# Employee Health Benefit Programs

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*Two major developments in recent years have had a significant effect on the health status of millions of American workers. One has been the shifting emphasis of inplant health programs from care of work injuries to concern for the general health of the worker. Through diagnostic and preventive services, these programs are contributing more and more to health conservation and maintenance. The second development, more widespread and far-reaching, has been the phenomenal growth of employee health benefit plans providing, or paying the cost of, medical care. These two types of programs can and do stand alone. But where both exist, they are more effective, each drawing strength from the other.*

A VITAL component of the benefit programs for workers in private industry which have mushroomed in the United States during the last 15 or 20 years are employee health benefit plans, designed to provide health insurance or health services to workers and their dependents. At present, health insurance programs made available and paid for through the worker's place of employment cover more than 35 million employees and their 54 million dependents, a total of 89 million people. Under such plans, about 68 percent of all nonagricultural employees are protected against the cost of certain health services or have the services themselves made available to them. The growth since 1935 in the number of employees and dependents covered for hospitalization, surgical, and medical benefits under employee health benefit plans is shown in table 1.

Before the early 1930's, employee health benefit programs consisted largely of plans developed by a few employers, frequently those in isolated areas, for the direct provision of health services. Most of these plans were in the mining, railroad, lumber, and textile industries. Employee health benefit plans as we now know them began to evolve in the midthirties when hospital and medical service plans, precursors of today's Blue Cross and Blue Shield, were formed, and insurance companies began writing group hospital, surgical, and medical insurance.

The rapid development of employee benefit programs since 1940 is the result of several factors. Among them are (*a*) high corporation taxes during and since World War II, (*b*) various court decisions holding that welfare and pension programs are "bargainable" issues, (*c*) wage stabilization programs during World War II and the Korean conflict, which tended to keep wage rates down but permitted increases in fringe benefits, and (*d*) the movement of labor unions to incorporate welfare and pension benefits in their wage policy.

Since 1948 health benefits, along with life and disability insurance benefits, have come to be important elements in collective bargaining agreements. Only a half million workers were covered for health or life and disability

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**Table 1. Employees and dependents covered under employee health benefit plans**

[Millions of persons]

| End of year | Hospitalization | Surgical benefits | Medical benefits [1] |
|---|---|---|---|
| 1935 | 2.0 | 1.8 | 1.8 |
| 1940 | 9.5 | 3.5 | 2.0 |
| 1945 | 24.8 | 9.3 | 3.2 |
| 1950 | 54.5 | 38.6 | 16.8 |
| 1955 | 81.6 | 73.4 | 40.8 |
| 1956 | 89.3 | 82.0 | 54.3 |

[1] Mainly restricted to care in the hospital.

SOURCE: Estimates based on the annual surveys of the Health Insurance Council on the extent of voluntary health insurance in the United States, the annual surveys of group insurance by the Life Insurance Association of America, annual Blue Cross and Blue Shield enrollment reports, and publications of the Social Security Administration on extent of coverage under independent prepayment plans.

insurance benefits under such agreements in 1945. By 1950 about 7 million workers were so covered, and in early 1954, more than 11 million.

### Types of Health Benefits and Carriers

Table 2 shows the number of employees and their dependents covered under health benefit plans for various health services, by type of carrier. At the end of 1956 approximately 35.4 million employees were covered for hospitalization through plans made available and paid for through the workplace. With their dependents a total of 89.3 million people, more than half of the population, were so covered. The latest figures of the Health Insurance Council show that, after allowance for duplicating coverages, approximately 116 million persons in the United States have some type of hospitalization coverage. The difference between these two figures represents people covered by individual (nongroup) insurance and those covered through rural and similar non-employer-employee groups.

More than 94 percent of the persons covered by employee health benefit plans for hospitalization benefits are insured, in roughly equal proportions, through Blue Cross plans and the few Blue Shield plans that offer hospitalization benefits or through group policies of insurance companies. The remaining 6 percent, 2.1 million employees and their dependents, are served through other types of plans. These last include the so-called independent prepayment plans under community, cooperative, or private medical group auspices, such as the Kaiser Health Plan, the Group Health Association, and the Ross-Loos Medical Group, and management- and union-sponsored self-insured programs such as the United Mine Workers medical program. The self-insured plans provide health services or benefits directly rather than through the purchase of insurance or prepayment coverage.

For surgical benefits approximately 82 million workers and dependents are covered, more through insurance companies than through Blue Shield and the few Blue Cross plans that

**Table 2. Employees and dependents covered under employee health benefit plans, by type of benefit and carrier, end of 1956**

[Millions of persons]

| Type of benefit and carrier | Employees | Dependents | Total |
|---|---|---|---|
| Hospitalization | 35.4 | 53.9 | 89.3 |
| Blue Cross and Blue Shield plans | 16.6 | 24.9 | 41.5 |
| Insurance companies | 16.7 | 27.0 | 43.7 |
| Other [1] | 2.1 | 2.0 | 4.1 |
| Surgical | 32.9 | 49.1 | 82.0 |
| Blue Shield and Blue Cross plans | 13.3 | 19.9 | 33.2 |
| Insurance companies | 17.4 | 27.0 | 44.4 |
| Other [1] | 2.2 | 2.2 | 4.4 |
| Medical | 22.3 | 32.0 | 54.3 |
| Blue Shield and Blue Cross plans | 10.6 | 15.9 | 26.5 |
| Insurance companies | 9.6 | 14.1 | 23.7 |
| Other [1] | 2.1 | 2.0 | 4.1 |
| Major medical expense [2] | 3.1 | 3.8 | 6.9 |
| Comprehensive medical expense [2] | .5 | .9 | 1.4 |

[1] Independent prepayment plans and self-insured programs.

[2] Insurance companies only.

SOURCE: For Blue Cross and Blue Shield, the 1956 survey of the Health Insurance Council (reference 1), the data being adjusted to show employer-employee group enrollment only; for insurance companies, the 1956 survey of group insurance by the Life Insurance Association of America (Group Insurance and Group Annuity—Continental United States Business—1956); for the "other" plans, the Health Insurance Council's report with adjustments to show employer-employee group enrollment only.

provide such benefits. Again only a small proportion are covered under independent or self-insured programs. For medical benefits about 54 million persons are covered, the great majority under programs which provide only inhospital medical service. Probably not more than 9 million persons have coverage for physician service in the office and home as well as in the hospital.

About 6.9 million workers and their dependents are also covered under group major medical expense policies, which supplement regular hospitalization, surgical, and medical coverages, and another 1.4 million are covered under comprehensive medical expense insurance policies.

**Table 3. Contributions under employee health benefit plans, 1956**

[Millions of dollars]

| Type of benefit and carrier | Total | Employer | Employee |
|---|---|---|---|
| Hospitalization: | | | |
| Blue Cross and Blue Shield plans | $812 | $244 | $568 |
| Insurance companies | [1] 690 | 345 | 345 |
| Other [2] | 79 | 39 | 40 |
| Surgical-medical: | | | |
| Blue Shield and Blue Cross plans | 353 | 106 | 247 |
| Insurance companies | [1] 436 | 218 | 218 |
| Other [2] | 83 | 58 | 25 |
| Major medical expense (insurance companies) | [1] 52 | 26 | 26 |
| Comprehensive medical expense (insurance companies) | [1] 42 | 21 | 21 |
| Total | $2, 547 | $1, 057 | $1, 490 |

[1] Premiums after deduction of dividends.
[2] Independent prepayment plans and self-insured programs.

SOURCE: In "Total" column, data for Blue Cross and Blue Shield plans are total subscription income as reported by the central organizations of these plans to the Social Security Administration, adjusted to show only income from employee-employer groups; data for life insurance companies are total net premiums as reported from the 1956 survey of group insurance by the Life Insurance Association of America, adjusted for deduction of dividends; data for "other" plans are from the 1956 survey by the Health Insurance Council.

It is estimated that employee contributions represent 30 percent of total Blue Cross and Blue Shield group premiums, 50 percent of total insurance company premiums after dividends, and 70 percent of income of "other" plans. These approximations are based mainly on estimates from the executives of a few large Blue Cross plans and insurance companies as to the relative proportions of employer and employee contributions, on knowledge of the situation in some of the large independent plans and self-insured programs, and on the general showing of a few surveys of group insurance programs which indicate prevailing cost-sharing arrangements.

### Amounts and Sources of Contributions

Contributions, or expenditures, for employee health benefit plans in 1956 totaled, it is estimated, approximately $2.5 billion (table 3.) Precise data are not available on the portion of the contributions paid by employees and the portion paid by employers. The figures given in table 3 are only rough approximations based mainly on estimates by a number of insurance company and Blue Cross executives as to the prevailing division in their programs. Of the contributions for all plans it is roughly estimated that about two-fifths represent employer and three-fifths employee contributions.

There is a decided trend toward increased financial participation by employers in health insurance plans for their employees. Employers frequently pay the total cost of the program for both employees and their dependents. Also common are arrangements under which the employer pays a part or all of the cost for the employee, who in turn pays the cost for his dependents. Under most collectively bargained plans the employer pays from one-half to all of the cost. Welfare funds are almost universally financed wholly by employer contributions.

Employers' contributions arranged through collective bargaining agreements are generally regarded by the workers as part of their compensation. Even under programs not collectively bargained, there is a tendency for employees to consider fringe benefits as part of their pay.

The tax situation is a contributing factor toward encouragement of employers to assume the costs. An employer's payments for benefit programs are a business expense, deductible from the concern's gross income. An employee's payments come out of personal income subject to income taxes. An employer's dollar buys a dollar's worth of benefits, but it takes more than a dollar of an employee's income to buy a dollar's worth of benefits.

### Administrative Arrangements

Employee benefit plans are set up and administered in two ways: by the employer alone or by the employer and the union as part of a welfare fund. Under the first arrangement the employer makes a certain program of insurance benefits available to his employees, paying either the whole cost or that portion over and above specified employee contributions. Where there is no union, the employer decides on the program, chooses the insurance carrier or plan through which benefits will be made available, maintains the contacts with the carrier, and deducts the employees' contributions, if any, from their pay. Where there is a union, the union and the employer together choose the program, determine the level of benefits, and sometimes select the insurance carrier.

Under a welfare fund arrangement, a single employer, or much more commonly many employers, and a union have agreed upon establishment of the fund into which the employer makes specified contributions, usually a certain number of cents per employee-hour worked or a certain percentage of wages paid to workers covered under the agreement. Such funds must be set up in accordance with requirements in the Labor-Management Relations Act of 1947. They must be managed by trustees representing in equal numbers the union and the employer (or employers) with an arrangement for breaking ties in the event of a deadlock. There must be a written agreement stipulating the basis of the employer's contribution, an annual audit of the finances, and separation of money for welfare benefits from that for pension benefits.

Typically, a jointly managed welfare fund results from an areawide or regionwide agreement between a union and all employers of members of that union in the area. Once the fund has been established, its trustees agree on a program of benefits and the vehicle through which the benefits are to be provided.

It has been estimated that of all employees under welfare plans, 92 percent are under employer-administered plans, 7 percent under funds managed jointly by several employers and a union, ½ of 1 percent under funds managed jointly by a single employer and a union, and ½ of 1 percent under wholly union-administered (no employer contributions) plans.

### Trends and Issues

A salient feature of employee health benefit plans is their diversity. Benefits range from meager to fairly comprehensive. The plans are written by perhaps 250 prepayment organizations and 100 or more insurance companies, all with diverse offerings, some with permutations of contracts or policies ranging into the hundreds, and many willing to write virtually any contract requested by an employer, an employee group, or a union.

A major trend has been toward more comprehensive coverage of health services. Prepayment plans and insurance companies, 20 years ago, first offered only hospitalization benefits, and these were limited to 21 or 30 days and were restricted to employees. The contracts were quickly expanded to include dependents. Progressively, they were extended to include surgical and inhospital medical benefits. Hospital benefits were broadened until today some Blue Cross plans and insurance companies will provide complete care for 365 days or longer. There has also been some coverage of physician calls in the office and home, and of X-ray and laboratory services outside the hospital.

Within the last few years there has been a wide sale by insurance companies of major medical expense policies, supplementing the basic hospitalization, surgical, and in some instances medical coverages. These policies typically pay 75 or 80 percent of all medical expense in any illness over and above the benefits provided by the basic policy and a "deductible" of a given amount which the employee must pay himself. More recently, there has been considerable growth of comprehensive medical expense policies, which in effect combine the basic and major medical coverages in a single package. These plans meet 75 or 80 percent of medical expenses in any illness or year over and above an initial deductible amount. The Blue Cross and Blue Shield plans to some extent have developed analogous coverages or have ex-

tended their basic programs to offer more comprehensive coverage.

These developments indicate an awareness on the part of the public of the need for and desirability of prepayment coverage which will provide all-inclusive protection against the cost of serious illness. While further impressive advances in the growth of health insurance may be expected, there are no settled views in this country as to the nature and scope of such programs. Certain fundamental questions must now be faced: How far should health insurance go in providing a completely comprehensive health service? Should it cover physician service in the office and home, nursing care, dental care, drugs, eye care? Should it provide periodic health examinations and preventive services? What is the basic objective of these programs? Is it to provide protection against the risk of heavy medical costs? Is it to make available to people on a convenient budgeting basis all services necessary to prevent illness, maintain health, and care for disease and injury? These initial questions are central to the underlying philosophy of health insurance plans.

Other equally fundamental questions concern the administration and operation of such plans. For example, is it desirable that insurance should provide or make available specified health services, with the insured having no direct payments or charges to pay, or should it be content to pay a major portion of the costs? Are "deductibles" and "co-insurance" necessary to keep utilization of health services within reasonable limits, or can this goal be best achieved by other means? By what means can the costs of hospital and medical services best be held to reasonable levels? Is medical service best and most economically provided through individual practitioners selected by the patient and paid on a fee-for-service basis, or through organized medical groups where physicians work as a team? Does insurance have no concern or every concern with the quality and adequacy of care received by patients?

As yet not even the beginnings of agreement on the answers to these and other questions are apparent.

In this situation employee health benefit plans are playing an important role. These plans marshal the consumers of medical care into cohesive and vocal groups. An employer with tens of thousands of workers and an outlay for health insurance of several million dollars a year has a strong interest in the answer to the questions posed. So does a labor union with hundreds of thousands of members which is bargaining for and shaping a health benefit plan.

Employee health benefit programs are a dynamic factor in the development of health insurance. Large employers and unions are continuing to seek experimental health insurance policies or contracts with broadened coverage and scope of benefits. In some instances, where they find they cannot purchase the broad insurance coverage that they want, they are developing their own self-administered program. In the future, the influence of employee health benefit plans may be expected to extend beyond the worker groups which they cover directly. They may well contribute to the evolution of health insurance plans which will provide more comprehensive benefits to the rest of the population as well. In this way they could help raise the level of protection against the costs of medical care for the Nation as a whole.

#### REFERENCE

(1) Health Insurance Council: The extent of voluntary health insurance coverage in the United States as of December 31, 1956. New York, N. Y., The Council (Association of Casualty and Surety Companies and other associations), 1957.