

Twenty-Five Years of Employee-Benefit Plans

by ALFRED M SKOLNIK*

The Social Security Administration has prepared annually statistics on coverage, contributions, and benefits under employee-benefit plans, starting with data for 1950. The 25 year series has now been reviewed and revised in accordance with the latest source material. Accompanying the revised data here is a discussion of the characteristics of and trends in health and welfare plans. The June 1976 issue of the Bulletin contained a similar review of private pension plans.

THE YEAR 1974 was one of continuous but cautious growth as far as privately organized employee-benefit plans were concerned. The imminent passage of Federal pension reform legislation introduced an element of uncertainty into the picture that is still continuing. The Employee Retirement Income Security Act, signed by President Ford on September 2, 1974, concentrated on the establishment of minimum standards for retirement plans, but it also contained many provisions with respect to administration and disclosure and fiduciary standards that affected practically every health and welfare plan in the country.¹

In the health field, repercussions from the Health Maintenance Organization Act of 1973² have yet to be determined. This law requires employers (of 25 or more workers) who provide health insurance benefits for their employees to offer them an option to join a health maintenance organization (HMO)—essentially a prepaid group-practice plan in the area—approved by the Secretary of Health, Education, and Welfare. An increasing number of plans are providing such dual options for their employees as the number and geographical dispersion of HMO's increase.

The year 1974 also saw enactment of a man-

dated health insurance program in Hawaii.³ Effective January 1, 1975, the law requires employers to provide protection against the costs of hospital and medical care for their employees. The employer may purchase an insurance policy or arrange for a medical or nonprofit organization either to furnish services to employees or to defray costs or reimburse employees for the expense of health care. The premium cost of the program may be paid entirely by the employer or shared with his employee. The latter's share is limited to not more than 15 percent of his wages.

At the end of 1974, 61 million workers were covered for life insurance and death benefits, 58 million for some type of health care benefits, 31 million for cash sickness benefits, and 30 million for retirement benefits. Except for life insurance, which rose sharply, these figures represent modest coverage increases of 1-2 percent for the year. Much greater increases were registered in aggregate contributions and benefits. Contributions to employee-benefit plans rose by 14 percent and benefits by 16 percent in 1974, the highest annual increases since 1968-70.

An "employee-benefit plan," as defined here, is any type of plan sponsored or initiated unilaterally or jointly by employers or employees and providing benefits that stem from the employment relationship and that are not underwritten or paid directly by government (Federal, State, or local). In general, the intent is to include plans that provide in an orderly predetermined fashion for (1) income maintenance during periods when regular earnings are cut off because of death, accident, sickness, retirement, or unemployment and (2) benefits to meet medical expenses associated with illness or injury. The series thus excludes such fringe benefits as paid vacations, holidays, leave with pay (other than formal sick leave), legal aid, savings and stock-purchase plans, discount privileges, and free meals.

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¹ Alfred M Skolnik, "Pension Reform Legislation of 1974," *Social Security Bulletin*, December 1974, pages 35-42

² Marjorie Smith Mueller, "Health Maintenance Organization Act of 1973," *Social Security Bulletin*, March 1974, pages 35-39

³ Alfred M Skolnik, "Compulsory Health Insurance in Hawaii," *Social Security Bulletin*, December 1975, pages 23-24

Private plans written in compliance with State temporary disability insurance laws are included in the series, but workmen's compensation and statutory provisions for employer's liability are excluded. Severance-pay provisions are included only to the extent that they are linked with the supplemental unemployment benefit plans.

Government employees who are covered by plans underwritten by nongovernment organizations are included in the series, whether or not the government unit contributes (as an employer) to the financing of the program. Specifically included here are plans providing government civilian employees with group life insurance, accidental death and dismemberment insurance, and hospital, surgical, regular medical, and major-medical expense insurance. Retirement and sick-leave plans for government employees, which are financed and administered directly by government, are excluded from the series.

HISTORICAL DATA

Coverage

Table 1 presents a revised historical series on estimates of employee coverage for health, welfare, and retirement benefits. An earlier BULLETIN note revised the estimates for some of the years, and this article carries the series back to 1950.⁴ An explanation of the changes appears in the technical note at the end of the article.

During the 25 years spanned by table 1, the expansion of employee-benefit plans has been impressive, with life insurance and death benefit coverage increasing by 42 million employees, hospital insurance by 33 million, major-medical expense insurance by 28 million, and retirement plans by 20 million. Coverage under life insurance, surgical insurance, and retirement plans has more than tripled since 1950. Among the more recently developed forms of protection such as regular medical expense insurance, major-medical expense insurance, and long-term disability insurance, the growth rate has been even greater. Only in the areas of temporary disability and supplemental unemployment benefits have the

gains been moderate. In most instances, however, the rate of growth has been progressively smaller in each succeeding decade.

A somewhat more significant indication of real growth is provided in table 2 and in chart 1, which relates employee coverage to the entire wage and salary labor force. Almost every type of employee-benefit plan registered coverage gains in the past quarter-century that exceeded the growth in the employed labor force.

This coverage growth was most rapid in the 1950's when employee-benefit plans, under the stimulus of collective bargaining, emerged as a major factor in the security arrangements of the American worker. From 1950 to 1960 the proportion of the employed civilian wage and salary labor force with some type of health insurance through the employment place expanded from one-half to two-thirds, the proportion with group life insurance went from about two-fifths to almost three-fifths. The coverage of private retirement plans during this decade increased from 22 percent to 37 percent of the private wage and salary labor force.

The decade of the 1960's saw a definite slackening off in the growth rate. Health insurance protection moved up to 71 percent of the wage and salary labor force, life insurance to 69 percent, and retirement benefits to 42 percent. Since 1970, this deceleration has continued, with coverage barely keeping ahead of the growth in the labor force, except for life insurance and long-term disability. In the case of hospital expense insurance, surgical expense insurance, and temporary disability plans, the proportion of the labor force covered in 1974 was slightly lower than that in 1970.

In the health area, chart 1 shows that the trend has been more toward providing broadened health care to those already having some health protection than toward extending coverage to larger proportions of new workers. Of those covered for basic hospital expense insurance in 1950, only two-thirds also had surgical expense insurance and only one-third had medical expense insurance. During the following decades, this gap was rapidly closed and by the 1970's almost all persons having hospitalization insurance were also covered for surgical and regular medical expenses. The rapid growth of major-medical expense insurance is another indication of this trend toward

⁴ Alfred M. Skolnik, "Revised Coverage Estimates for Employee Benefit Plan Series," *Social Security Bulletin*, October 1975, pages 18-20.

TABLE 1—Estimated number of wage and salary workers covered under employee-benefit plans¹ by type of benefit, 1950-74

[In millions]

End of year	All wage and salary workers							Wage and salary workers in private industry				
	Life insurance and death ³	Accidental death and dismemberment ⁴	Hospitalization ⁴		Surgical ⁴	Regular medical ⁴	Major-medical expenses ^{4,5}	Temporary disability, including formal sick leave		Long-term disability ⁶	Supplemental unemployment ⁷	Retirement ⁸
			Total ⁴	Written in compliance with law				Total ⁷	Written in compliance with law			
1950	19.4	8.1	24.3	1.2	17.7	8.2	---	20.1	6.6	---	---	9.8
1951	20.8	9.5	27.1	1.4	21.7	10.7	---	21.7	6.8	---	---	10.8
1952	22.3	10.7	28.8	1.5	24.2	12.7	0.2	22.4	7.0	---	---	11.3
1953	24.2	11.8	31.0	1.5	26.9	15.8	5	23.4	7.0	---	---	12.6
1954	25.7	14.0	31.1	1.4	27.8	17.5	8	22.9	6.7	---	---	13.4
1955	28.1	15.6	32.8	1.4	30.2	20.2	2.2	23.5	6.8	---	---	14.2
1956	29.8	17.3	35.1	1.5	32.4	22.0	3.5	24.7	7.2	---	1.0	15.5
1957	31.2	18.4	36.4	1.6	34.2	23.9	4.0	24.9	7.2	---	1.9	16.7
1958	31.7	18.7	36.2	1.4	34.1	24.5	5.9	23.8	6.8	---	1.7	17.2
1959	33.5	19.7	37.2	1.5	35.4	26.1	7.2	24.4	6.9	---	1.9	18.2
1960	34.2	20.9	39.3	1.2	37.4	28.2	8.8	24.5	6.8	---	1.7	18.7
1961	35.5	21.3	39.9	1.1	38.0	29.8	10.3	24.6	6.8	---	1.9	19.2
1962	36.4	22.6	41.0	9	39.0	31.3	11.7	25.3	6.8	---	1.8	19.7
1963	37.8	24.7	42.6	3	40.8	33.3	13.2	23.6	6.2	0.7	1.8	20.3
1964	40.1	26.5	43.9	3	41.8	35.4	14.7	23.9	6.2	1.2	2.0	20.9
1965	41.9	28.4	45.7	3	43.4	38.2	16.6	24.5	6.4	1.9	2.1	21.8
1966	43.5	28.5	47.2	4	45.2	40.2	18.3	25.5	6.6	2.3	2.2	22.7
1967	45.7	30.4	48.7	4	47.0	42.5	20.2	26.0	6.7	3.7	2.2	24.3
1968	48.2	33.7	50.1	4	48.3	43.6	21.7	27.9	6.7	4.6	2.2	24.8
1969	49.0	36.5	52.1	4	50.6	46.1	23.4	29.4	6.9	5.5	2.2	26.0
1970	52.0	38.7	53.1	4	51.5	48.0	24.6	29.7	7.1	7.0	2.0	26.1
1971	53.5	39.2	53.2	4	51.7	48.3	25.7	30.0	6.9	7.9	2.0	26.4
1972	55.6	40.7	54.2	4	52.9	49.4	26.4	31.0	7.1	9.5	2.1	27.5
1973	57.8	42.7	56.8	4	55.4	53.7	27.6	31.5	7.2	10.6	2.3	29.2
1974	61.1	44.3	57.6	4	56.1	54.9	28.2	31.1	7.0	11.1	2.2	29.8

¹ Plans whose benefits flow from the employment relationship and are not underwritten or paid directly by government (Federal, State, or local). Excludes workmen's compensation required by statute and employer's liability.

² Group and wholesale life insurance coverage based on data from Institute of Life Insurance, *Group Life Insurance and Group Annuity Coverage in the United States*, annual issues, modified to exclude group plans not related to employment, excludes coverage under servicemen's group life insurance plan. Self insured death benefit plan coverage based on data for various trade-union, mutual benefit association, and company-administered plans.

³ Data from Health Insurance Association of America, *Group Health Insurance Coverages in the United States*, annual issues.

⁴ Data from "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, March 1976, Health Insurance Association of America (see footnote 3), and Health Insurance Institute, *Source Book of Health Insurance Data, 1975-76*. Data modified to exclude participants not actively employed and to allow for duplication resulting from participation in more than one plan, using benchmark data from a special household survey of employed workers conducted in conjunction with the April 1972 Current Population Survey. Data for hospitalization, surgical, and regular medical coverage adjusted to include employees covered by group comprehensive major medical expense insurance.

⁵ Includes private hospital plans written in compliance with State temporary disability insurance law in California, shown separately in next column.

⁶ Represents coverage under group supplementary and comprehensive major-medical insurance underwritten by commercial insurance carriers.

⁷ Includes private plans written in compliance with State temporary disability insurance laws in California, Hawaii, New Jersey, and New York, shown separately in next column. Data from *A Survey of Accidental and Health Coverage in the United States* (Health Insurance Council, 1950), Health Insurance Association of America (see footnote 3), and Health Insurance Institute (see footnote 4), adjusted to exclude credit accident and health insurance. Data for 1950 modified slightly to adjust for effect of State temporary disability insurance laws on formal paid sick leave and self insured plan coverage. Before 1963, includes group long-term disability.

⁸ Data from Health Insurance Institute (see footnote 4).

⁹ Based on trade union and industry reports and "Financing Supplemental Unemployment Benefit Plans," *Monthly Labor Review*, November 1969. Excludes dismissal wage and separation allowances, except when financed from supplemental unemployment benefit funds covering temporary and permanent layoffs.

¹⁰ Estimated by the Social Security Administration from data furnished primarily by the Institute of Life Insurance and the Securities and Exchange Commission. Data adjusted for duplication resulting from participation in more than one plan and the vesting of benefits, using benchmark data from a special household survey of employed workers conducted in conjunction with the April 1972 Current Population Survey. Includes pay-as-you-go and deferred profit-sharing plans, plans of nonprofit organizations, union pension plans, and railroad plans supplementing the Federal railroad retirement program. Excludes pension plans for Federal, State, and local government employees, tax sheltered annuity plans, and plans for the self employed. Data exclude beneficiaries.

broadening the base of health insurance protection. By 1974, almost one-half of those with hospital protection were covered for catastrophic medical expenses,⁵ in 1960, the ratio had been one-fifth.

There is evidence that employee-benefit plans for State and local government employees have been enjoying much greater growth than that

of employees in private industry. According to data compiled by the quinquennial Census of Governments, the number of full-time employees of State and local governments with life insurance quadrupled in 10 years—from 1.0 million in 1962 to 4.0 million in 1972. Those with some form of health insurance more than tripled—from 1.8 million to 5.7 million.⁶

⁵ Data on major-medical expense insurance refer exclusively to plans underwritten by commercial insurance companies and exclude Blue Cross-Blue Shield plans of this type.

⁶ Andrea Novotny, *Group Life and Health or Hospital Insurance Coverage of State-Local Government Employees, October 1972* (Research and Statistics Note No. 19), Social Security Administration, Office of Research and Statistics, 1975.

TABLE 2—Coverage and contributions under employee-benefit plans,¹ by type of benefit, in relation to employed wage and salary labor force and payroll, 1950-74

Year	Life insurance and death	Accidental death and dismemberment	Hospitalization	Surgical	Regular medical	Major-medical expense	Temporary disability, including formal sick leave	Long-term disability	Supplemental unemployment	Retirement	
	Covered employees as percent of all wage and salary workers ²						Covered employees as percent of wage and salary workers in private industry ³				
1950	38.8	16.2	48.6	35.4	16.4	---	46.2	---	---	22.5	
1951	39.5	17.9	51.4	41.2	20.2	---	47.1	---	---	23.5	
1952	41.7	19.9	53.7	45.1	23.8	0.4	48.1	---	---	24.3	
1953	44.2	21.5	56.5	49.1	28.9	0.9	49.0	---	---	26.4	
1954	48.2	26.2	58.2	52.0	32.7	1.5	49.5	---	---	29.0	
1955	50.8	28.2	59.3	54.6	36.6	4.0	49.1	---	2.1	29.6	
1956	52.2	30.2	61.4	56.7	38.6	6.2	50.1	---	4.0	31.4	
1957	54.3	32.1	63.2	59.5	41.6	8.7	50.2	---	3.8	33.7	
1958	56.4	33.3	64.4	60.7	43.6	10.5	49.5	---	3.5	35.8	
1959	57.7	34.0	64.1	61.0	45.1	12.4	49.2	---	3.8	36.7	
1960	57.8	35.3	66.5	63.3	47.7	14.8	48.7	---	3.4	37.2	
1961	60.0	35.9	67.3	64.2	50.4	17.3	49.0	---	3.8	38.3	
1962	60.0	37.2	67.4	64.2	51.5	19.2	49.2	---	3.5	38.3	
1963	61.2	39.9	68.9	65.9	53.9	21.3	45.3	1.4	3.5	38.9	
1964	63.3	41.8	69.2	66.0	55.8	23.2	44.8	2.3	3.8	39.2	
1965	63.7	43.1	69.4	65.9	58.0	25.2	44.3	3.4	3.8	39.5	
1966	62.8	41.2	68.2	65.3	58.1	26.4	44.1	4.0	3.8	39.3	
1967	64.6	42.9	68.7	66.4	60.0	28.5	44.2	6.3	3.7	41.2	
1968	66.2	46.3	68.9	66.3	59.9	29.8	46.1	7.6	3.6	41.0	
1969	65.4	48.7	69.5	67.5	61.5	31.3	47.1	8.9	3.5	41.7	
1970	69.3	51.5	70.7	68.6	63.9	32.7	47.9	11.2	3.2	42.1	
1971	71.0	52.0	70.6	68.6	64.1	34.1	48.5	12.8	3.2	42.6	
1972	71.6	52.4	69.8	68.1	63.6	34.0	48.6	14.8	3.2	43.1	
1973	71.4	52.7	70.1	68.4	66.3	34.0	47.2	15.9	3.4	43.7	
1974	74.2	53.7	69.9	68.1	66.5	34.3	45.9	16.4	3.2	44.0	
	Employer and employee contributions as percent of all wages and salaries ⁴						Employer and employee contributions as percent of wages and salaries in private industry ⁵				
1950	0.34	0.01	0.40	0.21	---	---	0.41	---	---	1.67	
1951	0.32	0.01	0.45	0.25	---	---	0.45	---	---	1.87	
1952	0.35	0.02	0.50	0.28	---	---	0.45	---	---	1.95	
1953	0.37	0.02	0.57	0.32	---	---	0.47	---	---	2.12	
1954	0.39	0.02	0.65	0.37	---	0.01	0.48	---	---	2.17	
1955	0.44	0.02	0.69	0.38	---	0.02	0.49	---	0.02	2.19	
1956	0.46	0.02	0.73	0.41	---	0.04	0.48	---	0.07	2.23	
1957	0.47	0.02	0.79	0.45	---	0.07	0.52	---	0.09	2.38	
1958	0.51	0.03	0.84	0.47	---	0.12	0.53	---	0.06	2.45	
1959	0.52	0.03	0.90	0.48	---	0.14	0.52	---	0.06	2.52	
1960	0.54	0.03	0.96	0.49	---	0.18	0.53	---	0.05	2.46	
1961	0.58	0.03	1.05	0.54	---	0.24	0.53	---	0.04	2.47	
1962	0.58	0.03	1.10	0.56	---	0.26	0.54	---	0.06	2.40	
1963	0.62	0.03	1.15	0.56	---	0.28	0.54	---	0.06	2.53	
1964	0.63	0.03	1.20	0.58	---	0.30	0.51	---	0.04	2.68	
1965	0.64	0.03	1.24	0.60	---	0.31	0.54	---	0.04	2.86	
1966	0.62	0.03	1.19	0.60	---	0.31	0.55	---	0.04	2.89	
1967	0.62	0.03	1.15	0.62	---	0.32	0.56	---	0.03	2.99	
1968	0.65	0.04	1.23	0.65	---	0.36	0.63	---	0.03	3.02	
1969	0.65	0.04	1.28	0.68	---	0.38	0.66	---	0.03	3.11	
1970	0.68	0.04	1.44	0.76	---	0.44	0.71	---	0.03	3.25	
1971	0.69	0.04	1.63	0.80	---	0.47	0.71	---	0.03	3.66	
1972	0.71	0.04	1.56	0.84	---	0.58	0.76	---	0.03	3.74	
1973	0.64	0.04	1.55	0.87	---	0.60	0.71	---	0.03	3.82	
1974	0.63	0.04	1.54	0.95	---	0.62	0.70	---	0.03	4.15	

¹ See footnote 1, table 1

² Coverage of private and public employees related to average number of private and government full-time and part-time civilian employees (82.5 million in 1974) from table 6.8 in *Benchmark Revision of National Income and Product Accounts*, Department of Commerce, 1976 (in press)

³ Coverage of private employees related to wage and salary employed labor force in private industry (67.7 million in 1974) from Department of Commerce (see footnote 2)

⁴ Amounts for private and public employees related to private and government civilian wages and salaries (\$740.7 billion in 1974) from table 6.6 from Department of Commerce (see footnote 2). Data for contributions for surgical and regular medical benefits not available separately

⁵ Amounts for private employees related to wages and salaries in private industry (\$603.0 billion in 1974) from table 6.6 from Department of Commerce (see footnote 2). Includes contributions for long-term disability

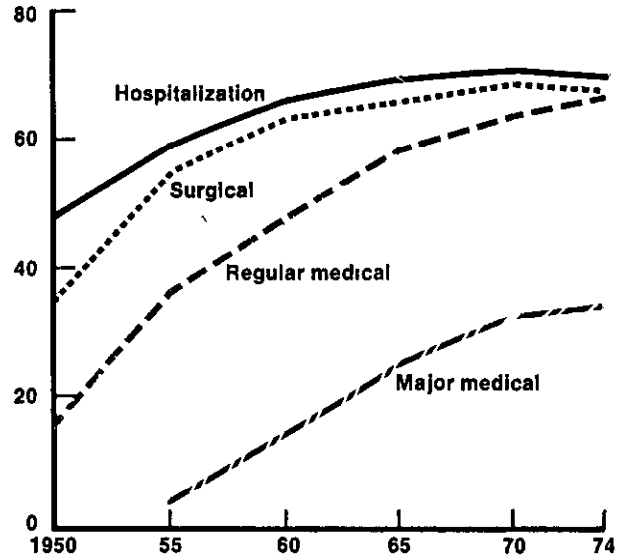
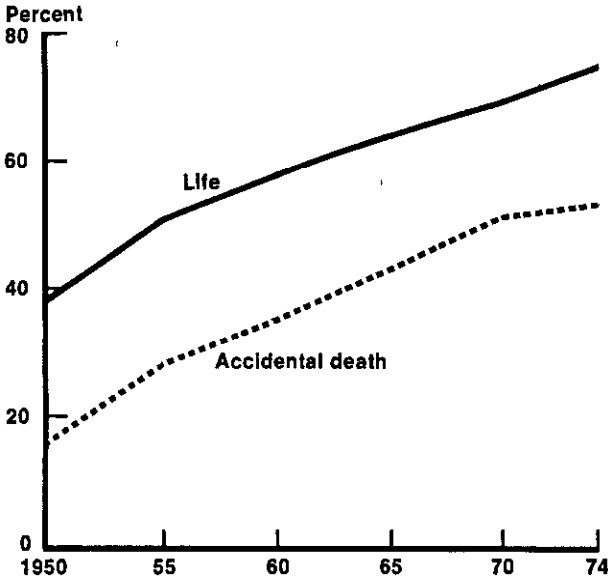
In terms of the labor force covered, the proportion of State and local government employees with health insurance rose from 1 out of 3 in 1962 to 2 out of 3 in 1972. Life insurance covered one-fifth of the State and local government labor force in 1962 and almost one-half in 1972.

Contributions

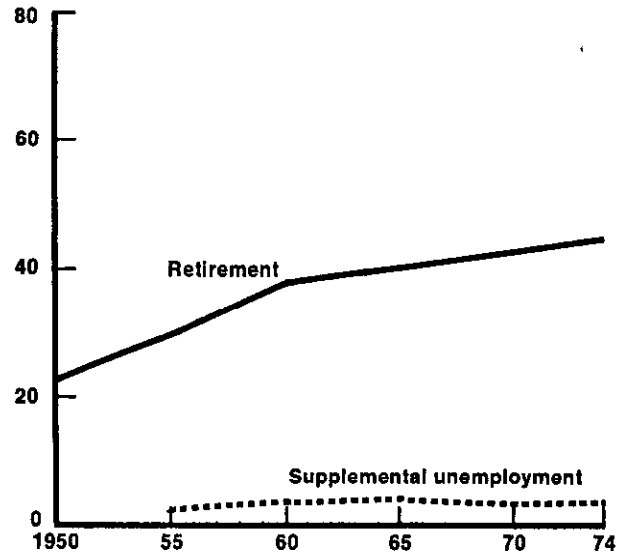
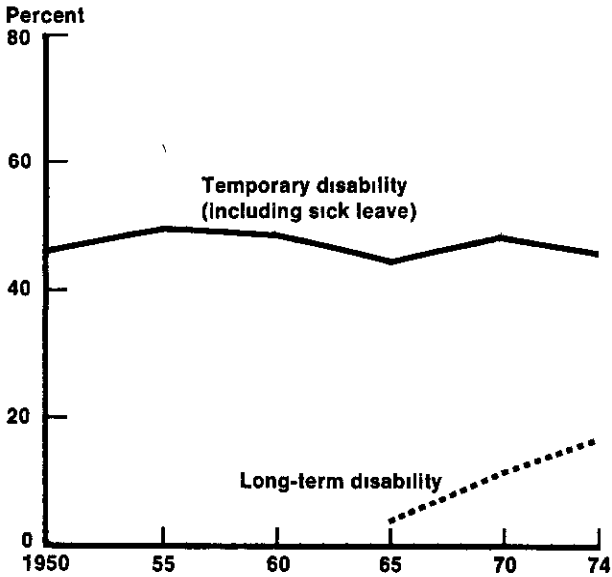
Employer-employee contributions to employee-benefit plans were some \$7 billion higher in 1974 than in 1973 (table 3). The estimated \$57.5 billion contributed in 1974 was 14.2 percent greater than the 1973 total and represented the largest relative

CHART 1—Workers covered under employee-benefit plans as a percent of employed wage and salary labor force, 1950–74

All Wage and Salary Workers



Wage and Salary Workers in Private Industry Only



annual increase since 1968. Inflation was undoubtedly one of the factors at work. Another was the liberalization of benefits. The largest increase—18.6 percent (\$3.9 billion)—took place, however, among retirement plans—an indication that some of the rise may have reflected attempts to replenish the assets of plans whose market value had declined. The market value of the

assets of all noninsured plans dropped from \$154.4 billion in 1972 to \$111.7 billion in 1974, according to the Securities and Exchange Commission. The 1974 increases in contributions, excluding those of retirement plans, ranged from 7 percent for life insurance plans to 13 percent for health insurance plans.

The following tabulation shows that aggregate

Type of benefit	Average annual rate (percent) of growth in contributions		
	1950-60	1960-70	1970-74
Total ¹	12 3	10 8	13 3
Life insurance ²	11 5	9 8	7 2
Health.....	17 4	12 5	13 5
Disability.....	8 9	10 0	8 5
Retirement.....	10 2	9 8	15 6

¹ Includes supplemental unemployment benefits
² Includes accidental death and dismemberment

contributions increased at a faster pace during the 1950's than during the 1960's, reflecting the more rapid extension of coverage during the earlier period. Then, in the 1970's, the slackening growth in numbers covered was more than offset by the higher amounts needed in a period

of escalating costs to provide a specified level of benefits per individual. As a result, the overall annual growth rate in the 1970's exceeded that of the 1950's.

The growth rate of contributions has varied, however, for the different types of benefits. Contributions for life insurance and temporary and long-term disability rose at a little over half the rate of those for health and retirement benefits during the 1970's. During the 1960's the variation among plans was much narrower, and in fact pension plans during the 1950's and 1960's had annual increases below the overall averages. Contributions to health plans remained, however, consistently above the overall average.

Table 2, which relates contributions to the

TABLE 3—Estimated total employer and employee contributions¹ under employee-benefit plans,² by type of benefit, 1950-74

[In millions]

Year	Total	All wage and salary workers						Wage and salary workers in private industry			
		Life insurance and death ³	Accidental death and dismemberment ⁴	Health benefits				Temporary disability, including formal sick leave		Supplemental unemployment benefits ⁵	Retirement ⁶
				Total	Hospitalization ⁷	Surgical and regular medical ⁸	Major medical expense ⁹	Total ³	Written in compliance with law		
1950	\$3,940 0	\$480 0	\$18 4	\$856 3	\$562 4	\$293 9	---	\$505 3	\$75 9	---	\$2,080 0
1951	4,986 4	524 4	23 2	1,139 1	727 2	411 9	---	639 7	143 8	---	2,680 0
1952	5,678 8	619 8	27 0	1,373 4	880 5	492 9	---	686 6	155 8	---	2,970 0
1953	6,629 8	693 6	31 2	1,663 8	1,070 8	593 0	---	766 2	186 5	---	3,475 0
1954	6,988 5	731 5	33 5	1,923 6	1,221 4	684 2	---	784 9	178 1	---	3,535 0
1955	7,856 6	880 5	43 4	2,193 6	1,385 1	769 5	\$18 0	859 1	178 8	\$40 0	3,840 0
1956	8,910 5	1,002 0	49 7	2,594 7	1,603 2	897 5	94 0	914 1	177 1	---	4,225 0
1957	10,041 7	1,076 9	56 5	2,995 8	1,805 5	1,021 3	169 0	1,022 5	217 2	---	4,720 0
1958	10,520 6	1,179 0	60 9	3,286 4	1,944 9	1,075 5	206 0	1,049 3	232 3	---	4,820 0
1959	11,714 5	1,291 7	66 0	3,774 2	2,230 3	1,186 9	357 0	1,097 6	232 8	---	5,360 0
1960	12,580 1	1,416 2	70 0	4,257 0	2,504 8	1,282 2	470 0	1,178 9	238 8	---	5,490 0
1961	13,482 4	1,556 6	75 0	4,924 2	2,833 9	1,439 6	651 0	1,214 6	255 3	---	5,610 0
1962	14,768 4	1,677 1	80 0	5,507 9	3,159 0	1,595 9	753 0	1,311 4	255 4	---	6,030 0
1963	15,880 6	1,867 0	82 0	5,993 3	3,472 2	1,684 1	837 0	1,360 3	244 4	---	6,420 0
1964	17,657 4	2,043 6	99 0	6,725 7	3,884 6	1,876 1	965 0	1,397 1	238 0	---	7,290 0
1965	19,918 3	2,233 0	116 0	7,520 0	4,332 8	2,109 2	1,078 0	1,573 8	258 4	---	8,360 0
1966	21,682 6	2,375 7	131 0	8,041 5	4,546 8	2,299 7	1,195 0	1,754 4	280 1	---	9,250 0
1967	23,410 0	2,538 0	142 0	8,548 8	4,702 7	2,552 1	1,294 0	1,897 2	310 6	---	10,180 0
1968	26,888 8	2,936 5	169 0	10,075 6	5,539 4	2,915 2	1,621 0	2,332 7	342 0	---	11,250 0
1969	30,568 9	3,221 9	190 0	11,594 8	6,341 4	3,363 4	1,890 0	2,702 2	399 1	---	12,750 0
1970	34,873 0	3,566 5	224 0	13,877 6	7,569 3	3,998 3	2,310 0	3,074 9	417 4	130 0	14,000 0
1971	39,792 1	3,853 9	229 0	15,702 7	8,578 4	4,489 3	2,635 0	3,226 5	442 8	140 0	16,840 0
1972	45,299 7	4,323 2	283 6	18,248 2	9,527 5	5,152 3	3,568 4	3,749 7	499 3	155 0	18,540 0
1973	50,370 5	4,368 7	302 8	20,500 2	10,512 0	5,937 8	4,050 4	3,938 8	522 2	160 0	21,100 0
1974	57,512 0	4,684 6	329 2	23,068 1	11,437 2	7,022 4	4,608 5	4,250 1	517 1	160 0	25,020 0

¹ Excludes dividends in group insurance

² See footnote 1, table 1

³ Group and wholesale life insurance premiums based on data from Institute of Life Insurance, *Group Life Insurance and Group Annuity Coverage in the United States*, annual issues, modified to exclude group plans not related to employment. Also excludes premiums for servicemen's group life insurance. Self-insured death benefit costs based on data for various trade union, mutual benefit association and company administered plans.

⁴ Data from Health Insurance Association of America, *Group Health Insurance Coverages in the United States*, annual issues.

⁵ Data from "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, March 1976, and Health Insurance Association of America (see footnote 4). In estimating contributions for employees under plans other than group insurance and union and company plans, it was assumed that the proportion of subscription income attributable to employed groups increased gradually from 75 percent in 1950-60 to 85 percent in 1974.

⁶ Includes private hospital plans written in compliance with State temporary disability insurance law in California, separate data not available for these plans.

⁷ Represents premiums for group supplementary and comprehensive

major-medical insurance underwritten by commercial insurance carriers. Data from Health Insurance Association of America (see footnote 4).

⁸ Data from "Cash Benefits for Short Term Sickness, 1948-74," *Social Security Bulletin*, July 1976. Includes private plans written in compliance with State temporary disability insurance laws in California, New Jersey, and New York, shown separately in next column. Includes contributions under long term disability policies.

⁹ Based on trade-union and industry reports, and "Financing Supplemental Unemployment Benefit Plans," *Monthly Labor Review*, November 1969. Excludes dismissal wage and separation allowances, except when financed by supplemental unemployment benefit funds covering temporary and permanent layoffs.

¹⁰ Estimated by the Social Security Administration from data compiled by the Institute of Life Insurance, *Pension Facts 1975*, and the Securities and Exchange Commission, *1974 Survey of Private Noninsured Pension Funds*. Includes contributions to pay-as-you-go and deferred profit sharing plans, plans of nonprofit organizations, union pension plans, and railroad plans supplementing the Federal railroad retirement program. Excludes contributions to plans for Federal, State, and local employees, to tax-sheltered annuity plans, and to plans for the self-employed.

total wage and salary bill of the Nation, also demonstrates how contributions have been accelerating for retirement and health benefits in recent years. For retirement benefits, employer and employee contributions advanced from \$3.25 per \$100 of payroll in private industry in 1970 to \$4.15 in 1974. Before 1970, a cumulative increase of this magnitude—90 cents—had not been registered for 13 years. Similarly, for health insurance, contributions rose \$1.02 per \$100 of all wages and salaries from 1967 to 1974. For the previous 7 years, the increase had been only 46 cents. In contrast, contribution rates for life insurance and temporary disability plans have shown no unusual accelerations in the past few years.

Benefits

Benefits payable under all types of employee-benefit plans rose at even a faster pace than contributions in 1974. The estimated total of \$41.9 billion disbursed was 16 percent larger than the \$36.1 billion expended the previous year (table 4). Benefits for health and retirement again led the way with increases of 17 percent and 15 percent, respectively. The 17-percent increase for health was the greatest since 1970 and reflects in part the lifting of mandatory economic controls for the health industry in April 1974. As the following tabulation shows, retirement

Type of benefit	Average annual rate (percent) of growth in benefits		
	1950-60	1960-70	1970-74
Total ¹	15.6	12.8	12.7
Life insurance ²	12.6	9.5	8.2
Health	18.6	13.1	12.5
Disability	9.7	9.4	8.5
Retirement	16.6	15.6	15.1

¹ Includes supplemental unemployment benefits
² Includes accidental death and dismemberment

benefits have been expanding at a faster pace than health benefits since 1960, with benefits for life insurance and disability showing the least expansion—about 8-9 percent per year.

The figures above also show that for every major type of program, benefit outlays have been increasing at a slackening rate. Even the average annual increases for health and retirement bene-

fits were lower in the 1970's than in the 1960's, in contrast to the contribution pattern.

The relative growth of health and retirement benefits is reflected in the growing proportion of the benefit dollar that is going for these purposes. As chart 2 shows, in 1950 health benefits accounted for \$4 out of every \$10 expended under employee-benefit plans and retirement benefits for \$2 of every \$10. By 1974, health benefits accounted for more than \$5 out of \$10 expended and retirement benefits for \$3 out of \$10.

In contrast, expenditures for life insurance and temporary disability as a proportion of total disbursements dropped more than half during this period. Supplemental unemployment benefits (SUB), since they were first established in 1955, have never accounted for more than a small fraction of the total. In 1974, however, as the fuel shortage cut into automobile production, the amounts expended under SUB plans were almost quadruple the amounts in the previous year.

CHARACTERISTICS OF HEALTH PLANS

Health plans are designed to help workers and their dependents meet the cost of hospital services, physicians' charges for surgery and non-surgical care in and out of the hospital, drugs, nursing care, and other medical care items. Historically, separate plans were developed to provide these basic benefits (hospital expense insurance, surgical expense insurance, and regular medical expense insurance) and major-medical expense insurance.

The basic hospital-surgical-medical plans generally pay expenses for specified medical services within limits established for each kind of service. How well a plan covers a particular medical bill depends on the cost and mix of services used in each case.

In contrast, a major-medical plan covers a broad range of expenses, encompassing substantially all services that may be required for the successful diagnosis and treatment of an ailment. This type of plan pays a specified fraction of the whole bill.

Hospital Benefits

Basic hospital benefits may take the form of cash indemnity benefits or service benefits, or a

TABLE 4—Estimated benefits paid under employee-benefit plans,¹ by type of benefit, 1950-74

(In millions)

Year	Total	All wage and salary workers						Wage and salary workers in private industry			
		Life insurance and death ²	Accidental death and dismemberment ³	Health benefits				Temporary disability, including formal sick leave		Supplemental unemployment benefits ⁴	Retirement ⁵
				Total	Hospitalization ^{6, 7}	Surgical and regular medical ⁸	Major medical expense ⁹	Total ⁷	Written in compliance with law		
1950	\$1 815 5	\$310 0	\$16 0	\$708 7	\$477 5	\$231 2	---	\$410 8	\$54 3	---	\$370 0
1951	2 385 4	362 5	16 6	1 011 5	659 6	351 9	---	544 8	113 3	---	450 0
1952	2 748 6	405 3	19 6	1 201 6	790 9	410 7	---	600 1	127 8	---	520 0
1953	3 183 1	463 1	21 9	1 445 9	954 1	491 8	---	632 2	139 7	---	620 0
1954	3 530 6	508 9	25 1	1 642 5	1 079 9	552 6	---	644 1	132 0	---	710 0
1955	4 075 9	581 5	26 1	1 902 9	1 241 8	637 1	---	715 4	135 2	---	850 0
1956	4 829 0	649 7	30 5	2 320 3	1 495 4	757 9	---	823 5	151 2	\$0 0	1 000 0
1957	5 585 3	779 4	36 7	2 722 0	1 714 1	876 9	---	897 2	174 1	20 0	1 140 0
1958	6 274 7	850 0	42 8	3 054 8	1 892 7	929 1	---	901 7	183 7	135 0	1 290 0
1959	6 999 8	918 5	43 0	3 403 8	2 107 6	1 024 2	---	959 5	189 5	75 0	1 540 0
1960	7 812 5	1 017 6	47 3	3 898 2	2 355 0	1 116 2	---	1 038 4	196 4	91 0	1 720 0
1961	8 807 5	1 122 3	53 0	4 481 5	2 675 8	1 243 7	---	1 045 7	201 4	130 0	1 970 0
1962	9 962 7	1 256 5	63 8	5 082 7	3 004 8	1 410 9	---	1 142 7	204 3	102 0	2 330 0
1963	10 848 9	1 341 8	82 5	5 536 2	3 312 4	1 471 8	---	1 241 4	198 2	97 0	2 590 0
1964	12 032 4	1 430 1	88 0	6 241 6	3 730 7	1 641 9	---	1 220 7	191 4	62 0	2 900 0
1965	13 566 7	1 550 0	89 5	7 012 1	4 100 5	1 847 6	---	1 333 1	197 6	62 0	3 520 0
1966	14 965 6	1 706 9	97 0	7 427 5	4 312 0	1 979 5	---	1 462 2	208 4	82 0	4 190 0
1967	16 295 3	1 899 0	101 4	7 836 6	4 389 1	2 141 5	---	1 306 0	222 4	119 0	4 790 0
1968	19 233 9	2 137 1	120 5	9 414 6	5 288 5	2 468 1	---	1 658 0	1 926 7	251 7	5 530 0
1969	22 224 4	2 384 9	128 7	10 984 1	6 128 3	2 993 8	---	1 922 0	2 176 7	281 2	6 450 0
1970	25 984 1	2 483 1	151 4	13 322 7	7 344 0	3 503 7	---	2 415 0	307 2	125 0	7 360 0
1971	29 127 4	2 639 2	170 6	14 961 6	8 253 0	3 959 6	---	2 749 0	310 4	130 0	8 590 0
1972	32 684 4	2 918 8	182 2	16 539 0	8 871 7	4 480 3	---	3 187 0	2 904 4	238 5	10 000 0
1973	36 084 7	3 171 6	211 5	18 266 8	9 646 2	5 185 2	---	3 435 3	3 104 8	353 6	11 220 0
1974	41 852 9	3 359 2	255 7	21 380 6	11 059 0	6 292 6	---	3 527 4	381 6	400 0	12 930 0

¹ See footnote 1, table I

² Group and wholesale life insurance benefits based on data from Institute of Life Insurance, *Life Insurance Fact Book 1975*, modified to exclude group plans not related to employment, excludes benefits paid under the servicemen's group life insurance plan. Self insured death benefits based on data for various trade-union, mutual benefit association, and company administered plans

³ Unpublished data from the Institute of Life Insurance

⁴ Data from "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, March 1976. In estimating benefits paid to employees under plans other than group insurance and union and company plans, it was assumed that the proportion of benefits attributable to employed groups increased gradually from 75 percent in 1950-60 to 85 percent in 1974

⁵ Includes private hospital plans written in compliance with State temporary disability insurance law in California

⁶ Represents benefits paid under group supplementary and comprehensive major-medical insurance underwritten by commercial insurance carriers

⁷ Data from "Cash Benefits for Short Term Sickness, 1948-74," *Social Security Bulletin*, July 1976. Includes private plans written in compliance with State temporary disability insurance laws in California, New Jersey and New York, shown separately in next column. Includes benefits under long term disability plans, not available separately

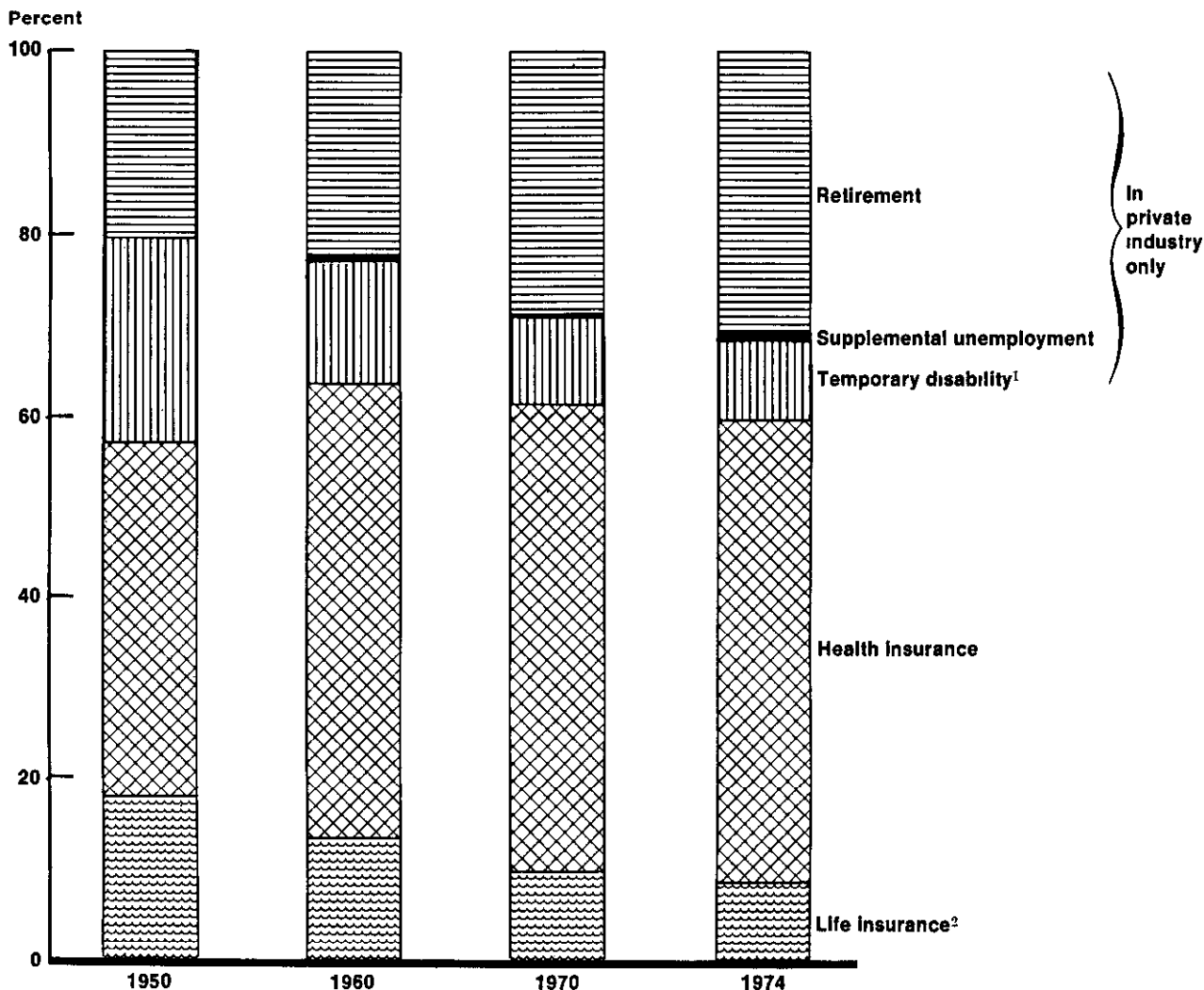
⁸ Based on trade union and industry reports and "Financing Supplemental Unemployment Benefit Plans," *Monthly Labor Review*, November 1969. Excludes dismissal wage and separation allowances, except when financed from supplemental unemployment benefit funds covering temporary and permanent layoffs

⁹ Estimated by the Social Security Administration from data compiled by the Institute of Life Insurance, *Pension Facts 1975* and the Securities and Exchange Commission, *1974 Survey of Private Noninsured Pension Funds*. Includes benefits paid under pay-as-you-go and deferred profit-sharing plans, plans of nonprofit organizations, union pension plans, and railroad plans supplementing the Federal railroad retirement program. Excludes benefits paid under plans for Federal, State, and local employees, under tax-sheltered annuity plans, and under plans for the self-employed

combination of the two Under plans providing for cash indemnity benefits, workers are reimbursed for the cost of (1) room and board up to a fixed amount per day for a specified period and (2) ancillary or "extra" services, usually subject to a dollar limitation, in some cases with part of the cost consured (payment of fees shared by plan and employee) Under plans providing for service benefits, the plan pays the full cost of specified room-and-board accommodations and extra services for a specified period. The combination plans generally pay a cash allowance for room and board and provide specified hospital extras on a service basis. A few plans specify a maximum dollar amount available to pay for all covered hospital services.

Slightly more than half the employees having hospital protection through their job in 1974 were insured through group insurance contracts issued by commercial insurance carriers. Historically, these contracts have provided for cash indemnity benefits, but many now provide service benefits. Forty-four percent of the employees were covered by group contracts issued by non-profit Blue Cross and certain Blue Shield plans. These plans generally provide service benefits. The remaining 5 percent of the employees with hospital expense protection were subscribers to or members of self-insured or "independent" prepayment plans, which usually make their own direct arrangement with hospitals or operate their own hospitals. This distribution by type of

CHART 2—Percentage distribution of benefits paid under employee-benefit plans, by type of benefit, selected years, 1950-74



¹ Including sick leave and long term disability

² Including accidental death and dismemberment

insuring organization has shown little change over the past 15 years

Some indication of the trend in the scope and nature of hospital and other medical care benefits provided by insurance companies may be observed from the continuing sample surveys⁷ made by the

⁷ Health Insurance Institute, *Group Health Insurance Policies Issued in 1960, 1961, Group Health Insurance Policies Issued in 1965, 1966, New Group Health Insurance Policies Issued in 1970, 1971, New Group Health Insurance Policies Issued in 1975, 1976, and New Group Health Insurance Policies Issued in 1975 and The Five Year Trend 1970-1975, 1976*. These surveys obviously do not measure the many improvements that are made in the older, well established plans, often pacemakers in the field

Health Insurance Institute (HII) of new group policies written by commercial carriers during specified periods, usually the first 3 months of the year. The insurance companies participating in the survey account for two-thirds to three-fourths of the health insurance premiums written in the year.

The HII surveys present only part of the picture since they do not include the coverage provided by Blue Cross-Blue Shield plans, independent prepayment plans, and self-insured union-management welfare funds. A study conducted by the Conference Board in late 1972 and 1973 gives data for all kinds of group health

plans (as well as other kinds of employee benefits) that emanate from the employment relationship in the private sector.⁸ About 1,800 companies responded to the health insurance questionnaire. Unlike the HII data, the Conference Board figures are available in terms of plans covered rather than employees affected. The firms surveyed were generally the largest, having in most cases 500 or more employees (except for financial institutions, hotels, restaurants, small manufacturers, and construction firms).

Another source of data is the Bureau of Labor Statistics periodic surveys of health benefits in a selected group of employee-benefit plans, covering varying periods since 1966.⁹ Although these plans are not statistically representative of all health plans, they are generally large plans that tend to reflect current trends in provisions. Plans in the BLS survey include prepayment and self-insured plans, as well as commercial insurance policies and Blue Cross-Blue Shield plans.

The HII surveys show that dollar amounts provided by new group health insurance policies were substantially increased during the past 15 years. From 1960 to 1975, the average maximum daily room-and-board benefit rose from \$15 to \$50. As recently as 1970, only 13 percent of the employees under cash indemnity policies with 25-499 employees had room-and-board benefits of \$50 or more a day. By 1975, this ratio had reached 58 percent. The BLS periodic surveys reported increases in average daily allowances of 75 percent between 1966 and 1971 and of 38 percent between 1971 and 1974.

To a large extent these dollar increases merely reflected rising hospital costs. The difficulties encountered by many plans in keeping their cash allowances up to date has led to a shift away from cash indemnity to full-service benefits, which have the advantage of providing automatic

protection against rising costs. The HII survey shows that in 1965 for employees in new commercially insured plans covering 25-499 employees, only 8 percent were in plans utilizing full-service benefits. In 1975, 41 percent of the employees were being reimbursed in full for room and board.

For ancillary or "extra" hospital services such as the use of the operating room, surgical dressings, drugs, and various laboratory services, a similar shift to service benefits is noted. In 1965, for employees covered by new group insurance policies with 25-499 employees, only 1 percent were being reimbursed in full for hospital extras, according to the HII. By 1975, the ratio was 37 percent. Where maximum dollar amounts were specified, the proportion of employees with maximums of \$600 or more rose from 5 percent to 78 percent during this period. The BLS periodic surveys reported that, by 1974, 78 percent of the plans summarized provided service benefits for room and board and 70 percent for ancillary services.

Another area where real improvements have been registered is in the duration of benefits for hospital confinement. In the HII survey for 1965, 15 percent of the employees in plans with 25-499 employees were covered for a maximum of 120 days or more; in 1975, 38 percent were so covered, with 8 percent eligible for a full year's hospitalization. The Conference Board study found that the median length of hospital stay covered by office and nonoffice employees' plans was 120 days in 1973, about 25 percent of the nonoffice plans offered a year of care as did 20 percent of the office plans.

The BLS conducted a sample survey for the Social Security Administration of 52,000 private industry health plans reported under the Welfare and Pension Plans Disclosure Act. The first results of the survey revealed that 65 percent of the employees covered by basic hospital benefits in 1974 were eligible for hospital benefits of 120 days or more duration and 34 percent for 365 days or more.¹⁰

⁸ Mitchell Meyer and Harland Fox, *Profile of Employee Benefits*, Conference Board Report No. 645, 1974.

⁹ Kevin G. Wetmore, "Improvements in Employee Health Care Benefits," *Monthly Labor Review*, August 1972, and Dennis F. Quigley, "Changes in Selected Health Care Plans," *Monthly Labor Review*, December 1975. The first study analyzed changes in health benefits in 50 plans for office employees and 96 plans for nonoffice employees between 1966 and 1971, the second analyzed changes in essentially the same plans between 1971 and 1974. Both articles were based on the plan summaries published in Bureau of Labor Statistics, *Digest of Insurance and Health Plans*, 1974 and earlier editions.

¹⁰ Daniel N. Price, "Health Benefits for Laidoff Workers," *Social Security Bulletin*, February 1976. This survey, which covered some 28.4 million workers, excludes plans with fewer than 26 participants and plans for government workers and nonprofit organization workers. Only limited data are available from this survey as yet.

This BLS-SSA survey also gathered data on the financing of health benefits. As of 1974, 68 percent of the employees were in plans that were financed solely by employers (noncontributory plans), 28 percent were in plans that were financed jointly by employer and employee (contributory plans), and the remainder were in plans financed exclusively by employees or whose financing could not be determined. The Conference Board survey reported that 74 percent of the basic plans for nonoffice workers and 62 percent of those for office workers were noncontributory in 1973.

Other surveys show a lower proportion of employees in health plans whose benefits are completely paid for by employers. The HII survey reported that 38 percent of the employees surveyed in 1975 were in noncontributory plans. A household sample survey of full-time wage and salary workers with group health plans in April 1972 found that 34 percent were in noncontributory plans.¹¹ When government workers are excluded from that survey, the percentage rises to 38 percent. The HII survey, of course, was limited to new plans underwritten by private insurance companies, and the household survey may have suffered from failure of responding workers to be fully aware of health benefits for which they are not making any contribution.

While the absolute figures may show differences among the surveys, most of the data indicate a continuing shift toward elimination of the employee contribution. This trend was more pronounced in the 1960's than in the 1970's.

Surgical and Regular Medical Benefits

Basic surgical and regular medical expense¹² benefits may be provided on a cash indemnity basis. Under a cash indemnity plan, the employee is reimbursed for the cost of operations in accordance with a fee schedule for individual surgical

¹¹ Walter W. Kolodrubetz, "Group Health Insurance Coverage of Full Time Employees, 1972," *Social Security Bulletin*, April 1974, page 32.

¹² Often termed nonsurgical expense, regular medical expense refers to medical expense of physicians' services other than surgery. Regular medical benefits invariably include protection against the cost of physicians' visits in a hospital and in many cases coverage for visits at home or in the physician's office. Benefits may also apply to out-of-hospital laboratory and X-ray expenses.

procedures. For regular medical expense he is allowed a specified amount for each physician visit at the home, office, or hospital, the allowance is sometimes limited to a fixed amount per day, to a stated number of visits, or to a maximum dollar amount. These amounts do not necessarily cover charges in full, and the employee is responsible for the difference.

Under a service plan, the employee is covered for the full cost of specified services rendered by physicians and surgeons, who are paid directly by the plan. Under the combined service-cash indemnity plan (sometimes called a service plan with an income limitation), employees whose annual income is less than a specified amount (say \$10,000) receive service benefits—that is, the participating physicians and surgeons agree to accept the amount of reimbursement shown in the fee schedule as payment in full for service. Workers whose income is more than the specified amount must pay any differences between the amount provided by the plan and the surgeon's or physician's charges.

Fifty-three percent of all employees with surgical and regular medical expense protection were covered in 1974 through group insurance contracts purchased from commercial carriers. The Blue Shield plans and a number of Blue Cross plans covered 40 percent of the employees who had such protection. The Blue Shield plans generally provide surgical and regular medical expense insurance on a service-cash indemnity basis, the commercial carriers generally furnish cash indemnity benefits.

The remaining 7 percent were covered by independent prepayment plans, many of which are group-practice plans (HMO's). These plans tend to provide a broad range of surgeons' and physicians' services both in and out of the hospital on a service basis. The distribution by type of underwriting organization has remained relatively constant over the past 15 years.

In this area, again, trends can be noted from the HII studies. In 1975, 84 percent of the employees in new group insurance plans with 25-499 employees had available surgical expense benefits of \$500 or more for the most expensive operation listed. In 1970, the ratio had been 55 percent, in 1965 it was 8 percent. The percentage of those with maximum surgical benefits of \$1,000 or more increased from 23 percent in

1970 to 65 percent in 1975. The percentage of employees with maximum benefits of \$8 or more toward the cost of each physician hospital visit rose from 5 percent in 1970 to 31 percent in 1975. Similar increases were registered for in-office and in-home visits. The BLS periodic survey also reported substantial increases in cash allowances from 1966 to 1974.

An increasing number of plans, including Blue Shield plans, are departing from surgical and physician fee schedules with their maximums and providing instead for full payment of reasonable and customary fees. In 1970, 3 percent of the employees under group insurance policies with 25-499 employees had this type of arrangement under surgical plans, and 1 percent of those under regular medical plans. By 1975, the proportion had risen to more than 10 percent under surgical plans and to 8 percent under regular medical plans. The Conference Board study of 1973 reported that 22 percent of the office employees' plans and 28 percent of the nonoffice plans surveyed reimburse for reasonable and customary charges for surgical operations.

Virtually all regular medical expense plans pay for physicians' visits in the hospital, the number paying for doctors' visits in the home or office is much smaller. Both the BLS periodic surveys and the Conference Board study reported that only about a fourth of the plans cover visits in home or office.

Major-Medical Benefits

Major-medical expense insurance¹³ helps pay the costs of illness not covered by the basic insurances, including such items as private-duty nursing care, drugs and medications, medical appliances, and psychiatric treatment. The key element is a "coinsurance" feature, under which the insured person, after paying an initial cash deductible amount (usually \$75-\$100 a year), pays a fixed percentage (usually 20 percent) of

¹³ Some Blue Cross-Blue Shield plans also offer major-medical expense coverage, often under the name "extended benefits." Most prepayment group practice plans also provide "comprehensive care" that includes most of the types of expenses covered by major medical insurance contracts. The discussion here on major-medical expense insurance and the data presented in the tables, however, refer exclusively to the coverage provided by commercial insurance carriers.

all specified medical care expenses. The insurance covers the rest up to a maximum dollar amount—often as high as \$50,000 or more—determined in terms of per disability, per calendar year, or a lifetime maximum or a combination.

Two types of group major-medical insurance are found—supplemental and comprehensive. The former is designed to supplement the basic hospital-surgical-medical insurance, paying out benefits only after benefits under the basic plan are exhausted and a specified "corridor" deductible amount has been paid by the insured. The comprehensive type of major-medical insurance replaces the basic plan completely by combining both the basic and major-medical protection in the same package. The coinsurance features are applied to "basic" as well as "major" medical expenses, though comprehensive plan deductibles are frequently smaller than those imposed by supplemental plans in recognition of the basic plan's absence. Some plans compensate for the lack of a basic plan by paying some expenses in full before applying the deductible.

According to the Health Insurance Association of America, the supplemental type of plan covers most of the employees who have group major-medical insurance—71 percent at the end of 1974.¹⁴ This ratio has varied from 70 percent to 75 percent in the past decade.

As in other health benefit areas, the past few years have seen a significant trend toward higher maximum major-medical benefits. According to the HII studies, 92 percent of the employees covered by new major-medical insurance policies with 25-499 employees in 1975 had annual maximum benefits of \$25,000 or more, compared with 27 percent in 1970.

A trend toward payment of a larger share of charges by major-medical expense plans is also evident. The BLS periodic surveys reported that in 1966, less than one-half of the plans surveyed paid 80 percent of all covered charges above the deductible (most of the remainder paid 75 percent). In 1971, the 80-percent ratio was found in about 5 out of 6 plans; in 1974, in 19 out of 20.

One area where benefits have been deliberalized is the treatment of nervous and mental disorders,

¹⁴ Health Insurance Association of America, *Group Health Insurance Coverages in the United States, 1972-1974* (Bulletin No. 7), December 5, 1975, and earlier editions.

especially out-of-hospital treatment. The HII study shows that in 1965, 91 percent of the employees insured by new comprehensive major-medical contracts with 25-499 employees were covered for such illnesses in full for hospital charges, with reduced or limited benefits when the individual is not confined in the hospital. In 1975 the ratio was 83 percent. For supplementary major-medical contracts the comparable ratios were 83 percent in 1965 and 68 percent in 1975.

Other Health Benefits

The last decade has seen the rapid extension of health insurance to cover new types of health care. In tables 1-4, these new coverages do not appear separately but are submerged as part of surgical and regular medical expense benefits. Nevertheless, some information is available on the characteristics of the separate plans providing dental services, nursing-home services, and prescription drugs.

Group dental health plans that either provide dental services or help to reimburse for the cost of dental services and supplies came into being in the 1950's. Such benefits were first provided by the nonprofit plans of dental service corporations organized by State dental societies. Dental care remained a peripheral employee benefit until negotiations brought the benefits into union-management health and welfare programs using either direct-service clinics or third-party arrangements such as insurance companies. During the period 1971-74, prepaid dental plans covering large numbers of workers and dependents were negotiated by the United Auto Workers, the United Steelworkers, the Amalgamated Meat Cutters, the Aluminum Workers International Union, the United Aerospace Workers, and the Communications Workers of America.

The effects of this activity may be noted from a special survey by the Conference Board, which reported that an estimated 19 percent of the companies surveyed in 1975 had dental plans, compared with 8 percent in 1972.¹⁵ The BLS reported in its periodic surveys that one-fourth of

the plans studied in 1974 reported such benefits. The HII study reported that among employees with new group health policies in 1975, 15 percent had dental insurance coverage. The HII figure excludes plans that cover dental care in their major-medical policies. About one-fourth of the dental plans surveyed by the Conference Board used their major-medical policies to provide the coverage.

Dental insurance plans, which invariably include children and other family members as well as employees, provide coverage in the form of (1) scheduled benefits—with a dollar limit on each procedure performed, (2) comprehensive benefits with coinsurance on covered expenses after an initial deductible (\$25-\$50, usually)—subject to an annual overall dollar maximum, usually \$500-\$1,000, or (3) a combination of scheduled benefits with a deductible (usually \$100) on some or all types of dental expenses and with eligible expenses reimbursed at 80-100 percent.

The HII studies show that for new group dental plans underwritten by private insurers the trend has been toward combination plans, but comprehensive plans are still the most prominent. In 1975, 31 percent of those covered for the first time by dental plans had combination plans, compared with less than 1 percent in 1970. The proportion of employees covered by comprehensive plans dropped from 83 percent in 1970 to 41 percent in 1975. Plans with scheduled benefits covered 28 percent of employees in 1975 and 16 percent in 1970. The Conference Board reported that 29 percent of the dental plans it surveyed in 1975 paid benefits according to a fixed schedule.

The Conference Board study also found that the typical dental plan is fully paid by the company, with the employee's own dental protection more likely to be provided on a noncontributory basis than is dependent's coverage. In 1975, 76 percent of the dental plans provided noncontributory coverage for the employee and 63 percent did so for dependents.

Another rapidly growing type of benefit is nursing-home or extended-care facility coverage. The HII studies showed that the proportion of employees in new group insurance plans that had convalescent or nursing-home care rose from 13 percent in 1970 to 46 percent in 1975. Of those

¹⁵ Mitchell Meyer, *Dental Insurance Plans*, Conference Board Report No. 630, 1976. The 1972 survey queried 1,657 companies, the 1975 survey was based on a 25-percent sample of the 1,657 companies.

with such coverage in 1975, 8 out of 10 had daily room-and-board benefits of \$30 or more, including 4 in 10 with full payment for semiprivate accommodations. In 1970, only 2 out of 10 had room-and-board benefits of \$30 or more, about half of whom had full payment provisions.

Coverage of out-of-hospital prescription drugs is another area where a separate type of health insurance plan has developed. Stimulus came from the 1967 negotiations in the automobile industry, followed by agreements won by the major industrial unions with agricultural equipment manufacturers, tire and rubber companies, and meat packers. The Conference Board study of 1973 found that 7 percent of the nonoffice workers' plans and 4 percent of the office workers' plans had separate prescription drug programs with a separate deductible that may be low enough to allow payment of most drugs. The BLS periodic surveys report that nearly one-fourth of the plans in 1974 had prescription drug programs. Many other plans cover prescription drugs as part of major-medical benefits.

Coverage After Retirement

Most group health plans permit continuation of coverage after retirement either by conversion to an individual policy or plan or by continuing coverage under the group plan. According to the HII studies, out of every 10 employees in new group health insurance plans surveyed in 1975, 4 could continue coverage through conversion and 3 could continue coverage under the group plan. In 1965, coverage had been available under an individual policy of conversion to 7 out of 10 new employees, with 1 out of 10 continuing coverage as a member of the existing group.

The Conference Board study reported that almost half the companies in 1973 extended the coverage of their basic benefits to workers after retirement, with nonoffice employees somewhat less likely than office employees to be covered in retirement. In most cases where the company was providing the employee's own coverage before retirement free of charge, this policy was continued.

The BLS periodic surveys report that 71 percent of the plans in 1974 continued coverage for retirees over age 65. Of the plans with such benefits, more than half used the "benefit carve-

out" method, which provides for retirees over 65 the same benefits provided before age 65 but reduced by the Medicare benefits under the Social Security Act. Nearly 15 percent used the "building block" approach, which covers deductibles, co-insurance, and other charges not covered by Medicare. The remaining plans follow a major-medical approach, under which retirees have the same or modified major-medical benefit received by active employees, or a combination of approaches.

CHARACTERISTICS OF EMPLOYEE WELFARE PLANS

The employee welfare plans described here are those providing for temporary disability insurance and sick leave, long-term disability, life insurance and death benefits, accidental death and dismemberment insurance, and supplemental unemployment benefits. These plans have one characteristic in common. They are designed to provide cash payments to replace lost wages. They are thus unlike the health insurance plans, designed to help finance medical bills, or, less frequently, to provide actual health care.

Temporary Disability Benefits, Including Formal Sick Leave

Protection against loss of earnings during periods of temporary nonoccupational disability may take the form of weekly disability insurance benefits or of paid sick leave. In four States—California, Hawaii, New Jersey, and New York—temporary disability insurance laws make coverage mandatory but permit employees the option of providing protection for their workers through a private plan generally insured by a commercial carrier or through self-insurance.¹⁶ About 23 percent of the Nation's wage and salary workers with private disability coverage are protected by insured or self-insured private plans under these four State laws.

About 70 percent of the employees having

¹⁶ In Rhode Island and the railroad industry, covered employees are compulsorily insured through publicly operated cash sickness funds that do not permit the substitution of private insurance for the government coverage. Puerto Rico has also enacted a temporary disability insurance law, but its program is excluded here because the data in this article are confined to the 50 States and the District of Columbia.

private disability protection are covered for weekly cash sickness benefits through group accident and sickness insurance policies purchased from private insurance companies by employers, unions, employee mutual benefit associations, and union-management trust funds. About 9 percent of the employees are covered by self-insured plans (excluding sick-leave plans), administered by these groups. Under both insured and self-insured plans, the benefits are designed to replace a portion (one-half to two-thirds) of weekly pay for a specified number of weeks (usually 26) per year or per disability. Before benefits begin, an uncompensated waiting period—1 week for sickness—is generally required, for accidents or hospitalization, a shorter waiting period or no waiting period is common.

The remaining employees are covered by formal sick-leave plans that generally provide for the continuance of full wages or salary for a specified number of days or weeks of illness—usually without a waiting period. The role of these plans in providing the exclusive source of protection during sickness has been slowly broadening. During the 1950's they accounted for less than 15 percent of the coverage, but the proportion has risen from 14 percent in 1960 to 21 percent in 1974.

The HII and the Conference Board studies include data on plans providing weekly accident and sickness insurance benefits. The greatest change noted has been the movement to a 26-week maximum duration coverage—partly as a result of the desire to integrate these short-term benefits with long-term disability's typical 180-day waiting period. Weekly maximums have generally been increased in accordance with increases in wages.

The HII study reported that under new group policies covering 25–499 employees, the proportion of employees covered for 26 weeks or more of benefits increased from 40 percent in 1965 to 66 percent in 1975. Almost 8 percent of the employees in 1975 were protected for 52 weeks or more, compared with 3 percent in 1965. The ratio of employees covered by 26-week policies that provide maximum weekly benefits of \$100 or more went from 33 percent in 1970 to 42 percent in 1975.

The 1973 study by the Conference Board reported that about two-thirds of the plans for nonoffice employees limited benefits to 50–70 percent of pay, subject to a dollar maximum that

equaled \$100 or more a week in 27 percent of the plans. Benefits were paid in the case of a normal pregnancy by approximately 40 percent of the plans.

A comparison of manufacturing plans surveyed by the Conference Board in 1964 and in 1973 reveals that, in both years, 55 percent provided a maximum of 26 weeks of benefits. About 20 percent of the 1973 plans extended benefits for longer than 26 weeks (typically for 52 weeks); fewer than 5 percent did so in 1964. As a result, the proportion of plans that limited benefits to only 13 weeks has declined—from approximately 30 percent of the 1964 plans to 15 percent of the 1973 plans.

The Conference Board study also collected data on formal paid sick-leave plans. Fifty-six percent of the nonoffice plans, 50 percent of the office plans, and 38 percent of the managerial plans provided for 1 or 2 weeks' sick leave per year, with the remaining plans providing maximums of longer duration. According to the Conference Board, the duration of sick-leave benefits has apparently changed little.

Forty percent of the nonoffice plans and 33 percent of the office plans surveyed in 1973 allowed an employee to carry sick pay that was not used in a given year over into the next year. Sick-pay benefits were given in the case of normal pregnancy by approximately 25 percent of the plans.

The use of formal sick-leave arrangements to meet the wage-loss problem created by sickness has been growing in importance, and by 1974 such provisions were applicable to more than one-third of all employees with private disability protection, compared with less than a fourth in 1960. Most of these plans, however, were used to supplement insurance benefits payable under group accident and sickness policies, usually by providing payments during the waiting period or by bringing the insurance benefit up to the level of full pay. Only about 40 percent of the employees with sick-leave protection in 1974 relied on paid sick leave as their exclusive source of protection, in 1960 the ratio was almost one-half.

Long-Term Disability

Group long-term disability income plans, which were first developed for managerial and office

employees in the late 1950's, are designed to supplement the short-term protection provided through group accident and sickness insurance policies or sick leave.¹⁷ Benefits usually begin after the employee has been totally disabled for 6 months and continue until age 65. The size of the long-term monthly benefit is generally stated as a percentage of pay (50-60 percent) up to a maximum of \$1,000-\$2,000 per month, less part or all of the disability insurance benefits paid under the Social Security Act or other statutory benefits, such as workmen's compensation.

Both the HII and the Conference Board studies show that the characteristics of these plans have changed little over the years. According to the HII study of new long-term disability policies covering 25-499 employees, benefits were provided until age 65 for 85 percent of the employees in 1965 and 89 percent in 1975. The remaining employees had their benefits limited to a specified number of years or sometimes, in case of accident, continued until death. The proportion of employees in plans that commence to pay benefits after 3-6 months was about 83-84 percent in both years. The Conference Board, likewise, reported in its 1965 and 1973 surveys that most plans pay benefits until age 65 (88 percent in 1973) and require a 6-month waiting period before benefits begin (60 percent in 1973), 23 percent have a 3-month elimination period.¹⁸

As might be expected, what has changed is the maximum available monthly income benefit. According to the HII study, 94 percent of the employees in plans with 25-499 employees in 1975 had a maximum of \$1,000 or more, compared with 76 percent in 1970. The Conference Board reported that in 1973, 46 percent of the plans set the maximum monthly benefit at 60 percent of pay and 29 percent provided for 50 percent of pay. In 1965, 20 percent of the plans had set the maximum at 60 percent and 50 percent at half-pay.

Long-term disability is one of the few benefits paid for completely by employees to any extent.

¹⁷The data in this article on long-term disability refer exclusively to group long term disability policies underwritten by private insurance companies—generally defined as those providing benefit durations of 2 years or more.

¹⁸David A. Weeks, "Long-Term Disability Insurance—Your Next Employee Benefit?" *Conference Board Record*, January 1965, page 19.

The Conference Board reported that employees paid the entire premium in approximately one-fourth of the plans surveyed in 1973. The cost was shared by the employee and the firm in another fourth of the plans, and the firm paid the entire premium in the remaining half. A comparison with the results of the 1965 survey, however, reveals a definite trend toward the company's paying more of the cost of the plan. In 1965 only 25 percent of the plans were non-contributory and 33 percent of the plans required the employee to pay the entire premium.

Life Insurance and Death Benefits

Almost all employees covered through their place of employment against the contingency of death are protected through group life insurance contracts purchased from private insurance companies by employers, unions, mutual benefit associations, and union-management funds. A small number of employees are protected through self-insured benefits, often termed "funeral" or "death" benefits, that are provided by unions or fraternal organizations for their members.

Life insurance policies provide cash benefits to an employee's survivors in the event of his death, whether on or off the job and whether from natural or accidental causes. The protection provided is usually 1-year renewable term insurance, with no cash surrender, paidup, or other nonforfeitable features. The benefit amounts are most frequently graduated according to annual salary (commonly the equivalent of 1-2 years' salary) but may be in flat amounts (the same for all employees regardless of salary) or, occasionally, in amounts related to periods of service or class of employment.

With the growth of pension plans, death benefits have taken other forms. Growing in significance are arrangements for the payment of a lifetime pension to the spouse of a long-service employee who died before retirement, generally when he would otherwise be eligible for an early retirement benefit.¹⁹

Over the past decade the characteristics of group life insurance policies have changed little,

¹⁹For discussion of these benefits, see Alfred M. Skolnik, "Private Pension Plans, 1950-74," *Social Security Bulletin*, June 1976.

except to provide higher benefit levels. For the most part, these higher levels reflect higher wage and salary levels but some trend toward providing greater protection in relation to annual salary is apparent. Thus, the Conference Board study of 1973 found that among salary-graduated plans, the median benefit was approximately twice the base salary, somewhat higher for managerial employees, somewhat lower for employees in negotiated plans. In a 1961 Conference Board study, only 30 percent of similar plans provided coverage of twice the salary or more.²⁰

Among companies providing uniform or flat benefits for nonoffice employees the median benefit in 1973 was \$5,000. In 1961, only 22 percent of a similar group of uniform benefit plans provided coverage of \$5,000 or more. In the latest of these surveys, plans providing uniform benefits, although declining in number, still represent a sizable number (35 percent).

The Conference Board surveys show a strong trend toward noncontributory group basic life insurance plans, with a doubling of the incidence of such plans (to 54 percent) since 1961. This trend is not so pronounced, however, when supplemental or optional life insurance plans are considered. These are plans that make additional life insurance coverage available to workers who are willing to assume all or part of the additional cost.

Group life insurance for dependents of employees—typically in the form of \$1,000 burial policies—remains a minority practice. The 1973 Conference Board study found that 15 percent of the plans surveyed provided such benefits for office employees and 11 percent for nonoffice employees. A 1964 Conference Board study found that 11 percent of the manufacturers surveyed followed this practice.²¹

A majority of plans continue some part of group life coverage for an employee who retired, but the prevalence of this benefit apparently has not increased during the past decade. The Conference Board found that 72 percent of the industrial companies in the 1973 study continued life insurance after retirement, compared with 76 percent of a group of manufacturers in a

1963 study.²² When protection continues after retirement, most plans reduce the amount of insurance on either a gradual or one-time basis.

The Conference Board reports that group life insurance for retired workers has shown a trend toward smaller benefits (as a percentage of pre-retirement coverage) and toward the practice of reducing benefits immediately upon retirement rather than gradually over a span of years following retirement. In 1973, the median postretirement benefit was one-third of the amount of life insurance in effect just before retirement. In the 1963 Conference Board study, the median was usually 50 percent of the preretirement benefit.

As a general rule, the employer pays the entire premium for that part of the coverage continued after retirement. The 1973 Conference Board study showed that 83 percent of the industrial companies paid the full premium for postretirement coverage, compared with 77 percent of manufacturers in 1963.

Accidental Death and Dismemberment Insurance

About three-fourths of the employees covered by group life insurance had accidental death and dismemberment riders²³ attached to their policies in 1974—a moderate increase from the roughly two-thirds of a decade before. These riders provide cash benefits in the event of death or dismemberment caused by accidental means and customarily cover both occupational and nonoccupational accidents.

The amount of the benefit is often the same as that under group life insurance and determined in the same manner, though frequently the maximum is lower. The full amount is paid in the event of accidental death, the loss of the sight of both eyes, or the loss of two members of the body. One half the amount is paid for the loss of the sight of one eye or the loss of one limb.

According to the 1973 Conference Board study, the salary-graduated accidental death and dis-

²⁰ Harland Fox, "Group Life Insurance, 1961," *Management Record*, November 1962, page 6.

²¹ The Conference Board, *Personnel Practices in Factory and Office Manufacturing* (Studies in Personnel Policy, No. 194), 1964, page 99.

²² Harland Fox, "Life Insurance for Retired Employees," *Management Record*, February 1963, page 12.

²³ The data in this article on accidental death and dismemberment insurance refer exclusively to group policies issued by private insurance companies.

membership benefit was identical to the employee's group life insurance coverage in 70 percent of the plans. In a 1961 Conference Board study, the median accidental death and dismemberment benefit was less than the median life insurance benefit²⁴

In addition to higher benefit levels, a trend toward noncontributory plans is noted. Eighty percent of nonoffice workers' plans surveyed by the Conference Board in 1973, for example, required no employee contribution, in 1964 only 57 percent of the plans for blue-collar workers in manufacturing were noncontributory²⁵. A similar shift is apparent for office employees.

Supplemental Unemployment Benefits

Supplemental unemployment benefits (SUB) were first introduced on a large scale in 1955 as a result of union-company negotiations in the automobile industry. During the next few years the plans spread into aluminum, can, gas, maritime, rubber, and steel industries, but since then they have shown little tendency to expand further. The SUB plans in the automobile, rubber, and steel industries are of prime importance since they cover about three-fourths of the workers with such coverage.

Under the automobile plans, for example, the intent is to ensure that combined State and private unemployment weekly benefits will be equivalent (after a 1-week waiting period) to 95 percent of take-home, straight-time pay minus a flat \$7.50 (to take into account work-related expenses such as transportation and lunches, not incurred). After unemployment benefits under the State programs are exhausted, SUB payments are increased in like amount.

The plan is designed to pay benefits for as long as 52 weeks. The employee earns one-half of one "credit unit" for each full week of employment, up to 52 units. One credit unit is good for 1 week's benefit when the fund is fully valued. If the fund is not fully valued then the credit units are deflated according to a table that takes into account, in part, the seniority of the individual applying for benefits.

²⁴Harland Fox, "Group Life Insurance, 1961," *op cit*, page 12.

²⁵The Conference Board, *Personnel Practices in Factory and Office Manufacturing*, loc cit.

SUB benefits are completely financed by employers. In 1974, contribution rates in the auto industry ranged from 7 cents to 12 cents an hour, depending on the level of the fund. In the steel industry the maximum funding figure was 15 cents an hour and the SUB maximum benefit was \$100 a week for an employee without dependents when the employee was receiving State unemployment insurance benefits and \$135 a week when the employee was not receiving such benefits.

Technical Note

The historical series on coverage appearing in table 1 has been revised in accordance with the concepts discussed in "Revised Coverage Estimates for Employee-Benefit Plan Series," in the October 1975 issue of the *BULLETIN*. Differences between the figures published here and in the October 1975 article are mainly due to revisions in the data furnished by the Institute of Life Insurance and the Health Insurance Association of America²⁶.

Estimates on private health insurance coverage for workers are derived from reports of gross enrollment by the Health Insurance Association of America, the Blue Cross Association, the National Association of Blue Shield Plans, and the independent health plans²⁷. Data for individual segments of the health industry are estimated first and then adjusted by the Social Security Administration to exclude workers not actively employed because of sickness, retirement, layoff, or job shifts and to allow for duplication resulting from participation in more than one plan, using benchmark data from a special household survey²⁸ of employed workers in con-

²⁶Health Insurance Institute, *Source Book of Health Insurance Data, 1975-76*, Health Insurance Association of America, *Group Health Insurance Coverages in the United States, 1972-74*, and Institute of Life Insurance, *Group Life Insurance and Group Annuity Coverage in the United States, 1971-74 and Pension Facts, 1975*.

²⁷Marjorie Smith Mueller and Paula A. Piro, "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, March 1976, pages 3-20, and earlier articles in the series.

²⁸Walter W. Kolodrubetz, "Group Health Insurance Coverage of Full-Time Employees, 1972," *Social Security Bulletin*, April 1974, pages 17-35, and "Employee-Benefit Plans, 1972," *Social Security Bulletin*, May 1974, pages 15-21.

junction with the April 1972 Current Population Survey

In estimating employee coverage, the enrollment data are classified by age—those under age 65 and those aged 65 and over. For group commercial health insurance, data on employees under age 65 are from *Group Health Insurance Coverages in the United States*, annual issues. This publication breaks down the enrollment data between employees and dependents. For other plans except union and company plans, the data are first adjusted to exclude nongroup plans (estimated to account for 10–25 percent of gross enrollment) and then the number of covered employees under age 65 are estimated by applying the employee-dependent factor derived from the commercial group insurance data. For group major-medical insurance under commercial policies a further adjustment for duplication between supplementary and comprehensive coverage is made in accordance with information presented in *Source Book of Health Insurance Data, 1975–76*, page 27. Data for employees aged 65 and over are derived from gross enrollment data in the BULLETIN's private health insurance series²⁶ and in the *Source Book*, reduced by roughly five-sixths to exclude dependents and nonworking participants.

The cumulative data thus derived from the individual insurers are then tied in to the benchmark data for 1972, and the data for years before and subsequent to 1972 are estimated by applying to the 1972 benchmark data the percentage changes in the coverage figures reported by the private insurers.

The coverage estimates of private retirement plans are based on gross figures for insured and noninsured plans, adjusted to exclude workers

not actively employed, workers with dual coverage, and workers with vested rights, on the basis of benchmark data from a special survey of pension coverage of employed workers conducted in April 1972.³⁰ Estimates for subsequent years are based on trends indicated by the financial data and worker-beneficiary relationships reported by the Institute of Life Insurance and the Securities and Exchange Commission.

Data on group life insurance coverage from the Institute of Life Insurance are modified to exclude group plans not related to employment. This adjustment is made in accordance with special surveys conducted by the Institute on the extent to which group life insurance protection covers employer-employee groups.³¹

The historical series on contributions and benefits in tables 3 and 4 have also been revised from the data appearing in the May 1975 BULLETIN. For group life insurance, the new, higher estimates take into account the latest data developed by the Institute of Life Insurance on the extent to which group life insurance contributions and benefits refer to employment groups. For temporary disability insurance, the changes take into account (1) additional amounts of contributions and benefits paid under funded self-insured plans, which had been previously underestimated, and (2) revisions in formal paid sick-leave benefit estimates.³² Changes in health insurance estimates primarily involve the updating of preliminary data.

²⁶ See Walter W. Kolodrubetz and Donald M. Landay, "Coverage and Vesting of Full-time Employees under Private Retirement Plans," *Social Security Bulletin*, November 1973, pages 20–30, and the technical note in Alfred M. Skolnik, "Private Pension Plans, 1950–74," *Social Security Bulletin*, June 1976.

³¹ Institute of Life Insurance, *Life Insurance Fact Book, 1974*, page 32, and unpublished data.

³² Daniel N. Price, "Cash Benefits for Short-Term Sickness, 1948–74," *Social Security Bulletin*, July 1976.

²⁸ Marjorie Mueller and Paula Piro, *op cit*