History of Health Insurance Benefits

Employment-based health benefit programs have existed in the United States for more than 100 years. In the 1870s, for example, railroad, mining, and other industries began to provide the services of company doctors to workers. In 1910, Montgomery Ward entered into one of the earliest group insurance contracts. Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase for several reasons. When wages were frozen by the National War Labor Board and a shortage of workers occurred, employers sought ways to get around the wage controls in order to attract scarce workers, and offering health insurance was one option. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: Unions supported employment-based health insurance, and workers' health benefits were not subject to income tax or Social Security payroll taxes, as were cash wages.

Under the current tax code, health insurance premiums paid by employers are deductible for employers as a business expense, and are excluded, without limit, from workers' taxable income.

Below is a compilation of key dates in the history of health insurance benefits as they have evolved in the United States.

- **1789**—Congress establishes the U.S. Marine Hospital Service. The service was funded by compulsory contributions from seamen's wages.
- **1847**—The Massachusetts Health Insurance Company of Boston becomes the first insurer to issue sickness insurance.
- **1849**—New York passes the first general insurance law.
- **1853**—French mutual aid society, La Societe Francaise de Bienfaisance Mutuelle, establishes prepaid hospital care plan in San Francisco.
- **1863**—The Travelers Insurance Company of Hartford, CT, offers accident insurance for railway mishaps (followed by other forms of accident insurance). Travelers was the first to issue insurance resembling today's policies.
- **1870s**—Railroad, mining, and other industries begin to provide company doctors funded by deductions from workers' wages.
- **1877**—Granite Cutters Union establishes first national sick benefit program.
- **1910**—Montgomery Ward & Co. enters into one of the earliest group insurance contracts.
- **1910s**—Physician service and industrial health plans established in the Northwest and remote areas.
- **1912**—National Convention of Insurance Commissioners (now the National Association of Insurance Commissioners) develops first model for state law, the Standard Provisions Law, for regulating health insurance.
- **1913**—International Ladies Garment Workers Union (ILGWU) begins first union medical services.
- **1915-1920s**—Efforts to establish compulsory health insurance programs fail in 16 states.
- **1929**—A group of schoolteachers arranges for Baylor Hospital in Dallas, TX, to provide room, board, and specified services at a predetermined monthly cost. This plan is considered the forerunner of Blue Cross plans.
- **1937**—Blue Cross Commission established.
- **1939**—Revenue Act of 1939 (Sec. 104), establishes employee tax exclusion for compensation for injuries, sickness, or both received under workers' compensation, accident, or health insurance.
1943—War Labor Board rules wage freeze does not apply to fringe benefits.

1945—Kaiser Foundation Health Plan opens to non-Kaiser groups.

1948—McCarran-Ferguson Act gives states broad power to regulate insurance.

1949—Supreme Court upholds National Labor Relations Board ruling that employee benefits are subject to collective bargaining.

1954—Revenue Act of 1954 (Sec. 106) excludes from taxation employers' contributions to accident and health plans benefitting employees, and clarifies that such contributions had always been deductible as business expenses.

1965—Medicare and Medicaid legislation passed as Title XVIII and Title XIX of the Social Security Act.

1968—Firestone Tire and Rubber Co. begins to self-fund health benefits.

1973—Health Maintenance Organization (HMO) Act of 1973 establishes benefit, administrative, financial, and contractual requirements for entities seeking designation as federally qualified HMOs. The act also requires most employers who offer an HMO to offer a federally qualified HMO.

1974—Employee Retirement Income Security Act of 1974 (ERISA) establishes uniform standards that employee benefit plans must follow to obtain and maintain their tax-favored status. ERISA supersedes or preempts all state law otherwise applicable to pension and welfare plans covered by ERISA. ERISA still recognizes the states' role in regulating insurance.

1978—Pregnancy Discrimination Act amends Title VII of the Civil Rights Act of 1964. Requires that employers treat disabilities and medical conditions associated with pregnancy and childbirth the same as other disabilities or medical conditions.

1984—Deficit Reduction Act of 1984 (DEFRA) changes the tax treatment and contribution limits of voluntary employee beneficiary associations (VEBAs) and imposes new nondiscrimination rules for VEBAs similar to those for tax-qualified pension and profit-sharing plans. DEFRA makes Medicare the secondary payer for covered health expenses of workers ages 65-69 who are covered by an employer plan.

1986—Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer continued health coverage to terminated employees and dependents for a specified period (18 or 36 months).

1996—Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets national nondiscrimination and "portability" standards for individual health insurance coverage, HMOs, and group health plans; establishes tax-favored treatment of long-term care insurance. The administrative simplification section of the act calls for regulations on standard electronic formats and for the privacy of personal health information. The act institutes a pilot medical savings account (MSA) program, limited to 750,000 individuals by the year 2000. See Consolidated Appropriations Act of 2001, enacted in 2000, for extension of MSA pilot program.

1996—Mental Health Parity Act requires group plans that offer mental health benefits to provide the same level of coverage for such benefits that they provide for medical and surgical benefits. The act does not apply to groups of fewer than 50 and substance abuse or chemical dependency treatment. The act provides an escape clause for plans in the event plan costs increase more than one percent due to the act. The provisions of this act expired on Sept. 30, 2001, and have not been extended.

1996—Newborns' and Mothers' Health Protection Act requires plans that provide coverage for maternity benefits to provide coverage for a minimum 48-hour (for normal vaginal birth) and 96-hour (for caesarean delivery) inpatient length of stay for a mother and her newborn following delivery. The act also mandates timely post-delivery care when the mother and newborn are discharged prior to the expiration of these minimum lengths of stay.

1997—Balanced Budget Act of 1997 (BBA) provides several health benefits related provisions. Creates Medicare+Choice program. Establishes new guarantee opportunities for Medicare supplement policies in conjunction with the expansion of private plan options. Creates the Children's Health Insurance Program (CHIP), a new state children's health program, modifies Medicaid to increase state flexibility in administering the program, and provides $24 billion in federal funds over five years to support the program.

1998—Omnibus Consolidated and Emergency Supplemental Appropriations Act requires plans to provide coverage for reconstructive surgery after mastectomies.
• 1999—Financial Services Modernization Act of 1999 restricts financial institutions' disclosure of "non-public personal information." Limits the ability of financial institutions to disclose (i) certain information about consumers to nonaffiliated third parties, and (ii) certain information the institutions receive from nonaffiliated third parties. Requires financial institutions to disclose to consumers their policies and practices with respect to information sharing among both affiliated and nonaffiliated entities. Requires that—in certain circumstances—consumers be notified prior to disclosure and given the opportunity to prevent the disclosure of personal information.

• 2000—Electronic Signatures in Global and National Commerce Act of 2000 gives electronic signatures and records the same weight as written signatures and records, which should lead to easier administration of electronic benefit, compensation, and human resources systems.

• 2000—Consolidated Appropriations Act 2001 extends pilot MSA program by two years to Dec. 31, 2002, and renames the program Archer MSAs.