] Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 56. Hospital inpatient benefits for mental health conditions: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with mental health inpatient benefits	Full semiprivate charge[a]		Limited daily benefit[c]
		No deductible, high maximum[b]	Other	
	Percent	Percent distribution		
All persons[d]	82.4	18.0	48.1	33.8
Type of insurance				
Nongroup	65.0	19.4	35.6	45.1
Any group	84.3	17.9	49.4	32.6
25 or fewer members	85.3	11.8	49.2	39.1
26-250 members	87.2	10.1	49.3	40.6
251-2,500 members	83.8	9.0	53.4	37.6
More than 2,500 members	83.2	27.3	48.9	23.7
Sex				
Male	82.9	19.4	47.0	33.5
Female	81.1	14.0	51.1	34.9
Employment status				
Full time	83.8	17.1	49.4	33.4
Part time	74.0	26.1	39.6	34.3
Self-employed	82.9	16.9	49.1	34.0
Did not work in 1977	68.0	38.1	37.6	24.2
Industry				
Agriculture	69.8	*12.7	36.0	51.3
Manufacturing and mining	83.7	24.7	44.7	30.6
Construction	80.4	*2.9	50.1	47.0
Transportation, communication and utilities	80.8	8.0	62.7	29.2
Sales	79.9	11.6	45.6	42.7
Financial services	82.4	15.7	51.7	32.6
Professional services	86.6	14.6	53.1	32.3
Other services	79.5	19.4	45.8	34.9
Public administration and military	88.2	16.9	38.1	44.9

[a] Or at least $90 per day. [b] At least $50,000 or 365 days of basic coverage alone, or at least $100,000 and unlimited days of major medical coverage alone, or at least 90 days of basic coverage in combination with at least $50,000 of major medical coverage. Persons with basic and major medical benefits are categorized by their basic benefits. [c] Less than 100 percent of semiprivate charge, or less than $90 per day. [d] Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 57. Outpatient physician benefits for mental health conditions: Percent distribution of the privately insured population under 65 with coverage, by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Privately insured population with mental health outpatient benefits	High maximum[a]			Other maximum		
		Service benefit or full UCR charge[b]	Intermediate visit benefit[c]	Limited visit benefit[d]	Service benefit or full UCR charge[b]	Intermediate visit benefit[c]	Limited visit benefit[d]
	Percent	Percent distribution					
All persons[e]	71.4	7.4	19.9	25.1	8.8	11.0	27.9
Type of insurance							
Nongroup	20.5	8.2	14.0	31.4	13.9	7.8	24.7
Any group	76.8	7.4	20.0	25.0	8.6	11.0	27.9
25 or fewer members	65.9	4.1	11.1	23.4	10.9	10.4	40.0
26-250 members	78.8	5.2	12.9	24.5	9.0	12.6	35.8
251-2,500 members	77.8	5.7	22.7	19.9	9.0	13.3	29.4
More than 2,500 members	81.8	12.0	21.7	31.5	6.6	8.7	19.6
Sex							
Male	72.9	7.0	20.2	25.2	9.1	11.2	27.2
Female	67.3	8.5	19.0	24.8	7.6	10.3	29.[illegible]
Employment status							
Full time	76.6	7.3	19.9	25.5	8.5	11.1	27.8
Part time	60.0	11.4	19.1	22.4	11.7	10.3	25.6
Self-employed	45.8	6.9	13.0	18.0	9.6	12.1	40.3
Did not work in 1977	31.2	*10.7	17.2	*15.7	*11.0	18.3	27.1
Industry							
Agriculture	52.1	*9.8	12.4	28.0	18.1	12.4	[illegible].2
Manufacturing and mining	81.5	8.6	18.5	26.1	13.2	8.6	25.0
Construction	64.1	8.2	14.0	17.3	7.9	9.8	42.7
Transportation, communication and utilities	77.3	7.1	19.2	38.9	3.1	10.3	21.4
Sales	65.6	7.0	14.4	22.9	10.1	11.9	33.6
Financial services	72.7	8.5	19.6	25.7	*2.4	9.5	34.2
Professional services	69.0	8.0	21.4	20.4	7.4	13.0	29.7
Other services	66.3	5.8	11.0	26.4	5.4	10.7	40.7
Public administration and military	75.2	*6.1	22.8	20.8	7.5	21.1	21.7

[a] $1,000 or more, no visit limit. [b] Or $20 or more per visit. Persons with basic and major medical benefits are categorized by their basic benefits. [c] 80 to 99 percent of UCR charge, or copayment of less than $4, or $16-$19 per visit. [d] Less than 80 percent of UCR charge, or copayment in excess of $4, or less than $16 per visit. [e] Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 58. Benefits for routine dental examinations and bridgework: Percent distribution of the privately insured population under 65 with coverage,[a] by type of insurance, sex, and employment characteristics of the primary insured (United States, 1977).

Characteristics of primary insured	Routine exam: Percent with benefit	Full coverage, no deductible	Limited coverage[b]	All other	Bridgework: Percent with benefit	High benefit[c]	Limited benefit[d]	All other
		Percent distribution				Percent distribution		
All persons[e]	22.7	35.1	32.8	32.1	19.6	28.5	49.8	21.7
Type of insurance								
Any group	25.1	35.1	32.8	32.1	21.7	28.4	49.9	21.7
25 or fewer members	9.0	18.3	41.2	40.5	7.6	37.7	45.3	*17.0
26-250 members	14.7	22.4	31.4	46.2	13.3	27.9	56.5	15.5
251-2,500 members	27.2	20.9	38.3	40.8	23.9	28.3	46.8	24.9
More than 2,500 members	38.4	44.1	30.7	25.2	32.4	31.2	44.0	24.8
Sex								
Male	24.0	34.9	33.2	31.9	20.8	29.3	49.8	20.9
Female	19.0	35.8	31.4	32.8	16.1	25.4	49.8	24.8
Employment status								
Full time	25.9	35.4	33.1	31.5	22.3	27.6	50.4	21.7
Part time	16.8	20.4	45.3	34.4	14.1	19.9	54.6	25.5
Industry								
Manufacturing and mining	28.6	49.9	23.6	26.5	26.6	22.7	59.6	17.7
Construction	29.5	18.8	44.5	36.7	21.3	62.9	*11.2	25.9
Transportation, communication and utilities	44.4	44.7	33.1	22.1	36.3	23.0	51.2	25.8
Sales	20.0	28.8	30.2	40.9	18.0	37.9	31.9	30.2
Financial services	22.5	13.7	31.3	55.1	20.6	33.3	50.7	16.0
Professional services	16.0	15.9	46.7	37.4	13.5	18.7	49.9	31.4
Other services	14.3	16.4	26.5	57.0	13.5	32.8	52.6	*14.6

[a] Omits estimates where primary insured had nongroup insurance, was self-employed or not working in 1977, or in agriculture, public administration, or the military; the population covered in these categories is too small for reliable estimates of benefits. [b] 75 percent of UCR charge, or $10 per treatment, or less. [c] 80 percent of UCR charge, or $300 or more. [d] 50 percent of UCR, or $100 or less. [e] Includes persons for whom industry and employment status of the primary insured and group size are unknown. * Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 59. Private insurance coverage of the population under 65: Percent covered and percent with group insurance, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Population under age 65	Privately insured	Population privately insured	With group coverage	Without group coverage
	Thousands	Percent	Thousands	Percent distribution	
All persons[a]	189,837	80.8	153,315	90.3	9.7
Age in years					
Less than 19	69,014	77.3	53,332	92.5	7.5
19-24	22,109	76.9	17,003	90.4	9.6
25-34	32,155	83.3	26,772	93.2	6.8
35-54	46,354	84.3	39,080	90.0	10.0
55-64	20,206	84 8	17,128	79.7	20.3
Ethnic/racial background					
White	141,234	86.1	121,624	89.9	10.1
Black	19,630	62.3	12,222	94.1	5.9
Hispanic	9,264	64.2	5,950	90.9	9.1
Family income[b]					
Poor and near poor	25,413	39.3	9,979	78.4	21.6
Low	27,005	72.1	19,462	87.4	12.6
Middle	75,238	87.4	65,789	92.2	7.8
High	62,182	93.4	58,084	91.2	8.8
Perceived health status					
Excellent	89,027	85.3	75,892	90.8	9.2
Good	71,249	80.2	57,139	90.7	9.3
Fair	16,881	71.2	12,026	87.2	12.8
Poor	4,572	54.1	2,474	78.3	21.7
Place of residence					
16 largest SMSAs	47,611	83.5	39,774	91.6	8.4
Other large SMSAs	46,901	81.4	38,188	91.3	8.7
Small SMSAs	36,834	80.2	29,535	91.7	8.3
Other, not rural	35,011	78.4	27,433	89.1	10.9
Other rural	23,480	78.3	18,385	85.3	14.7
U.S. Census region					
Northeast	39,915	85.5	34,113	88.6	11.4
North Central	55,947	88.0	49,231	91.5	8.5
South	60,474	75.8	45,859	89.1	10.9
West	33,502	72.0	24,113	92.8	7.2

[a] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [b] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 60. Comprehensive and supplemental major medical coverage: Percent distribution of the privately insured population under 65 with and without major medical coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Population privately insured	Type of major medical coverage: None	Comprehensive only	Supplementary[a]
	Thousands	Percent distribution		
All persons[b]	153,315	17.8	16.6	65.6
Age in years				
Less than 19	53,332	16.3	18.3	65.4
19-24	17,003	16.3	15.4	68.2
25-34	26,772	16.2	18.2	65.7
35-54	39,080	18.0	16.2	65.8
55-64	17,128	25.7	11.1	63.2
Ethnic/racial background				
White	121,624	17.5	16.9	65.5
Black	12,222	18.7	15.3	66.0
Hispanic	5,950	20.3	15.1	64.7
Family income[c]				
Poor and near poor	9,979	23.6	17.1	59.3
Low	19,462	22.0	14.9	63.1
Middle	65,789	16.1	17.6	66.4
High	58,084	17.2	16.0	66.7
Perceived health status				
Excellent	75,892	16.3	17.4	66.3
Good	57,139	18.2	16.3	65.5
Fair	12,026	21.7	14.4	63.8
Poor	2,474	32.8	11.7	55.6
Place of residence				
16 largest SMSAs	39,774	21.9	15.1	63.0
Other large SMSAs	38,188	17.7	16.2	66.1
Small SMSAs	29,535	13.9	18.1	68.0
Other, not rural	27,433	16.4	19.0	64.6
Other, rural	18,385	17.3	14.9	67.8
U.S. Census region				
Northeast	34,113	25.2	5.5	69.4
North Central	49,231	14.8	15.7	69.5
South	45,859	14.8	22.5	62.7
West	24,113	18.9	23.2	57.9

[a] Includes 3 percent of the privately insured holding both supplementary and comprehensive major medical coverage. [b] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [c] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 61. Coverage for selected hospital inpatient services: Percent of the privately insured population under 65, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Population privately insured	Hospital room and board	Surgery	Anesthesia	Inpatient medical	Ambulance	Skilled nursing facility	Hospital indemnity
	Thousands	Percent covered						
All persons[a]	153,315	97.7	97.0	94.3	95.7	85.6	48.7	1.8
Age in years								
Less than 19	53,332	97.6	97.0	94.8	96.2	86.4	47.1	1.1
19-24	17,003	98.5	97.4	95.2	95.7	87.3	52.7	*0.9
25-34	26,772	98.0	97.4	95.3	96.4	86.5	50.0	1.3
35-54	39,080	98.2	97.5	94.7	96.0	85.8	48.5	1.8
55-64	17,128	95.6	95.2	89.8	92.0	79.8	48.7	5.5
Ethnic/racial background								
White	121,624	98.0	97.2	94.8	95.9	85.8	49.3	1.8
Black	12,222	96.8	96.0	91.9	94.0	82.6	40.4	2.4
Hispanic	5,950	96.2	95.8	92.0	94.7	84.8	45.0	*1.0
Family income[b]								
Poor and near poor	9,979	97.7	96.1	89.6	92.2	78.4	47.8	2.8
Low	19,462	98.6	97.6	95.2	95.3	85.2	49.5	1.7
Middle	65,789	97.4	96.7	94.2	95.7	86.3	47.1	1.9
High	58,084	97.8	97.3	95.0	96.1	86.3	50.5	1.5
Perceived health status								
Excellent	75,892	98.0	97.5	95.6	96.5	86.4	48.7	1.5
Good	57,139	97.8	96.9	93.4	95.3	85.3	48.6	1.8
Fair	12,026	96.8	96.5	91.1	93.7	84.1	48.5	3.2
Poor	2,474	95.9	93.3	90.2	91.5	77.0	53.2	*5.7
Place of residence								
16 largest SMSAs	39,774	97.4	96.9	94.8	95.9	84.4	48.8	1.5
Other large SMSAs	38,188	98.5	96.4	95.6	95.4	84.1	50.4	1.2
Small SMSAs	29,535	97.2	97.0	93.0	95.8	87.0	47.0	1.3
Other, not rural	27,433	98.0	97.8	94.5	96.0	88.0	42.8	3.0
Other, rural	18,385	97.4	97.4	92.2	94.9	85.8	57.0	2.2
U.S. Census region								
Northeast	34,113	98.7	96.7	96.0	96.3	77.0	48.8	1.2
North Central	49,231	98.3	98.1	95.6	97.4	87.1	46.8	1.6
South	45,859	97.6	97.4	92.8	94.1	88.1	43.5	2.6
West	24,113	95.5	94.7	92.2	94.2	90.2	62.5	1.4

[a] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [b] Adjusted for family size.
* Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 62. Coverage for outpatient physician, diagnostic, and outpatient facility services: Percent of the privately insured population under 65, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Population privately insured	Physician office visit	Physician home visit	Routine physical exam	Outpatient diagnostic services[a]	Outpatient facility services		
						Surgery	Accident	Emergency
	Thousands	Percent covered						
All persons[b]	153,315	83.3	77.7	6.0	93.0	94.4	94.9	80.9
Age in years								
Less than 19	53,332	84.0	78.3	6.1	93.9	95.2	95.2	81.0
19-24	17,003	83.7	77.8	6.3	93.3	95.8	96.2	83.8
25-34	26,772	85.0	77.3	6.4	93.5	94.3	94.2	81.1
35-54	39,080	83.9	79.4	5.9	93.4	95.0	95.9	82.4
55-64	17,128	76.4	72.2	5.2	88.1	89.2	91.2	74.3
Ethnic/racial background								
White	121,624	83.2	77.3	5.9	93.3	94.5	94.9	80.4
Black	12,222	81.4	80.4	4.1	91.1	94.4	94.7	87.1
Hispanic	5,950	82.7	71.5	7.5	90.4	94.1	94.1	80.9
Family income[c]								
Poor and near poor	9,979	74.4	62.5	3.4	88.5	94.8	93.4	72.3
Low	19,462	80.1	73.6	5.3	92.7	97.9	95.7	83.9
Middle	65,789	85.0	79.1	6.0	93.1	93.7	94.9	81.4
High	58,084	84.0	79.6	6.7	93.8	94.0	94.9	80.8
Perceived health status								
Excellent	75,892	84.7	80.6	6.1	93.4	94.3	94.9	82.8
Good	57,139	82.2	73.9	5.6	93.2	95.0	95.1	79.2
Fair	12,026	80.9	78.9	5.8	90.1	94.3	94.1	79.0
Poor	2,474	75.6	69.4	9.0	89.5	95.5	95.8	84.9
Place of residence								
16 largest SMSAs	39,774	82.4	73.1	9.4	94.0	94.0	95.0	78.7
Other large SMSAs	38,188	83.9	83.3	4.3	94.4	94.8	95.5	82.1
Small SMSAs	29,535	83.7	72.1	4.6	91.4	94.4	94.8	79.6
Other, not rural	27,433	83.6	80.5	4.3	93.2	95.1	95.0	84.4
Other, rural	18,385	82.5	76.9	7.2	90.2	93.6	93.2	78.3
U.S. Census region								
Northeast	34,113	78.6	75.3	5.8	94.6	97.9	98.9	83.7
North Central	49,231	82.2	72.2	3.2	94.6	93.4	92.6	80.6
South	45,859	84.7	82.9	4.1	91.2	94.2	95.4	80.0
West	24,113	89.4	84.6	15.8	90.8	90.1	91.2	78.4

[a] Includes X-ray and laboratory services. [b] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [c] Adjusted for family size.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 63. Coverage for selected outpatient services: Percent of the privately insured population under 65, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Population privately insured	Prescribed medicines	Durable equipment/ supplies	Home health care	Supplemental accident	Vision care	Hearing care
	Thousands	Percent covered					
All persons[a]	153,315	81.8	83.6	24.2	23.2	8.2	3.[illegible]
Age in years							
Less than 19	53,332	82.9	86.0	22.2	22.4	8.6	3.9
19-24	17,003	83.0	82.8	26.7	29.3	7.4	3.7
25-34	26,772	84.0	86.8	22.6	23.1	8.3	3.5
35-54	39,080	82.0	82.9	25.5	23.2	8.7	3.6
55-64	17,128	73.6	74.3	27.3	19.5	6.4	2.1
Ethnic/racial background							
White	121,624	81.7	82.7	24.6	2[illegible].0	8.1	3.6
Black	12,222	82.1	91.0	20.5	26.7	5.6	3.0
Hispanic	5,950	78.4	84.4	22.4	36.[illegible]	14.4	*1.6
Family income[b]							
Poor and near poor	9,979	72.1	71.1	18.4	27.8	6.5	*1.1
Low	19,462	79.2	84.4	24.7	23.8	7.5	2.8
Middle	65,789	83.2	84.1	23.7	23.3	7.7	4.2
High	58,084	82.8	84.9	25.7	22.2	9.3	3.4
Perceived health status							
Excellent	75,892	83.1	85.5	24.4	25.8	7.6	3.5
Good	57,139	80.9	81.8	24.0	21.7	8.6	3.4
Fair	12,026	80.0	84.0	23.5	14.8	7.6	4.7
Poor	2,474	71.9	62.2	28.8	21.0	*6.8	*4.8
Place of residence							
16 largest SMSAs	39,774	79.2	78.2	29.1	19.9	11.1	3.7
Other large SMSAs	38,188	81.9	84.9	29.2	21.3	8.5	2.9
Small SMSAs	29,535	83.6	84.9	19.7	26.8	8.1	1.4
Other, not rural	27,433	83.0	85.6	16.9	29.1	7.3	5.6
Other, rural	18,385	82.8	87.0	21.4	18.4	2.9	4.9
U.S. Census region							
Northeast	34,113	75.7	75.6	49.6	8.1	7.1	3.0
North Central	49,231	85.2	86.0	15.8	23.2	8.2	3.3
South	45,859	82.8	87.7	14.4	24.5	2.4	4.3
West	24,113	81.8	83.9	24.1	51.5	20.9	3.4

[a] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [b] Adjusted for family size.
* Relative standard error equal to or greater than 30 percent.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 64. Coverage for mental health services: Percent of the privately insured population under 65, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Population privately insured	Any mental health coverage	Inpatient hospital	Inpatient physician	Outpatient physician
	Thousands	Percent covered			
All persons[a]	153,315	89.7	82.4	78.6	71.4
Age in years					
Less than 19	53,332	90.9	83.3	79.6	72.9
19-24	17,003	90.1	83.7	79.3	73.2
25-34	26,772	90.4	83.0	79.4	72.1
35-54	39,080	89.8	82.7	78.8	72.0
55-64	17,128	84.1	76.8	72.8	62.7
Ethnic/racial background					
White	121,624	90.4	82.8	78.7	71.6
Black	12,222	89.4	82.8	79.7	71.0
Hispanic	5,950	79.5	70.7	67.5	65.1
Family income[b]					
Poor and near poor	9,979	84.1	78.5	71.2	61.0
Low	19,462	89.3	81.9	78.7	67.6
Middle	65,789	90.0	82.6	78.6	73.1
High	58,084	90.4	83.0	79.8	72.5
Perceived health status					
Excellent	75,892	90.7	83.5	79.4	72.9
Good	57,139	89.1	81.8	78.5	70.4
Fair	12,026	86.2	77.7	73.2	68.7
Poor	2,474	84.5	79.8	73.3	63.7
Place of residence					
16 largest SMSAs	39,774	89.0	81.5	78.4	68.5
Other large SMSAs	38,188	91.2	85.8	81.4	73.4
Small SMSAs	29,535	89.6	81.2	76.4	71.2
Other, not rural	27,433	88.8	80.7	77.8	72.0
Other, rural	18,385	89.5	81.7	77.9	73.1
U.S. Census region					
Northeast	34,113	93.9	88.7	84.0	69.2
North Central	49,231	92.7	84.1	80.1	73.2
South	45,859	87.1	79.6	76.0	72.8
West	24,113	82.5	75.3	72.7	68.3

[a] Includes all other ethnic/racial groups not shown separately and unknown perceived health status. [b] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 65. Coverage for selected maternity services (normal deliveries): Percent of privately insured women aged 15-44, by type of insurance, sociodemographic characteristics, and perceived health status (United States, 1977).

Population characteristics	Women privately insured	Any maternity coverage	Normal delivery	
			Hospital	Physician
	Thousands	Percent covered		
All women 15-44[a]	39,035	89.2	77.4	75.3
Type of insurance				
Nongroup	3,199	72.6	51.0	46.4
Any group	35,836	90.7	79.7	79.0
250 or fewer members	10,537	88.2	71.4	68.0
251-2,500 members	9,738	89.8	79.8	70.0
More than 2,500 members	11,093	93.3	87.0	87.8
Age				
Under 19	6,676	85.8	64.4	64.4
19-24	8,659	86.8	73.5	66.1
25-34	13,534	89.7	80.6	80.7
35-44	10,166	92.8	84.9	82.5
Ethnic/racial background				
White	30,330	89.5	77.9	76.3
Nonwhite	5,012	88.6	74.9	66.4
Family income[b]				
Poor, near poor, or low income	7,827	87.6	73.8	78.5
Middle income	17,132	89.4	78.7	74.3
High income	14,076	89.9	77.7	75.1
Marital status				
Not married	16,427	84.0	66.8	62.7
Married	22,132	93.2	85.4	84.6
Perceived health status				
Excellent	19,035	89.8	78.0	75.0
Good	15,407	88.4	76.3	75.0
Fair or poor	3,520	89.7	77.9	79.4
Place of residence				
16 largest SMSAs	9,978	92.0	79.8	78.6
Other large SMSAs	10,012	88.1	77.3	74.4
Small SMSA	7,893	86.1	75.3	70.8
Other, not rural	6,716	90.9	77.3	76.5
Other, rural	4,436	88.5	76.0	74.8
U.S. Census region				
Northeast	8,642	91.2	81.2	82.3
North Central	12,075	91.5	81.2	76.2
South	11,983	85.7	74.0	74.4
West	6,335	88.7	71.3	63.4

[a] Includes women for whom group size, ethnic/racial background, marital status, or perceived health status are unknown. [b] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 66. Coverage for selected dental services: Percent of the privately insured population under 65, by sociodemographic characteristics (United States, 1977).

Population characteristics	Population privately insured	Any dental care	Routine maintenance[a]	Orthodontia	Periodontia	Prosthodontia[b]
	Thousands	Percent covered				
All persons[c]	153,315	25.4	23.7	13.0	19.9	22.6
Age in years						
Less than 19	53,332	27.8	25.7	15.2	21.9	25.1
19-24	17,003	21.1	20.2	10.7	16.7	19.1
25-34	26,772	27.1	25.3	12.7	20.8	23.8
35-54	39,080	26.0	24.4	13.0	20.6	23.0
55-64	17,128	18.5	16.7	8.6	13.6	16.0
Ethnic/racial background						
White	121,624	25.1	23.5	13.2	19.7	22.5
Black	12,222	24.4	22.5	14.2	19.4	21.5
Hispanic	5,950	30.4	28.7	10.3	22.3	27.2
Family income[d]						
Poor and near poor	9,979	18.4	17.3	9.7	[illegible]	17.2
Low	19,462	19.7	19.1	10.1	16.0	18.4
Middle	65,789	24.9	22.7	12.8	19.7	22.3
High	58,084	29.2	27.4	14.7	22.5	25.4
Place of residence						
16 largest SMSAs	39,774	28.9	26.9	15.6	22.3	25.3
Other large SMSAs	38,188	28.1	26.6	12.8	21.7	25.3
Small SMSAs	29,535	27.8	25.6	14.1	22.9	24.8
Other, not rural	27,43[illegible]	20.6	19.2	11.5	15.9	18.6
Other, rural	18,385	15.9	14.2	8.0	12.0	13.9
U.S. Census region						
Northeast	34,113	27.0	24.8	14.4	20.9	22.7
North Central	49,231	26.5	24.9	16.4	20.9	24.5
South	45,859	14.9	13.7	8.2	11.5	12.6
West	24,113	41.0	38.8	13.0	32.1	37.8

[a] Prophylaxis, examination, or full X-ray. [b] Bridgework or full dentures. [c] Includes all other ethnic/racial groups not shown separately.
[d] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 67. Major medical benefits: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Privately insured population with major medical coverage	Standard deductible or less[a]: Low coinsurance[b]	Standard deductible or less[a]: Standard or high coinsurance[c]	High deductible[d]	Out-of-pocket limit and standard maximum or less[e]	Out-of-pocket limit and high maximum[f]	No out-of-pocket limit
	Percent	Percent distribution			Percent distribution		
All[g]	82.2	23.3	69.7	7.1	32.4	26.3	41.2
Age in years							
Less than 19	83.7	21.6	71.2	7.1	32.6	23.7	43.6
19-24	83.6	29.1	64.8	6.1	31.8	31.5	36.6
25-34	83.9	24.7	68.3	7.0	32.5	28.3	39.1
35-54	82.0	22.8	70.1	7.0	32.5	26.3	41.2
55-64	74.3	20.4	71.0	8.5	31.4	26.4	42.1
Ethnic/racial background							
White	82.4	23.4	69.4	7.2	32.3	25.9	41.8
Black	81.3	22.7	70.8	6.5	38.6	26.9	34.6
Hispanic	79.8	20.1	70.3	9.5	27.4	33.5	39.1
Family income[h]							
Poor and near poor	76.4	22.8	68.3	8.9	29.1	25.1	45.8
Low	78.0	18.8	75.2	5.9	32.5	20.7	46.6
Middle	84.0	22.7	70.6	6.7	33.5	24.3	42.2
High	82.7	25.4	67.0	7.6	31.6	30.6	37.7
Perceived health status							
Excellent	83.7	24.6	68.1	7.3	32.5	26.7	40.7
Good	81.8	22.0	70.8	7.2	32.1	26.3	41.6
Fair	78.2	21.0	72.6	6.4	33.4	26.7	39.8
Poor	67.3	21.1	71.6	*7.3	30.8	18.2	51.0
Place of residence							
16 largest SMSAs	78.1	24.0	69.7	6.3	30.6	27.5	41.8
Other large SMSAs	82.3	21.5	72.1	6.4	28.7	28.4	43.0
Small SMSAs	86.1	18.2	73.3	8.5	36.9	26.4	36.7
Other, not rural	83.6	29.8	62.9	7.3	33.1	24.9	41.9
Other, rural	82.7	23.6	69.0	7.3	35.1	21.8	43.2
U.S. Census region							
Northeast	74.9	19.3	75.0	5.8	23.2	23.3	53.6
North Central	85.2	27.3	66.3	6.3	34.8	24.5	40.6
South	85.2	22.0	68.9	9.2	37.5	24.2	38.2
West	81.1	22.2	71.7	6.1	28.9	38.7	32.4

[a] $100. [b] Less than 20 percent. [c] 20 percent or more. [d] More than $100. [e] Insurer is liable for a maximum of $250,000 per person or less. [f] More than $250,000. [g] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [h] Adjusted for family size. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 68. Benefits for hospital room and board: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Characteristics of primary insured	Privately insured population with hospital room and board benefits	Full semiprivate charge[a]		Limited daily benefit[c] or hospital indemnity
		High maximum[b]	Other	
	Percent	Percent distribution		
All[d]	98.3	53.2	21.1	25.7
Age in years				
Less than 19	97.9	53.4	21.7	24.9
19-24	98.8	54.7	19.6	25.7
25-34	98.4	54.8	20.2	25.0
35-54	98.8	52.4	22.0	25.6
55-64	98.1	50.2	20.4	29.5
Ethnic/racial background				
White	98.5	52.8	21.7	25.5
Black	98.2	54.3	19.3	26.3
Hispanic	96.8	42.0	23.1	34.8
Family income[e]				
Poor and near poor	98.6	42.5	23.9	33.6
Low	99.1	47.7	23.0	29.3
Middle	97.9	52.7	21.5	25.8
High	98.5	57.3	19.6	23.0
Perceived health status				
Excellent	98.5	54.3	21.0	24.6
Good	98.3	52.8	21.0	26.2
Fair	98.2	51.0	20.4	28.7
Poor	98.4	43.6	25.5	30.9
Place of residence				
16 largest SMSAs	97.9	57.9	22.4	19.6
Other large SMSAs	98.9	56.0	20.0	24.1
Small SMSAs	97.9	50.1	20.9	28.9
Other, not rural	98.7	49.4	21.9	28.8
Other, rural	98.1	47.5	20.2	32.4
U.S. Census region				
Northeast	98.8	60.4	29.4	10.1
North Central	98.6	59.5	20.3	20.1
South	98.7	43.4	21.1	35.5
West	96.4	48.4	11.0	40.5

[a] Or at least $90 per day. [b] 365 days of coverage or $50,000 of basic benefits, 90 days or $10,000 of basic benefits with major medical benefits of at least $100,000, or only major medical benefits and a maximum of $250,000 or more. Persons with basic and major medical benefits are categorized by their basic benefits. [c] Less than 100 percent of semiprivate charges, less than $90 per day. [d] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [e] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 69. Benefits for skilled nursing facility services: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Privately insured population with skilled nursing facility benefits	Full semiprivate charge[a]	Less than full semiprivate charge
	Percent	Percent distribution	
All[b]	48.7	54.6	45.4
Age in years			
Less than 19	47.1	56.4	43.6
19-24	52.7	55.1	45.0
25-34	50.0	52.4	47.6
35-54	48.5	57.2	42.9
55-64	48.7	47.3	52.8
Ethnic/racial background			
White	49.3	53.7	46.2
Black	40.4	59.2	40.7
Hispanic	45.0	64.5	35.5
Family income[c]			
Poor and near poor	47.8	29.9	70.2
Low	49.5	60.1	39.9
Middle	47.1	55.1	44.9
High	50.5	56.3	43.7
Perceived health status			
Excellent	48.7	53.2	46.9
Good	48.6	54.9	45.1
Fair	48.5	53.8	[illegible]
Poor	53.2	59.9	40.0
Place of residence			
16 largest SMSAs	48.8	66.[illegible]	33.9
Other large SMSAs	50.4	45.5	54.5
Small SMSAs	47.0	43.8	56.2
Other, not rural	42.8	60.0	40.0
Other, rural	57.0	64.1	36.0
U.S. Census region			
Northeast	48.8	57.3	42.7
North Central	46.8	53.6	46.4
South	43.5	54.3	45.7
West	62.5	53.2	46.9

[a] Or at least $50 per day. Persons with basic and major medical benefits are categorized by their basic benefits. [b] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [c] Adjusted for family size.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 70. Benefits for inpatient surgery: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Privately insured population with surgery benefits	Percent of UCR charge[a]			
		100 percent	80-99 percent	Basic less than 80 percent, with major medical	Less than 80 percent, only basic or major medical
	Percent	Percent distribution			
All[b]	97.0	48.5	20.4	23.1	8.0
Age in years					
Less than 19	97.0	47.5	21.6	23.9	7.0
19-24	97.4	50.3	19.7	22.4	7.5
25-34	97.4	47.9	21.7	23.5	7.0
35-54	97.5	48.9	19.6	23.0	8.4
55-64	95.2	49.7	16.8	21.2	12.2
Ethnic/racial background					
White	97.2	48.5	20.9	22.6	8.0
Black	96.0	48.0	18.8	25.2	7.9
Hispanic	95.8	35.8	17.8	36.7	9.7
Family income[c]					
Poor and near poor	96.1	43.7	20.5	22.5	13.2
Low	97.6	45.4	17.2	27.4	10.0
Middle	96.7	49.2	21.2	22.5	7.2
High	97.3	49.6	20.[illegible]	22.6	7.3
Perceived health status					
Excellent	97.5	49.0	20.8	22.7	7.6
Good	96.9	48.1	20.2	23.4	8.2
Fair	96.5	48.3	19.0	22.8	9.9
Poor	93.3	49.9	16.5	24.1	9.6
Place of residence					
16 largest SMSAs	96.9	45.4	18.4	26.3	9.8
Other large SMSAs	96.4	49.6	20.9	23.3	6.2
Small SMSAs	97.0	53.6	23.8	16.1	6.5
Other, not rural	97.8	47.1	18.5	24.4	10.0
Other, rural	97.4	46.[illegible]	20.8	25.4	6.9
U.S. Census region					
Northeast	96.7	50.9	11.5	25.6	12.0
North Central	98.1	57.8	19.2	18.0	5.0
South	97.4	37.8	24.8	27.8	9.6
West	94.7	46.4	26.8	21.4	5.3

[a] Persons with basic and major medical benefits are categorized by their basic benefits. [b] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [c] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 71. Benefits for physician office visits and outpatient diagnostic services: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Privately insured population with physician office benefits	Service benefit or full UCR charge[a]	Inter-mediate visit benefit[b]	Limited visit benefit[c]	Privately insured population with outpatient diagnostic benefits	Full UCR charge or at least $200	Limited UCR charge basic benefit but major medical	Other[d]
	Percent	Percent distribution			Percent	Percent distribution		
All[e]	83.3	20.5	70.9	8.6	93.0	42.6	21.9	35.0
Age in years								
Less than 19	84.0	17.4	74.4	8.2	93.9	42.1	21.4	36.5
19-24	83.7	25.8	67.1	7.1	93.3	45.2	23.4	31.3
25-34	85.0	22.8	69.2	8.1	93.5	43.2	21.0	35.9
35-54	83.9	20.9	69.8	9.3	93.4	42.1	22.2	35.7
55-64	76.4	20.4	68.6	11.0	88.1	41.2	22.7	36.0
Ethnic/racial background								
White	83.2	20.3	71.0	8.7	93.3	42.6	22.1	35.4
Black	81.4	19.7	73.9	[illegible].4	91.1	44.5	15.9	39.6
Hispanic	82.7	21.4	65.[illegible]	1[illegible].7	90.4	34.4	24.6	41.0
Family income[f]								
Poor and near poor	74.4	17.2	73.6	9.2	88.5	40.6	19.1	40.3
Low	80.1	16.4	74.9	8.6	92.7	40.7	23.4	35.9
Middle	85.0	19.4	72.0	8.5	93.1	42.4	21.7	36.0
High	84.0	23.[illegible]	67.8	8.7	93.8	43.7	22.0	34.3
Perceived health status								
Excellent	84.7	20.7	71.0	8.3	93.4	42.8	22.8	34.4
Good	82.2	20.1	71.6	8.2	93.2	42.3	20.7	37.0
Fair	80.9	20.5	68.7	10.9	90.1	41.8	22.0	[illegible]
Poor	75.6	21.2	63.9	14.8	89.5	45.1	15.8	39.1
Place of residence								
16 largest SMSAs	82.4	21.9	67.6	10.5	94.0	42.1	22.7	35.2
Other large SMSAs	83.9	17.3	73.6	9.0	94.4	44.0	19.8	36.2
Small SMSAs	83.7	21.2	70.1	8.7	91.4	44.6	19.6	35.8
Other, not rural	83.6	22.0	70.8	7.2	93.2	43.4	22.8	33.9
Other, rural	82.5	20.6	73.[illegible]	6.1	90.2	35.8	26.8	37.3
U.S. Census region								
Northeast	78.6	22.1	67.6	10.2	94.6	47.7	20.5	31.8
North Central	82.2	18.9	74.9	6.1	94.6	51.0	25.6	23.5
South	84.7	17.3	77.6	5.1	91.2	31.9	16.8	51.2
West	89.4	27.1	55.3	17.6	90.8	37.7	25.9	36.4

[a] Or $20 or more per visit. Persons with basic and major medical benefits are categorized by their basic benefits. [b] 80 to 99 percent of UCR charge, or copayment of less than $4, or $16-$19 per visit. [c] Less than 80 percent of UCR charge, or copayment in excess of $4, or less than $16 per visit. [d] Includes basic limit of $200 or less without major medical, less than 100 percent UCR charge, fee schedule, or copayment. [e] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [f] Adjusted for family size.
Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 72. Hospital inpatient benefits for mental health conditions: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Privately insured population with mental health inpatient benefits	Full semiprivate charge[a]		Limited daily benefit[c]
		No deductible, high maximum[b]	Other	
	Percent	Percent distribution		
All[d]	82.4	18.0	48.1	33.8
Age in years				
Less than 19	83.3	20.2	46.8	32.9
19-24	83.7	16.4	50.7	32.9
25-34	83.0	20.1	46.1	33.7
35-54	82.7	16.8	49.7	33.5
55-64	76.8	12.3	48.6	39.1
Ethnic/racial background				
White	82.8	18.8	48.2	32.9
Black	82.8	7.2	47.1	45.7
Hispanic	70.7	16.3	54.8	28.9
Family income[e]				
Poor and near poor	78.5	9.8	48.4	41.7
Low	81.9	27.6	35.9	36.4
Middle	82.6	18.8	49.1	[illegible]
High	83.0	15.5	50.4	34.1
Perceived health status				
Excellent	83.5	17.9	46.4	35.8
Good	81.8	17.3	48.8	33.8
Fair	77.7	18.4	54.2	27.4
Poor	79.8	28.7	49.0	22.3
Place of residence				
16 largest SMSAs	81.5	13.8	55.8	30.4
Other large SMSAs	85.8	12.0	49.7	38.3
Small SMSAs	81.2	7.3	55.6	37.0
Other, not rural	80.7	33.1	38.6	28.3
Other, rural	81.7	29.1	34.0	36.9
U.S. Census region				
Northeast	88.7	11.9	68.4	19.7
North Central	84.1	26.6	42.0	31.3
South	79.6	18.0	43.9	38.1
West	75.3	7.6	23.3	69.1

[a] Or at least $90 per day. [b] At least $50,000 or 365 days of basic coverage alone, or at least $100,000 and unlimited days of major medical coverage alone, or at least 90 days of basic coverage in combination with at least $50,000 of major medical coverage. Persons with basic and major medical benefits are categorized by their basic benefits. [c] Less than 100 percent of semiprivate charge, less than $90 per day. [d] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [e] Adjusted for family size

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

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Table 73. Outpatient physician benefits for mental health conditions: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics and perceived health status (United States, 1977).

Population characteristics	Privately insured population with mental health outpatient benefits	High maximum[a]			Other maximum		
		Service benefit or full UCR charge[b]	Intermediate visit benefit[c]	Limited visit benefit[d]	Service benefit or full UCR charge[b]	Intermediate visit benefit[c]	Limited visit benefit[d]
	Percent	Percent distribution					
All[e]	71.4	7.4	19.9	25.1	8.8	11.0	27.9
Age in years							
Less than 19.	72.9	6.3	19.6	25.5	8.9	11.2	28.4
19-24	73.2	10.8	18.7	21.8	8.8	11.2	28.8
25-34	72.1	8.0	19.1	25.3	9.1	11.4	27.0
35-54	72.0	7.2	21.3	25.5	8.0	11.1	26.9
55-64	62.7	6.8	19.7	26.3	9.5	8.8	29.0
Ethnic/racial background							
White	71.6	7.4	19.5	25.1	9.2	11.5	27.3
Black	71.0	9.7	25.4	29.0	3.8	6.2	25.9
Hispanic	65.5	5.6	15.1	20.9	6.2	8.8	43.5
Family income[f]							
Poor and near poor	61.0	10.5	16.7	15.2	5.6	14.7	37.4
Low	67.6	4.5	19.2	24.3	11.2	10.2	30.6
Middle	73.2	7.2	19.8	26.1	8.6	9.5	28.7
High	72.5	8.1	20.6	25.7	8.6	12.3	24.7
Perceived health status							
Excellent	72.9	7.5	19.6	24.8	9.6	11.2	27.2
Good	70.4	6.9	20.7	25.9	7.6	[illegible]	28.5
Fair	68.7	7.3	17.9	26.6	8.4	[illegible]	29.2
Poor	63.7	9.5	18.6	28.6	8.0	14.0	21.2
Place of residence							
16 largest SMSAs	68.5	8.2	22.7	22.9	6.2	13.0	26.9
Other large SMSAs	73.4	7.7	20.5	26.5	11.0	8.9	25.3
Small SMSAs	71.2	6.4	18.1	23.8	8.5	10.0	33.1
Other, not rural	72.0	6.3	17.9	28.4	6.3	12.4	28.6
Other, rural	73.1	8.4	18.2	23.9	13.5	10.6	25.3
U.S. Census region							
Northeast	69.2	7.8	24.1	21.3	14.7	8.0	24.0
North Central	73.2	8.4	19.6	22.0	12.9	14.5	22.6
South	72.8	6.9	19.7	33.8	1.9	10.3	27.4
West	68.3	5.5	14.7	20.4	4.8	8.8	45.8

[a] $1,000 or more, no visit limit. [b] Or $20 or more per visit. Persons with basic and major medical benefits are categorized by their basic benefits. [c] 80 to 99 percent of UCR charge, or copayment of less than $4, or $16-$19 per visit. [d] Less than 80 percent of UCR charge, or copayments in excess of $4, or less than $16 per visit. [e] Includes all other ethnic/racial groups not shown separately and persons with unknown perceived health status. [f] Adjusted for family size.

Source: National Center for Health Services Research and Health Care Technology Assessment, NMCES Health Insurance/Employer Survey.

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Table 74. Hospital benefits for normal deliveries: Percent distribution of privately insured women aged 15-44 with coverage, by type of insurance, sociodemographic characteristics, and perceived health status (United States, 1977).

Population characteristics	Women with hospital maternity benefit	Full coverage[a]	Limited coverage[b]	Other
	Percent	Percent distribution		
All women 15-44[c]	77.4	54.3	6.8	38.9
Type of insurance				
Nongroup	[illegible]1.0	26.2	*8.6	65.2
Any group	79.7	55.9	6.7	37.5
250 or fewer members	71.4	51.2	6.9	41.9
251-2,500 members	79.8	53.1	7.3	39.6
More than 2,500 members	87.0	61.0	5.6	33.4
Age				
Under 19	64.4	60.2	4.7	35.[illegible]
19-24	73.5	56.6	7.7	35.7
25-34	80.6	51.2	6.9	41.8
35-44	84.9	53.5	7.0	3[illegible].4
Ethnic/racial background				
White	77.9	54.2	6.8	39.1
Nonwhite	74.9	51.9	7.0	41.1
Family income[d]				
Poor, near poor, low income	73.8	47.8	10.1	42.2
Middle income	78.7	54.3	6.2	39.5
High income	77.7	57.7	5.8	36.5
Marital status				
Not married	66.8	55.2	6.1	38.7
Married	85.4	52.6	7.6	39.7
Perceived health status				
Excellent	78.0	56.2	6.4	37.4
Good	76.3	53.9	6.7	39.5
Fair or poor	77.9	46.7	9.0	44.2
Place of residence				
16 largest SMSAs	79.8	51.7	6.1	42.1
Other large SMSAs	77.3	53.3	6.6	40.1
Small SMSA	75.3	51.5	8.9	39.5
[illegible]er, not rural	77.3	60.2	7.2	32.7
Other, rural	76.0	58.7	*4.4	36.9
U.S. Census region				
Northeast	81.2	46.4	4.8	48.8
North Central	81.2	69.7	4.4	26.0
South	74.0	49.4	9.0	41.5
West	71.3	43.4	10.7	4[illegible].9

[a] Or at least $90 per day. Persons with basic and major medical benefits are categorized by their basic benefits. [b] Less than $500, 4 days of stay, or $90 per day. [c] Includes women for whom group size, ethnic/racial background, marital status, or perceived health status are unknown. [d] Adjusted for family size. * Relative standard error equal to or greater than 30 percent.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

Table 75. Benefits for routine dental examinations and bridgework: Percent distribution of the privately insured population under 65 with coverage, by sociodemographic characteristics (United States, 1977).

Population characteristics	Routine exam				Bridgework			
	Percent with benefit	Full coverage, no deductible	Limited coverage[a]	All other	Percent with benefit	High benefit[b]	Limited benefit[c]	All other
	Percent	Percent distribution			Percent	Percent distribution		
All[d]	22.7	35.1	32.8	32.1	19.6	28.5	49.8	21.7
Age in years								
Less than 19	24.9	32.9	33.0	34.1	21.9	30.6	48.2	21.2
19-24	19.5	38.0	32.8	29.2	16.6	24.8	50.1	25.1
25-34	24.2	33.7	32.7	33.6	20.2	26.7	53.0	20.2
35-54	23.1	36.2	34.0	29.9	20.0	28.4	47.2	24.4
55-64	15.9	41.5	28.6	29.9	13.7	26.4	58.6	15.0
Ethnic/racial background								
White	22.7	34.6	33.9	31.5	19.6	28.9	48.1	23.0
Black	22.2	48.4	21.8	29.8	19.2	28.6	55.7	15.7
Hispanic	25.8	17.9	41.4	40.7	21.2	25.5	57.2	17.3
Family income[e]								
Poor and near poor	16.1	29.1	32.3	38.6	14.2	53.1	31.6	15.3
Low	18.1	35.5	31.4	33.1	16.2	32.5	43.2	24.3
Middle	22.1	32.6	32.9	34.5	19.6	27.7	50.6	21.6
High	26.1	38.0	33.1	28.9	21.7	25.4	52.7	21.9
Place of residence								
16 largest SMSAs	25.1	34.5	34.3	31.2	21.4	35.6	47.3	17.1
Other large SMSAs	25.6	42.5	25.1	32.4	22.2	26.0	46.6	27.4
Small SMSAs	24.8	31.8	37.2	31.0	21.9	32.4	42.8	24.7
Other, not rural	18.9	32.8	37.0	30.2	16.1	15.2	66.5	18.3
Other, rural	13.5	25.5	33.2	41.3	11.9	26.0	58.4	15.6
U.S. Census region								
Northeast	23.9	43.7	34.3	22.0	18.7	25.3	39.9	34.8
North Central	24.0	42.3	26.0	31.7	22.2	34.3	52.0	13.7
South	13.0	34.5	27.2	38.4	11.2	19.4	62.6	18.0
West	36.7	18.4	44.7	36.9	31.8	28.6	46.6	24.8

[a] 75 percent of UCR charge, or $10 per treatment, or less. [b] 80 percent of UCR charge, $300, or more. [c] 50 percent of UCR charge, or $100 or less. [d] Includes all other ethnic/racial groups not shown separately. [e] Adjusted for family size.

Source: National Center for Health Services Research and Health Care Technology Assessment. NMCES Health Insurance/Employer Survey.

4. Summary remarks

Despite variations among population groups and in specific benefit provisions, the private insurance of much of the U.S. population under 65 showed a consistent pattern in 1977. Most of the privately insured held major medical insurance, sometimes alone but more often to supplement a basic plan. Virtually all of the privately insured were covered for the inpatient physician and hospital care expenses commonly associated with a hospitalization, and these expenses were frequently covered in full. But insurance for physician office visits, prescribed medicines, and many other outpatient services was far from universal, typically limited to major medical insurance, and consequently characterized by a deductible and coinsurance. Benefits for mental health care, especially on an outpatient basis, were more restrictive than for hospital or physician services in general. Dental insurance was relatively uncommon in 1977, as was coverage for vision or hearing care.

While not reflecting particular developments since 1977, this overall picture of the health insurance of most noninstitutionalized Americans is still fairly close to the present state of private coverage. What has changed is the greater breadth of covered services (especially the extent of dental insurance), a trend toward greater choice of comprehensive prepaid group plans instead of traditional insurance, and some increase in cost sharing combined with pronounced improvements in limiting the out-of-pocket liability of the insured. Also, substantial changes in the financing of health insurance have occurred. Although not directly affecting individual benefits, these may well become significant in shaping future private coverage.

Some of these changes are evident in more recent data, although these data are not generally representative of the entire U.S. population nor as detailed as those from NMCES. A main source of current estimates, the Bureau of Labor Statistics (BLS) annual survey of health insurance benefits in medium and large firms, covers a population that amounts to only about half the privately insured population described in this report. Sources such as the health expenditure data published by HCFA (Levit et *al.*, 1985) or the health insurance estimates of HIAA (1985) provide only national aggregates or are limited to particular types of plans (e.g. HIAA, 1983). The following relates the NMCES findings to these more recent data to provide a fuller assessment of private health insurance in the United States.

The extent and structure of benefits

Eighty-two percent of the privately insured noninstitutionalized civilian population were covered by major medical insurance in 1977. About a fifth held comprehensive major medical plans, while the remaining four-fifths held supplementary plans designed to accompany basic benefits. Enrollment in major medical insurance has increased more rapidly since 1977 than private enrollment overall (HIAA, 1985), so that currently an even larger proportion of the privately insured are covered by major medical insurance. There also has been a shift away from the supplementary to the comprehensive type of plan (HIAA, 1985). For example, just 12 percent of the employees covered in the BLS survey in 1980 held solely major medical benefits for hospital room and board charges, compared to 28 percent in 1984. (These percentages treat modified comprehensive plans, which fully cover hospital expenses at least up to some specified limit, as a basic-plus-major medical plan. They consequently correspond to the percent of employees subject to major medical coinsurance for hospital expenses in each year.)

That the dollar amounts of deductibles and maximum benefits have changed is in part a reflection of the substantial inflation in the costs of care over the last decade. In 1977, 75 percent of persons with major medical insurance faced a coinsurance rate of 20 percent, and 60 percent had a $100 deductible. These are still the most common major medical provisions, but deductibles of $150 or more are becoming more common and $50 deductibles are becoming rare. Eight percent of employees with major medical coverage in the 1980 BLS survey had deductibles of $150 or more, compared to 21 percent in 1984 (BLS, 1980, 1984; Chollet, 1984). With regard to maximum benefits, 62 percent of persons with major medical insurance were insured for more than $100,000 in 1977, and only 30 percent for more than $250,000. While only 15 percent of employees covered through commercial major medical insurance had a maximum of $50,000 or more in 1970, 89 percent did in 1980 (HIAA, 1982). Fifty-three percent of employees in the 1984 BLS survey had a maximum benefit

greater than $250,000, including 18 percent without any maximum.

Probably the most significant trend with respect to major medical insurance is the improvement in protection against catastrophically high coinsurance payments. Forty-one percent of persons with major medical insurance in 1977 had no limit on out-of-pocket expenses, including about 45 percent of those in larger groups (250 members or more), comparable to those surveyed by BLS. By 1984, 75 percent of employees in BLS had such stop-loss provisions, up from 55 percent in 1980. HIAA (1982) reports a similar improvement in the catastrophic protection of major medical plans sold by commercial insurers through employer groups.

Traditionally, hospital and inpatient physician (including surgical) charges have been covered under private health insurance plans. Furthermore, 74 percent of persons with hospital insurance had full semiprivate benefits in 1977; nearly all of these were fully insured for miscellaneous hospital charges. Almost half had full UCR charge benefits for surgery or its fee-schedule equivalent, and the percent with a service benefit or full UCR charge benefits for other inpatient physicians was nearly as great. Federal legislation enacted since 1977 required employers to offer the same insurance for maternity care as for other health conditions, extending these benefits to cover normal deliveries as well.

Full coverage of inpatient services, especially hospital charges, is still common. The BLS data indicate that the comprehensiveness of basic hospital insurance remains unchanged (see also HIAA, 1983). However, as noted earlier, there has been a shift from basic hospital plans toward major medical insurance alone, and an accompanying increase in hospital cost sharing. The BLS data indicate that hospital cost sharing increased from 20 percent of employees in 1980 to 32 percent in 1984. Surveys of large companies between 1980 and 1982 (Chollet, 1984) indicated that a tenth increased their hospital cost sharing to 10 to 20 percent of covered expenses. Nevertheless, Health Care Financing Administration data indicate that the proportion of private expenditures for hospital care that are paid out of pocket remains unchanged on a national basis (Gibson, 1979; Levit *et al.*, 1985).

Some outpatient services, specifically the use of outpatient hospital facilities and outpatient diagnostic and laboratory services, are also widely covered. Both NMCES and more recent data show them to be generally insured as a basic benefit, often in combination with a supplementary major medical plan. Correspondingly, full payment of at least initial expenses is typical. Coverage of physician office visits, prescription medicines, and durable equipment and supplies remains less widespread and often limited to major medical insurance, with reimbursement usually subject to a deductible and coinsurance. Only 83 percent of the privately insured had office visit benefits in 1977; barely a sixth (17 percent) of those covered had no deductible, and a fifth (21 percent) were fully insured for UCR charges.

Separate treatment of mental health conditions remains common. Sometimes, these are excluded from hospital and physician benefits; if covered, benefits are often more restricted than for general medical conditions, especially with regard to outpatient mental health care. Ninety percent of those insured in 1977, and 90 percent of insured employees in the 1984 BLS survey, had different benefits for outpatient mental health care than for other outpatient physician services. The majority in 1977 were insured for less than 80 percent (often 50 percent) of outpatient expenses, and about half were subject to a limit on the number of visits or a maximum payment below $1,000. The trend in the 1980 to 1984 BLS data is toward an increasing proportion of employees subject to a maximum dollar benefit.

Dental insurance is the fastest growing element in private health insurance coverage. Enrollment has more than doubled since 1977 (HIAA, 1985), when only about a quarter of the privately insured were covered for dental care. However, except for a trend towards somewhat higher maximum benefits and more frequent separate dental deductibles, the structure of dental insurance remains largely unchanged (BLS, 1980, 1984; Bureau of Health Professions, 1981). Dental benefits most often cover routine preventive care and simple procedures like fillings and extractions; benefits for preventive care are the most comprehensive. Often, only about half of charges for major restorations such as crowns and bridges are covered. Orthodontia benefits are still the most limited in terms of the percentage reimbursed and have not

kept pace with dental insurance as a whole in terms of the number of persons covered. Only half of those with dental plans were covered for orthodontics in 1977; of these, two-thirds were insured for no more than either 50 percent of expenses or $[illegible].

The range of services covered by private insurance has widened in other respects (BLS, 1980, 1984; Chollet, 1984); in 1977, for example, only 13 percent of enrollees in even the largest groups had vision benefits and 10 percent had hearing benefits. BLS reports that 33 percent of the employees covered by its survey had vision benefits in 1984 (up from 21 percent in 1980); 14 percent had hearing benefits; 38 percent were insured for second surgical opinions; 61 percent for alcoholism treatment; and 52 percent for drug abuse treatment. Insurance for nursing and related care outside the hospital, especially home health care, has also become somewhat more common, although it still excludes long-term nursing home care. Eleven percent of employees in the BLS survey had hospice benefits in 1984 and 46 percent were insured for home health care, compared with 22 percent of those enrolled in groups of 250 or more who had home health benefits in 1977.

The distribution of private insurance and benefits

The nation's insurers were not equally distributed around the country in 1977, and regional patterns of private health insurance reflected the types of benefits that each emphasizes. For example, Blue Cross and Blue Shield were predominant in the Northeast, with about a 45 percent enrollment rate in the country as a whole. Major medical insurance, which is sold more extensively by commercial insurers (HIAA, 1985), was least common in the Northeast, and coverage of many outpatient services was consequently lower as well. Enrollment in HMOs was about four times the national average in the West. There, coverage of the routine and preventive services favored by HMOs was both more common and more comprehensive, although more so than in proportion to the actual HMO enrollment. Commercial insurers, who insured close to two-thirds of the privately insured, were more evenly distributed, but held their largest share of enrollment in the South and the North Central region, where major medical insurance was most prevalent. In some respects, however, benefits in the South were less generous than elsewhere in the country.

Aside from these regional patterns, it was the dif[illegible] between group and nongroup insurance, combined with employment-related differences in group enrollment, that accounted for most variations in the private insurance of the population under 65. Group enrollees were insured for a much wider range of services than nongroup enrollees, partly due to a twofold difference in enrollment in major medical plans. For expenses commonly insured under both group and nongroup plans, such as inpatient charges or outpatient facility and diagnostic charges, group benefits were more comprehensive. For example, only 38 percent of persons with nongroup hospital benefits were fully insured for semiprivate room and board charges, compared to 78 percent of persons with group hospital benefits.

The comprehensiveness of group benefits generally increased with the size of the group, and industry differences in insurance largely reflected company size and the availability of group benefits. Thus, manufacturing and mining, along with transportation, communication and utilities, were the [illegible] sectors with the richest benefits. Workers in agriculture, construction, sales, and other than financial or professional services had the least group insurance and on average the most limited benefits.

Those without access to an employment-related group plan could either purchase a limited nongroup policy for a higher premium than most group enrollees pay out of pocket, or forego private health insurance altogether. Consequently, rates of enrollment in private insurance tended to follow rates of employment across the population; persons with less access to employee health benefits were more likely to have nongroup insurance when insured and less comprehensive benefits. Full-time workers and their families were most often insured (97 percent in 1977) and had the most extensive insurance. The self-employed without group insurance were more likely to purchase a nongroup plan for themselves and their families than part-time workers; they were insured more often (80 percent compared to 59 percent) but had fewer benefits. The benefits of the few nonworkers and their families who had any private insurance generally followed the pattern of nongroup insurance, *i.e.*, relatively little major medical insurance,

limited inpatient benefits, and less frequent coverage of many outpatient services.

The link between employment and private health insurance, particularly group insurance, was evident in many other ways. Overall, young adults, nonwhites, and female heads of household and their dependents were much less often covered by group insurance than their older, white, male counterparts. They did not compensate by enrolling more frequently in nongroup plans, leaving large proportions without private insurance; those insured had benefits roughly comparable to the rest of the insured population. By contrast, older persons nearing retirement age, the poor, and those in poor health, who also had less group coverage, were disproportionately enrolled in nongroup plans when insured. Their private insurance benefits were consequently characteristic of a higher proportion of nongroup plans. Furthermore, although persons 55-64 were insured as often as other adults above age 25, those who were poor or in poor health were the most likely to lack private insurance.

Implications

Since 1977, the share of personal health expenditures paid by private insurance has increased as a percentage of nongovernmental payments, from 44 percent in 1977 to 52 percent in 1984 (Gibson, 1979; Levit *et al.*, 1985). The system of employment-related health insurance groups provides extensive coverage of most inpatient and a wide range of outpatient services to much of the population. Major medical insurance is common, and protection against unusually large and potentially catastrophic expenses is both extensive and improving. The most expensive services are associated with an inpatient admission, and these are the best insured. Nevertheless, there are exceptions to this general rule and, since group insurance involves so many people, the small proportion of employees with inadequate benefits amounts to a large proportion of the underinsured. Moreover, since neither employment nor access to employee health benefits is evenly distributed across the population, a small portion of the population is left with limited nongroup benefits or without private insurance. This population comprises the groups most likely to incur large expenses (those near 65 years or persons in poor health) and the least able to pay (the poor and other than full-time workers; Farley, 1985b).

Recent developments in the financing and organization of employee health benefits may be more significant than the redesign of some benefit and cost-sharing provisions described here. Most notable in this respect is the number of employers who now choose to self-insure or otherwise pay employee claims directly. Under these arrangements, employers are exempted from state laws mandating specific insurance benefits. They also avoid premium taxes and can make interim use of the funds set aside for benefit payments, including tax-free interest earnings, in return for assuming at least some of the risk ordinarily carried by third-party insurers (Arnett and Trapnell, 1984). In 1965, self-insured plans accounted for 4 percent of total private benefit payments; since 1977, that figure has been 16 to 19 percent annually (Gibson *et al.*, 1984). The most rapid change since 1977 is the share of benefits that are partially self-funded but not self-insured, with the employer setting aside a percent of expected claims and an insurance company picking up the risk for the rest under a "minimum premium plan." For the commercial insurers in particular, providing administrative services and reinsurance to self-insured employers has become an increasingly important business. More than half the benefits under self-insured plans are administered by commercial insurers or other third parties on behalf of the employer under an Administrative Services Only (ASO) contract (Arnett and Trapnell, 1984).

In addition, HMO enrollment nearly tripled between 1977 and 1984 (Interstudy, 1984), increasing from about 6 million to 17 million persons. The most recently published data indicate that more than 6 million persons were enrolled in preferred provider organizations (PPOs) (Rice *et al.*, 1985), a figure that may have doubled again since then (private communication).

These organizational innovations pertain mainly to employment-related insurance. Employee groups remain the primary source of private health insurance in the United States, with only a small proportion of the privately insured under 65 purchasing nongroup plans directly from insurers. The differences between group and nongroup insurance also remain much greater than the differences between group plans shown in this report or evident from other sources since 1977. Thus, unequal access to work-related health insurance remains the single most important determinant of enrollment and benefit differences in the population under age 65.

Data sources and methods of estimation

The data in this report were obtained from two major components of the National Medical Care Expenditure Survey (NMCES). Sociodemographic characteristics of the privately insured population were identified from data obtained in a sample household survey of approximately 40,000 persons. The sample was representative of the civilian, noninstitutionalized population of the United States. The household survey reference period was January 1 to December 31, 1977. (For the survey instruments, see NHCES Instruments and Procedures 1, Bonham and Corder, 1981.) Estimates of the distribution of private health insurance and of specific benefits held by the population are based on the Health Insurance/Employer Survey (HIES). The HIES was undertaken to obtain more detailed data than household respondents could provide on insurance benefits and specifications of coverage. To this end, verification of coverage and information on specific benefits was obtained from employers, unions, insurance companies, and other organizations identified by NMCES households as the source of their health insurance coverage. The Uninsured Validation Survey (UVS), a subcomponent of the HIES, asked employers to verify the lack of work-related coverage reported by their employees. For HIES data collections instruments, survey procedures, and sampling weights, see NHCES Instruments and Procedures 3 (Cohen and Farley, 1984).

Derivation of insurance information

Copies of policies or brochures describing the benefits offered through each HIES respondent were requested and the information abstracted onto forms suitable for computer analysis. (The abstracting forms were initially developed for the Rand Corporation's Health Insurance Study; Newhouse, 1974.) The abstracting was performed by highly trained coders, most experienced health insurance claims examiners. Basic and major medical coverage for specific health services was identified, as were deductibles, reimbursement rates, limitations, and other basic and major medical benefit provisions for each covered service. For approximately 20 percent of the privately insured under 65, a long form was used to abstract additional information. All data items on the short form were included on the long form, so that estimates for all short-form items can be derived for persons with any abstracted information. Copies of the abstracting forms are available from NCHSR.

Where the policies or brochures describing private insurance benefits for the sample did not explicitly specify whether certain services were covered, it was assumed that there was no coverage for that service. This assumption was made for the proportions of privately insured persons in the HIES sample shown in Table I.

Table I

Service	Percent with coverage unspecified; assumed not to be covered
Hospital, room and board	0.5
Hospital, miscellaneous	0.5
Surgeon	0.7
Physician, inpatient	1.2
Anesthesia	3.8
Outpatient Hospital	
Accident	3.3
Surgery	3 9
Emergency	7.3
Outpatient diagnostic	2.9
Maternity	3.5
Ambulance	6.0
Durable equipment/supplies	2.8
Physician, outpatient	3.0
Any mental health care	6.4
Mental health care, hospital	13.2
Prescribed medicines	1.7
Mental health care	
Inpatient physician	16.2
Outpatient physician	15.4
Skilled nursing facility	29.9
Supplemental accident expense	5.5
Home health care	3.5
Vision	2.3
Hearing	0.7
Hospital indemnity	1.4

Persons whose policies or brochures specified coverage of a given service but provided no or inadequate benefit information were ignored in calculating the percent distribution of those insured for the service by type of benefit, assuming in effect that covered persons with unknown benefits and covered persons with known benefits were distributed equally. The distribution of persons insured for each service by type of coverage (basic only, basic and major medical, major medical only), as shown in Table 1, and by service (the total rows of Tables 2 to 43), is based on all persons known to be covered, including those with unknown benefits. The information on benefits (the other rows in Tables 2 to 43) is derived from the distribution of covered persons with known benefits and consequently does not exactly sum to the total row. Thus, the distributions of covered persons in tables showing benefits are slightly different from the distribution based solely on coverage variables.

Construction of insurance variables

The insurance estimates presented in this report are based on several types of measures. Most categorize the entire privately insured population under age 65 in terms of their health insurance, allowing estimates of the percent insured for particular services and the percent distribution with specific benefits for each service as characterized by deductibles, reimbursement provisions, maximum benefits, benefit restrictions, and other provisions. These distributions are constructed so as to indicate basic and major medical benefits of persons with either or both types of coverage (see part 2), as discussed in the following.

Coverage of health services

Insurance for the following services is described in this report:

Inpatient care. Services provided by a hospital (other than a psychiatric facility; see below) and physicians to a hospitalized patient. Hospital insurance benefits (including hospital indemnity benefits) comprise coverage for charges made for room and board, or miscellaneous services such as diagnostic or therapeutic procedures. Other inpatient benefits cover the surgeon's fee for operations or surgical procedures; physician fees for medical services provided to a hospitalized patient; and services provided by an anesthesiologist.

Skilled nursing facility care. Inpatient facilities providing extended nursing care, often in connection with a previous hospital stay.

Physician office care. Services provided in a physician's office, but not necessarily including routine physical examinations, psychiatric or accident care, minor surgery, or diagnostic procedures.

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Outpatient diagnostic services. Outpatient diagnostic procedures such as X-rays or laboratory tests.

Outpatient hospital facility care. Charges by a hospital for use of its outpatient facilities, such as visits to clinics and emergency rooms for the care of accidents, outpatient surgery, and medical emergencies.

Maternity care. Pregnancy services, including hospital or physician care associated with complications of pregnancy, normal delivery, cesarean delivery, abortion or miscarriage, and nursery care for normal infants.

Mental health care. Treatment of mental conditions, including drug and alcohol dependency, by both specialists and other providers. Includes services provided to a patient hospitalized for a mental condition or outpatient visits to psychiatrists and other physicians, and sometimes other providers of mental health services.

Home health care. Services provided at a patient's home, usually by nonphysician personnel such as registered nurses or physical therapists.

Prescribed medicines. Medicines obtained out of the hospital by a physician's prescription.

Ambulance services. Transportation by special vehicle to a provider or facility.

Durable equipment and supplies. Medical equipment and supplies, including items such as crutches, wheel chairs, hearing aids, prostheses, and support devices.

Dental care. Coverage for dental services other than surgery or treatment of accidents or injuries.

Vision care. Coverage for vision examinations, and the purchase of lenses and frames.

Hearing care. Coverage for hearing examinations or hearing aids.

Coverage of particular services according to the categories and definitions in the HIES forms for abstracting insurance benefits was ascribed to the HIES sample under the following rules. A person was counted as having coverage for a particular service even if there were limitations or exclusions restricting coverage to narrowly defined circumstances. Likewise, all individuals not specifically excluded from benefits for a particular service were counted as covered, regardless of their likelihood of using the service; for example, men, children, and older women are included in the overall estimates of the population covered for maternity care. The specific exclusion of certain individuals from coverage for services offered to other family members was taken into account, as in the case of spouses and children covered under an employer's plan but excluded from certain benefits limited to the employee. As the distinction between basic and major medical benefits was not incorporated in the abstracting form for dental, vision, or hearing benefits, it is not used in the estimates of coverage for these services.

Benefits

Benefits for services. Benefit provisions are described as applicable to expenses for a specific service, although they may not apply uniquely to that service. For instance, and especially when part of a major medical plan, the deductible or maximum benefit for a specific service typically applies in common to other covered services. Provisions that are part of a major medical plan and are especially likely to apply to several services are distinguished from basic benefits in describing the insurance of different persons and should be interpreted accordingly.

Deductibles. Deductibles are defined as the amount of covered expense that the insured would initially have to pay before receiving any benefits from an insurer. Some insurance plans effectively impose deductibles by not covering the first day(s) of a hospital stay or the initial utilization of other services. In such cases the approximate dollar value of the exclusion was calculated from the national average cost of the service in 1977, and a deductible in terms of dollars was defined. If the deductible also applies to and has been satisfied by payment of expenses for some other covered service, especially under major medical insurance, the insured need not necessarily satisfy the deductible applicable to a specific service by payment of expenses associated with that service.

Major medical benefits. Major medical plans sometimes contain special provisions for certain services, so that more than one deductible, coinsurance rate, or maximum may be specified. Nevertheless, a single major medical deductible, coinsurance rate, limit on out-of-pocket expenses, and maximum benefit was defined for each person with major medical insurance, identifying the main provisions of their major medical insurance as the set of benefits applying to the largest number of covered services.

Basic and major medical benefits held in conjunction. For persons with both basic and major medical coverage, insurance for initial health care expenditures is largely governed by their basic plans. Therefore, deductibles and reimbursement provisions (e.g. the benefit per day of hospital stay or per physician visit) are characterized in terms of each person's basic benefits. The depth of coverage is generally characterized by each person's major medical benefits, since insurance for high levels of expense is largely governed by the supplementary major medical plan. Where only one or the other type of benefit is described for persons with both basic and major medical benefits for a service, such persons are identified. A few persons with both basic and major medical benefits (for example, about 5 percent with hospital room and board coverage) were covered by a basic plan and a comprehensive major medical plan from different sources, rather than a supplementary major medical plan designed to accompany the basic plan. In general, however, major medical in combination with basic benefits should be interpreted as supplementary major medical coverage.

Reimbursement provisions. Percents or amounts per unit of service to be paid by the insurer or the insured refer to the payment of covered expenses after deductibles are satisfied and before the maximum benefit is exhausted. Insurers are assumed to base their payment on the specified percentage of usual, customary, and reasonable rates unless otherwise noted. Fee schedules for surgeon benefits were converted to a percentage of the UCR charges, as follows. The scheduled amounts for twelve specific operations, if identified in the insurance policy or brochure, were entered on the HIES abstracting form and weighted by the relative national frequency of the respective operations to obtain the ratio to the weighted average of estimated usual, customary, and reasonable fees for the same set of operations in the local county. Local UCR fees were estimated by obtaining UCR dollar amounts from the Health Insurance Association of

America (HIAA, 1979) for two cities with medical care prices close to the national urban average (Bureau of Labor Statistics, 1978), and then adjusting for local variations in physician fees according to intercounty variations in the Medicare prevailing specialist charges.

Benefit maximum. Defined in most cases as the maximum total payment for which the insurer is liable. If the maximum payment for a particular service was smaller than the overall policy maximum, the smaller amount is shown. The maximum applicable to a specific service may also apply to other services, especially under major medical insurance, and consequently exceed the benefits actually available for that service if expenses are also incurred for other services included under the maximum.

Benefit periods. While most deductibles and maximum benefits are defined with respect to a year, other benefit periods such as six months, per disability or illness, or per lifetime are sometimes specified by insurers. Unless distinguished in the tables, maximum benefits can be interpreted as the annual maximum available for a given disability. To facilitate this interpretation, the maximum benefits shown in this report were annualized in some instances, e.g., by doubling the maximum for a six-month benefit period.

Persons with multiple plans

Estimates of the number of persons with particular types of coverage and the categorization of their benefits are based on all insurance plans covering each person over the course of 1977. Multiple policies were obtained for about 15 percent of persons in the sample, but respective dates of enrollment could not be identified. It was consequently impossible to distinguish benefits held simultaneously, and essentially additive, from benefits that were held at different times during the year and thus not additive. However, review of the data, including changes in the employment of persons with multiple plans, indicated that most of the coverage was simultaneous.

The estimates consequently assume that all plans were held at the same time, and benefits were calculated for persons with coverage from more than one plan in keeping with industry procedures for coordination of benefits. Under this system, benefits from multiple plans are additive, but total benefits from all payers are limited to the total expense. A primary payer is identified, and payments by the secondary payer are limited to whatever expenses covered under that policy are not paid by the primary payer. However, benefits payable by the secondary payer can be used for any covered expenses that the primary payer does not reimburse. For example, if the primary payer covers a hospital stay in full, hospital benefits payable by the secondary payer can be used to offset a deductible and coinsurance for outpatient expenses under the secondary plan. Although such benefit provisions and distinctions by service are consequently somewhat artificial for persons with more than one plan, in these cases different benefit provisions were defined as follows:

Coverage for a particular health service was included in a person's insurance if at least one plan offered coverage.

The smallest applicable **deductible** (including zero) among the different plans was selected as constituting the maximum expense a person could possibly incur before benefits were payable by any source. For persons with both basic and major medical benefits (whether supplementary or comprehensive) for a particular service, only basic deductibles were considered.

The percent or amount per unit of service to be paid by each insurer after satisfaction of that insurer's deductible was summed across all plans offering coverage to indicate **reimbursement provisions**. Persons were categorized in terms of the most generous basis for reimbursement. For example, a person with a fee schedule under one plan and a UCR charge benefit under another plan was classified as having UCR charge benefits; a person with semiprivate room and board benefits and a fee schedule was classified as having semiprivate benefits; and a person with a service benefit and a UCR charge benefit was classified as having a service benefit. Where necessary, dollar amounts were converted to percentages by employing national averages in 1977 for the expense per unit of service. For persons with both basic and supplementary or comprehensive major medical benefits for a particular service, only basic benefits were considered.

The **limit on out-of-pocket expense** under major medical coverage was determined by setting off the deductibles and coinsurance rates of two or more major medical plans to define the maximum amount that could be paid out-of-pocket. For example, the maximum possible out-of-pocket expense for a person with two plans, both having deductibles of $100 and 20 percent coinsurance, is $100, since at higher levels of expense, the benefits payable by the secondary payer would offset the 20 percent coinsurance under the primary plan while leaving 60 percent of covered expenses to defray the deductible. Yet no benefits would be payable under either plan for the first $100 of expense.

The **benefit maximum** or ceiling on payments by the insurer was determined by summing maximum dollar amounts across all plans offering coverage. Benefits were categorized as unlimited if there was at least one plan offering unlimited coverage. Where applicable, the maximum amount of covered service for persons with full coverage (considering all plans together) was defined as the number of fully covered days or units of service that could be paid for with benefits for all plans. For example, for a person with 120 fully covered hospital days under one plan and 90 days of 80 percent coverage under another, the maximum was defined as 192 days. The maximum amount of coverage for persons with less than full coverage was defined as the maximum number of days or visits covered by any one plan. Basic and major medical maximum benefits were summed separately across the respective plans.

In categorizing persons with respect to **benefit restrictions**, such as requirements regarding the immediacy of treatment or prior hospitalization, the least restrictive benefits were applied.

Characteristics of the insured

In part 3, the measures described in the foregoing are summarized and related to several characteristics of the U.S. population. In Tables 44 to 58, categories of coverage and type of benefits are related to characteristics most pertinent for enrollment; they describe the privately insured population in 1977

according to type of insurance (group or other, group size), and the sex, employment status, and industry of employment of the person in whose name the coverage was issued and who is designated the primary insured in this report. In Tables 59 to 75, the same insurance measures are related to sociodemographic characteristics of the privately insured population in terms of age, ethnic/racial background, family income, and perceived health status as well as place and region of residence.

In the following, some of these characteristics are defined for the purposes of this report. With the exception of primary insured status and type of private insurance (group or nongroup, size of group), they were obtained from the NMCES household component (see Bonham and Corder, 1981, for the survey instruments, and Cohen and Kalsbeek, 1981, for household survey sampling, estimation, and adjustment methods).

Primary insured. When persons are classified in this report according to the sex and employment of the primary insured, any primary insured is classified according to his or her own characteristics without regard to coverage under another person's policy. For example, college students covered by their own and their parents' policies are classified according to their own employment.

Group and other insurance. Group and nongroup health insurance were attributed to insured persons based on the descriptions of plans by employers, insurers, and other organizations contacted in the HIES. Group size was defined as the largest number of primary insured members (excluding spouses and children insured as dependents) enrolled in any of a person's group plans.

Industry of employment. The industry in which persons were employed on their main job was determined from questions asked in Round 5 of the household survey of employed persons 14 years of age or older. The coding categories correspond to the standard U.S. Department of Labor, Bureau of the Census classification, with repair services, personal services, and entertainment services shown as "other services."

Employment status. Employment status was determined from a series of questions about employment that were asked of persons 14 years of age or older in two rounds of the household survey. Among persons who were employed at some time during 1977, those who worked 35 or more hours as wage earners on their main job in a usual week were classified as full-time employees. Persons who worked fewer than 35 hours were classified as part-time employees. Persons who were self-employed in their main job were classified as self-employed.

Family/household. For the purpose of these estimates, families are defined as households consisting of individuals related by blood, marriage, or adoption. Unrelated individuals residing in the same sample housing unit were treated as distinct single member families. College students who lived away from their original household and did not have their own private health insurance policies were included with the rest of their families.

Family income adjusted for family size. Incomes as reported for each member of the family during round 5 were summed across income types and family members to yield measures of total annual gross family income. These were then adjusted for family size in keeping with the definition of poverty line income. The definition of **poverty line income** follows that of the Bureau of Census for 1977, using family income within family size categories to establish the poverty line. For the purposes of this report, other income groups were defined as follows in relation to poverty line income: income near the poverty line (near poor), from more than 1.00 to 1.25 times; **other low income**, from more than 1.25 to 2 times; **middle income**, from more than 2 to 4 times; and **high income**, greater than 4 times poverty line income in 1977. The poverty line in 1977, for example, for a family of four was $6,157.

Race/ethnicity. Classification by ethnic/racial background was developed from a series of questions asked in the round 5 interview. Persons 17 years of age or older were asked if their racial background were best described as American Indian or Alaskan Native, Asian or Pacific Islander, black, white, or other. They also were asked if their main national origin or ancestry was among one of the following:

- Puerto Rican
- Cubano
- Mexican
- Mexicano
- Mexican-American
- Chicano
- Other Latin
- Other Spanish

This grouping classifies as Hispanic all persons who claimed main national origin or ancestry in one of these Hispanic groups, regardless of racial background. Other persons were then classified as white, black, or other depending on their reported racial background.

These classifications were extended to the under 17 population based on family relationship codes. Persons who dropped out of the survey prior to round 5 are coded as unknown.

Place of residence. The type of geographic area for each household was determined from its location in one of the geographic sampling units established for the NMCES survey. These sampling units often corresponded to Standard Metropolitan Statistical Areas (SMSAs) as defined by the 1970 U.S. Census. Households living in the 16 largest SMSAs at the start of the survey were so classified. Households living in other SMSAs with 500,000 or more residents were classified as living in **other large SMSAs.** SMSAs with fewer than 500,000 population were classified as **small SMSAs**. Households living outside SMSAs where less than 60 percent of the population (as defined by the sampling unit) lived in rural areas were classified as **other, not rural**. Otherwise, if 60 percent or more of the population lived in rural areas, the household's location was classified as **other, rural**.

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Technical notes

Sample design

The NMCES sample was designed to produce statistically unbiased national estimates that are representative of the civilian noninstitutionalized population of the United States. To this end, the household survey used the national multistage area samples of the Research Triangle Institute and the National Opinion Research Center. Sampling specifications required the selection of about 14,000 households. Data were obtained for about 91 percent of eligible households in the first household interviews and 82 percent by the fifth interview. For a detailed description of the household survey sample and of sampling, estimation, and adjustment methods, including weighting for nonresponse and poststratification, see NHCES Instruments and Procedures 2 (Cohen and Kalsbeek, 1981).

Similar procedures were employed in the HIES to adjust for nonresponse on the part of household sample members and HIES respondents (NHCES Instruments and Procedures 3, Cohen and Farley, 1984). Permission forms authorizing contact with employers and insurance carriers in HIES were obtained from approximately 90 percent of household respondents who were the primary insured in either group or nongroup plans and from approximately 70 percent of household respondents eligible for the Uninsured Validation Survey (UVS). Approximately 16,000 questionnaires were mailed to insurance carriers and insurance groups between October 1978 and August 1979. Responses were obtained for 85 percent of household members who had signed permission forms. For persons under 65, national estimates of private health insurance benefits derived from the short abstracting form are based on a sample of approximately 15,700 individuals, with a sample of approximately 3,400 individuals for items only on the long abstracting form.

Reliability of estimates

Since the statistics presented in this report are based on a sample, they may differ somewhat from the figures that would have been obtained if a complete census had been taken. This potential difference between sample results and a complete count is the sampling error of the estimate.

The chance that an estimate from the sample would differ from a complete census by less than one standard error is about 68 out of 100. The chance that the difference between the sample estimate and a complete census would be less than twice the standard error is about 95 out of 100.

Tests of statistical significance were used to determine whether differences between population estimates exist at specified levels of confidence or whether they simply occurred by chance. Differences were tested using Z-scores having asymptotic normal properties, based on the rounded figures at the 0.05 level of significance. Unless otherwise noted, only statistically significant differences between estimates are discussed in the text.

Rounding

Estimates as presented in the data tables are rounded to the nearest tenth of a percent and to the nearest thousand population.

Standard errors

Standard errors for the statistics presented in this report were approximated, by interpolation where necessary, using a curve smoothing procedure developed at the National Center for Health Services Research (Cohen, 1979). Because estimates of items coded only on the long abstracting form are based on a smaller sample, the absolute and relative standard errors of these statistics differ by an inflation factor equal to 2.15 from the standard error of identical statistics based on the short form. The following services and benefits are based on long-form estimates (all other estimates are from the short form), with the corresponding tables shown in parentheses.

All SNF benefits other than fact of coverage (8-11, 53, 69)
Assistant surgeon (13)
Outpatient surgery facility benefits (1, 14, 47, 62)
Outpatient facility accident benefits (1, 15, 47, 62)
Outpatient facility emergency benefits (1, 16, 47, 62)
Supplemental accident benefits (1, 17, 48, 63)
Outpatient prescribed medicines—restrictions on coverage (23)
Medical supplies and durable equipment (1, 24, 48, 63)
Coordination of hospital and home health benefits and restrictions on home health visits (27)
Specific mental health care providers and mental health conditions (except mental health hospital care, facility unspecified; inpatient and outpatient physician visits) (28-29)
Hospital and inpatient physician benefits for mental health conditions, other than fact of coverage (30-32, 56, 72)
Physician's delivery fee, normal pregnancy; nursery and pediatrician's charges, well born infants; cesarean delivery and miscarriages (36-37, 74)
Type of hospital benefits, normal pregnancy (37)
Eligibility requirements for maternity care (38)
Physician home visit (47, 62)

Relative standard errors. Where the statistics of interest are total estimates (T) of the population, an estimate of the standard error, SE, can be obtained by multiplying the relative standard error, expressed as a percent, of the respective T, RSE(T), by T, and then dividing by 100. Thus,

$$SE(T) = \frac{T(RSE(T))}{100}$$

For estimated population totals of persons with a given insurance characteristic coded on the short form, the approximate relative standard errors expressed as a percent are as shown in Table II.

Table II

Estimated population totals (in thousands)	Relative standard error (%)
500	20.8
1,000	14.7
2,500	9.4
5,000	6.7
10,000	4.8
25,000	3.2
50,000	2.4
100,000	2.0
150,000	1.8
200,000	1.7

Example (short form): An estimate of 149,846,000 persons under 65 with hospital room and board insurance (Table 1) has a relative standard error of about 1.8 percent (Table II). The standard error of this estimate, then, is:

$$SE(T) = \frac{149{,}846{,}000\ (1.8)}{100} = 2{,}697{,}228$$

Example (long form): An estimate of 128,261,000 persons under 65 in the U.S. population with insurance for durable equipment and supplies (Table 1) has a relative standard error of about 2.15 x 1.9 percent (as interpolated from Table II), or about 4.1 percent. The standard error of this estimate, then, is:

$$SE(T) = \frac{128{,}261{,}000\ (2.15)(1.9)}{100} = 5{,}239{,}462$$

Direct standard error estimates. When the statistic of interest is expressed as a person-based percent, direct estimates of standard errors for items on the short form have been derived for ease of calculation. For the estimated percent of persons with an insurance characteristic coded on the short form, approximate standard errors expressed as a percent are as shown in Table III.

Table III

Persons in the base of the percent (in thousands)	Estimated percent						
	2 or 98	5 or 95	10 or 90	20 or 80	30 or 70	40 or 60	50
500	2.9	4.5	6.2	8.3	9.5	10.2	10.4
1,000	2.1	3.2	4.4	5.9	6.7	7.2	7.3
2,500	1.3	2.0	2.8	3.7	4.3	4.5	4.6
5,000	0.9	1.4	2.0	2.6	3.0	3.2	3.3
10,000	0.6	1.0	1.4	1.9	2.1	2.3	2.3
25,000	0.4	0.6	0.9	1.2	1.3	1.4	1.5
50,000	0.3	0.5	0.6	0.8	1.0	1.0	1.0
100,000	0.2	0.3	0.4	0.6	0.7	0.7	0.7
150,000	0.2	0.3	0.4	0.5	0.5	0.6	0.6
200,000	0.1	0.2	0.3	0.4	0.5	0.5	0.5
212,000	0.1	0.2	0.3	0.4	0.5	0.5	0.5

Example (short form): The estimate of 97.7 percent of the privately insured under 65 with room and board benefits in 1977 is based on a population total of 153,315,000 (Table 1). This estimate has a standard error of 0.2.

Example (long form): The estimate of 83.7 percent of privately insured persons under 65 in the U.S. population with insurance for durable equipment and supplies in 1977 is based on a population total of 153,315,000 (Table 1). Multiplying the appropriate figure from Table III (0.5) by the long-form inflation factor (2.15), the standard error of this estimate is (0.5) (2.15) = 1.1.

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Glossary of selected insurance terms

Basic coverage. Basic coverage generally provides reimbursement for the major expenses associated with an illness, particularly those arising from hospital care, inpatient physician visits, surgery, and diagnostic tests both in and out of the hospital. Basic plans typically limit coverage in terms of the maximum expense or frequency of utilization of each service that is insured, although benefits for 120 to 365 days of hospital care, for instance, are not uncommon.

Benefit period. The unit of time to which a coverage provision applies (e.g. the dollar amount of a maximum benefit may be specified for a hospital stay, a disability, a year or some other time period, or the insured's lifetime).

Blue Cross-Blue Shield (BC-BS) plans. Private coverage sold or underwritten by a Blue Cross and/or Blue Shield plan. Traditionally, most Blue Cross-Blue Shield plans are community-based nonprofit plans chartered under special state enabling legislation. In general, Blue Cross covers hospital room and board and miscellaneous care and Blue Shield covers physician services.

Carryover provision. Allows expenses incurred during one benefit period to be applied against the deductible of the next period.

Catastrophic coverage. Pays for large medical expenses associated with prolonged or medically complex illness or injury. Also called "back-end" coverage.

Coinsurance. Percent of charge or allowable charge that must be paid by the insured; it may apply only after a deductible has been met and be limited to an out-of-pocket maximum payable by the insured.

Commercial insurance plan. Private coverage sold or underwritten by a for-profit insurance company, as distinct from Blue Cross-Blue Shield plans.

Comprehensive major medical coverage. A policy characterized by a deductible, coinsurance, and a high benefit maximum applicable to all covered expenses; usually replacing the combination of basic and major medical coverage.

Coordination of benefits (COB). Insurance industry procedures for determining liability of each insurer for benefit payments when more than one plan is held by an individual.

Copayment. Dollar amount payable by the insured for units of covered services, applies only after any applicable deductible is exhausted and up to any out-of-pocket maximum.

Covered expenses. All expenses for services insured under a policy, whether to be paid by the insurer or the insured.

Deductible. Amount payable by the insured before insurance benefits start being paid. Can apply per event (e.g. hospitalization), period of time (e.g. year), or lifetime. May apply to one service (e.g. under basic plans) or any combination of covered services (usually under major medical plans).

Employment related plan. Insurance obtained as a work-related benefit, usually through an employer or union. Typically provided as group insurance.

Family coverage. Insurance covering the primary insured, spouse, and children, as applicable. Also called dependent coverage.

First-dollar coverage. Pays benefits starting with initial expenses incurred for health services, to the exclusion of a deductible.

Fee schedule. See Schedule of benefits.

Group plan. Provides coverage to group members, and often their spouses and children, under a contract between an insurer and a health insurance group, usually an organization such as an employer, a labor union, or a voluntary association.

Health Maintenance Organization (HMO). Traditionally, a medical provider organization undertaking to furnish a comprehensive mix of hospital and outpatient services to enrolled members in exchange for a fixed and prepaid fee, usually on an annual basis. Also called a prepaid health plan, it includes but is not limited to all federally qualified HMOs.

Hospital indemnity coverage. Coverage for a specified cash payment per day, week, or month of hospitalization, without reference to the actual expenses incurred.

Individual plan. Provides insurance to primary insured policy holder only.

Major medical coverage. Usually obligates the insurer to pay a specified portion of a wide range of medical expenses in excess of a deductible. Typically characterized by few internal limits for particular services and a high overall limit.

Maximum benefit. Highest amount of insurer liability for covered services. May apply per medical event (e.g. hospitalization), period of time (e.g. year), or lifetime.

Nongroup plan. Provides coverage under a contract directly between an insurer and a primary insured.

Out-of-pocket limit. Maximum liability of the insured for covered services.

Participating providers. A provider of a covered medical service or product, such as a physician or pharmacy, who has entered into an agreement with an insurer or insurance group to provide that service or product at an agreed price or other special arrangement.

Policyholder. See Primary insured.

Preferred Provider Organization (PPO). A group of health care providers who agree with an insurer or insurance group on the provision of services to its enrollees at a discount in return for designation as a preferred provider whose use by the insured is encouraged over that of other providers.

Primary insured. Person in whose name insurance is issued or held, in contrast to a spouse or children covered under a family plan.

Private health insurance. Any insurance for medical or related expenditures, but excluding in this report "extra cash" coverage (small supplemental payments in the event of hospitalization), medical benefits linked to diseases such as stroke or cancer ("dread disease"), and casualty benefits.

Schedule of benefits. A list by the insurer of maximum allowable payments for specific medical or surgical services.

Service benefit. A benefit traditionally associated with Blue Cross-Blue Shield plans, under which the provider agrees to accept the payment allowed by the insurer for the covered expense as payment in full.

Stop-loss provision. *See* Out-of-pocket limit.

Supplemental accident coverage. Special provisions of a basic or major medical plan to cover medical expenses resulting from an accident. Benefits often require that care be sought within a specified period of time after the accident.

Supplementary major medical plan. Complements a basic plan by recognizing and providing reimbursement for services and expenses not allowed under the basic plan.

Usual, customary and reasonable (UCR) charge. The reimbursement by an insurance plan of the typical charge for a service in the geographic area in which it is rendered, determined on a statistical basis and making allowance for the complexity of the case, or the amount actually or usually charged by that provider if less than the customary or reasonable charge.

Waiting period. Time before an insured becomes eligible for coverage of some service or group of services.

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16. Abstract (Limit: 200 words)

The estimates in this report are for 1977 and are based on the National Medical Care Expenditure Survey (NMCES). Information on private insurance policies in force in 1977 was obtained from the employers and insurance companies of a nationally representative sample of the civilian noninstitutionalized population. A brief discussion of the financing of health care through private health insurance and the importance of employer sponsored plans introduces a detailed description of insurance benefits of the population under age 65 in the United States. Their insurance is characterized in terms of the inclusion of specific health services, the provisions of basic and major medical insurance, and the benefits applicable to expenses for a variety of health services. The distribution of insurance characteristics is described in general and in relation to group enrollment, employment, and the characteristics of insured persons. The description of private health insurance in the United States incorporates more recent data from other sources to complement the more detailed and comprehensive estimates from NMCES.

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