The development and growth of employer-provided health insurance

Various BLS surveys track the development of health insurance plans provided by employers—from the first plan covering only hospital services in 1798 to the emergence of managed-care plans today

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Approximately 35.7 million people under the age of 65 were not covered by health insurance in 1990, according to the Current Population Survey, conducted by the Bureau of the Census for the Bureau of Labor Statistics, an increase of 2 million persons since 1988.[1] That increase, with rising costs for health care services, have intensified interest in reforming the health care system. Over the past few years, the Congress has introduced numerous bills designed to improve access to, and reduce the cost of, health care, and modify the tax treatment of health care benefits.

Among the proposals currently being considered to change the health care system are: establishing a national health plan and requiring all employers to provide health care coverage through regional health alliances. These efforts are directed at changing the current national health care system, which relies heavily on health insurance provided by employers.

In the late 1940's, BLS began regularly studying the incidence of health care benefits in various programs. In 1979, BLS began analyzing comprehensive information on health insurance it collected in the Employee Benefits Survey program. This article tracks the development and growth of employer-provided health insurance, from its beginning as sickness insurance to its current form.

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Early coverage

The earliest coverage for health services in the United States dates to 1798, when the Congress established the U.S. Marine Hospital services for seamen. Compulsory deductions for hospital services were made from the salaries of seamen.

Early insurance policies frequently protected against lost income due to accidents, rather than covering health services. The first accident policy was written by the Franklin Health Assurance Co. of Massachusetts in 1850. For a 15-cent premium, the policy would pay the bearer $200 in the case of bodily injury as a result of an accident by railway or steamboat. If the accident resulted in total disability, the policy would pay $400. In 1863, the Travelers Insurance Co. entered the field, and is credited for developing accident insurance copied widely by insurers that organized a few years later. A typical policy provided a $1,000 death benefit and a $5 weekly disability benefit. By 1899, 47 insurers of accidents had issued 463,000 policies.[2]

During the 1870's and 1880's, companies in several industries, including mining, lumber, and railroads, developed plans that covered medical services. The first plan of this type was at the Western Clinic in Tacoma, WA, to provide their members with needed services. The clinic prepaid doctors a fixed monthly fee to provide their members with needed services. Throughout Washing-

ton and Oregon, 20 such group industrial clinics were established, providing medical care to employees for industrial accidents and common illnesses.

The growth in health insurance is tied by many historians to the growing industrialization of America.

> Group health insurance initially developed in the United States in the early part of the twentieth century as a response to the growing industrialization in the Nation, the increasing degree to which people worked together in large groups, and to the employers' and labor unions' realization that employed persons needed economic protection against the unforeseeable losses, which result from premature death and disability.[3]

In March 1899, the Aetna Life Insurance Co. and Travelers Insurance Co. offered a new type of health plan. It provided the insured with coverage against "loss due to temporary total disability occasioned by all diseases except tuberculosis, venereal disease, insanity, or disabilities due to alcohol or narcotics." This coverage was issued to select and preferred risks to residents of towns with populations of 5,000 or more. The premium rate ranged from $8 per year at ages 20 to 29 to $50 at age 50. The $5 per week benefit was limited to 52 weeks, and began 7 days after the date of the disability.[4] By 1908, most of the restrictions on these plans were eliminated: most diseases were no longer excluded, the premium rate was abandoned, the 7-day waiting period was no longer in effect, and a medical examination was no longer required for insurance.

Growing support. In 1910, Montgomery Ward and Co., looking for the means to protect its employees from financial loss due to illness or injury, sought a plan for its employees. The plan covered illness and injury, and is regarded as the Nation's first group health insurance policy. It was written by the London Guarantee and Accident Co. in New York. The policy provided weekly benefits equal to one-half of the employee's weekly salary, with a minimum benefit of $5 and a maximum of $28.85 per week, if the employee was unable to work due to illness or injury. The company paid benefits directly to the employee; it did not reimburse for medical services.

Early in the 20th century, a growing force advocated "compulsory" health insurance. This issue became prominent after most major European countries had enacted legislation for compulsory

Glossary of terms

First-dollar coverage: Coverage for an insured individual who is not required to make an initial payment for care before insurance benefits are available.

Health maintenance organization (HMO): A managed care insurance plan that provides a wide range of comprehensive health care services to subscribers for a predetermined rate.

Group/staff arrangements: A health maintenance organization arrangement that delivers health services at one facility or more with groups of salaried physicians.

Individual practice associations: A health maintenance organization plan that contracts with physicians who maintain their own offices and usually are paid by the HMO according to an agreed upon fee-for-service schedule.

Preferred provider organization (PPO): A managed care insurance plan that covers individuals on a fee-for-service basis and offers a choice of providers. Out-of pocket expenses for medical care are lower if the subscriber uses designated hospitals, physicians, or dentists.

Open-ended enrollment plan: The most popular variation in HMO's in which members of this plan may use providers outside the HMO network but incur an additional cost, typically a deductible and coinsurance beyond those normally imposed for services.

Deductible: A specified amount that the insured individual must pay toward medical expenses before the plan pays charges. Any medical expenses that are more than the deductible are shared by the employee and the plan in a predetermined coinsurance formula.

Supplemental insurance: Supplemental plans offer additional coverage to what is provided in the basic plan by covering expenses that exceed the limits of the basic plans and expenses not covered by the basic plan.

Comprehensive insurance: Comprehensive major medical plans do not offer "additional" coverage to a basic plan; they cover a wide range of medical services in one package. For "pure" comprehensive major medical plans, all covered expenses are subject to a deductible and a coinsurance requirement before benefits are provided.

coverage or provided subsidies to voluntary plans. The progressive movement, led by I. M. Rubinow, founder of the American Association for Labor Legislation, was at the forefront of this issue. Proponents of compulsory insurance sought to achieve two goals. First, they wanted to "relieve poverty caused by sickness by distributing individual wage losses and medical costs through insurance." Second, they wanted to "reduce the social costs of illness by providing effective medical care and creating monetary incentives for disease prevention."[5]

Reformers believed a compulsory health insurance system would distribute financial losses among workers, employers, and the State. Opposed to compulsory insurance were AFL President Samuel Gompers, physicians, and insurance companies. Gompers believed that a government insurance system would weaken unions by denying them the ability to provide social benefits. Physicians objected to a uniform fee structure because in earlier experiences with fraternal lodges and industrial companies health care providers were forced to bid against each other for business.

Insurance companies mounted the strongest opposition to compulsory insurance because of the inclusion of a death or funeral benefit, which amounted to $50 or $100. This type of insurance was sold to working class families to guard against a pauper burial. In exchange for payments of less than 50 cents per week, a family was entitled to a lump-sum payment at death that was used to pay funeral and medical expenses. By including this benefit, compulsory insurance would eliminate the business that insurance companies had developed marketing individual policies. These types of insurance policies were so widespread that Metropolitan Life Insurance and Prudential Insurance had become successful marketing these policies.

The progressive era ended without the passage of compulsory insurance legislation. By the end of 1919, 11 States had formed commissions to look into this issue. Six commissions favored some type of legislation, but no action was taken. The chairman of the Ohio commission believed that the State commissions were "somewhat handicapped by the confusion into which the public mind had been thrown by the misleading, malicious, and false statements emanating from an interested and active commercial insurance opposition led by the Prudential Insurance Company and the Insurance Economics Society of Detroit."[6] Federal actions fared no better. Resolutions were brought before the U.S. House of Representatives, but met strong opposition and were defeated.

Blue Cross and other plans. The Depression in the 1930's brought about a significant development in health insurance. Due to economic conditions, few people could pay for hospital care, leaving most hospitals in serious financial condition. More than 100 hospitals nationwide had failed in the first years of the Depression and those that remained in business had only about a 50-percent occupancy rate. In 1929, a group of teachers at the Baylor University and the University Hospital in Dallas, TX, made arrangements to provide coverage for room and board and for specified ancillary services for 21 days at an annual premium of $6 per teacher. This development is considered a forerunner of what is now known as Blue Cross.

The idea spread, first in Dallas and later in other cities throughout the country, with employees entering into arrangements with individual hospitals. The concept expanded to include citywide plans with more than one hospital, the first of which was in Sacramento, CA, in 1932. Individuals contributed a small amount monthly to a central fund that was redistributed to participating hospitals. This fund allowed the hospitals to remain solvent with a guarantee of payment of hospital bills, although coverage for dependents was excluded. By 1935, 19 plans had been created in 13 States.

Prepayment plans to cover physicians' services (Blue Shield) paralleled the development of Blue Cross plans. The first Blue Shield plan—the California Physicians Service—was founded in California in 1939 and provided physician services to employee group members for $1.70 per month for each member of the group. The plan was limited to employees earning less than $3,000 annually. These first plans owe their origin to the lumber, mining, and railroad industries of the late 1880's, which provided medical care to employees for a predetermined rate.

At the same time Blue Cross and Blue Shield plans were being formed, development of Health Maintenance Organizations (HMO's) began on the West Coast. An HMO provides a wide range of comprehensive health care services to subscribers for a predetermined rate. One of the first and oldest HMO's still operating was begun in 1929 by physicians Donald Ross and H. Clifford Loos in Los Angeles, CA, for employees of the city Department of Water and Power. The Ross-Loos Clinic had a prepaid program that provided medical care for department employees. In 1937, another HMO—the Group Health Association—was founded in Washington, DC.

The largest and most widely known HMO that was formed during the 1930's was Kaiser Permanente. The Kaiser Co. was building a dam in a remote area of California, and workers with serious injuries were sent to medical facilities 200 miles from the building site at the request of the construction workers' insurance company. Sidney Garfield, a physician at the construction site, con-

vinced the insurance company to pay him directly and in advance for each employee in exchange for providing all necessary on-the-job medical care. Garfield also arranged for voluntary deductions to be withheld from a worker's salary to provide off-the-job care for workers and their families. Henry Kaiser, who was responsible for the building of the dam and who owned the insurance company, was so impressed with Garfield's efforts that he asked him to establish similar programs at construction sites in Washington and later in San Francisco, CA. These medical facilities opened to the community under the name of Kaiser Foundation Health Plan.

During this period, commercial insurance companies were concentrating on writing medical reimbursement benefits with accident policies. These policies covered medical expenses only when care was provided as a result of an accidental bodily injury. This type of insurance failed to attract many subscribers because of the restrictive underwriting and lack of promotion by the insurance company. It was not until after the development of Blue Cross health insurance plans that insurance companies became aware that costs of medical care could be underwritten without an undue risk to the insurer.

Employer-provided health insurance

By 1940, the population of the United States was 132 million with only 12 million—a little less than 10 percent—covered by some form of health insurance. For individuals with coverage, Blue Cross/Blue Shield predominated, with a participation rate of 50 percent, followed by commercial insurance with 31-percent participation, and other plans, including HMO's, with 19 percent. Ten years later, one-half of the U.S. population had some form of health care insurance.[7]

World War II contributed to the growth in the health care industry. In 1942, the Congress enacted the Stabilization Act, which limited the amount of wage increases employers could grant, but at the same time permitted the adoption of employee insurance plans. This stimulated the growth of plans through collective bargaining agreements. In 1945, the War Labor Board, in a number of cases, held that employers could not modify or discontinue group insurance plans during the life of a contract. The Board also ordered employers in some cases to include in the agreement unilateral benefit plans already in effect. By 1949, employee benefit programs in collective bargaining agreements became widespread. A dispute between Inland Steel Co. and the United Steel Workers Union resulted in a ruling by the National Labor Relations Board that the term "wages" be construed to include pension and insurance benefits, including health insurance. This ruling was later upheld by the U.S. Supreme Court.[8]

Also in 1949, the Liberty Mutual Insurance Co. introduced major medical insurance to supplement basic medical care expenses. Major medical plans are designed to protect individuals against extended illnesses or injuries, by providing coverage for services not covered under the basic portion of a plan (such as Blue Cross/Blue Shield) and supplemental benefits after coverage under the basic plan has expired. Basic plans typically cover facility care and physician care in the hospital. The emphasis on "basic" plans is on "first-dollar" coverage; that is, an insured individual is not required to make an initial payment for care before insurance benefits are available. Most basic plans limit the eligible charges or the duration of coverage for each type of expense or procedure.

Major medical insurance does not provide first-dollar coverage but instead requires cost-sharing by the employee through yearly deductibles and coinsurance requirements. The deductible is a specified amount that the insured individual must pay toward medical expenses before the plan pays any charges. Any medical expenses in excess of the deductible are shared by the employee and the plan calculated in a predetermined coinsurance formula; plans typically pay 80 percent of the covered charges and the insured pays the remaining 20 percent. In addition, plans typically limit what the individual has to pay under major medical coverage with provisions known as catastrophic limits or out-of-pocket maximum costs. For example, a plan may pay 80 percent of medical expenses until the insured individual's expenses reach $5,000, and pay 100 percent of any additional charges.

Today, major medical insurance is in two forms, supplemental and comprehensive. Supplemental plans offer additional coverage to what is provided in the basic plan by covering expenses that exceed the limits of the basic plans and expenses not covered by the basic plan. However, comprehensive major medical plans do not offer "additional" coverage to a basic plan; they cover a wide range of medical services in one package. For "pure" comprehensive major medical plans, all covered expenses are subject to a deductible and a coinsurance requirement before benefits are provided.

Major medical plans, both supplemental and comprehensive, have grown rapidly. In 1951, 2 years after the inception of these plans, 100,000 individuals and their dependents were covered by major medical policies. By the end of 1960, the number had grown to 32 million, and by the end of 1986, it had reached 156 million.[9]

Throughout the 1950's, the types of insurance

offered to individuals expanded. In 1957, vision care benefits were introduced, followed in 1959 by dental care benefits provided by the Continental Casualty Co. Vision benefits typically provide a variety of services that usually are not covered by regular health insurance plans, such as eye examinations, and costs of eyeglasses and contact lenses. Dental benefits cover a variety of services, ranging from preventive services such as X-rays and examinations, to more expensive procedures, including restorations and endodontic, periodontic, and orthodontic care.

Managed care plans

Health care costs have increased rapidly in the past 20 years. From December 1971 to December 1991, the Consumer Price Index for all items increased 235.5 percent; the medical care component of the index increased 398.9 percent, 70 percent higher than for all items. In an effort to slow this rapid rise in health care costs, new health care systems and updated ways of delivering health care services, generally known as managed care, have emerged.

Although components of managed care may exist in any health insurance plan, there are two common types—HMO's and Preferred Provider Organizations (PPO's). Managed care integrates the financing and delivery of appropriate health care services to covered individuals and has the following common elements:

- arrangements with selected providers to furnish a comprehensive set of health care services to members;
- explicit standards for the selection of health care providers;
- formal programs for ongoing quality assurance and utilization review; and
- significant financial incentives for members to use providers and procedures covered by the plan.[10]

Enrollment in HMO's has increased rapidly, rising from fewer than 2 million members in 1970 to more than 39 million in July 1992.[11] Efforts to revitalize HMO's can be linked to Paul Ellwood, a physician and executive director of the American Rehabilitation Institute, who claimed in 1985 that, unlike managed care, the fee-for-service system "created perverse incentives, which rewarded physicians and institutions for treating illnesses and then withdrew those rewards when health was restored."[12] Ellwood believed that the health care system could be more functional if it were restructured and incorporated incentives to promote health.

In his research, Ellwood found that Kaiser Permanente and similar organizations provided health care to large populations at reasonable costs. At the same time, the public voiced concern over the rising health care costs and government expenditures for Medicare and Medicaid. Ellwood convinced the Nixon administration that a nationwide system of prepaid group practice would be cost efficient and would provide a solution to the Nation's health care problems. In 1973, the Congress passed the Health Maintenance Organization Act, designed to stimulate the formation of comprehensive prepaid health care programs by:

- providing grants, loans, and loan guarantees to HMO's;
- preempting State laws and practices impeding the development and operation of qualified HMO's;
- requiring employers to include the option of membership in a qualified HMO in any employee health benefit package, if the employer is covered by the minimum wage provisions of the Fair Labor Standards Act, has at least 25 employees residing within an HMO's service area, has an employee health benefit plan to which the employer contributes, and has received a written request from a qualified HMO for inclusion in the employer's health benefits program.

Two major types of HMO's are available: group/staff arrangements and individual practice associations (IPA). The group/staff arrangement delivers health services at one facility or more with groups of salaried physicians. The IPA contracts with physicians, who maintain their own offices and usually are paid by the HMO according to an agreed upon fee-for-service schedule.[13]

Variations in HMO's have appeared in recent years, the most popular being the "open-ended enrollment plan." Members of these plans may use providers outside the HMO network but incur an additional cost, typically a deductible and coinsurance beyond those normally imposed for services.

During the 1980's, PPO's emerged as an alternative for fee-for-service users. A PPO provides coverage for individuals on a fee-for-service basis and offers a choice of providers. Out-of-pocket expenses for medical care are lower if the subscriber uses designated hospitals, physicians, or dentists. Subscribers are penalized with higher deductibles, higher coinsurance payments, and other limits when care is not provided from a designated provider. Most PPO's include mandatory cost containment features, such as requiring certification for hospital admissions, concurrent review by the physician and the plan's "gatekeeper," a health plan official who controls referrals to specialists and hospitals regarding the length of stay in the hospital, and mandatory second surgical opinions.

Distinctions between types of health care plans have become blurred in recent years. Costs con-

tinue to rise, requiring plans to add features to attract members, and to copy characteristics of others. As this trend continues, it may become more difficult to distinguish between individual plans.

Employer-provided health insurance

BLS has documented the expansion of employer-provided health insurance throughout the 20th century. Before World War II, infrequent special studies of employee benefits, including health insurance, were described in the *Monthly Labor Review* and in other BLS publications. With the growth of employer-provided health insurance in the 1940's, BLS looked toward a more systematic means of collecting such data.

The Occupational Wage Survey Program, which began in the late 1940's, was the first effort at regular collection and publication of health insurance data. In subsequent years, data were collected on the incidence of employer-sponsored health insurance benefits in selected industries (Industry Wage Surveys) and selected metropolitan areas (Area Wage Surveys). Although the surveys have changed significantly over the past half century, these data are still collected.[14]

From 1950 to 1974, The BLS *Digest of Selected Health and Insurance Plans* provided a detailed look at health insurance benefits. The Digest series contained information on the principal features of health plans of selected employers, including maximum lengths of hospital stays, maximum payments for selected surgical procedures, coinsurance rates, and maximum major medical benefits. In 1964, the BLS Collective Bargaining Statistics program began collecting data on benefit provisions—including health insurance contained in collectively bargained contracts—in addition to data on wage changes. These data were available through the early 1980's.

The increased availability of health insurance coverage and other benefits created a need for comprehensive data on employee benefits. In 1979, BLS began the Employee Benefits Survey, which provides information on the incidence and characteristics of employee benefit plans, including health, life, and disability insurance, retirement plans, and paid leave.[15]

The Employee Benefits Survey includes data on the percentage of employees participating in health insurance plans and of participants who have coverage available for selected types of care. Among the medical services studied are hospital room and board, and physician, mental health, dental, and vision care (see table 25 in the Current Labor Statistics section). The proportion of covered workers required to contribute toward the cost of health insurance and their average monthly contributions also are tabulated. In addition, data are presented on the incidence of coverage in fee-for-service plans, PPO's, and prepaid HMO's. These and other features of health insurance plans have changed in recent years, as the survey's data documents.

Between 1979 and 1989, at least 90 percent of full-time employees in medium and large private establishments were provided health insurance coverage; the employee's average monthly contribution for health insurance has risen steadily over the period. (See table 1.) In 1979, health insurance was provided by the employer for 97 percent of full-time employees covered by the survey. Ten years later, the participation rate had fallen to 92 percent and in 1991 to 83 percent. The decline in 1991 is due to a decrease in participation among workers who were offered health care benefits.[16]

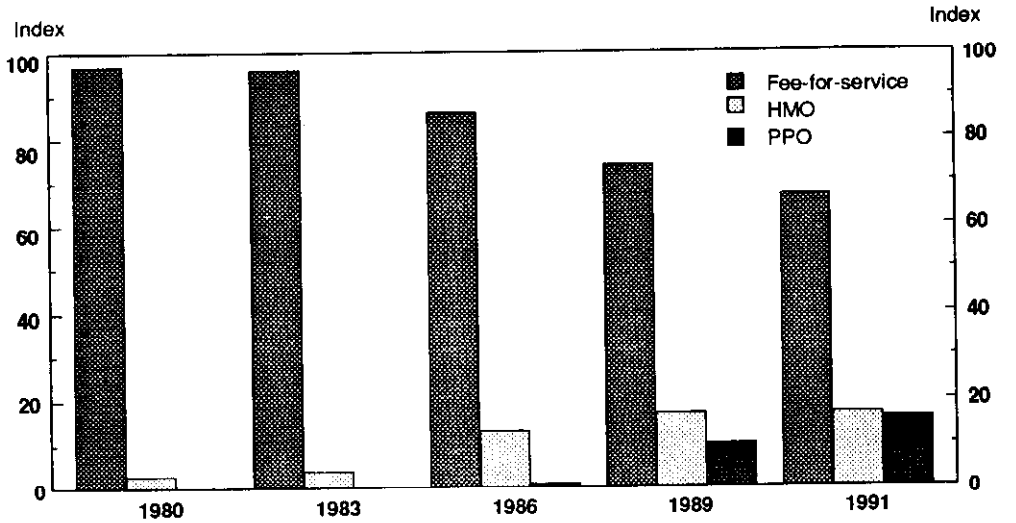
This decrease coincides with the increase in the percent of full-time workers required to contribute

Table 1. **Percent of full-time employees participating in health insurance and of participants with selected features, medium and large private establishments, 1979–86, 1988–89, and 1991; State and local governments, 1987 and 1990; and small private establishments, 1990**

Item	Medium and large private establishments											State and local governments		Small private establishments
	1979	1980	1981	1982	1983	1984	1985	1986	1988	1989	1991	1987	1990	1990
Percent of employees participating in medical care plans	97	97	97	97	96	97	96	95	90	92	83	93	93	69
Required employee contribution for self coverage	27	26	27	27	33	36	36	43	44	47	51	35	38	42
Average monthly contribution	—	—	—	—	$10.13	$11.93	$12.05	$12.80	$19.29	$25.31	$26.60	$15.74	$25.53	$25.13
Required employee contribution for family coverage	—	46	49	51	54	58	56	63	64	66	69	71	65	67
Average monthly contribution	—	—	—	—	$32.51	$35.93	$38.33	$41.40	$60.07	$72.10	$96.97	$71.89	$117.59	$109.34

NOTE: Dashes indicate data are not available

Chart 1. **Percent of full-time health insurance participants by type of fee arrangement, medium and large private establishments, selected years**



NOTE: Data were first tabulated separately for preferred provider organizations in 1986. Because of rounding, sums of individual items may not equal 100 percent.

toward their health care premium. Between 1979 and 1991, the percent of participants sharing the cost of health care for individual coverage has nearly doubled. In 1979, 27 percent contributed toward their own health care; by 1991 that proportion had risen to 51 percent. The percentage of workers contributing for family coverage also has risen: in 1980, 46 percent of the workers paid at least a portion of the cost for family coverage, compared with 69 percent in 1991. The average monthly premium paid by an employee for self-coverage was 2.5 times higher in 1991 than in 1983—$10.13 versus $26.60. The average premium paid by an employee for family coverage tripled, from $32.51 in 1983 to $96.97 in 1991.

The growth in managed care plans is another trend the Employee Benefits Survey has documented. Managed care plans direct patients to specific providers in an effort to monitor care and reduce costs. When data on such plans were first tabulated in 1980, only 3 percent of health care participants in medium and large establishments were in managed care plans—all in HMO's. (See chart 1.) By 1986, 14 percent of participants were in managed care plans, including 13 percent in HMO's. Participation in HMO's continued to climb and by 1991 represented 17 percent of participants. PPO's, first surveyed in 1986, covered only 1 percent of health care participants that year. Enrollment in PPO's quickly expanded, with participation rising to 16 percent in 1991. In 1991, 33 percent of participants were in managed care plans.

The Employee Benefits Survey also has monitored the growth of managed care features within traditional health insurance plans. Fee-for-service plans have developed these features as a way to hold down costs. The goal of these programs is to make sure that the services rendered are medically necessary and provided in the most appropriate medical setting. The Employee Benefits Survey has provided this information since 1986. (See table 2.) Three of the most widespread cost containment features are: requiring hospital preadmission certification, "utilization review", which monitors the quality and appropriateness of care, as it is delivered, and imposing penalties when second opinions are not obtained for nonemergency surgical procedures.

HEALTH INSURANCE in the United States began nearly 200 years ago with hospital care for seamen paid for by compulsory wage deductions. It was not until 1929, with the development of Blue Cross, that health insurance began to resemble its current form. In the 1970's and 1980's, enrollment

Table 2. **Percent of full-time employees with health insurance participating in selected cost containment programs, medium and large private establishments, 1986, 1988–89, and 1991; State and local governments; 1987 and 1990, and small private establishments, 1990**

Item	Medium and large private establishments				State and local governments		Small private establishments
	1986	1988	1989	1991	1987	1990	1990
Hospital preadmission certification requirement[1]	16	37	49	63	22	63	59
Care subject to utilization review[1]	—	—	27	32	—	33	27
Plan provides incentives for second surgical opinion[1]	35	35	36	43	23	39	33

[1] Data are based on all medical participants between 1986–88 and on fee-for-service participants between 1989–91 for hospital preadmission certification and utilization review. Data are based on all medical participants between 1986–89 and fee-for-service participants between 1990–91 for incentives for second surgical opinion.

NOTE: Dashes indicate data are not available.

surged in "managed care plans"—HMO's and PPO's. These plans were a direct response to the sharp rise in health care costs. Health care is now comprehensive, providing hospital, surgical, and medical benefits and also may include such benefits as dental, vision, mental health, and home health care. Current reform efforts may add a new chapter to the history of health insurance in the United States. Policy makers can gauge the extent of current benefits, and may design future health care programs, using data provided by the BLS Employee Benefits Survey.

Footnotes

[1] The Current Population Survey is conducted by the Bureau of the Census for the Bureau of Labor Statistics. Tabulations of health care data from the Current Population Survey may be found in "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey," *EBRI Issue Brief Number 123* (Washington, Employee Benefit Research Institute, February 1992).

[2] Edwin J. Faulkner, *Health Insurance* (New York, McGraw-Hill Co., 1960), pp. 514–517.

[3] J.F. Follmann, Jr., "Development and Significance of Group Health Insurance," in Robert D. Eilers and Robert M. Crowe, *Group Insurance Handbook*, (Homewood, IL, R.D. Irwin, 1965), p. 59.

[4] Faulkner, *Health Insurance*, p. 532.

[5] Ronald L. Numbers, *Compulsory Health Insurance—The Continuing Debate*, (Westport, CT, Greenwood Press, 1982), p. 116.

[6] John A. Lapp, "The Findings of the Official Health Insurance Commission," *American Labor Legislation Review*, 1920, Vol. 10, p. 31.

[7] *Source Book of Health Insurance Data, 1981–82* (Washington, Health Insurance Institute, 1982), p. 13.

[8] *Inland Steel Co.* v. *NLRB*, 170 F.2d 247 (7th Cir. 1948). For more information about changing labor laws, see Alvin Bauman, "Measuring employee compensation in U.S. industry," *Monthly Labor Review*, October 1970, pp. 17–24.

[9] *Source Book of Health Insurance Data 1980–81* (Washington, Health Insurance Institute, 1982), p. 20. Separate data on the number of participants with major medical insurance were presented for the last time in 1986.

[10] *Source Book of Health Insurance Data, 1991* (Washington, Health Insurance Association of America), p. 18.

[11] *InterStudy Competitive Edge*, Vol. 2, No. 2, 1993 (Minneapolis, InterStudy), p. 1.

[12] Thomas R. Mayer, R. N. Mayer, and Gloria Gilbert, "Occasional Notes, HMO's: Origins and Development," *New England Journal of Medicine*, February 28, 1985, p. 593.

[13] Employers must offer at least one group or staff HMO and at least one IPA if both are qualified and request inclusion in a health benefit program. In organizations in which employees are represented by a union, the employer must offer the HMO to the union; the employer's obligation ends if the union rejects the offer. For more information, see Allan Blostin and William Marclay, "HMO's and other health plans: coverage and employee premiums," *Monthly Labor Review*, June 1983, pp. 29-31.

[14] *Handbook of Methods*, Bulletin 2414 (Bureau of Labor Statistics, September 1992), pp. 42–50.

[15] Surveys were conducted annually from 1979–86, 1988–89, and 1991 from medium and large private establishments, *Employee Benefits in Medium and Large Private Establishments, 1991*, Bulletin 2422 (Bureau of Labor Statistics, May 1993). In 1987 and 1990, surveys were conducted in State and local governments, *Employee Benefits in State and Local Governments, 1990*, Bulletin 2398 (Bureau of Labor Statistics, February 1992). In 1990, surveys were conducted in small private establishments, *Employee Benefits in Small Private Establishments, 1990*, Bulletin 2388 (Bureau of Labor Statistics, September 1991). Surveys on medium and large establishments are conducted in odd-numbered years and surveys on State and local governments and small establishments in even-numbered years.

[16] The scope of establishments included in the survey of medium and large private establishments was expanded in 1988. See Technical Note, Appendix A, *Employee Benefits in Medium and Large Private Establishments, 1991*, p. 129, for details on changing survey methodology.