HMOs and other health plans: coverage and employee premiums

Ten years after the passage of the HMO Act, health maintenance organizations represent a small proportion of employee health plans; benefits are more comprehensive and worker premiums higher than for traditional insurance, but other variables make comparisons difficult

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How do Health Maintenance Organizations (HMOs) compare with traditional health insurers—such as Blue Cross and Blue Shield organizations and commercial carriers—in terms of benefits provided and premiums required of employees? Although HMOs account for a small portion of the individuals with health insurance protection, interest in them has grown in recent years, particularly since the passage of the Health Maintenance Organization Act of 1973.

The Bureau of Labor Statistics' annual surveys of the incidence and characteristics of employee benefit plans in medium and large firms shed considerable light on the comparative coverages provided by HMOs and other sources of health insurance protection. Data from the 1981 study demonstrate that HMOs as a rule provide unlimited hospital-related care for physical ailments—such as room and board, surgical care, and doctors' visits to the hospital—with no charges over subscriber premiums; other health insurers typically curb such benefits through deductible or coinsurance provisions, ceilings on dollar payments, and limits on the maximum number of days of hospitalization coverage.

Differences were also found between HMOs and the traditional health insurers in other areas of health care —visits to physicians' offices, diagnostic X-ray and laboratory work, mental health care in and out of the hospital, care at home and in nursing facilities, prescription drugs, and dental and vision care. In these areas, however, even HMOs may limit the number of days of coverage or include copayment requirements, thereby imposing out-of-pocket charges on subscribers.

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These patterns partly reflect a principal requirement of the HMO Act: Federally qualified HMOs must provide comprehensive care. However, the more extensive benefit schedules generally offered by HMOs commonly result in higher premium payments by employees. It must be emphasized that this review contrasts only plan provisions offered by HMOs and other health insurers and the employee premiums required for each. Overall evaluation of the two approaches to health care must also consider such factors as quality of care and total costs.

The HMO concept

A health maintenance organization provides a wide range of comprehensive health care services to a voluntarily enrolled population. Covered individuals receive care from specified providers for a fixed, prepaid fee, rather than on a fee-for-service basis.[1] There are two basic types of HMOs—the group/staff arrangement and the individual practice association (IPA). The group/staff HMO delivers health services at one or more facilities through groups of physicians working on a salaried or contractual basis. The IPA contracts with physicians in the community, who maintain their own offices and usually are paid by the HMO on an agreed fee-for-service schedule.[2]

Health maintenance organizations differ from traditional insurers in the following key respects:

- HMOs serve both as health care insurers as well as providers of health services to subscribers. Traditional insurers concentrate on financing health care, while insured individuals seek out their own providers.
- HMOs encourage preventive health care by paying for periodic physical examinations. Other health plans typically do not pay for routine physical examinations.

HMO growth

Although the term "health maintenance organization" was not coined until 1970,[3] the concept goes back to a much earlier time. During the latter part of the 19th century and early in the 20th century, prepaid medical care programs for employees, and usually for their dependents, were established in a number of industries, including mining, lumbering, and the railroads.[4] The Nation's largest prepaid group practice—the Kaiser Foundation Health Plan—originated in 1938, when a health care program was established for Kaiser construction workers building the Grand Coulee Dam, in a remote location in Washington. This led to a company-sponsored plan covering Kaiser shipyard workers and their families in 1942 and to a plan open to the community at large in 1945.[5]

The further establishment of HMOs was slowed by a variety of forces, including initial opposition by the medical profession, competition from other health insurers, the costs of establishing an HMO, and reluctance of employees to limit their choice of physicians to a particular group. In the past decade, however, Federal legislation provided the catalyst for individual employers and traditional health insurers, among others, to encourage HMO growth.[6] The Health Maintenance Organization Act of 1973, as amended, greatly stimulated formation of comprehensive prepaid health care programs by:

- Providing grants, loans, and loan guarantees to HMOs.
- Preempting State laws and practices impeding the development and operation of qualified HMOs.
- Requiring an employer to include the option of membership in a qualified HMO in any employee health benefit package—dual-choice—if the employer (1) is covered by the minimum wage provisions of the Fair Labor Standards Act, (2) has at least 25 employees residing within an HMO's service area, (3) has an employee health benefit plan to which the employer contributes, and (4) has received a written request from a qualified HMO for inclusion in the employer's health benefits program.[7]

As described later in this article, requirements for Federal qualification include provision for a comprehensive range of "basic health services."

Enrollment almost doubles

The June 1981 enrollment in HMOs (subscribers and covered dependents) totaled 10.3 million, nearly double the enrollment 7 years earlier. About half of all the HMOs functioning that month were Federally qualified, but they covered 7.3 million subscribers and dependents.[8] Despite this impressive growth, HMO coverage is still quite limited. The 1981 BLS survey of employee benefit plans found 21 million workers under health insurance plans. Three percent participated in HMOs.[9]

Table 1. Percent of health insurance plans[1] by extent of coverage for selected categories of health care, medium and large firms, 1981

Category of health care	Covered in full[2]		Covered with limitations		Not covered	
	HMO	Other	HMO	Other	HMO	Other
Hospital room and board	95	4	5	96	—	—
Hospitalization—miscellaneous services	95	4	5	96	—	—
Extended care[3]	40	1	56	56	4	43
Surgical care	95	28	5	72	—	—
Physician visits—in-hospital	99	6	1	94	—	(4)
Physician visits—office	59	2	41	95	—	3
Diagnostic X-ray and laboratory[5]	84	16	16	84	—	—
Hospital outpatient care	57	7	43	93	—	—
Prescription drugs—non-hospital	10	2	52	95	38	3
Private duty nursing	89	(4)	6	96	5	4
Mental health care	—	—	96	99	4	1
In-hospital[6]	7	(7)	80	(7)	13	(7)
Non-hospital[5]	3	(7)	92	(7)	5	(7)
Dental	4	1	8	50	[8]87	49
Vision[9]	37	2	38	18	25	80

[1] Excludes plans restricted to dental benefits. Two plans combining non-HMO hospitalization care with HMO coverage of other health care categories are treated here as non-HMO plans.

[2] All needed coverage for a specific service is provided at no cost to the subscriber above the regular prepayment fee, that is, there are no copayment, deductible, or coinsurance features or limits on maximum days of coverage. Coverage need not extend to all aspects of a health care category; for example, vision care may be limited to eye examinations and exclude the cost of eyeglasses.

[3] Care provided by a nursing facility or home health care agency.

[4] Less than 0.5 percent.

[5] Charges incurred in the outpatient department of a hospital and outside of the hospital.

[6] Charges for room and board and for physicians' visits.

[7] Separate data were not available for non-HMO coverage of mental health care in and outside of the hospital.

[8] Employer-funded dental care plans frequently supplement these HMOs. Separate dental plans are not in the tabulations.

[9] Excludes care for children only.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in this category.

Although the HMO Act requires many employers to offer a dual choice of health insurance plans, indications are that relatively few workers having the option actually select these prepaid arrangements. BLS Area Wage Surveys conducted during 1980 and 1981 yielded this finding on HMO availability and selection in 51 areas.[10] Typically, office workers were offered and selected HMO coverage to a greater degree than production workers. Moreover, HMOs were more popular in the Western States than in other parts of the country. The following tabulation shows the percent of full-time workers offered coverage and participating in HMO plans (asterisks indicate below 0.5 percent) in eight of the largest areas studied:[11]

Area	*Production workers*		*Office workers*	
	Offered	*Participating*	*Offered*	*Participating*
Boston	41	2	65	8
New York	16	*	42	3
Atlanta	7	*	8	1
Washington	35	4	65	9
Chicago	22	1	38	4
Minneapolis-St. Paul	46	13	64	19
Los Angeles-Long Beach	53	18	60	14
San Francisco-Oakland	66	28	62	25

BLS benefit survey

The Bureau's annual survey of employee benefit plans in medium and large firms—those with at least 50, 100, or 250 workers, depending on the industry—provides a rich data base for comparing HMOs and traditional health insurance plans. Industrial coverage comprises mining; construction; manufacturing; transportation, communications, electric, gas, and sanitary services; wholesale and retail trade; finance, insurance, and real estate; and selected services. An estimated 21.5 million full-time employees were within the scope of the 1981 survey.[12] Because the detailed information collected on health insurance plan provisions includes data on type of insurer, it is possible to contrast benefit coverages provided by HMOs and other insurers.

Approximately 1,300 establishments, employing 4.1 million workers, provided information for the survey. The data in this article relate to the number of HMO and other health plans reported by these establishments. In counting these plans, each HMO in an establishment was treated as a separate "plan." When several establishments in the survey offered the same HMO, each offering was counted as an independent plan. To reduce the effect of such duplication in counting HMOs, data in the accompanying tables show the proportion of HMO plans, rather than the absolute number of HMOs.[13] Participants in other forms of health insurance frequently are covered under basic hospital, surgical, and medical plans, supplemented with a major medical benefit policy. The combined coverages were treated here as single plans.[14]

Coverage patterns

All health insurance plans reported for full-time workers in the 1981 survey had provisions for inpatient and outpatient hospital care and surgical, X-ray, and laboratory benefits (table 1). Provisions for physician care—both in the hospital and in the office—were always included by HMOs and nearly always by other health insurance plans. Similarly, nearly universal inclusion of some private duty nursing and mental health care was found for both HMOs and the traditional insurers.

Significant differences, however, did exist. Extended care in a licensed nursing facility or through home health care services was provided in virtually all of the HMOs, compared with almost three-fifths of the other plans. This largely reflects a requirement of the HMO Act that qualified organizations provide home health care services as part of a package of basic health services.[15] Approximately 86 percent of the HMO plans reported in the 1981 survey were Federally qualified.

Both dental care and prescription drugs—which are not included in the Act's definition of basic health services—are covered more frequently by other insurers. Only 1 out of 8 HMO plans surveyed in 1981 included dental coverage. HMO sponsored dental care—where it exists—is almost always limited to the preventive services of examinations and X-rays. Traditional insurers provide a wider range of coverage, including restorative procedures such as fillings, periodontal care, inlays, and crowns. Quite often HMOs are supplemented by separate employer-financed dental insurance.[16]

Non-HMO health insurance almost always covers at least part of the costs of prescription drugs, commonly under the major medical portion of the plan. In contrast, three-fifths of the HMO plans provided this benefit in 1981. This includes coverage accepted by the employer as an optional, additional premium benefit in the employee health package.

Three-fourths of the HMOs included vision care benefits, compared with one-fifth of the other plans. Generally, however, HMOs with vision care provided only eye examinations, while the traditional insurers usually included eyeglasses and contact lenses, as well as examinations.[17]

Limits to coverage

Table 1 also shows significant differences in the extent of health coverage provided. For many key categories, HMOs usually furnish full coverage; that is, monthly premiums cover the full cost of providing all needed care. In contrast, traditional insurance plans commonly limit the extent of benefits paid by periodic premiums; employees must pay the balance of the bill.

Where HMOs limit coverage, it is usually by a restriction on the number of days for which benefits are provided—either on an annual or per illness basis—or through a requirement for copayments. A copayment is a nominal fee that the HMO subscriber pays when a service is rendered. Copayments serve to reduce premiums and they may tend to discourage overuse of HMO facilities.

As already described, non-HMO health insurance packages commonly combine basic health and major medical insurance. Basic health benefits usually have limits on the number of days of covered services or on the maximum dollar amount payable. Major medical insurance covers expenses which exceed basic benefit limitations and also covers types of expenses not paid for by the basic plan. Major medical insurance almost always includes a deductible—an amount the insured individual must pay before the policy will cover any expenses. The deductible was most commonly $100 a year in 1981, usually with a family limit of $200 or $300.[18] In addition, expenses are shared under major medical insurance (coinsurance), with the insurer commonly paying 80 percent of the total (50 percent for non-hospital mental health care). Usually, there is a lifetime ceiling on insurer payments—generally $250,000 or less.

Except for mental health care, HMOs in 1981 usually provided unlimited coverage of hospital-related care,

Table 2. Percent of health maintenance organization plans with limitations on days of coverage per year and per confinement for selected categories of health care, medium and large firms, 1981

Limit on days of coverage	Care in nursing facility	Mental health care—in-hospital[1]	Mental health care—non-hospital[2]
All HMOs	100	100	100
Benefit not covered	22	13	5
Covered with no limitations	32	12	13
Covered with limitations	47	76	82
Limits days per year	33	67	80
Less than 20 days	—	1	1
20	—	2	65
21–29	—	([3])	8
30	2	34	3
31–44	—	4	—
45	([3])	14	2
46–59	—	—	1
60	5	11	—
61–99	1	1	1
100	21	—	—
Greater than 100	4	1	—
Limits days per confinement	14	8	2
Less than 20 days	—	1	1
20	2	—	1
30	1	3	—
45	—	1	—
60	2	1	—
100	6	—	—
120	1	2	—
125	1	—	—
Greater than 125	1	1	—

[1] Charges for room and board and for physicians' visits.
[2] Charges incurred in the outpatient department of a hospital and outside of the hospital.
[3] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in this category.

such as room and board charges, surgical care, doctors' visits to the hospital, and miscellaneous services (including diagnostic X-rays, drugs, and laboratory work). Except for surgical care, these hospital services were covered in full by less than one-tenth of the non-HMO plans. Non-HMO plans often limited coverage of hospital charges to 120 or 365 days per confinement. Slightly more than a fourth of the traditional insurance plans paid in full the usual, customary, and reasonable charges for surgical care. The most frequent non-HMO limitation on coverage for surgical care was a schedule of maximum payments for individual procedures.

HMOs and traditional insurance plans in varying degrees limited coverage of non-hospital services, including visits to physicians' offices, prescription drugs, extended care in a nursing facility, care in a hospital's outpatient department, and mental health care (both in and out of a hospital). As already observed, HMO limitations often take the form of ceilings on the number of days of coverage or copayment provisions. The traditional plans typically cover non-hospital benefits under major medical provisions only; thus, they are subject to deductible and coinsurance features.

HMO limitations on days of coverage

Mental health care (in and out of the hospital) and extended care in a nursing facility are the major types of health care for which HMOs limit the days of coverage. (See table 2.) Three-fifths of the HMO plans limited mental health coverage in the hospital to 30, 45, or 60 days per year. Outside the hospital, the limit was 20 visits a year in nearly two-thirds of the plans.

As for extended care in nursing homes, three-fifths of the HMO plans providing this benefit limited the length of the stay, expressed on an annual, rather than on a confinement, basis. The most frequent restriction was 100 days.

HMO copayment requirements

As indicated, HMOs may charge subscribers a stated dollar amount per visit—copayment—for services outside the hospital. Table 3 shows the relative frequency and amounts of such copayments in five areas of health care where they are commonly found.

Even in each of these five areas, less than half of the plans in 1981 required copayments. Copayments typically were $1, $2, or $3 for visits to physicians' offices, laboratory tests and X-rays, and vision care. This was also true for such services in the outpatient department of a hospital as physical therapy or chemotherapy. However, outpatient services covering accidents and sickness performed in the emergency room of a hospital or an HMO facility may require a copayment of $10 or $15.[19]

Table 3. Percent of health maintenance organization plans with copayment provisions for selected categories of health care, medium and large firms, 1981

Copayment limits	Physicians' visits—office	Diagnostic X-ray and laboratory—non-hospital[1]	Mental health care—non-hospital[1]	Hospital outpatient care	Vision care[2]
All HMOs	100	100	100	100	100
Category not covered	—	—	5	—	25
Covered with no copayment provision	59	84	50	68	45
Covered with copayment provision (per visit)	41	16	45	32	29
$ 1.00	7	4	4	6	7
$ 1.50	([3])	—	—	—	([3])
$ 2.00	20	6	5	8	9
$ 2.50	—	—	—	—	([3])
$ 3.00	8	2	1	2	2
$ 4.00	4	1	2	1	2
$ 5.00	2	1	7	3	5
$ 7.50	—	—	—	—	1
$10.00	([3])	([3])	5	4	1
$15.00	—	—	5	6	1
$20.00	—	—	7	([3])	([3])
Greater than $20.00	—	—	1	1	—
Other	—	[4]1	[5]7	—	—

[1] Charges incurred in the outpatient department of a hospital and outside of the hospital.
[2] Excludes care for children only.
[3] Less than 0.5 percent.
[4] Plans calling for a copayment of $6.00 for each laboratory and diagnostic procedure and $5.25 for each X-ray.
[5] Plans varying the copayment based on the number of visits.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in this category.

Both copayment requirements for doctors' visits and limitations on the number of visits applied frequently to mental health care outside the hospital. These copayments were often greater than those required for other non-hospital services; charges of $5 or greater per visit were found in one-fourth of the plans. In 7 percent of the plans, the amount of the copayment varied by the number of visits. For example, a subscriber might not be charged for the first 10 visits but was charged $10 for each subsequent visit.

HMO prescription drug plans often require a copayment per prescription, most commonly $1 or $2. However, as the following tabulation shows, coinsurance provisions also applied for 10 percent of the HMO plans (asterisk indicates under 0.5 percent):

	Percent of HMO plans
Total	100
Drugs not covered	38
Drugs covered with no limitations	10
Drug coverage subject to copayment per prescription	37
Less than $1.00	2
$1.00	11
$2.00	15
$2.50	5
$3.00	5
$3.50	*
Drug coverage subject to coinsurance provision	10
Other limitations	4

Prescription drugs were the major category of HMO coverage for which coinsurance provisions applied. The insurer virtually always paid 80 percent of the charge, with the subscriber paying the balance. Other limitations shown above for 4 percent of the plans consisted mainly of annual deductibles of $50 or $100.

Fewer than 10 percent of the HMOs limited coverage through coinsurance features, yearly deductibles, or maximum dollar payments in each of the following benefit areas: extended care in a nursing facility; diagnostic X-ray and laboratory tests outside the hospital; mental health care; outpatient care; and vision care.

Coinsurance provisions, where found, were commonly at the 50-percent level for non-hospital mental health care and at the 80-percent level for in-hospital mental health care and for hospital outpatient services. The few coinsurance requirements for outpatient services usually were accompanied by a $50 or $100 yearly deductible and a ceiling on maximum dollar benefits. These limitations on coverage of outpatient services were generally in HMO plans which did not fully cover hospital room and board. Nine percent of the plans limited vision care by a specified maximum dollar benefit or by a scheduled dollar amount per examination or prescription for eyeglasses.

Employee premiums

Because benefits are more likely to be covered in full by health maintenance organizations, their premium charges may exceed those of traditional insurers. The Health Maintenance Organization Act does not require an employer offering a dual choice of health plans to contribute more toward HMO coverage than toward other health insurance. Consequently, when an HMO's premium exceeds that of a traditional insurance plan, an employee may be required to pay the additional cost of the HMO plan.

Although the BLS employee benefit surveys do not obtain data on employer expenditures, they do collect information on the extent of worker contributions toward the cost of premiums. The 1981 survey found that nearly three-fourths of all non-HMO plans were fully paid for by employers for employee coverage, and just over one-half were noncontributory for dependent coverage. In contrast, about one-third of the HMO plans were noncontributory for employee coverage, and one-fourth for dependents (table 4).

Moreover, when employee contributions were required, they were higher, on the average, for HMO services. Monthly employee premiums in contributory HMO plans averaged $12.77 for employee coverage and $27.21 for dependent coverage. Corresponding figures for non-HMO plans were $7.21 and $18.96. A monthly

Table 4. Percent of health insurance plans[1] by amount of employee premium, medium and large firms, 1981

Employee premiums	HMO plans[2]		Other plans[3]	
	Employee coverage	Dependent coverage	Employee coverage	Dependent coverage
Total plans	100	100	100	100
Noncontributory plans	35	25	72	51
Contributory plans	62	72	28	49
Dollar amount of monthly employee premium:				
Less than $5.00	10	6	11	7
$ 5.00–$ 9.99	19	6	9	10
$10.00–$14.99	13	9	5	7
$15.00–$19.99	7	8	1	5
$20.00–$29.99	9	15	1	7
$30.00–$39.99	3	12	(4)	5
$40.00–$49.99	1	6	—	2
$50.00 or greater	—	8	—	3
Other[5]	—	(4)	(4)	(4)
Amount not determinable[6]	(4)	(4)	1	3
Contributory status not available	3	3	(4)	(4)

[1] Excludes plans restricted to dental benefits. Two plans combining non-HMO hospitalization care with HMO coverage of other health care categories are treated here as non-HMO plans.

[2] Average monthly employee premium in contributory plans was $12.77 for employee coverage and $27.21 for dependent coverage.

[3] Average monthly employee premium in contributory plans was $7.21 for employee coverage and $18.96 for dependent coverage.

[4] Less than 0.5 percent.

[5] Contributions based on percent of employee earnings.

[6] Employee contribution is specified only as a percent of the total premium.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates no plans in this category.

employee premium of $20 or more for individual coverage was found in 13 percent of the HMO plans and in 1 percent of other plans. Similarly, $30 or more for dependent coverage was required in more than one-fourth of the HMO plans and in one-tenth of the other plans.

Consideration of employee *premiums* focuses on just one aspect of total health care *costs* borne by employees. It ignores out-of-pocket employee expenses at the time services are rendered. The BLS survey, however, focuses on benefit provisions and not on usage or its full cost. As noted, full comparison of HMOs and traditional insurers must consider more than cost factors, including quality of care and intangibles such as doctor-patient relations, and the health of the insured. □

FOOTNOTES

[1] For a comprehensive discussion of HMOs, see Robert G. Shouldice and Katherine H. Shouldice, *Medical Group Practice and Health Maintenance Organizations* (Washington, Information Resources Press, 1978). For a briefer introduction, see *A Student's Guide to Health Maintenance Organizations,* DHEW Publication No. (HRA) 79–3 (U.S. Department of Health, Education, and Welfare, Public Health Service, 1978).

[2] A 1981 National HMO Census, covering 243 plans, found that only 15 percent of all participants were enrolled in individual practice association prepayment plans. *National HMO Census 1981,* DHHS Publication No. 82–50177 (U.S. Department of Health and Human Services, Public Health Service, 1982), p. 5.

[3] Credit for the term goes to Dr. Paul M. Ellwood, Jr., president of InterStudy, a research institute on prepaid health plans.

[4] Margaret C. Klem and Margaret F. McKiever, *Management and Union Health and Medical Programs,* Public Health Service Publication 329 (U.S. Department of Health, Education, and Welfare, Public Health Service, 1953), pp. 3–5.

[5] For a more detailed history, see Herman M. Somers and Anne R. Somers, *Doctors, Patients, and Health Insurance* (Washington, The Brookings Institution, 1961), Chapter 17.

[6] The employer viewpoint is presented in Ruth H. Stack, *HMOs from the Management Perspective* (New York, AMACOM, 1979). Labor unions, at the national level, usually support HMOs but, because of possible requirements for employee contributions, local union officials at times have reacted negatively. The overall union viewpoint is in Bert Seidman, "HMOs and Health Care for All Americans," *AFL-CIO American Federationist,* June 1979, pp. 10–11.

[7] 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. Where employees are organized, the HMO offer must be made to the union; the employer's obligation ends if the union rejects the offer.

[8] *National HMO Census 1981,* pp. 1, 5.

[9] *Employee Benefits in Medium and Large Firms, 1981,* Bulletin 2140 (Bureau of Labor Statistics, 1982), p. 27. The BLS study may not be fully indicative of HMO penetration into employee health benefit plans. An analysis by the General Accounting Office of HMO contracts with employers of 25 workers or more found that the percentage of employees enrolled in the HMOs was considerably higher in small than in large firms. See *Can Health Maintenance Organizations Be Successful?—An Analysis of 14 Federally Qualified "HMOs,"* HRD–78–125 (U.S. General Accounting Office, June 30, 1978), pp. 48–49.

[10] The surveys are conducted annually in 70 areas, but questions related to HMO participation were phased into the program over a 3-year period beginning in 1980. The surveys provide data on earnings in selected blue- and white-collar occupations common to a wide variety of industries. Data are also obtained on weekly work schedules and employee benefits, separately for nonsupervisory office workers and for production and related workers (nonoffice). While wage data are collected annually, benefits are studied every 3 years.

[11] For data on each of the 51 areas, see tables B-14 and B-18 in *Area Wage Surveys: Selected Metropolitan Areas, 1980,* Bulletin 3000–72 (Bureau of Labor Statistics, 1982) and *Area Wage Surveys: Selected Metropolitan Areas, 1981,* Bulletin 3010–72 (Bureau of Labor Statistics, 1983).

[12] This employment total excludes executive management, part-time, temporary, seasonal, and operating personnel in constant travel status (for example, airline pilots), who are outside the scope of the survey. The 1981 survey collected data on employee work schedules and developed information on the incidence and detailed characteristics of 11 private sector employee benefits paid for at least in part by the employer: paid lunch and rest periods; holidays, vacations, and personal and sick leave; accident and sickness, long-term disability, health, and life insurance; and private retirement pension plans. Data were also collected on the incidence of 17 other employee benefits, including stock, savings and thrift, and profit sharing plans. Survey findings of general interest are included in annual BLS bulletins (see, for example, *Employee Benefits in Medium and Large Firms, 1981*). More intensive treatment of individual topics—such as the present analysis—appears in *Monthly Labor Review* articles. Tables in the bulletins show the proportion of full-time workers participating in the individual benefit plans studied or covered by specific types of plan provisions. Unlike the simple counts of reported plans in this article, these proportions in the bulletin tables are computed by applying appropriate sample weights to the reports from the individual establishments in the survey. For detailed information on the background and conduct of the survey, see Robert Frumkin and William Wiatrowski, "Bureau of Labor Statistics takes a new look at employee benefits," *Monthly Labor Review,* August 1982, pp. 41–45.

[13] A total of 365 HMO plans within individual establishments was included in the analysis.

[14] Plans restricted to dental benefits were excluded.

[15] The Act defines "basic health services" to include: (1) physicians' services; (2) inpatient and outpatient hospital services; (3) emergency health services; (4) short-term outpatient mental health services; (5) medical treatment and referral services for the abuse of or addiction to alcohol and drugs; (6) diagnostic laboratory and diagnostic and therapeutic radiologic services; (7) home health services; and (8) preventive health services (including immunizations, well-child care from birth, periodic health evaluations for adults, voluntary family planning services, infertility services, and children's eye and ear examinations).

[16] As indicated in footnote 14, such dental-only plans are excluded.

[17] Vision care benefits limited to children are excluded.

[18] *Employee Benefits in Medium and Large Firms, 1981,* p. 24.

[19] Where an HMO varied the copayment by type of outpatient services, table 3 includes the charge for the most common service. If a charge for emergency care was specified, it was tabulated.